Safeguarding and Protecting Children & Young People Policy and Procedure

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<td>Safeguarding Lead Nurse</td>
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Managers are responsible for ensuring staff within their area of responsibility are aware of Central Lancashire Primary Care Trust policies and that staff adhere to them.

Managers are responsible for ensuring that a system is in place for their area of responsibility that keeps staff up to date with new policy changes.

Staff are responsible for ensuring they are familiar with policies, know where to locate the documents on the PCT's internet, and seek out every opportunity to keep up to date with Central Lancashire PCT policies.

Independent contractors are expected to identify a lead person to be responsible for ensuring staff employed within their practice are aware of Central Lancashire PCT policies.

This policy is individual to Central Lancashire PCT. Central Lancashire PCT does not accept any liability to any third party that adopts or amends this policy.

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## CONTENTS

<table>
<thead>
<tr>
<th></th>
<th>INTRODUCTION</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>Background</td>
<td>4</td>
</tr>
<tr>
<td>1.2</td>
<td>Scope</td>
<td>4</td>
</tr>
<tr>
<td>1.3</td>
<td>Principles</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>IMPLEMENTATION</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1</td>
<td>Legal Requirements</td>
<td>5</td>
</tr>
<tr>
<td>2.2</td>
<td>Confidentiality &amp; Information Sharing</td>
<td>6</td>
</tr>
<tr>
<td>2.3</td>
<td>Health Staff Responsibilities for Safeguarding and Protecting Children</td>
<td>7</td>
</tr>
<tr>
<td>2.4</td>
<td>Safeguarding and Protecting Children – Professional Development</td>
<td>11</td>
</tr>
<tr>
<td>2.5</td>
<td>General Procedure for Staff when Child Abuse is suspected</td>
<td>15</td>
</tr>
<tr>
<td>2.6</td>
<td>Attendance at Court</td>
<td>18</td>
</tr>
<tr>
<td>2.7</td>
<td>Review following Death or Serious Injury of a Child as a result of Suspected or confirmed Abuse</td>
<td>19</td>
</tr>
<tr>
<td>2.8</td>
<td>Making a Safeguarding &amp; Protecting Children Referral</td>
<td>21</td>
</tr>
<tr>
<td>2.9</td>
<td>Subsequent Action following a Safeguarding and Protecting Children Referral</td>
<td>22</td>
</tr>
<tr>
<td>2.10</td>
<td>Referring a Child and Family with Needs</td>
<td>22</td>
</tr>
<tr>
<td>2.11</td>
<td>Procedure for Safeguarding and Protecting Children Referrals involving Staff Members</td>
<td>24</td>
</tr>
<tr>
<td>2.12</td>
<td>Procedures for the Health Storage and Transfer of Community Health Records for Children Named on the Safeguarding Children Plan (or where there are Child Welfare concerns)</td>
<td>25</td>
</tr>
<tr>
<td>2.13</td>
<td>No Access Visits</td>
<td>27</td>
</tr>
<tr>
<td>2.14</td>
<td>Record Keeping</td>
<td>30</td>
</tr>
<tr>
<td>2.15</td>
<td>A Guide to Safeguarding and Protecting Children and Family Support Meetings</td>
<td>32</td>
</tr>
<tr>
<td>2.16</td>
<td>Safeguarding and Protecting Children Conferences</td>
<td>35</td>
</tr>
<tr>
<td>2.17</td>
<td>Responsibilities for Children Looked After</td>
<td>41</td>
</tr>
<tr>
<td>2.18</td>
<td>Child Accommodation over a period of 3 months</td>
<td>42</td>
</tr>
<tr>
<td>2.19</td>
<td>Requests for Information from Solicitors, Children’s Guardians, Children and Family Reporters or the Police</td>
<td>44</td>
</tr>
<tr>
<td>2.20</td>
<td>Witness Statement Procedure</td>
<td>45</td>
</tr>
<tr>
<td>2.21</td>
<td>Statement Writing</td>
<td>46</td>
</tr>
<tr>
<td>2.22</td>
<td>Aggression, Violence &amp; Intimidation</td>
<td>46</td>
</tr>
</tbody>
</table>

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APPENDICES

Appendix 1  Sections 85 & 86 of the Children Act 1989  51
Appendix 2  Making a Safeguarding & Protecting Children Referral  53
Appendix 3  Safeguarding & Protecting Children Supervision Session  54
Appendix 4  Initial Referral Safeguarding Plan on Family or Child/ren causing concern  55/55
Appendix 5  Review Referral Safeguarding Plan on Family or Child/ren causing concern  57
Appendix 6  Referring a Child & Family with Needs  58
Appendix 7  Transfer Out of Children with Strictly Confidential File  59
Appendix 8  Transfer of Information from Health Visitor to School Nurse  60
Appendix 9  Aide Memoir  61
Appendix 10  Chronology of Significant Events  62
Appendix 11  Lancashire Model of Children in Need – Thresholds & Process of Assessment  63
Appendix 12  Drafting a Statement for Court: A Step by Step Guide  65
Appendix 13  Writing a Statement for Court: A Suggested Format  67
Appendix 14  Suspected Child Abuse of Neglect – Flowchart
  Preston Locality  68
  Chorley & South Ribble Locality  69
  West Lancashire Locality  70
1. INTRODUCTION

Central Lancashire PCT staff have a duty of care to ensure that we protect children at risk of harm and neglect from negative outcomes and support all children to achieve their full potential.

This PCT Policy should be read in conjunction with the procedures laid down by the Local Area Safeguarding and Protecting Children Committee (LSCB). Although Family & Children’s Social Care Team have legal duties in respect of children under the Children Act 1989\(^1\), the protection of children has to be a shared responsibility between all agencies & professional working in partnership with the family.

1.1 Background

Every child has the right to be protected from potential significant harm. The Laming Report 2003/Every Child Matters 2003 highlights the importance of safeguarding all children by effective communication: -

- Multi agency partnership information sharing
- Common assessment framework
- Accountability
- Supporting parents and carers

1.2 Scope

The policy together with the procedures is to be followed by all staff working for Central Lancashire Primary Care Trust and Independent Practices, GPs etc.

Definitions of the various types and/or indicators of abuse are provided in the Local Area Safeguarding and Protecting Children Committee (LSCB) multi agency policy, guidance and procedures. These can also be downloaded from the Lancashire County Council Website\(^2\) - Family & Children’s Social Care Team – Working to Safeguard Children/Central Lancashire Primary Care Trust Website.\(^3\)

1.3 Principles

This policy is founded on the principles that health professionals should always act in the child’s best interests. The safety and well being of the child is paramount.\(^4\)

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\(^1\) Children Act (1989)
\(^2\) http://www.lancashiresafeguardingchildrensboard
\(^3\) http://www.centrallancashirepct.nhs.uk/
2. IMPLEMENTATION

Promoting children’s well being and safeguarding them from significant harm depends crucially upon effective sharing, collaboration and understanding between agencies and professionals. Agencies and professionals need to work in partnership to plan comprehensive and co-ordinated children’s services.

No one person or single agency in isolation can deal effectively with child abuse or neglect.

All staff have a duty to familiarise themselves with the risk factors and signs/symptoms of child abuse, and to be aware of the action to be taken should such an incident present itself. All staff are directed to follow procedures by the Lancashire Safeguarding Childrens Board and should have access to a copy of the Lancashire Child Area Protection Procedures.

2.1 LEGAL REQUIREMENTS:

(As amended by the Care Standards Act 2000)\(^5\)

The Children Act 1989 places specific duties on agencies to co-operate in the interests of vulnerable children. (See Appendix 1 Sections 85 & 86 of the Children Act 1989


Section 27 provides that a local authority may request help from: -

- Any local authority.
- Any local education authority.
- Any local housing authority.
- Any health authority, National Health Service Trust.

Section 47 places a duty on any of the above to help a local authority with its enquiries in cases where there is reasonable/cause to suspect that a child is suffering or likely to suffer, significant harm.

The Children Act 1989 introduced the concept of Significant Harm as the threshold that justifies compulsory intervention in family life in the best interest of the children. There are no absolute criteria on which to rely when judging what constitutes significant harm.

Where the question of whether harm suffered by a child is significant, their health or development shall be compared with that which could reasonably be expected of a similar child.

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\(^5\) Care Standards Act (2000)

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Section 325 The Criminal Justice Act 2000(duty to co-operate)

Section 17 places a duty on any of the above to safeguard and promote the welfare of children who are in need. Section 17 (10) states that a child shall be taken to be in need if:

- He is unlikely to achieve or maintain, or have the opportunity of achieving or maintaining a reasonable standard of health or development without the provision of services by a Local Authority.

- Or his health or development is likely to be significantly impaired, or future impaired, without the provision of such services, or he is disabled.

2.2 CONFIDENTIALITY & INFORMATION SHARING

2.2.1 Staff must protect all confidential information concerning patients and clients obtained in the course of professional practice. Disclosures should only be made with consent, where required by the order of a Court, where justification of disclosure is in the wider public interest or where there is an issue of Safeguarding and Protecting Children. All PCT employees and independent contractors must abide by their own Code of Professional Conduct. ‘The public interest’ means the interests of an individual or groups of individuals or of society as a whole, and would, for example, cover matters such as serious crime, child abuse, drug trafficking or other activities, which place others at serious risk.

2.2.2 Detailed guidance regarding information sharing for the purposes of safeguarding and promoting the welfare of children is available in ‘What to do if you’re worried a child is being abused’ (DoH) which all health staff should have received.

Health Professionals should always act in the child’s best interest - the safety and well being of the child must come first. The welfare of the child is always paramount. (Children Act 1989).

2.2.3 It is expected that Health Professionals and independent contractors will work in partnership with parents/carers, therefore, if a concern is noted regarding the child’s physical or emotional well-being or that the child is being neglected, then this should be discussed with parents as soon as possible, informing them that further discussion will take place with other professionals, i.e. Line Manager, Safeguarding and Protecting Children Named Nurses, Safeguarding and Protecting Children Supervisor.

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7 What to do if you are worried a child is being abused, page 43, (DoH 2003)
In cases of sexual abuse the child should **not be questioned** and immediate referral to the Family & Children’s Social Care Team Directorate should be made. (Ref: to Lancashire Area Safeguarding and Protecting Children Procedures). The Lead Nurse/ Named Nurses for Safeguarding and Protecting Children /Line Manager/ Legal support services are available to advise staff if they are concerned regarding breach of confidentiality.

2.2.4 Any member of staff who has reasonable belief/concern that a child is: At risk of Significant Harm or In need of Service. Should

Gain parental permission to refer to Family & Children’s Social Care Team.

**UNLESS**

Permission seeking itself may place a child at Risk of Significant Harm. If permission is refused and the concern is of a Safeguarding and Protecting Children nature then a referral can be made without consent.

*(See Appendix 2 Making a Safeguarding and Protecting Children Referral)*

2.3 **HEALTH STAFF RESPONSIBILITIES FOR SAFEGUARDING AND PROTECTING CHILDREN**

2.3.1 **Overview**

All those who come into contact with children and families in their everyday work, including adult workers whose clients may have childcare responsibilities have a duty to safeguard and promote the welfare of children. **All health professionals** have a responsibility to:

- Be knowledgeable about Safeguarding and Protecting Children issues.
- Be aware of PCT and LSCB in need of protection, Multi-Agency Policy, Guidance & Procedures.
- Access Safeguarding and Protecting Children training and ensure that by regular updates they are equipped with the knowledge and skills to help protect children.
- Maintain accurate, contemporaneous, legible and complete health records.
• Access Safeguarding and Protecting Children advice, support and supervision as per contract of employment.

