Safeguarding Children

Managing the Risks Associated with Safeguarding Children and Child Protection Policy

Version: 3.2

Executive Lead: Executive Director of Quality and Safety / Deputy CEO
Lead Author: Head of Social Work and Safeguarding

Approved Date: January 2013
Approved By: Safeguarding Strategy Group

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Ratified By: Policy Panel

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Target Audience:
This Policy must be understood by staff working in: HPFT services who work directly or indirectly with children or who may come into contact with children.
Preface - concerning the Trust Policy Management System (PMS)

P1 - Version Control History:
Below notes the current and previous Version details- full history is in Part 3

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<td>V3.1</td>
<td>9th December 2013</td>
<td>Safeguarding Practitioner/named Nurse Safeguarding Children</td>
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| V3.2    | 14th February 2014 | Safeguarding Practitioner/named Nurse Safeguarding Children | Current | Page13 Child Sexual Exploitation has been moved to this page  
Page 18 Child pornography & Historical abuse  
Page 19 Safeguarding Supervision  
Page 24 Record Keeping |

P2 - Relevant Standards: as stated in the Care Quality Commission, Essential Standards of Quality and Safety, Outcome 7 – Safeguarding people who use services from abuse (March, 2010)

- Working together to Safeguard Children (HM Government, 2013)
- Statutory guidance on making arrangements to safeguard and promote the welfare of children under section 11 of the children act 2004 (DCSF, 2007)
- What to do if you are worried a child is being abused (HM Government, 2006)
- Statement on the duties of doctors and other professionals in investigations of child abuse (DCSF and DH, 2007)

P3 - The 2012 Policy Management System and the Policy Format:

- **Policy Template** is the essential format for most Policies. It contains all that staff need to know to carry out their duties in the area covered by the Policy.
- **Operational Policies Template** provides the format to describe our services, how they work and who can access them
- **Care Pathways Template** is at the moment in draft and only for the use of the Pathways Team as they are adapting the design on a working basis.

Symbols used in Full Policies:

- **RULE** = internally agreed, that this is a rule & must be done the way described
- **STANDARD** = a national standard which we must comply with, so must be followed

Managers must bring all relevant policies to the attention of their staff, where possible, viewing and discussing the contents so that the team is aware of what they need to do.

Individual staff/students/learners are responsible for implementing the requirements appropriate to their role, through reading the Policy and demonstrating to their manager that they understand the key points.

All Trust Policies will change to these formats as Policies are reviewed every 3 years, or when national Policy or legislation or other change prompts a review. All expired & superseded documents are retained & archived and are accessible through the Compliance and Risk Facilitator Policies@hertspartsft.nhs.uk

All current Policies can be found on the Trust Policy Website via the Green Button or http://trustspace/InformationCentre/TrustPolicies/default.aspx
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1. **Flow Chart for Hertfordshire** (see Appendix 1 for Norfolk, Appendix 2 for Essex)

Practitioner has concerns about a child’s welfare?  
(Child Need Screening form must be completed as part of assessment procedure for all adult service users)

**YES**

Practitioner discusses with first line manager or on call manager and, if necessary, lead nurse / doctor for safeguarding children  
*(IF CHILD IS AT RISK OF IMMEDIATE HARM CALL 999)*  
Safeguarding children concerns are confirmed?

**NO**

- Record discussions and actions taken on service user record
- Review again at next appointment and keep under review
- Further concerns must be discussed with first line manager and lead nurse / doctor for safeguarding children

**YES**

Single Service Request Form: send to relevant service. If unsure and you are concerned about a child at risk of suffering significant harm

**Send Child Protection Referral Form by**

- Email to: protectedreferrals.cs@hertscc.gcsx.gov.uk or protectedreferrals.cs@hertfordshire.gov.uk
- Or - Fax to: Customer Services on 01438 737402
- Or - Post to: Customer Services, PO Box 123, Stevenage Herts SG1 2GH

And - Send a copy of referral to the Safeguarding Practice team

**For urgent child protection referral also ring 0300 123 4043**

**Remember**

Record all actions taken and the outcome of discussions on service user record

There must be management oversight of all safeguarding children concerns and practitioners must raise safeguarding matters routinely in clinical supervision

**Trust Safeguarding Practice Team:** Tel 01727 804717 - Fax 01727 804967

Trust Office, 99 Waverley Road, St Albans, Herts AL3 5TL

**Lead Doctor:** Peace Children’s Centre, Watford – Tel 01923 470600
2. Summary

This policy and procedure sets out the process for managing risks associated with safeguarding children and child protection. It describes the responsibilities of Hertfordshire Partnership NHS Foundation Trust (HPFT) staff in the recognition and prevention of child abuse, and the actions that must be taken when abuse or neglect is suspected or identified.

3. Purpose

The policy and procedure has been adapted from and must be used in conjunction with the interagency Safeguarding Children Board Child Protection Procedures for Hertfordshire, Norfolk and Essex. These procedures are recognised and apply to public agencies, private and voluntary services in the protection of children from abuse and neglect. Staff working for the Trust in Hertfordshire, Norfolk and Essex must be familiar with and fully comply with the relevant Safeguarding Children Board Child Protection Procedures.

Associated Trust guidance is also available on “Trust Space”, the HPFT staff intranet, including:

- Sharing information and involvement in the legal process of child protection
- Child visiting policy
- Care coordination policy
- Risk assessment policy
- The Learning from Adverse Events Policy/Reporting and Managing Adverse Incident/Accident Procedure" should be used as part of the learning process to improve practice in the area of safeguarding children.
- Safeguarding Adults from Abuse Policy and Procedures

The policy and procedure provides a consistent approach to the delivery of services and ensures compliance with legislation, national standards and best practice.

The objectives of this policy are:

- To set out agreed ways for managing risk to children who are service users, or related to or connected with service users, and support for parents by using the care coordination approach framework.
- To set out how Trust staff should implement the local safeguarding children board child protection procedures.
- To set out how the Trust will provide specialist advice and support.
- To show how the Trust will incorporate learning into its practice

Compliance with Local Safeguarding Children Board Child Protection Procedures

Children’s social care have key legal powers to protect children, however government legislation and guidance spells out that all agencies including adult mental health, child and adolescent mental health, addictions services and learning disability services have to play their part in safeguarding children in a proactive way. This is set out in the statutory guidance that accompanies the Children Act 2004 entitled Working Together to Safeguard Children – a guide to inter-agency working to safeguard and promote the welfare of children (HM Gov 2013). Working Together states that each agency must follow the child
protection procedures agreed by the local safeguarding children board. Member agencies have agreed to follow their local procedures; this applies to staff working across the Trust in Hertfordshire, Norfolk or Essex.

4. Definitions

STANDARD

CQC - Care Quality Commission
CAF – Common Assessment Framework
DH – Department of Health
CAMHS – Children Adolescent Mental Health Services
AMHP – Approved Mental Health Practitioner
SCR – Serious Case Review
IMR – Internal Management Review
PCT – Primary Care Trust
ISA – Independent Safeguarding Authority

5. Duties and Responsibilities

RULE

Duty of Public Sector Organisations
The Trust, as a public sector organisation has a duty to take all responsible measures to ensure that the organisation minimise risk of harm to the welfare of children and take appropriate action when there are child protection concerns by working to agreed local policies and procedures in full partnership with other agencies.

Duties Within the Organisation
The Trust has a duty to:

- Provide a senior officer to represent the Trust on the safeguarding children boards
- Contribute to Serious Case Reviews ensuring the single agency investigation process is integrated with the SUI processes and that SCR timescales are met
- Embed learning from Serious Case Reviews
- Ensure staff are trained with regard to their responsibilities for safeguarding children
- Ensure that in all risk assessments of service users, the needs and vulnerabilities of any children associated with the service user are considered
- Ensure that appropriate referrals are made to Children’s Social Care where there are child protection concerns
- Ensure that children in need are referred to Children’s Social Care or CAF
- Ensure that staff contribute to child protection processes and share information in line with statutory requirements

Heads of services and managers are responsible for ensuring their services meet these requirements. This should occur through an identified operational lead manager for safeguarding children in each service, working closely with the Named nurse and doctor for safeguarding children, the Safeguarding Practice Team through the Safeguarding Practice Group.

Lead Directors for Safeguarding Children
The Chief Executive is ultimately responsible for ensuring that the Trust meets its obligations with regard to safeguarding children. The Trust Board has over-arching
responsibility for this policy. The lead Director with responsibility is the Director of Quality and Safety/Deputy CEO.

The Director of Quality and Safety/Deputy CEO chairs the Safeguarding Strategy Group and the Quality & Risk Committee, which takes the lead in monitoring compliance with the requirements in this policy. The Director of Quality and Safety/Deputy CEO will present an annual report to the Trust Board.

The Trust is also accountable to the local safeguarding children Boards and to the commissioning PCT. The Director of Quality and Safety/Deputy CEO and Head of Social Work & Safeguarding has responsibility for representing the Trust on the Safeguarding Children Board and for ensuring appropriate representation at sub-groups of the Board and other partnership meetings/groups relating to safeguarding children.

The Trust, with Foundation status is also accountable to Monitor.

**Named Nurse and Named Doctor Safeguarding Children**

All NHS Trusts, NHS Foundation Trusts and Primary Care Trusts (PCT) providing services for children should identify a Named Nurse and Named Doctor for safeguarding. The Named Nurse and Named Doctor for Safeguarding Children working in conjunction with the Head of Social Work & Safeguarding are responsible for:

- Taking the professional lead in safeguarding children matters across the Trust.
- Leading the Safeguarding Children Practice Group
- Ensuring the Trust is supported in its governance role by ensuring audits on safeguarding are undertaken and that safeguarding issues are part of the Trusts practice governance system
- Ensuring a safeguarding children training strategy is in place and delivered within the organisation
- Promoting good professional practice and providing specialist advice and expertise to all staff
- Undertaking serious case and management reviews and following up resulting action plans
- Represent the Trust at sub groups of the local safeguarding children board

The Head of Social Work & Safeguarding is the strategic lead for safeguarding, responsible for leading the work on safeguarding children & adults across the Trust services, to ensure the Trust meets its safeguarding children responsibilities, ensures the responsibilities of the Named Nurse are undertaken as the head of the Trusts Safeguarding Practice Team.

**Support Provided by the Head of Social Work & Safeguarding, the Named Nurse, the Named Doctor Safeguarding Children and the Safeguarding Practice Team**

The Head of Social Work & Safeguarding is the Head of the Safeguarding Practice Team and works closely with the Named Doctor Safeguarding Children. The Named Nurse, as part of the Safeguarding Practice Team is a source of information, advice, consultation, training, supervision and support on all child protection matters. At an operational level advice and support can also be sought from Senior Social Workers and Principal Social Workers who lead on safeguarding as part of their roles. There may also be occasions where The Head of Social Work & Safeguarding, the Named Nurse, the Named Doctor Safeguarding Children or the Safeguarding Practice Team need to intervene in cases that come to their attention to ensure a child’s welfare is safeguarded. They are involved in
reviewing and auditing incidents and cases involving children, parents or pregnant women and in some cases may instigate a referral being made.

The Role of Trust Staff.
It is the role and responsibility of each member of staff to:

- Be alert to the potential indicators of abuse and neglect
- Be alert to the risks of harm that individual abusers, or potential abusers may pose to children
- Identify children in a service users family who may be suffering or at risk of suffering significant harm from abuse or neglect
- Work in partnership with service users, families and carers in order to meet their identified needs, unless this is inconsistent with ensuring the child’s safety.
- Take action and make a referral to Children’s Social Care when a service user discloses they have abused a child or children
- Make a referral to Children’s Social Care if a child is in need of support or protection
- Contribute to Section 47 Child Protection investigations, subsequent child protection conferences and reviews
- Contribute to Children’s Social Care assessments and planning
- Accept the principle that agencies work together in order to ensure health and social care is appropriately co-ordinated and children are protected from suspected or actual abuse. Staff are expected to maintain close links with all relevant statutory agencies in the pursuit of achieving protection for children
- Provide information for other agencies and Courts where appropriate and necessary
- Treat children who have been abused or neglected
- Support parents to care for their children and keep them safe
- Advise parents about the impact of their mental illness or substance misuse may have on their children (including unborn)
- Support parents who have a specialist learning disability
- Identify when the impact of a service users mental illness, substance misuse or learning disability is impairing his / her child’s health or development. This will lead to taking action to safeguard the child including adapting the care and treatment plan for the adult
- Contribute to multi agency assessments of children and their families (CAF and Think Family)
- Share and help to analyse information so that an assessment can be made of a child’s needs and circumstances and whether the child is suffering, or is likely to suffer harm.
- Treat or work with adults who have been the subject of child abuse
- Co-operate with child protection serious case reviews and with serious untoward incident investigations where children are affected
- Seek advise from the safeguarding practice team, named nurse or the Named Doctor for safeguarding children to support work and document on the service user record any discussions and advice given
- Be familiar with the safeguarding children and child protection policy and procedure and own role and responsibilities within it.

