Born into Care: Developing Best Practice Guidelines for when the State Intervenes at Birth

Review of current guidance documents

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About this review

This review of guidance in eight participating local authorities covers professional practice concerning parent/infant separation within the first few days of life.

This paper is part of a larger scale project funded by the Nuffield Foundation - *Born into Care: Developing best practice guidelines for when the state intervenes at birth.*

The research project aims to improve professional practice when the state intervenes in the lives of newborn babies, by creating new national guidelines for practice in England and Wales.

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Introduction

At present there is no national authorised guidance which sets out expectations of the range of health and social work professionals who are involved in the very difficult task of removing a baby from his or her mother's care within hours or days of birth. The overarching aim of this Born into Care project is to improve professional practice when such an intervention has been deemed necessary, through the co-design and testing of new national guidelines for frontline practice. In order to understand and build upon the best local area practice, a review of current guidance documents in the eight local authorities participating in the project in England and Wales was undertaken. This paper reports on that review.

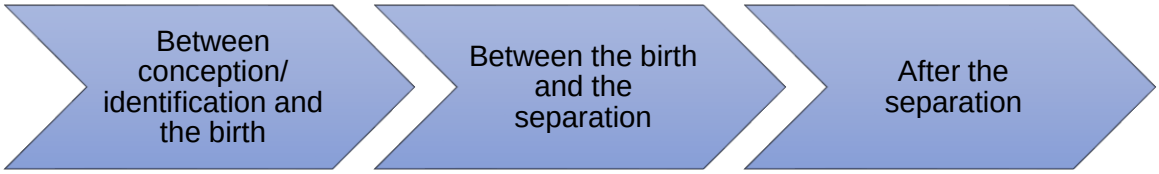
Methodology

Eight local authorities (six in England and two in Wales) and their partner NHS Trusts were recruited to participate in this study. Within each of these areas, the research team searched local authority websites for relevant guidance covering professional practice concerning parent/infant separation within the first few days of life. Such guidance, if it only covers the process of removal, is unlikely to be sufficiently sensitive to the issues involved or to provide adequate support for the complex decisions to be made, and so covered support for parents and infants from the point of identification before the birth to support for parents after removal. The following websites were scrutinised in each local authority area: the local safeguarding children board (LSCB); the regional safeguarding children partnership (in Wales the regional safeguarding partnership); the children and families section of the local authority website; and the adoption section of the local authority website and/or the regional adoption agency. NHS Trust websites were outside the scope of this inquiry. However, relevant documents produced by local NHS Trusts are posted on safeguarding websites and these were included in the analysis. Some searches were also made on websites for the Department for Education (England) and the Welsh government website, and where these linked to further websites (eg the National Independent Safeguarding Board, Wales), they too were searched. It quickly became evident that much of the existing guidance had been developed in response to the findings of a serious case review (now a child safeguarding practice

review (England) or a child practice review (Wales)), following the death or serious injury of an infant. The National Society for the Prevention of Cruelty to Children (NSPCC) national repository and the National Independent Safeguarding Board (Wales) websites were, therefore, searched for such reviews undertaken by the safeguarding children boards and partnerships or child death overview panels associated with the eight participating authorities over the last five years. Where indicated by guidance in the participating authorities, documents produced by the National Institute for Health and Care Excellence (NICE), the Royal College of Paediatrics and Child Health (RCPCH), and the NSPCC systematic review programme at Cardiff university were also scrutinised. The full list of documents consulted has not been included in this report in order to preserve the anonymity of participating authorities.

Identified guidance covered professional practice concerning parents over a timeline divided into three periods, as shown in Figure One:

Figure One: Timeline showing periods covered by guidance



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Relevant guidance for each of these periods was extracted from the documents and analysed. A brief summary of the guidance available from their websites was prepared for each participating authority. These were then sent to key representatives from the respective authorities who were asked to check them for accuracy and completeness; four responded with new information that had not been accessed through the website search, and their respective summaries were duly updated. This report draws together key information from these summaries. The study was paused for five months because of the Covid19 pandemic; as a result, data were collected over a protracted period (2020-2021) and some guidance changed during the course of the study, as we have indicated in the following discussion. It is important to note that documents of this nature are constantly being

updated, and a report such as this can only capture the picture at a particular moment in time. No doubt there will have been further changes between data collection and the completion of this report.

Participating authorities

The eight participating authorities are drawn from two regions in England and one in Wales. One authority has outsourced children's social care services to an agency owned by the council but controlled by an independent board to ensure operational independence; in the other authorities, such services are managed directly by the council.

The Children and Social Work Act 2017 replaced local safeguarding children boards in England with multi-agency safeguarding children partnerships that are the joint responsibility of local authorities, the police and clinical commissioning groups. Local arrangements can cover two or more local authorities (Working Together, 2018), and all the local authorities participating in this study are members of regional safeguarding children partnerships, one covering the three participating authorities in Region One, one covering six authorities in Region Two (including three participants), and one regional safeguarding board covering both participating authorities in Region Three (Wales). In Wales the safeguarding boards cover adults as well as children.

The eight participating authorities are served by five regional adoption agencies – two in Region One, two in Region Two and one in Region Three (Wales).

