Buckinghamshire Healthcare NHS
NHS Trust

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CHILD PROTECTION POLICY

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Document History

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1	**0**	**New Policy**- Merger of Child Protection Policy of Community Bucks Health and Guidelines of Buckinghamshire Hospitals NHS Trust	**Approved: Women and Children's Divisional Board**	**08.04.11**
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1	**1**	**Minor update-**July 2013 updated to reflect new Working Together and other Local and National Changes.	**N/A**	
2	**0**	**Formal Review .** (*incorrectly labelled as version 3 through approval process)*	**Nursing, Midwifery and Therapy Board**	**May 2014**
			Quality Committee	**06.05.14**

Associated documents

BHT Ref	Title	Location/Link
BHT S013 or **131.3**	Child Protection Training Strategy	**http://swanlive/sites/default/files/guideline_131.pdf**
BHT Pol 106 Or **HR36**	Management of Corporate and Local Induction Policy Procedure HR36	**http://swanlive/policies-guidelines/staff-policies**
BHT Pol 174	Child Protection Supervision Policy.	**http://swanlive/policies-guidelines/safeguarding-children**

1. CONTENTS

CHILD PROTECTION POLICY PART 1

2. INTRODUCTION.

2.1. This document is based on "Working Together to Safeguard Children" (2013) WTG covers the legislative requirements and expectations on individual services to promote the welfare of children The policy reflects the principles contained within the United Nations Convention on the Rights of the Child (ratified by the UK in 1991), and the European Convention of Human Rights, in particular Articles 6 and 8. Working Together is particularly informed by the requirements of the Children Act 1989, which provides a comprehensive framework for the care and protection of children, and the Children Act 2004

2.2. This document sets out how Buckinghamshire Healthcare NHS Trust will work to safeguard and promote the welfare of children. There is a need for a shared responsibility and effective joint working between agencies and professionals that have different roles and expertise if children are to be protected from harm and their welfare promoted. Buckinghamshire Safeguarding Children Board (BSCB) is the key statutory mechanism for agreeing locally how relevant organisations will co-operate to safeguard and promote the welfare of children, and for ensuring the effectiveness of what they do.

2.3. This policy must be used in conjunction with the multi-agency policies and procedures of the Local Safeguarding Children Board (LSCB) - Buckinghamshire Safeguarding Children Board (BSCB) www.bucks-lscb.org.uk and *"Working Together to Safeguard Children: A Guide to Inter-Agency Working to Promote the Welfare of Children March 2013"*

2.4. When considering Child Protection issues in law a child is anyone who has not yet reached their 18th birthday. The fact that a child has reached 16 years of age, is living independently or is in further education, is a member of the armed forces, is in hospital, in prison or in a Young Offenders Institution, does not change his or her status or entitlement to services or protection under the Children Act 1989.

2.5 Ultimately, effective safeguarding of children can only be achieved by putting children at the centre of the system, and by every individual involved playing their full part, working together with a child-cantered approach with services based on a clear understanding of the needs and views of children, failings have too long been the result of loosing sight of the needs and views of the children or placing the interests of adults ahead of the needs of children.

2.6 No single professional can have a full picture of a child's needs and circumstances and if children and families are to receive help at the right time, everyone who comes into contact with them has a role to play in identifying concerns, sharing information and taking appropriate action.

3. POLICY STATEMENT

- The Trust will comply with the principles outlined in 'Working Together 2013' and will actively work to recognise signs of abuse and work to promote the welfare and safety of children.
- The Trust has a responsibility and duty to safeguard the children who access the organisation. This includes the children of those adults and carers who use the Trust's services on a daily basis. This duty is reinforced through "The Children Act 2004"
- Children are best protected when professionals are clear about what is required of them individually and how they work together.

4. PURPOSE

The purpose of this policy is to:

- Ensure that all staff are aware of their duties to safeguard children from abuse and neglect.
- Ensure staff are aware of what constitutes child abuse and have a recognition of the key indicators
- Ensure all professionals share appropriate information in a timely manner and understand the need to discuss concerns about a child with colleagues and social care as appropriate.
- Provide the procedures and guidance (included in appendices) on what to do if a staff member has concerns within BHT who to contact for advice and support and how to make a referral to Children's Services this is via First Response in Buckinghamshire other areas may have different arrangements
- Set out the training requirements for staff.
- Set out the requirements for staff to access supervision.

The policy also contains some additional information and resources for staff.

5. SCOPE OF THE DOCUMENT

The policy applies to all staff working for Buckinghamshire Healthcare NHS Trust and agents of other employers providing healthcare on behalf of the Trust.

6. DUTIES AND RESPONSIBILITIES

6.1 Responsibilities of Healthcare Organisations

Health professionals and organisations have a key role to play in actively promoting the health and well-being of children. Section 11 of the Children Act 2004 places a duty on all Statutory Health Care Bodies to make arrangements to ensure that in discharging their functions they have regard to the need to safeguard and promote the welfare of children.
Health professionals are in a strong position to identify welfare needs or safeguarding concerns regarding individual children and where appropriate, provide support. This includes understanding risk factors, communicating effectively with children and families, liaising with other agencies, assessing needs and capacity, responding to those needs and contributing to multi-agency assessments and reviews.

Clinical Commissioning Groups (CCGs) will be the major commissioners of local health services and will be responsible for safeguarding quality assurance through contractual arrangements with all provider organisations.

Effective safeguarding systems are child centred the policy will ensure there are:

- Clear priorities for safeguarding and promoting the welfare of children explicitly stated in strategic policy documents.
- A clear commitment by senior management to the importance of safeguarding and promoting children's welfare.
- A clear line of accountability within the organisation for work in safeguarding and promoting the welfare of children.
- Recruitment and human resources management procedures that take into account the need to safeguard and promote the welfare of children and young people including arrangements for appropriate checks on new staff and volunteers.
- Procedures for dealing with allegations of abuse against members of staff and volunteers.
- Arrangements to ensure that all staff undertake appropriate training to equip them to carry out their responsibilities effectively, and keep this up to date by refresher training at regular intervals; and that all staff, including temporary staff and volunteers who work with children are made aware of the establishment's arrangements for safeguarding and promoting the welfare of children and their responsibilities for them.
- Policies in place for safeguarding and promoting the welfare of children, including a child protection policy, and procedures that are in accordance with guidance from the local authority and locally agreed inter-agency procedures;

- Arrangements in place to work effectively with other organisations to safeguard and promote the welfare of children, including arrangements for sharing information.
- A culture of listening to and engaging in dialogue with children – seeking their views in ways appropriate to their age and understanding, and taking account of those both in individual decisions and the establishment or development of services.
- Appropriate whistle blowing procedures and a culture that enables issues about safeguarding and promoting the welfare of children to be addressed.

6.2 Trust Board

The Trust Board is statutorily responsible for safeguarding and promoting the welfare of children in its care, and is committed to meeting these obligations. Implementation of the Trust Board's strategies for the purpose is delegated to the Chief Executive Officer, who has designated the Chief Nurse and Director of Patient Care Standards as the Executive Lead for child protection and arrangements for safeguarding children.

BHT Safeguarding Organisational Chart and list of key personnel for Safeguarding within BHT can be found in Appendix 1

6.3 Named Staff

"Named" staff must have specific expertise in children's health and development and in treating children who have been abused or neglected. Their work includes:

- Providing supervision and support to other staff in child protection issues
- Offering advice on local arrangements within the provider organisation for safeguarding children
- Providing an important role in promoting, influencing, developing and delivery of relevant training for staff (including effective evaluation)
- Providing input from skilled professionals to child safeguarding processes, in line with the procedures of the LSCB.
- Contribute to reviews undertaken by the LSCB including Serious Case Reviews as appropriate.

6.4 Duties of the Executive Directors

Chief Nurse and Director of Patient Care Standards
Duties include:

- Ensuring that the Trust has policies and procedures that reflect the commitment of the Board in all the aspects identified in 'Working Together to Safeguard Children' (2013).'
- Liaising as appropriate with the Designated Doctor and Designated Nurse appointed by the CCG
- Ensuring the appointment of named professionals with a key role in promoting good professional practice, and providing advice and expertise for fellow professionals.
- Ensuring that the trust's training strategy meets the need of staff to be competent and confident at each level in carrying out their responsibilities for safeguarding and promoting the welfare of children.
- Ensuring the establishment and implementation of an appropriate child protection supervision structure that supports meeting the trust's obligations.
- Ensuring appropriate staff attend and represent the trust on BSCB sub-committees
    - Policies and Procedures
    - Training
    - Monitoring and Evaluation
    - Strategic and Serious Case Review
    - Safer Employment and Allegations against Staff
    - Child Death Overview Panel

6.5 Duties of Managers

6.5.1. Senior Managers throughout the trust have a duty to ensure that the approved strategies, policies and procedures of the trust for safeguarding and promoting the welfare of children in their care are understood and implemented in their own areas of responsibility. They are accountable in this regard directly to their own executive director.

6.5.2. Line Managers will have varying degrees of responsibility for services that directly or indirectly provide care for children. The general duty of all staff applies in all circumstances, along with their duty to the trust and accountability to their own senior managers.

Line managers also have responsibility

- for ensuring that the duty to safeguard and promote the welfare of children is reflected in individual job descriptions
- for ensuring that staff have appropriate access to training
- for ensuring that the training needs of their staff are identified at induction, developmental reviews and in their personal development plans, and
- for ensuring staff are aware of the supervision policy, including when and how to access supervision.

6.6 Human Resources

Have a responsibility to ensure

- Safe recruitment practices that take into account the need to safeguard and promote the welfare of children and young people including arrangements for appropriate checks on new staff and volunteers.
- Procedures for dealing with allegations of abuse against members of staff and volunteers are in place. (see section 16)

6.7 Duties of all Staff.

6.7.1. All staff working directly with children have a duty to ensure that safeguarding and promoting their welfare forms an integral part of all stages of the care they offer. Other health professionals who come into contact with children, parents and carers in the course of their work also need to be aware of their responsibility to safeguard and promote the welfare of children and young people. **This is important even when health professionals do not work directly with a child, but may be seeing their parent, carer or other significant adult.**

6.7.2. All staff who work with children and families will:

- Identify children and families who would benefit from early help recognition that early help is more effective in promoting the welfare of children than reacting later
- Understand the risk factors and recognise children in need of support and/or safeguarding.
- Recognise the needs of parents who may need extra help in bringing up their children, and know where to refer for help.
- Recognise the risks of abuse to an unborn child.
- Contribute to enquiries from other professionals about children and their family or carers;
- Liaise closely with other agencies, including other health care professionals;
- Assess the needs of children and the capacity of parents/carers to meet their children's needs including the needs of children who display sexually harmful behaviours;
- Plan and respond to the needs of children and their families, particularly those who are vulnerable;
- Contribute to child protection conferences, family group conferences and strategy discussions;
- Contribute to planning support for children at risk of significant harm e.g. children living in households with domestic violence or parental substance misuse; (e.g. those who have mental health problems) have access to services to support them;

- Play an active part, through the child protection plan, in safeguarding children from significant harm;
- As part of generally safeguarding children and young people, provide ongoing promotional and preventative support through proactive work with children, families and expectant parents;
- Contribute to serious case reviews and the learning identified
- Participate in child protection supervision.

7. DEFINITIONS

7.1 General

7.1.1. **Safeguarding and promoting the welfare of children means:**

- protecting children from maltreatment
- preventing impairment of children's health or development; and
- ensuring that children are growing up in circumstances consistent with the provision of safe and effective care

7.1.2. **Child Protection** is part of safeguarding and promoting welfare; it refers to the actions taken to protect children who are suffering or at risk of suffering significant harm, as defined under Section 47 of the Children Act (1989)

7.1.3**. Children in Need** are children defined under Section 17 of the Children Act 1989, as those whose vulnerability is such that they are unlikely to reach or maintain a satisfactory level of health or development or their health or development will be significantly impaired, without the provision of services. It includes children who are disabled.

7.1.4. **Significant harm** is a concept introduced by the Children Act 1989 as the threshold which justifies compulsory intervention in family life in the best interests of the children. There are no absolute criteria to define significant harm; it may be a single traumatic event or more commonly a compilation of significant events. Consideration should be given to the severity of ill treatment, duration and frequency of abuse or neglect, extent of premeditation, and the presence of threat, coercion, sadism, and bizarre or unusual elements.

7.2 Definitions of Abuse

7.2.1 Abuse and neglect are forms of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting, by those known to them or, more rarely, by a stranger; for example, via the internet. They may be abused by an adult or adults, or another child or children.

7.2.2. **Physical abuse**

Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces, illness in a child.

7.2.3. **Emotional abuse**

Emotional abuse is the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may include not giving the child opportunities to express their views, deliberately silencing them or 'making fun' of what they say or how they communicate. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond the child's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction. It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying (including cyber-bullying), causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.

7.2.4. **Sexual abuse**

Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet). Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.

7.2.5. **Neglect**

Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to:

- provide adequate food, clothing and shelter (including exclusion from home or
- abandonment);
- protect a child from physical and emotional harm or danger;
- ensure adequate supervision (including the use of inadequate care-givers); or
- ensure access to appropriate medical care or treatment.

It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

For further information on defining child abuse and the signs and indicators of child abuse, please refer to the BSCB Inter-Agency Child Protection and Safeguarding Procedures www.bucks-lscb.org.uk

8. TRAINING

8.1. Requirements

8.1.1. Health organisation are responsible for ensuring that their staff are competent and confident in carrying out their responsibilities for safeguarding and promoting the welfare of children. This includes being able to recognise child abuse and knowing what to do in making an appropriate referral.

8.1.3. The minimum requirements for training for all staff are set out in the Intercollegiate Document Guidance Safeguarding Children and Young People: Roles and Competencies for Health Care Staff 2014. This guidance outlines that different groups of staff will have different training needs to fulfil their duties, depending on their degree of contact with children and young people and their level of responsibility.

Level 1: All non-clinical staff working in health care settings

Level 2: All clinical staff who have any contact with children, young people and/or parents/carers

Level 3: All clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating20 the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns.

8.1.4. Staff require updates or refresher training at regular intervals following their initial training – currently every three years is recommended. They should also receive, at least once year, written briefings of any changes in legislation and practice from named or designated professionals.

8.1.5. The Training Strategy (hyperlink) gives full details of training, including how to access training.

8.2. Ref: Child Protection Training Strategy S013

8.2.1. Induction - **all staff** on joining the Trust are required to attend the corporate induction day which includes an introduction to child protection session. Staff are then advised to identify with their manager at local induction what additional training is required.

8.2.2. E-learning is available within the Trust for mandatory training and updates for identified staff. Details of how to register and access the on-line learning programme can be found on the Trusts intranet by clicking on the e-learning icon or type in https://bucksnhs.premieritelearning.com/login/index.php

8.2.3. Managers are responsible for identifying what level of training is appropriate for their staff and can seek advice from the Named Professionals for Child Protection to assist with this if unsure. For commissioned and contracted providers without a named professional, advice can be obtained from the Designated Nurse.

8.2.4. A training database of all mandatory and essential training undertaken for Trust employees is maintained by the Education, Learning and Development Department.

The purpose of training for inter-agency work at both strategic and operational levels is to achieve better outcomes for children and young people by ensuring:

- a shared understanding of the tasks, processes, principles, roles and responsibilities outlined in national guidance and local arrangements for safeguarding children and promoting their welfare;
- more effective and integrated services at both the strategic and individual case level;
- improved communication and information sharing between professionals, including a common understanding of key terms, definitions and thresholds for action;
- effective working relationships, including an ability to work in multi-disciplinary groups or teams;

9. SUPERVISION

9.1 Definitions

9.1.1 Supervision

"Supervision is the cornerstone of good practice and should be seen to operate effectively at all levels of the organisation" – Lord Laming 2003

9.1.2. Clinical Supervision.

(BHT clinical supervision protocol http://swanlive/sites/default/files/clinical_supervision_protocol_may_2013.pdf)

" Clinical Supervision is a term used to describe a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and to enhance consumer protection and the safety of care in complex clinical situations" (NMC 2008).

Clinical Supervision is not within the scope of this policy.