Central Lancashire Primary Care Trust has to have a Named Doctor, Lead and Named Nurses with appropriate Safeguarding and Protecting Children expertise, to take a lead on Safeguarding and Protecting Children matters.

2.3.2 Contacts

Central Lancashire Primary Care Trust

Refer to Safeguarding and Protecting Children Flow Chart. See Appendices.

2.3.3 Responsibilities of the Lead Nurse for Safeguarding and Protecting Children

• Representing local healthcare agencies on Lancashire Safeguarding Childrens Board.

• The development of Safeguarding and Protecting Children practice.

• The provision of Safeguarding and Protecting Children advice and support.

• Offering consultation, support and advice on Safeguarding and Protecting Children, as an expert resource available to all practitioners.

• Contributing to the review and updating LSCB procedures and guidance.

• Ensuring there are robust internal guidelines/protocols for Safeguarding and Protecting Children with the PCT.

• Management of internal Safeguarding and Protecting Children reviews and contribute to multi-agency serious case reviews.

• Conducting the PCT review and contribution to Part 8 Reviews.

2.3.4 Responsibilities of the Named Nurses for Safeguarding and Protecting Children

• Identification of Safeguarding and Protecting Children training needs and the co-ordination/provision of appropriate training.
• Facilitate multi-agency Safeguarding and Protecting Children training.

• Initiate and facilitate the monitoring and audit of Safeguarding and Protecting Children practice.

• Facilitating advice on legal matters in conjunction with the PCT legal advisors.

• Ensuring that Safeguarding and Protecting Children clinical supervision is available to staff as appropriate.

• Provide training in line with the PCT Training Strategy.

2.3.5 Safeguarding and Protecting Children Supervisors

The role of the Safeguarding and Protecting Children Supervisor is to support Health Visitors, School Nurses and all Clinical Staff, where required would include CMO’s. The Supervisors role will include supporting Allied Health Professionals and clerical/admin staff. Working with child welfare/ Safeguarding and Protecting Children issues by:

• Appraising existing programmes of Safeguarding Plans with Practitioner ensuring that they are sensitive to the current safeguarding needs of the child and family.

• Clarifying roles and responsibilities.

• Establishing that practice is compliant with national and local Safeguarding and Protecting Children policies, procedures and guidance.

• Providing appropriate supervision and support, to enable safe and effective practice.

• Promoting professional development, identifying with the practitioner gaps in knowledge and skills and directing staff into appropriate training.

• Ensuring that there is close communication with the Lead Nurse, Named Nurses/Doctor/ Line managers, regarding Safeguarding and Protecting Children issues arising from practice.

2.3.6 Integrated Services Managers/Head Professional Lead’s

Integrated Services Managers and/or Head Professional Lead with a responsibility for practice should provide effective leadership and ensure that: -
• All staff are aware of and have contact details for the Safeguarding and Protecting Children professionals within their organisation.

• Clinical practice takes a proactive approach to protecting children.

• Staff responds appropriately to instances of suspected or actual abuse and neglect.

• Staff within their areas of responsibility access training, which provides information regarding, known indicators and predictors of abuse, and an awareness of the Local Safeguarding Childrens Board procedures and protocols for safeguarding children.

• There is monitoring of adherence to Safeguarding and Protecting Children policies, and clinical practice is audited.

• Resources are utilised appropriately to provide caseload cover where there are areas of concerns regarding a child’s welfare.

N.B. General Practitioners or Line Managers may recognise limits to their own experience/knowledge and should not feel inhibited from seeking the advice of the PCT’s Lead Nurse/Named Nurses/Doctor.

2.3.7 All Health Staff

• Everyone must be aware of, and follow, Department of Health, PCT and LSCB Safeguarding and Protecting Children policies, procedures and guidance.

• General practices should devise and maintain procedures to ensure that they, and all members of the practice staff, are fully conversant with the above policies procedures and guidance.

• Those working in the community and primary health care should be aware of children who are ‘in need’ of services and/or protection, and should make appropriate referrals to ensure the needs of children are addressed.

• Health Visitors and School Nurses assess child health, growth, physical, emotional and social development and parenting capacity. These roles help to promote children’s health, prevent ill health and provide and opportunity to identify children in need including those in need of protection.

• Everyone has a responsibility to access Safeguarding and Protecting Children training and ensure that by regular updates they are equipped with the knowledge and skills to help protect children.
• Health care staff are required to attend Safeguarding and Protecting Children conferences, reviews, core group meetings, and any other appropriate multi-disciplinary/agency meetings to which they are invited.

• Health Professionals/Allied Health Professionals are required to provide information in the form of a written report when invited to a Safeguarding and Protecting Children conference Core Group. Written reports are not a necessary requirement for other multi-disciplinary/agency meetings, but a report should be submitted in the unlikely event of the health professional not being able to attend the meeting.

• All staff must maintain accurate, legible and complete records.

• Safeguarding and Protecting Children supervision must be accessed according to that discipline’s own procedures, but should include proactive, immediate, and reactive supervision.

2.4 SAFEGUARDING AND PROTECTING CHILDREN–PROFESSIONAL DEVELOPMENT

2.4.1 Safeguarding and Protecting Children Training

In order to safeguard children effectively all staff need to have a basic awareness of how to recognise, child in need/Safeguarding and Protecting Children issues, how to respond to their findings, and how to refer to Family & Children’s Social Care Team if necessary.

It is expected that:
• All new staff attend the PCT Induction day in which a brief overview of Safeguarding and Protecting Children is included.

• All staff attend the Basic Awareness in Safeguarding and Protecting Children course provided by the Primary Care Trust.

• Staff who regularly works with children should access mandatory Safeguarding and Protecting Children updates at least three yearly.

• Staff recognise the importance of safeguarding and protecting children and that this is given high priority in their professional development Plans.

• Staff who regularly works with children should access LSCB Safeguarding and Protecting Children training.

2.4.2 Safeguarding and Protecting Children Supervision

Supervision provides a framework for examining a case from different perspectives. Supervision will facilitate quality, innovative reflective practice in a safe environment.

Supervision is intended to:

• Appraise existing programmes of care protection Plans and ensure that they are sensitive to the current needs of the child and family.

• Clarify roles and responsibilities.

• Establish whether policies and procedures are being followed.

• Offer appropriate support, enabling safe and effective practice.

• Promote professional development; identify any gaps in knowledge and skills requiring further training.

Health visitors and school nurses should receive planned individual/group Safeguarding and Protecting Children supervision every month/two months if part-time. Other professionals should receive Safeguarding and Protecting Children supervision as necessary or as determined by their Line Managers/Lead Nurse Safeguarding and Protecting Children.

A record of supervisors is to be kept by the supervisor and supervisee. (See Appendix 3 - Safeguarding and Protecting Children Supervision Session)

2.4.3 Peer Group Support

1. This is a Multi-disciplinary group, which will be facilitated by a Safeguarding and Protecting Children Supervisor who has undergone the training and protection course.

2. Meetings will be held monthly.

3. Health Visitors and School Nurses, irrespective of whether the member of staff has Safeguarding and Protecting Children cases or not, or whether the family is seen as having problems, will attend the group. Representatives from Adult Mental Health Services and Learning Disabilities Midwife Paediatrician nominated by their Line Manager, will also attend. (To be rolled out across the PCT).
4. A list of Safeguarding and Protecting Children Peer Support Groups will be kept by the Safeguarding and Protecting Children Supervisor/Named Nurses Safeguarding and Protecting Children.

2.4.4 One to One Supervision

2.4.5 Cause for Professional Concern and using the Safeguarding Plan Forms

Any child / family in receipt of additional support from Child Health Services, where there has been identified professional concern i.e. the ability for child / young person to be protected and live in a safe, stimulating environment.

Any child who has been the subject of a Safeguarding and Protecting Children Case Conference, but not subject to a Child Protection Plan, but for whom a Care Plan has been deemed necessary, should be recognised as a child for whom there is a Cause for Professional Concern. Any child for whom there is a Cause for Professional Concern should be discussed and reviewed as part of Peer Group Support and staff should complete an Initial Safeguarding Plan Form, which is signed by the Safeguarding and Protecting Children Supervisor, with a copy to the Named Nurses Safeguarding and Protecting Children. The original should be kept in the Case Notes. (See Appendix 4 – Initial Safeguarding Plan Form)

Review Safeguarding Plan Forms should be signed by the Safeguarding and Protecting Children Supervisor and then kept in the Case Notes. (See Appendix 5 – Review Safeguarding Plan Form)

If the case is closed, the appropriate reasons are recorded on the Review Safeguarding Plan Form, signed by the Safeguarding and Protecting Children Supervisor and a copy sent to the Named Nurses Safeguarding and Protecting Children.

If a child with a Safeguarding Plan transfers to another health visitor or school nurse within the PCT, the professional transfers the child’s record with the Safeguarding Plan open. The professional who the child is transferring from completes an updated Review Safeguarding Plan Form, sending a copy to the Safeguarding and Protecting Children Office. The professional to whom the child is transferring to, following an assessment subsequently keeps the Safeguarding Plan open or closes it. In either situation an updated Review Safeguarding Plan needs to be completed. If the case is closed follow the guidelines stated above.

When a child with a Safeguarding Plan transfers from health visitor to school nurse at school entry, a Transfer of Information from Health Visitor to School Nurse Form (See Appendix7), should be
completed and a copy sent to the Named Nurses Safeguarding and Protecting Children.

If a child with a Safeguarding Plan **transfers out of the PCT** see Section 13.3 for the procedure, which includes the use of the **Transfer Out of Children with a Strictly Confidential File Form (Appendix8)**

**NB** In no circumstances, must the Safeguarding Plan Supervision system take the place of appropriate action under the Safeguarding and Protecting Children Procedures. The Lead/Named Nurses for Safeguarding and Protecting Children’s advice should be sought without delay where there is any doubt as to the appropriate course of action.
2.5 GENERAL PROCEDURE FOR STAFF WHEN CHILD ABUSE IS SUSPECTED

All staff have a duty to familiarise themselves with the risk factors and signs/symptoms of child abuse, to be aware of the action to be taken if an incident occurs and have access to a copy of the Lancashire Area Safeguarding and Protecting Children Guidelines.

2.5.1 Procedure

When a member of staff suspects child abuse the following procedure must be implemented immediately.

1. Follow Lancashire Safeguarding Children Board Procedures for a Safeguarding and Protecting Children Referral.

   Discuss with the Named Nurses for Safeguarding and Protecting Children or the Safeguarding and Protecting Children Facilitator, and then telephone the Family & Children’s Social Care Team Duty Officer. Please make reference to Safeguarding and Protecting Children’s Flow Chart for your Locality.

2. If Necessary, ask the Family & Children’s Social Care Team Duty Officer to check the Plan or out of hours Emergency Duty Team. Please make reference to Safeguarding and Protecting Children’s Flow Chart for your Locality.

4. Arrange a medical opinion in consultation with Family & Children’s Social Care Team/Police via the hospital or from the Named Doctor Consultant on call for Safeguarding and Protecting Children.

