Newborn babies | February 2022

Born into Care: Developing best practice guidelines for when the state intervenes at birth.

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Report

Separating a baby from his or her mother at birth when there are safeguarding concerns is traumatic for birth parents and painful for professionals. This report presents findings from a study that analysed qualitative data from the lived experiences of parents and professionals where the state intervened at birth. The aim was to identify key challenges and to surface good practice examples with a view to developing a draft set of best practice guidelines for piloting with partner research sites in England and Wales.

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Recommended citation
Mason, C., Broadhurst, K., Ward, H., Barnett, A. and Holmes, L. (2022). *Born into Care: Developing best practice guidelines for when the state intervenes at birth*. Nuffield Family Justice Observatory. http://www.nuffieldfjo.org.uk/resource/born-into-care-developing-best-practice-guidelines-for-when-the-state-intervenes-at-birth

Summary and Welsh translation available from: www.nuffieldfjo.org.uk

This report has been written in partnership with

Centre for Child & Family Justice Research

Lancaster University

Rees Centre, Department of Education

University of Oxford

Acknowledgements

The research team wishes to express sincere thanks to the Nuffield Foundation for funding this study, which is a special interest project of the Nuffield Family Justice Observatory (Nuffield FJO). We would like to thank the Nuffield FJO team for their support and interest throughout the project.

The research would not have been possible without the support of our local authority and health trust partners. We are indebted to them for ensuring the project could continue despite the demands brought by the COVID-19 pandemic. We are particularly indebted to each of the project leads within our sites who have given so much time and energy to this project during what has been an incredibly difficult time for them and their organisations. We also extend thanks to all the professionals who gave their time to take part in focus group discussions and shared honestly and openly their experiences of practice. In particular, we would like to acknowledge the contribution made by each of the mothers and fathers who took part in interviews with the team and gave their time to share their own very personal and emotional journeys.

We would like to acknowledge all our reviewers for their very helpful comments on the report and draft guidelines. Through the course of the project we have benefited enormously from the discussions and advice of our international colleagues, Melissa O'Donnell, Sarah Wise and Steph Taplin. Special thanks to our specialist advisors, Dr Louise Roberts and Professor Jane Barlow. Thank you also to our colleagues who helped facilitate our project summer workshops and those who participated. Your contributions were invaluable.

Our work was guided by two advisory groups and we would like to thank each member for making the time to attend our meetings and workshops and to respond to our requests for advice. We are hugely appreciative of the contributions of Sally Jenkins who chaired our professionals board and Angela-Frazer Wicks who sat on both our lived experience and professionals boards and helped ensure integrity, cohesion and integration between them. In particular, we would like to acknowledge the women who joined our lived experience advisory board. You have given selflessly of your time and brought so much expertise and knowledge to this project, and we give our heartfelt thanks.

Contents

Executive summary

The removal of a newborn baby from his or her mother at birth in response to safeguarding concerns is an emotionally charged and highly contentious issue. Although the number of such separations and rates of newborn babies in care proceedings are increasing (Broadhurst et al. 2018, Alrouh et al. 2020), national guidance is insufficient and there remain many unresolved ethical and practical dilemmas.

This study comprised the collection and analysis of new empirical data through collaborative research with eight participating local authorities and seven corresponding NHS trusts in England and Wales. The study aimed to explore compulsory intervention at birth from the perspectives of parents as well as professionals in children's social care, health services and the courts. The study forms part of the *Born into Care* series (Broadhurst et al. 2018; Mason et al. 2019; Mason and Broadhurst 2020; Griffiths et al. 2020a, 2020b; Doebler et al. 2021; Pattinson et al. 2021; Mason et al. 2022; Ward et al. forthcoming; Ott and McGrath-Lone forthcoming).

The data was analysed to explore practice throughout the parents' journeys:

- pre-birth – referral, assessment and support
- maternity setting – in the maternity ward and at first court hearing
- following the return home – support given to parents as they leave hospital and return home, without the baby, and often alone.[1]

The purpose was to identify challenges that stand in the way of best practice and achieve consensus about what needs to change. The initial findings were shared through a series of online workshops composed of parent advocacy organisations and professionals from policy and practice.

The findings form the basis for constructing local area action plans to address the identified system-level challenges and for developing and piloting practice guidelines designed to introduce more sensitive and humane practice when the state intervenes at birth. The draft guidelines will be published alongside this report and will be piloted in the participating authorities and NHS trusts in England and Wales.

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[1] Not all care proceedings at birth result in the separation of the baby from their parents. In most cases, however, they do involve separation; Pearson et al. (2020) found that once babies have been separated from their parents very few are returned to their care.

Key findings

There was considerable consensus across the range of professionals consulted, as well as from parents, as to what constitutes best practice when the state intervenes to safeguard a baby at birth. However, the study also identified numerous challenges in the way of best practice.

Cross-cutting challenges

- **Resource constraints** in terms of austerity measures and cuts to social care and health services have reduced preventative services and led to high thresholds for support and long waiting lists. In some authorities, services that were previously introduced to support parents to make positive changes during pregnancy, or to support them after their baby was removed, were no longer available. Resource constraints have also affected legal proceedings because the low fees attached to pre-proceedings work mean that parents receive a fragmented service, and frequently fail to access the skilled advocacy they need. Limited availability and high costs associated with alternatives to separation were also highlighted by professionals and parents as significant constraints.
- **Discontinuities and turnover of key professionals** that are partly attributable to resource constraints have made it harder to retain social work staff and increased the likelihood that agency workers will be employed. However, other discontinuities are built into children's social care and maternity services: parents and professionals described a system in which parents move from one practitioner to another as they pass through different parts of the systems. Discontinuities and staff turnover have made it harder to establish a trusting relationship with parents whose life experiences have been marked by transience. They also impede collaborative working between agencies, and partnership working under the Public Law Outline.
- **Delays and time constraints** were found to be a major challenge. Delays in identifying need, offering early help and referring pregnant women to children's social care meant that opportunities to support parents to make positive changes were lost. Some delays were incurred by a rigid adherence to inappropriate timeframes and a two-stage assessment process that left little time for accessing specialist services. Delayed referrals and social worker churn also meant there was little time to establish evidence of parents' capacity to change, and too much weight was given to their past histories. Delays in making decisions and sharing plans resulted in parents being ill-prepared for court. Such delays had implications for parents' ability to benefit from robust legal advice and participate fairly in a first court hearing. Some mothers (and some midwives) did not know that the plan was for removal at birth until after the baby was born. Delayed decisions could also have meant too little time to find a mother and baby placement or other provision, thereby increasing the likelihood of separation.
- **Resource constraints, discontinuities and delays** posed extensive challenges throughout all three stages of the process (pre-birth, in the maternity ward and following the return home). They had a knock-on effect on one another and tended to exacerbate the numerous other challenges to best practice.

- Professionals were aware of the importance of including mothers, fathers, grandparents and other family members in decision-making and planning, but there were **shortfalls in family-inclusive practice** throughout all three stages. Although some authorities had introduced family group conferences as an intrinsic element in their child protection pathways, others had not. The fathers who participated in interviews felt routinely marginalised, and in at least one authority they were not included in decision-making and planning until issues of paternity had been resolved. Little use was made of family networks to help mothers during the pregnancy, to support them or provide supervision on the ward if it was required, or to provide practical and emotional support when they returned home from hospital. Some parents had histories of violence, but there were concerns that in other cases, risk-averse attitudes had unnecessarily prevented fathers and other relatives from visiting mothers and babies on the ward or being present at the birth.

Specific challenges at the pre-birth stage

- Most parents had multiple experiences of trauma and loss, including the removal of previous children, prior to this pregnancy. However, while social workers recognised parents' difficult histories, **trauma and repeat child removal were insufficiently addressed as specialist issues**. Resource constraints have led to a lack of specialist expertise. Practitioners in non-specialist teams were aware that they were unable to give sufficient attention to the needs of parents whose previous experiences had often led them to mistrust professionals, but they were constrained by service structures and heavy caseloads. In busy generic social work teams, it was not always possible to prioritise the unborn child.
- **Unresolved legal dilemmas** included the use of voluntary agreements under the Children Act 1989, Section 20 (Social Services and Well-being (Wales) Act 2014, Section 76). On the one hand, these potentially offer an opportunity to safeguard the baby while social workers work proactively with parents to improve their parenting capacity. Voluntary agreements also avoid the need for court hearings at a time when mothers may not be physically or psychologically able to participate meaningfully. On the other hand, some parents considered that they had been coerced into signing them. When there was no plan for reunification it was considered unethical by parents and indeed some professionals to use this provision to gain time to prepare papers for a court hearing.
- There were also **dilemmas concerning the ethics** of encouraging parents to invest financially and emotionally in equipment for a baby from whom they were likely to be separated. Social work assessments require evidence that parents are preparing for their baby, and this includes practical preparation. However, the emotional impact on parents of returning alone to a home full of baby items was insufficiently acknowledged.

Specific challenges within the maternity setting and at the first court hearing

- Time and resource constraints and lack of specialist care led many mothers on the postnatal maternity ward to experience acute feelings of **shame and stigma**. While some mothers were offered a side room, others remained in a communal bay while social workers, solicitors and midwives sometimes discussed highly sensitive legal and medical issues with little regard for their privacy.
- The practice of instigating **court proceedings immediately after the birth** meant that parents had few opportunities to focus on bonding with their babies when their energies were taken up with navigating safeguarding and legal processes. The requirement for mothers to attend court within hours or days of giving birth posed considerable practical and emotional difficulties, and also meant that they had little capacity to take in vital information or to adequately instruct a solicitor. Mothers also faced the impossible choice of either attending the hearing (and missing out on precious time with the baby) or staying with the baby and risking giving the court the impression that they were not taking the proceedings sufficiently seriously.
- Shortfalls in practice also included **inadequate planning, time, choice and support at the point of separation**. It was helpful for parents to meet foster carers before the birth or at the very least in advance of the separation, but this was often not possible. Choices over details such as who they would hand the baby to, and what the baby would wear, were of great significance to parents who had so little power over life-changing decisions. However, in a system focused on the legal process, professionals had little time for these sensitive discussions.

Specific challenges on leaving hospital and returning home

- Following discharge from hospital, many mothers fell into a support vacuum with **no professionals having responsibility for their care**. Some had to face leaving hospital alone and returning to an empty home with no one to comfort them.
- In areas without specialist teams there might be no continuity of midwifery care. Many mothers who returned home without their babies found it difficult to accept routine postnatal care; some also missed out on later post-natal services offered by primary care, with adverse consequences for their long-term physical and mental well-being.
- **Contact arrangements** were often made without consulting parents or considering their circumstances, and without taking into account the possibility of reunification.
- Parents were more positive about **mother and baby foster placements** than residential assessment centres. However, budgetary or recruitment constraints meant that these were in short supply and not always of sufficient quality to provide parents with adequate support.

Examples of good practice

Despite the numerous obstacles there were nevertheless several examples of good practice, and in some cases, considerable evidence of progress in addressing some of the system-level challenges. These included:

- the provision of specialist multidisciplinary teams to support parents throughout the pregnancy and sometimes beyond
- dedicated pre-birth social work teams to ensure timely specialist assessments and coordinated intervention plans
- pre-birth pathways in early help to try to address concerns regarding late intervention
- amended protocols designed to better align service responses with parents' needs
- bespoke recurrent care services for parents who had previously experienced the removal of a child
- imaginative use of foster carers to plug the gaps in family support services.

There were also numerous instances of individual practitioners and foster carers who went out of their way to provide sensitive support to parents facing the removal of a baby.

Information sources

This report draws on data collected through in-depth interviews held with 44 parents (38 mothers and 6 fathers) who had experienced (or come close to experiencing) the removal of a baby at birth. Data from parents were complemented and illuminated by findings from focus groups and interviews conducted with 263 midwives, social workers, social work managers, Cafcass workers, local authority lawyers and foster carers in six local authorities and NHS trusts in England and two local authorities and one NHS trust in Wales.

Introduction

Overview

The findings shared in this report have resulted from in-depth qualitative engagement with eight local authority areas and the corresponding seven health trusts in England and Wales (June 2019 to June 2021) to understand current challenges when safeguarding action is taken at birth. The research has uncovered challenges shared by professionals and family members during pregnancy and at birth – including the experience of urgent care proceedings. In addition, the research draws attention to the hidden experience of parents who return home without their babies. The overarching aim of this qualitative study has been to generate new knowledge to shape a set of draft best practice guidelines, which are to be published alongside this report and tested and refined in partner research sites in 2022 (Mason et al. 2022).

The project forms part of the *Born into Care* series – a programme of work designed and delivered for the Nuffield Family Justice Observatory (Broadhurst et al. 2018; Broadhurst et al. 2021; Mason et al. 2019; Mason and Broadhurst 2020; Griffiths et al. 2020a, 2020b; Doebler et al. 2021; Pattinson et al. 2021; Ward et al. forthcoming; Ott and McGrath-Lone forthcoming).

Extensive background research has informed this study, including the production of successive statistical releases by the Family Justice Data Partnership – a team of researchers located at Lancaster University and Swansea University.[2] Statistical releases have focused on rates of newborn babies in care proceedings in England and Wales (Broadhurst et al. 2018; Broadhurst et al. 2021), maternal mental health, well-being and engagement with antenatal services (Griffiths et al. 2020a;2020b), local area deprivation (Doebler et al. 2021) and urgent care proceedings (Pattinson et al. 2021). The study also builds on a review of published literature on birth parents' and professionals' experiences of removal of babies at birth (Mason et al. 2019), a case law review (Ryan and Cook 2019), a review of the perinatal loss literature (Ott and McGrath-Lone forthcoming) and a review of national and local area protocols (Ward et al. forthcoming).

This is the first qualitative study to examine compulsory intervention at birth from the perspective of a range of health, welfare and legal practitioners, as well as from parents. Although the perspectives of both parents are included where possible, far more mothers participated in the research than fathers. In addition, given the focus on removal of babies at birth in maternity settings, issues

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[2] See: https://popdatasci.swan.ac.uk/centres-of-excellence/family-justice-data-partnership/

pertaining to the maternal experience in the immediate postnatal period are central to this study.

From this in-depth engagement work and integration of findings, the team has been able to identify the main shortfalls in current practice, but also real-time examples of good practice. The study provides vital insights into the impact of removals at birth for all adults involved, as well as the practice and impact of urgent hearings. It also provides some possible reasons behind the rising number of newborn babies in care proceedings in England and Wales, corroborating findings from other studies (see Mason and Broadhurst 2020; Doebler et al. 2021). The qualitative findings help to address questions raised by statistical releases produced as part of the *Born into Care* series, as well as adding completely new insights. Together, the reports in the series provide a firm foundation for reforming legislation, policy and practice concerning compulsory intervention at birth, including care proceedings.