9.2 Child Protection Supervision.

(http://swanlive/sites/default/files/child_protection_supervision_policy-_bht_pol_174.pdf)

9.2.1. Child protection supervision is more focused in its approach and is concerned with issues to support staff members to ensure that they are competent to safeguard and promote the welfare of children.

9.2.2. Working Together to Safeguard Children (2013) states "Effective supervision can play a critical role in ensuring a clear focus on a child's welfare. Supervision should support professionals to reflect critically on the impact of their decisions on the child and their family.

9.2.3. Supervision for practitioners is an essential component for maintaining safe and effective practice. Organisations should ensure that a robust supervision model is available to all frontline staff and first line managers. Supervision should involve elements of reflection and case management.

10. INFORMATION SHARING

10.1 Sharing

10.1.1. Sharing of information in cases of concern about children's welfare will enable professionals to consider jointly how to proceed in the best interests of the child and to protect children generally. Often, it is only when information from a number of sources has been shared and is then put together that it becomes clear that a child is at risk or suffering harm.

10.1.2. Practitioner's often feel confused by different legislation relating to confidentiality and information sharing. The non-statutory guidance – ***'Information Sharing: Guidance for practitioners and managers' (2008*)** provides further advice to improve practice by giving clear guidance on when and how to share information legally and professionally

10.2 Consent and Confidentiality.

10.2.1 When deciding whether there is a need to share information there must be consideration as to whether the information is confidential, and if it is, whether there is a public interest sufficient to justify sharing. Confidential information can be shared if the person to whom it relates gives consent. However, where sharing of confidential information is not authorised, you may lawfully share it if this can be justified in the public interest. Seeking consent should be the first option, if appropriate.

10.2.2. The child's best interests must be the overriding consideration in making any such decision on sharing information. The key factor in deciding whether or not to share confidential information without consent is proportionality, i.e. is the information you wish to, or are asked to share, a balanced response to the need to safeguard a child or young person? In making the decision you must weigh up what might happen if the information is shared against what might happen if it is not, and make a decision based on a reasonable judgment.

BHT 283: Child Protection: Guidelines on Information Sharing

Ref: Information Sharing: Guidance for practitioners and managers (2008)
http://webarchive.nationalarchives.gov.uk/20130401151716/https://www.education.gov.uk/publications/eOrderingDownload/00807-2008BKT-EN-March09.pdf

10.2.3. Access to Trust Policies relating to data protection and information sharing can be found within the Information Governance Document Store and the existing **'*Buckinghamshire Information Sharing Protocol'*** established between local agencies and organisations will assist staff in making decisions on information sharing

Ref: Buckinghamshire Multi-Agency Data and Information Sharing Protocol for Children and Young People:
http://www.buckinghamshirepartnership.gov.uk/media/1024923/cop.pdf

10.2.4. It is accepted that all information provided by service users is confidential in nature. Information will not be disclosed without the consent of the person concerned, unless there are statutory grounds and an overriding justification for doing so.

BHT 228.5: Guideline for Patient Confidentiality and giving Information to the Police.

10.3. Handling of Requests for Patient Information

Requests made for patient information or access to health records from the Local Authority must be received in writing and Trust protocol adhered to at all times to protect both the practitioner and the client about whom the information is requested.

Ref: Handling of Requests for Patient Information – BHT intranet protocol on reviewing public documents for legal issues

10.4 Consent in cases of Fabricated or Induced Illness

10.3.1. In cases of suspected Fabricated or Induced Illness (FII) it may be detrimental to discuss initial suspicions with the parents or carers. Advice needs to be sought from safeguarding professionals when unsure.

10.3.2. Further advice and information can be obtained from the ***BSCB 'Fabricated or Induced Illness' Procedure (January 2013),*** and the Royal College of Paediatrics and

Child Health ***'Fabricated or Induced Illness by Carers (FII): A Practical Guide for Paediatricians' (2009),***

http://www.bucks-lscb.org.uk/sites/default/files/Procedures/Fabricated_Illness_2013.pdf

http://www.rcpch.ac.uk/system/files/protected/page/Fabricated%20or%20Induced%20Illness%20by%20Carers%20A%20Practical%20Guide%20for%20Paediatricians%202009_0.pdf

The following guidance provides a national framework within which agencies and professionals at local level can draw up, and agree upon, their own more detailed ways of working together where illness may be being fabricated or induced in a child by a parent or carer who has parenting responsibilities.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/190235/DCSF-00277-2008.pdf

http://webarchive.nationalarchives.gov.uk/20130401151716/https://www.education.gov.uk/publications/eOrderingDownload/DCSF-00277-2008.pdf

11. INFORMATION COMMUNICATION TECHNOLOGY (ICT)

11.1.1 ICT (information and communications technology) is an umbrella term that includes any communication device or application, encompassing: radio, television, cellular phones, tablets, smart-phones laptops, computer and network hardware and software, satellite systems, as well as the various services and applications associated with them, such as videoconferencing and distance learning. The importance of ICT's is in its ability to create greater access to information and communication.

Professionals working with children, adults and families should be alert to the possibility that:

- A child may already have been / is being, abused and the images distributed on the internet or by mobile telephone;
- An adult or older child may be grooming a child for sexual abuse, including for involvement in making abusive images. This process can involve the child being shown abusive images;
- An adult or older child may be viewing and downloading child sexual abuse images.

Further information and guidance is available at:

www.bucks-lscb.org.uk

http://webarchive.nationalarchives.gov.uk/20130401151716/https://www.education.gov.uk/publications/eOrderingDownload/ukccis%20advice%20on%20child%20internet%20safety.pdf

12. IMAGING

12.1.1 For most children, parents, grandparents, other family members and friends are the guardians of safety and security. For some children these carers or others can be responsible for abuse and or neglect. During the course of normal activity children will sustain accidental injury; both groups of children require careful investigation which will or

may include some form of clinical imaging. A child who may have suffered physical abuse, imaging may be essential if patterns of trauma that are consistent with Non-Accidental Injury (NAI) are to be detected.

12.2.1 Guidance on imaging in cases of concern of possible NAI can be found via BHT-intranet.

239.2 Guidelines for Imaging in suspected Non-Accidental Injury.

CHILD PROTECTION POLICY PART 2

SUPPORTING PROCEDURES AND GUIDANCE

12. MAKING A REFERRAL TO BUCKINGHAMSHIRE COUNTY COUNCIL CHILDREN & FAMILY SOCIAL CARE

12.1 Introduction

12.1.1. If it is believed that a child is suffering, or may be at risk of suffering significant harm, then those concerns must be referred to Buckinghamshire County Council (BCC) First Response Team.

12.1.2. Referrals can be made 24 hours a day as there is an out of hours emergency Children and Family Social Care team. These children are often referred to as 'Children in Need of Protection' under Section 47 of the Children Act.

BUCKINGHAMSHIRE SOCIAL SERVICES
FIRST RESPONSE TEAM
0845 4600001
Local rate: 01296 383962

Out of hours – Emergency Duty Team – 0800 9997677
Secure email: secure-cypfirstresponse@buckscc.gcsx.gov.uk

12.1.3. BCC Children & Family Social Care also has a responsibility towards all children whose health and development may be impaired without the provision of support and services; and this includes children who have a disability. These children are often referred to as 'Children in Need' under Section 17 of the Children Act, and can also be referred to BCC Children and Family Social Care if it is felt that they can or should provide services to support the child and/or their family.

12.1.4. If a child is from a neighbouring local authority it will be necessary to contact the individual Social Care department to establish what systems they have in place and to whom to make a referral **see appendix 8.**

12.2. Consent/Consultation

12.2.1. In accordance with Inter-Agency procedures and as a matter of good practice, professionals should seek to discuss any concerns with the parent/carer of the child/children. Where possible, seek their agreement to making a referral to BCC Children & Family Social Care. However, if the referrer believes that seeking consent would place the child at increased risk of significant harm it would not be appropriate to discuss or inform the parents or carers of the referral.

12.2.2. Depending on the child's age and understanding it may be appropriate to discuss the concerns with them.

12.2.3. If professionals are uncertain about a situation and require advice they can contact the Named Nurse Child Protection Team or consult BCC Children & Family Social First Response Team by telephone for a discussion on a no-names basis.

12.3. Timescale for referrals

12.3.1. When a professional makes contact with BCC First response team with concerns about a child's welfare, it is their responsibility to clarify the nature of concerns, how and why they have arisen, and what appear to be the needs of the child and family.

12.3.2. If professionals identify that there is possible or actual significant harm to a child then the referral should immediately be made by telephone to the first response team, followed by the completion and sending of a Multi Agency common referral form (Appendix 3) to First Response within 24 hours. Ideally the referral form should be sent to the First response secure email address via an nhs.net email account. If professionals do not have an nhs.net account then it should be hand delivered (see appendix 9) or posted via recorded delivery. A copy should always be sent to the Named nurse for child protection team.

12.3.3. All other referrals should be made within 24 hours of a child being identified as being in need and requiring support/services/assessment. This should also be done by sending a Multi-Agency Referral Form to BCC Children & Family Social Care First Response Team, or by telephoning them, followed by the completion of a referral form within 24 hours as already detailed. A copy should always be sent to the Named nurse for child protection team.

12.3.4. When making a referral it must be made clear exactly what your concerns are and you must be sure that the social worker has correctly understood your concerns.

12.4. The Assessment Framework

12.4.1. **Making a Referral**.

All referrals to BCC Children & Family Social Care First Response Team should be made by completing a Multi-Agency Referral Form **Appendix 3**.

This can also be down-loaded from the BHT staff intranet http://swanlive/policies-guidelines/child-protection or BSCB web-site. www.bucks-lscb.org.uk

12.4.2. The following points should be observed when making a referral:

- All indicated sections of the referral form must be completed. If information is not known, this must be recorded accordingly.
- The form must clarify whether it is a new referral or confirmation of a telephone call.
- The form must be legible and completed in accordance with the relevant Trust's record keeping policy. Typing of the forms is preferable; however, if the form is hand-written, care should be taken to ensure that all of the information is readable.
- It should be identified whether the family is aware of the referral and if they are not, the reasons why.
- Section 1, Box 11 is the most crucial. The reason for the referral needs to be identified here in a clear, concise and relevant manner. A separate sheet of paper can be used to provide this if necessary, which should be stapled to the form if hand delivered. You should not presume that information previously provided or known to Children & Family Social Care has been re-read. Include a summary or reference to any previous concerns or referrals.
- The information should be presented in a logical format by considering and including information you have regarding the child's developmental needs; their parents/carers' ability to meet their needs; and wider family and environmental factors as identified in the Assessment Framework
- **Referral forms and other information must only be faxed to Children & Family Social Care, if in an urgent situation, the faxing of information is necessary in order to protect a child. In such circumstances, the Trust guideline on faxing should be followed.**

Ref: BHT - Protocol for the Transfer of Personal Data by Facsimile (fax)

12.4.3. A copy of the referral form should be sent to the Named Nurse for the relevant area and a copy filed in the notes.

12.5. Response from BCC Children & Family Social Care to a Referral

Referrals are assessed by the First Response Team to check the seriousness and urgency of the concerns. The First response team aim to act on the referral:
Within 3 hours if the decision is that the information indicates high risk.
Within 24 hours if the decision is that the information indicates medium risk.
Within 72 hours if the decision is that the information indicates low risk.

The referrer will be informed of the outcome of their referral. However, if an outcome is not forthcoming, the referrer is required to contact the First Response Team within 3 days (or earlier if the referral was more urgent) to clarify the outcome.

12.5.2. Referrals to BCC Children & Family Social Care First Response Team may have 5 outcomes:

- No further action
- Signposting or referral to another agency such as the Family resilience service for early help
- Transfer to CIN unit for assessment and the provision of services under section17 (Children Act 1989)
- If there reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm a Section 47 (Children Act 1989) inquiry is initiated and transfer to CIN unit for further assessment and the provision of services
- Or emergency action to safeguard and promote the welfare of the child

12.5.3. It may be appropriate to challenge a decision made by BCC Children & Family Social First Response Team in response to a referral, as stated in the Inquiry into the Death of Victoria Climbie (DH 2003), especially if it is to clarify that they have understood the nature of the concerns. The named child protection professionals can support staff with this if necessary.

Ref: BSCB Procedure - Conflict Resolution between Practitioners or Agencies.

12.6. Assessment

12.6.1. Under the children Act 1989 for each referral that is accepted, social care will analyse the nature and level of risk and harm, undertake an assessment of the needs of the individual children to determine what services to provide and action to take. Since April 2013 there is no longer a requirement to conduct separate initial and core assessments; this is to facilitate a shift to an assessment process which brings continuity and consistency for children and families.

12.6.2. Assessment is undertaken in accordance with the Framework for the Assessment of Children in Need and their Families (DH 2000) (Appendix 2). Information is gathered and analysed within the 3 domains of the Assessment Framework. All relevant information will be taken into account, including seeking information from relevant services, e.g. health.

12.6.3. The speed with which an assessment is carried out after referral is determined by the level of risk and the needs identified. The maximum timeframe for the assessment to conclude, such that it is possible to reach a decision on next steps, should be no longer than 45 working days from the point of referral. Where particular needs are identified at any stage of the assessment social care should not wait for the assessment to reach conclusion before commissioning or providing the services.

12.7. Early Help

12.7.1. Providing early help is more effective in promoting the welfare of children and sustaining positive outcomes than reacting at a later date when the child is at increased risk. Health based services such as health visiting; school nursing and the family nurse partnership provide early intervention and prevention work. Children's centres are a particular effective source of early help for families with children under the age of 5 years. There is a range of other services within Buckinghamshire and the Family information service is the key information bank to obtain knowledge of these services; http://www.bucksfamilyinfo.org/kb5/buckinghamshire/fsd/home.page

12.7.2. Where there are multiple issues, low level additional support through a multi-agency coordinated approach is appropriate. In Buckinghamshire this is now provided by the Family Resilience service. It is a consent based service and referrals are taken over the phone; 08454 600 300 (Monday – Friday 9.00 – 16.30).

12.7.3. Professionals should be alert to the potential need for early help and refer to appropriate services as necessary. Social care may sign post professionals to make a referral to the Family resilience team or they make a referral to the team themselves if they assess that it doesn't meet social care threshold.

12.8. Child in Need

12.8.1. A child in need is defined under Section17 of the Children Act 1989 as a child who is unlikely to achieve or maintain a satisfactory level of health or development, or their health and development with significantly impaired, without the provision of services; or a child who is disabled. When assessing children in need and providing services, social care may need to provide specialist assessments and should coordinate care so that the child and family experience a coherent process and a single plan of action.

12.9. Strategy discussion

12.9.1. At any point in the process when there is reasonable cause to suspect that a child is suffering or likely to suffer significant harm, a strategy discussion involving Children's Social Care, the police and other agencies such as health will take place. This may be as soon as a referral has been made. As a health professional you may be invited to a strategy meeting, your role is to share relevant information about your involvement and the health and development of the child in question. The purpose of the strategy meeting is to decide whether Section 47 enquiries will be initiated or continued and plan how these will be handled, including action required immediately to safeguard the child.

12.10. Suspected actual or likely significant harm

12.10.1. The Children Act 1989 introduced the concept of significant harm as the threshold that justifies compulsory intervention in family life, in the best interests of children. It gives local authorities a duty under section 47 to make enquiries when they have reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or likely to suffer, significant harm, to enable them to decide whether they should take action to safeguard or promote the child's welfare.

12.10.2.This statutory guidance adopts specifically the legislative terminology of 'significant harm' in preference to the use of the word "risk", given the need both to reflect the legislative requirements and to avoid confusion with the wide variety of contexts and associated tools and methodologies associated with risk assessment/analysis. When assessing whether a child is suffering, or likely to suffer, significant harm, local authority children's social care will, of course, draw on a wide variety of information, including the outcomes of relevant risk assessments or judgments provided by other agencies and professionals, to inform their own evidence based assessment.

12.10.3 Where a child is suspected to be suffering, or likely to suffer, significant harm, the local authority is required by Section 47 of the Children Act (1989) to make enquiries, to enable it to decide whether it should take any action to safeguard and promote the welfare of the child.

