

**Gwasanaeth
Diogelu Cenedlaethol**

Diogelu GIG ar gyfer Cymru Ddiogelach

**National Safeguarding
Service**

NHS Safeguarding for a Safer Wales



Guidance for Children who become pregnant prior to their 13th birthday

May 2026

This document is also available in Welsh



**GIG
CYMRU
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WALES**

Iechyd Cyhoeddus
Cymru
Public Health
Wales

Contents

1. Foreword	1
2. Introduction	2
3. Definitions	2
4. First Practitioner Response Steps	3
5. Roles and Responsibilities	4
6. Procedure/Process/Protocol	4
7. Termination of Pregnancy (TOP) in Children	7
8. Continuation of Pregnancy	11
9. Aftercare	13
10. Training / Competency Requirements	13
11. Monitoring Compliance	14
12. Useful Information	14
Appendix 1: The Protocol Flowchart	15
Appendix 2: Consent	16
Appendix 3: Example of Good Practice	17

1. Foreword

This guidance was instigated as a crucial learning objective following a recent significant case requiring high court judicial guidance. Navigating this multi-agency legal pathway was uncharted territory resulting in the rapid learning recognition of the need for a national guideline.

Timeliness is paramount in these rare but life-changing cases, and the wellbeing of the pregnant child must always be central to any decision making.

In producing this guidance, a task and finish group with multi-disciplinary and multi-agency expertise was formed. In sharing expertise, the practical difficulties around access to termination services became apparent. There needs to be easy and timely access to these services in the best interests of the pregnant child with process and service provision considerations for all gestations due to the unpredictability and variation in presenting gestation.

Currently the non-NHS abortion providers are not licensed to provide termination services for any children under 13 in Wales. This results in logistical difficulties in combination with a markedly depleted staff resource to provide a surgical termination procedure in this age group and into the second trimester. It brings up challenges around care closer to home and inequities in provision around Wales. It is an age group where surgical termination will likely be considered more often due to concern about how the child will tolerate the pain and psychological distress from a medical termination when compared with a procedure under General Anaesthetic.

Consideration should be given to whether the child was previously or concurrently known to have safeguarding concerns or may be a child looked after. This may further complicate the consent and decision-making process, all of which needs to be pre-empted in order to ensure a timely decision is made.

The task and finish group has highlighted some excellent practice in parts of Wales. One example of this is the Swansea Bay University Health Board Jig-so Team who provide support for vulnerable women and families.

**>> See Appendix 3:
Example of Good Practice.**

The key message from this work is the vital importance of timely decision-making (days not weeks) as with every day, the risks increase to the pregnant child, and this should not be underestimated.

Currently the non-NHS abortion providers are not licensed to provide termination services for any children under 13 in Wales.

2. Introduction

This Guidance is designed to assist health practitioners in the management of children who have become pregnant under the age of 13 years.

Under the Sexual Offences Act 2003, children under the age of 13 are not considered able or competent to give consent to any form of sexual activity and penetrative sex is considered statutory rape. This remains the case even if the perpetrator is a child themselves.

In considering the child's feelings about continuing the pregnancy or termination of pregnancy (TOP), practice should not retraumatise but always prioritise safeguarding the child and their immediate medical care to further prevent harm.

Pregnancy in children under 13 years is a rare event, which creates challenges in training staff and keeping knowledge up to date. This guidance aims to contain all the information you will need to know.

>> [See Appendix 1: The Guidance Flowchart, a simple overview.](#)

It is paramount that decisions are made in a timely manner as with every day that increases the gestation of the pregnancy, the complexities and associated risks of procedures increase.

3. Definitions

Termination of Pregnancy (TOP) is when pregnancy is ended so that it does not result in the birth of a child.

TOP is legal in England, Scotland and Wales providing it meets the terms of the 1967 Abortion Act. The law allows doctors to end a pregnancy if they believe that:

- The pregnancy is prior to 24 weeks gestation and continuing the pregnancy would pose a risk to the physical or mental health of the woman (in this case a child) or her existing children greater than if the pregnancy was terminated; or
- The termination is necessary to prevent grave permanent injury to the woman (in this case a child), or to save her life; or
- There is substantial risk that if the child was born, it would suffer mental abnormality or serious physical handicap.