In England, the local councils issue some guidance on early help and publicise guidance on thresholds for referral to children's social care, but most of the guidance on children at risk of harm and their parents is produced by regional safeguarding children partnerships. However, the regional partnerships allow for local variations, and these are produced by the local safeguarding children partnerships. In Wales, much of the guidance is produced at national level. The All Wales Safeguarding Website holds the *All Wales Safeguarding Procedures* and a number of *All Wales Practice Guides*; the regional safeguarding boards also issue additional guidance.

Accessibility of guidance

In all the participating authorities, the relevant guidance is spread across a number of different websites and is, therefore, difficult to access and piece together. In England, the replacement of local safeguarding children boards with multi-agency safeguarding children partnerships, and the creation of overarching regional partnerships, which came into effect in September 2019, meant that, in 2020-2021, when the data were collected, much of the existing guidance was in the process of being migrated from one website to another and updated, so that some documents held on local safeguarding children board websites may have been obsolete. There were also numerous duplications and anomalies as some local procedures had been incorporated into regional procedures without changes of title. It was also not always possible to distinguish obsolete documents from those which represented current local variations to regional safeguarding partnership procedures, which again were difficult to piece together. For instance, most relevant guidance from Local Authority 8 was being migrated to the Regional Safeguarding Children Partnership (RSCP) website. However, some local guidance specific to the authority was held on the RSCP website, and some on the local safeguarding children partnership website. A key document for this project, *Child Protection /Child in Need Birth Arrangements* (containing the birth plan), developed by NHS Trust 7 and specific to one of the local authorities, could not be found on either the local safeguarding children partnership website or the local NHS Trust website, which was aimed at service users rather than professionals. It could be accessed with some difficulty from the regional partnership website, but it was not indexed. During the course of the study it was incorporated into another document aimed specifically at social workers and referenced under a different name.

There were similar difficulties in piecing together guidance in the Welsh authorities, and also some anomalies. For instance, the regional safeguarding partnership practice guidance on neglect does not include a reference to the unborn child, while the *All Wales Safeguarding Children from Neglect* document states that: ‘Child neglect is a failure on the part of either the male and/or female caregiver or pregnant mother to complete the parenting tasks’ and goes on to state that neglect can occur during pregnancy as a result of maternal substance misuse or when a parent ‘fails to

prepare appropriately for the child's birth, to seek antenatal care and/or engages in behaviours that place the child at risk'.

Finally, the guidance does not always mesh together very well. For instance, the list of pre-birth risk factors identified in the *Local Authority 3 Continuum of Need and Threshold Guidance 2018* (see Figure Three below) is different from the less detailed version shown in the relevant *Regional Pre-birth Protocol*, and only one of these documents gives a similar list of potentially mitigating protective factors. Moreover, although there is some guidance covering the first and second stages in the timeframe (from conception to birth and from birth to separation) this do not always link together. At the time the data were collected, only one authority had developed guidance covering all three stages.

In addition to the national guidance, the search of local and regional websites identified the following documents as being of greatest relevance to the aims of the current study. Issues raised by these documents are discussed below and might form a starting point for the development of protocols designed to support the Born into Care Best Practice Guidelines.

Figure Two: Key documents

Local Authority 1	Relinquished Children Care and Supervision Proceedings and the Public Law Outline
Local Authority 2	Neglect Strategy
Local Authority 3	Continuum of Need and Thresholds Guidance
Region One Safeguarding Children Partnership	Pre-birth protocol
Local Authority 7	Midwifery/Health Visitor and FNP - Early Intervention/Help Pathway Guidance Safeguarding Unborn Babies
Local Authority 8	Birth Arrangements Guidance for Social Workers TfC Pre-birth locality team: Pre-birth Support Plan TfC Pre-birth locality team: Post-birth Support Plan Local Authority 8 Early Help Strategy
Region Two Safeguarding Children Partnership	Pre-birth Practice Guidance

Region Three (Wales) Safeguarding Board	Birth Planning Guidance
All Wales Safeguarding	Findings from a Thematic Analysis of Child Practice Reviews in Wales
NHS Trust 7	Child Protection /Child in Need Birth Arrangements

Factors that shape the guidance

Local and regional guidance, issued by the eight participating authorities and their safeguarding children partnerships, appears to be shaped primarily by two factors. National Guidance (Working Together to Safeguard Children 2018 in England, and Working Together to Safeguard People, Vol 5, in Wales) provides the fundamental statutory basis for safeguarding children procedures and processes to be operationalised by the authorities; however, the findings of serious case reviews shape a wide range of local protocols and training programmes. One local authority has been restructured following an 'unsatisfactory' rating from an Ofsted inspection a few years previously; the *Joint Strategic Needs Assessment* that followed this inspection forms the basis for further relevant guidance in this authority.

National Guidance

In both England and Wales, the national guidance points out that assessments of unmet needs and risk of harm should cover unborn children, and suggests that where there are concerns, consideration should be given to holding a child protection conference before the birth. The National Panel of Independent Experts on Serious Case Reviews has also advised that *Working Together to Safeguard Children* should extend the definition of serious harm to include serious harm to a child *in utero* where a stillbirth is related to abuse (Department for Education, 2015). In Wales, under the Social Services and Well-being (Wales) Act, 2014, relevant partners have a duty to report children at risk of harm, including those who are not yet born.