Consensus across different professional groups and between family members can be difficult to achieve. Nevertheless, we found strong agreement around a set of 10 core best practice principles, which we have used to shape draft guidelines that are designed to inform effective and humane practice. The overarching aim of the proposed guidelines is to ensure timely and family-inclusive intervention in pregnancy that seeks to avert the need for care proceedings at birth where this is safe and in the interests of the baby. At the same time, guidelines aim to ensure that when care proceedings are needed to protect a baby at birth, parents are fully prepared and unplanned urgent hearings in the immediate postpartum period are avoided. The guidelines also seek to raise the profile of parents' needs beyond the removal of a new baby. At present, beyond routine postnatal midwifery checks, support for mothers who leave maternity settings without their babies is not strictly the business of any particular professional group – hence these women can find themselves alone and in acute distress.

Following the collection of primary empirical data and analysis, a series of online workshops was completed to test consensus about the 10 best practice principles arising from the study with key stakeholders, and to ensure that the new guidelines are aligned closely with the values and experience of professionals and family members. Throughout this work, we have been inspired by the pioneering efforts of frontline practitioners, as well as the expertise shared by parents. It is clear that professionals and parents alike bear the brunt of deficits in resources in regions characterised by high rates of deprivation (see Mason and Broadhurst 2020; Doebler et al. 2021).

We have benefited enormously throughout the project from the support and expertise of two advisory groups: the first, a group of mothers with lived experience of being separated from their babies at birth; and the second, a group of professionals from policy and practice. To bring an international lens to this work, parallel qualitative research has also been taking place in Australia (Victoria and Western Australia). This is led by colleagues at the University of South Australia and the University of Melbourne and funded separately. Looking ahead, we will seek to work with our international colleagues to learn from parallel research efforts, as questions of humane and effective practice at birth are not particular to the UK.

Background

In England and Wales state intervention to protect infants at birth has been described as ‘draconian’ by leading judges with successive published family court judgments highlighting shortfalls in frontline practice (Masson and Dickens 2015; Broadhurst et al. 2018; Ryan and Cook 2019; Ward et al. 2012). Evidence produced as part of the *Born into Care* series has documented rising rates of newborn babies subject to care proceedings (Broadhurst et al. 2018; Alrouh et al. 2020) in England and Wales, with considerable regional variability. The broader literature on infants in care also documents rising rates of infants entering care in a number of high-income countries (Marsh et al. 2017; O’Donnell et al. 2019; Cusworth et al. 2019; Woods and Henderson 2018; Bilson and Bywaters 2020; Pearson et al. 2020). Yet before this research, there had been no focused review of how local authorities and partner agencies use statutory powers at birth, including the actual practices of infant removal.

At present there is no *national* authorised guidance that sets out expectations of the range of health and social work professionals who are involved in the very difficult task of assessing the risk of significant harm and, where necessary, removing a baby from his or her mother’s care within hours or days of birth. Working Together to Safeguard Children (Department for Education 2018) contains scant reference to the unborn child, falling short of giving details of the particular challenges of providing and receiving effective support in the pre-birth period. Moreover, the team’s recent analysis of local area protocols has uncovered very different timescales for assessment and intervention (see Ward et al. forthcoming for a fuller account). Recognition of considerable variation between local authorities in terms of timeframes for pre-birth assessment and sharing plans is not new; in 2018 Lushey et al. drew similar conclusions.

Removing a baby from his or her mother’s care close to birth is distinctly different from removing older babies or children. A whole host of specific questions arise because removal usually takes place in maternity settings. From our review of the literature, there are multiple, specific questions that pertain to the removal of a baby at birth, concerning breastfeeding, privacy needs, timing of removal, processes of serving notice, involvement of the police, involvement of wider family, actions to address immediate distress and appropriate aftercare for mothers, and infant placement (Mason et. al. 2019). To date, studies that provide insights into these particular challenges are few in number (Poinso et. al. 2002; Wood 2008; Radcliffe 2011; Everitt et al. 2015, 2017; Marsh 2016; Bicknell-Morel 2021) and this has left practitioners with limited opportunities to compare their own practices or learn from best practice in other areas.

During this study, frontline practitioners shared multiple concerns with the research team, including a lack of resources and the withdrawal of preventative services, making separation more likely; pressures over hospital beds in postnatal wards, which impact the timing of separation; vulnerable women returning from hospital to empty homes, alone and unsupported just after having given birth and having been separated from their babies; and placement of babies in temporary foster care due to lack of planning. In the following chapters we provide in-depth reports of these challenges, drawing on verbatim extracts of focus group and interview data.

We have also seen examples in some areas of considerable work undertaken by professionals across the groupings who have gone above and beyond to try to support parents despite system-level obstacles. Furthermore, findings provide evidence in some sites of practice innovation that addresses these barriers.

Questions about effective pre-proceedings practice have been central to the work of the President's Public Law Working Group (PLWG) led by Mr Justice Keehan, which included questions about practice in pregnancy and at birth.[3] The final report of the PLWG (2021) also called for further data on, and analysis of, the scale of urgent hearings, making very clear widespread concerns from practitioners about proceedings that are issued in an unplanned or hasty manner. The findings from this study substantiate our earlier statistical release on urgent care proceedings (Pattinson et al. 2021; Broadhurst et al. 2021) because many parents described having to attend a first hearing after birth, at very short notice, and with limited support to engage meaningfully in the proceedings.

It is surprising that to date, there has been limited policy activity regarding unborn babies, or the removal of infants at birth. The NSPCC invested considerable resources in developing a framework for effective social work pre-birth. Although for various reasons the full potential of this initiative was not realised, it nevertheless resulted in a number of preliminary evaluations and impacted new models of working in some parts of the country, none of which were part of the current evaluation (Barlow et al. 2016).

The broader landscape of policy and practice

It is important to locate this study in the broader political and economic context of service delivery. The UK has experienced a period of harsh cuts to services under the former government's austerity measures, which have had a lasting effect and are now compounded by COVID-19. There have been increases in adverse indicators and the wider determinants of health, such as poverty and insecure housing, widening health inequalities and diminished life expectancy (Marmot et al. 2021; Watkins et al. 2017). The poorest local authorities have been hit the hardest, with a growing divide between the north and south in terms of family adversity and child welfare inequalities (Bywaters et al. 2018; Pickett et al. 2021; Broadhurst et al. 2021). Although it is possible to redeploy resources creatively as we have seen, local authorities that already have high numbers of children in care face considerable challenges in respect of redirecting investment towards prevention (Broadhurst et al. 2021). Long waiting lists for drug and alcohol services, high thresholds for mental health services and severe cutbacks to domestic violence services mean that parents have little specialist support to help them overcome the difficulties that place their babies at risk of significant harm; a lack of mother and baby placements mean that more babies are separated at birth. Inevitably – and in light of the findings we present in this report – this

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[3] The PLWG was set up by the President of the Family Division to investigate the steep rise in public law children's cases coming before the court and to offer recommendations for improving the ability of the child protection and family justice systems to address the needs of the children and families involved.

practice context will impact on the capacity of local authorities to transform services for the very youngest children in the family justice system.

Methodology

Participating authorities and the sample

Eight local authority areas and their seven corresponding health trusts in England and Wales were selected for participation in the study. Local authorities were selected on the basis of high rates of infants in care proceedings to ensure that we would have sufficient data collection opportunities during the timeframe for the study. The challenges that our sites report may therefore be more acute than in other areas, such as London, where rates of infants in care proceedings are much lower (see Broadhurst et al. 2018; Alrouh et al. 2019; Pattinson et al. 2021 for regional statistics). This also means that findings from this report may not be strictly generalisable across England and Wales.

A multi-agency steering group was developed within each of the participating sites, and relevant professionals were briefed about the study, its purpose and the inclusion criteria. Midwives, social workers, Cafcass workers, foster carers and heads of local authority legal services who had relevant experience in each of the participating authorities were invited to participate in focus groups or interviews. Parents were also interviewed in each of the eight local authority areas.

Most focus groups were conducted online because of the COVID-19 pandemic but, because of the sensitivity of the material, efforts were made to interview parents face to face, adhering to social distancing rules and with personal protective equipment.

The final sample is set out in Table 1. The final sample size (n= 307) indicates the scale of the qualitative research, and the systematic collection of data across each site and each professional grouping.

Table 1: Study sample

	Stakeholder groups	**No. focus groups/ interviews**	**Total no. participants across sites**
Focus groups	Social workers	16	105
	Foster carers	9	46
	Midwives	19	81
	Cafcass	4	22
Individual interviews	Principal lawyers (local authority)	8	9
	Parents	44	44
Total participants			**307**

Approach to focus groups and interviewing

Focus groups and interviews were conducted by two members of the research team (CM and KB) either face to face or online. Participants were invited to reflect on and discuss their experiences of the key stages of the parent journey:

- pre-birth
- in the maternity ward
- leaving hospital and returning home.

The groups were semi-structured, with the researcher initiating the discussion and guiding it to ensure that specific themes were covered, but at the same time encouraging participants to converse freely. Where focus groups took place online, these were recorded in MS Teams.

The focus groups were typically 90 minutes in length. The interviews varied in length (between 45 minutes and 1 hour 40 minutes). All were video recorded with the consent of participants and securely stored.

Data analysis

The interviews and focus groups were initially coded and compared for consistency between three of the authors (CM, KB and HW), using a structured data capture tool and dividing findings into the three categories identified above. The team also captured examples of good practice or local area innovation.

The researchers then analysed the data independently and were assigned to a particular stakeholder group. Regular data analysis workshops were held to compare findings.

Initial coding was informed by detailed background reading of the literature and engagement with the focus group and interview material. First stage coding resulted in a large number of open codes and early comparisons between these codes enabled commonalities between interviews to emerge and provisional themes to be developed.

The research team also paid attention to conditions of practice that were particular to the pandemic and reference is made to these, where relevant, in the body of this report. The most consistent issue raised by professionals concerned reductions in face-to-face visits – although professionals were already using online forms of engagement and telephone contacts, due to pressures on caseloads before the pandemic.

Moreover, most parents participating in the study were not in care proceedings at the time of the interview. Rather they were looking back at their experience of intervention at birth, before the pandemic. Most parents had experienced care proceedings, concerning a number of children, sequentially.

Regarding professionals, the research interviewers (CM and KB) encouraged participants to consider the issue of state intervention at birth more broadly, rather than specific to any period of lockdown or geographically specific social distancing rules. Professionals also drew on multiple examples of cases, tending to span a number of years. The findings were shared through a series of online workshops, to test the consensus about best practice and the barriers that prevented this happening. The workshops identified many commonalities and few areas of significant disagreement. They did, however, identify different priorities for different stakeholder groups, which was to be expected. The workshops also provided a forum for identifying further examples of good practice.

Rigour and quality standards

The process of data collection and analysis adhered to recognised standards for robust qualitative research (Daly et al. 2007; Davies and Dodd 2002; Hannes 2011). Key considerations included ethics, transparency in methods of recruitment and description of participants, the use of appropriate and rigorous methods of collecting interview and focus group data, as well as transparency in all elements of study reporting (Cohen and Crabtree 2008). Standards for online interviewing and focus groups were also important, given that much of the data collection took place during the COVID-19 pandemic. Here, we were guided by emerging new standards and principles that have provided guidance to researchers during the pandemic (Calia et al. 2021).

Two advisory groups provided advice to the team, one group comprising mothers with lived experience of being separated from their babies at birth and the second comprising policy, practice and academic experts.

Research approval and ethical considerations

The project was subject to ethical scrutiny and approval by the respective ethics committees at Lancaster University and University of Oxford. In addition, the project was subject to full scrutiny by any relevant governance groups within the participating local authorities and the Health Research Authority. A steering group was established in each participating site and a protocol was developed with each participating health trust, structured by Health Research Authority’s Information Organisation Document. Appropriate amendments were placed before all ethics committees when data collection moved online, and revised data collection plans were subject to further approval.

Recruitment to the study was informed by principles of voluntarism as outlined by the British Sociological Association (2017). Regarding parents, capacity to consent to interview was critical, and hence we did not include parents in this study who had previously required the services of the Official Solicitor within care proceedings or who the local authority felt were not able at this point to participate in interviews without harm. Regarding all participants, we paid careful attention to our explanation of interview/focus group protocols as well as how we would preserve anonymity and publications plans. Careful attention was paid to ensuring that birth parents understood the nature of their participation and the consent process, through a one-to-one conversation before the interview. Written consent was obtained following the sharing of a participant information document, before any data collection.

Procedures were in place to enable an effective response to parental distress/disclosure, given the sensitive nature of the project. These included the identification of a named professional within each local authority who supported recruitment and would respond to either a request for help from parents themselves or serious concerns about parents’ well-being on the part of the researchers.

A similar approach was adopted for the lived experience advisory group. Additional support for the group was provided by a specialist lived experience engagement lead from the charity Birth Companions.

Upon completion of the focus groups and interviews, all audio and MS Teams video recordings were stored securely within MS Teams for analysis, protected by 365 authentication and encryption. Following completion of the study the data will be moved to Lancaster University's Secure Data Hub, pending deletion within 10 years. The project budget did not allow full transcription of all interviews and focus group recordings, hence permissions were sought to retain the original audios and videos.

Diversity and inclusion

This study adhered to high standards in respect of participatory research and was steered throughout by a wide range of representative organisations and the dedicated mother advisory group. Women with lived experience of being separated from one or more of their children at birth were recruited via a range of relevant organisations. In the first instance, two groups were established, one in the north of England and one in the south. Following the pandemic and restrictions to face-to-face meetings, the groups merged and met online.

Regarding interviews, plans to recruit parents from a broad range of organisations could not be taken forward because of the constraints felt during the pandemic. All parents were therefore recruited via the local authority. Parents from Black, Asian and other minority ethnic communities were underrepresented, which is a limitation of this study. The disproportionate way in which infant removal affects some communities has been highlighted in the international literature and points to the importance of issues of racial disproportionality (Marsh et al. 2017; O'Donnell et al. 2019; Keddell et al. 2021a, 2021b). Disparities in outcomes for women from different ethnic minority groups in the UK have also been highlighted in Saving Lives, Improving Mothers' Care – Lessons Learned to Inform Maternity Care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016–18 (Knight et al. 2020). While the *Born into Care* research has demonstrated wide regional variation, further research is needed to interrogate the extent to which ethnicity is an important factor in this variation. Further work is planned to consult families from a more diverse range of communities and relevant advocacy organisations to adapt the draft best practice guidelines. The same also applies to parents with learning difficulties, who are overrepresented in this cohort but underrepresented within this particular study sample, reflecting the constraints on recruitment and online participation during the pandemic. In the final chapter of this report ('Conclusion and next steps'), we outline how we plan to ensure the draft guidelines that accompany this report are further developed and adapted to take account of these additional consultations.

Efforts were made to include both mothers and fathers in this study, however local authorities reported that considerable difficulties were met when attempting to recruit fathers. In total, 49 parents were interviewed – 6 fathers and 43 mothers. While this report includes references to fathers' issues, much of the evidence concerning parents' experiences comes from mothers. Again, further work with fathers' organisations will be important as part of a programme of work aiming to transform services for families subject to state intervention at birth.