   Share concerns with the General Practitioner and other relevant members of the Primary Health Care Team and other professionals as appropriate.
   E.g. education, voluntary sectors, parenting teams etc…

6. Where English is not the first language of the child concerned and communication is necessary for the purpose of safeguarding and promoting the child’s welfare, the use of an interpreter must be considered.

2.5.2 Suspected/Actual Abuse

Emergency Situation - Where the child requires IMMEDIATE medical treatment

1. Dial 999 for an ambulance.
2. Inform Family & Children’s Social Care Team Department by telephone and fax Multi Agency Assessment Referral form (MAARF) within 24 hours.

3. Inform the Lead/Named Nurses for Safeguarding and Protecting Children.

4. Inform the relevant member of the Primary Care Team.

**Urgent Situations - With Parental consent**

Advise parents of proposed action and if necessary accompany parent/carer for medical examination. If the child needs to be seen by a paediatrician and to be medically examined please refer to your Locality arrangements. Telephone the Family & Children’s Social Care Team Department stating the extent of the injuries/cause for concern.

**Urgent Situations - Without parental consent - or if atmosphere hostile**

Inform Family & Children’s Social Care Team Duty Officer or if the child is known to them inform the key worker stressing the urgency of the situation and then inform the Police at the Safeguarding and Protecting Children Unit if the child is considered to be in danger.

**Non-urgent Situations**

Non-urgent situations may be discussed with the Safeguarding and Protecting Children Professionals, Family & Children’s Social Care Team duty officer or emergency duty team.

**2.5.3 If a Child Discloses Abuse**

1. Listen to what the child is telling you and try not to show you are shocked.
2. Do not question the child or try to encourage further disclosure.
3. Tell the child that you will do your best to support him/her but you must tell others in order to do this. You **cannot** promise confidentiality / secrecy.
4. Reassure the child that it is not their fault.
5. Record accurate contemporaneous notes on observations, events and actions taken. Sign with designation and date.

**2.5.4 Sexual Abuse**

Any suspicion of sexual abuse should be referred immediately to the Duty Officer, Family & Children's Social Care Team or the police by phone/fax, followed by Multi Agency Assessment Referral Form (MAARF) To Family & Children's Social Care Team within 24 hours.
N.B. In the case of suspected sexual abuse the police will arrange the medical examination.

2.5.5 If Child Abuse is reported to Staff Employed by Central Lancashire PCT

Response to informant

1. Listen and record the information given then date and sign.

2. Check with the informant that the message is correct.

3. Tell the informant to refer to the appropriate Family & Children's Social Care Team or the Police.

If the informant is: -

a. A child, reassure and state that you will be informing the appropriate service to help them. Document the information and refer on to Family & Children's Social Care Team.

b. A parent/relative/non-professional, explain that they have a responsibility to refer to Family & Children's Social Care Team – if they refuse – explain that now you are in receipt of the information, you have a duty to refer to Family & Children’s Social Care Team to protect the child. Document and refer on the information to Family & Children's Social Care Team. Check they have made the referral.

c. Another professional - request they make a direct referral following Lancashire Safeguarding Childrens Board procedures. Document and ensure the information has been referred to Family & Children's Social Care Team.

All staff employed by Central Lancashire PCT should inform the relevant head of service.

2.5.6 Procedure for School Nurses

In the case of a school nurse/health visitor suspecting an incident of child abuse discovered within the school setting. Inform the Head Teacher who will implement educational procedures and document. Inform the Named Nurses for Safeguarding and Protecting Children.
2.6 ATTENDANCE AT COURT

(Refer to Policy & Procedure for Staff required to Attend as a Witness in Court/Criminal Court Proceedings - 2007)\textsuperscript{9}

2.6.1 Subpoenas/witness summons, require the named person to appear at court and may also stipulate that records are required – should be made to the Lead / Named Nurses.

2.6.2 Question a subpoena and separate subpoena for records.

2.6.3 Always inform your Line Manager/Lead/Named Nurses Safeguarding and Protecting Children when you are notified of or receive a subpoena/witness summons. (Subpoenas should always be in writing)

2.6.4 Staff should never attend court unsupported, staff will be accompanied by the person designated as appropriate or Lead/Named Nurses Safeguarding and Protecting Children.

2.6.5 Legal Advice may be sought prior to attendance at court via the PCT Legal Representative.

2.6.6 A report will have previously been submitted to the court.

2.6.7 All reports must be seen by the Named Nurses for Safeguarding and Protecting Children.

2.6.8 All reports need to be based on the facts from the notes / guidance on writing report, should be made to Named Nurses prior to writing report.

N.B Other people’s information must not be reported.

\textsuperscript{9} Policy & Procedure for Staff Required to Attend as a Witness in Court/Criminal Court Proceedings (2004)
2.7 REVIEW FOLLOWING DEATH OR SERIOUS INJURY OF A CHILD AS A RESULT OF SUSPECTED OR CONFIRMED ABUSE

The sudden unexpected death of a child or young person is obviously one of the most tragic events that a family or practitioner will have to experience. It is essential that all sudden, unexpected deaths are rigorously reviewed so that lessons can be learnt for future practice. Not all sudden unexpected deaths will be as a result of child abuse but there are often common features which when identified will ultimately influence future practice. All sudden unexpected infant and child deaths should be notified to the Safeguarding and Protecting Children office as soon as the practitioner becomes aware so that the critical incident reporting mechanism can be activated. It is the practitioner’s responsibility to ensure that the child health system and any other professionals/departments are informed of the death to prevent further distress to the family.

“Whenever a case involves an incident leading to the serious harm or death of a child, where child abuse is confirmed or suspected, consideration will be given by the Area Safeguarding and Protecting Children Committee to conducting a Serious Case Review” (Working Together to Safeguard Children 2006)^10

2.7.1 The Lead Nurse/Named Nurses Safeguarding and Protecting Children will instigate a review as follows: -

1. Alert Chief Executive of the PCT, Head of Operational Services (Children & Families) Lead Nurse for Safeguarding and Protecting Children and Professional Manager of discipline/s concerned, of the need for review of the case.

2. Ensure all notes and files relating to child/family are secure.

3. Offer support and guidance to Practitioner involved.

4. Liaise with the PCT Legal Advisor

2.7.2 The review will establish

1. Whether internal and Area Safeguarding and Protecting Children Procedures have been followed.

2. Whether there is a need to review those procedures.

3. Whether there are any training implications.

^10 Working Together to Safeguard Children (1999)
2.7.3 The review report - (report from each discipline must be completed within 14 days)

The Lead Nurse/Named Nurses Safeguarding and Protecting Children working with Service Managers will ensure each discipline carries out the following management objectives.

1. Establish a factual chronology of all actions/interventions taken by professionals involved with the child/ren family.

2. Assess whether actions/interventions in the case areas are per PCT policies/procedures.

3. Identify any significant gaps in professional practice or service provision.

4. Recommend appropriate action.

2.7.4 The Lead Nurse Safeguarding and Protecting Children will coordinate the Inter-disciplinary review and will within 4 weeks present the full case review to:

- Director of Provider and Operational Services, Chief Operating Officer / Head of Operations Children & Families Locality Lead.

- Service Managers of disciplines concerned.

- The professional advisor for the discipline.

- The Designated Safeguarding and Protecting Children Professionals.

2.7.5 Communication

- Staff directly involved in the case should be informed of the purpose of the review, the way it will be conducted and the support available.

- Staff not directly involved in the case should be kept informed of progress.

- It should be made clear that the review is separate from, even if it were to lead to, any action necessary under established disciplinary procedures.
2.8 MAKING A SAFEGUARDING AND PROTECTING CHILDREN REFERRAL

All staff are directed to follow procedures laid down by Lancashire Safeguarding Children's Board and should have access to a copy of the Lancashire Safeguarding Children's Board Procedures.

- **All professionals** have a personal responsibility to respond to such concerns. Advice information is available from Line Manager/Named Nurses Safeguarding and Protecting Children.

- Urgent referrals should be made by telephone to the local Family & Children's Social Care Team (see Locality Flow Chart for telephone numbers).

- The referring professional should offer a clear, concise account of concerns about a child's welfare, whether there are issues of significant harm and whether these require urgent action to safeguard the child.

- All referrals should be confirmed in writing within 48 hours using the multi-agency referral form (MAARF) and a copy sent to:

  **Named Nurses for Safeguarding and Protecting Children**
  (see Locality Flow Chart for telephone numbers)

  A copy should be kept in the records

- All relevant information held by the professional should be included e.g. skin maps, centile charts and a chronology of significant events.

- Personal information about children and families is subject to a legal duty of confidentiality and **ideally** should only be disclosed with consent. **However, in Safeguarding and Protecting Children, discussion of concerns and consent from parents/persons with parental responsibility should be sought only if this will not place the child at increased risk of significant harm.**

- In cases in which English is not the first language of the child/carer/family concerned, **the use of an interpreter is advised.**

- At the end of any referral discussion, the referrer and the Family & Children’s Social Care Team should be clear about who will be taking what action if any.

- Professionals must record, the discussion and decisions taken, document the name of the person accepting the referral and date and sign the records.
• All referrals to Family & Children’s Social Care Team will be dealt with in accordance with Lancashire Safeguarding Childrens Board Procedures.

• Family & Children’s Social Care Team are responsible for making the necessary investigations and taking any immediate action required.

• Outside of office hours, referrals should be made to the Family & Children’s Social Care Emergency Duty Team. Refer to Locality Flow Chart for telephone numbers.

• Review and discuss progress with Line Manager, Team Co-ordinator, Lead/Named Nurses Safeguarding and Protecting Children or Safeguarding and Protecting Children Supervisor.

2.9 SUBSEQUENT ACTION FOLLOWING A SAFEGUARDING AND PROTECTING CHILDREN REFERRAL

1. Follow-up all telephone referrals to Family & Children's Social Care Team, in writing using a multi-agency referral form (MAARF) within two working days.

2. Seek confirmation from Family & Children’s Social Care Team as to what action has been taken.

3. Any concerns relating to response from Family & Children’s Social Care Team should be discussed with the Safeguarding and Protecting Children Named Nurses.

4. Record accurate, contemporaneous notes on observations, events and actions taken. Sign with designation, date and time.

2.10 REFERRING A CHILD AND FAMILY WITH NEEDS (Section 17)

“If Safeguarding and Protecting Children processes are to result in improved outcomes for children, then effective Plans for safeguarding children and promoting their welfare should be based on a wide ranging assessment of the needs of the child and their family circumstances”. (Lancashire Safeguarding and Protecting Children Procedures).

• All staff are directed to follow procedures laid down by the Lancashire Safeguarding Childrens Board and should have access
to a copy of the Lancashire Safeguarding Childrens Board Procedures.

- When a member of staff has concerns about the welfare of a child a request for other services may be appropriate in accordance with the Lancashire Children in Need categories.

- **Referrals should only be made after discussion and with the consent of the family / young person.** Families must be made aware that a referral constitutes consent for Family & Children’s Social Care Team to contact them to facilitate the provision of services and enables Family & Children's Social Care Team to make enquiries of other agencies.

- **Consent must be sought from families before contact and information sharing with another agency.** This should be recorded clearly on the multi-agency assessment and referral form (MAARF) and documented, signed and dated within the family records by the professional.

- In cases in which English is not the first language of the child/ carer/ family concerned, the **use of an interpreter is essential.** (It is impossible to accurately assess the needs of the child without understanding the full family circumstances) It is recommended that family members are not used to translate information.

- Family & Children’s Social Care Team will give appropriate feedback about outcomes to the family’s referrer and other involved professionals.