A parent / carer is responsible for ensuring their child is cared for, feels loved and valued, stays safe and is protected from abuse or neglect

Legal Context – Definitions and Duties
**Definition of a Child**
A child is anyone who has not yet reached their 18th birthday (Children Act 1989)

**Definition of Safeguarding Children and Child Protection**
Working Together (HM Gov 2013) states that safeguarding and promoting the welfare of children means the process of;
Protecting children from maltreatment, and preventing impairment of children’s health and development, and ensuring that children are growing up in circumstances consistent with the provision of safe and effective care, and undertaking that role so as to enable children to have optimum life chances and to enter adulthood successfully

Child protection is part of safeguarding and promoting welfare. The term “child protection” refers to the activity which is undertaken to protect specific children who are suffering, or at risk of suffering significant harm

**Legal Duties Under the Children Act 2004**
The Trust has a statutory duty under Section 11 to make arrangements to ensure that it has regard to the need to safeguard and promote the welfare of children in exercising its functions. This is the duty that the Government will inspect:

S10 – reinforces and updates the Trust’s existing duty (under the Children Act 1989) to co-operate and share information with local authorities in order to improve children’s well being and promote the five outcomes for children and young people set out in Every Child Matters: Change for children

**Legal Duties Under the Children Act 1989**
S27 of the Children Act 1989 provides that a local authority may request help from any NHS Trust (and other bodies). S47 of the Children Act 1989 places a duty on any NHS Trust (and other bodies) to help a local authority with its enquiries in cases where there is reasonable cause to suspect that a child is suffering, may be suffering, or is likely to suffer significant harm, unless doing so would be unreasonable in all the circumstances of the case.

**Care Quality Commission (CQC)**
The CQC is an independent regulator of health and adult social care services in England. Health and adult social care services need to demonstrate compliance with the Health and Social Care Act 2008 (regulated activities) Regulations 2009 and the Care Quality Commission (registration) Regulations 2009.

Outcome 7: safeguarding people who use services from abuse states that the Trust must make suitable arrangements to ensure that service users are safeguarded against the risk of abuse and take reasonable steps to identify the possibility of abuse and prevent it before it occurs and respond appropriately to any allegation of abuse. Where control or restraint is necessary, service users must be protected from unlawful or excessive use.

The Trust must also have regard to any guidance issued by the Secretary of State or appropriate expert body in relation to the protection of children and vulnerable adults.

**Common Assessment Framework for Children and Young People**
The Common Assessment Framework (CAF) has been introduced by the Government to strengthen inter-agency assessments and to provide:
A simple pre-assessment checklist to help practitioners identify children who would benefit from a common assessment by more than one agency;

A process for undertaking a common assessment; to help practitioners gather and understand information about the needs and strengths of the child, based on discussions with the child, their family and other practitioners as appropriate;

A standard form to help practitioners record and where appropriate share with others the findings from the assessment in terms that help the family find a response to unmet needs

The CAF can be led by any agency working with a child and should be undertaken prior to any referral to Children's Social Care unless there is immediate risk to a child. Trust staff may identify a need for a CAF or may be required to contribute to a CAF.

Further advice about the CAF can be sought from the Safeguarding Practice Team.

**Job Descriptions**

All staff responsible for, and involved in, recruitment should ensure that the following statement is included in job descriptions:

“The Trust is committed to ensuring adults and children are protected and come to no harm from abuse. All employees have a responsibility to be aware of national and local polices, their individual responsibilities with regards to the protection and safeguarding of both adults and children, and must adhere to them at all times”.

**Safe Recruitment**

The Trust has a recruitment and selection policy which reflects safeguarding procedures as outlined in the 6 NHS Employment Check Standards - the Department of Health safer staffing procedures. Warner interviews are undertaken across Child and Adolescent Mental Health Services. Recruitment training is available for managers and provided by the HR department. Records of CRB checks are held in the individual’s personal file and held centrally.

**Independent Safeguarding Authority (ISA)**

The ISA takes responsibility for all vetting and barring of individuals who may pose a risk to children or vulnerable adults from working with these groups. There is now a legal duty to make referrals to the ISA. The existing barred lists for individuals working with children or vulnerable adults (POCA, POVA and List 99) were repealed and replaced with the Children's Barred List and the Vulnerable Adults Barred List, held and administered by the ISA. The Human Resources Department will advise managers on all aspects of the referral process.

**Child Protection Allegations Against Staff – Action That Must be Taken**

Allegations against staff in relation to child protection either while carrying out their work or in relation to their private lives must be dealt with in accordance with the local safeguarding children board child protection procedures. The procedures require the Trust to designate a Named Senior Officer in relation to allegations against staff. This individual has overall responsibility for ensuring that the organisation deals with allegations against staff in accordance with the local safeguarding children board procedures. Resolving inter-agency issues and liaising with the Local Authority Designated Officer for Allegations Management. To ensure this takes place, and in addition to reporting an allegation to the line manager, the Head of Social Work & Safeguarding, Head of Nursing & Patient Safety, Named Nurse
Safeguarding Children and the Director of Workforce & Organisational Development, who are the Named Senior Officers, must also be informed. Guidance on what may be considered a concern about a member of staff working with adults & children and the template risk assessment to be completed by the manager in response to a concern can be found in (appendix 8).

**Embedding Learning**

Learning from Serious Case Reviews, Partnership Case Reviews, Serious Incidents (SI’s) audits and complaints all help inform our training, advice and practice across services. Service Line Leaders have a responsibility to ensure that staff attend their local Practice Governance meetings, Patient Safety meetings, Serious Case Review workshops and other events organised by the local safeguarding children boards.

**Minimising Risk and Promoting the Welfare of Children as Part of Routine Practice**

All services across the Trust have a responsibility to comply with statutory duties and to ensure that their work always considers the impact on children. Consideration of the needs of children and the support needs of parents must take place on a routine basis. Service users must be asked about their children and family situation as part of an initial assessment. This should take place whether or not there are child protection concerns.

**CPA and Service Users who are Parents**

The Trust organises its care provided to adults with mental health problems through care co-ordination including the Care Programme Approach (see Care Co-ordination Policy (2012)).

Where the local authority's Children’s Services are involved - whether to safeguard children or for other reasons - the care co-ordinator should ensure that they are invited to all reviews. This includes discharge planning meetings when the parent or carer has been receiving acute inpatient care. As usual, the consent of the parent or carer and child (where appropriate) should always be sought.

Refocusing the Care Programme Approach (DH 2008) highlights adults with mental health problems who have parenting responsibilities as a key group who need to be identified consistently and provided with holistic assessments and support. Supplementary to this guidance the Department of Health and the Social Care Institute for Excellence have produced Care Programme Approach Briefing: Parents with mental health problems and their children (2008) which provides additional guidance as to how to ensure service users who are parents and their children receive the services they need.

**The Child Need Screening Form (on Paris)**

The child need screening form is part of the comprehensive risk assessment document on Paris. It should be completed for all service users, whether or not they are a known parent. Basic details about all service users children, whether or not they live with their children should be recorded. Service users should be asked what other agencies are involved with them, record the name and contact details and obtain consent for communicating with other professionals e.g. health visitor, children’s social care. Consider whether the service users behaviour and/or illness is having a detrimental impact on their ability to safely parent their child and ensure this is taken into account when prioritising allocation of cases. Consider whether the child/ren are providing support to the service user, without which the service users condition would deteriorate – e.g children taking on additional chores, interpreting,
looking after younger siblings, don’t bring friends home, don’t attend school, accompany parents to appointments or activities. Children may be entitled to a Young Carer’s Assessment or a Child in Need Assessment. These assessments can be accessed by making a referral to Children’s Social Care, in this situation parental consent is always required to make a referral.

Consider whether there is any need for family support or any child protection concerns that warrant a referral to Children’s Social Care. If a child is suffering, or likely to suffer significant harm a referral must be made to Children’s Social Care immediately. If concerns arise about a child who is already known to Children’s Social Care the allocated social worker must be immediately informed of the concerns.

Always discuss concerns about a child who may be in need or at risk of harm with a manager and, if necessary seek further advice from the Trust Safeguarding Practice Team, the Named Doctor for safeguarding children or the Head of Social Work & Safeguarding.

Never delay emergency action to protect a child, record concerns about a child’s welfare, record any discussions and what action has been taken.

The above applies where there are concerns about an unborn baby.
6. Guidance on Recognition, Definitions and Indicators of Child Abuse

STANDARD

What constitutes abuse?
Working Together to Safeguard Children (HM Government 2013) and the local safeguarding children boards’ child protection procedures set out four broad categories of abuse and neglect which are used to determine if a child protection plan is required:

- Physical abuse including fabricated and induced illness
- Emotional abuse
- Sexual abuse
- Neglect

Child Abuse Is?

- A violation of an individual's human and civil rights by any other person or persons
- May consist of a single act or repeated acts
- May be physical, or emotional, or it may be an act of neglect or an omission to act to protect, or it may be sexual, occurring when a vulnerable child or young person is persuaded to enter into a sexual transaction to which he or she has not consented, or cannot consent. Abuse can occur in any relationship and may result in significant harm to, or exploitation of the child subjected to it.

Abuse is when a person or persons have caused harm, or may be likely to do so, to the physical, sexual, or emotional wellbeing of a child.

Harm may be caused by direct acts or by failure to act to prevent harm. It may be systematic and repeated or may consist of a single incident.

- Abuse can occur within a family, institution or community setting and across all social, religious, culture, class or financial positions
- Children may be abused by an adult or another child. It is more common to be abused at the hand of a familiar person than by a stranger.

Child Exploitation

What is child sexual exploitation?
Sexual exploitation is a form of sexual abuse, in which a young person is manipulated or forced into taking part in a sexual act. This could be as part of a relationship which seems to be normal and loving or in return for attention, affection, money, drugs, alcohol or somewhere to stay. In many cases, victims will be ‘groomed’ by an abusing adult, who befriends them and makes them feel special by buying them gifts or giving them lots of attention. Usually the abuser will have power of some kind over the young person. It may be that they are older or more emotionally mature, physically stronger, or that they are in a position where they are able to control the young person.

This type of abuse could happen to any young person from any background. However, certain young people, such as those who are having difficulties at home, regularly go missing or who have experienced care, are more vulnerable.
What are the signs?
Often, the victims of sexual exploitation are not aware that they are being exploited. Sometimes, a victim may think they won't be believed - especially if the abuser is the partner of their mum or dad, a relative or close family friend - and so they may be reluctant to ask for help. However, there are a number of signs that a child or young person may be being groomed.

These include:
- going missing for periods of time or regularly coming home late
- regularly missing school or no taking part in education
- appearing with unexplained gifts or new possessions
- associating with other young people involved in exploitation
- having older boyfriends or girlfriends
- suffering from sexually transmitted infections
- mood swings or changes in emotional wellbeing
- drug and alcohol misuse
- displaying inappropriate sexualised behaviour
- changes in eating patterns.