However, no national guidance was found that focuses specifically on unborn children at risk of harm and their parents, or the support of parents whose infants are removed at birth.

Local guidance

Between 2016 and 2018, six of the eight participating local authorities experienced at least one serious case review following the avoidable death or serious injury of an infant; four had experienced four or more. Outcomes of criminal investigations related to these reviews are not consistently recorded, but at least seven parents had been subsequently convicted of murder, manslaughter, cruelty, or failing to prevent the death of a child. This is the context against which many of the local and regional protocols have been written, and they - together with the professional development courses, training materials and leaflets for the wider community - focus largely on learning points from the serious case reviews and the need to prevent another tragedy. The most common issues include: parental substance misuse and alcohol abuse; mental health problems; domestic violence; learning disability; working with parents perceived as uncooperative; child sexual exploitation; teenage pregnancy; concealed or denied pregnancy; coping with a crying baby; safe sleeping arrangements; bruising on a pre-mobile infant; and inter-agency working.

The *Thematic Analysis of Child Practice Reviews in Wales,* undertaken in 2019, acknowledged that some practitioners were over-optimistic, but also found that:

> Mothers in particular …, seemed to be polarised as either good or bad, rather than having an appreciative understanding of human beings for whom it is normal to have a range of actions and behaviours that can be both good and bad. This is evident in a range of characterisations of parents as generally negative, i.e. 'challenging', 'un-cooperative' and/or feigning compliance. Such views can lead to practitioners not adopting a sufficiently strengths based approach that recognises the abilities (and not just the deficits) of the parents. (p10)

Local Authority 2 has openly adopted 'a risk sensible, strengths-based approach' informed by resilient therapy and Local Authority 4 states that their child protection practice model emphasises partnership and collaboration with service users who are encouraged to bring an advocate to support them in decision-making. Nevertheless, much of the guidance issued by participating authorities focuses on identifying risks of harm and there is much less on supporting vulnerable parents.

Before the birth

Given the above, it is unsurprising that the majority of accessible guidance focuses on the period between conception and birth, when decisions have to be made as to whether the risk of harm is so great as to necessitate immediate removal. Most of the authorities have issued guidance on the risks to the unborn child posed by parental alcohol and substance misuse, domestic violence, neglect, and concealed or denied pregnancy. Many of these documents refer to research findings concerning the impact of adverse parental behaviours on the growth and development of the foetus. Guidance developed by the two Welsh authorities includes three additional risks: surrogacy (where there has been a private agreement); 'concerns that the baby, once born, may be at risk of human trafficking'; and 'where the pregnant mother has been subject to female genital mutilation and the unborn has been confirmed, by ultrasound, to be female'. Local Authority 8's guidance on parents with learning disabilities refers to a possible lack of understanding concerning pregnancy and birth, and a need for long-term support after the baby is born. An in-depth research study has been undertaken to ascertain the number of children taken into care from learning disabled parents in Wales, and the reasons for their removal (Burch et al, 2019); however, it is noteworthy that we found no specific guidance on supporting learning disabled parents through the pregnancy and after in either the Welsh or the English authorities.

The English authorities have also issued multi-agency guidance concerning continuums of need and thresholds for referral to different levels of service for children and families for whom there are concerns. In some authorities, attention has been given to ensuring that indicators specifically include the unborn child. Perhaps the most comprehensive is the list of indicators relating to the unborn child included in the *Local Authority 3 Continuum of Need and Thresholds Guidance* (see Figure Three).

Figure Three: Local Authority 3 Continuum of Need and Thresholds Guidance

Indicators of unmet need/low risk factors requiring early help (Level 2)

- Refusal/avoidance of registration with health care services (eg midwife, health visitor) including timely booking of pregnancy (16 weeks) and post-pregnancy appointments
- Pregnant aged 16 years or under
- Parent appears to lack affection, attachment or bonding (including during pregnancy)
- Parents who are care leavers
- Very young and inexperienced parents whose basic needs are not being met (in conjunction with other indicators).

Indicators of Child in Need (Level 3)

- Carers with chronic ill health or terminal illness which is impacting on child/young person or pregnancy
- Refusal/avoidance of registration with health care services (eg midwife, health visitor) including late booking of pregnancy (24 weeks) and antenatal/post-pregnancy appointments
- Pregnant age 16 or under, and there is no wider family support and/or lack of engagement with health services
- Inability of parents to be affectionate and attentive and there are attachment issues (including during pregnancy)
- Domestic abuse, instability or violence within the home which is impacting on the health and development of the child/unborn
- Child or unborn is living in communities with potential harmful values, such as Honour-Based Violence, FGM etc

Indicators that child/young person is suffering or likely to suffer significant harm (Level 4)