4. First Practitioner Response Steps

1. Confirm Pregnancy



2. Document verbatim details offered by child about rape



3. Immediate Safeguarding Referral



4. Inform Named Doctor and Named Midwife for Safeguarding



5. Ensure Strategy Meeting takes place within 24 hours

5. Roles and Responsibilities

It is the first Practitioner who becomes aware of conception in an under 13-year old's duty to report this statutory rape to the local authority.

- **Children's Social Care** are responsible for organising a strategy meeting and safeguarding the child.
- **Police** are responsible for any criminal investigation and advising on the need for and type of forensic samples using their Sexual Offence Examiner (SOE) to advise appropriately. The police will respond to concerns of imminent harm.
- TOP would be arranged by **NHS Wales**, considering the principle of care close to home.
- **Sexual Assault Referral Centre (SARC)** are responsible for acute child sexual abuse medicals. Follow local SARC pathway for Child Sexual Abuse (CSA) pathway. If there is a history of CSA in the last week, urgent referral to the SARC is required.
- **Health** are responsible for mental and physical health assessments including capacity assessments.
- **Corporate Heads of Safeguarding/Named Professionals within Health** should convene debrief and supervision sessions to support health staff involved.

6. Procedure/Process/Protocol

In the case of conception in an under 13-year-old, there is a Duty to Report (DTR) concerns to the local authority (the relevant Local Authority Children's Safeguarding Team) and professionals are required to follow the appropriate flowchart (Appendix 1). The questions embedded within the flowchart encourage a holistic assessment considering how best to protect the pregnant child.

The first point of contact for a child who thinks they may be pregnant, or anybody with responsibility for the child, may be to a number of different professionals. In order to understand what happened, whether there are any ongoing risks to the child or other children and the child's view about the pregnancy, this professional should ask the following questions (whilst being mindful of not causing further trauma to the child or asking leading questions that might prejudice a future criminal investigation):

- Confirm child demographics (name, address, date of birth, contact information).
- Determine whether the child looked after or in care.
- Who has parental responsibility?
- Who has engaged in sexual activity with the child? Document name, address, date of birth, contact information if volunteered.

- When did this happen?
- Where did it happen?
- How does the child know they are pregnant?
- Has the pregnancy been confirmed by a health care professional?
- Do they have any injuries or are they in pain at the time of the conversation?
- Has the child experienced any form of sexual contact in the last 7 days?

Assess:

- Is there an immediate risk posed to the child?
- Does the child require urgent medical care?

Follow-up Actions

- Early discussion with a Sexual Abuse Referral Centre (SARC) Paediatrician, ensuring joined-up care with local Paediatric services.
- Contact the Lead Midwife for Safeguarding who will arrange for an ultrasound scan (USS) within 24 hours.
- Contact the Named Doctor for Safeguarding.
- Identify who is acting as adult support for this child.

 **Please do not ask any additional questions relating to the disclosure.**

The questions listed above will provide sufficient information to consider any immediate risk of harm to that child or any other children.

Any information provided by the child and/or their responses to questions asked should be recorded verbatim by the member of staff. **Ensure that the child has the opportunity to speak with professionals alone.**

Please note that if a child is speaking openly and wanting to talk, do not shut the child down, just record what is being said verbatim. Ensure the child feels they are being listened to. When the child has finished talking, allow them to stop, and do not ask follow on questions if the above points have been covered.

The safeguarding and urgent medical care of the child should take priority over all other actions and all children should be treated in a holistic and child centred way with agencies coordinating their work together.

Any child who has become pregnant while under the age of 13 (even if only a few days before their 13th Birthday) MUST be referred immediately to Children's Social Services and a strategy discussion convened within 24hrs.

The Strategy Meeting (local authority is the lead agency) Invitation should always be extended to the following professionals (professionals should make every effort to attend but where they are unable, they should either send a suitable representative or submit relevant information and opinions in writing).