12.10.4 Where there is a risk to the life of a child or a likelihood of serious immediate harm, police or social care should act to secure the immediate safety of the child. This emergency action should then be followed by Section 47 enquiries.

12.11. Section 47 enquiries

12.11.1 When a child is suspected to be suffering or likely to suffer significant harm, Children's Social Care are required to make enquires to decide what action they should take to safeguard and promote the child's welfare. These are known as Section 47 enquiries. The Children Act places a statutory duty on other agencies, including health, to help Children's Social Care with these enquiries. Section 47 enquiries may have three outcomes:

- Concerns are not substantiated, although they may still require support as a child in need,

- Concerns are substantiated but the child is not judged to be at continuing risk of significant harm, for example if the perpetrator no longer has contact with the child or it is judged that those involved are willing and able to co-operate with actions to ensure the child's safety and well-being.

- Concerns are substantiated and child is judged to be at continuing risk of significant harm. In this case a child protection conference should be convened.

12.12. Initial Child Protection Conference

12.12.1. An initial child protection conference brings together family members, the child (where appropriate) and those professionals most involved with the child and family following Section 47 enquiries, which have concluded that a child is at continuing risk of significant harm.

12.12.2 Its purpose is to:

- Bring together and analyse in inter-agency setting information about the child's health and development, and the parents' capacity to ensure the child's safety and to promote their child's health and development.
- Make judgments about the likelihood of the child suffering significant harm in the future,
- Decide and plan future action needed to safeguard and promote the welfare of the child, along with intended outcomes.

12.12.3 Any health professional that has a (significant) contribution to make to the conference will be invited to attend. Attendance at conference needs to be considered as high priority and a written report provided (see report writing guidelines and template in **Appendix 4A & 4B**). It is advisable for health professionals to start a chronology of significant events to be kept in the child's records. This will aid practitioners in identifying and analysing events that impact the child's health and development give indications of any emerging patterns and will help in any further report writing. Guidance on Chronologies is included in **Appendix 5A.**

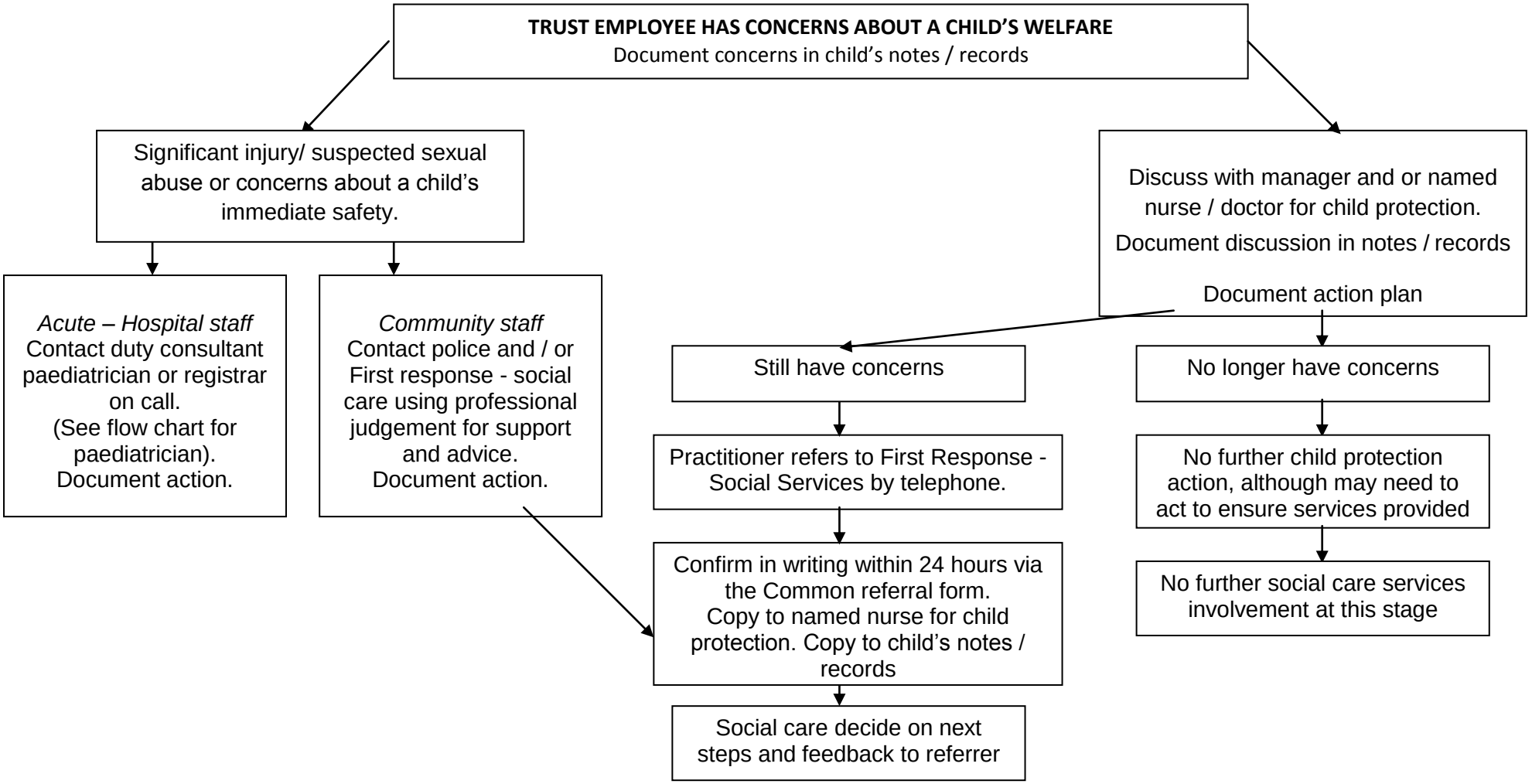
12.12.4. If the decision of the conference is taken that the child is at continuing risk of significant harm then the child will become subject to a child protection plan under one or more of the following categories: physical abuse; sexual abuse; emotional abuse or neglect.

12.12.5. A range of tasks including appointing a key worker, the lead professional and identifying membership of the core group will be agreed. Identifying further assessments, outlining the child protection plan and a contingency plan, if agreed actions are not completed, or circumstances change, will be undertaken, and the date for the first review child protection conference, usually 3 months later, will also be agreed.

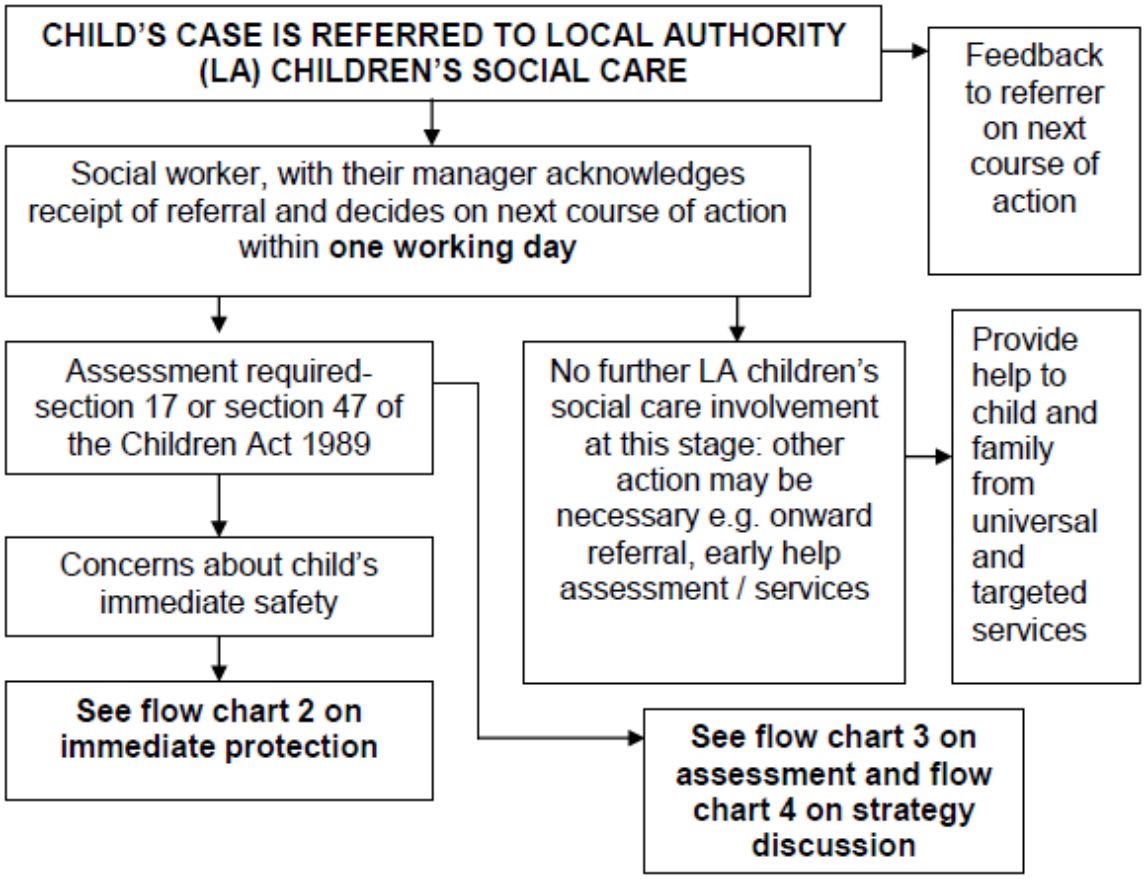
12.12.6. Discontinuing the Child Protection Plan should never lead to an automatic withdrawal of services

See flow-charts on the following pages for further guidance:

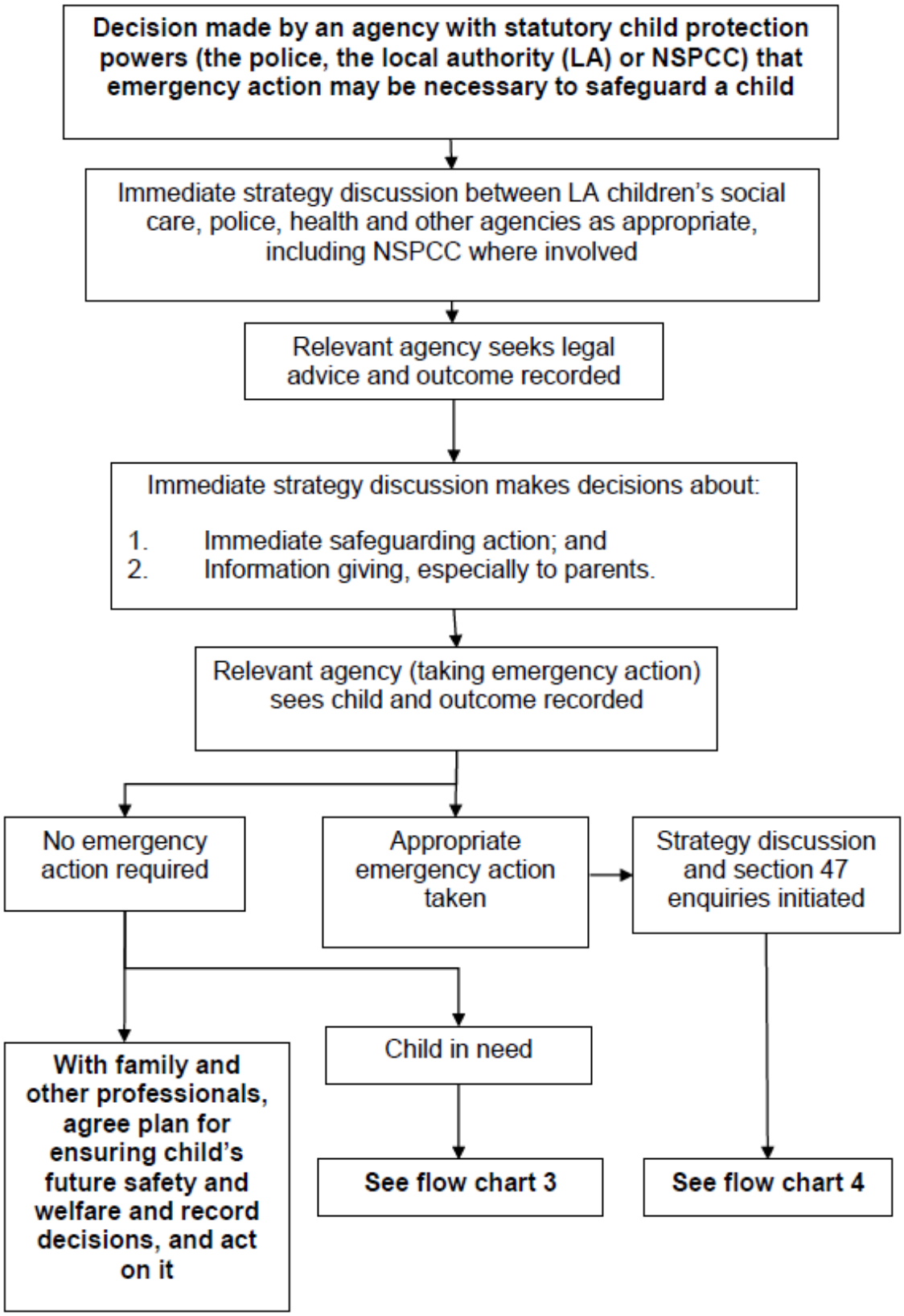
12.13.1. Flow Chart 1: What to do if you are worried a child is being abused



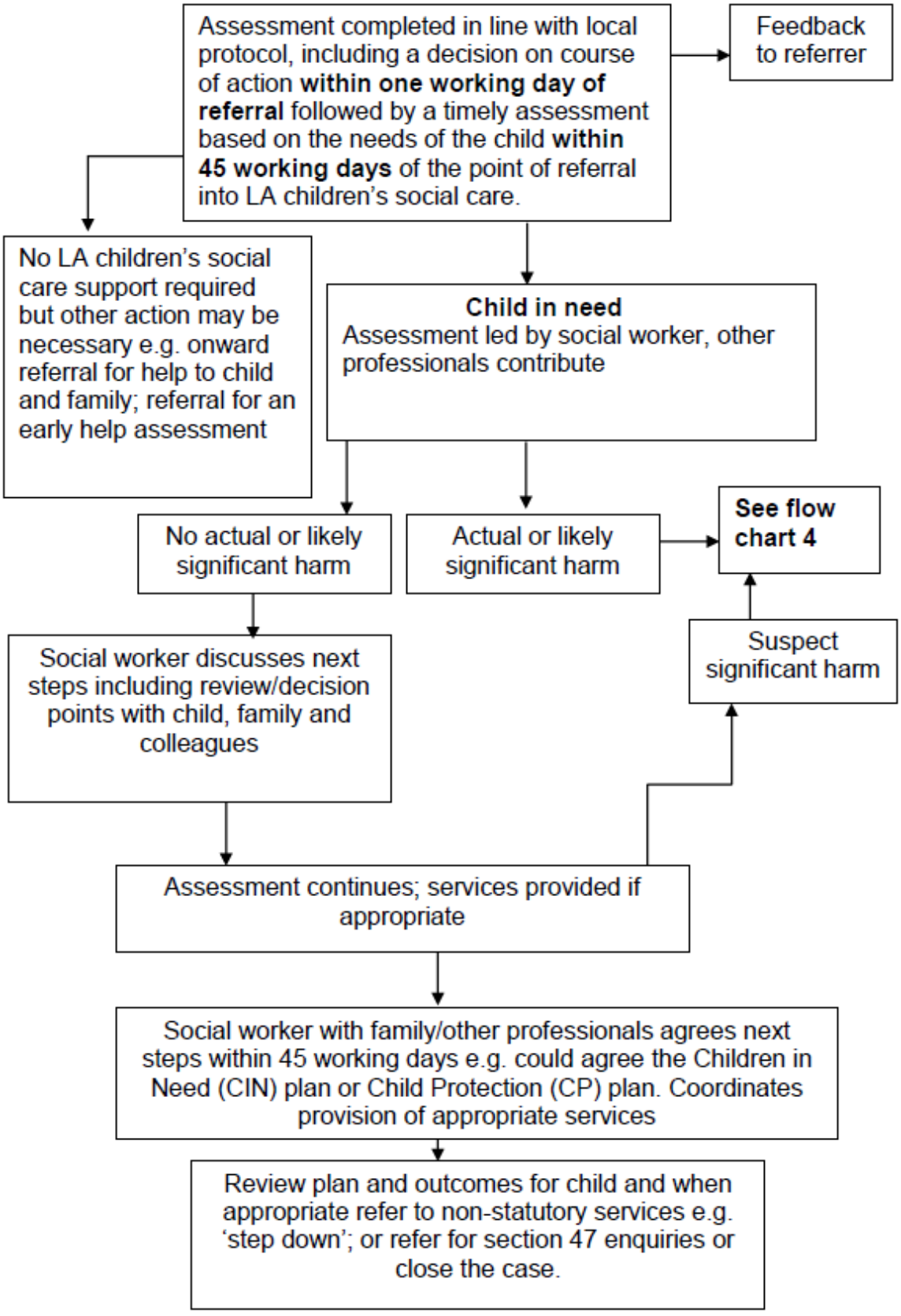
12.14.2 Flow chart 1a: Action taken when a child is referred to local authority children's social care services (Working Together 2013)