Child Related Indicators of Abuse
The following child related factors may justify a referral to Children’s Social Care for an assessment of the child’s needs:
- A child acting as a young carer for a parent or sibling
- Child having restricted social and recreational activities
- A child missing school regularly as s/he is being kept home as a companion for the parent / carer
- Child's physical and emotional needs neglected (may be associated with parental depression)
- Impact has been observed on child’s growth, development, behaviour and/or mental / physical health, including alcohol / substance misuse and self harming behaviour
- The parent / carer’s needs or illnesses taking precedence over the child’s needs
- Insufficient alternative care for the child within extended family to prevent harm

(see Appendix 6 “Presentations of child abuse and neglect” for additional guidance)

Indicators in the Care Provided
- Failure by parents or carers to meet basic essential needs e.g. adequate food, clothes, warmth, hygiene
- Failure by parents or carers to meet the child’s health and medical needs e.g. poor dental health, failure to attend or keep appointments with health visitor, GP or hospital; lack of GP registration; failure to seek or comply with appropriate medical treatment; failure to address parental substance misuse during pregnancy
- A dangerous or hazardous home environment including failure to use home equipment safely; risk from animals
- Poor state of home environment e.g. unhygienic facilities, lack of appropriate sleeping arrangements; inadequate ventilation (including passive smoking) and lack of adequate heating
- Lack of opportunities for child to play and learn
- Child left with adults who are intoxicated or violent
- Child abandoned or left alone for excessive periods
7. Risk Management
RULE:

Risk Factors for all Types of Abuse
- Parents or carers with serious mental health problems
- Parents or carers with drug and/or alcohol problems or misuse
- Parents or carers with learning disabilities
- Parent with history of abuse
- Very young or socially isolated parents
- Domestic violence
- Children with special needs, and children born very pre-term
- Dependent children between the ages of one to five, particularly under the age of 1 year

Mental Health of Parent or Carer

Approximately 30% of adults with mental illness have dependent children (Reupert & Maybery 2007). Mental illness of the parent or carer does not necessarily have an adverse impact on a child but should always be considered in the context of the impact of the illness on the care provided to the child. The following risk factors may justify a referral to Children’s Social Care for an assessment of the child’s needs:
- The impact of the illness on the adult (being a parent and having a mental health illness), especially chronic severe illness with co morbid disorders, such as episodes of mental illness complicated by substance misuse or the presence of a personality disorder
- Poor compliance with treatment, problematic relationships with professionals and diagnostic uncertainty
- Parental personality factors (pre-existing and/or exacerbated by the illness, e.g. Irritability, hostility, inability to cope, self-preoccupation, etc)
- A history of overdose and self-harm (prior to and especially since having children), especially when there has been more than one such action
- A parent’s own experience of severe childhood trauma and adversity, including discontinuities in cares and experience of abuse and being “looked after” (in care)
- A history of violence (as a perpetrator or a victim) with unstable, discordant parental relationships
- Environmental stressors outweighing support and protective factors- for example, poor quality support and social isolation in association with multiple adversities such as discrimination (on grounds of gender, ethnic minority status and mental illness), material deprivation and poverty.
- Parents with a learning disability
- Predisposition to, or severe post natal illness
- Delusional thinking involving the child
- Altered states of consciousness e.g. splitting / dissociation, misuse of drugs, alcohol, medication
- Obsessional compulsive behaviours involving the child
- Unsupported and /or isolated mentally ill parents

Examples of Emotional Abuse that should lead to consideration of a referral to Children’s Social Care for them to investigate further and/or liaison with CAMHS to consider a joint assessment:
• Persistent negative views expressed about a child, including rejection
• On-going emotional unavailability, unresponsiveness and neglect, including lack of praise and encouragement, lack of comfort and love and lack of age-appropriate stimulation
• An inability to recognise a child’s needs and to maintain appropriate parent-child boundaries
• On-going use of a child to meet a parent’s own needs
• Distorted, confusing or misleading communications with a child including involvement of a child in parent’s symptom’s or abnormal thinking, including for example, delusions targeting the child, incorporation of the child into a parent’s obsessional cleaning/contamination rituals, or keeping a child at home because of excessive parental anxiety or agoraphobia
• On-going hostility, irritability and criticism of the child
• Inconsistent and/or inappropriate expectations of the child

Parents with Learning Disabilities

Parental learning disability is not correlated with child abuse or wilful neglect, although there is evidence that children may suffer neglect from omission where parents are not adequately supported (HM Gov 2010). Research has shown that in many cases of physical or sexual abuse it is the male partner of the mother who is responsible (Booth & Booth 2002). Issues that cause most concern arise from a lack of understanding about the child’s needs rather than deliberate abuse. It is essential to know what family support network is available and who else provides care for the child. Parents with learning disabilities and their children are often the target of abuse by others; practitioners should always take this into account and discuss family cases regularly in team meetings and in personal supervision, further advice about risks to a child or whether a referral to Children’s Social Care is required can be provided by the Trust safeguarding Practice Team or doctor if necessary.

Parental Substance Misuse

Problem parental substance misuse, drugs or alcohol becomes relevant to safeguarding a child when misusing substances impacts on the care provided to the child or, an unborn baby in the case of maternal substance misuse. It is important not to generalize or make assumptions about the impact on children of parental substance misuse and to consider every family and child’s needs separately making appropriate referrals to Children’s Social Care where there are concerns that a child’s needs are not being met or they are suffering, or likely to suffer significant harm from abuse or neglect. When considering if a child’s needs are being met the following factors should be taken into account;

• Whether the parent or carer has difficulty organising their own or their children’s lives
• Whether the parent or carer is able to meet their children’s needs for safety and basic care
• Whether the parent or carer is emotionally unavailable to the children
• Whether the parent or carer is having difficulty in controlling and disciplining their children
• Whether the children are at risk from environmental dangers such as dirty needles or drugs
• Whether there is another responsible adult in the home to provide care for the children
**Risk Assessments**

Staff should have honest discussions with service users about any potential risks to children arising from their mental illness, learning disability or problem substance misuse. Consideration should be given to the level of insight service users have about the impact of their illness on their children including actual or potential risk and how they apply their insight. Risks will vary according to the age of the child and research has shown that children under five, particularly infants are the most vulnerable. The potential impact of illness in the antenatal and postnatal period should be considered when working with pregnant women or women with infants.

Risk assessments must include an assessment of any current or potential risk to children in the household and / or in the wider community. Protective factors should also be considered, which can include:

- Mild problems
- Short duration
- No family dysfunction
- Family remains together
- Presence of responsive other carer
- Good early attachment between parent and child / later onset of mental illness in parent
- Extended family support

Information must be clearly recorded in the risk assessment. Identified risk and relevant actions required must be reflected in the service user's care or management plan. If the service user lives apart from his or her children, staff must find out the extent of the contact he/she has with their children and whether it constitutes any risk.

If identified risks could lead to actual or potential significant harm to children requiring a child protection investigation under S47 Children Act (1989) staff must make a referral to Children's Social Care and provide full written information about the risks identified. A copy of the referral must be sent to the Trust Safeguarding Practice Team.

Partners of service users should be informed of any potential risk to their children so they can make informed decisions about how best to safeguard their own children. Assessments should be realistic about the capacity for partners or family members to manage identified risks. This should be discussed within the clinical team and with Children's Social Care and considered within a Carer's Assessment.

Staff should ensure that they ask and clearly record full and accurate details of who will look after the children in case of emergency and what the service user wishes their children to be told. They should consider whether proposed arrangements will keep the children safe and well and discuss with Children’s Social Care where appropriate.

**8. Receiving Information Concerning Suspected or Actual Abuse**

**RULE:**

A member of staff may suspect or identify a child at risk of harm through direct work with a service user, in response to a request to assess an individual perceived to pose an actual or potential risk to a child, or in the course of their duties hear an allegation about a member of staff who has harmed or may have harmed a child. The member of staff must
discuss their concern with a line manager regardless of the level of concern, minor or serious.

If the member of staff is concerned that the alleged abuser is a manager they must discuss with a more senior manager in the service.

The Named Nurse or Named Doctor Safeguarding Children or the Safeguarding Practice Team should also be consulted in serious cases of suspected or identified child abuse or neglect and a copy of all referrals sent to Children’s Social Care must be sent to the Safeguarding Practice Team.

Direct contact should be made with the Police if:

a. There is a serious injury
b. A crime is being committed

**NB:** Ensure the crime number provided by the Police is noted in the record.

Once a referral has been made to Children’s Social Care or the Police it is the responsibility of those agencies to undertake an assessment or investigation. Children’s Social Care should acknowledge a referral within one working day of receipt. If this does not happen the referrer should contact them to establish the status of the referral. Staff must telephone Children’s Social Care to find out the status of the referral if they have not heard the outcome after 72 hours.

**Service Users who Disclose Abuse of Children**

If a service user discloses that they have, or may have abused a child, or children, this must be taken seriously, should be clearly documented and discussed within the multi-disciplinary team. Staff are able to seek advice from the Trust Named Nurse or Named Doctor Safeguarding Children or the Safeguarding Practice Team and discuss arrangements for making a referral to Children’s Social Care and / or the Police as appropriate.

**Child pornography**

In the event of a disclosure of individuals (whether service user’s or Trust staff) accessing child pornography, staff should see advice from the Trust Named Nurse or the Named Doctor for Safeguarding Children or the Safeguarding Practice Team. In many instances such disclosures will need to be reported to the police to ensure further investigation is considered.

**Historical allegations of abuse**

Staff should be aware that adult service users may disclose that they or others in their family were abused in childhood. Response to allegations by an adult of abuse experienced as a child warrants the same response as that of a current abuse due to the likelihood that the alleged abuser has continued to abuse children or may be doing so now. The professional receiving the information should record the discussion in detail and inform the service user of their professional duty to safeguard children. A key factor that should be explored is the alleged abuser’s present contact with children. If there is a belief that a child is suffering or likely to suffer significant harm, concerns should be shared with children’s social services or the police. See Hertfordshire Safeguarding Children Board Child Protection Procedures section 4.11.
Staff should seek advice/guidance from the Trust Named Nurse, Named Doctor or the Safeguarding Practice Team.

Staff should also consider appropriate level of support for the adult who has disclosed the abuse.

**Private Fostering**

**STANDARD**

The Local Authority Private Fostering Team must be informed by Law if children are being cared for by anyone other than close relatives and the situation may constitute a private fostering arrangement. A Private Fostering Arrangement is one that is made privately by the family and not instigated by a Local Authority for the care of a child under the age of 16 years (under 18 years if disabled) by someone other than a parent or close relative, with the intention that it should last for 28 days or longer.

A close relative (under the Children Act 1989) is a grandparent, brother, sister, uncle or aunt (whether full or half blood or by marriage) or a step-parent.

**Pregnant Women**

**RULE:**

The needs of pregnant women and their unborn baby must be considered at the earliest opportunity whether or not there are obvious child protection concerns. As pregnancy is a change of circumstances for all service users a multi-disciplinary / multi-agency review and planning meeting must be held under Care Coordination arrangements.

The Care Plan for the service user must include appropriate support and advice during pregnancy and following birth and that the needs and safety of the unborn baby are considered early enough to arrange support.

If child protection concerns arise before, at or after the meeting the relevant Child Protection Procedures on Pre-Birth Referral and Assessment must be followed. If one or more of the criteria set out below are met staff should make a referral to Children’s Social Care for them to instigate a pre-birth child protection assessment.

- There has been a previous unexplained death of a child whilst in the care of either parent
- A parent or other adult in the household has committed an offence against a child
- A sibling in the household is subject to a child protection plan
- A sibling has previously been removed from the household either temporarily or by Court Order
- Domestic violence is known to have occurred
- The degree of parental mental illness is likely to significantly impact on the baby’s safety or development
- There are concerns about parental ability to self care and / or to care for the child – e.g. unsupported young or learning disabled mother
- Any other concern exists that the baby may be at risk of significant harm including a parent previously suspected of fabricated or inducing illness in a child
Consideration should also be given to the effect of the pregnancy and parenthood on expectant fathers and risks and needs assessments should take account of the pregnancy.

**Safeguarding Supervision**

Supervision is a vital component of keeping children safe. Clinical supervision must include safeguarding as a routine component. Child protection cases should be regularly discussed in supervision and any decisions and the reasons of them should be recorded by the supervisee. All cases where there is child protection/safeguarding concerns must have a documented plan of action devised between the practitioner and supervisor which is monitored through supervision and includes a timescale of review and this must be recorded on Paris. Where cases which include risk to the safety or welfare of children are discussed in multi professional or other team meetings, a record of that discussion and any decisions/plans made should be made in the service user's records on Paris.

The practitioner is responsible for raising with their line manager/team leader/supervisor all cases of:
- A child’s welfare or safety that may be affected by parental mental health
- Looked after children
- Children in the family with a child protection plan
- Families who have children which gives cause for concern.

The Named Doctor will take responsibility for providing guidance and support regarding clinical assessment and management of cases by medical staff.

A flow diagram outlining supervision action is attached - Appendix 9

**Consultant Psychiatrists Direct Involvement in Cases Involving Potential Risks to Children**

**STANDARD**

Consultant Psychiatrists must always be informed and directly involved in clinical decisions for service users who express delusional beliefs or suicidal ideation that may involve and pose a risk to children. Where the service user is an inpatient this will include any decision regarding discharge, leave, CPA reviews or contact arrangements with children. These decisions must not be delegated to a junior doctor.

The above cases are likely to be the small minority. Therefore, Care Co-ordinators must have a low threshold for acting in cases where there may be a significant risk to children. All such cases must be discussed in the multi-disciplinary team meeting to ensure a group decision is taken about how to manage risks and plan actions. When a consultant psychiatrist is not present at the meeting the discussion must include whether it is necessary for the consultant to be alerted to the case to make a decision about whether there is a need for direct consultant involvement and / or oversight of the case.

If urgent action is required to safeguard a child, before the routine team meeting, the clinician must seek advice from the manager or senior clinician immediately and make a referral to Children’s Social Care if needed. If in any doubt advice should be sought from the Trust Named Doctor or Named Nurse Safeguarding Children or the Safeguarding Practice Team.
9. Threshold for Action

**RULE:**

Where there is reason to believe that a child under the age of 18 years or an unborn baby is suffering or likely to suffer significant harm a referral should be made to Children’s Social Care. Professionals should seek to discuss concerns with the parent / carer and where possible seek their agreement to making a referral. This should only be done where such discussion and agreement seeking will not place a child at increased risk of significant harm.