- **To refer a family/child with needs, a multi-agency assessment and referral form (MAARF) should be completed.** All relevant information held by the professional should be included on the form and forwarded to Family & Children’s Social Care Team.

- A copy of the MAARF should be kept by the referring member of staff, and filed in the child’s records and a copy sent to the Locality based Named Nurses for Safeguarding and Protecting Children.

- All written referrals to Family & Children’s Social Care Team will be dealt with in accordance with LSCB procedures.

(See Appendix 6 Referring a Child and Family with Needs)
2.11 PROCEDURE FOR SAFEGUARDING AND PROTECTING CHILDREN REFERRALS INVOLVING STAFF MEMBERS

Where allegations of child abuse are made against members of staff the situation requires sensitive but appropriate management. It is important to remember that the allegation will be investigated by other agencies.

In the event that a Safeguarding and Protecting Children referral is made involving a member of staff employed by Central Lancashire Primary Care Trust whether or not the alleged offence occurs on PCT premises the following procedure will apply.

1. The normal Lancashire Safeguarding Childrens Board Procedures will be followed to instigate the investigation.

2. The employee’s Line Manager will be advised of the situation immediately by the employee making the Safeguarding and Protecting Children referral, or just receiving information of the referral.

3. A formal discussion regarding the management of the situation will take place between: -
   - The employee’s line manager.
   - Senior personnel staff members.
   - PCT named professionals for Safeguarding and Protecting Children

   To decide on the course of action with regard to: -
   - Suspension from duty pending investigation.
   - Alternative workplace where there is no possibility of contact with children or other vulnerable groups.

4. Senior management of the PCT will be informed.

5. In line with Lancashire Area Safeguarding and Protecting Children Procedures a multi-disciplinary strategy meeting will be convened to decide on the multi-agency response to the referral.

6. On conclusion of any investigation, consideration to be given to whether action as required by the Protection of Children Act (1999)\(^\text{11}\) must be undertaken.

Check if staff are victims of abuse procedure.

\(^{11}\) Protection of Children Act (1999)
2.12 PROCEDURES FOR THE STORAGE AND TRANSFER OF COMMUNITY HEALTH RECORDS FOR CHILDREN NAMED ON THE SAFEGUARDING CHILDREN PLAN (OR WHERE THERE ARE CHILD WELFARE CONCERNS)

2.12.1 Storage

- All health records must be stored in such a manner as to ensure that confidentiality is maintained.

- All health record storage facilities must be locked, with access only by appropriate personnel.

Records containing information of a Safeguarding and Protecting Children nature must be stored securely, but in such a manner that the information is available, on a need to know basis, by other professionals, who are seeking to promote the child’s welfare, and acting in the child’s best interest. Records should be held by the health professional who retains responsibility for case management.

In order to keep an accurate and central record of the transfer of children’s records into and out of the PCT, where there are Child Welfare Concerns or Safeguarding and Protecting Children Issues, will all staff please use the following procedure.

2.12.2 Transfers In

The recognised system for transferring records containing information of a Safeguarding and Protecting Children nature is via the Named Nurses Safeguarding and Protecting Children. For Children Looked After via the Designated Nurse for Children Looked After.

Where incoming records contain information of a Safeguarding and Protecting Children nature, and the sender has not used the recognised procedure of transferring the records via the Named Nurses Safeguarding and Protecting Children, the following action must be taken by the health professional receiving the records:

- The Named Nurses Safeguarding and Protecting Children must be informed, within two working days.
- Child Health and/or School Health Department must be informed.
- Discuss with Safeguarding and Protecting Children Supervisor or Named Nurses Safeguarding and Protecting Children and agree and document a Plan of care/action. (See Appendices 7 & 9)
2.12.3 Transfer Out

It is a requirement of the Children Act 1989, that there is a procedure, which will facilitate the transfer of records as a **matter of urgency** to inform the receiving area’s professionals.

- When a child who is subject to the Safeguarding Children Plan (or where there are child welfare concerns) moves to another area, the health professional responsible for the case management will ensure that the records are **collated and complete** with the new details.

- The health professional responsible will liaise with Health Visitor / School Nursing colleagues within the PCT to ensure all records for each child in the family (if also transferring out) are available to be transferred together.

- A **Transfer of Records Form** must be completed and forwarded with the records see appendices 8 & 9.

- Child Health and/or School Health Department must be informed of where the health records are being transferred.

- The records will be transferred by hand to the Named Nurses Safeguarding and Protecting Children/Named Nurses for Children Looked After as appropriate, in a **sealed brown envelope marked confidential, they will then be transferred out of the PCT**.

- The records will be transferred using **Recorded delivery**

- Wherever possible the health professional will inform their counterpart in the new area that the records are being transferred and share relevant information relating to the child and the Safeguarding Children Plan. This contact to be recorded in the records.

2.12.4 Children who are leaving the PCT catchment area to be adopted

All requests for records from the child’s new Trust for adoption records must be forwarded to the Named Nurses Safeguarding and Protecting Children based at the Willows Child Development Centre.

**NO RECORDS SHOULD BE SENT DIRECT TO THE NEW TRUST**

A resume of the child’s health history containing basic information such as developmental progress and immunisation state should be sent to the new Health Visitor/School Nurse **VIA THE LOCALITY LEAD/NAMED NURSES (recorded delivery)**.
2.12.5 Children who move into the PCT area after adoption

The Named Nurses Safeguarding and Protecting Children in each Locality are notified of all children moving into the PCT area after adoption. The Practitioner will make a written request for the child’s records.

If records are received by the Community Paediatrician, Health Visitor, School Nurse or Child Health Clinic direct, they should be forwarded to the Named Nurses Safeguarding and Protecting Children.

All records will be sealed in a brown envelope, marked Private and Confidential and a new set of records will be implemented with the child's name, address and details.

2.13 NO ACCESS VISITS (When working within the Community)

No access visits require a course of action to be decided and then acted upon, and some have serious implications and require urgent action. If in doubt always act in the best interests of the child.

2.13.1 Not at home

The health professional is satisfied that the house is unoccupied but the objective to see the child/ren is not achieved. Routine action could include visiting at a different time, phone call or letter to arrange an appointment, check with the GP for change of address, visit to relatives address. If these measures fail and a third home visit results in no response, the following action should be taken:

If there are no Safeguarding and Protecting Children/welfare concerns, this should be discussed with line manager and action documented.

If there are Safeguarding and Protecting Children/welfare concerns, these should be discussed with the Named Nurses Safeguarding and Protecting Children/line manager. The next appropriate course of action will then be decided upon.

2.13.2 No admittance

The health professional suspects the house is occupied but the door is not answered, or the door is opened and the health professional is not admitted and access to the child/ren is refused.

If the child/ren's names are not subjected to a Child Protection Plan and there have been no previous concerns, the incident should be discussed with the Line Manager, and a course of action decided upon and documented.
In either event, if the child/ren's names are subject the Safeguarding Children Plan, the Police/Family & Children's Social Care Team Department should be asked to investigate. Line Manager/Named Nurses Safeguarding and Protecting Children to be informed, and action documented.

2.13.3 Admission to home - no access to child/ren

The Health Professional is admitted to the home and after reasoned discussion, is refused access to the child/ren.

If the child/ren's names are entered on Lancashire Child Protection Plan and are subject to a Child Protection Plan the Key Worker should be informed. The Line Manager/Named Nurses Safeguarding and Protecting Children must also be informed. Arrangements may be made to provide an alternative intervention, in agreement with the statutory agency - Family & Children’s Social Care Team. If the child/children’s names are not entered on the Safeguarding Children Plan, the incident should be discussed with your Line Manager to decide the appropriate course of action.

N.B. Be wary of excuses for you not to see the child/children. A reoccurring theme in child abuse inquiries is carers avoiding or refusing professionals to have sight of the child.

2.13.4 No access to adults - child/ren unattended

Action must be taken for the child's/children’s immediate protection. The Health Professionals concern should be notified to the police immediately for their intervention and investigation. Document all actions taken and by whom then refer to Family & Children’s Social Care Team.

2.13.5 Service refused

The parent/s decline the services of the Health Professional in a rational manner. This should be discussed with their Line Manager who will provide advice regarding future Plan of action.

If parent/s are prepared to put their “refusal of services” in writing this should be encouraged.

Where the child/ren's names are on the Safeguarding Children Plan, the key social worker should be informed. Discuss with appropriate Safeguarding and Protecting Children named professional and document action Plans formulated. Arrangements should be made to provide an alternative intervention, in agreement with the statutory agency (Family & Children’s Social Care Team).
All “no access” visits must be recorded in the records and chronology of significant events sheet.

2.13.6 Incomplete or conflicting Details/Information

As a matter of routine all practitioners/staff are responsible for making sure that at each new contact with a child basic information is checked/obtained and recorded. This must include the child’s name, address, General Practitioner, school and the name of their primary carer. Incomplete details should give rise to concern. **Gaps in the basic information available must be addressed, trigger further inquiries and be communicated to the relevant authority, agency or practitioner.**

2.13.7 Action to be taken if child is not placed with a GP

Give the child’s main carer, information and contact numbers for local GP's in their area of residence.

If the family cannot plan with a local GP because their client lists are full give the address and contact number for Lancashire and South Cumbria Agency who will allocate the family a GP.

Lancs and South Cumbria Agency
3 Caxton Road
Fulwood
Preston
PR2 9ZZ    Tel no: 01772 221444

When a member of staff has advised a carer to place a child with a GP and given the above information, it is that staff members responsibility to liaise with the health visitor / school nurse manager (depending on the age of the child) to ensure that a health visitor / school nurse can follow this up.

In the event of a child requiring medical treatment prior to a GP being allocated, children can be treated at any GP Surgery at Primary Care. Alternatively in an emergency they can attend the Accident and emergency department at Royal Preston Hospital, Southport & Ormskirk Hospitals NHS Trust or a Walk-In Centre.

2.13.8 Child of school age not placed with a school

1. Give the child’s main carer details of schools in their area of residence.
2. Inform: Educational Welfare for your Locality
3. Inform School Nurse Lead for your Locality
2.13.9 Missing families

Where a family goes missing, where there are Safeguarding and Protecting Children/welfare concerns, then inform the Named Nurses Safeguarding and Protecting Children and key social worker. The information will then be cascaded to the appropriate professional groups. It is the responsibility of professionals to familiarise her or herself with the information at regular intervals. Information is available to all key workers electronically. If the child/ren is on the Safeguarding Children Plan the Named Nurses Safeguarding and Protecting Children and Practitioner must be informed immediately as there is a mechanism to alert colleagues in other areas of missing families.

If a professional is made aware of the whereabouts of a ‘Missing Family’ the Named Nurses Safeguarding and Protecting Children should be informed immediately.

2.14 RECORD KEEPING

2.14.1 The Laming Report (2003) recommends that all front line staff who regularly come into contact with children and families must ensure that in each new contact especially when family moves into area or registered with a new GP, basic information about the child is recorded. This must include the child’s name, address, age, the name of the child’s primary carer, the child’s GP and the name of the child’s school if the child is of school age. Gaps in this information should be passed on to the relevant authority in accordance with local arrangements. (see: action to take place when child is not planned with a GP/School – Page 35, 14.8)

2.14.2 Good record keeping is an important part of the accountability of professionals to those who use their services. Clear and accurate records ensure that there is a documented account of a professional’s involvement with a child and/or family. They help with continuity when individual workers are unavailable or change, and they provide an essential tool for managers to monitor clinical performance, quality of care and resource management. Well-kept records provide an essential underpinning to good Safeguarding and Protecting Children practice.