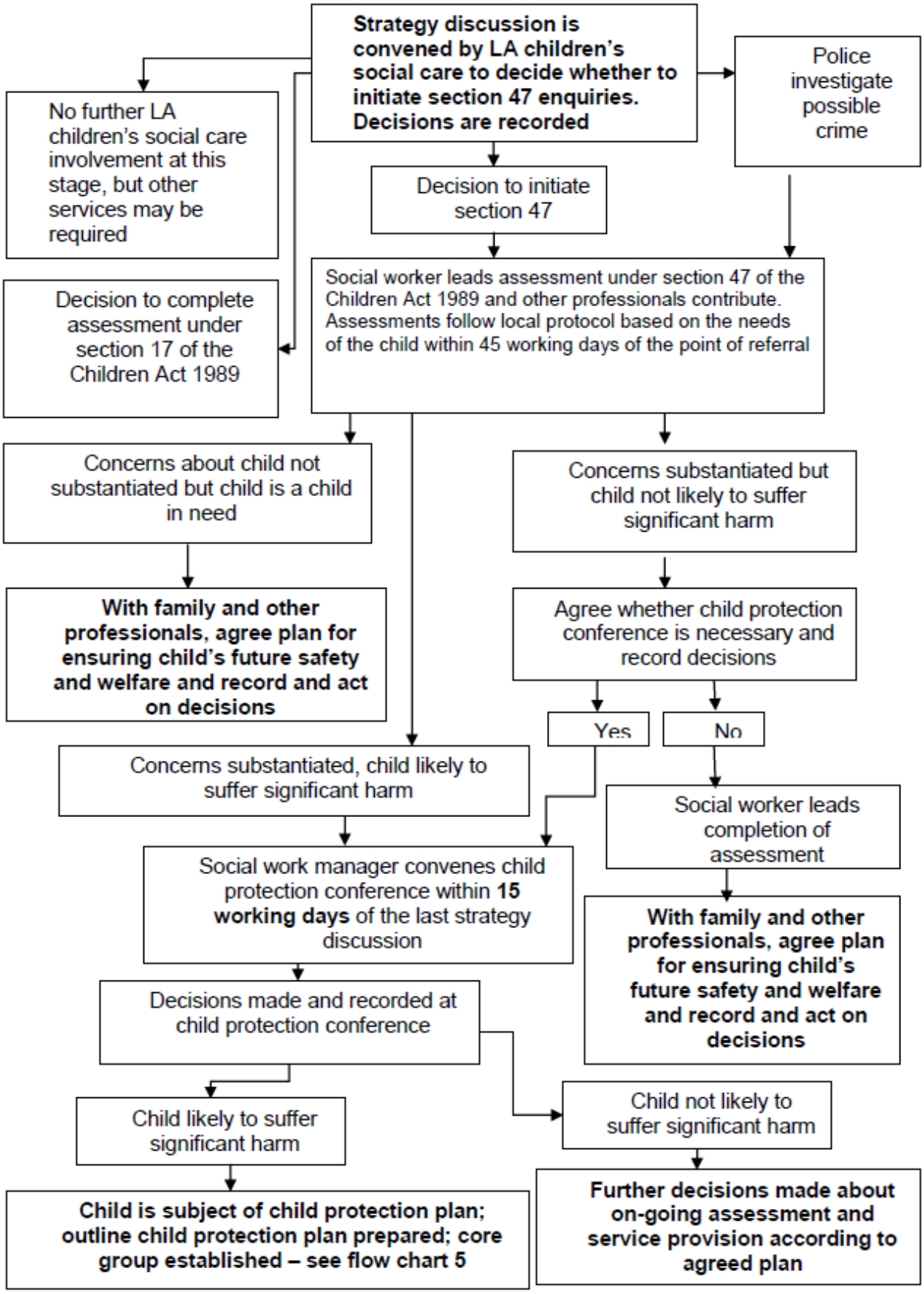
12.14.3 Flow chart 2: Immediate protection (Working Together 2013)



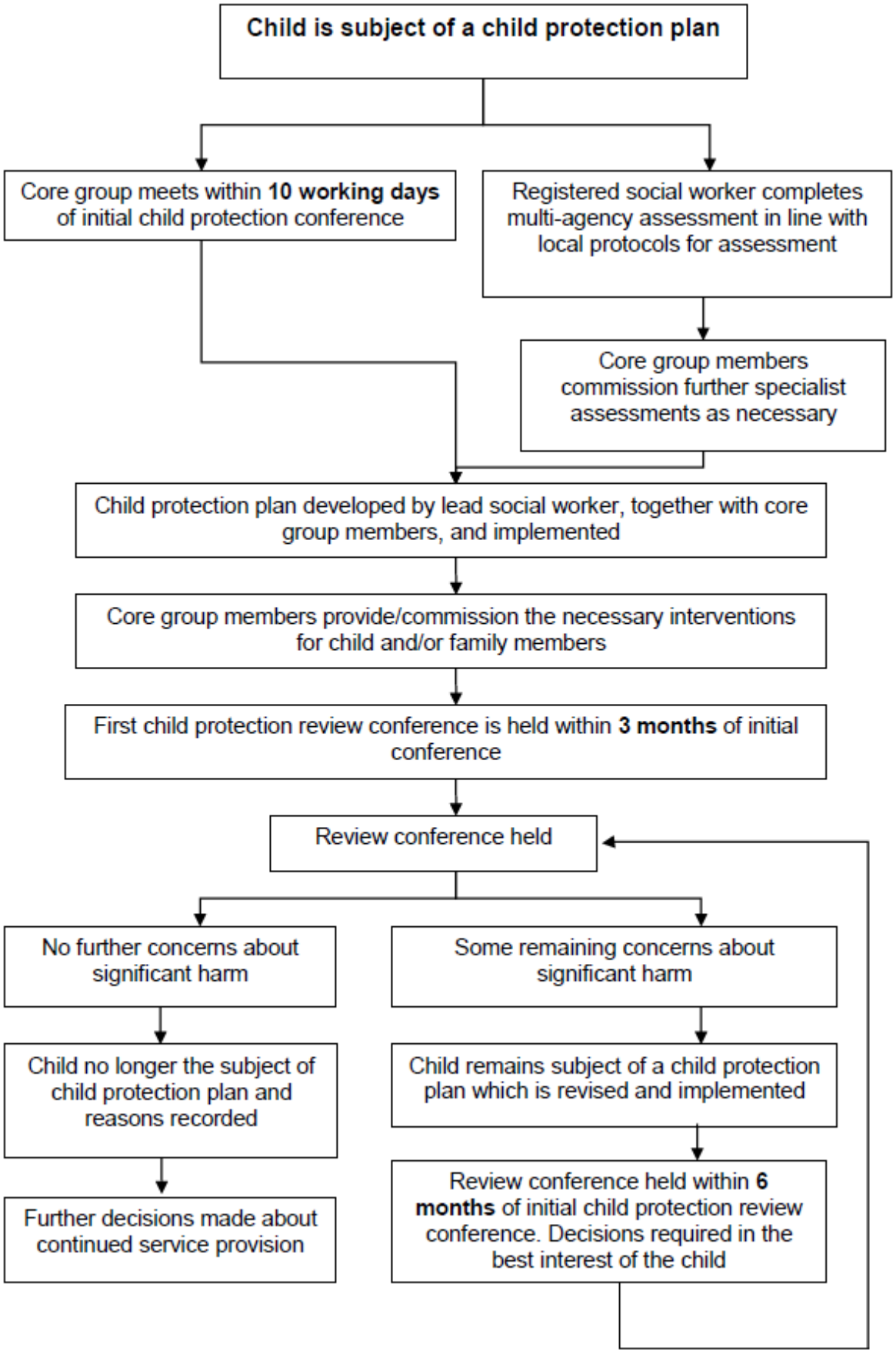
12.14.4 Flow chart 3: Action taken for an assessment of a child **(Working Together 2013)**



12.14.5 Flow chart 4: Action following a strategy discussion **(Working Together2013)**


Strategy discussion is convened by LA children's social care to decide whether to initiate section 47 enquiries. Decisions are recorded
Police investigate possible crime
No further LA children's social care involvement at this stage, but other services may be required
Decision to initiate section 47
Decision to complete assessment under section 17 of the Children Act 1989
Social worker leads assessment under section 47 of the Children Act 1989 and other professionals contribute. Assessments follow local protocol based on the needs of the child within 45 working days of the point of referral
Concerns about child not substantiated but child is a child in need
Concerns substantiated but child not likely to suffer significant harm
With family and other professionals, agree plan for ensuring child's future safety and welfare and record and act on decisions
Agree whether child protection conference is necessary and record decisions
Yes
No
Concerns substantiated, child likely to suffer significant harm
Social worker leads completion of assessment
Social work manager convenes child protection conference within 15 working days of the last strategy discussion
With family and other professionals, agree plan for ensuring child's future safety and welfare and record and act on decisions
Decisions made and recorded at child protection conference
Child likely to suffer significant harm
Child not likely to suffer significant harm
Child is subject of child protection plan; outline child protection plan prepared; core group established – see flow chart 5
Further decisions made about on-going assessment and service provision according to agreed plan

12.14.6 Flow chart 5: After child protection conference **(Working Together2013)**


Child is subject of a child protection plan
Core group meets within 10 working days of initial child protection conference
Registered social worker completes multi-agency assessment in line with local protocols for assessment
Core group members commission further specialist assessments as necessary
Child protection plan developed by lead social worker, together with core group members, and implemented
Core group members provide/commission the necessary interventions for child and/or family members
First child protection review conference is held within 3 months of initial conference
Review conference held
No further concerns about significant harm
Some remaining concerns about significant harm
Child no longer the subject of child protection plan and reasons recorded
Child remains subject of a child protection plan which is revised and implemented
Further decisions made about continued service provision
Review conference held within 6 months of initial child protection review conference. Decisions required in the best interest of the child

13. LEGAL ADVICE

13.1. There are a range of legal proceedings that may be instigated by Buckinghamshire County Council's Legal Department. Staff may be asked to contribute to this process. Such requests should always be in writing with details of the case and guidance on what information is required.

13.2. Staff within Buckinghamshire Healthcare NHS Trust have access to legal advice when this is deemed necessary. If staff members feel they have a child protection issue which should be addressed by appointed Trust solicitors they should discuss this with their line manager and/or the Named/Lead Nurse Child Protection.

Appendix 6 – Flow Chart

14. COURT PROCEEDINGS

14.1. Introduction

14.1.1. The first part of the section relates to when staff have had involvement with children and families in the normal course of their work and are required to give evidence in care/other (e.g. adoption) proceedings under the Children Act (1989) and other legislation. These are known as public law proceedings.

14.1.2. The second section relates to when staff are involved in private law proceedings.

14.1.3. Medical staff may be called upon to provide a report, independently of their employment with the Trust, in the capacity of an "Expert Witness". This falls outside of their normal NHS responsibilities and is not covered in this document.

14.2. Public Law Proceedings

It is recognised that Children Act Proceedings are non-adversarial in nature. The Local Authority will usually be the applicant in Public Law Proceedings and will be requesting statements and reports from professionals who have been involved with the family as part of their routine NHS work.

In order for the court to make the right decision in the child's welfare it is important for the court to have all the relevant information before it. The role of the Local Authority lawyer is to assist the court to address the welfare of the child, and providing information, which is complete and accurate.

Under the Children Act (1989) the Local Authority may request the help of other agencies in carrying out this work. Trust staff has a duty and responsibility "to comply with the request if it is compatible with their own statutory or other duties and obligations and does not unduly prejudice the discharge of any of their functions" (Section 27(2) of the Children Act 1989). This would include a request for the provision of Children Act Statements and attendance at Court to give evidence.

Normally the member of staff will be called as a witness by the Local Authority lawyer. However, the evidence from a health care professional is impartial and given in the best interests of the child.

Advice and support for staff will be made available from the named professionals for child protection and/or the line manager. If it is felt that the staff member needs legal advice from an appointed Trust solicitor, this should be arranged through the line manager or named child protection professional.

14.3 Requests for Statements: (see guidance Appendix 6)

The statement should be drafted taking account of the following points:

1. The front page of the statement should follow the format laid out in the exemplar statement. **Appendix 7.**

2. In cases where work with the child/family commenced at a time when proceedings were not being contemplated and therefore no child protection discussion had taken place with the family, this fact should be set out as a preface to the statement.

3. The report should be written in the first person, and in the past tense. Any reference to third parties in the report should give their name and identify who their role (i.e. Mr X, child's paternal grandfather, or Mrs Y, Speech therapist). Ensure it is clear to whom statements are attributed.

4. Children should be referred to by their first name and adults by their surname.

5. You are usually requested to write a report on your involvement with the child.

6. Do not use jargon or abbreviations; consider whether technical terms need further explanation, so that anybody who has cause to read the report can understand it.

7. The main body of the report should give a factual account of the staff member's involvement, observations and concerns, relating to the child or care of the child. Only information pertinent to the care of the child should be included. If there are supplementary records to the main records (i.e. personal child health record) these should be obtained, in order to compile a complete report.

8. The content should be laid out in chronological order, identifying the date, venue, whether contact was planned or opportunistic, purpose of the contact along with any relevant factual information for each contact.

9. At the end give a summary for each child and a general conclusion based on professional judgment and sound evidence. Speculation and suppositions that cannot be supported by evidence must not be included in the written statement except as a working hypothesis. If an opinion is given it must be made clear what authority the staff member has to give the opinion.

   Once a draft statement has been produced, ideally typed and double-spaced non medical staff should arrange for this to be reviewed by their Team Lead and/or Named Nurse Child Protection.

10. The final statement will be printed, signed and dated by the member of staff. It is essential that staff check the final statement thoroughly for any inaccuracies, as this is the statement which will be used if the staff member is called to the court proceeding as a witness.

11. The staff member must send a copy of the final signed statement to the Chief Nurse, based in Stoke Mandeville Hospital. This will be 'signed off'. The staff member will then retain a copy for the file and securely send the other printed and signed copy to the Local Authority's lawyer who, in turn will send a copy to the court and a copy to the solicitors for the other parties i.e. the family and the children's guardian.

12. In some circumstances, e.g. emergency applications or first hearings of Interim Care Orders, it may not be possible to follow this process, to ensure reports are filed in time a degree of flexibility will be needed by all those involved.

13. Before a final hearing date is set – (this happens early on in the proceedings), the Local Authority's lawyer will check the availability of the staff member in order to try to avoid inconvenient dates. The date of the final hearing is set based on this information. It is very difficult to change dates of final hearings therefore the staff member needs to give information which is as full as possible. Once the date has been set the staff member will be informed by the solicitor. The staff member should then inform the named nurse and line manager, who will discuss whether someone should attend court with the staff member in a supportive capacity.

14. Usually it is not clear until late in the proceedings what witnesses will need to be called at the final hearing. Once this has been clarified the witnesses will be timetabled and informed of the date and time they will need to attend.