- Suspected NAI... or unexplained/inconsistent explanation of bruising in non-mobile babies
- Chaotic parental drug/alcohol misuse with chronic impact on health and wellbeing for children and young people and that of unborn babies
- Concealed or denied pregnancy, following LSCB multi-agency guidance
- Inability of parents to be affectionate and attentive and there are attachment issues (including during pregnancy) which are significantly…
- Person within the home is identified as posing a risk to children or unborn babies
- Domestic abuse and/or violence within the family which is having significant adverse impact on the child/unborn
- Child involved in /victim of criminal activity… which is placing themselves or others (including unborn babies) at high risk of harm

All three of the regional safeguarding children partnerships have issued separate practice guidance focusing on the unborn child and provide detailed protocols on the process of referral, assessment, child protection conference and child protection plan, all to be completed before birth within specific timeframes, although these can differ both locally and regionally. All three documents point out that, wherever possible, child protection plans should be shared with birth parents. The Region Two document specifies that, if there is a decision to remove a child at birth, the risk assessment and care plan should be shared with parents and their solicitor to give them an opportunity to challenge them. This point is also made in guidance on *Care and Supervision Proceedings and the Public Law Outline* (only found on the LSCB website in one local authority), which also gives details of timescales within a framework for legal proceedings.

Support for birth parents

The *Region One Multi-Agency Pre-birth Protocol* and the *Region Three Safeguarding Board Birth Planning Guidance* both include statements that stress how the antenatal period offers an opportunity to work proactively with families through a multi-agency approach that can identify needs and risks and develop 'robust plans which address the need for early support and services.' Nevertheless, there are no indications as to what preventative services might be available or how parents might be adequately supported. The Region One guidance refers to a number of local serious case reviews that show that, in the past, poor decisions have been made because key workers have 'failed to recognise that significant harm was already being caused to the unborn child', and the focus is on identifying and acting on risks. The Region Three guidance stresses the need for good communication between the professionals involved and focuses on the child protection processes once a risk of harm has been identified.

The *Region Two Safeguarding Children Partnership Pre-Birth Practice Guidance* places considerably more emphasis on supporting parents during the pregnancy. This guidance stresses the importance of clear communication not only between professionals in adult and children's services, but also between professionals and birth parents and other family members. It states that: 'the antenatal period provides a window of opportunity for practitioners and families to work together.' Most of the

recommended activity is around identifying and understanding risks, ensuring the safety of the baby, and promoting joint working between agencies. However, the following recommendations focus specifically on supporting parents, by working with them to:

- form relationships with a focus on the unborn baby;
- identify if any assessments or referrals are required before birth, for example Early Help Assessment; and
- plan on-going interventions and support required for the child and parents.

The guidance also includes a section on working with fathers, partners and other family members.

During the course of the study, one of the local authorities in the partnership introduced a new pre-birth service, the aim of which is to support parents to safely care for their baby by providing intensive support at the same time as completing robust assessments. If it becomes evident that parents will not be able to care for the baby the focus moves to securing permanence for the baby with alternative carers without unnecessary delay.

Following the establishment of the pre-birth locality team, the authority has issued its own comprehensive guidance on supporting birth parents both before and after the baby has been born. This guidance is much more comprehensive than that offered by the regional partnership and is designed to underpin a streamlined programme for assessing parents' needs and supporting them from conception until six months after the birth, ***wherever*** the infant is placed.

The *Local Authority 8 Pre-birth Locality Team Support Plan* is divided into 4 week blocks and gives comprehensive practice guidance to social workers in relation to what is required throughout the pregnancy. Each month the following domains are covered: mother's/father's health; parenting roles; child health, development and wellbeing; and goal setting. Within these domains specific issues are explored throughout the pregnancy. These include adjustment to parenting roles, parents' relationships, bonding with the foetus, informal support from wider family, safe care of the baby, breastfeeding, contraception and so on. The plan adopts a strengths-

based approach with little attention to parents' problems except to indicate that these should be referred to specialist services. Specific exercises are given to parents to complete between meetings – these include a diary of baby movement to help them become attuned to the foetus and understand responses, and one on 'thoughts and feelings from my past'.

Guidance in only one local authority/regional partnership includes a section on problematic issues that may arise if a referral is made to children's social care for a pre-birth risk assessment:

> The involvement of Children's Social Care (especially if there is a decision to remove the baby at birth) can result in the parents going missing or the woman not attending hospital at the time of birth. It may have an adverse effect on the parents' mental or physical health or heighten the risks that had raised the concerns in the first place. The fear of losing the baby may undermine the attachment and bonding process between the parent and child. There is a danger that the woman may end up harming herself or her unborn baby or seeking to terminate her pregnancy. It is vital that there is good communication with the pregnant woman, the birth father and, if different, her current partner in order to reduce the chance of such issues arising.
>
> (Region Two Safeguarding Children Partnership Pre-Birth Practice Guidance)