- Children’s Social Services – local authority
- Police
- The Named Doctor for Safeguarding Children
- The Designated Safeguarding Lead from the child’s school
- The Child’s GP
- The Head of Safeguarding from the Health Board or representative
- Child Looked After (CLA) health service representative if the child is CLA
- Public Health Nursing representative (school nurse)
- SARC Health Professional
- The Named Midwife for safeguarding
- A representative from the obstetric/ gynaecology team
- Sexual Health Nurse
- A member of the BPAS Safeguarding Team

If the child is CLA and placed in a host area in Wales, there must be communication and representation from the placing local authority/ health service.

The strategy meeting should seek to address the following points and agree a clear plan of support. There may be a need for a follow-up strategy discussion if further investigations or information is needed to inform decision making. Actions should be SMART and allocated to a named professional.

Strategy Meeting Considerations:

- What are the safeguarding issues we need to address in the immediate and medium term for this child and any other children at risk?
- What happened to the child?
- Are there any ongoing risks including consideration of child sexual exploitation?
- Who is the alleged perpetrator of the abuse? Or who is in the pool of possible perpetrators?
- Are there multiple perpetrators?
- Is the perpetrator another child and are they also a victim? Consider whether any other children could also be at risk.
- Is the child safe to be at home?
- A historic colposcopy examination should be booked in if a TOP is the chosen route (in order to obtain the second set of Sexually Transmitted Infection swabs following TOP if needed).
- Who is able to support the child through the process of decision making.
- Consideration should be given for a holistic child protection medical.
- Consider psychology support for child throughout the process.

Legal Considerations

If the child is subject to Child Protection Procedures and the child is not deemed to be Gillick competent, application to the high court (family division) can be made for the decision to be made promptly. The decision should not be made by a health care practitioner. If legal advice is deemed necessary e.g. no appropriate adult to support child's decision making, **an urgent red referral to Legal and Risk Services (NHS Wales Shared Services Partnership (NWSSP) within 24 hours** should be submitted in the best interest of the child, for whom a timely decision is paramount, and in the best interest of reputation for the health board.

7. Termination of Pregnancy (TOP) in Children

If the child has competency to consent and wishes to continue the pregnancy, they should be referred to the specialist midwifery team for women requiring extra support for antenatal care and consultant-led care. If not, consider who can make these decisions for them including who has parental responsibility? What reasonable adjustments might be required?

Considerations:

- **Is the child competent to decide** if they want to terminate the pregnancy and by which method? ([See Appendix 2](#)). Consideration of which professional should assess this is important legally.
- An ultrasound scan is required urgently to confirm a normal intrauterine pregnancy.
- Are there any additional medical or mental health issues (including Child and Adolescent Mental Health Services (CAMHS) involvement) that may be relevant?
- Does the child have any special educational needs, or broader social or emotional concerns?
- **Who can support the child** in making the decision and subsequent choices such as method of TOP?
- Does the parent or carer have the child's best interests at heart or is there concern that they may be coercing the child into a particular course of action or concerns about their abilities to make a decision in the best interest of the child?
- Where a child and parent are unable to consent or there are concerns the parent is not advising the child in their best interests there may need to be recourse to the high court (family division) to make a final decision ([see Section 6 – urgent red referral to Legal and Risk Services NWSSP](#)).
- **What is the estimated gestation of the pregnancy?** This is the time since the first day of their last period. Sometimes there is bleeding in early pregnancy that can mimic a period and when periods are irregular this date can be unreliable. If unknown or unsure then an urgent ultrasound scan needs to be arranged.
- If the child is requesting a medical TOP, can they swallow pills (there are no liquid or alternative ways to administer one of the pills)? If not, then they should be advised to have a surgical TOP. The abortion provider must consider options for cervical preparation if oral medication cannot be tolerated.