15. Before a final hearing, on request the Local Authority's lawyer will see the staff member, and the named professional/manager, to discuss the format of the final hearing so that the staff member is prepared.

16. Every effort will be made to ensure that the time the staff member needs to be available is kept to a minimum. If it is necessary to call the staff member to give oral evidence, he or she will be released as soon as possible.

17. Although their work is confidential, health service staff have no legal privilege which entitles them to withhold information. However, especially when engaged in an on-going therapeutic relationship with a client, the staff member can insist on being served with a Witness Summons so that they can make it clear that they are attending and giving evidence under compulsion. This should only be done in conjunction with a Named Nurse Child Protection professional. It is envisaged that this would be the exception rather than the rule and, in this case, the staff member should notify the Local Authority lawyer in good time prior to the hearing.

14.4 Private law proceedings

While staff will always provide statements and be willing to appear in court when the local authority is bringing care proceedings, this is NOT the case in private law proceedings (those not involving the Local Authority) under the Children Act (1989), they typically involve family disputes over contact or residence. If a staff member is approached by a family's solicitor for information, they should refer the matter to his/her manager and draw their attention to this guidance. A letter has been produced that can be sent out following such requests (Appendix 8)

15. SERIOUS CASE REVIEWS AND INTERNAL CASE REVIEWS

15.1. Purpose

This section outlines the roles and responsibilities of healthcare providers, when the Local Safeguarding Children Board (LSCB) has made a decision to undertake a serious case review and also when a decision has been made to initiate an internal case review, within "health".

15.2 Serious Case Reviews

Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the functions of LSCBs. This includes the requirement for LSCBs to undertake reviews of serious cases in specified circumstances. Regulation 5(1) (e) and (2) set out an LSCB's function in relation to serious case reviews, namely:
5 (1) (e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.
(2) For the purposes of paragraph (1) (e) a serious case is one where:
(a) abuse or neglect of a child is known or suspected; and
(b) either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

Cases which meet one of these criteria (i.e. regulation 5(2)(a) and (b)(i) or 5 (2)(a) and (b)(ii) above) **must always** trigger an SCR. In addition, an SCR **should always** be carried out when a child dies in custody, in police custody, on remand or following sentencing, in a Young Offender Institution, in a secure training centre or a secure children's home, or where the child was detained under the Mental Health Act 2005. Regulation 5(2)(b)(i) includes cases where a child died by suspected suicide.

Where a case is being considered under regulation 5(2)(b)(ii), unless it is clear that there are no concerns about inter-agency working, the LSCB **must** commission an SCR. The final decision on whether to conduct the SCR rests with the LSCB Chair. If an SCR is not required because the criteria in regulation 5(2) are not met, the LSCB may still decide to commission an SCR or they may choose to commission an alternative form of case review. For example a Partnership Review.

LSCBs should consider conducting reviews on cases which do not meet the SCR criteria. They will also want to review instances of good practice and consider how these can be shared and embedded. LSCBs are free to decide how best to conduct these reviews. The LSCB should oversee implementation of actions resulting from these reviews and reflect on progress in its annual report. (Working Together…2013)

15.2.3. The purpose of serious case reviews is to:

- Establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to safeguard and promote the welfare of children;
- Identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a result; and
- As a consequence, improve inter-agency working and better safeguarding and promote the welfare of children.

15.2.4. Case reviews are not enquiries into how a child died or who is culpable. That is a matter for coroners and criminal courts respectively to determine. It is not about professional competence. (See Appendix. 8 for BSCB information leaflet re SCRs)

15.2.5. Any professional may refer a case to the LSCB if it is believed that there are important lessons for inter-agency working to be learnt from the case. For health professionals this should be done via the designated professionals for child protection.

15.2.6. The LSCB in the area where the child is/was normally resident (or the responsible authority in the case of Looked After Children), should take the lead in conducting a review.

15.2.7. If it is agreed by the LSCB that a serious case review will take place, then a serious case review panel will be established. This should include a "health" representative, which will usually either be the Designated Doctor or Designated Nurse for Child Protection.

15.2.8. The Named Nurses will have a responsibility to review and evaluate the practice of all involved health professionals and providers within the organisation. This may involve reviewing the involvement of individual practitioners and Trusts, and also advising named professionals and managers who are compiling reports, such as IMR and chronologies, for the review panel. They also have an important role in providing guidance on how to balance confidentiality and disclosure issues.

15.2.9. Each healthcare organisation or agency will then be expected to undertake a separate individual management review of its involvement with the child and family. This information will be collated by the designated professionals and presented to the serious case review panel.

15.2.10. The LSCB will commission an overview report, which brings together and analyses the findings of all the various reports from organisations and others, and makes recommendations for future action.

15.2.11. The designated professionals will ensure that the NHS England Area Team is aware that a serious case review is taking place.

15.3. Individual Management Reviews

There is now a national panel of independent experts, appointed in June 2013, to advise LSCBs about the initiation and publication of SCRs. The role of the panel will be to support LSCBs in ensuring that appropriate action is taken to learn from serious incidents in all cases where the statutory SCR criteria are met and to ensure that those lessons are shared through publication of final SCR reports. The panel will also report to the Government their views of how the SCR system is working.

15.3.1. Once it is known that a case is being considered for a serious case review, the trust should immediately secure records relating to the case to guard against loss or interference.

15.3.2. The aim of the Trust's individual management reviews should be to look openly and critically at individual and organisational practice to see whether the case indicates that changes could and should be made, and if so, to identify how these will be brought about.

15.3.3. Those conducting management reviews of individual services, or producing the overview report, should not have been directly concerned with the child or family, or the immediate line manager of the practitioner(s) involved.

15.3.4. Where staff are interviewed by those preparing the management reviews, a written record of such interviews should be made and this should be shared with the relevant interviewee.

15.3.5. The findings from individual management reviews collated by the designated professionals will be accepted within the Trust by the director with lead responsibility

for child protection who will be responsible for ensuring that the recommendations are acted upon

15.3.6. Feedback and de-briefing will be provided by the named health professionals in each Trust for all health staff involved and their managers, supported by the Designated Professionals.

15.3.7. Case reviews are not part of any disciplinary process but information emerging from it might indicate that disciplinary actions should be taken under established procedures. Reviews may be conducted concurrently with disciplinary action where necessary.

15.4 Process for conducting an individual management review:

15.4.1.

- The role of designated professionals to notify the Chief Executive Officer and Lead Director for Child Protection in each relevant Trust that a review is to take place.
- Inform named professionals that a review is to take place.
- Meet with the named professionals to agree and devise an action plan for carrying out the review.
- Give advice to named professionals and other individuals about issues regarding confidentiality or disclosure.
- If required collate the individual management reviews and submit to the LSCB case reviewer.

15.4.2.

- The role of the Named Professional is to produce the Trust's individual management report
- This will involve reviewing relevant records, informing and interviewing involved staff and then producing a comprehensive management report.
- Informing relevant service managers that a case review is being conducted.
- Arranging for the service manager to ensure that all case records related to individuals with a link to the child are located and secured, and delivered to the named professional within 24 hours.
- Reading all records and establishing a chronology of history of child(ren) and family (ies) plus a chronology of actions. It is important not to edit out what may seem as insignificant incidents. A chronology should include dates, times (if possible) of contacts and details of those contacts. Information should be as comprehensive as possible. (**Appendix 5B chronology template**)
- Submit the individual management within the agreed time scale.

15.4.3.

Records may include those held by:

- Hospital staff, i.e. children's ward, maternity, accident and emergency department, or paediatrician; or

- Community staff, i.e. community paediatrician, health visitors and school nurses (including parent held personal child health records), child or adult psychiatrists and psychologists, speech therapists; or
- Other local healthcare providers commissioned or contracted by the PCT
- Making arrangements for access to secured records by practitioners where the case is still active, or where work is still being undertaken with other family members, will be dealt with by medical records. It may be necessary for practitioners to be given a photocopy of the child's records

15.5 The role of clinical manager

- Release staff from duties to have time to participate in the review.
- Ensure staff are adequately supported during the process of the review.
- To liaise with named professionals throughout the process.
- Implement relevant recommendations that have been accepted by the LSCB Serious Case Review panel, the Lead Director for Child Protection or the Senior Officer.

15.6 Internal Case Reviews

15.6.1. Internal case reviews are case reviews that are carried out within "health" where it is believed there may be lessons to be learned from the management of a case by healthcare professionals and the case is not the subject of a Serious Case Review by the LSCB.

15.6.2. The purpose of internal case reviews is to:

- Establish whether there are lessons to be learned from the case about the way in which health professionals work together to safeguard children and promote the welfare of children;
- Identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a result.

15.6.3. Internal case reviews are initiated when:

There has been a serious untoward incident involving the safeguarding of a child; or
- The designated child protection professionals and the director responsible for child protection believe that lessons can be learned from a case; or
- The chair of the LSCB following a recommendation from the LSCB audit and evaluation sub group requests one is undertaken.

15.6.4. The designated professionals will inform the named professionals that an internal case review is to be instigated. The same process will be followed as for individual management review.

15.6.5. The findings from internal case reviews will be collated by the designated professionals. The Trust lead will take responsibility for ensuring recommendations and actions agreed are presented to the Healthcare Governance Committee and the Board as appropriate.

15.6.6. The designated professionals will monitor the implementation of the action plan.

16. SAFEGUARDING CHILDREN ALLEGATIONS AGAINST HEALTHCARE STAFF

It is important that all adults working with children understand that the nature of their work and the responsibilities related to it, place them in a position of trust.

Where it is alleged that any staff member has:

- Behaved in a way that has harmed a child, **or**
- May have harmed a child **or**
- Possibly committed a criminal offence against or related to a child; **or**
- Behaved towards a child or children in a way that indicates s/he is unsuitable to work with children.

It is important that a decision is made about whether the information should be treated as an allegation against a staff member or a complaint against a staff member. If in doubt it can be discussed with the Local Authority Designated Officer (LADO) who can be contacted via First Response.

Procedures need to be applied with common sense and judgement. Some allegations will be so serious as to require immediate referral to children's social care and the police for investigation. Others may be much less serious and at first sight might not seem to warrant consideration of a police investigation, or enquiries by children's social care. However, it is important to ensure that even apparently less serious allegations are seen to be followed up, and that they are examined objectively by someone independent of the organisation concerned. Consequently, the LADO should be informed of all allegations that come to the employer's attention and appear to meet the criteria above so that s/he can consult police and social care colleagues as appropriate. The LADO should also be informed of any allegations that are made directly to the police (which should be communicated via the police force designated officer) or to children's social care.

There may be up to 3 strands in the consideration of an allegation:

- A police investigation of a possible criminal offence;
- Enquiries and assessment by children's social care about whether a child is in need of protection or in need of services;
- Consideration by an employer of disciplinary action in respect of the individual.

16.2 Process

The usual procedures to report concerns that a child has suffered harm or may be at risk of suffering harm should be followed. However if a staff member from the trust or any health agency commissioned by the CCG's is implicated in the allegation then the following guidance should also be followed in conjunction with local policies.

As soon as a health care organisation becomes aware of an allegation (or potential allegation), either directly or via another agency, it should be reported immediately to the Named Senior Officer within the organization and the Designated Senior Manager. They should immediately liaise with the Local Authority Designated Officer who can provide advice and support.

Some allegations will clearly warrant a referral to Children's Social Care, others may be less serious but will still require follow up. If a strategy discussion is needed or it is clear that police or children's social care may need to be involved, then this should not be done until those agencies have been consulted, and agreement reached about what information can be disclosed to the staff member.

If there is cause to suspect that a child is suffering or likely to suffer significant harm, a strategy discussion will be convened.

If a formal strategy discussion is not considered appropriate because the threshold of significant harm is not reached, a police investigation might still be needed and discussion should still take place between the agencies about how to progress, including whether any disciplinary processes can take place in parallel with criminal processes, or whether disciplinary action needs to wait until police enquiries and/or prosecution are complete.

If it becomes clear that investigations by the police and or social care are not necessary or the strategy discussion / initial evaluation decides this is the case, then the Designated Senior Manager will agree the next steps with the LADO.

Point 38 to 42 of Appendix 5 of Working Together (2010) says "where the initial evaluation decides that the allegation does not involve a possible criminal offence it will be dealt with by the employer". In such cases, if the nature of the allegation does not require formal disciplinary action, appropriate action should be instituted within 2 working days. If a disciplinary hearing is required and can be held without further investigation, the hearing should be held within 15 working days.

Where further investigation is required to inform consideration of disciplinary action the employers should discuss who will undertake that with the LA Designated Officer. In some settings and circumstances it may be appropriate for the disciplinary investigation to be conducted by a person who is independent of the

employer or the person's line manager to ensure objectivity. In any case the investigating officer should aim to provide a report to the employer within 10 working days.

On receipt of the report of the disciplinary investigation, the employer should decide whether a disciplinary hearing is needed within 2 working days, and if a hearing is needed it should be held within 15 working days. (Information should be provided by police and children's social care as appropriate to assist with the process).

In some cases further investigation will be needed to enable a decision about how to proceed. This investigation process should be agreed between the Local Authority Designated Officer and the Designated Nurse / Doctor.

If a criminal investigation or prosecution is undertaken the police or the CPS should inform the employer and the LA once an investigation and/or trial is complete, or if the investigation is closed without charge, or if they have decided not to prosecute after charging. At this point a decision should be made as to whether further action is appropriate and how to proceed, and information may be provided by the police and children's social care to aid this decision. The options open to the employer will depend on the circumstances of the case, information from police and children's social care, and the different standards of proof required in disciplinary and criminal proceedings.

Depending on the outcome of the investigation consideration should be given as to whether a referral to the Protection of Children Act List or the DfES List 99 is required. The form and content of this referral will be discussed with the Local Authority and agreement reached about who will take responsibility for this. In addition consideration should be given as to whether a referral to any professional body or regulator is required.

When the case has concluded the Designated Nurse / Doctor for Child Protection will work with the relevant health organisation to review the circumstances of the case and determine if there are any lessons to be learned and identify if any improvements to the organisation's procedures or practice are required.

If the allegation is found to be unfounded but it is determined that it was deliberately invented or malicious, the police should be asked to consider whether any action against the person responsible for making the allegation might be appropriate.

Any lessons to be learnt and the outcome of the case will be presented to the LSCB, Trust Risk Monitoring Group and any relevant committee within the staff member's employing organisation.

Ref: BSCB web-site procedures – www.bscb-lscb.org.uk

16.3 Suspension

The possible risk of harm to children posed by the accused person needs to be effectively evaluated and managed. Staff should not be suspended automatically but a decision made which takes into consideration the individual circumstances of the employee. A risk assessment should be made around their continued working arrangements in relation to suspension from duty, amended duties, changed work base, or chaperoned attendance. This decision has to be made by the employer, as neither the Local Authority nor the Police can require a member of staff to be suspended. This authority is vested in the employer alone, though their views should be taken into account. For the Trust the Chief Executive or delegate, will make this decision. In addition the views of the service/organisation manager, the designated professionals for child protection, Human Resources, and the outcome of any investigation or enquiries should be taken into consideration when making this decision.

16.4 Confidentiality and information sharing

Health agencies may be requested to provide information or records on the staff member concerned to assist with the investigation. These requests should be considered following the usual process, giving due consideration as to whether it is in the public interest to "all agencies concerned, including the employer, should share all relevant information they have about the person who is the subject of the allegation, and about the alleged victim".

Every effort should be made to maintain confidentiality and guard against publicity. However, if the staff member is to be charged with a criminal offence their details may be released into the public domain. The Trust's Communications Department and the Communications Lead for the health organisation should be informed if this is the case, preferably in advance.

16.5 Support

If the staff member is a member of a Trade Union or professional association s/he should be advised to contact that body at the outset. The staff member should be keep informed of the progress of the case. This may require liaison with other involved agencies to ensure that only information which will not prejudice any investigation is shared with them. Support may be offered via Workplace Health and other employee welfare arrangements, i.e. ACAS, which the agency has in place. If the person has been suspended from duty they should be informed of developments in the workplace.