Notwithstanding the importance of including fathers, many of the issues specifically addressed in this report cover experiences that are exclusive to women. Giving birth, appearing in court a few hours after delivery, spending time as an inpatient on a maternity ward and breastfeeding a baby who is about to be removed are all essentially mothers' experiences. While we have included both parents’ perspectives wherever relevant, much of this report unavoidably focuses on the perspective of mothers.

Pre-birth practice (conception to labour)

In previous publications that form part of the *Born into Care* series, we described shortfalls in national guidance regarding pre-birth assessment and wide variation in local area guidance (Broadhurst et al. 2018; Ward et al. forthcoming). Given this context, it is not surprising that we found considerable variation in practice across the eight participating local authority sites. During the period of data collection (2019–2021) some sites had also taken steps to make major changes to pre-birth practice to ensure a far earlier, multi-agency response to mothers, fathers and extended family networks during pregnancy when there was a risk of significant harm. However, although the focus groups and interviews revealed considerable consensus between parents as well as professionals as to what might constitute good practice, numerous shared challenges were reported. In this chapter, we first report the common challenges highlighted across the participating sites by parents and professionals alike, together with their implications, before moving on to describe stakeholders' views of best practice. Points of divergence in perspectives are also noted.

Common challenges and their implications

Professionals and parents shared some clear and consistent messages about shortfalls in current practice that they wanted to see changed or that were in the process of changing. Shortfalls in practice in the pre-birth period were described as leading to missed opportunities to help parents overcome the problems that placed their babies at risk of significant harm and prevent care proceedings. They also had a knock-on effect in terms of family experience following the baby's birth.

We have grouped the key challenges to effective pre-birth practice into the following six core themes:

- insufficient focus on the impact of parents' experiences of trauma and history of involvement with children's services as specialist issues
- the uncertain status of the vulnerable unborn child in social work and midwifery practice, and the short pre-birth window of opportunity
- resource constraints and the loss of preventative services
- discontinuities and insufficient alignment between different professional services involved with families
- risk aversity and shortfalls in family-inclusive practice
- challenges to effective practice under the Public Law Outline (PLO) and unresolved legal dilemmas.

Insufficient focus on the impact of parents' experiences of trauma and history of involvement with children's services as specialist issues

Nearly half of cases of care proceedings at birth concern parents who have previously had a child removed from their care (Broadhurst et al. 2017). In keeping with findings from our previous work, many parents also had lengthy experience with children's services in their own childhoods or were care-experienced. Parents brought legacies of difficult childhood experiences to their engagement with children's services as adults. They wanted services to appreciate how hard it was for them to trust professionals, particularly where they viewed their public care experiences as contributing greatly to their adult difficulties:

> *Yes, I was in care. The reason I turned out the way I did is on them, do you know? I'm a product of their environment, so they want to tell me then oh, 'I'm this, I'm that'. Well, you're saying I'm all this, it's because of you. You had me in care since I was 11. You moved me from everywhere.* (Mother)

In earlier work, members of the research team have reported that many women who experience the repeat removal of children from their care have experienced multiple moves in care as children (Broadhurst et al. 2017). Earlier findings resonate with women's accounts in this study. Many of the parents had led lives characterised by transience, with numerous changes of parental figures, partners and domiciles, and changes of placement for those who had spent their childhood in care (see also Broadhurst et al. 2017; Broadhurst and Mason 2019; Ward et al. 2006). Frequent changes of key professionals reinforced these earlier experiences of discontinuity and affected parents' abilities to form trusting relationships with practitioners – a prerequisite to their engaging with services (Ward et al. 2019; Broadhurst et al. 2018; Mason et al. 2020). Feelings of shame and stigma associated with previous child removal also further compounded these difficulties (Broadhurst et al. 2017; Morriss 2018).

Professionals were, in general, acutely aware of the impact of loss and trauma on women's lives but felt that service structures and resource constraints left parents feeling let down by services, paralleling their childhood experiences of local authority children's services or public care. Although in this study we were only able to interview a small sample of fathers, they voiced the same frustrations.

Both parents and professionals alike felt that too much weight was placed on parents' histories either as children or on account of an earlier child removal. Social worker churn, and a fragmented service offer, tended to result in professionals falling back on the history of a case. In the absence of close engagement with parents, there was, in some cases, simply insufficient evidence of parents' capacity to change to challenge a tendency towards risk-averse practice (Critchley 2020).

What does good practice look like? In some of the participating local authority sites, a bespoke service was available for parents who had experienced prior removal of their children ('recurrent care service'). These services were reported to be invaluable in offering parents therapeutic support to address both the difficulties that had led to child removal, and also to help them come to terms with their loss. In some cases, this included improved relationships with children in kinship or foster care. Bespoke services designed to prevent repeat removal were also able to undertake pre-conception work with parents and to address issues of trauma and mistrust which could prevent parents from engaging with services. In some authorities, however, these had been discontinued due to a lack of funding.

The uncertain status of the unborn child in generic children and families social work and midwifery practice, and the short pre-birth window of opportunity

Professionals reported that the unborn child can get lost in children and families social work practice, particularly, where teams are overstretched.

> *A dedicated pre-birth team focuses on pre-birth, but in a generic team, the unborn can fall down the list.* (Cafcass worker)

Midwives in generic community teams also described similar difficulties in giving sufficient priority to mothers with complex social needs during pregnancy. They stated that the standard organisation of practice is tailored to the broader population and lacks both the focus and intensity of contact that is needed when mothers have higher levels of social need. The frequency of generic community midwife contact with these mothers during their pregnancies was described as insufficient; it does not readily lead to identification of need, nor to an effective response. Midwives also described a lack of consistency in levels of skill, confidence and training, leaving some community midwives ill-prepared to identify and respond to women with complex social needs and circumstances.

> *There are definitely midwives who would shy away from asking the questions, because they are difficult questions and they want to keep the woman happy. Just from being in the early days of this new role that I am doing I go onto the booking and see questions haven't been asked, and that is because they want to leave that for somebody else to ask. And that can then be hard a bit later on down the line when we have got to go back in and ask them... Others might have different opinions, but I think some midwives think that they are maybe questions that they shouldn't be asking.* (Specialist midwife)

Many midwives argued that properly resourced case-holding specialist midwifery practice was needed if antenatal care is to be sufficiently intensive and attuned to women's complex needs.

> *If you've got a clinic that runs on a certain day, and it's full, there's nothing you can do…when social services want a midwife to write a report on a woman, you can't find a midwife who knows that woman. You can find the midwife who booked her. You can find the midwife who was there when she had her 16 weeks scan, but you can't… You can in our roles [specialist midwife] but in the other, the traditional model, you can't find somebody who knows that woman well enough to write the report.* (Specialist midwife)

Social workers, midwives and local authority lawyers stated that if there were delays in referring unborn baby cases, if they were left unallocated or were not given priority within social work caseloads, the opportunity to help families make changes to their lives and avert care proceedings was reduced.

Many parents needed the earliest possible offer of help to enable them to address, for example, problems of mental health and substance misuse, or to secure stable housing. Professionals argued that timeliness of help in pregnancy was all the more pressing, given the 26 weeks statutory timescales for completion of care proceedings.

> *People are disadvantaged from the start if they are picked up too late in proceedings, because of drug and alcohol issues, given the [current] timescales for change.* (Cafcass worker)

Yet referrals of pregnant women whose infants were at risk of harm, and responses to them, often appeared to be driven by processes that were at odds with the swift and effective intervention needed within the short window of opportunity offered by the pregnancy. These qualitative findings dovetail with our previous research. For instance, our review of local guidance (Ward et al. forthcoming) found that, while all the participating authorities required a child protection plan and/or birth plan to be in place at 32 weeks' gestation, a number of sites did not accept referrals made before 16 weeks, cutting deeply into the time available in pregnancy to help parents effect change. There was considerable variation between local authorities regarding the timing of both assessment and support in pregnancy. This was influenced not just by local area protocols, but also by the availability of resources.

Moreover, despite changes to the front door of children's services to create a single child and family assessment following the Munro review, many authorities were still operating a two-stage assessment system. An initial screening process typically sees the unborn child and parents allocated to lower-level family support and it is only after a child protection conference is held that a more intensive parenting assessment takes place.

In some sites, attempts had been made to avoid delay by developing a pre-birth offer of early help delivered by specialist family support staff or outreach workers. Although this resulted in an earlier offer of support, these initiatives were not always integrated with the rest of the system. As a result, delays could still arise because this work was not taken into account when a pre-birth assessment was subsequently undertaken by an allocated social worker.

> *Early help won't undertake pre-birth work unless there is a CiN [child in need] plan. Does not go to CP [child protection] team until after ICPC [initial child protection conference] at 24 weeks and by then there is very little time left to work with family.* (Social work manager)

The greatest risk to effective help resulted from multiple assessments and transfers of social worker and, therefore, relationships. In some areas, an in-depth assessment with a focus on parental capacity for change did not start until after the initial child protection conference. Any delay in the identification of need or provision of services is problematic in pre-birth practice because there are often lengthy waiting lists for specialist help such as drug and alcohol treatment or mental health support.

Social workers also commonly commented on the artificial separation of assessment and support which created further delay and led to a service that was insufficiently change-oriented.

> *We have an assessment that recommends another assessment with a really short window to just assess and no intervention*. (Social work manager)

In many areas, a delayed referral followed by a late or limited social work response therefore resulted in a narrow service offer to families, largely focused on assessment, leaving parents feeling that they had not been given a fair chance to turn their lives around. Professionals also argued that once care proceedings had been issued, it could be far harder to help families overcome their difficulties.

> *I think it [referral] came in after 12 weeks and then there was just a delay with it going to conference. And I think it ended up going to conference sort of at 32/33 weeks. So realistically, then, we had had about, I, I picked it up at that point and had about four weeks 'til baby's due, so you know, for me, I was looking back over the history and thinking there's just absolutely shedloads of work here which hasn't been done, you know, and you know, we're going to get slated for that basically, because we're going to have to, you know, baby's going to have to come out, that's obvious. You know, referrals have only just gone in for pre-birth support work. You know, it's just absurd, really.* (Social worker)

It was evident from the data that pregnancy offered a window of opportunity that needed to be seized, but time was of the essence. The three authorities that had appointed a specialist pre-birth team or a dedicated pre-birth offer within Early Help had largely been able to make better use of this opportunity by allowing referrals to be made directly to them, thereby circumventing time-consuming processes and offering more time for intervention.

Although there is firm evidence from analysis of quantitative data presented in other reports in the *Born into Care* series (Griffiths et al. 2020a) that very few mothers conceal their pregnancies, social workers in at least two of the participating authorities described some reticence on the part of mothers, which could delay their engagement with antenatal care. In their experience, mothers who had previously experienced the removal of a baby, or who were in the midst of proceedings for another, older, child, could be reluctant to come forward for antenatal care.

> *I know a couple of my mums have been in that position and they've been like, 'I don't know what to do, …, because if I tell them I'm pregnant, it's going to be used against me in assessment, and actually, I don't want that to be skewing my chances of keeping this child as well'.* (Social worker)

Other parents who had been referred in a timely manner dealt with their anxieties by being out when the social workers visited, failing to respond to phone calls and generally avoiding them. Social workers stated that considerable time could be lost in the first few weeks because parents were angry or fearful, and for many reasons often relating to their own difficult pasts, attempted to avoid engagement.

> *One [issue] is whether the parents are engaging with you or willing to engage in the first place. And because if they won't speak to you, it's really difficult to have those conversations. And I know certainly in cases we've had, I've had as a manager here, we've had to have those communications through lawyers because, or solicitors, because the family don't want to speak to us, won't let the social worker through the door, won't pick up the phone.* (Social work manager)

Nevertheless, many parents were ready to engage and were determined to make the necessary changes to ensure they could keep their baby in their care. However, the qualitative data collected through interviews showed considerable evidence that despite parents' own help-seeking efforts in pregnancy, there were ongoing barriers to both timely referral by midwives and timely responses from children's social care that reduced the pre-birth window of opportunity.

For example, practitioners argued that while they may have had considerable concerns, in many cases it was difficult to predict how parents would respond to help. Earlier research has highlighted the very significant challenges parents face when involved in children's services during pregnancy (see Ward et al. 2019; Critchley 2019; 2020). In all sites, examples were provided of parents who had made considerable progress to overcome difficulties, where help was timely and tailored to need. Professionals and parents alike expressed disappointment and frustration where insufficient priority was given to the pre-birth period in terms of both practical and therapeutic help.

> *There are a good number of cases that end up in court because no one has a grip on the case*. (Local authority lawyer)

Examples were also given of parents who were not able to benefit from intensive support, despite it being offered. However, the consensus among professionals was that efforts should always be made to give parents the best chance of change, because even where they are unable to improve their capacity to care for a new baby, they are at least potentially left in a better place themselves and with a more positive experience of public services.

What does good practice look like?

In some areas a local authority specialist pre-birth team or early help pre-birth offer had been set up, either as part of the local authority or as a specialist service. The focus group data suggested that the specialist pre-term team ensured a timely focus on the unborn child, afforded far better communication with both legal and health services and that parents' experiences within these services was far better. A specialist pre-birth focus removed the risk of unborn cases being left unallocated and issues of service fragmentation were greatly reduced. The specialist pathways in early help also led to an earlier and more intensive offer of support that was greatly valued by parents. Earlier and specialist intervention also enabled issues of maternal and foetal health to be addressed. Similarly, specialist midwives who were able to case-hold women throughout pregnancy also had more time to ensure adequate support was given to women with complex social and health needs.

From evidence shared with the research team, multi-agency workers in a single specialist team appeared to deliver very promising results in averting the need for care proceedings in a greater number of cases. Not only did specialist teams provide an expert focus on the unborn child, if they were multidisciplinary, they also improved collaborative working and promoted better understanding of the perspectives of colleagues from other disciplines. In the authority where this had been introduced, they were also set up in such a way that they were more likely to produce a timely response to the needs of parents and had better opportunities to provide continuity of care. Multidisciplinary pre-birth teams and specialist midwives were able to accumulate experience and knowledge, which enabled them to work in partnership with mothers and babies in particular, to reduce risks to the unborn child and improve well-being in pregnancy. Notwithstanding the importance of the coordinated offer of support, it is also worth noting that where specialist pre-birth teams were not well integrated into other social work and midwifery services, some of the problems experienced by parents, such as delayed action and poor information-sharing, persisted.

Resource constraints and the loss of preventative services

Across our participating sites in England and Wales, shortfalls in services were identified. In some areas these were multiple. In some local authority areas, the hollowing out of preventative services was described as having had a devastating effect on the ability of social workers to work constructively with families to effect change. Acute social housing shortages combined with insufficient drug and alcohol or domestic abuse provision, and a lack of mother and baby placements, left social workers with very few options other than care proceedings.