Referrals should also be made to Children’s Social Care where it is thought the family may benefit from family support services. In this situation agreement of the parent / carer is always required.

If staff are unsure about making a referral then consultation should take place with the Named Nurse or Named Doctor for safeguarding children or the Safeguarding Practice Team (see appendix 7 for contact details). Consultation can also be made with the Targeted Advice Service. (see appendix 7 for contact details).

Referrals to Children's Social Care should always be made in writing. The following form should be completed:

- Hertfordshire – Child Protection & Single Service Request Forms (see Appendix 3)
- Norfolk – Assessment/Referral Form (see Appendix 4)
- Essex – Inter Agency Referral Form (see Appendix 5)

The Safeguarding Practice Team must receive a copy of the referral. Professional referrals cannot be made anonymously.

All cases of suspected or actual abuse must be taken seriously and acted on, from what initially appears minor to serious incidents.

Out of hours child protection referrals should be made via the children’s services customer service centre. If a situation is urgent staff should call the Police.

Professionals must ensure they record their concerns and actions taken onto Paris, including entering an alert on Paris about any child protection matters. Concerns regarding subsequent action taken by other agencies must be escalated by the professional to their line manager and discussed with the Trust Named Nurse or Named Doctor safeguarding children or the Safeguarding Practice Team who will advise on appropriate action.

**Staff Involvement in Formal Child Protection Processes**

**RULE:**

- Refer concerns about significant harm or child in need to Children’s Social Care by phone and on the relevant referral form within 24 hours of a verbal referral
- Co-operate and share information with Children’s Social Care when they undertake a Children Act Section 47 Child Protection Investigation or a Section 17 Child in Need Assessment
- Contribute to assessment of parenting capacity, child’s needs and family and environmental factors
- Attend and contribute to Strategy / Professionals Meetings, Child Protection Conferences and Core Groups and provide written reports
- Make a judgement about whether the child should be subject to a Child Protection Plan and category – neglect, emotional abuse, physical abuse, sexual abuse.
- Continue to work jointly until joint decision is reached that this is no longer necessary

**Dealing with Differences of Opinion and Escalating Concerns**

**RULE:**

If Children’s Social Care decide that an initial child protection case conference is not required but Trust staff remain seriously concerned about the safety of a child, they should seek further discussion with the social worker and their manager.

Staff should also involve their manager where necessary and if appropriate, escalate to the Service Line Leader. Staff should continue to escalate with senior managers until a satisfactory conclusion has been reached.

If concerns remain, staff may, with the support of their managers and the Head of Social Work & Safeguarding or Named Nurse or Named Doctor Safeguarding Children formally request that Children’s Social Care convene an initial child protection conference.

If this approach fails to achieve agreement or where differences of opinion across agencies occur about risk the procedures for resolution of conflicts in the Cross Service Protocol should be followed. Concerns, discussions and any agreements made should be recorded in the service user’s Paris.

Where differences of opinion occur within a Trust team, advice should be sought from the Trust Named Nurse or Named Doctor Safeguarding Children or Safeguarding Practice Team, if necessary, the situation should be escalated with senior managers in the relevant service stream.

**Ascertaining Whether a Family is Known to Children’s Social Care or Child Subject to a Child Protection Plan**

Staff can contact Children’s Social Care on 0300 123 4043 to make legitimate enquiries about whether the family are known or the child is subject to a child protection plan or previously on the child protection register. If the child is known, or believed to be resident in a different county staff should contact the appropriate local authority. The Trust Safeguarding Practice Team may be able to assist with this.

**Mental Health Act Assessments**

**STANDARD**

Consideration for the protection of other persons must include the impact on the welfare of any children if their parent is admitted to hospital. Children must not be left unsupported with caring responsibilities if the service user is not hospitalised. Staff should make a referral to Children’s Social Care if the family needs additional support.

Where possible, the presence of children should be ascertained before the assessment and Children’s Social Care involved in planning the assessment if there are likely to be childcare needs, whether or not the service user is hospitalised. It is good practice to take account of the views of children and any information that they may have about their
parent’s illness. Research shows that service users and children benefit if children are given an explanation about their parent / relatives illness, the role of professionals, what is happening and what will happen next.

If a person does not meet the criteria for admission to hospital the AMHP will make arrangements for the individual’s treatment and care in the community. This may include a referral to the Crises, Assessment and Treatment Team who will offer treatment in the person’s home. The AMHP must ensure appropriate arrangements are made for the welfare of the child.

Children Visiting Relatives in Hospital

**RULE:**

Staff must comply with the Trust’s Child Visiting Policy. Inpatients must have suitable and safe designated space for visits by children to take place.

See Trusts Child Visiting Policy for more details.

**Leave Arrangements**

Consideration must be given to the impact on children when planning leave. If a service user does not usually reside with his or her own children or other children checks must be made with the service user and if necessary, Children’s Social Care as to whether they are likely to be visiting or staying in a household with children and whether this poses any risks or practical problems for the household.

Occasionally, child protection plans have conditions regarding an adult’s contact with children. Staff should check if any conditions exist and should consult with Children’s Social Care prior to allowing leave.

Staff must ensure that leave arrangements comply with plans made at child protection conferences or as part of Children’s Services assessment plans.

Staff should ascertain from the service user what happened on leave and record any contact with children and the service user’s perceptions of the leave.

If Children’s Social Care are involved staff should inform them immediately if a service user goes absent without leave so they can carry out any checks into the safety of children that may be necessary. They should also be notified when the service user returns and provided with relevant information whilst absent.

**Discharge Planning**

Discharge arrangements must take account of any impact on children in the family, household or wider community. There must be a clear discharge plan that evidences this. Children’s Social Care, if involved must be consulted about discharge plans to give them an opportunity to put any necessary arrangements into place.

If there is a child under 5 years old the health visitor should be informed and invited to the discharge planning meeting.

**Carer’s Assessments**
If a service user has children under the age of 18 years staff should discuss with the service user whether the children are carrying out any caring responsibilities towards their parents, siblings, grandparents or other relatives.

Staff should be mindful of the fact that a caring role may have an impact on a child / young person’s own development, education, leisure activities etc.

Children under 16 years old with caring responsibilities may be entitled to a Child in Need Assessment carried out jointly with Children’s Social Care. Staff should discuss this with the family and make a referral where required. Young people over 16 years with caring responsibilities are entitled to a Carer’s Assessment.

Staff should consider applying for Carer’s Grants to support the children. They should also find out about young carer’s groups and offer to facilitate the child or young person to attend. Staff should also offer facilitation for children and young people to access and attend CAMHS provision within the Trust if appropriate.

**Children who Miss Out Patient Appointments - New Referrals (accepted by CAMHS but not yet seen) and on going Cases**

If a child does not attend an outpatient appointment there must be serious consideration given to whether there is any child protection or safeguarding concerns, the following action must be taken by the responsible clinician:

- Discuss the matter in the next team meeting (or with a senior clinician prior to the meeting if urgent) and document the outcome of the discussion onto Paris.
- A discussion with the referrer or Children’s Social Care must take place and consideration given to the need for a professionals meeting to discuss how to proceed with the non-attendance. The referrer should be asked to contact the parents to establish the reason for not bringing the child to CAMHS.
- CAMHS should consider what other, flexible arrangements for seeing the child can be made, such as at school or home.
- The parents should be informed that where child protection or safeguarding concerns exist CAMHS will inform Children’s Social Care about non-attendance.
- The referrer and the child’s GP must be notified in writing that the family did not attend CAMHS and a copy of the CAMHS letter to the family must be included.
- Staff must inform the team manager and the CAMHS Community Manager of all child protection or safeguarding concerns which must also be discussed in clinical supervision. Clinician’s case load is subject to review every three months.

**Record Keeping**

The following records should all show that children have been considered and include relevant information about children and the impact on children

- Child Need Screening Form
- Family and household composition including:
  - non-resident children
  - pregnant service user with estimated date of delivery
  - pregnant partner
- Risk assessments
• Contingency plans
• Leave arrangements
• Discharge arrangements
• Arrangements for children visiting service users in hospitals
• Incident reporting forms

When assessments show that a child is deemed to be vulnerable or at risk of significant harm information must be shared with colleagues in Children’s Social Care. Staff dealing with cases where there is a child or children at risk of significant harm must keep full factual records of what is said by all parties, details of all findings and observations and record dates and times of all entries. It is helpful to keep a chronology of events.

All children and young people with a child protection plan should have an alert against their names on Paris line with Laming recommendation 2003. Parents of children with a child protection plan should also have an alert against their name.

Sharing Information

STANDARD

It is recognised that information sharing can be a difficult issue and that Trust staff can feel constrained from sharing information by their uncertainty about when they can do so lawfully. It is best practice to discuss with service users, any concerns and any intention to share information, unless by doing so there would be increased risk to a child or children. Legally, staff can share confidential information with the service user’s consent.

See trust guidance on Sharing Information for more details.

Closing or Transferring a Case

STANDARD

Before closing a case or transferring a case to another team, staff must consider any impact on the children or unborn baby if the service discontinues contact with the family. If Children’s Social Care are involved in the case they must be invited to any transfer or closure / discharge meeting and be sent a copy of the discharge report. If children are subject to a child protection plan, staff should ensure transfer or closure plans are discussed first with the children’s social worker, the Core Group and the Child Protection Conference Chair because this is a change to the child protection plan.

Discharge letters should be copied with the service user’s knowledge and agreement to relevant health and social care children’s professionals involved with the family. Staff should ensure that there are appropriate family / parenting support services in place if necessary.

Incident Reporting

See HPFT Managers incident policy and review form.

The incident may have a practical or emotional impact on children – e.g. suicide or attempted suicide of a parent, or living in a household with violence. Staff must ensure that children are safe after an incident. Where a pregnant woman is involved staff must ensure there is no risk to the unborn baby, a maternity health check or midwifery assessment should be arranged if necessary.
**Consent and Confidentiality**

**RULE:**

A child or young person under 18yrs old may disclose that abuse is occurring and then request that it remains confidential. This **cannot** ever be guaranteed. Information must still be shared with Children’s Social Care and if a crime has been committed with the Police.

Likewise, an adult who discloses that s/he has abused a child and then requests that it remains confidential **cannot** ever be guaranteed. Information must still be shared with Children’s Social Care and if a crime has been committed with the Police.

The sharing of information held by the Trust with regard to service user/s, and if applicable, their families and carers must meet the requirements of the Data Protection Act. Research has demonstrated that keeping children safe from harm requires practitioners to work in partnership with parents and to share relevant information across professional, organisational and geographical boundaries.

Such information includes:

- Exposure of child to possible harm
- Impaired health and / or development of child
- Parent / carer unable to care adequately for child
- Individuals who may present a risk of harm to child

It is the duty of professionals, whether they are providing services to adults or children, to place the safety of the child first. Professionals should seek to discuss concerns with the parent / carer and where possible seek their agreement to making a referral. This should only be done where such discussion and agreement seeking will not place a child at increased risk of significant harm.

If there are concerns regarding the capacity of the person with parental responsibility to consent, an assessment of capacity to consent to the sharing of information in this situation is required which meets the requirements of the Mental Capacity Act 2005 (Refer to the Trust policy on Mental Capacity). This should not cause a delay in making a child protection referral, or sharing information with the local authority to protect a child from significant harm.

If Children’s Social Care have reasonable cause to believe that a child is suffering or at risk of suffering significant harm they may request Trust staff to share information about a service user during their investigation. The request should include whether consent of the Trust service user has been sought and provided, sought but withheld or whether consent has not been sought and the reasons for this. Any request for information and the sharing of information must be documented in the service user’s Paris.

Guidance on the release of information can be provided by the Records and Freedom of Information Act Manager, the Head of Social Work & Safeguarding, Named Nurse or Named Doctor Safeguarding Children or in the Policy for Sharing Information and Involvement in the Legal Process of Child Protection. There is also the Trust Management of Care Records Policy.
Multi Agency Public Protection Arrangements (MAPPA)

Staff may be working with a service user who is subject to, and monitored under MAPPA arrangements. These cover the management of individuals who pose a risk of harm to children. In these circumstances, staff should ensure that appropriate information is shared with the MAPPA panels.

Fabricated or Induced Illness

Staff may be working with service users who induce or fabricate illness in a child (formerly known as Munchhausen's by Proxy). Such situations can be difficult to evidence, it is essential to maintain a focus on the outcome and impact on the child and not on the diagnosis of the parent / carer. The Government produced guidance “working together to safeguard children in whom illness is fabricated or induced 2008” which practitioners should always consult where there are suspicions of FII and can be accessed via the safeguarding children folder on the staff intranet. The relevant Local Authority Child Protection Procedures should also be referred to.