Timeframes

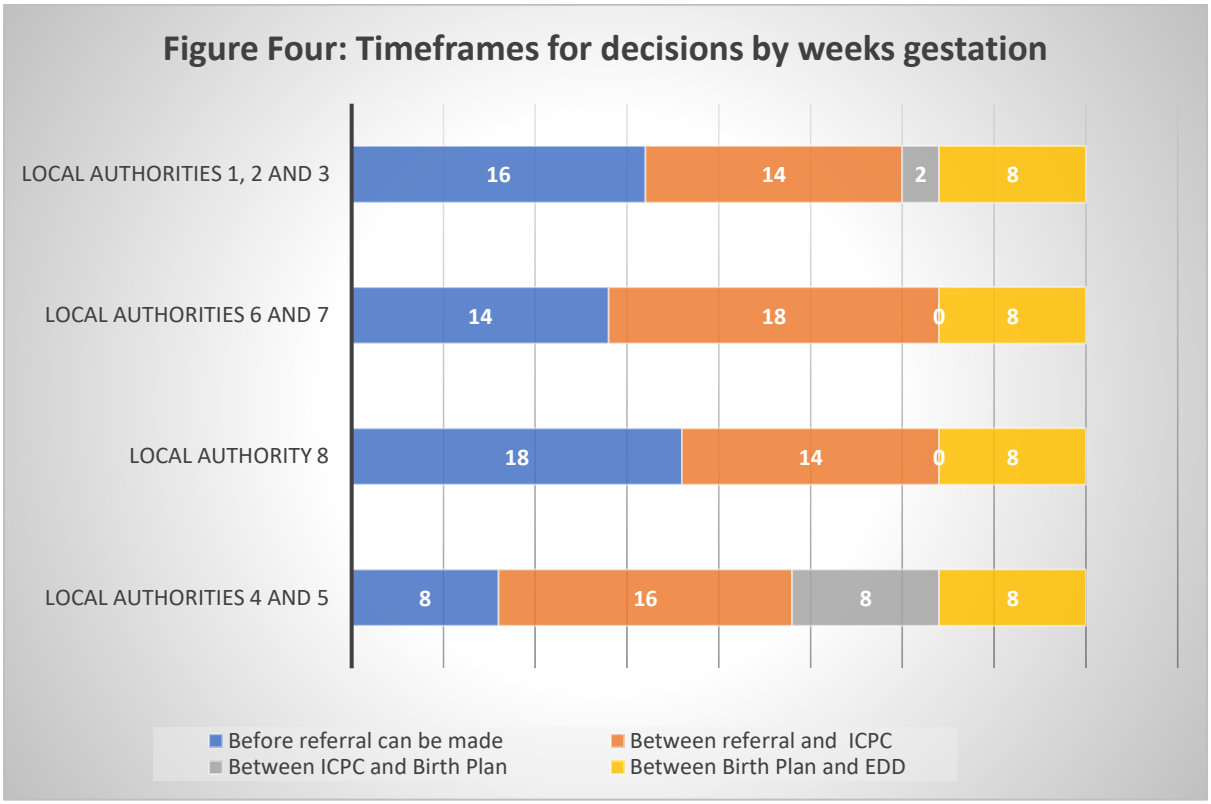
Some of this guidance indicates that the period between conception and birth could be used as an opportunity for professionals and parents to work together to develop parenting capacity and to overcome the problems faced by an expectant mother that might place her infant at risk of harm. Pregnant women in need of support should, therefore, be identified as early as possible during the pregnancy if they are to be given adequate opportunities to achieve change, and to ensure that timely decisions are made concerning how their infants can be adequately safeguarded (see also Barlow, Ward and Rayns, 2019). Local Authority 7's guidance on *Safeguarding Unborn Babies* states that early referral (by the 12th-14th week in this authority):

- provides sufficient time for a full and informed assessment;
- avoids initial approaches to parents in the latter stages of pregnancy, as this is already an emotionally charged time;

- enables parents to have more time to contribute their own ideas and solutions to concerns and increases the likelihood of a positive outcome;
- enables the provision of support services so as to facilitate optimum home circumstances prior to the birth; and
- provides sufficient time to make adequate plans for the baby's protection, where this is necessary. This includes consideration of placement with extended family if appropriate.

In most NHS Trusts, midwives complete a pre-birth vulnerability screening when a mother first accesses antenatal care (see NICE, 2010). However, in 2020, when these data were collected, timelines for subsequent decisions made in the eight participating authorities, as shown in their guidance documents, differed considerably. Figure Four shows the relationship between the decision-making processes and the number of weeks gestation in each of the participating authorities in 2020, demonstrating how these timelines can vary. All the authorities required a child protection plan and/or birth plan to be in place at 32 weeks gestation, eight weeks before the expected date of delivery. This is earlier than the practice outlined in the *Care and Supervision Proceedings and the Public Law Outline*, which specifies that assessments should be completed at least four weeks before the due date. Some of the guidance emphasises the importance of early planning because many vulnerable babies are born prematurely, and they can be discharged home as early as 34 weeks from conception. However, this early cut off point means that the window of opportunity for supporting change is relatively small, and much depends on the timeliness of referral and assessment. Guidance from the two Welsh authorities states that if the pregnancy has been confirmed, midwives or other professionals should make a referral to children's social care 'as soon as concerns are identified' (ie any time after about eight weeks gestation). This leaves about 24 weeks to work with the parents until the plan is agreed and finalised (16 weeks between referral and initial child protection conference, and a further 8 weeks between conference and plan). While some authorities have similar pathways for looked after children, in 2020 the timeframes were much shorter for other parents: Local Authority 8, for instance, specified that referrals should be made between the 16th and 18th week of gestation, leaving only 14 weeks for assessment, intervention

and plan. However, this is one area in which the Hawthorne effect of participating in the research programme may already be beginning to have an impact: during the course of the study, two authorities, including Local Authority 8, brought forward their thresholds for accepting referrals.