> *So, when we are writing our assessments in terms of identified risk, a lot of the times we have to say removal at birth because there are no facilities. Although we should never say this and this should never be as part of our assessments, we have to because you're not going to find foster carers who are going to be able to manage that risk.* (Social worker)

> *It's the first time I've seen assessments, where there is simply no evidence of anything being offered to the family.* (Cafcass worker)

Common to all areas was a concern that mental health services were unavailable for parents, or that there were long waiting lists, or parents did not meet the threshold or criteria for service provision. Appropriate mental health provision was described as vital for parents whose lives were characterised by trauma, loss and disadvantage. In our earlier reports in the *Born into Care* series we have documented the high incidence of mental health difficulties for parents (Griffiths et al. 2020a, 2020b; Johnson et al. 2021) and set out the kind of considerations that ought to shape the mental health response to parents in care proceedings (Griffiths et al. 2021).

Midwives similarly expressed concerns about the nature of available interventions for families, also identifying shortfalls, particularly around mental health provision. The use of 'standardised' packages and generic offers of support, as opposed to intervention matched to specific need, was also seen as problematic.

> *I think it's really poor. When family support workers are allocated from social care, it's the same old thing in the care plan, isn't it? You know, work around substance use and its effects on the family. It's a tick box exercise in my opinion…. We go to core groups and it's just, 'Oh, yes, they've done the Freedom', you know. And, 'Oh, go down to [drug service] and get a drug test, because you've had a past history of substance use'. That all needs looking at, because it's just dreadful, dreadful*. (Specialist midwife)

In some sites, panels of senior managers, established to control scarce resources and ensure best match of resource to need, had also had the unintended consequence of introducing a level of bureaucracy that led to delays in providing families with support and intervention. However, it was also clear that there were differences in how local authorities were using available resources. Most local authorities had moved away from residential placements, favouring mother and baby foster placements or placements with kin following a baby's birth. Some professionals described residential placements as overly rigid and with expectations not sufficiently tailored to the needs of young parents. Professionals also raised questions about whether a residential assessment provided adequate evidence of how a parent would manage when back in their own community. Residential placements were also expensive and their availability differed considerably from one area to the next, which could mean that mothers were placed in centres many miles from their homes. In some areas, there were also fixed criteria about which mothers could be placed in mother and baby foster placements. Some local authorities were restricting them to young mothers or care leavers. Moreover, placements tended not to include opportunities for fathers to be placed with their partners and babies. Across the board, professionals identified concerns about shortages in local mother and baby foster homes, and the cost of out-of-area placements.

What does good practice look like?

In some of our research sites, the skills of foster carers were used to plug the gaps in family support services to excellent effect, and foster carers generally felt that their services could be put to more creative use. The placement of mothers with foster carers in the third trimester of pregnancy appeared to be welcomed by professionals and parents as an opportunity to build relationships before the baby was born. Below, we also discuss wider family as a resource and consider the different ways in which family members were engaged by local authorities as a key support for parents.

Discontinuities and insufficient alignment between different professional services involved with families

By collecting data across different professional groups and probing parents' experience, it was clear that all stakeholders felt more could be done to reduce discontinuities and improve the coordination of multi-agency practice in pregnancy. Typically, professionals reported the following:

- discontinuity of professional involvement
- shortfalls in inter-agency cooperation and communication resulting in fragmented or inconsistent messages to parents.

Lack of resources had an adverse impact on good practice in numerous ways that went far beyond the obvious absence of key services. Not only were pregnant women unable to access services that might help them make positive changes before the birth, but they were also more likely to experience frequent changes of key practitioners as social workers were harder to retain and short-term agency staff were more likely to be employed. In areas where safeguarding or other specialist midwives did not hold responsibility for individual cases, community midwives were often overstretched and did not have time to attend key multi-agency meetings, with the result that their input was inconsistent and fragmented. Inadequate resources also underlay discontinuities in legal representation: because pre-proceedings work was so poorly paid, more junior members of legal practices or a paralegal might be sent to pre-proceedings meetings. Consequently, parents might not be contacted by their solicitor until after the birth, when care proceedings had been initiated. This inevitably had an adverse impact on continuity and the way in which parents were represented in court, and their perceptions of having had a fair hearing.

Not all discontinuities could be attributed to inadequate resources. For instance, in some local authorities, children's social care was organised in such a way that discontinuity was built into the system, as parents were transferred from one practitioner to another while they moved through the processes of referral, assessment and intervention. Changes in social worker were consistently highlighted by parents as problematic.

> *The one thing that got me was how many social workers we had… You need someone that is consistent and is going to be there and not keep changing. You build a bond with somebody and then they just keep leaving.* (Mother)

Similarly, in areas where there was adequate resourcing for enhanced or specialist midwifery teams to hold individual cases, discontinuity was less likely and was acknowledged by midwives and parents as a preferable option – a finding that is in keeping with other studies (Marsh 2016; Mason et. al. 2019; Bicknell-Morel 2021). While there was evidence in some areas of non-case-holding specialist midwives going above and beyond their duties to offer support to women, this clearly came at a personal cost.

> *If I have got a woman who has got complex social needs I do like to caseload [case-hold] them, but then that feeds into my time. And you do end up doing more in your own time or writing reports in your own time or just being at the end of a phone. And you do that because you want to care for them well, but it is beyond your day-to-day job, if that makes sense. You do it because you want to know that you have cared for them well, but then that does feed into your own non-work life as well sometimes, especially if they are quite intense.* (Specialist midwife)

Discontinuities also affected relationships between professionals, making cooperation difficult and sometimes resulting in inconsistent or conflicting messages to parents. Midwives consistently referred to the difficulties in contacting social workers and the lack of updates on case progression. Similarly, social workers found the lack of consistency of midwifery attendance at key child protection meetings frustrating.

> *I get that you can't have the same midwife there when you are delivering, but I don't know if I've ever had a situation where I've consistently had the same midwife attend core groups, or where a mum has consistently had the same midwife for her appointments. … the difficulty is then you are not getting a consistent narrative. You are getting different perceptions every single time at every single meeting, and it makes it all the more difficult to really get parents on board and feel like they are confident that everyone knows what they are doing. For me it's a massive issue, the inconsistency*. (Social worker)

In such circumstances, it was difficult for key meetings to reach jointly agreed decisions, and information could be poorly disseminated. In some authorities, poor information-sharing was exacerbated by limited access to shared IT systems and lengthy delays in producing and distributing minutes from meetings – in one authority they took four weeks to appear. In one health trust the continued use of paper records made it difficult to ensure the mother's notes were always in the right place at the right time. As a result, the plan for the baby at birth was not always shared between professionals and parents at a sufficiently timely point during the pregnancy, and midwives on the maternity wards sometimes had insufficient information regarding the local authority's plan and the reasons behind it.

What does good practice look like?

In one local authority area a working group had been set up across agencies to align services during pre-proceedings at birth. This had greatly reduced the likelihood of urgent, unplanned care proceedings and created flexibility on the part of hospitals, in contrast to the typical rigidity of hospital discharge policies. In another site, detailed work between midwifery and a new specialist pre-birth team had resulted in considerable improvements in the timing of birth plans, information-sharing and planning between children's social care and the specialist safeguarding midwifery team.

Risk aversity and shortfalls in family-inclusive practice

Clear efforts were made in all the sites to look for alternative family carers at the point at which care proceedings at birth appeared likely. However, some professionals argued that family members could be drawn in as a key resource for parents at a far earlier point in pregnancy, as some authorities were doing with foster carers (see above). Too often, family members were not approached until an alternative placement for the baby was required, although they could potentially have formed a key network of support throughout the pre-birth period and beyond.

While some of the local authorities had family group conferences or family meetings as an intrinsic part of their child protection pathways, this was not the case in all sites. Furthermore, in places where family group conferences were used, the referral to the relevant team was often not made until the third trimester. As a result, opportunities for the kin network to support parents and to address professional concerns with regard to the pregnancy were missed and inevitably the focus moved to possible alternative placements for the baby.

In keeping with the existing literature (Featherstone et al. 2007, Maxwell et al. 2012, Phillip 2020), fathers could also be marginal to any professional intervention in the pre-birth period; in at least one authority, they were not included in planning and decision-making unless they had parental responsibility. Difficulties with costs and timing of DNA tests were also cited as barriers to working with fathers at an earlier point.

Although few in number (n= 6), interviews with fathers suggested that they felt marginalised in the process – an issue further exacerbated by COVID-19 restrictions. In keeping with mothers, fathers spoke of finding it hard to escape their histories.

> *That's a main issue me personally, I wanted to get across because I felt like I was being judged because I used to drink. I was being judged because I've done domestic violence, I've done abuse. I felt I was judged. I felt like I was being tarnished. Once you feel like you're tarnished, you feel like you can never get out*. (Father)

Some social workers acknowledged that fathers tended to be excluded from the planning process:

> *So I would say more often than not, the dads really aren't included within the initial stages. It's kind of the focus is on the mum*. (Social worker)

On the other hand, women who were victims of domestic abuse raised considerable concerns when their partners were included in meetings with the social worker, as this prevented them discussing their concerns and needs openly.

> *And her dad came with us [to mother and baby foster home] but I didn't want him to, because obviously he'd been abusive to me and he was still continuing. And I didn't want him to come with me but, because he was there*

> *in the meeting at the hospital, I couldn’t tell anyone. So, he ended up having to come with us.* (Mother)

However, much of the data indicated that shortfalls in family-inclusive practice were related to perceptions of risk. Much of the local guidance had been produced in response to the findings of a serious case review following the avoidable death of a baby and it focused on identifying risks of significant harm (see Ward et al. forthcoming). Family members, and particularly fathers, were often perceived as a risk rather than a resource, and this was reflected in practice that excluded them or paid little attention to their potential role in supporting the mother throughout the process from pregnancy to removal (see also following chapters). Social work managers spoke of how infants came into the care system because professionals from all agencies found it difficult to manage risk. As one social work manager put it, ‘If in doubt, get them out’.

What does good practice look like?

The interviews provided examples of where fathers had felt more included and had offered considerable commitment to the process. In all these examples, the relationship between the parents was ongoing and they had committed to staying together. In these instances, the support the parents offered to each other was clear. In one local authority particular attention had been given to offering group work-based parenting programmes, specifically for fathers. In others offering specialist pre-birth interventions, particular attempts were made to include the father or mother’s partner at an early point regardless of whether DNA tests had confirmed paternity.

There was also evidence of individual social workers working intensively with mothers who were demonstrating capacity to change and questioning a culture that felt like ‘a draconian drive towards “just let’s just jump into care proceedings”’.

Challenges to effective practice under the Public Law Outline and unresolved legal dilemmas[4]

A consistent finding from all professional groups and from parents was that issuing care proceedings at birth is fraught with ethical challenges and legal dilemmas. Professionals consistently stated that mothers who have just given birth are not able either to instruct a solicitor or to engage meaningfully in care proceedings. The following extracts from interviews with two local authority lawyers capture this concern.

> *Late presentation into the legal gateway and late escalation to the PLO process, causes immense issues for us as lawyers, and also for parents not really having time to participate in these proceedings fairly.* (Local authority lawyer)

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[4] The Public Law Outline (PLO) was introduced in 2014. It provided rules and expectations as to how care proceedings would be managed; it is designed to give parents a final opportunity to work with the local authority and show capacity to care for their children and protect them from harm before care proceedings are instigated.

> *Insufficient time for assessment and planning pre-birth means that we are presenting our care plan after birth – we aren't getting into the PLO process soon enough so the work isn't complete and we can't share the outcome and discharge plan in advance of mum giving birth – the mum's given birth and parents won't agree to voluntary accommodation… parents can't access robust legal advice, it's 'off the hoof' and then you are looking at an urgent hearing which is not fair for them.* (Local authority lawyer)

Family-inclusive planning pre-proceedings and transparency was evident in some sites or cases, and this clearly mitigated some of the distress that parents inevitably experience when the local authority plans to issue care proceedings at birth. However, social workers and midwives expressed concerns about what constituted ethical practice in the period before the care plan at birth had been agreed: was it fair to encourage parents to spend money they could ill-afford on buying equipment, clothes and toys for a baby when it looked increasingly likely that they would be separated at birth? This was particularly salient where local authorities had a policy of not telling parents of the plan until very close to the birth. However, discouraging parents from preparing for the arrival of a new baby would be equally presumptive and certainly be viewed as prejudicing the outcome of any care proceedings in favour of removal.

Social worker turnover was also cited as a major impediment to partnership working under the PLO, leading to fragmented and confused messages to families and creating last-minute panic. Added bureaucratic demands and layers of decision-making introduced as part of the PLO process led to further delays in care planning. Local authority lawyers felt particularly compromised if they were asked to rush the preparation of papers for the court, citing the key role they play in ensuring evidence is robust, fair and shared with parties at a timely point.

> *That does happen in my team rather a lot unfortunately, we have to prepare papers in a hurry, we don't have time to consider the evidence we are putting before the court, we get a lot of external pressure for that, from solicitors representing parents, and we take all the flack for that*. (Local authority lawyer)

> *Our job isn't just to get the evidence and send it to the court – we are not 'a middleman'. Our job is to present the best possible case for the court and to make sure we are getting the right outcomes for the children, legally, and sometimes we aren't given the time to do that*. (Local authority lawyer)

Again, differences were evident across sites, with clear evidence that in some areas, the capacity and organisation of teams and workflow meant that fewer cases were issued on a 'panic' or 'Friday afternoon' basis. The following two extracts illustrate the contrasting experiences of local authority legal teams.

> *A poorly prepared case, baby is born on Friday, I am just putting my SWET [Social Work Evidence Template] together now, happens very rarely now.* (Local authority lawyer)

> *By the time you get to the end of a pregnancy it's usually very clear what the plan is, whether you are going to court or not – and I think it's at the stage, we want to have a good look at the evidence, even before baby comes, let's look at the draft evidence and share with parents and their solicitors – so we are not ambushing new mums and dads on the day that it's going to court. But that isn't what happens, baby arrives and blind panic seems to ensue. 'Oh God we've got to get a SWET written' … 'We've got to get it into court today'. So yes, it feels chaotic from our point of view.* (Local authority lawyer)

Professionals recognised the value of high-quality legal advice pre-proceedings, but again it was a matter of chance as to whether this was forthcoming. The low fee attached to pre-proceedings legal work meant that parents did not always receive the skilled advocacy that they needed. Parents were described as often having learning needs, which meant they needed sufficient time to digest and make sense of the legal process, closely supported by a good lawyer and, in some cases, an independent advocate.

> *…the majority of our parents have learning needs themselves, they need time and they need information in a different format than a telephone call or a quick chat with their legal advisor about their options.* (Local authority lawyer)

The President's Public Law Working Group (PLWG) has clearly stipulated that better funding is required for legal representation pre-proceedings, and this is a welcome recommendation (PLWG 2021).

Time to digest and understand a plan for separation was seen as critical for parents. Professionals and parents all considered that transparent partnership working in pre-proceedings was vital to achieving a plan that was understood and accepted by parents. Attention to parents' communication and learning needs and preferences should be established at the outset and, if required, specialist assessments to determine cognitive needs undertaken at an early stage. Understanding of the process should be checked with parents at multiple points, and plans need to be clear and shared at least four to six weeks before the pregnancy reaches term. There should be no surprises either to partner agencies, such as health professionals, or to family members. Parents' accounts demonstrated that where these conditions were present it made a huge difference to their experience of the process. Below, two women share their experiences. The first did not know until her baby was born that the plan was to remove him immediately from her care.