Safeguarding children requires information to be brought together from a number of sources and careful professional judgements to be made on the basis of this information.

2.14.3 Records are an essential source of evidence for investigations and inquiries, and may also be required to be disclosed in court/legal proceedings. They should be clear, accessible and comprehensive, with judgements/assessments made, and actions and decisions taken, being
carefully recorded. Where decisions have been taken jointly or endorsed by a manager, this should be made clear. Records should use clear, straightforward language, and should be accurate not only in fact, but also in differentiating between opinion, judgements and hypothesis. All telephone conversations should also be recorded. Children's records are kept for 25 years.

2.14.4 Laming (2003) recommends that there is only one set of health records kept for each child. This is something we need to be working towards. All children’s records should clearly indicate which other health professionals are involved with the child and a chronology of significant events form should be maintained and updated in all records.

The results of poor record keeping can be catastrophic for both clients and professionals, particularly in relationship to Safeguarding and Protecting Children issues.

2.14.5 The Data Protection Act (1998)\(^\text{12}\) came in to effect in March 2000 and applies to the obtaining, storage and protection of all personal information including both manual and computerised records. The principles are: -

1. All personal information shall be obtained and processed fairly and lawfully – i.e. notify individuals of the purposes for which their details will be used.
2. Personal information should not be used for any purpose(s) incompatible with that for which it was obtained.
3. Personal information should be adequate but not excessive.
4. Personal information should be accurate and kept up to date.
5. Personal information should not be kept for longer than necessary.
6. The rights of the data subjects should be respected (including right of access to records).
7. Personal information should be stored securely and protected against unauthorised or unlawful processing, and loss, damage or destruction of the data.
8. Personal information should not be transferred outside the European Economic Area, unless that country has appropriate data protection legislation.

The Data Protection Act (1998) gives living individuals the right of access to health records about themselves regardless of when they were created. (The previous Access to Health Records Act (1990)\(^\text{13}\) still applies to access to the records of deceased individuals and restricts access to entries recorded after November 1991). Requests for access to records should be made in writing.

Records must be: -

\(^{12}\) The Data Protection Act (1998)
\(^{13}\) Access to Health Records Act (1990)
2.15. A GUIDE TO SAFEGUARDING AND PROTECTING CHILDREN AND FAMILY SUPPORT MEETINGS

2.15.1 Overview

Health professionals working with vulnerable children and their families in Central Lancashire and Longridge will be invited to attend a variety of multi-agency meetings to share relevant information and develop Plans to safeguard children.

These multi-agency meetings are the forum for agreeing services for vulnerable children and their families and should be held at regular intervals to review the risks the child is facing and the range of support services provided. Decisions to commission new services or to withdraw services should be reported to the meetings.

These meetings should be formally minuted and the minutes distributed to all those involved. **All health staff should record the action Plan in the child’s health record, immediately following any multi-agency meeting they attend.**

2.15.2 Strategy discussion/meeting

The discussion or meeting takes place when there is reasonable cause to suspect that a child is suffering or likely to suffer significant harm. It may take place by telephone (within 24hrs of the initial assessment being completed) or by a meeting of all related professionals within 5 working days. It is not usual for family members to take part in Strategy discussions/meetings. Strategy meetings are chaired by the Safeguarding Children & Young People Named Nurses from Health, or a senior social worker, from the Family & Children’s Social Care Team department. The meeting will decide the intervention felt to be appropriate to an individual family. The information shared at this time is crucial to the decision on whether a Section 47 enquiry will be initiated, how the enquiries will be handled, what action is needed to investigate and how best to protect the child/children. **A report with a chronology of significant events may be required. (See Appendix 10)**
2.15.3 Initial Safeguarding and Protecting Children Conference

The conference brings together family members, the child where appropriate and professionals involved with the child and family following the completion of Section 47 enquiries (where a child is considered to be at risk of significant harm). It is chaired by an independent reviewing officer.

Its purpose is to collate information obtained about the child’s health development and functioning and the parent’s capacity to ensure the child’s safety and promote his or her health and development. From this the conference will decide whether the child is at risk of significant harm in the future and decide what action is needed to safeguard the child and promote his/her welfare.

A multi-agency decision is made regarding the level of concern and the need to place/not to place the child/children’s names on the Lancashire Child Protection Plan and under what category of abuse. A Safeguarding Children Plan is outlined and will usually involve health professionals.

All members of the meeting will be involved in this decision-making and planning process.

All initial Safeguarding and Protecting Children conferences should be attended. Where the practitioner is on leave a colleague should attend on their behalf. A written report is required. This report should be shared with the family prior to the conference if possible. This is especially necessary if the family’s first language is not English and a translation via the interpreter service is required.

2.15.4 Core Group Meetings

These are held at monthly intervals in respect of children currently on the Safeguarding Children Plan. The first core group meeting should be arranged at the end of the Initial Safeguarding and Protecting Children Conference and should be held within 7 working days of that conference.

The core group led by the key worker, is responsible for developing and implementing the Safeguarding Children Plan as outlined at the Safeguarding and Protecting Children Conference. The relevant health professionals identified at the Safeguarding and Protecting Children conference should attend. A written report is recommended together with outcomes of the health professional. If the identified health representative cannot attend a report must be prepared and submitted to the key worker prior to the meeting. It is also advised that a representative for the health professional attends the meeting.

2.15.5 Review Safeguarding and Protecting Children Conference

Once a child’s name is placed on the Safeguarding Children Plan, a date for a first review Safeguarding and Protecting Children conference
is usually set for 3 months time. Subsequent review conferences will always be planned, unless there has been a change in circumstances, in which case the conference can be brought forward. Health professionals should attend all Review Conferences. A written report is required. The report should be shared with the family prior to the conference if possible.

2.15.6 Transfer Safeguarding and Protecting Children Conference

When a child on the Safeguarding Children Plan moves to another area, the Family & Children’s Social Care Team department in the receiving area will convene a Safeguarding and Protecting Children conference within 14 working days. The transfer conference will decide whether the registration in the new area will continue. All practitioners should liaise with their colleagues in the receiving authority and depending on the distance and/or circumstances should either attend the Conference or provide a report detailing involvement to date. All liaison conversations should be documented and the records transferred to the new area via the Named Nurses Safeguarding and Protecting Children.

2.15.7 Family Support Meeting

This meeting is convened and chaired by the named Social Worker following the completion of the initial assessment. It should be attended by professionals and agencies involved with the family, an agreed action Plan to support the family should be formulated and individual roles and responsibilities to meet the child’s needs should be agreed. Family members are invited to the meeting. Further family support meetings should take place approximately 2 monthly to evaluate the support package and monitor the progress of the action Plan. Invited health professionals should attend these important meetings. A written report is advisable and that the relevant health professional attends the meeting and contributes verbally. If they are not able to attend a representative must attend in their place and a report must be submitted. The agreed action Plan must be recorded in the child’s records by the health representative immediately following the meeting. Staff should also ensure they receive a copy of the minutes of family support meetings to complete their records.

2.15.8 Initial Statutory Review (Children Looked After)

The meeting is arranged by the social worker and the review and protection chairperson as soon as possible after a child is accommodated. All relevant agencies and the family members are invited. The meeting is to clarify and consider a child’s care Plan whilst in the care of the local Authority. Invited practitioners should attend. A concise report on the child’s health and development, information on how the child has settled in the placement and any observations on the
interaction between the foster carers and child or parents and child should be presented at the meeting. A written report is required.

2.15.9 Statutory Review (Children Looked After)

A meeting to review the child’s health/education/development and placement and ensure needs are being met is held one month after the placement. Invited health professionals should attend. Planned regular reviews are held thereafter or on demand if there is a change of circumstances. A report as above is required.

2.15.10 Professional Abuse Strategy Meeting

This meeting is chaired by the independent reviewing officer from the Family & Children’s Social Care Team department. Its purpose is to clarify whether any further enquiries are required in relation to the safety and welfare of the children, any police investigation into a possible crime and the employer’s disciplinary procedures, which may be invoked.

2.16. SAFEGUARDING AND PROTECTING CHILDREN CONFERENCES

2.16.1 Attendance

The Health Professional must attend every Safeguarding and Protecting Children conference to which they are invited.

The only exceptions will be sickness or holiday, in such cases a deputy will be nominated by their line manager. A written report must be submitted.

Health professional should only give information for which they have ownership and should not be requested to impart information on behalf of other agencies.

2.16.2 Preparation for Conference

The key to successful participation in a Safeguarding and Protecting Children Conference is preparation beforehand.

The health professional should be aware of the implications of the Data Protection Act 1998, Article 8 of the European Convention on Human Rights.
2.16.3 Report Writing

Reports should be factual, concise and based on The Framework for the Assessment of Children in Need and their Families (DoH 2000)\textsuperscript{14} A guide to the expected report format is included below.

It is expected that information to be shared in the multi-agency arena is presented using this three dimensional approach. Some professionals will have sufficient information to address the three dimensions summarised in ‘body of report’ in detail, whereas others will not. If you have limited information, simply, present this within the appropriate dimensional format (see below). Reports should be presented, typed, signed and dated. The content of the report should be shared with the child/ child’s parents prior to the conference if possible.

2.16.4 Important points to include within the report

- Clarify what is fact, and what is your professional judgement.
- Interventions / referrals made and their outcomes
- Identify family strengths and weaknesses
- Analyse the information presented
- Chronology of significant events

2.16.5 Initial Safeguarding and Protecting Children Conference

1. All reports should be headed “\textit{Strictly Confidential}”, and include the date and time of the Initial Conference (when known).

2. Basic data to include.

- Family name (including aliases)
- Family address
- Child/ren names and dates of birth
- General Practitioner
- School/Nursery
- Health professionals and other agencies involved with the family.

3. Introduction should include:

Relevant background information including length of time known to the service, a description of the most recent incident if there has been involvement /assessment of risk and self involvement with the child/family.

4. The body of the report should include a health profile based on the ‘Assessment Framework’ (DoH 2000)\textsuperscript{14}.

\textsuperscript{14} The Framework for the Assessment of Children in Need and their Families (DoH 2000)
2.16.6 Dimensions of a child's developmental needs:

Developmental progress should be analysed in the context of the child’s age and stage of development. Accounts must be given of any particular vulnerability, such as a learning disability or a physically impairing condition, and the impact they may be having on progress in any of the developmental dimensions. Consideration should also be given to the socially and environmentally disabling factors, which may be impacting on the child’s development.

Include in this section:

Health
Include growth and development as well as physical and mental well-being. Includes whether appropriate health care has been accessed, i.e. immunisations, appropriate health assessments, hospital/GP/other medical appointments including dental and optical care. Include centile charts, and Chronology of significant events

Education
Include all significant issues relating to the child’s cognitive development e.g. opportunities for play and interaction, attendance at school.

Emotional and Behavioural development
Include the nature and quality of attachment to parents/carers, and the child’s ability to adapt to change, his response to stress etc

Identity
Include the child’s sense of himself as a separate and valued person (self-image and self-esteem). Include issues relating to race, religion, age, gender, sexuality and disability.

Family and Social relationships
Include whether the child has a stable and affectionate relationship with parent’s caregivers, and siblings and whether they have age appropriate friends.