- **In a medical TOP the child will experience significant pain and bleeding. They will be aware of the process and may see the products of conception as they pass them. Will this process cause the child and/or carer disproportionate distress, either at home or in hospital?**

- Consider if the child is likely to take the second dose of pills in the case of a medical TOP. If this is unlikely, there may be risks associated with only taking the first dose. A surgical TOP may be a safer option if this is a concern.
- Has consent been given, or have the police sought a court order, for the collection of products of conception for DNA analysis? If so, consideration needs to be given of the chain of evidence mechanism required to collect this evidence appropriately.
- If collection of products of conception is not required, would the home environment be sufficiently safe and supportive to enable the child to have

a medical termination in the home with due consideration of the pain and blood loss experienced? If not, then a surgical TOP would be recommended or alternative arrangements for a medical TOP. **Non-NHS abortion providers are unable to facilitate inpatient medical terminations. These would need to be arranged in conjunction with the local gynaecology department of the local Health Board.**

- Is a pregnancy or termination likely to confer any additional health risks? What must be put in place to address these?
- Are there any additional adaptations needed to support the child in accessing a TOP? E.g. does the child have a physical disability that requires the use of a hoist or other specialist equipment. If these cannot be met by the local non-NHS abortion provider, are there other professionals that could offer support or does the TOP need to be managed within a hospital?

Good Practice:

- The initial and follow up consultation for any child under 13 should always be face to face in a clinic and not online, ideally with the same person.
- **If children are not brought to follow up consultations, then the family should be contacted in a timely manner to explore the reasons for this, remembering the vital importance of swift decision making and action in these cases. If the family are uncontactable then a repeat referral (DTR) into the local authority should be made within 24 hours.**
- Period poverty is a significant issue for some families. Does the child have access to sanitary products, toilet paper, simple painkillers and other support such as snacks, sugary drinks, a hot water bottle and transport to hospital if needed? Will they be given the emotional support they need to go through the TOP? If not, can this be provided in another way?
- All children should be offered and encouraged to participate in counselling regarding their choices about the pregnancy before (and if needed, after) the TOP. In addition, referral for CSA counselling should be considered.
- Multi-agency discussion should be had to consider whether appropriate contraception, ideally long-acting reversible contraceptive (LARC), and safe sex advice should be provided and how this can be done in a way that avoids re-traumatising and ensures the best interests of the child are always central to any decision-making.

- All children should be offered screening for sexually transmitted infection (STI).
- It is important to use a trauma informed approach in supporting the child and consider the language to avoid being judgemental
- All intimate examinations and procedures should be undertaken with a suitably qualified chaperone – the use of a parent, carer or other accompanying person as chaperone is not acceptable.
- A summary of the TOP procedure, any contraception, STI screening and treatment should be sent to the GP who can provide ongoing support to the child and family.

Early Medical Abortion (EMA) can be done up to 9 weeks and 6 days gestation, however this process must be considered in the context of the child who may have only recently started menstruating and have little experience of menstrual pain. The pain associated with EMA is likened to the pain of contractions in labour, in addition to the consideration of the large blood loss. The psychological consequences of experiencing this must be considered against the physical risks of a surgical TOP under General Anaesthetic.

Surgical termination will require a surgeon who will likely need to be allocated a visiting contract in order to provide care closer to home. Initial referral for TOP goes to BPAS who may be able to provide a surgeon to perform a surgical abortion within an NHS setting if there is no NHS surgeon in the Health Board able to perform the procedure. This requires an urgent honorary contract being arranged and liaison between the Health Board and BPAS to confirm pre-employment conditions. This is similar to arrangements made for an urgent external locum. An NHS consultant obstetrician/gynaecologist will also need to be present during the procedure, as support for the visiting surgeon. With training and staffing changes, these arrangements may alter. The Clinical Director for Obstetrics and Gynaecology will be able to advise.

A multi-disciplinary team (MDT) meeting should be arranged in the health board, once decision has been made for a TOP, with representation from appropriate departments to ascertain the best location and staff support needed.

Forensic Evidence Collection

Is there a need to collect forensic evidence, either during a child sexual abuse medical or by collection of the products of conception? How will this be organised?

- Forensic swabs will only be taken by SARC if there is a sexual assault in the prior 7 days.
- Fetal remains following abortion can be retained but only with consent or a court order. Management of the products should follow local guidelines.
- The police will need to provide a suitable container in which to retain the products of conception (POC); such a container should be opaque plastic (not glass which may break if frozen), contain no preservative, in particular no formalin. Once obtained, the POC should be placed in the appropriately labelled container and into a tamper-evident bag, then frozen. The POC must remain frozen during storage and transport to the police.