> *I don't think anyone knew it was going to happen, no one knew but they did that and then they took out a protection order then…they came in and they said, 'You're not going to squeeze that baby and not give him to us.' I just gave him to them. I didn't want to kick off on them… [I had him] literally five minutes. Yes, I just think if you're going to do that to someone, I don't think you should make them go through labour without them knowing that they're not having their baby*. (Mother)

In contrast, another mother, currently pregnant following the removal of her previous baby at birth, described her experiences of a very transparent relationship with her social worker.

> *Just us knowing, just because she's [social worker] being so honest, and says, 'Look, I can't tell you for definite. I'm not going to tell you that he is coming home, I'm not going to tell you that he's not, until we know'. Just because she's been so open and honest about it now, rather than at the last minute, it's made a hell of a difference*. (Mother)

Some midwives and foster carers expressed a wish for greater involvement pre-birth, to ensure a consistent approach to parents. However, in this study, only a minority of foster carers had met parents before the birth. While understanding the challenges of this for local authorities, the minority of foster carers who had met parents in pregnancy were unequivocal about the benefits.

> *My experience was totally different in the beginning [when first became a foster carer] you used to get to meet the parents before the baby was born. And that was really, really good because they could ask me questions, I could ask them questions. You get prepared better. But now it's just a case of you get a phone call, there's a newborn wants discharge meeting tomorrow. And, then you go and it – it just feels heartless sometimes*. (Foster carer)

Voluntary agreements with parents

Many professionals felt that it was far better to gain the cooperation of parents before the end of the pregnancy to agree to voluntary accommodation of a baby following birth, rather than inflict a formal legal process on them in the immediate postpartum period. Professionals consistently described the use of voluntary agreements under s.20 of the Children Act 1989 or s.76 of the Social Services and Well-being Act (Wales) 2014, as a valuable collaborative option if the local authority intended to continue to work proactively to improve parenting capacity following birth, holding reunification firmly in mind. Voluntary accommodation of a baby with kin or with foster carers was seen as highly compatible with this intention.

> *[In previous local authority] We'd always try and get Section 20 first because we want to work with them and have them... It's kind of like an indicator that we're going to be working in partnership together and that it's going to be planned rather than just be an emergency hearing, and plus it gives us more time then to work with the parent and to get to court rather than it has to be there and then on that day, if it's a lot nicer for everyone involved, us as well, if we can then … and then they feel empowered because they're like part of that decision-making process*. (Social worker)

However, professionals generally felt that using s.20 as a holding position, pending the preparation of papers for care proceedings after birth, was neither ethical nor transparent and deprived parents and the baby of independent oversight by the children's guardian (Cafcass) and the courts. Best laid plans could, however, be overturned at birth, if parents who had initially agreed to a voluntary arrangement shifted their position once a new baby arrived.

Conversely, the majority of parents described feeling very unhappy with the voluntary agreements they had entered into pre-birth and wanted proper legal representation. A number of parents felt tricked or coerced by voluntary arrangements – particularly if the local authority's plan for contact and ongoing help was unclear.

> *…they said, if I didn't sign that and give consent, they were going to take her anyway. So, they said the easiest way would be to sign it, so I had to sign it*. (Mother)

Sometimes family lawyers were also seen as part of the problem, encouraging resistance to voluntary arrangements and an adversarial approach in pre-proceedings. Professionals said that where relationships between the local authority, parents' lawyers, Cafcass and the judiciary were adversarial, both in court and out, this was very problematic. There was some reference to an 'us and them' culture, which undermined concerted efforts to problem solve with families and between professionals.

Early notification and involvement of Cafcass

Local authority lawyers and guardians generally considered that early notification and involvement of Cafcass was positive. However, some stakeholders were concerned that if the guardian's engagement pre-proceedings was very limited, this might not always be helpful.[5] They referred to the risk of the guardian bringing a pre-conceived view of the family from previous involvement.

What does good practice look like?

Some parents described excellent support from their lawyers, particularly where they had previous involvement in care proceedings and the same lawyer represented them in new proceedings. Where legal representation was experienced positively by parents, they described a sense of feeling someone was on their side and fighting their corner.

In some cases, the local authority had ensured a timely and inclusive plan for infants to remain in the family network, with a very clear plan for contact in place, supported by the local authority. In some areas the development of a family group conference service was considered helpful in coordinating these conversations.

In one site a newly developed pre-birth protocol was supporting the timely use of pre-proceedings, and this was felt by professionals to be helpful in ensuring parents had earlier access to legal advice, so that they were clearer about the local authority plans. Families were aware of the local authority plan by 29 weeks of pregnancy, and this allowed greater opportunity to prepare them for separation and to find alternative placement options for the baby.

In summary

While there is evidence of social workers and midwives attempting to go the extra mile to work with families in very difficult circumstances, parents' accounts generally suggest a rushed process with insufficient support to address their identified issues. Professionals and parents were in agreement about the barriers to good practice. A late or insufficiently holistic response to families means that opportunities to prevent care proceedings are missed in the pre-birth period. Continuity of professional support, family-inclusive practice, and clear and transparent communication regarding plans are greatly valued by parents. In local areas that are experiencing the greatest demand but can offer the fewest resources, more families are missing out on opportunities to turn their lives around in pregnancy. Legal and ethical dilemmas regarding preparation for care proceedings during the pre-birth period remain unresolved, particularly with respect to the use of voluntary accommodation. A number of local authority lawyers and social workers are in favour of an approach to care proceedings that avoids the excesses of adversarial justice and want family members and practitioners to solve

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[5] In public law (care) proceedings, the Cafcass worker is known as a children's guardian. They are appointed by the court to represent the rights and best interests of the child.

problems together, to achieve a safe and mutually understood plan for a baby at birth. Some of the new approaches to pre-birth practice make it clear that some of the shortfalls that were shared with the team are not inevitable, but stem from long-standing structural hurdles to effective inter-agency working and the low priority of the vulnerable unborn baby in busy social work and generic midwifery teams.

Practice within the maternity setting and at first court hearing

The chapter builds on findings summarised in the team's previous review of the published literature on removal of babies at birth (Mason et al. 2020), and findings reported about urgent care proceedings at birth (Pattinson et al. 2021; Broadhurst 2021). We have grouped these key challenges into the following six core themes:

- discontinuities in professional support and insufficient specialist expertise
- shortfalls in family-inclusive practice and a risk-averse approach
- shame, stigma and lack of privacy
- insufficient opportunity for parents to bond with their new baby and insufficient recognition of the possibility of reunification
- unresolved legal and ethical challenges regarding care proceedings at birth
- inadequate planning, time, choice and support at the point of separation.

Discontinuities in professional support and insufficient specialist expertise

In the previous chapter we discussed the negative impact that social worker churn and discontinuity of professional help had on building positive relationships with families in the antenatal period. Professionals and family members alike reported very similar concerns in respect of practice following the baby's birth. In the maternity setting, discontinuities stemmed from shift patterns and staff handovers which, although routine, affected the sensitivity of care women needed. Midwives described very busy hospital wards, where there was simply insufficient staffing to provide the focused attention that women needed when faced with the prospect of care proceedings or the placement of their baby with alternative carers. They also reported insufficient specialist training, which meant that many felt midwives were inadequately prepared to deal with the acute challenges associated with compulsory safeguarding action at birth. As a result, professionals and parents all considered that practice could lack sensitivity and was not consistently attuned to women's needs or the level of distress being experienced.

A lack of effective and timely information-sharing resulted in midwives on the maternity ward not being fully versed in the mother's situation and the local authority plan. Midwives providing postnatal care within the hospital sometimes found it hard to understand local authority decisions regarding separation, based on their observations of women's care of the baby on the ward. Similarly, social workers sometimes found it difficult to cope with some of the negativity they felt was directed at them from midwifery colleagues.

> *Some of the midwives on the ward, who aren't necessarily a part of that, are quite good in understanding our role and why we are there, but there've been other occasions where I've had eyes rolled and been told that what I'm doing is disgusting*. (Social worker)

Inevitably, routine shift patterns and handover in busy wards can result in information about patients being less than complete. However, this group of mothers, who often arrived to give birth feeling unclear about the fate of their babies, found that a lack of knowledge on the part of midwives about their circumstances left them feeling further isolated. Conversely, where information had been shared with midwives but not parents, midwives felt compromised.

While any social worker managing the removal of a baby at birth will inevitably face the anger of parents, parents still complained bitterly about changes in allocated social workers. Depending on the structures and points of transfer within the local authority children's services, parents may have only known their baby's social worker for a brief period before the birth. In a minority of cases, the parent may *never* have met the social worker before proceedings were issued.

What does good practice look like?

Some interviews also provided positive accounts of midwifery practice. Midwives based within an enhanced team (vulnerable women's teams, substance misuse or case-holding safeguarding teams) appeared much more able to offer support to this group of mothers – and, despite most being community-based, did their best to visit them on the ward. Such visits provided women who had recently given birth with a far greater sense of emotional support and connection, helping to lessen distress. Not having to re-tell their story or guess what the midwife knew, or had surmised from their notes, helped women to feel that professional help was far more in tune with the enormity of the loss they were facing. There was also evidence of midwives on postnatal wards who had taken a special interest in this group of women and tried to do their best to offer additional care and support within time and resource constraints. However, it was also clear that without specialist pathways and designated professionals, providing the level of care that this particular group of mothers needed was a challenge for many health trusts.

> *I mean I'd love that there should be somebody who can take that lady into a room and have a cup of tea with her and talk to her and almost, not debrief her, but support her and look at when she's going home… But we don't have that resource. Unfortunately, with staff on the ward, with how busy it is, they don't have time to do that and they don't have the experience. A lot of them will be frightened to do that because they don't know what to say, what to do*. (Postnatal ward midwife)

Shortfalls in family-inclusive practice and a risk-averse approach

Consistent with findings in the previous chapter, interviews with parents indicated that practice often fell short in terms of including fathers and wider family within the maternity setting. Shortfalls applied to the inclusion of partners in the birth of a baby, visiting by friends and wider family, and in terms of broader partnership working and planning.

In keeping with findings from related research (Featherstone et al. 2007; Maxwell et al. 2012; Phillip et al. 2020) as well as our analysis of local guidance and the factors that drive it (Ward et al. forthcoming), decisions regarding the involvement of fathers also appeared, in some cases, overly focused on risk. This was particularly so if there were concerns about domestic abuse. While it is of course vital that women who are victims of domestic abuse feel supported and protected from partners, the data suggested a lack of nuance in decision-making with regard to these issues. We have already seen that fathers were often excluded from decision-making during the pregnancy. Where there had been a history of domestic abuse, they could also be excluded from key parts of the baby's life. Both professionals and parents cited examples of fathers being excluded as birthing partners, even where mothers had expressly asked for them to be present. Being excluded from the birth of their baby was particularly difficult to accept.

> *I think social services should always put something in place so the father's allowed at the birth, no matter what, do you know what I mean? No matter what his past is, what he's done, and all that carry on. Isn't that man allowed a chance to see his bairn coming into the world? That hurt me the most, that really badly hurt me... Ripped my heart out and stamped on it and put it back in, it was that bad*. (Father)

In other examples, information regarding histories of violence concerning both mothers and fathers led to hospital staff putting in place what parents (and some professionals) perceived as disproportionate levels of security. For instance, there were accounts of fathers who had had one episode of violence several years previously, being excluded from the ward. Again, this impacted significantly on women's birthing experiences.

Similarly, members of women's wider networks of friends and family might also face restrictions on visiting. As a result, some women felt insufficiently supported during their labour. In a minority of cases, women described giving birth without a birthing partner – no friend nor relative nor the father was present. Some women simply had no one to call on for support, but for others, feelings of isolation resulted from the exclusion of partners and/or family members from the maternity setting because they were deemed to be a threat to the mother, or to staff and other patients on the ward.

> *[I was] scared because, obviously, with being a care leaver and falling pregnant, you've got to have that. Like, they've got to make sure the birth plan's right. It's got to be what they want, not what I wanted. Also, my mum was always going to be my birthing partner, and I even told them if they tried stopping that, I wouldn't let them because who wants to give birth on their*

> *own? That's just a scary experience, but obviously, I had to be careful who visited me in the hospital and stuff like that*. (Mother)

In some instances, midwives overruled local authority advice, based on their assessment of the situation and what they considered to be in the woman's best interests.

> *It was just when I was actually in labour the midwife came in and she was like, 'We have looked at the plan, K. Apparently dad is not supposed to be round here while you are giving birth.' She went, 'But I can't understand why because he's been absolutely amazing.' This is what she said, you know? She went, 'I'm not going to ask him to leave, I'm sorry, not when you are halfway through giving birth.' He was there and he watched his daughter being born*. (Mother)

Evidence from social workers and midwives indicated that risk assessments that concluded that additional supervision of the mother and baby on the ward was required added additional pressures. In some instances, the local authority required 24-hour supervision, but there were considerable tensions about how this should be resourced. Midwives and social workers consistently raised this as an issue of concern.

> *That often seems to be a very contentious issue, when women do need that supervision, if they need some direct 24-hour support worker or someone in the room with them to observe them. Often, they are the women that arrive and there has not been anyone allocated. And we ring the number that we are told to ring and we are told, 'Oh, well, there is no one available tonight'. And that can be very difficult. And I think a lot of the time that is maybe because of finances as well. Who should be paying for that support? Should it be the trust or the local authority? And that can often be quite a tricky situation*. (Postnatal ward midwife)

While midwives were generally clear that the postnatal ward did not have capacity to offer supervision, in some areas they described children's social care as still exerting pressure. For example, midwives described being asked to put the mother in a bed near the nursing station and to ensure curtains were left open. In other instances, mothers were denied the opportunity to have a private side room because of concerns around potential lack of supervision. In other examples, the response had been to place the baby in a neonatal unit despite there being no specialist medical needs.

> *The social worker had written on the plan, after telling me that I could look after my baby for, like, a day or two in the room, she'd written down on the plan that I only got an hour skin-to-skin and [the baby] was going in the unit*. (Mother)

There also appeared to be a general lack of clarity as to the precise nature of concerns or the purpose of the supervision. For example, mothers described feeling unclear as to whether they were being assessed, and, if the person acting in a supervisory role was previously unknown to them, this felt very intrusive and added to feelings of a lack of privacy.

Professionals and parents all considered these requirements to be untenable. However, a focus on risk, coupled with ever shrinking-budgets and increasing workloads, made this a very vexed issue. While midwives and social workers understood the need to protect the baby as well as other patients and staff in the labour and postnatal ward, they also thought that current practice was in need of review and that a more proportionate response was required.