Social Presentation
Include whether the child is dressed appropriately for their age, gender, culture and religion and discuss cleanliness and personal hygiene.

Self-Care Skills
Include whether the child has developed age appropriate self care skills, if not, why not?

2.16.7 Dimensions of parenting capacity
Critically important to a child’s health and development is the ability of parents or caregivers to ensure that the child’s developmental needs are being appropriately and adequately responded to.

**Include in this section:**

**Basic care**
Include whether the child’s basic needs are being met i.e. are they receiving appropriate medical and dental care? Do they have adequate provision of food, drink, warmth, shelter and appropriate clothing?

**Ensuring Safety**
Include whether the child is being adequately protected from harm or danger e.g. are hazards and dangers in the home recognised by parents, is the child protected from ‘unsafe’ adults? Etc.

**Emotional Warmth**
Include whether the child’s emotional needs are being met e.g. Appropriate physical contact, comfort and cuddling sufficient to demonstrate warm regard, praise and encouragement.

**Stimulation**
Include whether the child’s cognitive development and potential is being stimulated through interaction, communication, talking, play, attending school etc

**Guidance and Boundaries**
Include whether parents/carers are providing guidance and setting appropriate and consistent boundaries for their child. Also include, whether parents are demonstrating and modelling appropriate behaviour and control of emotions and interactions with others.

**Stability**
Include whether parents/carers are providing a stable family environment for the child.

**2.16.8 Family and Environmental Factors**

The care and upbringing of children does not take place in a vacuum. All family members are influenced both positively and negatively by the wider family, the neighbourhood and social networks in which they live.

**Include in this section:**

**Family History and functioning**
Include genetic and psychosocial factors, which are impacting on the child. Include any significant changes in the family/household composition; history of childhood experiences of parents; chronology of significant life events and their meaning to family members; nature of
family functioning, including sibling relationships and its impact on the child; and parental strengths and difficulties.

**Wider family**
Include the wider families’ role and importance to the child and parents. Significant non-related persons can be included here if they have some importance to the child.

**Housing**
Include whether the child’s living accommodation has basic amenities i.e. water, sanitation, cooking facilities, adequate sleeping arrangements, hygiene and safety and their impact on the child’s upbringing.

**Employment**
Include who is working in the household and any impact this may have on the child.

**Income**
Include whether there is sufficient income to meet the family’s needs, the way available resources are used and whether there are financial difficulties, which affect the child.

**Family's Social Integration**
Include the degree of the family’s integration or isolation, their peer groups, friendship and social networks and what importance is attached to them and how this impacts on the child.

**Community Resources**
Include what resources are available in the community (e.g. Sure Start, Day Care facilities, shops, leisure activities, schools, health centres), and how the availability, accessibility and standard of these resources impact on the family and the child.

2.16.9 Summary

- Analysis of the issues of concern
- Risk assessment.

2.16.10 Conclusion

Reservations can be indicated: quote research (informed professional judgement/option - based on fact, professional opinion should be substantiated).

2.16.11 Recommendations (Action Plan)

- What will be your involvement in the future?
- What do you hope to achieve?
2.16.12 Requirements for a Review Safeguarding and Protecting Children Conference Report

Updated reports do not need the depth of background information as the report for an Initial Case Conference. A factual account of events since the initial Safeguarding and Protecting Children conference is adequate and this should be presented using the assessment framework format.

Centile charts should be kept on all children. These charts should record naked weight on children below the age of one and minimal clothing for children over the age of one.

Reporting in this way promotes the professional image of the health worker and not only reduces the need to persistently look through records, by removing the risk of attempting to give information from memory in the absence of written facts.

The Safeguarding and Protecting Children Conference

1. Always arrange to arrive at a Safeguarding and Protecting Children Conference **PUNCTUALLY**
   Punctuality will enable you to be part of the initial introduction of the Safeguarding and Protecting Children Conference members, and to identify others from different disciplines.
   It also enables you to gain all information from the Safeguarding and Protecting Children Conference, including the Chairperson’s opening remark.

2. Each person involved with the child will have an opportunity to comment on their report and questions may be asked. Parents/carers will also have an opportunity to comment and ask questions.

3. Whenever possible the Safeguarding and Protecting Children Conference will reach a unanimous decision on whether the child’s/children’s name requires to be placed on the Safeguarding Children Plan.

   If however, any member disagrees with the conclusion of the conference he/she has a responsibility to declare his/her dissent and reasons in order that it will be minuted as appropriate.

4. When a child’s/children’s name is placed on the Safeguarding Children Plan, a decision will be made at the conference to identify appropriate members of the Core Group. A date and time for the first core group meeting will be agreed and should be within seven working days of the conference.
5. The date of the Safeguarding and Protecting Children review conference will be arranged.

6. Minutes will be sent to all Conference attendees.

   **If you feel the minutes are not a true record and corrections are necessary, inform the Safeguarding and Protecting Children conference chair in writing within one week of receipt of the minutes.**

7. The outcome of the Safeguarding and Protecting Children Conference must be documented in the appropriate child/family records. Safeguarding and Protecting Children Conference Minutes must be filed in each child’s records. If it is necessary to photocopy the minutes to achieve a set for each individual child, pink photocopying paper must be used.

8. Support and guidance can be obtained from the Named professionals’ Safeguarding and Protecting Children, Safeguarding and Protecting Children supervisors or line managers.

### 2.17 RESPONSIBILITIES FOR CHILDREN LOOKED AFTER

Children who are provided with accommodation by the Social Service Departments are described as ‘Children Looked After’. This term pertains to children subject to compulsory care as well as those who are voluntarily accommodated.

Children Looked After can be accommodated with family and friends, Planed foster carers or in residential units.

#### 2.17.1 Children Looked After – Health Professional

For your Locality.

Responsibilities:

- To assist the PCT in fulfilling their responsibilities as commissioners of services to improve the Health of Children Looked After.

- Ensuring expert health advice on Children Looked After is available to Family & Children’s Social Care Team, PCTs, residential children’s homes, foster carers, school nurses, clinicians undertaking health assessments and other health staff.

- Develop policies and procedures and ensure those providing healthcare to Children Looked After are aware of local policy, procedures and their roles.
• Liaised with social service departments and other PCT’s regarding health assessments and health Plans for out of authority placements.

• Produce an annual report evaluating the delivery of services to Children Looked After

All Health Professionals

Responsibilities:

• Be knowledgeable about Children Looked After issues.

• Maintain accurate, legible and complete health records for Children Looked After.

• Attend/submit a report as appropriate for all Statutory Reviews to which they are invited, for children and young people in their care. This information will inform the health care Plan for that child/young person.

• Have a duty to identify and access training in the health needs of Children Looked After, to ensure they are equipped with the knowledge needed to promote good health among this vulnerable group of children and young people.

2.18 CHILD ACCOMMODATED OVER A PERIOD OF 3 MONTHS

In line with the Children Act 1989, the Health Authority is required to notify the Family & Children’s Social Care Team Department when a child is accommodated for a consecutive period of a least 3 months duration, and when the child leaves the accommodation.

• Senior Nursing Staff at ward/unit level will identify any children under the age of 19 years, who have been accommodated for a consecutive period of at least 3 months duration, (or it is intended will be accommodated for a period of, or exceeding 3 months).

• The Senior Manager will be informed and will inform, in writing, the Family & Children’s Social Care Team Department.

• The same procedure will apply when such a child leaves the accommodation.
2.19 REQUESTS FOR INFORMATION FROM SOLICITORS, CHILDREN’S GUARDIANS, CHILDREN AND FAMILY REPORTERS OR THE POLICE

2.19.1 Requests for information from PCT employees from:

- **Children’s Guardian** – (a social worker appointed by court in public law proceedings – formerly known as Guardian Ad Litem)
  - Requests should be made via Lead or Named Nurses Safeguarding and Protecting Children. Relevant information may be given; this should usually be during a face to face interview. Staff member accompanied by Line Manager/ Named Nurses Safeguarding and Protecting Children if required. Sight of the final report should be requested.

- **Children and Family Reporters** (appointed by the court in civil proceedings – formerly Court Welfare Officers)
  - Requests should be made via Lead or Named Nurses Safeguarding and Protecting Children. Relevant information to be given, this should usually be during a face-to-face interview. Staff member to be accompanied by Line Manager / Named Nurses Safeguarding and Protecting Children if required. Sight of the final report should be requested.

- **Police**
  - Sharing of information may be necessary in the child’s best interest. Advice must be sought prior to releasing any information from the Named Nurses Safeguarding and Protecting Children / Lead / Named Nurses, one of which will accompany staff when being interviewed or giving a statement. Statements must be checked and signed by the practitioner on each page. Do not release original health records/files, photocopies will be supplied if requested. Original records can be demanded by an order of a Court.

- **Local Authority Solicitors**
  - A written request for information is expected; a verbal request is not acceptable.
  - Relevant information may be given either by a prepared written statement or by an interview for the purpose of preparing a statement. Statements should be discussed with and seen by the Lead / Named Nurses for Safeguarding and Protecting Children and the trust legal representative prior to submission. If taken by interview the Named Nurses/line manager should be present. The statement should be signed and dated and a copy kept with the records.

- **Solicitors Acting for Parents/Carers**
  - Discuss all requests for information with the Named Nurses Safeguarding and Protecting Children. Do not provide information directly, there may be a conflict of interests which also breach
confidentiality. In custody/residence cases a child and family reporter will be appointed. A witness summons or subpoena may be required. Guidance or support is available from the PCT Legal Advisors.

**Written requests should always be made to the Lead / Named Nurses for Safeguarding and Protecting Children / Governance Directorate**

### 2.20 WITNESS STATEMENT PROCEDURE

A statement for court from a PCT employee may only be provided for a Children’s Guardian, Children and Family Reporter, Solicitor for the local Authority or very occasionally to an independent solicitor where there are exceptional circumstances.

The health care professional may disclose relevant information when it is in the child’s best interest as directed by the court.

#### 2.20.1 Initial Request

- In all cases a written request must be made by the applicant via the Lead / Named Nurses for Safeguarding and Protecting Children, or the Legal Representative for Central Lancashire Primary Care Trust.

- A statement must not be provided without prior consultation with your Lead or Named Nurses for Safeguarding and Protecting Children.

#### 2.20.2 Pre-statement Meeting

The health professional involved will have a face-to-face meeting with Lead / Named Nurses Safeguarding and Protecting Children.

- To review the case records and involvement with the family.
- Agree the statement content and format.
- To discuss any continued procedure and/or meeting with other agencies concerned in the case.

#### 2.20.3 Statements

The final version of a written statement must be shared with the Lead / Named Nurses Safeguarding and Protecting Children and the PCT Legal Advisor prior to submission.

If a statement is taken by interview, the member of staff must be accompanied, by the Lead / Named Nurses Safeguarding and Protecting Children.
2.21 STATEMENT WRITING

- A statement must be written by the health professional concerned with the child/children and family and not by any other person.

- The final version will be shared with the Lead / Named Nurses Safeguarding and Protecting Children and the PCT Legal Advisor prior to submission.

- Written statements should be clear, concise, factual, honest, accurate, chronological, always dated and signed.

- Give the name of the child, parents, siblings and other inhabitants of the household, addresses, dates of birth of the child/ren, General Practitioner, Health Visitor / School Nurse.

- Statement to be presented on PCT letterheaded paper, marked “Confidential” with each page numbered.

