# SAFEGUARDING CHILDREN

## State whether the document is:
- Trust wide
- Business Group
- Local

## State Document Type:
- Standard Operating Procedure

### APPROVAL / VALIDATION
Quality and Governance Committee

### DATE OF APPROVAL / VALIDATION
October 2014

### INTRODUCTION DATE
October 2014

### DISTRIBUTION
Intranet, Team Brief and Trust Committees

### REVIEW
Original Issue Date
July 2013

Review Date (If appropriate)
October 2016

### CONSULTATION
Director of Nursing and Midwifery
Associate Director of Children and Families
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Quality Board
Child and Family Business Unit
Governance and Risk Manager
Service Managers Healthy Child Programme

### EQUALITY IMPACT ASSESSMENT
(Tick)
- Screening
- Initial
- Full

### RELATED APPROVED TRUST DOCUMENTS
Safeguarding Children Training Strategy
Safeguarding Children Supervision SOP

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### THIS DOCUMENT REPLACES
Safeguarding Children SOP

### Document Change History:

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**Stockport NHS Foundation Trust**
1. INTRODUCTION / PURPOSE OF THE DOCUMENT

Stockport Foundation Trust and all health care organisations have a duty under the Children Act (2004) to make arrangements to safeguard and promote the welfare of children. Stockport Foundation Trust is committed to promoting the welfare of children and to protecting them from the risks of harm. The Trust also recognises its responsibility to ensure that safe working systems are in place for staff working with children and families, and for staff working with adults who have caring responsibilities for children. This Standard Operating Procedure (SOP) applies to all children up to their 18th birthday whether the children are patients of Stockport Foundation Trust in their own right or children cared for by parents or guardians who are receiving services from Stockport Foundation Trust and applies to all children irrespective of ethnicity, religion or belief, disability, gender or sexual orientation. The fact that a child who at 16 could be living independently, in further education; a member of the armed forces, in hospital, in custody or in a secure setting will not change his or her status or any entitlement to safeguarding or protection under The Children Act 1989 and 2004.

The Care Quality Commissioners (CQC) describe the standards that all healthcare organisations must meet. Core Standard (C2) of their standards document states

‘Health care organisations protect children by following national child protection guidance within their own activities and in their dealings with other organisations.’

The Government published its high level national guidance document Working Together to Safeguard Children (2013) which replaces the 2010 version. The explicit message in this guidance is that children are best protected when professionals are clear about what is required of them individually, and how they need to work together. Extensive research and enquiries into child deaths (CQC 2009; Laming 2009 and Ofsted 2010) has consistently underlined the damage that occurs to children from delaying intervention. The actions taken by professionals to meet the needs of vulnerable children as early as possible therefore become crucial.

2. STATEMENT OF INTENT / SCOPE OF THE DOCUMENT

This SOP applies to all those working in Stockport Foundation Trust, in whatever capacity. A failure to follow the requirements of the policy may result in investigation and management action being taken as considered appropriate. This may include formal action in line with the Trust's disciplinary or capability procedures for Trust employees; and other action in relation to other workers, which may result in the termination of an assignment, placement, secondment or honorary arrangement. This SOP also provides guidance to independent contractor services in determining their responsibilities to safeguarding and promoting the welfare of children.

The SOP is intended to be operational across the Trust including Tameside community services; some specific processes will vary; the only appendices which apply to Tameside staff are 1, 3b, 4 & 7.

3. SUMMARY OF THE DOCUMENT

Child Protection work and working with vulnerable children inevitably raises anxieties in a workforce. This SOP is to help practitioners to deal with these difficult situations. It is not however a substitute for professional practice and should be read in conjunction with the Greater Manchester safeguarding children policies accessed at:

www.safeguardingchildreninstockport.org.uk
www.tamesidesafeguardingchildren.org.uk
www.derbyshirescb.org.uk

The welfare of the child should be the paramount consideration for all workers (Children’s Act 1989 and 2004). This SOP applies to:

- All children under 18 years of age who live in Stockport, Tameside or Glossop including those with diverse needs
• A child living in Stockport, Tameside or Glossop whose permanent address is outside the authority
• A child at school in Stockport, Tameside or Glossop whose permanent address is outside the authority
• Children looked after by the local authority or placed in Stockport, Tameside or Glossop by another local authority

4. DEFINITIONS

Working Together (2013) changed the definition of safeguarding and promoting the welfare of children to:
• Protection children from maltreatment
• Preventing impairment of children’s health or development
• Ensuring children grow up in circumstances consistent with the provision of safe and effective care
• Taking advice and action to enable all children to have the best outcomes

(see appendix 1 for definitions of abuse)

5. ROLES & RESPONSIBILITIES

Accountability for Safeguarding across the Stockport Foundation Trust

In order to fulfil their commitment to safeguard and promote the welfare of children and young people, all organisations that provide services for children, parents or families or who work with children should have a clear line of accountability and governance within and across organisations. Stockport Foundation Trust’s is listed below.