If the person has been suspended from work and at conclusion of the case it is determined they can return to the workplace, consideration should be given as to how best to facilitate this. This may need to include consideration as to how to manage their contact with the child/ren that made the allegation, if appropriate.

16.6 Resignation and compromise agreements

Should the staff member about whom an allegation has been made, resign at any point, the investigations into the allegation should continue to be followed up. Compromise agreements to prevent action are not acceptable.

16.7 Record keeping

The Trust and the employing agency should ensure that clear and comprehensive records are maintained. This should include details of how the allegation was followed up and resolved, and details of any action taken and decisions reached. This should be stored in the individual's confidential personnel file and a copy given to the individual, and be retained (including for those who leave the organisation) until retirement age or for 10 years if that will be longer. This is to ensure that accurate information can be given in response to future requests for references, and will provide clarification in cases where future Disclosure Barring Checks (DBS) reveals an allegation not resulting in a prosecution or conviction, and should be kept to prevent unnecessary re-investigation if the allegation resurfaces

17. SUPPLEMENTARY GUIDANCE ON SAFEGUARDING AND PROMOTING THE WELFARE OF CHILDREN.

17.1. Scope

A number of documents have been published as supplementary guidance to Working Together to Safeguard Children (2013), containing more detail to reflect the specialist nature of the particular issues covered.

Healthcare practitioners should be aware of these guidance documents and access them as required.

17.2. Fabricated and induced illness

17.2.1. Concerns may be raised when it is considered that the health or development of a child is likely to be significantly impaired or further impaired by a parent or caregiver. Fabricated and induced illness, previously referred to as Munchausen's Syndrome by Proxy, has no generally agreed definition but has been found to have four central features:

- Illness in a child which is fabricated or induced by a parent or carer.
- A child is presented for medical assessment and care, usually persistently, often resulting in multiple medical procedures.
- The perpetrator denies the aetiology of the child's illness.
- Acute symptoms and signs cease when the child is separated from the perpetrator

17.2.2. The guidance “Safeguarding Children in Whom Illness is Fabricated or Induced” (2002), is available for further information and can be found at **www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/fs/en** . Also information is available at www.bucks-lscb.org.uk

17.2.3. It provides a national framework within which agencies and professionals at local level can draw up, and agree upon, their own more detailed ways of working together where illness may be being fabricated or induced in a child by a parent or carer who has parenting responsibilities.

17.3. Children abused through prostitution

17.3.1. Children involved in prostitution and other forms of commercial sexual exploitation should be treated as victims of abuse, and their needs carefully assessed. They are likely to be in need of welfare services and – in many cases – protection under the Children Act (1989). More information regarding Sexual Exploitation can be found at: https://www.gov.uk/government/publications/safeguarding-children-and-young-people-from-sexual-exploitation-supplementary-guidance and www.bucks-lscb.org.uk

17.3.2. The Home Office and Department of Health jointly published guidance, Safeguarding Children Involved in Prostitution (2000) which promotes an approach whereby agencies should work together to:

- Recognise the problem
- Treat the child primarily as a victim of abuse
- Safeguard the children involved and promote their welfare
- Work together to prevent abuse and provide children with opportunity and strategies to exit from prostitution
- Investigate and prosecute those who coerce, exploit and abuse children

17.4. Investigating complex (organised or multiple) abuse

17.4.1. This is defined as abuse involving one or more abusers and a number of children. It may occur as part of a network of abuse across a family or community, or within institutions. The designated and named professionals within the Trust should be aware of these cases and would offer support to individual healthcare practitioners who may be involved.

17.4.2. The guidance, Complex child abuse investigations: Inter-agency Issues (2002) are available for further information and can be found at **www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/fs/en and** www.bucks-lscb.org.uk

17.5. Female Genital Mutilation (FGM)

17.5.2. Female genital mutilation (FGM) is a collective term for procedures which include the removal of part or all of the external female genitalia for cultural or other non-therapeutic reasons.

17.5.2. FGM has been a criminal offence in the UK since 1985. In 2003 the Female Genital Mutilation Act made it an offence for UK nationals or permanent UK residents to carry out FGM abroad, or to aid, abet, counsel or procure the carrying out of FGM abroad, even in countries where it is legal.

17.5.3. Further information about the Act can be found in the Home Office Circular 10/2004 which is available on **www.hmso.gov.uk/acts/acts2003/20030031.htm**

17.6. Forced Marriage

17.6.1. A forced marriage is a marriage conducted without the full consent of both parties and where duress is a factor.

17.6.2. The Government's Forced Marriage Unit produced guidelines and are available at www.adss.org.uk/publicaitons/guidance/marriage.pdf and www.homeoffice.gov.uk/comrace/race/forcedmarriage/index.html

Buckinghamshire Local Safeguarding Children Board has ratified local guidance (2006) which is available on the Intranet.

18. SAFEGUARDING AND PROMOTING THE WELFARE OF CHILDREN WHO MAY BE PARTICULARLY VULNERABLE

This section outlines the circumstances of children who may be particularly vulnerable.

18.1. Children living away from home

18.1.1. Revelations of the widespread abuse and neglect of children living away from home have done much to raise awareness of the particular vulnerability of children living away from home. Many of these have focused on sexual abuse, but physical and emotional abuse and neglect – including peer abuse, bullying and substance misuse – are equally a threat in institutional settings.

18.1.2. Concern for the safety of children living away from home has to be put in the context of attention to the overall developmental needs of such children and a concern for the best possible outcomes for their health and development.

18.2 Private fostering

18.2.1. A private fostering arrangement is essentially one that is made privately (that is to say without the involvement of a local authority) for the care of a child under the age

of 16 (under 18, if disabled) by someone other than a parent or close relative for 28 days or more.

18.2.2. Under the Children Act (1989), private foster carers and those with parental responsibility are required to notify the local authority of their intention to private foster or to have a child privately fostered or where a child is privately fostered in an emergency. Health care professionals should notify the local authority of a private fostering arrangements that comes to their attention, where they are not satisfied that the local authority has been, or will be, notified of the arrangement.

http://baaf.org.uk/search/google?cx=015623310996288053387%3Acpemfjwk52i&cof=FORID%3A11&query=private+fostering&op=Search&form_build_id=form-60d88704acf6cc754a42d4624a52b34f&form_id=google_cse_searchbox_form

18.3 Children in hospital

18.3.1. The National Service Framework for Children, Young People and Maternity Services (NSF 2004), sets out standards for hospital services.

- When children are in hospital this should not in itself jeopardise the health of the child or young person further.
- The Local Authority where the hospital is located is responsible for the welfare of children in its hospitals.

18.3.2. Additionally, section 85 of the Children Act 1989 requires hospitals to notify the 'Responsible Authority' i.e. the Local Authority for the area where the child is ordinarily resident or where the child is accommodated if this is unclear – when a child has been or will be accommodated for 3 months or more for example, in hospital. This will allow the LA to assess the child's needs and decide whether services are required under the Children Act 1989.

18.4. Abuse of disabled children

18.4.1. The available UK evidence on the extent of abuse among disabled children suggests that disabled children are at increased risk of abuse, and that the presence of multiple disabilities appears to increase the risk of both abuse and neglect (see standard 5,7, and 8 of the National Service Framework for Children, Young People and Maternity Services).

18.4.2. Safeguards for disabled children are essentially the same as for non-disabled children. Particular attention should be paid to promoting a high level of awareness of the risks of harm and high standards of practice, and strengthening the capacity of children and families to help them.
https://www.gov.uk/government/publications/safeguarding-disabled-children-practice-guidance

18.5. Abuse by children and young people

18.5.1. Children, particularly those living away from home, are also vulnerable to physical, sexual and emotional bullying and abuse by their peers. Such abuse should always be taken as seriously as abuse perpetrated by an adult. It should be subject to the same safeguarding children procedures as apply in respect of any child who is suffering, or at risk of suffering significant harm from an adverse source.

18.5.2. Work with children and young people who abuse others – including those who sexually abuse/offend – should recognise that such children are likely to have considerable needs themselves, and also that they may pose a significant risk of harm to other children. Such children and young people are likely to be children in need, and some will in addition be suffering or at risk of significant harm and may themselves be in need of protection. Children and young people who abuse others should be held responsible for their abusive behaviour, whilst being identified and responded to in a way which meets their needs as well as protecting others.

https://www.gov.uk/government/publications/safeguarding-children-and-young-people-who-may-be-affected-by-gang-activity

18.6 Bullying

Bullying may be defined as deliberately hurtful behaviour, usually repeated over a period of time, where it is difficult for those bullied to defend themselves. The damage inflicted by bullying can frequently be underestimated. It can cause considerable distress to children, to the extent that it affects their health and development or, at the extreme, causes them significant harm (including self harm). All health care settings in which children are provided with services or are living away from home should have in place rigorously enforced anti-bullying strategies. https://www.gov.uk/search?q=preventing+and+tackling+bullying&tab=government-results

18.7. Children whose behaviour indicates a lack of parental control

When children are brought to the attention of the police or the wider community because of their behaviour, this may be an indication of vulnerability, poor supervision or neglect in its wider sense. It is important that consideration is given as to whether these are children in need and are offered assistance and services that reflect their needs. This should be done on a multi-agency basis.

18.8. Race and racism

Children from black and minority ethnic groups (and their parents) are likely to have experienced harassment, racial discrimination and institutional racism. Although racism can cause significant harm it is not, in itself a category of abuse. The

experience of racism is likely to affect the responses of the child and family to assessment and enquiry processes. Failure to consider the effects of racism will undermine efforts to protect children from other forms of significant harm.

18.9. Domestic violence

Children may suffer both directly and indirectly if they live in households where there is domestic violence. Domestic violence is likely to have a damaging effect on the health and development of children, and it will often be appropriate for such children to be regarded as children in need of protection. Healthcare professionals working with women with children should be alert to the frequent inter-relationship between domestic violence and the abuse and neglect of children (NSF for Children, Young People and Maternity Services 2004). Where there is evidence of domestic violence, the implications for any children in the household should be considered, including the possibility that the children may themselves be subject to violence or may be harmed by witnessing or overhearing the violence. Conversely, where it is believed that a child is being abused, those involved with the child and family should be alert to the possibility of domestic violence within the family (Responding to Domestic Abuse: A Hand Book for Health Professionals (2005). Domestic violence is now considered a valid reason for making a child subject of a Child Protection Plan. https://www.gov.uk/search?q=guidance+on+teenage+relationship+abuse&tab=government-results

18.10. Children of drug misusing parents

The advisory council on the Misuse of Drugs (ACMD) report Hidden Harm – Responding to the needs of children of problem drug users, concludes that parental drug misuse can and does cause harm to the children (and young people) at every age from conception to adulthood, including physical and emotional abuse and neglect. A thorough assessment is required to determine the extent of need and level of risk of harm in every case.

18.11. Child abuse linked to belief in "possession" or "witchcraft", or in other ways related to spiritual or religious belief.

https://www.gov.uk/search?tab=government-results&q=safeguarding+children+from+abuse+linked+to+faith+or+belief

18.11.1. The belief in "possession" and "witchcraft" is widespread. It is not confined to particular countries, culture or religions, nor is it confined to new immigrant communities in this country.

18.11.2 Such abuse generally occurs when a carer views a child as being "different", attributes this difference to the child being "possessed" or involved in "witchcraft", and attempts to exorcise him or her.

18.11.3 Health professionals should look for indicators and be able to identify children at risk of this type of abuse and intervene to prevent it. They should apply basic safeguarding children principles including: sharing information across agencies: being child-focused at all times: and keeping an open mind when talking to parents and carers.

18.12 Child abuse and information communication technology (ICT)

The range of child abuse definitions and concepts are now being seen in an ICT environment. As technology develops, the internet and its range of content services can be accessed through various devices. http://www.ceop.police.uk/Publications/

18.13 Children and families whose whereabouts are unknown.

If a practitioner becomes aware of a family whose whereabouts is not currently known, they should make efforts to 'trace' the family to ensure that any health needs are met. Liaison should take place with other agencies and professionals who have had involvement with the family e.g. education to determine whether they have more information on the families whereabouts and to alert them to the fact that you have 'lost contact' with them.
Ref: BSCB Thames Valley Missing Children Protocol www.bscb-lscb.org.uk/

18.14 Children of families living in temporary accommodation

It is important that effective systems are in place to ensure that the children from homeless families receive services from health and education as well as any other specific types of services because these families move regularly and may be at risk of being disengaged from services.

18.15. Migrant children

Over recent years the number of migrant children in the UK has increased for a variety of reasons, including the expansion of the global economy and incidents of war and conflict. Safeguarding and promoting the welfare of these children must remain paramount with agencies in their dealings with this group.
http://search.homeoffice.gov.uk/search?q=arrangements+to+safeguard+and+promote+childrens+welfare+in+UKBA&entqr=0&ud=1&sort=date%3AD%3AL%3Ad1&output=xml_no_dtd&oe=UTF-8&ie=UTF-8&client=ukba_frontend&proxystylesheet=ukba_frontend&site=ukba_collection&Submit=Go

18.16 Child victims of trafficking

18.16.1. Trafficking in people includes the exploitation of children through force, coercion, threat and the use of deception and human rights abuses. Exploitation occurs through prostitution and other types of sexual exploitation, and through labour exploitation. It includes the movement of people across borders and also the movement and exploitation within borders.

18.16.2. The UK is a destination country for trafficked children and young people. Such children enter the UK through various means. Some enter as unaccompanied asylum seekers, or students or as visitors. Children are also brought in by adults who state that they are their dependents, or are met at the airport by an adult who claims to be a relative. If it is suspected that a child is the victim of trafficking, the police or children's social care should be informed.
https://www.gov.uk/search?tab=government-results&q=safeguarding+children+who+may+have+been+trafficked

18.17. Unaccompanied asylum seeking children (UASC)

A UASC is an asylum seeking child under the age of 18 who is not living with their parent, relative or guardian in the UK. Based on this assessment, under the Framework for the Assessment of Children in Need and their Families (2000) local authorities have a duty to provide appropriate support and services to all UASC as these children should be provided with the same quality of individual assessment and related services as any other child presenting as being "in need".