Consultation with colleagues is an important part of the process of making sense of the underlying reasons for possible signs and symptoms a child may display. Information sharing between professionals at an early stage of concern is absolutely crucial.

When a possible explanation for the signs and symptoms is that they may have been fabricated or induced by a carer and as a consequence the child’s health or development is or is likely to be impaired a referral should be made to Children’s Social Care.

Whilst professionals should, in general, discuss any concerns with the family and, where possible, seek agreement to making referrals to Children’s Social Care, this should only be done where such discussion and agreement seeking will not place a child at increased risk of significant harm.

All decisions about what information is shared with parents should be taken jointly, bearing in mind the safety of the child.

If any professional considers their concerns are not responded to appropriately, the concerns should be discussed with the Trust Named Nurse or Named Doctor Safeguarding Children.

Domestic Violence / Abuse

Domestic abuse is a broad description of abusive relationships that develop within the home / family environment where power is exercised to the detriment of at least one party. Responsibility for domestic abuse rests with the perpetrator and without intervention, the evidence is that it is likely to get worse.

Such situations may involve threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults / young people who live in the same household or where one lives in the household and the other is a regular visitor, e.g. partners, ex partners and family members.

Domestic violence may be exacerbated by other factors e.g. mental illness, substance misuse (including alcohol), homelessness and housing need, pregnancy, new birth and
separation. Staff should be aware of the inter-relationship between domestic abuse / violence, child protection and adult mental health problems. Service users may be victims or perpetrators of domestic abuse.

If there is domestic abuse, the implications for children (including unborn child if the victim is pregnant) in the household must be considered since research indicates a strong link between domestic violence and all types of abuse and neglect. A key part in protecting children in a domestic abusive context involves an assessment of the risk presented by the perpetrator. Any child witnessing domestic abuse meets the threshold criterion for child protection enquiries and therefore a referral to children’s social care must be made.

Multi Agency Risk Assessment Conferences (MARAC) are local domestic violence meetings set up to manage and reduce risks to victims of domestic violence. When staff have a service user on their caseload who is involved in violent relationships they may be invited to attend MARAC meetings and to contribute to multi agency plans to protect individuals from domestic abuse, attendance at these meetings should be a priority.

Staff should discuss concerns with colleagues / manager and seek further advice from the Safeguarding Practice Team or Named Doctor Safeguarding Children or if required.

The relevant Local Authority Safeguarding Children Procedures provide additional information about domestic abuse including indicators and response to victims.

**Court Proceedings Concerning Children**

**STANDARD**

If any service user is subject to criminal, public or private family court proceedings concerning children, staff must inform the Trust Head of Social Work & Safeguarding and Named Nurse Safeguarding Children. As appropriate advice from the Trust Patient Safety Manager, this will enable appropriate support and advice to be offered to staff in relation to their role and any potential court directions with which the Trust has to comply.

**Use of Interpreting Services**

It is good practice that professional, accredited interpreters are used rather than children, partners or other family members for service users who need such services.

**Young People who Need Inpatient Care**

In line with Government Policy the Trust will not have children and young people under 18 years old on adult wards unless it is deemed more appropriate for particular young people approaching the age of 18 years. The Trust has a specialist unit, Forest House, for adolescent mental health which provides inpatient and day services for young people with serious mental health problem.

**Child Death Reporting Procedure**

The Local Safeguarding Children Board requires that all organizations notify child deaths of any cause to the regional manager for confidential enquiry into maternal and child health (CEMACH) to ensure comprehensive data is collated. In the event of the death, from any cause, of a Trust service user (under the age of 18yrs) the risk management
department will notify the Head of Social Work & Safeguarding who will complete the necessary reporting form and send it to the regional CEMACH manager.

Serious Case Reviews

STANDARD

Working Together to Safeguard Children (HM Government 2013) sets out criteria for the circumstances when local safeguarding children boards should initiate a serious case review (SCR).

Serious case reviews are held where a child dies, or sustains serious injury and abuse or neglect is known or suspected and there has been cause for concern about the way agencies have worked together to safeguard the child.

The purpose of a serious case review is to:
- Establish what lessons are to be learned
- Identify clearly what those lessons are, how they will be acted on and what is expected to change as a result
- Improve the way professionals and agencies work together to better safeguard and promote the welfare of children

Each agency involved must carry out an internal management review (IMR) to contribute to the overall serious case review. After notification about the requirement to undertake an IMR by the safeguarding children board an incident form will be completed by the Head of Social Work & Safeguarding and Named Nurse Safeguarding Children. The relevant Managing Director and the Patient Safety Manager will be notified. The Trust IMR will be carried out by a serious untoward incident panel.

Strict timescales for completing an IMR have been drawn up by the safeguarding board and must be adhered to. The Trust IMR will be incorporated into the overarching health IMR compiled by the Designated Nurse and Designated Doctor.

All IMRs are received by an independent person, commissioned by the safeguarding board who will collate and analyse the information contained in the IMRs. They will write an overview serious case review report for the safeguarding board. The report may contain additional recommendations for the Trust not already identified by the SUI panel.

Affected services will be expected to draw up an action plan in response to the IMR and relevant recommendations in the overview report. The implementation of SCR action plans will be monitored through service stream governance arrangements and the Trust safeguarding committee.

Ofsted is responsible for evaluating serious case reviews including the overview report and individual management reports. Ofsted evaluations will be reported through the Trust safeguarding committee and governance arrangements. Some serious case reviews are also subject to independent inquiries commissioned by regional or national government bodies.
10. Training/Awareness

**RULE**

Training must include being able to recognise and respond effectively to a child in need or who may require safeguarding. Practitioners and managers must be able to work effectively with others within their own agency and across organisational boundaries; this will be best achieved by a combination of single and multi-agency training.

The Trust is responsible for ensuring that all those in contact with children and young people and/or with adults who are parents or carers have a mandatory induction, which familiarises them with their child protection responsibilities, policies and procedures. Induction should be completed within the first six months of employment. Thereafter safeguarding children training is mandatory for all direct care staff and their managers and staff must have a refresher every three years.

**Training Needs Analysis**

<table>
<thead>
<tr>
<th>Level of Training</th>
<th>Service</th>
<th>Staff Group</th>
<th>Training Package and/or Provider</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Induction</td>
<td>All services</td>
<td>All new staff</td>
<td>Trust Induction</td>
<td>Once within 6 months of employment</td>
</tr>
<tr>
<td>1 – 1.5 hour mandatory training</td>
<td>All community and inpatient services across the Trust Including those working with adults in specialist LD, mental health services</td>
<td>All direct care staff and their managers</td>
<td>Trust – multi professional group sessions Or E-learning Introduction to Safeguarding Children</td>
<td>On employment or if not completed training within the Trust since commencing employment</td>
</tr>
<tr>
<td>2 – 3 hour Mandatory training</td>
<td>All community and inpatient services across the Trust Including those working with adults in specialist LD, mental health services</td>
<td>All direct care staff and their managers</td>
<td>Trust – multi professional group sessions Or E-learning Safeguarding Children Update / refresher</td>
<td>Within 3 yrs of completing the introduction to safeguarding children training</td>
</tr>
<tr>
<td>1 – 2 hour</td>
<td>Staff with responsibility for commissioning and delivering</td>
<td>Directors, Managing Directors and Senior Managers</td>
<td>Multi-agency Safeguarding Leadership e-learning Login &amp; password</td>
<td>Every 3 years</td>
</tr>
<tr>
<td>1 hour to 1 day</td>
<td>Multi agency training</td>
<td>In addition to completing Trust training CAMHS staff and Lead practitioners who are team and service representatives on the safeguarding children practice group</td>
<td>CAMHS staff and Lead practitioners who are team and service representatives on the safeguarding children practice group</td>
<td></td>
</tr>
<tr>
<td>Local Safeguarding Children Board</td>
<td>Seminars, workshops and study days available throughout the year</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| 1 hour to 3 day | Multi agency training | Safeguarding children leads and other professionals working with complex cases, including fabricated and induced illness. | Safeguarding Practice Team and Named Doctor for Safeguarding Children, Consultant Psychiatrists, Psychologists, Social Workers, Senior Nurses (band 7 and above). |
| Local Safeguarding Children Board | Seminars workshops and study days available throughout the year |

The training schedule applies to staff whether temporary or permanent.

Managers are responsible for ensuring staff are trained and updated as required, and must keep records of this.

Staff are responsible for completing training at the required intervals. Staff should use their personal development planning and appraisal process to monitor and identify training needs.
11. Embedding a culture of Equality & RESPECT

The Trust promotes fairness and RESPECT in relation to the treatment, care & support of service users, carers and staff.

RESPECT means ensuring that the particular needs of ‘protected groups’ are upheld at all times and individually assessed on entry to the service. This includes the needs of people based on their age, disability, ethnicity, gender, gender reassignment status, relationship status, religion or belief, sexual orientation and in some instances, pregnancy and maternity.

Working in this way builds a culture where service users can flourish and be fully involved in their care and where staff and carers receive appropriate support. Where discrimination, inappropriate behaviour or some other barrier occurs, the Trust expects the full cooperation of staff in addressing and recording these issues through appropriate Trust processes.

RULE: Access to and provision of services must therefore take full account of needs relating to all protected groups listed above and care and support for service users, carers and staff should be planned that takes into account individual needs. Where staff need further information regarding these groups, they should speak to their manager or a member of the Trust Inclusion & Engagement team.

Where service users and carers experience barriers to accessing services, the Trust is required to take appropriate remedial action.

<table>
<thead>
<tr>
<th>Service user, carer and/or staff access needs (including disability)</th>
<th>The HPFT safeguarding children policy and the Safeguarding children board policies for Hertfordshire, Norfolk and Essex are concerned for the safety of all children. All investigations into child abuse would be sensitive to age, ethnicity, gender, disability and religion but would also consider the need to protect children from abuse. The needs of the child are paramount a statement enshrined in child care legislation and this policy.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Involvement</td>
<td>Children are involved and consulted with in the safeguarding process depending on their age and the nature of the safeguarding concern.</td>
</tr>
<tr>
<td>Relationships &amp; Sexual Orientation</td>
<td>HPFT services respond sensitively to relationships and sexual orientation. The CAMHS service staff are also trained to work with individual service users where there are personal and family conflicts.</td>
</tr>
<tr>
<td>Culture &amp; Ethnicity</td>
<td>Interpreters are arranged where required when there are language difficulties that affect communication. Community CAMHS service staff and Inpatient staff are trained to ask questions and respond to ethnic and cultural needs.</td>
</tr>
<tr>
<td>Spirituality</td>
<td>CAMHS staff respond to spiritual needs as described above.</td>
</tr>
<tr>
<td>Age</td>
<td>This policy is for all children under the age of 18 years</td>
</tr>
<tr>
<td>Gender &amp; Gender Reassignment</td>
<td>Transgender issues are responded to sensitively by CAMHS staff.</td>
</tr>
<tr>
<td>Advancing equality of opportunity</td>
<td>The principles of safeguarding children applies to all children regardless of their age. There is a need to develop systems for service user feedback on the quality of services provided which would include equality issues.</td>
</tr>
</tbody>
</table>
12. Process for monitoring compliance with this document – STANDARD

This section should identify how the organisation plans to monitor compliance with the process/system being described, presented in a table.