Chief Executive – Holds Trust accountability and delegates safeguarding responsibility to an executive lead within the Trust.

Director of Nursing and Midwifery - Delegated overall responsibility for ensuring robust safeguarding systems and processes are in place to safeguard children within the Trust. This is achieved by working with the Named Nurses to ensure there are Stockport Foundation Trust internal policies and procedures in place that reflect the Stockport Safeguarding Children Board (SSCB), Tameside Safeguarding Children Board (TSCB) and Derbyshire Safeguarding Children Board (DSCB) policies and national guidance; a training strategy that identifies the level of training required by each service area; clinical and non-clinical, and mechanisms for supervision and support to front-line clinicians managing Children in Need at level 3 and 4.

Associate Directors – are responsible for ensuring that safeguarding children is embedded into practice within their integrated business units

Named Professionals - Stockport Foundation Trust has identified a named doctor and 2 named nurses whose roles focus on safeguarding children arrangements in the organisation. The Named Doctors ensure safeguarding children is embedded into practice and play an important role as a professional resource for the organisation including General Practitioners and their staff.

Named Nurse - The Named Nurse has a key role in promoting good professional practice within Stockport Foundation Trust. The Named Nurse is responsible for undertaking safeguarding children audits and working closely with the Designated Nurse for Safeguarding Children who sits in the Clinical Commissioning Group (CCG) to ensure safeguarding issues are embedded into the organisation’s clinical governance frameworks. She sets the strategies for safeguarding children training and supervision and is responsible for reviewing/updating the single agency safeguarding children policy. Their role is to also provide assurance to the commissioners; producing reports/undertaking investigations for Serious Case Reviews/Domestic Violence Homicide Reviews where children are involved and other reviews of practice. There are currently 2 named nurses; one
for the Community Healthcare Services Business Group and one covering community acute Stockport health services.

Named Midwife for Child Protection - The Named Midwife is the professional lead on safeguarding within maternity. She has a key role in supporting midwives to fulfil their safeguarding responsibilities by facilitating training and safeguarding supervision sessions to all midwives. She takes the lead in care planning for high risk vulnerable families including high risk domestic abuse cases, child protection cases, women with a severe mental illness and women working with the community drug and alcohol services. She promotes multi-agency working by ensuring maternity representation at MARAC, child protection conferences/core groups, social care strategy/legal planning meetings (where appropriate) etc. She has a key role to promote the local safeguarding policies and procedures, particularly the Common Assessment Framework (CAF) and Team Around the Child (TAC) processes to ensure good multi-agency working and early intervention is achieved. She continually reviews the service provided and adapts policies and guidelines to meet the needs of women and their families and the national safeguarding agenda.

Line Managers - are responsible for identifying the levels of specific safeguarding children training their staff require including refresher training; ensure that staff attend the appropriate training and maintain accurate records of who has attended each level. Children are best protected when professionals are clear about what is required of them individually and how they need to work together. Children want to be respected, their views to be heard and taken seriously and to have stable relationships with professionals which are built on trust.

Individual Practitioners - safeguarding children is everyone’s responsibility and all concerns about the welfare of children must be acted upon. This applies to all staff that come into contact with children. Where children are transferring between caseloads, there needs to be a clear documented handover of any concerns to the new practitioner; identifying the lead practitioner or social worker as appropriate and highlighting outstanding health needs. All health professionals who work with children, young people and families have specific responsibilities and should be able to:

- understand risk factors and recognise children and young people 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 using the CAF(common assessment framework) to access support as appropriate for them
- recognise the risks of abuse or neglect to an unborn child
- communicate effectively with children and young people and stay focused on the child’s safety and welfare
- liaise closely with other agencies, including other health professionals, and share information as appropriate
- assess the needs of the 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 families, particularly those who are vulnerable
- contribute to child protection conferences, family group conferences and strategy discussions
- contribute to planning and commissioning support for children who are suffering, or likely to suffer from significant harm, for example children living in households with domestic violence or parental substance misuse
- be alert to the strong links between adult domestic violence and substance misuse and child abuse and recognise when a child is in need of help, services or at potential risk of suffering significant harm
- where appropriate, play an active part, through the child protection plan, in keeping the child safe
- as part of generally safeguarding children and young people, provide ongoing promotional and preventative support, through proactive work with children, families and expectant parents.
Designated Professionals - The terms "designated" and "named professionals" refers to professionals with specific roles and responsibilities for safeguarding children. The Designated Nurse and Designated Doctor take the strategic lead on all aspects of the health service contribution to safeguarding children health economy which includes all providers. They provide support and supervision to the named professionals and sit within the respective CCG.