In some areas, working with the family network had delivered solutions in respect of supervision. However, interviews with mothers suggested this required careful consideration, as not all family members were supportive (see also Brown et al. 2016). Unless discussion had taken place and clear understanding and agreement reached in advance with the mother and her network, friction could manifest, leading to greater loss of control and further experiences of isolation.

Complaints about the lack of an inclusive approach to practice also applied to planning. In the previous chapter, we described some major problems in pre-birth planning in some teams where volumes of care proceedings were very high – outstripping professional capacity. Both mothers and fathers described the anguish that resulted from not knowing the details of the local authority plan for their babies, and rising anxiety levels as they waited for information.

> *I'd rather you tell me now because she is going to get taken...I'd rather you tell me your plans so I could prepare myself in my head. But they don't. They don't tell you*. (Mother)

Although parents gave positive examples of social workers attending the ward in person to explain the local authority plans, these were infrequent. In some cases, parents described phone calls from the social worker or a solicitor, taken while they were in bed in the main bay of a communal maternity ward, telling them for the first time that the authority was issuing care proceedings in order to remove their baby. For some parents, an absence of face-to-face contact with their social worker following the baby's birth was interpreted as a lack of compassion and care.

> *But in the two weeks we hardly saw them up at the hospital. We hardly saw them… That kind of hurts because we were thinking to ourselves, you're the one who's supposed to be taking our child off us, but yet you're nowhere near. You've not been up to see how she is. You've not been around to see how we are. I know it's fine for you to just ring up, but it would be better to see you face to face.* (Father)

The sharing of plans was also commonly described as hurried – again completely at odds with the enormity of care proceedings. Often midwives also described themselves as not knowing when the solicitor or social worker had shared plans with parents, and this further limited the chances of providing appropriate support. On the other hand, social workers described themselves as going to considerable lengths to ensure parents were aware of the likelihood of removal and were advised of the post-birth plan. As discussed earlier, given the emotionally charged nature of safeguarding babies at birth, the likelihood of miscommunication and misunderstanding is high. The need for information to be shared with parents multiple times, in a manner that takes account of their communication and learning needs, is crucial.

Importantly, parents' accounts illustrated the impact that 'waiting' had on their ability to focus on their baby. Midwives similarly described concerns about women left 'in limbo', as they waited for papers to be served, or a court date to be set. As will be discussed in more detail in the next chapter, a minority of midwives and mothers considered the waiting to be cruel and felt it would be better if the process were sped up. However, the majority consensus was that sufficient time and consideration should be given to the need to recover from the physiological impact of giving birth and to spend time with the new baby.

As was evident from the focus group and interview data, parents need adequate time and calm to come to terms with separation. However, conflicting timeframes and the limited time available to already overloaded professionals often made this impossible. NHS processes are predicated on the expectation that a healthy mother and baby will be ready for discharge within 24 hours after the birth. This allows little time to find a mother and baby foster home or arrange a court hearing, and pressures on hospital beds meant that social workers were sometimes faced with the threat of the local authority being charged for bed-blocking. The conflicting timescales were a source of tension between professionals and led to a sense of panic that conflicted with parents' need for time and calm.

What does good practice look like?

Focus group participants shared examples of practice that sought to tackle barriers to family inclusion, even in the context of problematic histories. Where family members could not be called on, there were instances where the resources of specialist organisations could be used. Professionals or community volunteers could serve as birthing partners and independent advocates, compensating for gaps in the mothers' own informal networks. In one local authority, family support workers sometimes supported mothers through the birth, in the absence of a birthing partner. There were also examples of foster carers supporting mothers at birth, particularly where they had been placed in a mother and baby placement during pregnancy.

In one of the participating research sites, concerns about aggressive or abusive behaviour that might prevent the father from being present at the birth were carefully interrogated. Agreements around managing potential conflict and minimising triggers that could lead to threatening or abusive behaviour were discussed, and strategies developed.

Shame, stigma and lack of privacy

Interviews highlighted the acute feelings of shame and stigma that many mothers had experienced within the maternity setting. They frequently cited examples of a lack of consideration of their need for privacy, compounding the stigma they felt. Many welcomed the opportunity to be in a private room away from other mothers, although this was not always offered or available. However, some wanted to be around other mothers who had just given birth, and sometimes being in a separate room added to their feelings of isolation.

For mothers and their partners, the most consistently cited privacy violation occurred when confidential conversations with their solicitor, social worker or other professionals were held within earshot of other women. Mothers described it as deeply stigmatising when professionals discussed legal, medical or other confidential matters in communal wards. The need for privacy was recognised by both professionals and parents, but again, professionals were overstretched and constraints on time and other resources meant that this was not always given sufficient consideration.

> *We didn't have any privacy at all. They wouldn't even let us go into a different room. She didn't see if we wanted to go to a different room, nothing. I couldn't really open up because of it… Yes. I didn't want them knowing or overhearing me, but I had to do what I had to do…. But I was okay talking about it. But it's just, I couldn't really open up more because I didn't have that privacy…. I know we could have closed the curtain, but it is still only a curtain*. (Mother)

Midwives described a shortage of individual rooms, office space or day rooms where women could meet with their social worker or solicitor in private as a key obstacle.

Data collection for this report took place, in part, during the pandemic. The constraints of social distancing and remote working meant that women were taking calls on their mobile phones, with no opportunity to be prepared for the call, or to request a private space where they could receive a call from a solicitor. In the most extreme case, one woman described attending the first court hearing from her mobile phone on the main ward with other women present. However, the issue of privacy on the ward in respect of confidential conversations with professionals pre-dated the current pandemic. In addition, it was clear that communication via telephone or online also pre-dated the pandemic.

Issues of choice were central for women. For example, although most women wanted a private room, some mothers described being placed in a side room without prior discussion or agreement leading to feelings of stigmatisation.

> *…they just gave me that room [near nurses station]. She didn't say anything, 'You're in this room because we've got no space'. She just gave me that room and had the door stopper under the door. I thought maybe they've done this because social services are involved, but it just made me, you know, like I was treated different to every other woman that's given birth*. (Mother)

What does good practice look like?

There were examples of midwives trying to offer women private rooms wherever possible, despite the lack of resource. Though a clear challenge, there were also examples of attempts to find rooms for private meetings with social workers or legal representatives.

Insufficient opportunity for parents to bond with their new baby and insufficient recognition of the possibility of reunification

The first few hours and days with a newborn baby are precious for all parents, but, when faced with the removal of that baby, these moments take on a new significance. Mothers and fathers described how navigating safeguarding and legal processes prevented them from focusing on, establishing breastfeeding (where chosen) and bonding with their newborn baby. Caught up in an often hurried and confusing legal process, it is unsurprising that parents felt their focus on their baby was overshadowed. Being unable to spend time or bond with their new baby was also salient for fathers who, for reasons previously discussed, may not have been encouraged or allowed to take part in parenting activities on the ward.

These reflections from parents are particularly important given that the actions the local authority takes at birth are interim, pending further assessment of parenting capacity. When the local authority issues care proceedings at birth, this is for an interim care order, and reunification of parents and child is one potential outcome of the court process. If an interim order is made, the local authority also has a duty under s.34 of the Children Act 1989 to promote contact with birth parents and other relevant family members.

Moreover, for this cohort of parents, the opportunity to parent and develop a bond with their baby in the first hours or days after birth may be the catalyst for their journey towards change (see Ward et al. 2012). Furthermore, in keeping with findings from the perinatal loss literature (Ott and McGrath-Lone forthcoming), creating memories in the maternity setting may be beneficial to parents and children in the long term, whatever the outcome of proceedings.

Unresolved legal and ethical challenges regarding care proceedings at birth

Professionals and parents highlighted significant challenges related to the legal process. As it currently stands, a first hearing may be scheduled within days, and in some circumstances hours, of the baby being born. Recent research in the *Born into Care* series has captured an increase in short-notice hearings for newborn babies (Pattinson et al. 2021; Broadhurst 2021). This research has drawn attention to 'same-day' hearings, where hearings are held on the same day that parents are served notice of proceedings. Findings from this qualitative study in the series indicate that risk-averse practice, early hospital discharge of mothers and babies (now a norm for all women), pressures on judge sitting time and priority listing of baby cases in the courts all appear to add to the stress and challenges parents and professionals face. Interviews demonstrate the painful impact that current arrangements have on parents. Mothers and fathers described receiving little notice – and in some circumstances no notice – of the court hearing.

> *The solicitor rang me and said we are going to court you need to get ready. I said, 'When?', and he said, 'Now. You need to leave now'...I needed to get someone to the hospital to look after my child, I need to get showered, dressed. I had no clothes, so I had to get clothes prepared, I had to get a lift prepared to get up there. I had literally not long to do that*. (Mother)

Professionals expressed considerable disquiet about court proceedings that followed swiftly after birth. They were concerned about women's capacity to assimilate vital information about the court process at such a time, and to access robust legal advice, undermining their ability to meaningfully participate in court proceedings. As stated in the previous chapter, the use of junior or paralegal staff during pre-proceedings also impacted on parents' sense of preparedness.

Midwives also consistently described the frustration they experienced because they often felt 'in the dark' about plans for care proceedings, or were given very little notice that women needed to attend a first hearing. As stated above, fathers could also feel left out of important discussions or, in cases where paternity disputes were still unresolved, completely excluded.

Mothers also discussed the anguish of having to decide whether to attend court. They described this as a Hobson's choice, either attending court and therefore being forced to spend time away from their baby, or forgoing the chance of participating in the proceedings and possibly giving the impression that they were insufficiently committed.

> I refused to go to court because I didn't want to leave him in hospital. So, his dad went to court and my solicitor went, representing me. But it was quite upsetting, because I didn't know what was going on in court or anything, because I'd stayed in hospital with the baby…. But then, at the same time, I didn't want to leave him at the hospital on his own. What if they hadn't heard him crying or something? (Mother)

Parents, midwives and indeed social workers voiced concern regarding the lack of consideration given to the mother's transport needs, with some mothers reporting having to travel significant distances by public transport to attend the hearing, within a day or so of the birth. Lack of time to consider who could care for the baby while the parents were at court added to the pressures placed on midwives and the emotional burden placed on parents. The time pressures often made it impossible for parents to arrange for family members or friends to either support them or care for the baby in their absence. Consistent with previous examples of good practice, in areas where a specialist pre-birth team was involved with parents or a specialist midwife was kept up to date and able to attend the postnatal unit, there was better consideration of the mother's needs. However, these examples were the exception rather than routine practice.

Professional conduct at the family court was also raised as a concern in parent interviews. Parents described an environment that commonly felt hostile and isolating. Many parents were emotionally raw and hypersensitive at this time, and behaviour which might, in other circumstances, have been considered innocuous, or simply polite, took on new meaning. Seeing parents' solicitors warmly greeting their local authority colleagues, or professionals meeting in private rooms outside of the court room, all led to parents feeling excluded, and in the worst examples, fuelled their fears that the system was corrupt and conspiring against them.

Behaviour of judges also had a considerable impact on parents. Where parents felt they had the opportunity to participate fully in proceedings, with robust legal representation, and requests to have their own voice heard were agreed, they felt a better sense of justice. On the other hand, where the parents felt proceedings were hurried, or they were not heard, they were left with a great sense of injustice.

What does good practice look like?

As stated above, continuity of legal advice was not typical, but where this was the case parents felt much more supported. Parents who felt they were given an opportunity to spend time with their solicitor had a greater sense of fairness. Where they were supported to attend court by a family member or friend this also mitigated feelings of isolation. Where parents had had some notice of the court hearing, this at least allowed some time to prepare emotionally and practically.

Inadequate planning, time, choice and support at point of separation

Unsurprisingly, where the court had granted an interim care order and the baby was to be placed away from them, parents described very traumatic experiences of separation and saying goodbye. Social workers and midwives also reported that being involved in this practice was a painful experience. While participants' perspectives varied in some respects, important commonalities emerged regarding planning, professional sensitivity, and time and choice. In most cases, the parents interviewed did not feel that adequate thought had been given to preparing them for the separation or to offering them any choice or control. In some examples, parents described a 'race against time' to get back to the maternity unit to spend any time with the baby before the social worker arrived. This was a particular issue when the court was some distance from the maternity unit and the parents were using public transport.

Social workers in focus groups also confirmed a lack of planning and consideration of the detail of separation. They described a system that focused on the legal process and left little time for them to think about the sensitivity of their practice. Social workers could see the problems with current practice and in most instances felt there was significant room for improvement.

> *And then there are situations where, you know, you've got a mum leaving the hospital who's given birth maybe last night, a few hours ago at worst, and, you know, she went through labour and she's at court for her child, but she's maybe only had, it's a few hours old. You know, that's an incredibly distressing situation and it's upsetting for social workers as well. You know, not that our feelings are the most important in that situation at all, but, you know, it's, it can be really upsetting to see women and dads put in that situation*. (Social worker)

Midwives also described being very unhappy with current practice. In a number of participating sites they felt that there was inadequate time to support the woman through the separation and that this was further exacerbated by lack of information from children's social care about the planned timeframe. Midwives working in the antenatal period considered the birth plan key to ensuring that adequate preparation took place.

> *Everyone knows it's coming but no one wants to talk about it, it's like when someone dies, no one wants to say it. But I think we should be talking about it and those conversations [with parents] – should be part of core group responsibility*. (Specialist midwife)

Currently, it is rare for birth plans to focus on parents' wishes if a separation is likely. Instead, the focus is on risk assessment (see Ward et al. forthcoming). Social workers in one authority raised concerns regarding pre-empting court decisions as the reason why the detailed conversation did not take place. However, parents' perspectives would suggest that having time to consider the detail before the birth – and to try to prepare emotionally – would be welcome, even if the court outcome could not be guaranteed. Parents wanted the opportunity to think through who should be present at the point of separation. Details such as who the baby should be handed to, what they would wear and who should leave the ward first, were all important choices. Choice and control over these and other details were hugely significant at a time when parents felt so fundamentally powerless. In these circumstances, small acts of kindness from professionals who showed empathy were greatly valued.

> *She got down on my level and she just held me hand. I remember her holding my hand. I'll never forget it. She was lovely*. (Mother)

Most (but not all) foster carers welcomed the opportunity to meet parents at the hospital and to discuss their wishes for the care of the baby before the discharge meeting. Those foster carers who expressed reservations about attending hospital had no prior experience of being there and were concerned about the highly charged emotion of the situation. However, those who had attended hospital felt this was beneficial if managed sensitively, and that meeting parents earlier was preferable. They emphasised the importance of the initial interactions with parents and saw them as critical to forging ongoing positive relationships once the baby was placed with them. As discussed, most could see the benefits to this first meeting happening before the birth, but also understood the process challenges. However, most wanted the opportunity to discuss parental wishes before the baby was given into their care. These included, for example, discussions about feeding preferences, including supporting ongoing breastfeeding, routines and even the parents' preferred brand of nappies. These discussions were considered as opportunities for foster carers to convey respect for parents' wishes and recognition of their ongoing role in the baby's life post separation.