Interventions to support birth parents

Much of the pre-birth practice guidance focuses on assessment and planning. In all but one of the authorities it says little about how, during the pregnancy, birth parents might be supported to bond with the baby and to overcome the difficulties that might indicate a risk of significant harm, or what interventions might be available to help parents through this process. However, other documents posted on the relevant websites indicate that several of the participating authorities have developed or commissioned programmes for this purpose. The *Local Authority 8 Early Help Strategy* makes a forceful case for developing preventive services and applying evidence-based programmes, and there is more evidence that these are available and have been strategically planned than in some of the other authorities. Much of

the guidance published on the website for this authority focuses on reducing teenage pregnancy and supporting vulnerable young women through pregnancy and in the early years. There is also an emphasis on preventing and reducing domestic violence. Guidance from this authority makes an explicit connection between child sexual exploitation, teenage pregnancy, domestic abuse and risks to the unborn child. Recommended interventions designed to address some of the wider issues that place an unborn child at risk of significant harm and that aim to support change in parents include: family group conferences, parenting programmes, the Relationships Matter programme to reduce parental conflict, and Family Focus (a local version of Troubled Families). This authority also offers two programmes aimed specifically at men: the BIG domestic abuse prevention programme and Lads to Dads.

Some services specifically designed to support vulnerable women through pregnancy and beyond, such as perinatal mental health services, are (or should be) available in all authorities. Others are available in some authorities on a wide basis. In the three authorities in Region Three, for instance, all young women who become pregnant before their 20th birthdays are assessed for support from the Family Nurse Partnership Programme. Other programmes specifically aimed at supporting vulnerable women through pregnancy and beyond include Parents under Pressure and Bumps to Babies (Local Authority 8) and Baby Steps (Local Authority 2). The research team also has evidence from other sources that several more interventions are available in the participating authorities, such as Better Start (Local Authority 2) and Flying Start (Local Authority 5 and Local Authority 4), although these were not publicised on their websites. There was, however, evidence from focus groups that, as a result of cuts to funding, some of these publicised services have been withdrawn; these include Family Nurse Partnerships in one authority and domestic abuse services in another.

Between birth and separation

The vast majority of the guidance focuses on the period between conception and birth. There is much less on the other two periods in the timeframe (birth to separation and after separation). Nevertheless, guidance concerning the period

between birth and separation was found on the websites of one local, and two regional safeguarding children partnerships.

Region Two Safeguarding Children Partnership's *Pre-birth Practice Guidance* gives detailed advice on what should be covered in the plan to safeguard the baby including: proposed length of hospital stay (allowing time for monitoring withdrawal symptoms if maternal substance misuse is an issue); risks in relation to breastfeeding (again following maternal substance misuse); the plan for discharge; arrangements for the immediate protection of the baby from parental substance misuse, mental ill health or domestic abuse; and the risk of parents seeking to remove the baby from hospital if the plan is for immediate separation. There is little acknowledgement of the mother's needs (or the father's) except to indicate that plans should include the proposed length of her stay on the ward, and arrangements for managing contact after removal.

The other two documents, Region Three's *Birth Planning Guidance* and NHS Trust 7's *Child Protection/Child in Need Birth Arrangements* cover the same issues, although they are more comprehensive, additionally covering: potential court involvement; staff health and safety issues; details of those who may or may not have access to the maternity unit; and arrangements for supervising contact between parents and the baby during the hospital stay if this is deemed necessary. They also cover arrangements for discharge from hospital, including a requirement to hold a pre-discharge planning meeting to confirm them. Both these sets of guidance are explicitly designed to facilitate consistent dialogue between the different parties involved and to promote close inter-agency working. The NHS Trust 7 document, for instance, has to be completed at the pre-birth conference/planning meeting, signed by the midwife, the health visitor, the social worker and the parents; and shared by 24 weeks gestation to ensure that the maternity unit are aware of children's social care involvement. During the course of the study one of the Trust's partner local authorities also issued additional guidance for social workers. This covers subjects such as the importance of offering parents opportunities to meet with foster carers before the birth and to choose the clothes the baby will wear at the time of separation as well as transport arrangements for the mother to return home from hospital.

The *Region Three Birth Planning Guidance* covers the period from identifying a risk of harm; through referral, assessment and the development of a multi-agency support plan (which includes the specific birth plan); to arrangements for discharge from hospital, including placement away from birth parents. Sections on specific circumstances covered late bookings and concealed pregnancies; pregnant mothers moving out of area at short notice; home delivery; babies born before arrival (at the hospital); babies relinquished at birth; and women identified as being at high risk of early post-partum mental health illness or puerperal psychosis. The *NHS Trust 7 Child Protection/Child in Need Birth Arrangements* protocol is not so detailed and covers a shorter timeframe: it replaces (and diverges from) the regional safeguarding children partnership guidance concerning the period covering the birth. The document is to be used for 'all unborn babies who become subject to complex child in need or child protection procedures.'