Pregnancies of up to 9/10 weeks gestation:

During the early stages of pregnancy there is relatively little fetal tissue available for analysis relative to the amount of maternal tissue present, so, although not impossible, the likelihood of successfully detecting DNA that is fetal in origin is much reduced.

Between 9/10-15 weeks gestation:

From 9/10 weeks onwards, the fetus is larger and more readily identifiable, consequently the likelihood of successfully detecting fetal DNA is increased.

Pregnancies over 15 weeks gestation:

By week 15 fetal development has reached a stage where it is no longer appropriate for entire products of conception/fetus to be submitted for analysis. Therefore, for terminations that are carried out at 16 weeks and above, samples for DNA analysis should be taken by an appropriate individual (either a doctor or a Pathologist). This is likely to be a portion of fetal tissue (e.g. a limb, muscle, blood from the heart), rather than the whole fetus. It is essential that police and/or clinicians discuss and confirm with the forensic team exactly what is required. The disposal of any remaining fetal tissue should not take place until the forensic team has confirmed that DNA analysis has been successful. DNA profiling should almost always be successful, unless the sample has deteriorated. Should complete products of conception be received at the laboratory that are at or past 15 weeks of development, these will be rejected and returned to the submitting police force without any examination or testing taking place with a recommendation that samples for analysis are taken by an appropriate individual at the hospital. The clinician performing the TOP will need to be made aware of this.

- Where a surgical TOP takes place, it is important that the surgical team are aware that the products of conception are required by Police and that adequate preparations have been made to retain and preserve them. As stated above, seek confirmation from the forensic team to ensure proportionate samples are taken.
- Reference samples: In addition to the fetus and a sample from the alleged father, it is strongly recommended that wherever possible a reference DNA sample from the mother is obtained. This is part of the forensic investigations and therefore police should gain consent for this. The reason for the sample is because in the event that the putative father cannot be excluded, the strength of any subsequent statistical evidence produced in support of this finding will be more significant if a reference DNA profile from the mother is available. Furthermore, in the absence of a reference DNA profile from the mother, assumptions are made that matching DNA components between the DNA profile of the fetus and the alleged father are the fetus's paternal DNA components. If it transpired that some of these DNA components were actually inherited from the mother, then it may be that the alleged father is actually excluded as being the father of the fetus.
- In some cases, the child may not be able or willing to support a police investigation (assuming one is required). There may need to be a multi-disciplinary discussion during or after a strategy discussion regarding the best interests of the child and the public interest in pursuing a criminal investigation. A court order may be required to seize POC as evidence if the child's parents are unable to consent or refuse consent.

In addition to the fetus and a sample from the alleged father, it is strongly recommended that wherever possible a reference DNA sample from the mother is obtained by the police.

Staffing Considerations

- Not all staff members may be willing to take a hands-on role in the provision of TOP as a result of a conscientious objection. Whilst it is important that this view is respected, it should not interfere with the appropriate care of the pregnant child.
- Where a member of staff has an objection to TOP, they should make this clear to their line manager as soon as possible. The child's care should be handed over to another member of staff who is comfortable to support the child through the TOP process.
- Supporting a child who has been sexually abused is emotionally demanding and can trigger unpleasant memories, thoughts and feelings for some individuals. Staff should be supported through the process with regular supervision and have access to additional help if they need it, including handing over the case to another professional, although wherever possible the same staff member should provide continuity of care for the child.
- A debrief after the event is helpful to support staff who may have been traumatised by the experience of supporting the pregnant child and is also a useful way to extract learning which will inform future improvements to this service.
- Consider staff who usually work with children relocating with the pregnant child e.g. paediatric nurse on gynaecology ward, as appropriate.

8. Continuation of Pregnancy

Effective counselling must be offered to the pregnant child with regard to the decision; and clear consideration is given to their competency to make the decision; this will require Gillick competency assessment due to age ([see Appendix 2](#)). Consideration should also be given to the support that the pregnant child's carers offer if they are already on a child protection plan.

Where a child and parent are unable to consent or there are concerns the parent is not advising the child in their best interests there may need to be recourse to the high court (family division) to make a final decision (see Section 6).