> *Because it's little, it's the little things, isn't it, like what kind of nappies we want them to wear and what milk that they're on, what formula do they want. We get told. But it's nice to be able to ask them because you're still saying, I know I might be taking your baby, but this is still your baby, this it's your choice. It's like what colour would you like them dressing in?... It's just the little tiny things that they don't get a chance to say*. (Foster carer)

Foster carers also stressed the importance of the parents knowing who was looking after their baby and offering some reassurance.

Unfortunately, foster carers described these opportunities as rare. Across the participating authorities, professionals agreed that opportunities for parents to meet foster carers in advance of discharge meetings were exceptions rather than the norm. Many foster carers described the baby being brought to their house by the social worker and not meeting the parents until a first contact (family time) meeting, and indeed, in authorities where babies were transported to contact centres by volunteers, foster carers might have very limited opportunities to meet the birth parents.

Foster carers who had had experience of going to the hospital typically described meeting parents in the context of highly charged and formal discharge meetings. Many practitioners as well as parents described their discomfort with the current discharge meeting arrangements. While there were clear differences in experience, which largely depended on the social worker chairing the meeting, participants consistently raised ethical concerns. Foster carers described, for example, their discomfort when information was shared about the mother's substance misuse and the baby's medical needs in the meetings, describing this as highly stigmatising for her. Examples were given of more sensitive ways that midwives had sometimes shared this information with foster carers.

Parents, foster carers and midwives all described frustration that, in some instances, the social worker was not able to provide the parent with specific details about the placement or an opportunity to meet the foster carers in advance of separation. Indeed, in some cases contact arrangements were also not finalised, meaning that parents were unclear when they would see their baby next. Given that the separation commonly took place within a day or two of the birth, the high level of anguish described is perhaps unsurprising. Although recognising the need to complete the paperwork for discharge, midwives also shared concerns that the need to hold the meeting often took priority over other considerations regarding the separation. In many instances professionals described parents becoming very agitated, and this leading to a highly emotive and difficult separation.

Across the interviews mothers described feeling that their own support needs were rarely considered at the point of separation. Lack of notice and time to prepare made it difficult for parents to think through what support they might be able to put in place. In many instances women had very minimal support networks and several said that the only people who were with them when the baby was removed were the social worker and a midwife they had had little or no previous contact with. Issues of privacy were also raised – mothers highlighted leaving the ward without their baby as particularly traumatic, evoking strong feelings of shame and stigma.

> *I think one of the worst bits when you hand your baby over is the coming out of hospital. Because you've spent days there and you're watching people come out with babies, and then you walk out empty handed*. (Mother)

Social workers regarded it as good practice for the case-holding worker to undertake the removal, although it was important for parents to be aware that this might not always be possible – for instance if the social worker was on leave when the baby was born. In some sites, policies were in place to keep the same social worker or midwife involved with birth mothers who had experienced previous child removals.

While continuity of care was usually valued by parents and professionals, there were exceptions, such as where the relationship between the social worker and parents had become particularly hostile. In keeping with findings from the broader perinatal loss literature (Ott and McGrath-Lone forthcoming), where separations had been more sensitively handled, midwives, parents and social workers all noted the ways that inclusive planning and offering choice had made a significant difference.

While parents described the anguish of having their newborn baby removed from their care, the experience was also traumatic for the professionals involved.

> *Obviously we're doing a job. But we're also human beings at the same time. And taking a baby away from a new mum goes against everything you stand for, you know, ethically and morally. And it's a really, really traumatic thing for everybody involved. So, I think it's just being able to have an outlet for your emotions afterwards. Obviously, you can't get upset whilst it's happening. You've got to try and hold yourself together. But afterwards you need to be able to have a kind of forum to acknowledge how you're feeling and that it's okay to be upset*. (Social work team manager)

Although social workers felt supported informally by peers who they might phone after the removal of a baby, there was little formal support from management, and the absence of clinical supervision was keenly felt. Lack of support had led some social workers to take time off for stress, or to feel they had become desensitised in order to protect themselves – both of which had an adverse impact on parents' experiences.

Midwives similarly described the psychological burden of the work and, in keeping with findings from other studies (Wood 2008; Everitt et al. 2015, 2017; Mars 2016), most felt that insufficient attention was given to offering specialist training, debriefing and supervision.

> *We have all these stories, and, like you said, we don't forget them. We are going through it with these women, just perhaps in a different perspective. And I am not saying as painful but we are living it with them. And that is challenging, because we are just building a book of these stories of all these women, and we remember them by name and we remember every little detail. So yes, it does have an emotional impact, I think*. (Midwife)

What does good practice look like?

In some health trusts, wherever possible, specialist midwives went to great lengths to be with the mother at the point of separation, despite their role being community-based. In addition, and informed by learning from bereavement midwives and from practice in other parts of the country, specialist midwives had made extensive efforts to support memory making with the mother before the separation (see Ott and McGrath-Lone forthcoming). Working with the research team's lived experience group, sites are now piloting the Hope Box scheme, designed to help parents capture key memories and keep connection post separation. In another area, specialist midwives are working with a group of women with lived experience of separation to knit blankets and pack the Hope Boxes (Mason and Chivers 2022).

In summary

It was clear from the evidence that separation at birth was traumatic for birth parents and distressing for the professionals involved. Insufficient regard to privacy, confidentiality and choice while on the ward, together with leaving the ward without their baby and in view of other parents, was particularly traumatic for mothers, evoking strong feelings of shame and stigma.

The inclusion of parents in the development of the birth plan helped them prepare themselves for the separation, even though the court's decision could not be guaranteed. The offer of choice regarding details and opportunities to meet foster carers before the baby was born appeared to ameliorate, at least in part, their pain.

The removal of babies from their birth parents also had a strong emotional impact on the professionals involved. Although they received informal support from peers, they were offered little formal or clinical supervision.

Overstretched midwives on busy postnatal wards were often ill-equipped to provide the specialist care required for women facing separation from their newborn babies, and inconsistent information-sharing between children's social care and the postnatal ward exacerbated inter-agency tensions. Midwives based within an enhanced team were more able to offer specialist support, but given their community focus, their availability could not be guaranteed.

Risk-averse practice often fell short of including fathers and wider family within the maternity setting. Professionals had little time to supervise the mother and baby on the ward where necessary, but family members were rarely included in these arrangements.

Issues such as the timing, notice and practical arrangements associated with attending the first hearing all raised significant ethical concerns, which potentially undermined women's ability to meaningfully participate in court proceedings. The pressures associated with navigating safeguarding and legal processes prevented parents from focusing on, and bonding with, their newborn baby.

Leaving hospital and returning home

Our previous research on women in recurrent care proceedings (Broadhurst et al. 2017; Broadhurst and Mason 2017, 2019) was the first to explore women's experiences in-depth following the removal (and repeat removal) of children. It drew attention to both the acute psychosocial crisis that followed the removal of a child, and the longer-term collateral consequences that heightened women's vulnerability. This programme of work has led to significant developments in support services for women, although major gaps in provision persist (Mason and Wilkinson 2021). The major contribution of this earlier research was to highlight the invisibility of parents following the removal of their children and the lack of accountability, on any profession, to provide follow-up support. Subsequent work focusing on fathers has identified their acute sense of loss and similar long-term costs to well-being following the removal of a child (Phillip et al. 2020).

The findings documented in this chapter build on and confirm the earlier studies but offer more detailed insights into the immediate experience of mothers upon leaving the maternity ward without their newborn babies, as well as perspectives of a range of different professionals. In keeping with our earlier observations, professionals had a far more limited grasp of the experience of parents following discharge from hospital – because they had limited contact with them once babies were removed from their care. It was foster carers, in this study, who stood out as being particularly attuned to the needs of parents at this difficult time.

We have grouped the challenges facing parents and practitioners in the period after the mother's discharge from hospital into the following five themes:

- leaving hospital alone: absence of professional help for parents returning home
- missing out on postnatal care
- lack of family-inclusive practice regarding contact planning
- keeping connections: the role of foster carers
- insufficient and unequal alternatives to separation.

Leaving hospital alone: absence of professional help for parents returning home

All professionals recognised the lack of consideration given to the mother's needs following her discharge from the postnatal ward. While women in the study gave vivid accounts of leaving the hospital without their babies and the psychosocial consequences of the removal, support for mothers was not a priority concern for any particular professional group. Mothers' immediate practical needs upon leaving the hospital within days of birth included getting home safely, heating and food, sanitary wear and medication as well as being able to obtain support to continue breastfeeding. Although, in some cases, a particularly proactive and empathic practitioner was able to stretch their remit to provide practical help and much needed emotional support, this was not usually possible. The role of midwives on the postnatal wards ends at discharge, and the social worker's focus moves to the baby in placement. No one has a clear responsibility for caring for the mother.

Midwives expressed concern that, following hospital discharge, the mother fell into a support vacuum, leaving her isolated and emotionally and physically vulnerable. They noted the benefits of continuity of midwife at this very difficult time, but in many areas, this was not possible, unless there were case-holding enhanced or specialist teams.

> *It's hard for postnatal workers. They are the [mothers] that tend to go off the rails a little bit and you can't get access [to the house] and things. I think if that support was there initially after it might help afterwards. I think postnatally the continuity is quite hard as well, because unless they are in an enhanced midwifery team with caseload midwives, if I'm honest the majority of mums that I've seen postnatally, like for mum checks whose babies have been adopted or in foster care, I've not seen the same one twice. They keep seeing different ones, and you find that quite a lot*. (Safeguarding midwife)

Parents verified points made by professionals, but were able to extend our understanding of the acute challenges they faced on returning home without their babies. The return to homes that had been prepared for a baby triggered huge distress for mothers.

> *I just left the hospital. I was on my own. I got a taxi home and that was me. All his stuff was upstairs. I couldn't even bear to look at it. It was locked in the spare room and that was it. No one. I wasn't speaking to my mum. We weren't speaking at all... So I was alone. I was on my own. Nobody to speak to. Nobody to comfort me. Nobody*. (Mother)

While some women did have support from partners or family members, many lacked any reliable emotional support, and this left them vulnerable. Many described returning to problematic coping strategies.

> *I started drinking then. Every weekend until I came to live where I am because I couldn't – I was a mum without a baby which no mum wants to be like that. It was pretty traumatic.* (Mother)

For others, the separation led to an acute and pronounced mental health crisis.

> *I returned home from hospital alone and with no support. I went home and I took an overdose, because I didn't want to be alive without my baby.* (Mother)

While there are examples in our data of professionals attempting to provide intensive support to women at this time, these were not routine. Again, findings resonate here with earlier published research from the authors, which described an acute psychosocial crisis following infant removal (Broadhurst and Mason 2020; Wall-Wieler et al. 2017; Knight et al. 2021). Midwives, in particular, raised concerns about the lack of support offered to women post discharge and contrasted it to the antenatal experience.

> *It's one of the things I've always hated about looking after women, because they get so much input during the pregnancy that they can't keep up with their appointments. Then as soon as the baby is removed, they don't see or hear from anybody, apart from the midwife. We're only there for two weeks. Even the health visitor doesn't come. So, we look after them for two weeks, and then that's it. There's nobody*. (Community midwife)

In keeping with concerns raised in a recent editorial by Critchley et al. (2021) professionals and parents also highlighted the current barriers to babies being able to reliably access breast milk post separation.

What does good practice look like?

Some social workers described ensuring they had telephoned the parents following discharge to give an update and provide reassurance that the baby had settled into placement. In one local authority area, a family support worker was allocated to families during pre-proceedings. Where the family/mother agreed, the family support worker could attend the birth and provide support to the mother at court and following her return home. The continuity that this afforded was seen as critical by the local authority in question, which was acutely aware of the vulnerability of mothers when babies were removed and the risk of self-harm or suicide, or of a return to serious substance misuse. In areas where a 'recurrent care' service had been established there was, in some circumstances, scope to offer assertive outreach support via a key worker to parents at this crucial point.

Missing out on postnatal care

A key concern, expressed by midwives in particular, was the very real risk of mothers who returned home without their babies missing out on vital postnatal support. While routine postnatal visits are offered to all women, community midwives suggested that many mothers who have been separated from their babies were reluctant to take this up. Interviews described some women's anguish at letting a midwife into their home when their baby was no longer with them. Midwives expressed concern regarding the potential physical and psychological consequences if women did not receive these routine checks.

> *Some won't want any [postnatal care] at all... some don't want you. They just want to move on with their lives and forget it all. I think it is difficult, isn't it, if they have got a medical need? If say they have had a [caesarean] section and they are on Clexane. The only way that they will have the Clexane is if we give it, and they don't want us to go, and they are very high risk. We are flying by the seats of our pants there, aren't we?* (Community midwife)

In one example, a mother explained how, despite being discharged home the same day as giving birth and having her baby removed, she received no postnatal midwife visits. Concerned about her stitches, she sought help from her GP.

> *Do you know what, I gave birth to that baby, I had to go and ask the doctor to check my stitches because not one midwife – because I didn't have that baby no one wanted to come see me. I was the worst; I was bad because that was my first kid. I didn't know what was normal*. (Mother)

Consistent with findings noted in earlier chapters of this report, and with other studies (Marsh 2016, Bicknell-Morel 2021), both midwives and mothers reported continuity of professional support as key to improving women’s engagement. Again, it was most commonly a specialist midwife who had the knowledge, skills and time to develop a relationship, and who understood that often a more assertive and persistent approach was required to ensure women did receive postnatal visits. Similarly, specialist midwives also seemed more likely to work with mothers for longer than the prescribed postnatal period, recognising the absence of other support available for them. In some instances, community midwives also extended their involvement because of particular concerns about the mother.

> *I’ll be honest, I find it hard to discharge. I find that really difficult because, if there’s nobody else to provide that emotional support to a woman, where are they going to get it? I think I find the postnatal part difficult because often, if their baby has been removed, they will go back to behaviours which mean it’s unlikely that baby is then going to ever get returned, because they’re regressing back to behaviour which is why they’re on the child protection plan. I find the postnatal period really difficult...you can often see that deterioration back into old habits.* (Community midwife)

Broadhurst et al. (2015) previously described women in recurrent care proceedings as a ‘hidden population’, noting the absence of support or accountability for mothers following child removal. In this study, we have extended our understanding to include these mothers’ low visibility within postnatal services. Other studies have identified the significant lack of national guidance and the exclusion of this cohort of women in key policy documents within both health and social care (Marsh 2016; Birth Rights and Birth Companions 2019; Ward et al. forthcoming; Bicknell-Morel 2021). While postnatal care is routinely provided for up to 42 days, this varies considerably and the number of face-to-face interactions has been subject to significant reduction (Albers and Williams 2002; Bicknell-Morel 2021). In addition, women who no longer have their baby in their care are not routinely allocated to health visiting services, and thus are potentially missing out on key mechanisms for mental and physical health screening.

What does good practice look like?

Support for the return home was clearly a blind spot for professionals. Therefore, the only examples of good practice resulted from the exceptional efforts of individual practitioners, and specialist midwives in particular, going above and beyond – or via support provided by a specialist team, for example a ‘recurrent care’ service.