Supervision of birth parents

The Welsh guidance is also closely aligned with the local *Multi-Agency Protocol for the Supervision of Parents and Carers of Children and Young People Admitted to Hospital where there are Safeguarding Concerns.* It focuses primarily on ensuring the safety of the infant, with less attention given to how the parents might be supported during this period. It is noteworthy that after the birth, the terminology tends to change: before the baby is born, the birth mother is referred to as 'the expectant mother', but after the birth she is frequently referred to as 'the woman', as is the case in some of the other guidance scrutinised for this study.

The guidance raises the question of how the mother is to be supervised in hospital, pointing out that 'in specific circumstances, concerns may be so high that 24-hour supervision of parents and baby may be necessary' and that midwives are not in a position to offer this. Similarly, the arrangements for home delivery state that 'social workers/emergency duty teams may be expected to attend the home at the time of the birth or shortly afterwards in case of safeguarding supervision requirements.' On the other hand, the *Local Authority 8 Birth Arrangements Guidance for Social Workers* suggests that the family network should be approached to identify relatives who might be in a position to provide supervision on the ward. It also points out that

assessments of the need for supervision should be proportionate and take account of the safety provided by the hospital setting.

Support for birth parents

Although the emphasis appears to be on making sure the parents do not harm the baby, the Welsh guidance also states that midwives and ward staff are expected to record their observations on interactions between parents and the baby and positive aspects of care, as well as any concerns noted. It also has a section entitled: *Care of mothers where a baby has been removed- should we consider both parents?* This points out that all professionals need to acknowledge that the removal of a baby can be a stressful and emotional time and states that midwives will offer to continue to care and attend to the mother's emotional and physical needs whilst she is in hospital.

The *NHS Trust 7 Child Protection/Child in Need Birth Arrangements* takes greater account of the parents' needs than the regional guidance, and offers more detailed indications of how parents might be supported during this period. It suggests that, where the infant cannot remain with the mother unsupervised during the hospital stay, a relative might be able to provide supervision so that the parents are 'able to see their baby'. It also indicates that, where appropriate, these mothers might, nevertheless, be able to have skin-to-skin contact (limited to one hour). Where the baby can remain with the mother during the hospital stay unsupervised, the document also asks whether each parent or a family member can provide basic care (or whether a family member can support the parents to do so), whether the father can stay with the mother and baby in hospital, and whether the mother intends to breastfeed. The document also asks who will accompany the baby when they leave the hospital.

Local Authority 1's *Guidance on Relinquished Children* might also be relevant for exploring how parents can be supported following compulsory removals at birth. Although obviously the circumstances are very different, nevertheless the document's statement that at this stage 'the focus should be on the mother's welfare' contrasts starkly with the guidance on removals, which focuses on the safety of the child. The *Guidance on Relinquished Children* states that both parents should be offered counselling after the decision to relinquish has been made, and this should

be progressed before the birth. It states that the stage of the process immediately after the birth is of particular sensitivity and should be led by the mother; and that 'the parent(s) can provide as much or as little for the child as they feel they want to at this very initial stage and should be encouraged or supported – but not pressured – to have contact with the child.' However, greater involvement at this stage may make later separation harder. The document also points out that this is the moment at which the child's Life Story Book begins, and the time on the ward provides an opportunity to collect photographs and other information for later inclusion.

After separation

Most authorities provide very little guidance on how to support parents after separation from the baby. The *Region One Pre-birth Protocol* specifies that the named social worker will undertake a home visit within 48 hours after discharge from hospital, but it seems unlikely that this includes a visit to the mother if the baby has been removed. On the other hand, midwives do have responsibilities towards the mother, and the *Region Three Birth Planning Guidance* states that they will care for her needs for at least 14 days after the birth, including when she is back in the community, and will also consider whether she needs further support from another agency.

The position is, however, changing. As already indicated, in Local Authority 8, new guidance on supporting parents, issued in the course of this study, covers the period from conception until six months after the birth. This includes a comprehensive *Post-birth Support Plan* that covers four potential pathways:

1 Baby in parents' care from birth.
2 Rehabilitation to care of parents; baby placed with alternative carers initially.
3 Connected carers to care for baby permanently.
4 Plan of adoption.

A post birth assessment has to be completed in all cases and support offered in each scenario. The overall aim is to progress the plan so that the baby is in his/her permanent placement from the earliest opportunity. The plan is a continuation of the

Pre-Birth Support Plan and is modelled on the same domains. It includes continuing goal-setting and monitoring of progress for those who follow pathways 1 and 2 and a requirement to assess parenting within 45 days of the birth. It covers three time periods for all parents: 0-6, 7-12 and 13-20 weeks post birth. Support for birth parents after removal is expected to last for 20 weeks, ending with the expectation that, post case closure, they continue to have long-term support in their own right.