APPENDIX 1

CHILD PROTECTION TEAM CONTACT DETAILS

Designated Nurse Child Protection
Bucks CCG
Tel: 01494 552212 Mobile: 07768 023 100

Designated Doctor Child Protection

Tel: 01494 426602
Mobile: 07780 739 384

Lead Professional Child Protection
Mobile 0787 942 3393

Named Nurses

07879486823 **01296-315165**	**07796996704** **01296-566081**	**07747443914** **01296-566021**	**07795823056** **01296-566082**

Named Midwife for Child Protection
Tel: 01494 425537 (Bleep: 3919)
Mobile 0776 995 1274

Named Doctor Child Protection - Community
Tel: 01296 566054/046

Named Doctors Child Protection - Acute
01296 315159 or 01494 426186

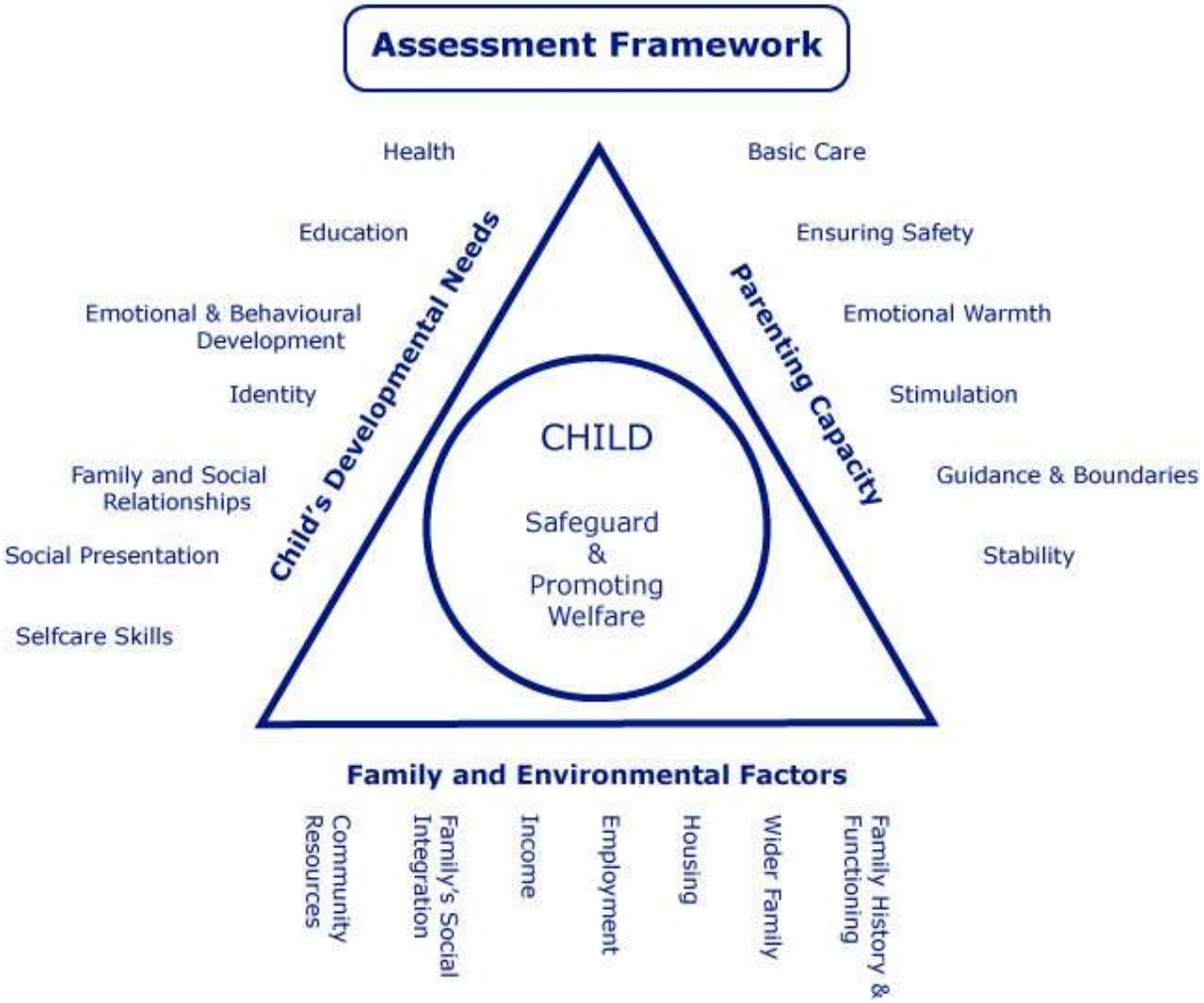
Named Nurses Child Protection Oxfordshire and Buckinghamshire Mental Health Trust
01865 782112
Mobile: 07880 784 743

Named Doctor Child Buckinghamshire Mental Health Trust

Social Care, Children and Family – FIRST RESPONSE
0845 4600 001
Emergency Duty Team (Out of Office Hours)
0800 9997 677
Thames Valley Police Child Protection and Child Abuse Investigation Unit
Tel: 01865 291046

Child Protection Team Secure Email
buc-tr.BHTchildprot@nhs.net

APPENDIX 3 - Guidance Multi-Agency Referral Form



APPENDIX 2- Assessment Framework

This form is for staff in Health, Education, Voluntary Organisations or other Council Services to use when requesting help from Children's Services for children and families

Situations where there is immediate possible or actual significant harm to a child should be referred to Children's Services by telephone and the form sent in confirmation.

In emergencies out of hours contact: 01494 675802.

The information provided will be used by Children's Services to determine what sort of response is needed. Children's Services aim to provide initial assessment and appropriate action where children are in need and there is a likelihood of significant harm, or where a child / young person will not achieve or maintain a reasonable standard of health or development without the provision of services. If an assessment takes place you will be contacted for further information.

Children's Services aim to respond within a week, but as a failsafe if you receive no contact about this referral within a week please ring First Response 0845 4600 001

You can ring First Response for consultation on whether to make a referral on the above numbers.

The Family or Young Person concerned should give permission for the referral to be made and receive a copy of the referral unless this would put the child's welfare at risk. Please confirm the situation in Section 3 and 6.

Wherever possible the category of ethnicity should be the family's own definition.

The referral form can be downloaded at:

1. www.bucks-lscb.org.uk (from the professionals page)

2. via the 'intranet' – Clinical Guidelines – Child Protection No : 26.4 Common Referral Form.

	Buckinghamshire Multi Agency Common Referral Form Assessment Framework initial information Confidential	

Note: Shaded areas are for Social Care use only

1	**SWIFT ID:**		Date:				
Is the parent / carer aware of the referral? *Please tick*			Yes		No		

2	Child / young person's name, address and responsible local authority		
Family name:		Forename(s):	
Date of birth:		Gender:	
Address:			
Postcode:		Tel no:	
Current address *if different from above*:			
Postcode:		Tel no:	
Social Care team:		**Responsible LA**	

3	**Child/young person's ethnicity**				
Child's ethnicity:		**Code:**			
Child's religion:		Child's first language:			
Parent(s) first language:		Is an interpreter or signer required?	Y☐	N☐	

4	Child/young person's principal carers						
Surname	**Forename**	**DoB**	**Relationship to child**	**Parental Responsibility**			
				Yes		No	

				Yes		No	

5	Other household members *including non-family members*				
Surname	**Forename**	**DoB**	**Relationship to child** *Tick if also referred to Social Care and complete a separate referral form*		
				Ethnicity	
				Ethnicity	
				Ethnicity	

5	Other household members *including non-family members* **(Continued)**				
Surname	**Forename**	**DoB**	**Relationship to child** *Tick if also referred to Social Care and complete a separate referral form*		
				Ethnicity	
				Ethnicity	
				Ethnicity	

6	Information on statutory status				
Child or other family member(s) is or has been on a Disability register?			Yes		No
If 'yes', please give details:					
Child or other family member(s) is or has been on a Child Protection register?			Yes		No
If 'yes', please give details:					
Child or other family member(s) has/have been Looked After by a local authority?			Yes		No
If 'yes', please give details:					
Child/young person has a Statement of SEN?			Yes		No

7	Significant family members who are not members of the child's household		
Name:		Relationship:	
Ethnicity:		**SWIFT ID:**	
Address:			

Postcode:		Tel no:	
Name:		Relationship:	
Ethnicity:		**SWIFT ID:**	
Address:			
Postcode:		Tel no:	
Name:		Relationship:	
Ethnicity:		**SWIFT ID:**	
Address:			
Postcode:		Tel no:	

8	**Other SWIFT cases associated with the child / young person**						
Name:		**Case no:**		**Name:**		**Case no:**	
Name:		**Case no:**		**Name:**		**Case no:**	

9	**Key agencies or other parties involved** *e.g. GP, HV, School, YOS, CMH, Police, EPS, EWS, etc.*		
Name	**Agency**	**Tel no**	*Currently working with the family*
			Yes ☐
			Yes ☐
			Yes ☐
			Yes ☐
			Yes ☐
			Yes ☐

10	**Referrer**		
Referred by:		Agency/relation to child/young person, etc:	

Address:			
Postcode:		Tel no and Fax no:	
Signature:		Designation:	
Date:		Method of transfer of communication to C&FSC: Tel / fax / letter	

11	**Reason for enquiry / referral / request for service**	*use separate sheet if necessary*

Enquiry type code:	

Name of staff member taking this referral:			
Signature:		Date:	

12	**Feedback to referrer**	*to provide acknowledgement of referral and feedback*

Name:			
Signature:		Date:	

13	**Further referral action**	***Practice note: Ensure this referral is collated with previous referrals or files***

No further action:		***Please tick***
Provision of information and advice:		***Please tick***
Referral to other agencies:		***Please tick***
Please state which agencies:		

Initial assessment:		***To be completed within 7 working days***	
Party category:		**Priority Code** **A** **B** **C** **D**	
Reason for further action ***(stated issues)***		**Stated Issue Code(s):**	
What further assessments are to take place?			
Receiving Worker's name:			
Signature:		**Date:**	
Team Manager's comments:			
Team Manager's name:			
Signature:		**Date:**	
This form, and its appendices, is available to download from Buckinghamshire County Council's Internet web site: www.buckscc.gov.uk/care_of_children/referral.htm			
Appendix 1	**Please answer all questions in Appendix 1, giving as much detail as possible.**		

1	**Have you discussed your concerns with the family / parents?**	Yes		No	
2	**If you answered 'no', why not?**				
3	**Why are you referring this child / young person?**				
4	**Why are you referring now?**				
5	**What are your main concerns?**				
6	**What are the child's / young person's strengths?**				
7	**What are the family's strengths?**				
8	**What is the likely impact of this referral for the child / young person and the family?**				
If you are referring from Health	**Please complete Appendix 2**				

If you are referring from Education	**Please complete Appendix 3**
If you are referring from any other agency	**Please answer any relevant questions for which you have further information**

Appendix 2	For referrals from Health professionals

Please answer all questions, giving a brief overview.

1	**Does this child have health / developmental needs?**
2	**Does the child's parent or other family member have health needs?**
3	**Are there concerns about parenting capacity?**
4	**Are there any environmental issues contributing to the child's needs?**
5	**Please add any other information which may be useful.**

Signature:		Date:	
Name (please PRINT):		Designation:	
Contact address details:			
Postcode		Tel no:	

Appendix 3	For referrals from Education professionals

Please answer as many questions as possible, giving a brief overview. Continue on a separate sheet if necessary, or attach the relevant school documents.

1	**Please comment on attendance / punctuality.**
2	**Are there any concerns about the general health of the child? Please describe.**
3	**Is the child cared for, clean and well presented?**
4	**Does the child have friends in school? How does he/she relate to peers?**
5	**How does the child respond or relate to adults? Is there any difference between male and female adults?**
6	**Are the parents supportive? Do they attend parents' evenings, school events, engage in meetings or help with rewards/sanctions?**

7	**Does the child do his/her homework?**
8	**What are the child's attainments?**

Appendix 3	For referrals from Education professionals *(Continued from previous page)*
9	**Does the child have any special educational needs? Does he/she have an individual education plan (IEP)? How are needs supported?**
10	**Does the child have any behavioural difficulties? Does he/she have a pastoral support programme (PSP)?**
11	**Has the child been excluded from school? Give details.**
12	**What is the likely educational impact of this referral?**

13	What other educational services are aware of this child?

Signature:		Date:	
Name (please PRINT):		Designation:	
Contact address details:			
Postcode:		Tel no:	

This form, and its appendices, is available to download from Buckinghamshire County Council's Internet web site: www.buckscc.gov.uk/care_of_children/referral.htm

APPENDIX 4A- Pro Forma for Case Conference Reports

PRO-FORMA FOR CASE CONFERENCE REPORTS – TO BE USED BY HEALTH PRACTITIONERS

As with all written reports, it is the responsibility of the professional to ensure their report is professional, objective and a true account of their contact with their client/patient. Professional opinions should be substantiated with evidence and any research material used must be fully cited.

Remember to:

- Use current headed notepaper with the appropriate Trust logo. Your name and work contact details should also be clearly displayed.
- Ensure the report is dated.
- Number pages of the report.
- Avoid jargon and abbreviations.
- The use of headings and sub-headings will make your report clear and concise.
- Sign the report and any photocopies. Have your name printed beneath the signature.
- Whenever possible, submit a typed report.
- Share the report with the parents/carers before the conference. It is good practice to give them a copy.
- Provide 12 copies of your report to hand to the clerk at the case conference.
- You may want to send a copy of the report to the Named Nurse Child Protection for monitoring purposes. This is not necessary for all cases.
- If you cannot attend the Case Conference, a report must be sent to the clerk at least 48 hours before the conference. Arrange for a colleague to represent you. If this is not possible, your manager must be informed and contact the Named Nurse Child Protection for advice.
- You may want to wait until you have heard all the information shared at the case conference before you make a decision as to whether a child should be subject to a child protection plan.

The following is a suggestion of headings to use when compiling your report; there may be more to report under some sections than others depending on the family circumstances. You may feel unable to report on some areas – it depends on the nature and frequency of the contact you have had with the family.

1. **Title**

   State clearly what this report is for, i.e. health visitor/school nurse/midwife
   Report for initial/review child protection Conference
   Include the conference date and, if appropriate, the date of your last report.

2. **Details of Child/Children**

   Give the full names and dates of birth of all the children considered at the Conference. State the current address for each child.

3. **Family Composition**

   State the full names of the parents of the children and any relevant
   Partners or carers, (including extended family members). If possible,

give date of birth and address for each relevant carer.

4. **GP**

5. **School (if registered)**

6. **Other Health Agencies involved (if relevant)**

7. **History and Current Situation**

State your knowledge of the reasons for the Child Protection conference and should this be a review conference, state when the child was subject to a child protection plan and under which category(ies).

8. **Pattern of Contacts**

State that the report will be based on X amount of contact with the family either during home visits, at core group meetings, at clinics or at school, since the last conference. Document any failed appointments, including the location, with reasons given. Include refusal of services. **It is not necessary to write the details of every visit**. An overview of contacts with the family will provide the case conference participants with a clear summary of your input. You may choose to include a chronology.

9. **Consent**

This section is designed for use by school nursing teams or for any health professional who is seeing an unaccompanied child. State whether consent has been given to enable you to see the child/children. Should consent have been refused, state this in your report. Record the name of the person from whom consent was obtained and state their relationship to the child. Remember that, in order to give consent, a person must have Parental Responsibility. Consent may also be given by the child involved should they, in your professional opinion, be competent to give consent. Record whether the consent received has been given verbally, in person or in writing and the date it was obtained.

10. **Health and Development**

Information relating to each child should be recorded under individual named sub- headings, where necessary. Include the height and weight of each child and state whether this falls within the expected parameters for that child. Where appropriate, include a copy of the centile chart. Include the development of the child, both social and emotional; explain exceptions to what is viewed as the 'norm'. If applicable, state their immunisation status.

11. **Views of the Child/Children**

This is an important area for consideration. The views of children who can not communicate due to the stage of their development or due to any disability issues can be discussed via your observation of their behaviour. For example, you do not expect

a child under the age of 12 months to speak but you can, with your professional knowledge, inform the conference if his/her behaviour is what you would **expect** of a child of a similar age or level of development. Consider here the child's interaction and relationship with his/her parents/main carer: is there evidence of bonding? Does the child look to their parent for affection, affirmation, protection? Does the child appear relaxed in their parents' presence? Or do they appear reticent, indifferent, hesitant, confused, or frightened? Your knowledge of the viewpoint of the child very important and will assist with the conference members' assessment of risk. For a child who can communicate freely, also consider their behaviour **alongside** what they have said to you – report on the actual words they have used, which again provides a powerful tool for assessment.

12. **Parental Capacity/Family Interaction**

Where observed, this includes parenting capacity. Illustrate positive parenting, i.e. good parent/child interaction, supportive parenting; attitude to advice focusing on the welfare of the child. Highlight any areas of reluctance to take up services to promote child health.

13. **Main Carer(s)**

Discuss each parent/carer with whom you have a professional relationship under a separate sub-heading. Discuss their strengths and weaknesses. Is advice and support sought appropriately and what is the response to that advice? Do parents work in partnership to enhance their children's welfare? Include information on the quality of the social relationships between the adults in the household and the extended family.

14. **Environmental Factors**

Any important identified stressors for the family should be highlighted here, i.e. housing, financial concerns, safety issues, mental/physical health problems, etc.

15. **Health Professionals assessment of risk**

Risk assessment is not a scientific process. The risk factors which should be presented at this part of the report should concern the actual or potential child protection concern you may have for each child. The assessment of risk should not present new information but should be viewed as a summary of all the previous concerns you have highlighted throughout your report. Risk factors can include health concerns, environmental issues, financial/housing/employment difficulties, domestic violence, non- compliance with health advice, difficulties in engagement, unrealistic expectations of a child, general lifestyle concerns, specific stresses within the family, alcohol/drug addiction and/or mental health issues. A good guide to assessment of risk factors would be to objectively decide exactly why you have concerns about this child at this time, compared to the other children on your caseload about whom you have no concerns.
Remember that for an initial conference, you may not have enough information about the family or sufficient time prior to conference to enable this assessment. Should it be the case, the practitioner should be confident to state clearly why the risk assessment has not yet been possible.
There are a number of 'Risk Assessment Tools' that can be used including the R.A.T. (found on the intranet)

16. **Recommendations**

You may wish to recommend a course of action based on your perception of the risk to the child/ren and the best way to promote their welfare. Include any action or service you will be able to offer to the family as a health professional. Recommendations about whether, in your opinion a child should or should not be subject to a child protection plan should only be made if you feel fully informed about the family situation.