Specialist Nurses Safeguarding Children - The specialist nurses provide specialist knowledge, advice and expert practice to health professionals. On a day to day basis they provide formal, structured child protection/child in need supervision and undertake audits around safeguarding children practice. They provide training to Stockport Foundation Trust staff as part of the Training Strategy. The specialist nurses for safeguarding children act as the health representative at MARAC (Multiagency Risk assessment conference for high risk domestic abuse cases) and MASE (Multiagency Sexual Exploitation).

Specialist Nurses for Looked after Children - provides support to professional colleagues and carers to encourage the take up and delivery of health care for Looked after Children. The role includes leading and developing a service which provides a dedicated health resource to address the health needs of children and young people who are looked after by Stockport, Tameside or Derbyshire Local Authorities, and young people who are living in Stockport, Tameside or Glossop who are looked after by other Local Authorities. An integral component of this role is to manage a caseload of young people aged 16-18 years and providing targeted clinical work with Looked after Children not met by existing services.

The Paediatric Liaison Nurse based at Stepping Hill Hospital for Stockport services is a member of the Vulnerable Children Team. The direct telephone number is 0161 419 2122.

The Paediatric Liaison Officer for the Community Healthcare Business Group (Tameside and Glossop Services) is based at Tameside Hospital. The director telephone number is 0161 922 4837.

The role is to ensure information regarding children who have accessed hospital services is shared with health visitors and school nurses. This includes all known child protection and safeguarding matters.

The liaison nurse is copied in to all child protection medical letters and ensures that the relevant practitioner receives this information for the child’s notes.

Accident and Emergency Staff and Staff on the inpatient wards (Stepping Hill Hospital only)- "Cause for Concern" forms are generated by the Accident and Emergency Department and the wards/outpatients departments at Stepping Hill Hospital to the paediatric liaison nurse and specialist nurse for child protection in order to highlight professional concerns/safeguarding issues. The concern may relate to a child about who there are safeguarding concerns. It may also relate to concerns about an adult who has accessed services and who is known to have children. The hospital staff may have assessed that the presentation of the adult will impact on their ability to care for the child and that the child is at risk of significant harm.

Good practice is that the professional completing the cause for concern form informs the parent if the cause for concern is about the child. The adult should also be informed if the cause for concern is about issues involving the adult. If the information indicates immediate concerns for a child’s welfare, the cause for concern form will be sent by the hospital staff directly to children's social care as a referral with a clear rationale documented about why adult information has been shared where appropriate. (See appendix 2)

Caldicott Guardian - A Caldicott Guardian is a senior person responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information sharing. The Stockport NHS Foundation Trust guardian is the Director of Nursing and Midwifery and should be consulted when there are concerns about the nature of any information to be shared. Practitioners could consult their line managers or a specialist nurse for safeguarding children. A
record of any information sharing decisions and reasons for them should be made – whether it is to share information or not. If a decision is made to share, then a record should be made of what has been shared, with whom and for what purpose.

6. THE STANDARD OPERATING PROCEDURE

All practitioners should discuss the concerns where possible with their manager or the specialist nurses within the safeguarding children team. This should help to decide if the concerns will warrant further action. However, if the concerns are about child protection, and it is considered that the child may be at risk of significant harm the absence of a manager must not delay contact with Children’s Social Care.

For Stockport services:

If the concerns are serious or urgent, child protection referrals must be made initially by telephone to the duty social worker via Children’s Services Contact Centre (0161 217 6028). A written referral will be required using the Common Assessment Framework (CAF) within 24 hours. Whilst a CAF is fundamentally used as the assessment tool to identify additional needs within a family, in Stockport it is used as a written child protection referral where necessary; the box stating that it is such should be ticked on the back of the CAF prior to sending into children’s’ social care.

When children's social care receive a referral, the initial consideration of this information will determine whether the referral should be responded to as a child in need of support (Children’s Act 1989, Section 17) or as a child in need of protection (Children’s Act 1989, Section 47). If not of urgent concern after the duty social care team have reviewed the case it will be screened through the Council’s Supporting Families pathway and potentially allocated within the Early Help team to assess which service is best placed to continue to support the family. The most appropriate service could be health.