Lack of family-inclusive practice regarding contact arrangements

While a detailed analysis of contact was beyond the scope of this study, interviews and focus groups with practitioners and parents alike described the added distress caused when contact arrangements were not clear at the point of hospital discharge. Although accounts varied, both parents and foster carers commented on a lack of clarity about contact arrangements. In some cases, parents left the maternity ward not knowing when they would see their baby again. This was particularly the case where pre-birth planning had been last minute, or plans had changed at birth. Midwives and foster carers also expressed dismay that they were, in some cases, unable to provide reassurances to parents about when they would see their babies again because plans had not yet been made.

> *Even regarding family time, you can leave that plan in a discharge meeting and the social worker will turn around to birth mum and say, 'We'll be in touch and let you know when you will see him', and that shouldn't happen. It should be 'these are the dates to put in your diary'. The contact should be arranged. So, when mum leaves the hospital, she knows when she is going to see the baby*. (Foster carer)

However, parent and foster carer comments suggest that even when contact arrangements were in place, they had not been made in partnership with parents, or with a view to optimising the likelihood of reunification. Parents faced many practical difficulties. For instance, contact might be arranged at considerable distance from their homes. The timing and location were also often changed at short notice, causing confusion and, in some instances, resulted in parents arriving at the wrong time or place.

> *They changed my times of my contact. I turned up at the normal time. I missed it, apparently. They didn't inform me. It's ridiculous. So, I didn't get to see her, even though it wasn't my fault. It was their fault*. (Mother)

For other parents, the cost of getting to contact centres was prohibitive, and this put them under additional pressure.

> *I saw her at contact sessions three times a week. Sometimes if I couldn't afford to get down, I'd walk. I'd walk from [place to place]. It took an hour and a half, two hours, but I didn't care*. (Mother)

Fathers who were no longer in a relationship with the mother also described feeling deliberately excluded when arrangements were made concerning the location and timing of contact.

> *My first one, they moved her all the way through to [town]. Like, literally miles away from me, so I couldn't have any contact or anything with her. I was going through once a week for an hour. Like, four hours on the bus and the train to go and see my daughter for an hour to come back. It was just horrible, they put certain obstacles in your way, but they know you cannot get through those obstacles.* (Father)

The fact that reliable attendance at contact was central to the assessment of parenting capacity fuelled mistrust in the system, and, as the quotation above indicates, some parents felt that they were being set up to fail.

The pain and pressures associated with contact were evident across parents' accounts, and for some the emotional cost was just too much to bear and they withdrew from contact as an act of self-protection.

> *I opted out [of contact], saying that my mental health was now getting to me. I could not stand there and be there with [baby], knowing that she's looking at me. I'm crying my eyes out knowing that I don't have a bloody chance.* (Father)

In keeping with findings from across the study, continuity of professional support was important. Parents said that always having the same contact supervisor helped them to manage their stress and anxieties. Unfortunately, this continuity appeared difficult for local authorities to provide.

What does good practice look like?

Again, good practice examples were few, but, as detailed below, the role of foster carers was key in enabling parents to remain connected to their babies. Some individual social workers made a point of ensuring that parents knew and understood contact plans, including when they would next see their babies. Some social workers also ensured that parents met foster carers and were given time to discuss the detail of the baby's care arrangements. While the quality and experience of contact supervision varied, there were examples of supervisors spending time with parents to help them manage the emotion experienced during contacts. This was greatly valued.

Keeping connections: the role of foster carers

Following on from observations drawn in the previous chapter, foster carers recognised the vulnerability of many parents and were very committed to reaching out and providing empathic support. Support provided by foster carers included findings ways to help them stay connected to their babies. Discussions within the focus groups demonstrated the sensitivity and respect foster carers displayed towards parents.

> *I always, always put them in clothes that parents have bought when I see them….and sort of being quite deferential towards them isn't it as well…plus I acknowledge the fact that they're still their children. And like Mother's Day, I always buy them presents, birthdays I buy cards and presents.* (Foster carer)

Foster carers saw their role as providing not just excellent care for new babies, but also offering support to the parents – recognising the difficult situations many of them were facing. As one foster carer described, 'In a lot of situations we are like mums to the mums aren't we?'. These actions and acts of kindness did not go unnoticed, and the empathy and consideration shown were greatly valued by parents.

> *It is amazing. Having this foster carer who is really good with me. Every visit. She had a diary in the bag. So, every day she would write in the diary exactly what my baby had been doing. So, every contact I had I would read through this diary and see … It is so important, because she was just a baby, and I wanted and needed to know that. She was lovely with me. She even rang me every now and then just to check in, just to make sure I was alright. She will check in with me. As well as looking after my children, she is trying to look*

> *after me as well. She keeps saying, 'You have got to keep going'. Some days I feel like rubbish. It is like, 'You have got to keep going'.* (Mother)

These acts of kindness resulted from the actions of insightful and compassionate individuals, rather than a system designed to promote empathy. Foster carers described a system that often stood in the way of them forming any relationship with parents and felt that their role in supporting the connection between baby and parent was often overlooked – something many found frustrating. It was evident from the focus groups that foster carers valued having time with parents at contact and indicated that they themselves could play a vital role in supporting parents – a point that has been made in other studies (Ward et al. 2022).

> *To me connections with parents are first and foremost. Even in contact taking those first two minutes to say everything is fine, making those connections… More contact [between parents and foster carers] is needed. In contact centres some [foster carers] are not allowed to talk to the parent. They try to stop us having contact with parents at the contact centre and that's not right. We are looking after their child. They need to have contact, they need to hear from us not read it in book. We need to have a rapport with the parents and a book isn't the way forward.* (Foster carer)

In keeping with comments from parents, foster carers felt frustrated when contact arrangements were changed and expressed frustration with the churn of social work and contact staff.

> *Yes, but for the parents as well, they don't know from one week to the next where it's going to be. It can be a different venue. It can be at different times. They're turning up in the wrong place at the wrong places. And the contact workers… there are faces in there that I just don't recognise…There are different faces each time*. (Foster carer)

What does good practice look like?

While focus groups suggested that most of these good practice examples emanated from foster carers themselves, the response to the COVID-19 pandemic and need for online contact has also opened local authorities' eyes to the possibilities of helping parents preserve their connection with their babies and be involved in some way with their day-to-day routines. Focus groups with social workers during the pandemic provided many examples of how parents had been able to virtually join bath times, bedtimes and read bedtime stories to their babies. While this is no replacement for face-to-face contact, social workers and foster carers were able to see the advantages of these activities in addition to face-to-face contact for both parent and baby. Some participants were hopeful that this type of contact would now become a mainstay of practice.

Insufficient and unequal alternatives to separation

Interviews with parents revealed a very mixed picture regarding alternatives to separation. Social workers, parents and midwives also shared these frustrations and felt that there were insufficient parent and baby placements or resources to fund them.

Although all stakeholders said that there was a greater need for more parent and baby placements, they also stated that quality was key as well, and parent and baby placements needed to be of a consistent standard. Not all parent and baby placements were described as providing the kind of supportive experience parents needed. In general, parents were more positive about mother and baby foster placements than residential assessment centres. It was, however, noteworthy how few foster placements included both parents. The high level of monitoring at assessment centres, including in some cases 24-hour CCTV, felt too intrusive for many, and led to extreme feelings of anxiety and stress (see also Munro et al. 2014).

> *[Cameras] in the actual room. They could see us doing everything. The only place they didn't have it was the bathroom. They had monitors in there, so they could monitor every single thing we were saying. And in a way, we didn't really have any privacy. We had no privacy; we couldn't really be ourselves because of it*. (Mother)

However, parents' accounts of mother and baby foster placements also varied considerably both between and within individual sites. In the most positive examples, these placements provided a secure and stable environment and, as described below, could be life-changing.

> *I live in a family home, they class me as family, we treat each other as family. We speak, we don't have any arguments and if something's happened we sit and talk and it's fine. It's very different compared to what I had as a child. … They all treat me as their family. I've messed up a few times and they're not bothered. They just think, 'Well, you're a new mum. You're still learning'. …Yes, they're very supportive, if I need help they're there… and the whole time I've been in care I've never come across someone as such, she's amazing. E, my daughter, calls her nana and everything. They've got a really good bond, which for me, she's got a good bond, then I've definitely got a good bond*. (Mother)

Sadly, not all women described such positive experiences of their foster placement. For some, the placement simply felt like a test and in contrast to the description above, some mothers described feeling unwelcome in the family's home.

> *…they have a little conservatory out the back and they call that their family room. So, sometimes they would take the baby in there and I would be sitting in the other room. I would feel like I cannot go in that space and that is my child… I walked in there sometimes, but sometimes they would make a comment like, 'Oh, this is our family room'. So, I felt quite like I cannot go in there, but they should be making you feel welcome. It is your child they have got with them in there*. (Mother)

Particular difficulties were experienced when placements were a long distance from home. Women described feelings of isolation and loneliness, of feeling cut off from their own communities and networks of support at a time when perhaps these were most needed.

> *Then when they told us we were going to [city] and where it was I looked it up, and it was half an hour away from my violent husband. I told them. I said, 'I don't want to go there because it's so far away from my family'. 'Oh you have to go there.' They just said, 'You have to go there'. I kept on saying, 'I don't want to go there because it's so close'. I said, 'Well if he sees me, because you know, it's always a possibility'. I kept on saying, 'I don't want to go there'. But whatever we were saying they were not considering us. They were not considering*. (Mother)

Social workers also expressed concerns about assessment units, in particular, and the varying quality of assessments and support offered to parents. For others, the question of giving false hope was also raised.

> *We used them, but there was almost acceptance of actually what impact does it have on placing a mother, a child in a mother and baby placement, when you know that the likelihood is that's not successful? And are you actually causing a lot more harm and we would have those conversations. And I feel the courts looked more at the emotional impact of, yes, removal has a tremendous emotional impact, but equally so does allowing somebody to care for their child for six months and building up a false expectation and then a removal*. (Social worker)

In summary

Accounts from both professionals and parents in this study suggest that support for parents following their discharge from hospital was seriously overlooked. While women provided vivid accounts of leaving the hospital without their babies, and the acute psychosocial crisis that often followed, no single professional group appeared to have responsibility for supporting these women at this critical time. In addition, midwives expressed concern regarding the low uptake of routine postnatal services among this population of women and the potential physical and psychological dangers that might follow. In keeping with the findings across this study, continuity of relationship was key to engagement.

The psychological impact of being separated from their babies was felt more acutely when contact arrangements were not clear at the point of discharge. Practical arrangements and financial barriers also contributed significantly to parents' ability to reliably engage with contact arrangements.

Foster carers and parents have provided important evidence of the crucial role foster carers can play at this time. Foster carers, attuned to the parents' loss, described going to considerable lengths to support parents to retain their parental identities.

There was considerable concern among professionals regarding the availability and costs of alternatives to separation. In some areas such placements were scarce, had very specific criteria, or involved parents travelling long distances from their homes.

Interviews with parents also suggested a very mixed picture regarding the quality and outcomes of these placements.

Conclusion and next steps

When looking across all elements of the parent and baby's journey, from pre-birth through to returning home and placement, this study uncovered several cross-cutting challenges. These included discontinuities, delays, resource constraints, risk averseness, a lack of family-inclusive practice, insufficient professional expertise and poor inter-agency collaboration.

We found considerable variation across the participating research sites, but there was marked consensus among professionals that at present, services are not consistently offering a sufficiently timely or effective response to either divert babies from care proceedings, or ensure that decision-making is sufficiently robust. The window of opportunity to support parents during pregnancy is being missed in too many cases, where practice is insufficiently change-oriented and focuses narrowly on the assessment of risk.

There was, however, considerable consensus across the range of professionals consulted, as well as from parents, as to what constitutes best practice in this difficult area. The good practice examples illustrate that change is possible. However, what is also clear is that, in general, principles of best practice are insufficiently embedded throughout organisations. Rather, they result from the efforts and insights of individuals whose own expertise and motivation drives them to work in a different way. As a result, currently too much is left to chance.

Practice guidelines

The draft set of practice guidelines that accompany this report set out aspirational standards for practice, derived through dialogue with frontline practitioners and parents, including our birth parents advisory group. The best practice guidelines take as their starting point the following overarching principles identified from the challenges discussed in this report:

- a specialist focus on the vulnerable unborn child and parents
- a specialist understanding of the impact of trauma
- timeliness and planning
- process and service alignment
- continuity of care
- family-inclusive practice
- partnership and collaborative working
- change-oriented practice
- adequacy, availability and fit of resources

- sensitivity and respect
- transparency and choice.

In the guidelines they are translated into action statements, specifying what can be done at different stages of the birth parent journey – from pre-birth through to separation and child placement – to deliver better and more consistent practice.

In terms of next steps, the research team will be working with partner sites to devise action plans, informed by the guidelines, and are supporting pilot transformation work in multiple local authorities. In turn, this work will inform and deliver a final iteration of the guidelines in 2022.

More needs to be done to ensure the new guidelines are inclusive and meet the needs of parents from minority groups, including parents from Black, Asian and minority ethnic groups and parents with learning difficulties. This consultation is underway and will also feed into the 2022 guidelines.

The research has also highlighted some key issues requiring further national consideration and action:

- the timing of proceedings concerning newborn babies
- the timing of separation of the baby from his or her parents within the maternity context, when there is no immediate risk of harm
- hospital discharge policies regarding this particular cohort of women
- continuity and quality of legal representation for parents within pre-proceedings/proceedings
- the use of voluntary agreements at birth to enable a baby to be placed with alternative carers
- continuity of social work support for parents with very complex needs and a reduction of changes or transitions within children's social care
- changes to national guidance regarding early intervention in pregnancy, to improve consistency in England and Wales and to strengthen a mandate for earlier assessment and support in the pre-birth period
- development of specialist pathways within midwifery to ensure adequate time, skills and continuity in the antenatal and postnatal period
- development of clinical supervision for social workers and midwives engaged in highly sensitive and distressing work of this nature
- drawing together and sharing of current examples of innovations in family-inclusive practice and effective support and intervention in the pre-birth and postnatal period.

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Nuffield Family Justice Observatory

Nuffield Family Justice Observatory (Nuffield FJO) aims to support the best possible decisions for children by improving the use of data and research evidence in the family justice system in England and Wales. Covering both public and private law, Nuffield FJO provides accessible analysis and research for professionals working in the family courts.

Nuffield FJO was established by the Nuffield Foundation, an independent charitable trust with a mission to advance social well-being. The Foundation funds research that informs social policy, primarily in education, welfare and justice. It also funds student programmes for young people to develop skills and confidence in quantitative and scientific methods. The Nuffield Foundation is the founder and co-funder of the Ada Lovelace Institute and the Nuffield Council on Bioethics.

Family Justice Data Partnership

The Family Justice Data Partnership is a collaboration between Lancaster University and Swansea University, with Cafcass and Cafcass Cymru as integral stakeholders. It is funded by Nuffield Family Justice Observatory.

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