<table>
<thead>
<tr>
<th>Action:</th>
<th>Lead</th>
<th>Method</th>
<th>Frequency</th>
<th>Report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Report</td>
<td>Head of Social Work and Safeguarding</td>
<td>Review safeguarding strategy and practice governance</td>
<td>annually</td>
<td>Safeguarding Strategy Group And integrated governance committee</td>
</tr>
<tr>
<td>Audit of cases</td>
<td>Head of Social Work and Safeguarding</td>
<td>Sample specified number of cases</td>
<td>Quarterly</td>
<td>Safeguarding Strategy Group</td>
</tr>
<tr>
<td>Updating Safeguarding Children Policy</td>
<td>Head of Social Work and Safeguarding</td>
<td>Make amendments to policy in response HSCB and national changes</td>
<td>As required</td>
<td>Safeguarding Strategy Group</td>
</tr>
</tbody>
</table>
PART 3 – Associated Issues

13. Version Control

STANDARD

<table>
<thead>
<tr>
<th>Version</th>
<th>Date of Issue</th>
<th>Author</th>
<th>Status</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>V1</td>
<td>August 2008</td>
<td>Lead Nurse, Safeguarding Children</td>
<td>Superseded</td>
<td>Archived</td>
</tr>
<tr>
<td>V1.1</td>
<td>August 2009</td>
<td>Lead Nurse Safeguarding Children</td>
<td>Superseded</td>
<td>Archived</td>
</tr>
<tr>
<td>V1.2</td>
<td>December 2009</td>
<td>Lead Nurse Safeguarding Children</td>
<td>Superseded</td>
<td>Archived 30.6.2010</td>
</tr>
<tr>
<td>V2</td>
<td>July 2010</td>
<td>Lead Nurse Safeguarding Children</td>
<td>Current</td>
<td>Approved by the safeguarding strategy group 24.4.2010</td>
</tr>
<tr>
<td>V3</td>
<td>December 2012</td>
<td>Head of Social Work &amp; Safeguarding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>V3.1</td>
<td>9th December 2013</td>
<td>Safeguarding Practitioner/named Nurse Safeguarding Children</td>
<td>Superseded</td>
<td>Updated with Appendix 9</td>
</tr>
<tr>
<td>V3.2</td>
<td>14th February 2014</td>
<td>Safeguarding Practitioner/named Nurse Safeguarding Children</td>
<td>Current</td>
<td>Page 13 Child Sexual Exploitation has been moved to this page Page 18 Child pornography &amp; Historical abuse Page 19 Safeguarding Supervision Page 24 Record Keeping</td>
</tr>
</tbody>
</table>

14. Archiving Arrangements

STANDARD: All policy documents when no longer in use must be retained for a period of 10 years from the date the document is superseded as set out in the Trust Business and Corporate (Non-Health) Records Retention Schedule available on the Trust Intranet
A database of archived policies is kept as an electronic archive administered by the Compliance and Risk Facilitator. This archive is held on a central server and copies of these archived documents can be obtained from the Compliance and Risk Facilitator on request.

15. **Associated Documents**
**STANDARD**

- HPFT Child Visiting Policy
- HPFT Guidelines for Sharing Information and Involvement in the Legal Process of Child Protection
- HPFT Guidelines for the Care and Management of Pregnant Service Users
- HPFT Care Records Policy
- HPFT Learning from adverse events

16. **Supporting References**
**STANDARD**


Norfolk Safeguarding Children Board (April 2008) *A guide to interagency working to safeguard and promote the welfare of children*. Norfolk Safeguarding Children Board


Children Act (1989) London. HMSO.


Department for Children, Schools and Families (2006) *Information Sharing; guidance for practitioners and managers*


Care Quality Commission (2009) *Essential standards of quality and safety – outcome 7: Safeguarding people who use services from abuse*


Intercollegiate document (2006) *Safeguarding Children and Young People; roles and competencies for healthcare staff*
SCIE guide 30 (2009) Think child, think parent, think family; a guide to parental mental health and child welfare

Department for Children, Schools and Families (2008) Safeguarding Children in Whom Illness is Fabricated or Induced. DCSF. HMSO

Bibliography


Department of Health (2007) Responding to Domestic Abuse; a handbook for health professionals

17. Comments and Feedback – List people/group involved in developing the Policy.

| STANDARD |
|------------------|------------------|
| Executive Director Quality & Safety/Deputy CEO/Caldecott Guardian | Director of Workforce and Organisational Development |
| Head of Practice Governance | Lead Nurses |
| Quality & Standards Manager | Practice Governance Leads |
| Compliance and Risk Facilitator | Directorate Manager MHA Legislation |
| Head of Practice Governance | Head of Facilities & Maintenance |
| Quality & Standards Facilitator | Information Governance Officer |
| Senior Social Workers | Head of Records & Access to Information |
| Equalities Manager | Patient Safety Manager |
| Safeguarding Practice Leads Group | Safeguarding Practice Team |
| Service Line Leaders | Managing Directors |
## Appendices

<table>
<thead>
<tr>
<th>Appendix</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix 1</td>
<td>Flow Chart – Norfolk</td>
</tr>
<tr>
<td>Appendix 2</td>
<td>Flow Chart – Essex</td>
</tr>
<tr>
<td>Appendix 3</td>
<td>Single Service Request Form – Hertfordshire</td>
</tr>
<tr>
<td>Appendix 4</td>
<td>Assessment / Referral Form – Norfolk</td>
</tr>
<tr>
<td>Appendix 5</td>
<td>Inter Agency Referral Form – Essex</td>
</tr>
<tr>
<td>Appendix 6</td>
<td>Presentations of child abuse and neglect Contact Information</td>
</tr>
<tr>
<td>Appendix 7</td>
<td>Contact Information</td>
</tr>
<tr>
<td>Appendix 8</td>
<td>Child Protection Allegations Against Staff Risk Assessment</td>
</tr>
<tr>
<td>Appendix 9</td>
<td>Safeguarding Children Supervision</td>
</tr>
</tbody>
</table>
Norfolk Service

**Practitioner has concerns about a child’s welfare?**
(Child Need Screening form must be completed as part of assessment procedure for all adult service users)

**YES**

Practitioner discusses with first line manager or on call manager and, if necessary, lead nurse / doctor for safeguarding children
(IF CHILD IS AT RISK OF IMMEDIATE HARM CALL 999)
Safeguarding children concerns are confirmed?

**NO**

- Record discussions and actions taken on service user record
- Review again at next appointment and keep under review
- Further concerns must be discussed with first line manager and lead nurse / doctor for safeguarding children

**YES**

Telephone Norfolk County Council Children’s Services
Customer Services Centre – 0344 800 8014 …

then send the completed referral form to social services
by Fax to: 01603 762 445
or Post to: Access Service, PO Box 3210, Norwich, NR7 7AB

And send a copy of referral to the lead nurse safeguarding children

If you are unsure whether to make a referral to Norfolk Children’s Services you can also have a telephone consultation with a children’s services manager on 01603 224134

**Remember**
Record all actions taken and the outcome of discussions on service user record
There must be management oversight of all safeguarding children concerns and practitioners must raise safeguarding matters routinely in clinical supervision

**Safeguarding children contact details:**

Service Manager Little Plumstead – Tel 01603 711165 or 07786 027289

Lead Nurse: Trust Office, 99 Waverley Road, St Albans, Herts AL3 5TL
Tel 01727 804229, Mob 07879 605208, Fax 01727 804967

Lead Doctor: Peace Children’s Centre, Watford – Tel 01923 470600
Practitioner has concerns about a child’s welfare?
(Child Need Screening form must be completed as part of assessment procedure for all adult service users)

YES

Practitioner discusses with first line manager or on call manager and, if necessary, lead nurse / doctor for safeguarding children
(IF CHILD IS AT RISK OF IMMEDIATE HARM CALL 999)
Safeguarding children concerns are confirmed?

NO
- Record discussions and actions taken on service user record
- Review again at next appointment and keep under review
- Further concerns must be discussed with first line manager and lead nurse / doctor for safeguarding children

YES

Normal telephone inquiries/referrals: 0845 603 7627 ...
then send the completed referral form to social services by
Email to: socialcaredirect@essexcc.gov.uk Or Fax to: 0845 601 6230 Or
Post to: Essex Social Care Direct, Essex House, 200, The Crescent,
Colchester, Essex CO4 9YQ
And send a copy of referral to the lead nurse safeguarding children

Out of hours (5.30pm - 9.00am Mon - Thurs, 4.30pm Fri - 9.00am Mon and Bank holidays): 0845 606 1212 and Fax 01245 434700
Where there are concerns about the immediate welfare or safety of a child/young person: 0845 603 7634 (all callers) OR 0845 606 1212 (Office hours number for professionals only).

Remember
Record all actions taken and the outcome of discussions on service user record
There must be management oversight of all safeguarding children concerns and practitioners must raise safeguarding matters routinely in clinical supervision

Safeguarding children contact details:
Service Manager – Tel 07747486711
Lead Nurse: Trust Office, 99 Waverley Road, St Albans, Herts AL3 6TL
Tel 01727 804229, Mob 07879 605208, Fax 01727 804967
Lead Doctor: Peace Children’s Centre, Watford – Tel 01923 470600
Hertfordshire Child Protection
Referral Form

This form should only be used when a child or young person is at risk of significant harm

If you have concerns that a child or young person is at immediate risk of harm, please contact the emergency services on 999

Please complete this form as fully as possible. However, do not delay the referral in a situation where this may place the child at further risk of significant harm.

<table>
<thead>
<tr>
<th>What is the reason for this referral?</th>
<th>How was this risk identified? Include:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Risk of significant harm to the child</td>
<td>1. where the incident took place</td>
</tr>
<tr>
<td>2. Expectation of service</td>
<td>2. who was involved (if appropriate)</td>
</tr>
<tr>
<td>3. Desired outcome</td>
<td>3. time and date of the incident</td>
</tr>
</tbody>
</table>

Please describe if child has visible injuries

Please give details of the steps already taken to make the child/young person safe. Include any contact with emergency services or a social worker.

<table>
<thead>
<tr>
<th>Child / young person / unborn baby details</th>
<th>Date of birth / EDD:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forename(s): For unborn baby insert “UBB”</td>
<td>00/00/0000</td>
</tr>
<tr>
<td>Surname: For unborn baby insert mother’s surname</td>
<td>Gender: Male □ Female □ Unknown □</td>
</tr>
<tr>
<td>Current address:</td>
<td>Disability: No □ Yes □ Please supply details</td>
</tr>
<tr>
<td>Postcode:</td>
<td></td>
</tr>
<tr>
<td>Add home address if different:</td>
<td>Immigration issues?</td>
</tr>
<tr>
<td>Postcode:</td>
<td>Asylum seeker: Yes □ No □</td>
</tr>
</tbody>
</table>

continued...
Child's first language:  
write N/A if pre-verbal

Religion:

Reference number:  
(e.g. NHS Number, Unique Pupil Number)

Ethnicity:

Name, address and contact details of GP:

Name, address and contact details of health visitor/school nurse:

Name of early years setting/school/college and contact person:

Parent/carer details
Please give names of child’s primary carer(s) and their relationship to the child/young person

<table>
<thead>
<tr>
<th>Full name</th>
<th>Address (if different from the child)</th>
<th>DOB</th>
<th>Gender</th>
<th>Parental Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>YYYY</td>
<td>M F</td>
<td>Yes No Unknown</td>
</tr>
<tr>
<td></td>
<td></td>
<td>YYYY</td>
<td>M F</td>
<td>Yes No Unknown</td>
</tr>
<tr>
<td></td>
<td></td>
<td>YYYY</td>
<td>M F</td>
<td>Yes No Unknown</td>
</tr>
<tr>
<td></td>
<td></td>
<td>YYYY</td>
<td>M F</td>
<td>Yes No Unknown</td>
</tr>
</tbody>
</table>

Do the parent/carer(s) have a disability?  
No ☐ Yes ☐ please give details

First language:

Is an interpreter /signer required? Yes ☐ No ☐

Family composition/significant others

<table>
<thead>
<tr>
<th>Full name</th>
<th>Address, postcode, and Tel</th>
<th>DOB if known</th>
<th>Relationship to child/ren named overleaf</th>
<th>Gender</th>
<th>If a child, are you referring as well?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>YYYY</td>
<td>M F</td>
<td>Yes No</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>YYYY</td>
<td>M F</td>
<td>Yes No</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>YYYY</td>
<td>M F</td>
<td>Yes No</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>YYYY</td>
<td>M F</td>
<td>Yes No</td>
<td></td>
</tr>
</tbody>
</table>
Other agencies/services involved with this child/young person/family e.g. CAMHS, adult services etc

<table>
<thead>
<tr>
<th>Name of professional and organisation</th>
<th>Contact details - Please include address, postcode, Tel, email</th>
<th>Brief description of work undertaken or ongoing support if known</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Has a CAF (Common Assessment Framework) been completed on this child or young person?
No ☐ Yes ☐ Please give the Lead Professional’s name and contact details

Information sharing
Professionals should share their concerns about a child/teen with the family unless doing so might place the child/teen at further risk of significant harm. You will need to make a professional judgment on informing the child or young person of this referral.

Form completed by:
(full name, job title and agency/service)

Date: DD/MM/YY

Who has been informed of this referral?

Contact details:
(include email address and contact number)

Is there any parent/carer/significant person named on this form who has not been informed of this referral and why?

Send completed form to:
Email: protectedreferrals.cs@hertscgcsx.gov.uk or protectedreferrals.cs@hertfordshire.gov.uk
Post: Customer Service Centre, PO Box 123, Stevenage, SG1 2GH

For urgent child protection referral also ring 0300 123 4043

Confidentiality: This form contains personal information. Please ensure secure document storage and safe information sharing.
### Hertfordshire Service Request Form

**Health and Wellbeing Board Hertfordshire**

**Children and young people**

This form should be used when a child or young person has a need which requires a response from **one agency only**. For multiple needs consider a CAF.