- Information to be included in statement: -
  
  i. Your name, qualifications, capacity employed, by whom and for how long. The purpose of your involvement with the child/children/family.
  
  ii. How long the child/family has been known to you, the number of home visits/contacts involved with the child, over what period of time.
  
  iii. Any relevant social information over the period i.e. cohabitee, extended family support, friends.
  
  iv. Any medical/nursing history i.e. developmental, immunisation status, clinic/ hospital attendance’s, illness and accidents and their outcomes.
  
  v. Any referrals made to other agencies including outcomes.
  
  vi. Overall professional opinion, based upon fact and possible recommendations.
  
  vii. Signature and date.

- In the case of a child whose injuries have been found by yourself, include in the statement a concise account of how, when and where the injuries occurred and the nature of the injuries.

- The statement will be forwarded to the applicant via the appropriate PCT Legal Services Department.
• The statement is highly confidential; information contained within it should not be divulged to other members of staff unless they are involved in the case.

Your statement will be seen by a number of people including parents; it may be used in legal evidence, sometimes by opposing parties. (See Appendix 11 – Writing a Statement for Court: A Suggested Formal)

2.22 AGGRESSION, VIOLENCE & INTIMIDATION

Aggression and violence towards practitioners is never acceptable. The PCT operates a zero tolerance stance and practitioners should update themselves in relation to their responsibilities regarding their own personal safety. Any incident relating to intimidation, aggression and violence should be clearly documented and shared with partner agencies/line managers and the Named Nurses. The critical incident reporting mechanism should be instigated. Aggression and violence to practitioners is an indicator that the children may also be at risk of abuse and is often used by parents to detract from child centeredness. Practitioners must at all times remain aware and seek advice and support in order to prevent the risk of professional collusion and dangerousness.
3. REFERENCE DOCUMENTS

http://www.dh.gov.uk


Lancashire Safeguarding Childrens Board (Children in need of protection)
Multi-Agency Policy, Guidance and Procedures (2007)


The Data protection Act (1998)

The Protection of Children Act (1999)

The Children Act (1989)

The Human Rights Act (1998)

Promoting the Health of Children Looked After DoH (2002)

Safeguarding Children in whom illness is fabricated or induced DoH (2002)

Safeguarding Children involved in prostitution DoH (2000)

Department of Health, letter from Jacqui Smith MP to PCTs (2002)

What to do if you’re worried a child is being abused DoH (2003)
Every Child matters DFES (2003)
4. BIBLIOGRAPHY

Information sharing to improve services for children (August 2003)

The Children Act (March 2004)

Every Child Matters – Next Step (September 2004)

Care Standards Act (2000)


The Education Act (2004)


Code of Professional Conduct, (5.3) page 7, Nursing and Midwifery Council (2007)

Bichard Enquiry (June 2004)


Mental Health Act (2005)
5. GLOSSARY

DfES Department of Education & Skills
DoH Department of Health
GP General Practitioner
LSCB Lancashire Safeguarding Children’s Board
MAARF Multi Agency Assessment Referral Form
NSPCC National Society Prevention of Cruelty to Children
PCT Primary Care Trust
APPENDICES
APPENDIX 1

PROTOCOL – SECTIONS 85 & 86 OF THE CHILDREN ACT 1989
(as amended by the Care Standards Act 2000)

Legal Requirements

Section 85 requires that:

1. Where a child is provided with accommodation by a Primary Care Trust, Acute Trust or Local Education Authority for a consecutive period of at least three months, or the intention of accommodating for such a period, then the accommodating authority should notify the responsible authority.

2. Where the above applies with respect to a child, the accommodating authority shall also notify the responsible authority when they cease to accommodate the child.

3. Where a local authority have been notified they shall take steps as are reasonably practicable to enable them to determine whether the child’s welfare is adequately safeguarded and promoted while he is accommodated by the accommodating authority.

Section 86 requires that:

1. Where a child is provided with accommodation in any care home or independent hospital, for a consecutive period of at least three months, or with the intention of accommodating him for such period the person responsible should notify the local authority.

2. Where a local authority have been notified under this section they should take steps as are reasonably practicable to enable to them to determine whether the child’s welfare is adequately safeguarded and promoted while he is accommodated in the home or independent hospital.
APPENDIX 1 (cont’d)

Sections 85 and 86 – Protocol between Lancashire County Council Family & Children’s Social Care Team Directorate and Health Services with responsibilities in Lancashire County area

Central Lancashire Primary Care Trust will:

Ensure that provision in their area for which they have responsibility is aware of the duties under these sections of the Children’s Act and will ensure that protocol with requirements to notify by letter the Area Manager in the area in which the child is accommodated.

Notification of accommodation should take place before placement where possible, or as soon as the period of accommodation can be predicted. In all cases, such notifications should be within 3 days of the period of accommodation or, in exceptional circumstances, within 3 days of it becoming apparent during a period of accommodation.

Notification of a child leaving accommodation should be issued in advance, if possible, or on the day of discharge. On receipt of a notification the Family & Children’s Social Care Team Directorate will:

Check the ISSIS client information system

Referral to the Initial Assessment Team Leader so that an initial assessment is undertaken in accordance with existing procedures and also to consider the notification and identify how the local authority should undertake its duties in the case.

Comply with the requirements of these Sections of 85 and 86 of the Children’s Act.
**Recent Sexual Abuse/or Child in Immediate Danger Refer to Police**
Forensic evidence may be available. Refer to the police to expedite collection of evidence immediate protection
Tel no: 01772 203203

**Suspected Child Abuse i.e. Sexual, Physical, Neglect or Emotional Abuse**
Refer to Local Children’s Social Care Department via telephone stating clearly that you are making a Safeguarding and Protecting Children (section 47) referral –
- Preston Locality Tel: 01772 538700
- Chorley Locality Tel: 01257 231585
- West Lancs Locality Tel: 01695 651200

**Out of Hours Duty Team**
0845 602 1042

- Document fully your concerns, observations, discussions, decisions made and by whom the referral was taken.
- Confirm the referral in writing via a multi-agency assessment and referral form (MAARF) within 48 hours.

**Advice and support available from the Lead Nurse, Central Lancashire Primary Care Trust. Cath Randall**
Tel no: 01772 401471

**Obtain consent of the parent/child for the referral and record, unless gaining consent puts the child at further risk of significant harm. E.g. when the professional has concerns relating to sexual abuse or Fabricated illness.**

- Do not question the child or try to obtain further disclosure.
- Listen to and record all information. Do not promise confidentiality but advise you must share information to ensure the child is protected.
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<th>Record of issues discussed</th>
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Date of next session: .............................................

Supervisor's signature: ............................................. Date: ........................

Supervisee's signature: ............................................. Date: ........................
### INITIAL SAFEGUARDING PLAN

**ONE FORM PER CHILD**

Original form (Yellow) to be kept in Child Health notes,  
(If closing or transferring send white copy to Safeguarding and Protecting Children Office)

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<th>Child Surname</th>
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<th>Parent / Guardian Surname</th>
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<th>Relationship To Child</th>
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**Other Professionals/Agencies involved**

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<tr>
<td>Previous Cause for Concern</td>
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<td>Is the Parent/Carer aware of your concerns?</td>
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**Reasons for Concern** – attach a chronology of events

**Care Plan and Agreed Objectives**

**Review Date**

**Date of Discussion**

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<td>Supervisee’s signature and Designation</td>
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# REVIEW SAFEGUARDING PLAN

## ONE FORM PER CHILD

Original form (Yellow) to be kept in Child Health notes,
(If closing or transferring send white copy to Safeguarding and Protecting Children Office)

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**Significant events since last report:**
(attach chronology)

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<th>Care Plan and Agreed Objectives</th>
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**Inter-transferral between professions**

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REFERRING A CHILD AND FAMILY WITH NEEDS

“If Safeguarding and Protecting Children processes are to result in improved outcomes for children, then effective Plans for safeguarding children and promoting their welfare should be based on a wide ranging assessment of the needs of the child and their family circumstances.” Lancashire Safeguarding Children’s Board.

CHILDREN IN NEED DEFINITION

Section 17(10) states that a child shall be taken to be in need if:

a) He is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining a reasonable standard of health or development without the provision of services by a local authority under this Part;

b) His health or development is likely to be significantly impaired, or future impaired, without the provision of such services; or

c) He is disabled.

All staff are directed to follow procedures laid down by the Lancashire Safeguarding Children’s Board and should have access to a copy of the Lancashire Area Safeguarding and Protecting Children Procedures.

When a member of staff has concerns about the welfare of a child a request for other services may be appropriate in accordance with the Lancashire Safeguarding Children’s Board in need categories.

Referrals should only be made after discussion and with the consent of the family. Families must be made aware that referral constitutes consent to Family & Children’s Social Care Team to make enquiries of other agencies.

Consent must be verbally sought from families and documented, signed and dated within the family records by the professional before contact and information sharing with other third party agencies.

Appropriate feedback about outcomes will be given to the families, referrer and other involved professionals by Family & Children’s Social Care Team.

To refer a family/child with needs a Multi Agency Assessment Referral Form should be completed. Including all relevant information held by the professional and sent to Family & Children’s Social Care Team.

A photocopy should be kept in the child’s records, with a copy to the Named Nurses for Safeguarding and Protecting Children.
APPENDIX 7

TRANSFER OUT OF CHILDREN WITH A STRICTLY CONFIDENTIAL FILE

Names of Children:

__________________________________ Dob ______
__________________________________ Dob ______
__________________________________ Dob ______

Previous Address: _________________________________

New Address: ______________________________________

Child Protection Plan: YES / NO

Category: _______________________________________

Date of Registration: ______________________________

Date of De-registration: ___________________________

Summary of reason for Strictly Confidential file: ______________________

_________________________________________________

Summary of current situation: _______________________

_________________________________________________

Staff Name & Title: ________________________________

Base/Address & Telephone No: ______________________

_________________________________________________
APPENDIX 8

TRANSFER OF INFORMATION
FROM HEALTH VISITOR TO SCHOOL NURSE

TO BE COMPLETED FOR CHILDREN COMMENCING SCHOOL

Name of child: ____________________________________________

DOB: _________________________________________________

Address: _______________________________________________

_____________________________________________________________________

_____________________________________________________________________

GP: _______________________________________________________

HV: _______________________________________________________

Which school will the child be attending: ______________________

_____________________________________________________________________

3 Year Developmental check completed? YES NO

Pre-school booster given? YES NO

Current problems: (Please refer to Aide Memoir) (Appendix 9) ______

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________
AIDE MEMOIR

HEALTH INFORMATION REQUIRED FOR HEALTH VISITOR HANDOVER
TO SCHOOL NURSE FOR SCHOOL ENTRY CHILDREN

Development

- Children referred for Griffiths assessment
- Children referred to the Clinical Medical Officer with problem
- Speech therapy referral
- Audiology referral
- Behavioural problem referral e.g. Bickerstaffe House, Clinical Medical Officer
- Not completed Child Health Surveillance

Continence

- Catheter
- Nappies

Medical Problems e.g.

- Mobility Problems
- Malignancy/childhood CA
- Cardiac problems
- Cystic Fibrosis
- Epilepsy
- Severe Eczema/Asthma
- Allergies e.g. peanuts
- Any Prosthesis
- Syndrome’s e.g. Down’s, FragileX, Prader Willi

Safeguarding and Protecting Children

- On Safeguarding Children Plan
- Cause for Concern
CHRONOLOGY OF SIGNIFICANT EVENTS

Including A & E attendances, injuries, GP contacts, complaints, missed appointments, inappropriate minding, changes of address or school etc., safety issues.