17. **Date report shared with main carer/ child as appropriate**

It is good practice to share your case conference report with the main carer and/or the child if appropriate. This should be done ideally in person by the health professional. If necessary, it can be done via the telephone. The date when the report was shared should be stated in this section. If the report was not able to be shared, the reason should be clearly stated.

APPENDIX 4B- Conference Report

Date of conference **Title**

Details of Child/Children

Family Composition

GP

School

Other Health Agencies involved

History and Current Situation

Pattern of Contacts

Consent : For School Nursing Service only or for health professionals seeing unaccompanied children.

Health and Development

Views of the Child/Children

Parental Capacity/Family Interaction

Main Carer(s)

Environmental Factors

Health Professional's Assessment of Risk

Recommendations

Date report shared with Main Carer/Child if appropriate

SIGNED: …….. DATE:……..
HEALTH PROFESSIONAL DESIGNATION:……..

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GUIDANCE FOR COMPILING CHRONOLOGIES

What is a Chronology?

A chronology is a succinct summary and overview of the significant dates and events in a child's life.

The key purpose of a chronology of significant events can give an early Indication of an emerging pattern of concern.

The chronology can be used as an analytical tool to help practitioners understand the impact, both immediate and cumulative, of events and changes on the child or young person's developmental progress.

It contributes to an emerging picture based on fact and interaction of a case, i.e. current information is understood in the context of previous information and helps inform professional judgement through a consideration of the patterns and relationship of the events and changes in the chronology.

The relevance / significance of an event can change over time. An historical event which appeared insignificant or irrelevant may become highly relevant and significant in the light of further information of more recent origin.

The chronology should enable the practitioner to see at a glance significant incidents in a child's life in summary format.

1. Guidelines

1.1 Children and young people are most effectively safeguarded if professionals work together and share information. Single factors in themselves are often perceived to be relatively harmless. However, if they multiply and compound one another, the consequences can be serious, and on occasions, devastating.

1.2 Professional judgement is required to decide on the relevance for a particular child / family of an event.

1.3 Information recorded in a chronology should be relevant and succinct so as not to be lost in a mass of insignificant and irrelevant events.

1.4 Chronologies are not only a means of organising and merging information. They enable practitioners to gain a more accurate picture of the whole case and highlight gaps and missing details that require further assessment and identification.

1.5 A chronology for a child, young person may start with events that occurred prior to his or her birth if of significance.

1.6 Chronologies should accurately reflect family circumstances, recording both positive and negative factors.

2. Multi-Agency Child Protection Chronology

2.1 It provides a mechanism through which information can be systematically shared and merged, and enables agencies to identify the history of a family, providing invaluable information about a child's life experience.

2.2 It can reveal risks, concerns, patterns and themes, strengths and weaknesses within a family, and can identify previous periods of professional involvement / support and the effectiveness / failure of previous intervention. It informs the overall assessment regarding the care-givers ability and motivation to change.

2.3 The chronology is only one means of collating information and will need supplementing by reports that draw out messages from the chronology, ensure facts are agreed and the overall pattern seen.

3. Significant Information / Events

There are a number of key events or incidents which should be recorded and depending upon the nature of the risks and harm, these may vary from case to case. Examples include:-

- Contacts or referrals about the child / family.
- Strategy discussions / meetings and Child Protection Conferences.
- Non-accidental injury/ suspicious injuries/ significant injury/ visible injuries, even if justified by history but child is subject to a Child Protection Plan/ Different accounts of history of injury
- Neglect events e.g. child inappropriately dressed for time of year
- Attendance at A&E/Out of Hours/Minor Injury Units/Walk In Centres/NHS Direct and Hospital Admissions
- Change of GP/excessive use of health services
- Delay in seeking medical treatment/time of day in seeking medical treatment
- DNA/CAN -non attendance or frequent cancellation of appointments
- Loss of weight/excessive weight gain (against centile chart)
- Births, deaths, serious illness of both adults and children.
- House moves/deterioration in home conditions

- Changes in family composition, including new partners, separations, non-family members moving into family home, excessive visitors/frequent presence of unknown adults

- Criminal proceedings and outcomes/ civil proceedings involving family/ court proceedings/changes in legal status of child.

- Change in school, school attendance, school exclusions.

- Self referrals and any referrals to other health professionals/ agencies / teams and support offered to family/assessments undertaken.

- Reported incidents of domestic violence, substance misuse of carers.
- Child absconders / missing from home.

- Attempted suicide or overdose of child, young person or family member.

- Events showing capacity of family to work in partnership and engage with professionals.

- Any event in the child's life deemed to have a significant affect on them, such as separation from main carer leading to poor attachment.

6. Format for Recording Chronology (Using Template)

Date	The date of the episode or event.
Name	The individual(s) involved in the episode or event.
Source	The Agency or individual sharing the information.
Episode/ Event	The significant piece of information.
Outcome	Any action taken in response to the event or episode.

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APPENDIX 5B- Health Chronology Template

HEALTH CHRONOLOGY

Complied by
Name: **Profession:** **Date:**

DATE	NAME	SOURCE	EPISODE/EVENT	OUTCOME

APPENDIX 6A- Guidance Request for Court Reports

PRACTICE GUIDANCE – REQUEST FOR COURT REPORTS.

1. All requests for court reports/statements must be received in writing – if a verbal request is made to speed up the process in cases of emergency this must be followed up in writing.

2. The use of secure email (nhs.net) for requests may be used but Trust policy on transfer of patient identifiable data must be adhered to.

3. **Requests from the Local Authority Solicitor must include:**

- all names and any alias used by parents/carers.
- names of all children and dates of birth (inc alternative surnames if applicable)
- current and past addresses if applicable
- the LA solicitor must be specific about the information requested and for what purpose
- the period of time they wish the report to cover should be included i.e. the last 2 years
- Timescale for completing report needs to be identified.

4. A copy of all requests for reports will be sent to the Named Nurses via their nhs.net administration account. buc-tr.BHTchildprot@nhs.net.

- all requests for reports will be logged on a database and a tracking system maintained.
- if on receipt of the request the Named Nurse is aware the practitioner is no longer involved or in post they will liaise with the LA solicitor similarly if timescales can not be achieved, this may be due to a/l, sickness, or workload there may need to be negotiation however in some cases this may not be possible due to court schedules.

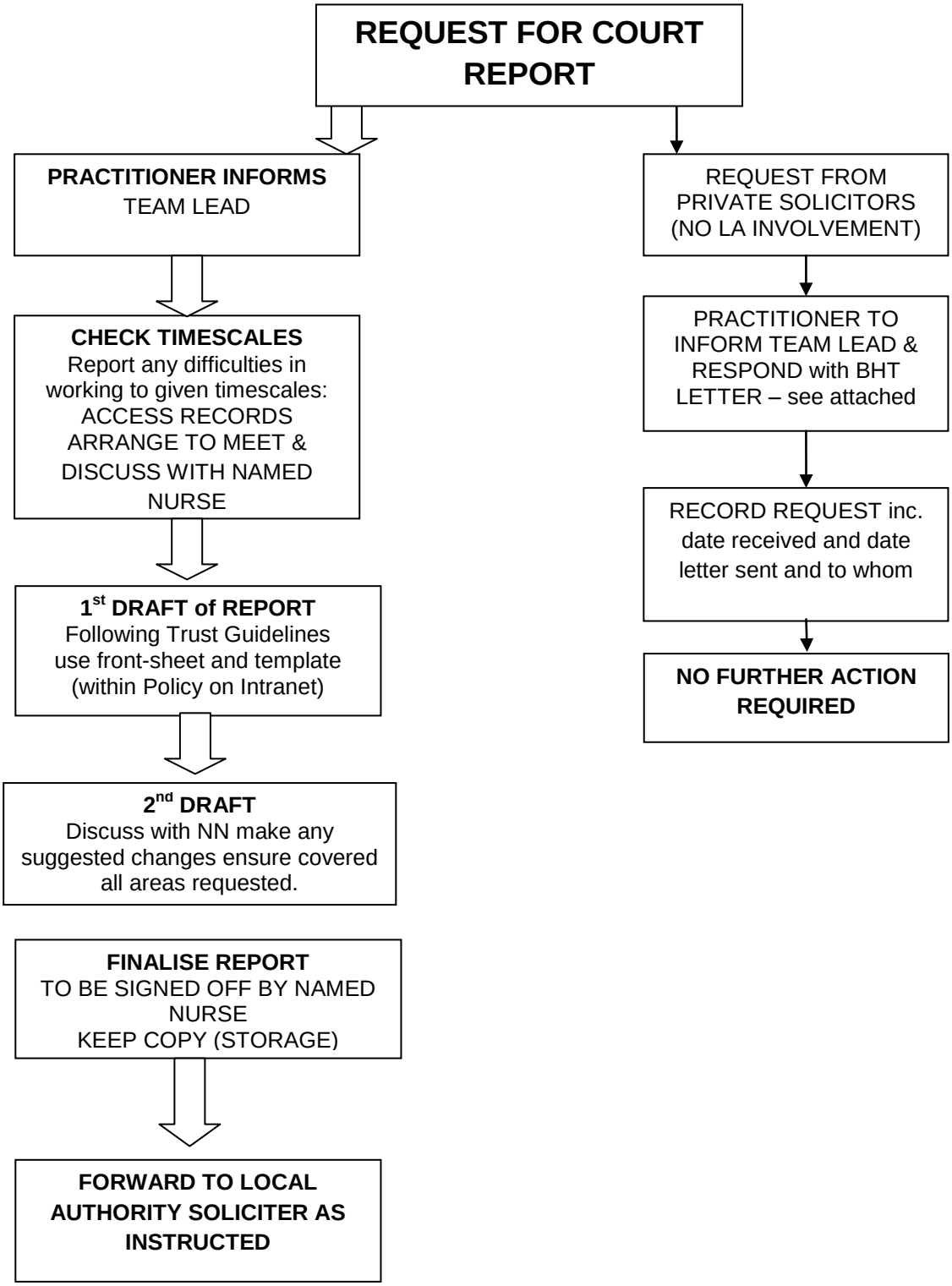
5. The practitioner will need to access records at the earliest opportunity in case of hospital records especially maternity, A&E cards these my be off-site and will need to be requested via the Office Manager in A&E.

6. **Meeting with the Named Nurse**.

- Meeting with the Named Nurse will give you the opportunity to discuss the case and to begin work on your first draft this is often the most difficult bit, “getting started” – make use of the guidance and template available and your time with the Named Nurse who will have had experience in producing reports and attending court and has regular discussions with the LA Solicitors as to what they are requiring.
- Once you have produced your first draft it is a good idea to share it with your Team Lead if changes are suggested consider these and once satisfied the report should be typed up using the template before sharing with the Named Nursesf1
- The front-page supplied by the LA should be completed including court number.
- Take a copy of the report for your records and arrange for a copy to be stored.
- A final copy is sent to the Named Nurse.

7. The report should be delivered by secure means ‘hand-delivery’ or recorded delivery. Record in the notes when this took place to whom it was sent/given and the date.

APPENDIX 6B- Flow Chart



ALL REQUESTS FOR RECORDS/NOTES MUST GO VIA THE MEDICAL LEGAL DEPARTMENT Stoke ext 5865 STAFF MUST NOT PHOTCOPY OR PROVIDE RECORDS UNDER ANY CIRCUMSTANCES

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APPENDIX 7 (alternative) Template Court Report

1	I am employed by……. I am currently based at……..
2	I am a registered ……RGN HV RM etc…….and have worked for Bucks for length of time…….
3	I make this statement form the HV nurse record which was recorded by me at the time in the child ……name's record.
4	I MET ……CHILD FOR THE FIRST TIME ETC **DATE TIME (IF YOU HAVE) AND PLACE** UNDERLINE EACH ENTRY AND PUT IN SEPARATE BOX AND NUMBER
5	**HISTORY**
6	**CHRONOLOGY OF SIGNIFICANT EVENTS**
7	

Appendix 8 - Local Areas social care contacts

Bedfordshire

North Bedford
Intake & Assessment and Family Support Team Children's Services (Open 8.45am – 5.20pm Monday to Thursday, 8.45am – 4.20pm Friday) **01234 223599**

Central Bedfordshire (including Luton)
Intake & Assessment and Family Support Team Children's Services (Open 8.45am – 5.20pm Monday to Thursday, 8.45am – 4.20pm Friday) **0300 300 8149**

South, West and Mid Beds (including Dunstable, Leighton Buzzard and Biggleswade)
Intake & Assessment and Family Support Team Children's Services (Open 8.45am – 5.20pm Monday to Thursday, 8.45am – 4.20pm Friday) **01582 818499**

Emergency Duty Team (Open 5.00pm – 9.00am Monday to Thursday, Weekends: 4.00pm on Friday to 9.00am Monday) **0870 238 5465**

Berkshire

West Berkshire
Referral and Assessment Team - **(01635) 503090**

Reading
Office hours - **0118 937 3641**
Emergency Duty Team - out of hours **01344 786 543**

Bracknell Forest
Office hours 8.30am to 5.00pm Mon-Fri - Tel: **01344 352020**
Emergency Duty Team (5.00pm - 9.00am Mon-Fri, 24 hrs on weekends and bank holidays) Tel: **01344 786543**

Windsor and Maidenhead
Referral and Assessment Team (8.45am to 5.15pm Monday to Thursday, 8.45am to 4.45pm Friday) - **01628 683150**
Out of Hours Emergency Duty Team (5.00pm to 9.00am and weekends) - **01344 786543**

Slough
Monday and Friday Office hours - **01753 690898** or **01753 875591**
Weekends and Out of Hours Service - **01344 786543**

Wokingham
Referral and Assessment Team: Monday and Friday Office hours - **0118 908 8002**
Out of office hours: **01344 786 543**

Hertfordshire

Children, Schools & Families (including out of hours): **0300 123 4043**

Milton Keynes

Referral and Assessment Team during office hours - **01908 253169/70**
Emergency Social Work Team; out of office hours - **01908 265545**.

Northamptonshire

Monday to Friday from 8:00am to 6:00pm - **0300 126** 1000
Secure email: cypsnccinitialcontact@northamptonshire.gcsx.gov.uk
Out of Hours Team phone **(01604) 626938**

Oxfordshire

Banbury Assessment Team: **01865 816670**
Oxford Assessment Team: **01865 323048**
Abingdon Assessment Team: **01865 897983**
Emergency Duty Team (outside office hours): **0800 833 408**

Hillingdon

Contact number: 01895 556644

Harrow

Duty and Assessment Team - Tel: **020 8901 2690**
Out of hours; weekends, bank holidays and between 5pm-9am weekdays - Tel: **020 8424 0999**

Appendix 9.

SECURE DELIVERY OF CLIENT CONFIDENTIAL INFORMATION

In order to ensure 'evidence' of safe delivery and receipt of client confidential information *(conference reports, social care referrals, court reports etc)* all staff should complete the form attached and file in the notes

Where possible if hand-delivering information it should be handed to the person it is intended for or somebody from the department who has been nominated to receive it on their behalf

If posting use the Royal Mail '**Recorded** Signed For' service, which offers proof of posting, online tracking and signature on **delivery**.

If reports etc are left at reception for collection please ensure the attached form is completed and filed in the notes.

In addressing envelopes/packages ensure the following:

- Name of person information intended for
- Job title or role if known
- Department
- Full address including post-code
- Mark envelope 'Private and Confidential'
- The envelope/package is securely sealed

Please ensure if 'hand-delivering' reports etc you complete the following and file in the notes with your copy.

Name of deliverer	
Content description *conference report, referral etc*	
Name of FAO intended recipient / destination	
Name of receiver	
Signature of receiver	
Date	
Time	