For child protection referrals use the [Hertfordshire Child Protection Referral Form](#) or ring **0300 123 4043**

<table>
<thead>
<tr>
<th>What service are you requesting?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the reason for your request?</td>
<td></td>
</tr>
<tr>
<td>What are the desired outcomes for the child/young person/family?</td>
<td></td>
</tr>
</tbody>
</table>

### Child/young person / unborn baby details

<table>
<thead>
<tr>
<th>Forename(s):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surname:</td>
</tr>
<tr>
<td>For unborn baby insert &quot;UMB&quot;</td>
</tr>
<tr>
<td>Gender:</td>
</tr>
<tr>
<td>Male □ Female □ Unknown □</td>
</tr>
<tr>
<td>Date of birth / EDD:</td>
</tr>
<tr>
<td>Current address:</td>
</tr>
<tr>
<td>Postcode:</td>
</tr>
<tr>
<td>Add home address if different:</td>
</tr>
<tr>
<td>Postcode:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Disability:</th>
</tr>
</thead>
<tbody>
<tr>
<td>No □ Yes □ Please supply details</td>
</tr>
<tr>
<td>Immigration issues?</td>
</tr>
<tr>
<td>Asylum seeker:</td>
</tr>
<tr>
<td>Yes □ No □</td>
</tr>
<tr>
<td>Religion:</td>
</tr>
<tr>
<td>Ethnicity:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Childs first language:</th>
</tr>
</thead>
<tbody>
<tr>
<td>write N/A if pre-verbal</td>
</tr>
<tr>
<td>Reference number:</td>
</tr>
<tr>
<td>(e.g. NHS Number, Unique Pupil Number)</td>
</tr>
</tbody>
</table>

| Name, address and contact details of health visitor/school nurse: |
| Postcode: |

| Name, address and contact details of GP: |
| Postcode: |

| Name of early years setting/school/college and contact person: |  |
What other services are involved?

Parent/carer details
Please give names of child’s primary carer(s) and their relationship to the child/young person

<table>
<thead>
<tr>
<th>Full name</th>
<th>Address (if different from the child)</th>
<th>DOB</th>
<th>Gender</th>
<th>Parental Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes ☐ No ☐ Unknown ☐</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes ☐ No ☐ Unknown ☐</td>
</tr>
</tbody>
</table>

Postcode:
Tel:

<table>
<thead>
<tr>
<th>Full name</th>
<th>Address, Postcode, and Tel</th>
<th>DOB if known</th>
<th>Relationship to child/ren named overleaf</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
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<td>M ☐ F ☐</td>
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<td>M ☐ F ☐</td>
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<td>M ☐ F ☐</td>
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<td></td>
<td>M ☐ F ☐</td>
</tr>
</tbody>
</table>

Consent: Professionals should obtain consent from an adult with parental responsibility or a young person who you judge to be able to give informed consent.

Who has given consent for this referral?

Who has not been informed of this referral and why?

Form completed by:
(full name, job title and agency/service)

Contact details:
(include email address and contact number)

Send the completed form to the relevant service. They may request further information from you on a supplementary form.

Confidentiality: This form contains personal information. Please ensure secure document storage and safe information sharing.
Norfolk Local Safeguarding Children Board

Assessment/Referral Form
(Family Support or Child Protection Conference Report)

**FAMILY COMPOSITION - Adults**

<table>
<thead>
<tr>
<th>Name</th>
<th>DOB</th>
<th>Address &amp; Tel. No.</th>
<th>Relationship to child(ren)</th>
<th>Parental Responsibility Yes/No</th>
<th>Ethnicity</th>
<th>First Language</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

**FAMILY COMPOSITION - Children**

<table>
<thead>
<tr>
<th>Name</th>
<th>Male/Female</th>
<th>DOB</th>
<th>Address &amp; Tel. No.</th>
<th>School &amp; Contact Name</th>
<th>General Practitioner</th>
<th>Ethnicity</th>
<th>First Language</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

A COPY OF THIS FORM MUST BE RETAINED IN THE CHILD’S RECORDS
Legal status of child(ren), if appropriate (e.g. subject of care order):

Family should be informed of a referral to another agency unless doing so would place the child at risk. Consent for referral to another agency should be gained from the parents unless doing so would place the child at risk of harm.

<table>
<thead>
<tr>
<th>Are the parents/carers aware of referral?</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If no, why not:

<table>
<thead>
<tr>
<th>Are the parents/carers in agreement with referral?</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Have the parents/carers given consent to share this information</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Have the parents/carers had a copy of this form?</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Key information including any immediate safety issues:

What has prompted the referral at this moment in time?
(to be completed if this is used as a referral form)

Chronology of significant events (use back sheet for full chronology if required):

Services received by family:

List the professionals past and present involved with this child or other family members with telephone numbers. Did the family perceive they were helpful?

<table>
<thead>
<tr>
<th>Did the family perceive they were helpful?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

Child/young person's developmental needs. Must include health, education, emotional and behavioural, identity, family and social relationships, social presentations, self care skills:

Professional Analysis:

Has the child been spoken to?

<table>
<thead>
<tr>
<th>Has the child been spoken to?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

If no, give reasons why not. If yes, what are their wishes, feelings and desired outcomes:

Professional discretion must be exercised before speaking to a child regarding their situation. If in doubt as to whether to speak to the child, consult within your own agency or with Social Services Department.
Capacity of parents/carers and other family members to ensure child’s safety from harm and to promote health and development. Must include strengths and weaknesses in the following dimensions:

- basic care skills
- ensuring safety
- emotional warmth
- stimulation
- guidance and boundaries
- stability

**Professional Analysis:**

The impact of family and environmental factors on parenting capacity and child care. Please use the following dimensions:

- family history and functioning
- wider family network
- housing issues
- employment
- income
- family social integration
- access to community resources

**Professional Analysis:**

Views, wishes and feelings of parents/carers and other significant family members, and desired outcomes:

“While professionals should seek, in general, to discuss any concerns with the family and, where possible, seek their agreement to making referrals to Social Services, *this should only be done where such discussion and agreement seeking will not place a child at increased risk of significant harm*” Working Together to Safeguard Children 1999. If in doubt as to whether to speak to the parents, consult within your own agency or Social Services Department.

**Professional analysis of family/child's needs and situation:**

**Plan of future contact:**

**Issues of worker safety:**

Signature: Date: Name:
### Full chronology of agency contact:

<table>
<thead>
<tr>
<th>Date</th>
<th>Agency Name</th>
<th>Contact Details</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Genogram (use separate sheet if necessary)

<table>
<thead>
<tr>
<th>Family Member</th>
<th>Relationship</th>
<th>Date of Birth</th>
<th>Contact Details</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Feedback Sheet - to be sent back to original referrer**

Name and address of person that form should be sent back to.

**To be completed by referrer:**

---

Date referral sent:

Date referral received: ______________

<table>
<thead>
<tr>
<th></th>
<th>Yes ✓</th>
<th>No ✓</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family seen as a result of this referral</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child seen as a result of this referral</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family have been advised of outcome of referral</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Background information has been collated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The family have been contacted by Social Services and an initial assessment will be completed (only complete if referral to SSD)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Outcome:**

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Services offered to family – if yes, please specify</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Further referral made – if yes, please specify</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No further action</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strategy discussion under Section 47 – (only complete if referral to SSD)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This form to be returned within 7 working days to original referrer
This form is to assist agencies to either make a referral about a child or young person to children’s social care services or confirm a referral in writing already made by telephone (all professionals making telephone referrals to social services must confirm this in writing within 48 hours). This form may be posted, transmitted by fax, or sent as an email attachment (see below). The form should be completed, with reference to the Guidance Notes (separately available).

Making a referral/inquiry by telephone

| Normal telephone inquiries/referrals: 0845 603 7627 |
| Out of hours (5.30pm - 9.00am Mon - Thurs, 4.30pm Fri - 9.00am Mon and Bank holidays): 0845 606 1212 and Fax 01245 434700 |
| Where there are concerns about the immediate welfare or safety of a child/young person: 0845 603 7634 (all callers) OR 0845 606 1212 (Office hours number for professionals only). |

Sending this form to social services

| By email to: socialcaredirect@essexcc.gov.uk as an attachment (must be password protected – see guidance notes) |
| By post to: Essex Social Care Direct, Essex House, 200, The Crescent, Colchester, Essex CO4 9YQ |
| By fax to: 0845 601 6230 |

☐ This is a new referral  
OR  
☐ This is confirmation of a referral I made by (date), Reference

PART 1 CHILD/YOUNG PERSON’S DETAILS

| Family Name: | Given names: |
| Date of Birth or expected date of delivery: |
| Gender: | Male ☐ Female ☐ Unborn ☐ |
| Usual or home address: | Post code: | Tel no.: |

Child or young person's first language or preferred means of communication:

| Is an interpreter required?: | Yes ☐ No ☐ |
| Current address if different: (e.g. staying with relative or friend) | Post code: | Tel no.: |
Responsible local authority (if child/young person is known to be in the care of another authority but living in Essex):

<table>
<thead>
<tr>
<th>Child/young person’s main carers:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name</strong></td>
</tr>
<tr>
<td>---------</td>
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</tr>
</tbody>
</table>

Is an interpreter/signer required?  
Mother: Yes ☐ No ☐  
Father: Yes ☐ No ☐

Other main carers (please specify name):  
Mother: Yes ☐ No ☐  
Father: Yes ☐ No ☐

Are any of the main carers disabled?  
Mother: Yes ☐ No ☐  
Father: Yes ☐ No ☐
The child/young person or the child’s parents should be asked which ethnic group the child belongs to. This information on ethnicity will help us to assess fair access to services by all communities, better plan services and complete statistical returns required by Government (these categories are supplied by Government).

<table>
<thead>
<tr>
<th>Black or White</th>
<th>Asian or White</th>
<th>Mixed</th>
<th>Other Ethnic groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black or Black British</td>
<td>Asian or British</td>
<td>White &amp; Black</td>
<td>Indian</td>
</tr>
<tr>
<td>Caribbean</td>
<td>Pakistani</td>
<td>White British</td>
<td>White &amp; Black Caribbean</td>
</tr>
<tr>
<td>African</td>
<td>Bangladeshi</td>
<td>White Irish</td>
<td>White &amp; Black African</td>
</tr>
<tr>
<td>Any other Black background</td>
<td>Any other Asian background</td>
<td>Any other White background</td>
<td>Any other ethnic group</td>
</tr>
<tr>
<td>Any other Black background</td>
<td>Any other Asian background</td>
<td>Any other White background</td>
<td>Any other mixed background</td>
</tr>
</tbody>
</table>

Further details regarding child/young person’s ethnicity:

Child/young person’s religion:

<table>
<thead>
<tr>
<th>Child/young person’s nationality (if not British and if known):</th>
<th>Home Office registration number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nationality:</td>
<td></td>
</tr>
<tr>
<td>Immigration status: Asylum seeking</td>
<td>Refugee status</td>
</tr>
</tbody>
</table>

Child/young person’s Unique Pupil Number (if school age and if known):

Other Unique identifier (if used – please give identifier and describe what this is):

Parent's details if not main carers (and if known):

<table>
<thead>
<tr>
<th>Mother’s name:</th>
<th>Mother’s address:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Postcode:</td>
<td>Tel:</td>
</tr>
<tr>
<td>Mother’s first language:</td>
<td>Mother’s ethnicity:</td>
</tr>
<tr>
<td>Father’s name:</td>
<td>Father’s address:</td>
</tr>
</tbody>
</table>

Does father have parental responsibility? Yes No

Is either parent disabled? Mother Yes No Father Yes No

Is an interpreter/signer required? Mother Yes No Father Yes No
## Other household members (including non-family members – if known):

<table>
<thead>
<tr>
<th>Family name</th>
<th>Given name</th>
<th>DoB</th>
<th>UPN identifier (If known)</th>
<th>Other unique identifier (if known)</th>
<th>Relationship to child</th>
<th>Tick if you are also referring to Social Services at same time as child</th>
</tr>
</thead>
<tbody>
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</table>

As far as you know has the child/young person, or another child of the family been: (please give details)

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Name:</th>
<th>Date(s):</th>
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</thead>
<tbody>
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</table>

on the disability record

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Name:</th>
<th>Date(s):</th>
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<tbody>
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</table>

on a child protection register

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Name:</th>
<th>Date on:</th>
<th>Date off:</th>
<th>Category:</th>
</tr>
</thead>
<tbody>
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</table>

looked after by a local authority

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Name:</th>
<th>Date(s):</th>
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</thead>
<tbody>
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</tbody>
</table>

Any other family members who are not living in the child/young person’s household but who has significant involvement (e.g. sibling, relative)

<table>
<thead>
<tr>
<th>Surname</th>
<th>Forename</th>
<th>Relationship</th>
<th>Address</th>
<th>Phone No.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>
**Agencies involved with the child.** Please complete if currently involved with family. You do not need to contact other agencies, social services will do so if necessary.