Best Practice

- Routine care should be with the Vulnerable Women's Team or community midwife with an enhanced program of support.
- Care should be consultant led with named midwife for safeguarding and named Doctor for Safeguarding (or other Paediatrician) attending all appointments for best practice and continuity of care being prioritised.
- Planning meetings around the pregnant child's education, antenatally and post-partum, should be put in place.
- 1:1 practical family antenatal education in the home should be offered.
- Screening for STIs: as well as the initial screening, it must be remembered that a second check for chlamydia and gonorrhoea nucleic acid amplification test (NAAT) testing more than 2 weeks after the last episode of contact must be done. A third check must also be done at 12 weeks after the last episode of contact, for blood borne virus testing, to ensure the latency period is accounted for.
- Reference to NICE Guideline for Antenatal Care NG201 should be made as standard to ensure evidence based clinical management.

Consideration of Adoption:

- Effective counselling must be offered to the pregnant child with regards to the decision. Clear consideration should be given to their competency to make the decision; this will require Gillick competency assessment due to age. Consideration should also be given to the support that the pregnant child's carers offer if they are already on a child protection plan and who has parental responsibility for the pregnant child.
 - Contact Children's Social Services who should seek to ensure that, following a request for a child to be relinquished, the referral should be transferred to the appropriate team best able to work with the pregnant child and progress the unborn/newborn plan as soon as possible.
 - Maternity services must ensure that protocols and processes are in place for women and their babies to have continuity of care.
 - Consider location of pregnant child: which ward is appropriate and with which staff caring remembering at all times the pregnant patient is a child. Consider where inpatient postnatal care will be given i.e. not on the general postnatal ward around other mothers and newborn babies.
 - Consider the wider family, what they know, and how they can offer support.
 - Consider detailed birth planning: mode of delivery; labour analgesia; who will support the pregnant child during the birth; whether she wants to see or hold the baby; and contraception.
 - Consider who will care for the baby on the ward if the birth mother does not want to.
 - Consider how the mother wants the baby to be fed.
 - Consider/offer breast milk suppression medication, as per local protocols.
 - Offer mementos/cot cards/name tags/photos/hand and/or footprints, does she want to give anything to the baby? Special blanket/soft toy etc. Local authority adoption team will also support with life story work for the baby.
 - Consideration during multi-agency discussions should be given to offering the birth mother to meet with the person who the baby is going to be placed with.
 - Consider impact on pregnant child's mental health referring accordingly to appropriate services.
 - Recognise grief/loss and identity of motherhood during the process
- **Advocate for the birth mothers wishes throughout antenatal, labour and postnatal care.**
- Arrange Discharge Planning Meeting.
 - Postnatal maternity care provision according to maternal request.
 - Continuity of postnatal carer should be put in place where possible.
 - It is for the Local Authority to consider the birth father's wishes if appropriate/relevant and whether the birth father intends to acquire parental responsibility, outlining his role and potential rights.
 - The child can be returned to the biological mother's care anytime within the 6 weeks following birth and legislation allows for this time for parents to change their minds before the local authority seek legal orders.
 - Specific counselling in relation to the adoption before and after child's birth should be offered by the respective Local Authority team.

9. Aftercare

Consider the need for future contraception: if the child is considered as requiring ongoing contraception, consider this being fitted at time of surgical TOP. If the child delivers the baby and was considered as requiring ongoing contraception, with her consent, this should be fitted prior to discharge.

- **Ongoing multi-agency support is essential; a safeguarding multi-agency meeting should be convened within a week of termination, to discuss safeguards needed to ensure the child's risk of future rape is minimised, and in the case of a birth, a discharge planning meeting should be convened.**
- A referral should be made for therapeutic psychological support.
- Where appropriate, post-abortion counselling should be offered.
- In the event of a birth, enhanced post-natal midwifery and health visiting care should be provided.