NAME: ................................................................................................ DOB: ..............................................

<table>
<thead>
<tr>
<th>Date</th>
<th>Age</th>
<th>Event</th>
<th>Professional’s Signature</th>
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NB: Definition of significant harm - ‘a compilation of significant events, both acute and long standing, which interact with the child’s ongoing development and interrupt, alter or impair physical or psychological development
## LANCASHIRE MODEL OF CHILDREN IN NEED – THRESHOLDS AND PROCESS OF ASSESSMENT

<table>
<thead>
<tr>
<th>Level of Need</th>
<th>Definition of Need</th>
<th>Examples of Need</th>
<th>Threshold for Assessment</th>
<th>Process of Assessment</th>
<th>Provider of Service</th>
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</thead>
<tbody>
<tr>
<td>1. Universal Need</td>
<td>Child’s Developmental Needs&lt;br&gt;Child is disabled</td>
<td>Parenting&lt;br&gt;Health Care&lt;br&gt;Education&lt;br&gt;Recreation</td>
<td>None</td>
<td>Own Agency assessment reflecting the 3 domains of the Framework for Assessment</td>
<td>Parents&lt;br&gt;Mainstream Services&lt;br&gt;E.g. Health&lt;br&gt;Education&lt;br&gt;Housing&lt;br&gt;Leisure</td>
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<tr>
<td>2. Need for Support</td>
<td>Child “is unlikely to achieve or maintain or have the opportunity of achieving or maintaining a reasonable standard of health or development without the provision… of services by a local authority”&lt;br&gt;Child is disabled.</td>
<td>Specific health need&lt;br&gt;Specific education need.&lt;br&gt;Specific emotional or behavioural needs&lt;br&gt;Needs arising from disability&lt;br&gt;Needs arising from lack of parental capacity or family and environmental factors</td>
<td>Child needs “something extra” which warrants referral to another service either within the agency or to an outside agency or uni-disciplinary work.</td>
<td>Own Agency assessments, which may be multi-disciplinary influenced by liaison with other professionals.&lt;br&gt;Assessments should reflect the 3 domains of the Framework for Assessments.&lt;br&gt;Possible referral on multi-agency Assessment and Referral form for assessment for SSD service alone</td>
<td>As above voluntary organisations.&lt;br&gt;Other specialist services within mainstream agencies e.g. Audiology, Education Welfare, CAMHS, Education Psychology Service, Adult and Child Care and Family Services of the SSD.</td>
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<tr>
<td>3. Child Welfare Concerns/ Additional Developmental Needs</td>
<td>Child’s “health or development is likely to be significantly impaired or further impaired without the provision of such services.&lt;br&gt;Child is disabled</td>
<td>As above but more acute and/or needs from more than one domain. Possible need for protection or to be looked after. Mental health needs&lt;br&gt;More complex needs arising from disability</td>
<td>Child’s needs cannot be met solely by a single agency and co-ordinated intervention is needed to promote, safeguard or protect the welfare of the child</td>
<td>Multi-agency Assessment and Referral Form to Family &amp; Children’s Social Care Team&lt;br&gt;Decision re response within one working day of referral may lead to:&lt;br&gt;Initial Assessment led by Family &amp; Children’s Social Care Team within 7 working days of referral</td>
<td>As above multi-agency provision of support packages on a uni-disciplinary or multi-disciplinary basis including Family &amp; Children’s Social Care Team as providers or commissioners.</td>
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<tr>
<td>4. Safeguarding and Protecting Children Concerns</td>
<td>As above Protection from harm or from substantial risk of harm</td>
<td>Child is suffering or likely to suffer significant harm Preventative strategies have failed.</td>
<td>may lead to: Core Assessment led by Family &amp; Children’s Social Care Team within a further 35 working days (mandatory at level 4) may lead to Specialist Assessment</td>
<td>As above multi agency provision of section 47 services Legal Services Court</td>
<td></td>
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</tbody>
</table>
Remember the following key points:

1. To write a successful statement you must be very clear about the kind of information, which is required. You need to ask yourself a number of questions:
   - why are you writing the statement?
   - who will read the document?
   - what are the facts?
   - when is the statement needed?
   - what guidance have I available?

2. All statements must firstly be prepared in draft form and discussed with your line manager/Named Nurses for Safeguarding and Protecting Children.

3. Find out whether your employing organisation has a policy for employees regarding statement writing for use in court proceedings.

4. Ensure the availability of legal advice from your local authority social service department/NHS Trust/DMU. If you find that independent legal advice is not available, you should contact your professional organisation for further advice.

5. Think before you write anything down and refer to all your records.

6. Statements must be accurate and written in chronological order.

7. Write down the statement in English, using uncomplicated language. Be clear, comprehensive and concise in your writing skills. Check your spelling and punctuation are correct.

8. Statements must be factual, that is, based on what was said, what was heard, what was observed and what was done. What was the result of your assessment? Ensure your assessment is within your own professional limits. What were your concerns?

   Key events/incidents must be written up in full detail.

9. You may need to include headings and sub-headings to make your statement clearer, particularly if it is a lengthy document. Dates and times of home visits/other contacts should be recorded with a brief summary of what happened, what you observed on each occasion and your action Plan.
10. Do not forget to record ‘No access’ visits and the action you took following these.

11. Non-contentious entries in nursing records can be summarised by entries in the following style: ‘Between 1.9.92 and 10.10.93, home visits continued and no problems were identified’.

12. Professional opinion and judgement is valued by the court; however they should be clearly differentiated from fact.

13. Do not include unsubstantiated opinions or assumptions as facts. ‘There is no room for hypothesis or conjecture’, (Barnes et al, 1989).\(^{15}\)

14. Try to make the statement as brief and concise as possible.

15. Be truthful.

16. Before signing the statement you should consider the content carefully and make any necessary amendments.

17. Sign and date the final draft.

18. Keep a copy of the statement for your own reference – this is very important.

\(^{15}\) Barnes et al (1989)
WRITING A STATEMENT FOR COURT:
A SUGGESTED FORMAT

To:                     Date:

From:                   

Name:                   

Designation:            

Professional Qualifications: 

My experience has been: 

Work address:           

Work telephone number:  

Stages of the Statement

1. **Introduction**
   
   I first became involved with the family/child(ren) in:
   
   (statements must be written in chronological order)

2. **Main body of statement**
   
   The main body of the statement will be a series of dated paragraphs summarising the corresponding entry in your records.
   
   Give an account of the contacts and events in chronological order from your records.
   
   Each section should have a date as the heading.
   
   Statements must be factual. Opinion should be stated as such.
   
   Each section must include what was observed, heard, your professional assessment and any actions taken.
**SUSPECTED CHILD ABUSE OR NEGLECT**

**SOCIAL CARE**

Refer to Local Social Care
Department Offices
Preston: 01772 538700
Fax: 01772 201813

Out of Hours?
Social Care Emergency Duty Team
0845 6021043

Confirm the referral in writing within 2 working days, keeping a copy for your records. (MAARF)
Document fully your concerns, observations, discussions, decisions.

**RIBBLE VALLEY SOCIAL CARE**

Clitheroe Social Care
Tel: 01200 425146
Fax: 01200 443436

**PAEDIATRIC LIAISON**

01772 522446

**PRESTON PARENTING CO-ORDINATOR**

Sheila Snape
01772 401842

**CHILDREN LOOKED AFTER**

Shona Cornthwaite / Fiona Rowlands
01772 401475

**LANCASHIRE CARE TRUST**

Bridgett Welch
Named Nurses Safeguarding
Tel: 01772 645790

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**Check CP Register 01772 254868**

**Recent Sexual Abuse or Child in Immediate Danger?**

Forensic evidence may be available. Refer to the Police to expedite collection of evidence or to ensure immediate protection.

**POLICE:**

Preston: 01772 203203

**FAMILY PROTECTION UNIT:**

TEL: 01772 416214 / 232
FAX: 01772 416215

NB. A referral must also be made to Social Care, check this has been done.

**Obtain consent of the parent / child for the referral and record, unless gaining consent puts the child at further risk of significant harm.**

**Do not question the child or try to obtain further disclosure.**

Listen to and record all information. Do not promise confidentiality but advise you must share information to ensure child is protected.

**GP’s may wish to discuss less clear-cut cases with a Consultant Paediatrician.**

In these cases either the GP or the Paediatrician should undertake to refer to Social Care if necessary.

**Record incident / injury date and referral in records.**

* Skin maps can be used.

**Safeguarding Advice**

**LEAD NURSE**

Cath Randall
Tel: 01772 401471
Mobile: 07795351055

**NAMED NURSES**

Helen Duncan
Tel: 01772 644525
Mobile: 07887844273

Maria Coll
Tel: 01695 598109
Mobile: 07887657126

Liz Thompson
Tel: 01772 401471
Mobile: 07747477342

**ROYAL PRESTON HOSPITAL**

Cathy Honnah
Lead Nurse, Safeguarding
01772 523226

**MIDWIFERY**

Community Midwife Manager

Rhona Hartley
Tel 01772 524448

**NAMED MIDWIFE**

Vivien Barnes
Vivien.barnes@lthtr.nhs.uk
01772 524575

**DESIGNATED DOCTOR**

Dr Mahmood
Lancashire Teaching Hospital
Dhia.mahmood@lthtr.nhs.uk
Tel: 01772 523551

**LANCASHIRE CARE TRUST**

Bridgett Welch
Named Nurses Safeguarding
Tel: 01772 645790
Suspected Child Abuse or Neglect

Social Care

Refer to Local Social Care Department Offices

Chorley:
01257 231585

Bamber Bridge:
01772 904650

Skelmersdale:
01695 651200

Out of Hours?
Social Care Emergency Duty Team
0845 6021043

Confirm the referral in writing within 2 working days, keeping a copy for your records. (MAARF)
Document fully your concerns, observations, discussions, decisions made and who took the referral.

Safeguarding Advice

Lead Nurse
Cath Randall
Tel: 01772 401471
Mobile: 07795351055

Named Nurses
Helen Duncan
Tel: 01772 644525
Mobile: 07887844273

Named Nurses
Maria Coll
Tel: 01695 598109
Mobile: 07747477342

Named GP
Dr Ronnie Lowe
Tel: 01772 254484

Royal Preston Hospital
Cathy Honnah
Lead Nurse, Safeguarding
01772 523226

Midwifery
Community Midwife Manager
Rhona Hartley
01772 524448

Named Midwife
Vivien Barnes
Vivien.barnes@lthtr.nhs.uk
01772 524575

Preston Parenting Co-Ordinator
Dr Mahmood
Lancashire Teaching Hospital
Dhia.mahmood@lthtr.nhs.uk
01772 523551

Designated Doctor
Shona Cornthwaite / Fiona Rowlands
01772 401475

Children Looked After
Specialist Health Visitor for Children with Disabilities / Safeguarding
Barbara Cartmell & Annette Ashcroft
Tel: 01772 621062

Record incident / injury date and referral in records. 
* Skin maps can be used.
Recent Sexual Abuse or Child in Immediate Danger?

Forensic evidence may be available. Refer to the Police to expedite collection of evidence or to ensure immediate protection.

POLICE:
Local: 01695 566331

FAMILY PROTECTION UNIT:
TEL: 01772 614444

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