Under the Adoption and Children Act 2002, local authorities also have a duty to assess the support needs of anyone who is affected by an adoption, including the birth parents, who may receive post adoption services including counselling, advice and information (Department for Education, 2013). A high proportion of infants removed at birth will later be placed for adoption (Broadhurst et al, 2018; Alrouh et al, 2019), and it seems probable that, in authorities that are unable to provide the comprehensive post separation service introduced in Local Authority 8, birth parents are most likely to be offered support under these provisions. However, we found no protocols developed from the national *Statutory Guidance on Adoption for local authorities, voluntary adoption agencies and adoption support agencies* (Department for Education, 2013). Information concerning what services might be available to birth parents is aimed at service users rather than professionals. The website of one regional adoption agency gives no details of post adoption support for birth parents whose infants have been removed or who have voluntarily relinquished them. Other websites indicate that the support available is variable. Much of it covers support with post adoption contact arrangements. However, two of the regional agencies offer support through care proceedings and help to enable birth parents to 'work through your feelings about adoption.' These existing services might form useful entry points for developing and implementing the guidelines.

The adoption agencies also signpost birth parents to more specialist counselling and advocacy services, including Family Rights Group and the Information, Advice and Support Services Network (for parents and carers of young people with special educational needs and disabilities). Again, the contribution that these agencies might make to the guideline and its implementation should not be overlooked. Finally, one local authority has had some involvement with the Lullaby Trust, which offers counselling and support to parents after the death of a child, and some of their work might prove appropriate to birth parents following compulsory removal.

Findings from other research studies (Cossar and Neil, 2010; Broadhurst et al, 2017) indicate that, even where services are available, many parents find it difficult to engage with them, or drop out during the often lengthy period between separation and adoption order, indicating that considerable outreach work will be necessary to encourage parents to make use of post separation support services should they become more comprehensively available.

Conclusion

This review of the available guidance in the eight participating authorities has raised a number of issues that needed to be taken into account in developing the Born into Care Best Practice Guidelines. It was clear that the guidelines would need to be accessible, balanced and integrated between the wide range of professionals involved in decisions to remove at birth and across a timeframe that stretches from conception to the period after removal, when parents are trying to come to terms with the separation. If the emerging guidelines are to be successfully implemented, they will also need to be fully integrated into national policy directives and local interpretations of said directives.

Accessibility

It is difficult to access current guidance. This is partly because the transition from local safeguarding children boards to regional multi-agency safeguarding children partnerships has meant that much of the current guidance is being re-written, and some of the available documents are probably obsolete. However, there are also problems because guidance covering a specific time period – from conception to post separation – sometimes has to be pieced together from more than one document, and they do not always fit neatly together. The Born into Care Best Practice Guidelines need to underpin the development of local guidance that can be issued as one streamlined document that can be easily accessed from all relevant websites.

Balance

Much of the current local guidance has been shaped by the learning points from serious case reviews in which an infant has died or suffered serious harm as a result

of abuse or neglect. Understandably, the main emphasis tends to be on preventing another such tragedy; existing protocols focus on identification and prevention of risks to the unborn and ensuring the infant's safety after the birth. Yet professionals are not presented with a binary choice between safeguarding the infant or supporting the birth parents, and as we know, many mothers whose baby is removed at birth soon become pregnant again and enter a cycle of repeat appearances before the family courts (Broadhurst et al., 2016; Alrouh et al., 2019; Broadhurst and Mason, 2020). Recent research has also provided the first empirical evidence of fathers' repeat appearances (Bedston et al., 2018). The guideline needs to achieve a careful balance between advising on best practice to ensure that both the infant's and the mother's needs are adequately met. While some attention is currently given to developing practices and accessing interventions designed to support the mother during the pregnancy, in most authorities there is little guidance on best practice towards her or the father around the birth, the time spent in hospital or the period after the separation. The new guidelines need to point practitioners to best practice to support parents as well as infants over the whole period from conception to after the separation. Special consideration will need to be paid to supporting parents with specific needs, such as those with learning disabilities, for whom no guidance appears to be currently available. Elements of current guidance on pre-birth practice, such as: adopting a strength-based approach; ensuring that fathers are involved in decision-making; promoting the use of advocates to support parental participation; including the extended family in contact; and supervision arrangements after the birth might form useful starting points for developing and implementing the new protocol. Guidance on related subjects, such as infants relinquished for adoption, also offer some indicators of issues that need to be included.

Integration

This documentary review also makes it clear that, before moving to plans for implementation, a feasibility study (currently being undertaken) needs to explore how the Best Practice Guidelines can be fully integrated into existing systems and programmes. It also needs to consider how the guidelines might inform and be informed by the national guidance and linked up with both local and regional guidance in related areas. Some local guidance also offers one protocol for practitioners to use, whether the plan is for the infant to remain with birth parents or

to be removed. This would appear to be a useful starting point for agencies considering developing new documentation based on the guidelines – a protocol focussing solely on removals risks increasing the negative view of these parents.

Finally, for many years now both national and local guidance have been informed by increasing understanding of the importance of close communication and cooperation between the many different professionals involved in safeguarding children from harm. The first person to identify an unborn child at risk of harm is likely to be the general practitioner or the midwife. The feasibility study will need to explore how the guidelines can be used as a basis for developing a continuous pathway that links their practice with that of health visitors; social workers; family justice professionals; and all the many people who have responsibility for safeguarding infants and supporting their parents, including members of their immediate and extended family.

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