10. Training / Competency Requirements

Health staff should be up to date with their safeguarding training as outlined in the Intercollegiate document (2025) Safeguarding children and young people & children and young people in care: Competencies for health care staff:

www.rcn.org.uk/professional-development

11. Monitoring Compliance

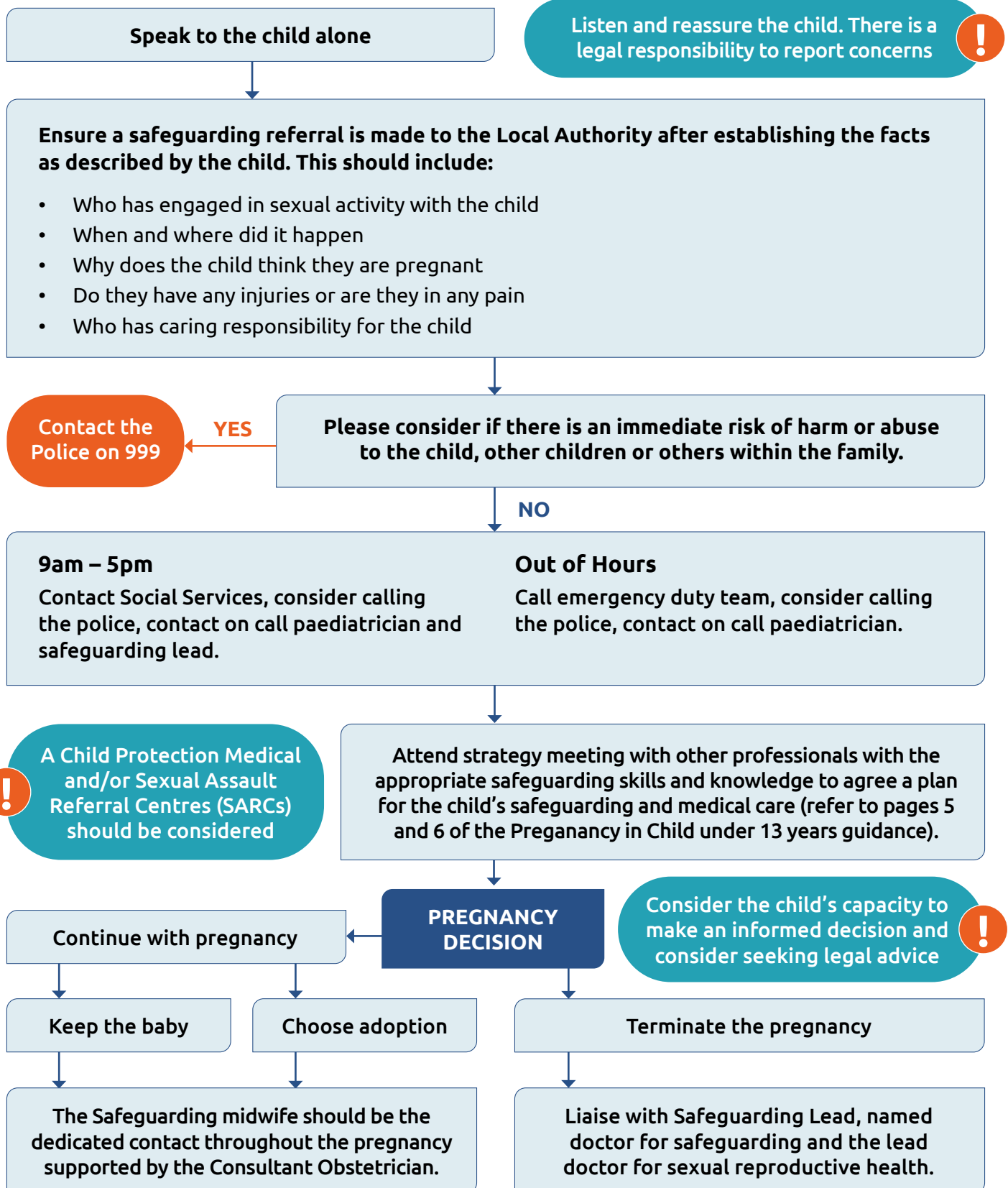
Element of the protocol for monitoring	Whole protocol
Section	All
Monitoring Method – Information Source (e.g. audit) / measure / performance standard	As the protocol is likely to be used very infrequently, there should be a debrief after each TOP for a child under 13 with representatives from the SSCP and BPAS. If possible, feedback from the child and family should be sought.
Item lead	NHS Wales Designated Doctor for Safeguarding Children, National Safeguarding Service.
Monitoring frequency / reporting frequency and route	Within 2 months of a TOP taking place.
Arrangements for responding to shortcomings and tracking delivery of planned actions	A review of learning after each use of this protocol will inform future development of the service and this protocol.