<table>
<thead>
<tr>
<th>Agency</th>
<th>Name</th>
<th>Phone No.</th>
<th>If a common assessment has been completed &amp; permission has been given for it to be shared please tick</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Visitor</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Nursery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>School</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education Welfare Officer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>School Nurse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Paediatrician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dentist</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Child and Family Consultation Service</td>
<td></td>
<td></td>
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<tr>
<td>Police</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Youth Offending Team</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
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</tbody>
</table>

**PART 2 REASON FOR REFERRAL**

Please give your reasons for referral/request for services (please continue on separate sheet as necessary)
Awareness of referral (The child/young person and parents/carers should be made aware of your intention to make a referral to Social Services, unless there is a specific reason for this being inappropriate, e.g. risk of significant harm)

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the parent/carer aware of the referral?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is child/young person aware?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

Has the parent, carer (or young person if competent) given consent to the referral?

<table>
<thead>
<tr>
<th>Parent/carer</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Young person</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

Is the parent/carer aware of the referral? [Yes] [No]

Is child/young person aware? [Yes] [No]

Has the parent, carer (or young person if competent) given consent to the referral? [Yes] [No]

If No consent please give reason for this being inappropriate [ ]

PART 3: REFERRER’S DETAILS

<table>
<thead>
<tr>
<th>Referred by</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency:</td>
<td>Name:</td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>Post Code</td>
<td>Phone No.</td>
</tr>
<tr>
<td>Email address</td>
<td></td>
</tr>
</tbody>
</table>

Date of any previous referral to Social Services if relevant

What services are you or your organisation are already providing to the child/young person or family?

Have you completed a Common Assessment concerning this child/young person? [Yes] [No] (if yes please attach)

Any safety issues to be aware of? [Yes] [No] [unknown]

If yes please specify

Completed by:

Name …………………………………….Signature…………………………………… Date: ………………
PART 4: TO BE COMPLETED BY ECC STAFF ONLY

Action by Social Care Direct

Date Received by Social Care Direct

SWIFT Record number:

Date sent to children’s operational team:

Action by Children’s operational team

Date Received by Children's operational team

Decision by Team Manager on referral: NFA □ Initial Assessment □

Date referral acknowledged

Date outcome of referral notified to referrer (if different)
PART 5: TO BE COMPLETED BY ECC OPERATIONAL TEAM, DETACHED AND SENT TO THE REFERRER

Date:

Referrers Name:
Referrer’s Address:

Dear Colleague

Concerning: (Child’s/young person’s name)

Address: (Child’s/young person’s address)

Referred on: (Referral date)

Thank you for your referral. I am writing to confirm the outcome of your referral.

<table>
<thead>
<tr>
<th>Decision on referral:</th>
</tr>
</thead>
<tbody>
<tr>
<td>NFA ☐ Reason for NFA:</td>
</tr>
<tr>
<td>OR Initial Assessment ☐</td>
</tr>
<tr>
<td>Date of decision</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Contacts for further inquiries about this referral:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ The social worker who should be contacted about this matter is</td>
</tr>
<tr>
<td>OR ☐ There is no allocated social worker in this case. Any further inquiries should be directed to (name and contact details)</td>
</tr>
</tbody>
</table>

Signed ..............................................................................................................
Team Manager Name
Team Manager Contact Details
Table 1: Presentations of child abuse and neglect

<table>
<thead>
<tr>
<th>Presentation</th>
<th>May be indicative of</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-accidental or unexplained injury. e.g., not compatible with the child’s developmental stage Injurious punitiveness.</td>
<td>Physical abuse</td>
<td>Social services and possibly police investigation. Paediatric assessment</td>
</tr>
<tr>
<td>Inadequate feeding, failure to thrive. Illness and injuries not appropriately attended to. Child not attending school.</td>
<td>Neglect of provision</td>
<td>Social services investigation Paediatric assessment</td>
</tr>
<tr>
<td>Child left alone. Unsafe environment, Variety or lack of continuity of caregivers</td>
<td>Neglect of supervision</td>
<td>Social services assessment</td>
</tr>
<tr>
<td>Various forms of parent-child interaction including scapegoating and rejection; emotional unavailability; Developmentally inappropriate expectations. Non-specific emotional, social and behavioural difficulties</td>
<td>Emotional abuse and emotional neglect</td>
<td>Psychological/psychiatric assessment Social services investigation</td>
</tr>
<tr>
<td>Illness that cannot be explained. Child presented very frequently for attention or investigations. Fabricated illness or disease. Poisoning or other form of illness Induction.</td>
<td>Fabricated or induced illness</td>
<td>Reliant on paediatric diagnosis, with multi-disciplinary involvement. If diagnosis confirmed, investigation by social services</td>
</tr>
<tr>
<td>Allegations of sexual abuse. Inappropriate sexualised behaviour. Sexually transmitted disease or pregnancy. Genital injuries.</td>
<td>Sexual abuse</td>
<td>Social services and police investigation Possibly paediatric examination</td>
</tr>
<tr>
<td>Unexplained developmental delay. Unexplained major change in behaviour. Depression, misery and avoidant. behaviour (parasuicide, self-harm, running away) Child’s behaviour which is overfriendly to strangers or unduly apprehensive</td>
<td>Any of the above</td>
<td>Careful multidisciplinary assessment</td>
</tr>
</tbody>
</table>

This is not a comprehensive list and there may be other signs or no obvious signs

Although all forms of child abuse and neglect can occur in the children of parents with mental illness, the issue of emotional maltreatment is highlighted in the Royal College Document “Patients as Parents”, as the least studied, but perhaps the most relevant and potentially problematic type of maltreatment. In many cases, the neglect of children’s emotional needs is unintentional. A parent or carer may be doing their best while also struggling with serious mental illness. Nevertheless the damaging effect on children still occurs. Negative outcomes for children include low self-esteem, educational underachievement, poor quality relationships and emotional and behavioural problems. Many of these negative effects may well persist into adulthood with lifelong consequences. Emotional maltreatment does not present in the readily observable way that physical abuse and neglect are manifest but if actively sought, is evident in families whose children are known to Child Protection services.
Contact Information

HPFT Contacts

- Head of Social Work and Safeguarding: 01727 804117
- HPFT Named Doctor Safeguarding Children: 01923 470610
- Safeguarding Practice Team: 01727 804229 / 01727 804516
- Patient Safety Manager Risk Management Department: 01727 804262
- HPFT Records and Freedom of Information Act Manager: 01727 804279
- Service Manager Little Plumstead: 01603 711165 or 07786 027289
- Community Service Manager North Essex Learning Disability Services: 01206 747725 or 07765 256854
- HPFT Community Mental Health Forensic Team: 01923 853893 (for queries about individuals who may pose a risk to children or adults)

HERTFORDSHIRE Contacts

- Children’s Social Care, Customer Service Centre: 0300 123 4043 (all telephone referrals must be followed up in writing within 24hrs)
- Targeted Advice Service – Practitioner Consultations: 01438 737511
- Making a referral in Hertfordshire:
  1. Child Protection Referral (red) form email to protectedreferrals.cs@hertsc.gcsx.uk or protectedreferrals.cs@hertfordshire.gov.uk
  2. service request (green) form – send to identified service
     Send a copy of the red or green referral form to the HPFT Safeguarding Practice Team
- For out of hours service ring the Customer Service Centre number
- Hertfordshire Safeguarding Children Board Child Protection Procedures can be accessed via Connect, Hertfordshire County Councils intranet, on the HPFT Trust Space
- MAPPA Manager from Hertfordshire Probation Service: 01438 747074

NORFOLK Contacts

- Service Manager Little Plumstead 01603 711165 or 07786 027289
- Named Nurse Safeguarding Children Norfolk Primary Care Trust – 01603 216999
- Named Doctor Safeguarding Children Norfolk Primary Care Trust – 01603 216999
- Norfolk County Council Children’s Services Customer Services Centre – 0344 800 8014
- If you are unsure whether to make a referral to Norfolk Children’s Services you can also have a telephone consultation with a children's services manager on 01603 224134
- Details of Norfolk child protection procedures can be accessed via: http://www.lscb.norfolk.gov.uk

NORTH ESSEX CONTACTS

- Community Service Manager North Essex Learning Disability Services 01206 747725 or 07765 256854

http://microsites.essexcc.gov.uk/microsites/ESCB/professionals.htm
Child Protection Allegations Against Staff Risk Assessment

Introduction
This risk assessment should be completed by senior managers when an allegation that a staff member either professionally or personally, has abused a child, behaved in a way that has harmed a child/vulnerable adult or withheld information that may have prevented a child/vulnerable adult from being at risk of harm.

Purpose
The purpose of this document is to ensure that as part of a safe recruitment process we ensure as far as is possible that staff are safe to work with children/vulnerable adults.

Responsibility
We must ensure that dealing with an allegation that a staff member has abused a child/young person or adult is taken seriously, dealt with objectively and in a timely manner.

The Director of HR as the Trusts Designated Officer, the Head of Social Work & Safeguarding and the relevant Managing Director MUST be informed of all allegations against staff. Additionally, where the allegation is about a member of staff working with children, the manager must inform the Local Authority Designated Officer (LADO) who has responsibility for managing and overseeing all individual allegations from across the workforce. Managers of the services where the staff member is deployed should complete a risk assessment when:

A) It appears that a person has behaved in a way that has harmed a child/vulnerable adult
B) Potentially committed a criminal offence against/or related to a child/vulnerable adult
C) Behaved in an inappropriate way towards a child/adult which may indicate that he or she is unsuitable to work with children/vulnerable adults
D) Withheld information that may have prevented a child/vulnerable adult from being at risk of harm.
E) When an allegation is made about abuse that took place some time ago and the accused person may still be working with or having contact with children/vulnerable adults
F) Additionally, if there are concerns about the persons behavior towards their own children or children/vulnerable adult unrelated to their employment or voluntary work and there are concerns that this may affect their suitability to work with children/vulnerable adults

Please note: Safeguarding Children and Safeguarding Adults policies MUST be followed and advice can be sought from the Safeguarding Team.
## Details

<table>
<thead>
<tr>
<th>Name of staff member:</th>
<th>Team/Work address:</th>
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<table>
<thead>
<tr>
<th>Profession/Job title:</th>
<th>Line Manager:</th>
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<thead>
<tr>
<th>Role/Nature/Scope of work:</th>
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<table>
<thead>
<tr>
<th>Risk Assessment Completed by:</th>
<th>Date:</th>
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</table>

## Allegation/concern

<table>
<thead>
<tr>
<th>Source</th>
<th>Date of alleged incident/action</th>
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Nature of Allegation

<table>
<thead>
<tr>
<th>Any immediate protection planning put in place</th>
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If an allegation about a person working with children has the LADO been informed

Details:

<table>
<thead>
<tr>
<th>What are the ongoing risks to children/vulnerable adults</th>
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If yes, what are there measures that can/have been out in place to mitigate against and reduce the risk of harm to children/vulnerable adults

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<tr>
<td>Does the person have access to child/vulnerable adults</td>
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<tr>
<td>-----------------------------------------------------</td>
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<table>
<thead>
<tr>
<th>Do you consider it safe for the person to remain in clinical activity/work with children/vulnerable adults</th>
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<table>
<thead>
<tr>
<th>Actions/Recommendations</th>
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</table>
Safeguarding Children Supervision

- Safeguarding issue highlighted e.g. by carer, other team member
- Staff member has a concern
- Safeguarding issue highlighted during supervision

If raised in supervision, discussion recorded in supervision notes and highlighted as a safeguarding issue

The following actions are required:
1. Alert team manager and keep team manager informed of discussions
2. Record concern on Paris (title of entry, safeguarding), include action plan/protection plan
3. If in doubt seek advice from Named Nurse Safeguarding Children and/or Head of Social Work and Safeguarding

Record discussion on Paris and agreed actions. Add safeguarding alert to Paris

Record discussion within supervision record and ensure safeguarding is always on supervision agenda

Continue recording actions taken on Paris and continue recording in supervision notes until safeguarding issue(s) resolved
Our vision

‘to be the leading provider of mental health and specialist learning disability services in the country’

To be a leading provider, we must offer high quality care with excellent treatment outcomes, within a safe environment which meets the needs of service users.

Our vision is underpinned by eight goals which inform our entire strategy.

- To deliver high quality integrated health and social care services in accordance with recovery principles
- To be the provider of choice for service users, carers, the community and commissioners
- To work in partnership with the community to promote the wellbeing of others, whilst making a positive contribution to the environment
- To be the employer of choice where staff are highly valued, well supported and rewarded
- To create a dynamic and flexible working environment where staff are motivated and committed to providing high quality care
- To embed a learning culture where staff develop their full potential and deliver excellent care
- To ensure a sustainable future through income growth and efficient use of resources
- To be an innovative and learning organisation that embraces new and modern approaches to health and social care