12. Useful Information

- Child Exploitation Screening Tool (CSERQ) – [Microsoft Word – CSERQ paper & guidance](#)
- Family Strengths and Needs Toolkit – [Family-Strengths-and-Needs-Toolkit-November-2024.pdf](#)
- Child Not Brought NHS Wales National Guidance [Was Not Brought Guidance – Public Health Wales](#)
- A Trauma-Based Approach to Intimate Examinations and Chaperone – [Intimate-examinations-and-chaperones_pdf-58835231.pdf](#)
- Wales Relinquished Child Protocol <https://nasapi.kinsta.cloud/wp-content/uploads/2023/10/RELINQUISHED-CHILD-PROTOCOL-FINAL-OCTOBER-2021.pdf>

Appendix 1: The Protocol Flowchart

Child under the age of 13 discloses that they may be pregnant to a member of staff



Appendix 2: Consent

What is consent?

Informed consent comes from the person with parental responsibility. However, the child may provide consent if they are able to fully understand the situation, the possible outcomes, the choices and their implications and is deemed to be competent to consent.

Fraser/Gillick Guidance for children/ young people under 16 years:

- Does she, although under sixteen, understand the advice from the health professionals?
- Has the health professional discussed parental involvement but is unable to persuade the individual to inform their parents.
- Will her mental or physical health potentially suffer if treatment is not given.
- Is the treatment in her best interest with or without parental involvement.

Parental Responsibility

Who has it:	
Mother	Always.
Married Father	From the point of marriage (before or after the birth).
Unmarried Father	Since December 2003 – if he is named on the birth certificate, or, if not on birth certificate obtain through court.
Relatives	Only if they have a Residence/Child Arrangement Order for the child.
Local Authority	If they have an Emergency Protection Order or a Care Order (in both cases they must be consulted).
Others	Adoption – once an adoption order is granted the adoptive parents become the legal parent for the child and birth parents lose parental responsibility.

Court Orders

Police Powers of Protection last up to 72 hours. Allows child to be removed to place of safety.

Emergency Protection Order lasts up to 8 days. Local Authority has Parental Responsibility for duration of order but PR for CPMA has to be stipulated in the order.

Care Order Lasts until the child's eighteenth birthday or until revoked by the court. Gives the Local Authority parental responsibility in addition to the parents.

Residence Order/Special Guardianship states where a child is to live. Also give parental responsibility to the person to whom the order is made.

Children subject to court proceedings: Where the child is already the subject of proceedings in a court, the consent of the same Court is required. If the child is subject to a **Care Order**, the Head of Children's Services for the Local Authority can give consent.

Appendix 3: Example of Good Practice

Jig-so is a multi-agency team within Swansea Bay University Health Board, created in 2016 to provide intensive support for all child pregnancies, teenage pregnancies and vulnerable mothers. The team is made up of Specialist Midwives, Nursery Nurses and Parenting Workers who provide intensive support from the booking of pregnancy until the baby is two years old (if required).

The Jig-so Midwives become the Named Midwife and take over all clinical care from generic midwifery services following the booking of the pregnancy and complete all appointments in the home environment and welcome extended family members to be involved in the session being delivered to the parents of the unborn. Sessions include: ACE's and delivering Public Health messages, Gro-brain and fetal development, infant feeding, labour and birth, what to expect in the post-natal period, contraception, care of the newborn (bathing, safe sleeping and handling) and common childhood ailments.

The Jig-so Midwives also attend Consultant appointments and ultra-sound scans if the pregnant person would like extra support during these times. There is always only one Jig-so Midwife allocated to the family as continuity is key to gaining trust and achieving better outcomes, especially in the safeguarding arena if the family are also working with the local authority to safeguard the baby following birth or the young Mum.



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