Whilst it is good practice to have the CAF signed by the parent/carer, there will be occasions where the child would be at more risk of significant harm or the referrer’s safety would be compromised when asking for a signature. On these occasions, the CAF would be sent in to children’s services, detailing the concerns and explaining the reason for not obtaining the signature.

Where a child is presenting with an injury and there are concerns that this is non-accidental in nature then a paediatrician must be asked to undertake a child protection medical examination; this would also apply to a child who is 16-18 years old. Where non-accidental injury is suspected and further investigations are being undertaken the child should be kept in hospital overnight as a minimum.

If the referral or query is in relation to a child or unborn child you are already working with in the CAF/TAC process you will be asked to forward the relevant assessment plan. Where health are the lead professional in the TAC process then any minutes should be sent to the relevant GP.

Where there are concerns around parents/carer/s sexually abusing a child or young person or where there are concerns around fabricated/induced illness, the parent/carer would not be informed of the initial referral.

The latest Common Assessment Form (CAF) can be downloaded from the Stockport Council website at [www.stockport.gov.uk/caf](http://www.stockport.gov.uk/caf). This site will also cover all the necessary detail staff require in order to complete a CAF and explore how the Team around the Child (TAC) process works in practice. Support for staff around this work is also available through safeguarding supervision or consultation with the safeguarding team.

Contact with Children’s Services can be made by telephone to the Customer Enquiry Referral Management Team based at Fred Perry House 217 6028. The calls are answered by a customer care officer and practitioners can ask to speak to the duty social worker to discuss the concern in more detail. Their fax number is 476 3504 if a request is made to fax over information for the attention of a social worker. Their secure e-mail address is
contactcentre.cyp@stockport.gcsx.gov.uk. A referrer should always check to see if their information regarding a child protection referral they are making has been received by children’s social care.

Social Care Out of hours (after 5pm until 8.30am Mon-Thursday, after 4.30pm Fridays, all day Saturday and Sunday) contact number is 0161 718 2118.
Advice can also be obtained from the Duty Reviewing Officer (8.30am-5pm Monday to Friday) at the Safeguarding Children Unit on 0161 474 5657
    Police: 0161 872 5050
    Child Protection Police Unit: 856 9931

Children out of school
When a practitioner becomes aware of a child being educated at home then checks should be made with School Services; a register is maintained for this cohort of children and an initial home visit is arranged; notifications should be made to School Services on 0161 474 3842

For Tameside and Glossop services:
If the concerns are serious or urgent, child protection referrals must be made initially by telephone to the duty social worker via Children’s Social Care HUB on:
Tel. no: 0161 342 4206 / 4187 / 4008 or 4210
Out of hours contact tel. no.: 0161 342 2222
A written referral will be required using the Multi-Agency Referral Form within 24 hours. If a CAF has been completed this information can be used to support the referral.

When Children’s Social Care receives a referral, the initial consideration of this information will determine whether the referral should be responded to as a child in need of support (Children Act 1989, section 17) or as a child in need of protection (Children Act 1989, section 47).

Where there are concerns around parents / carers sexually abusing a child or young person or where there are concerns around fabricated / induced illness, the parent / carer would not be informed of the initial referral.

Support for staff around this work is available through safeguarding supervision or consultation with the safeguarding team.

Contact with Children’s Services can be made via the HUB on:
Tel. no.: 0161 342 4206 / 4187 / 4008 or 4210
Out of hours contact tel. no.: 0161 342 2222
Advice can also be obtained from the reviewing officer at the Safeguarding Children Unit:
Tel. no.: 0161 342 4343
Or Police via the PPIU:
Tel. no.: 856 9314

7. RECORD KEEPING

The need for excellent, high quality standards of record-keeping when working with families of concern becomes apparent when notes/chronologies are required to write reports for court/police statements/serious case reviews and domestic abuse homicide reviews. It becomes difficult to provide adequate evidence to demonstrate the journey of a child through health services where records are inaccurate/incomplete/ambiguous or unclear.

All record keeping should be compliant with the Trust’s organisation wide record-keeping policy. Professional groups should also be aware of their professional codes of conduct in relation to record keeping.

- All practitioners must maintain an accurate, clear record of their involvement with the child/family.
• Entries should have a clear structure, be succinct and indicate accurately the nature of the contact. The entry should also indicate where the contact took place and who was seen at the contact.

• Entries should be written in black ink and should be legible, dated, time of contact and signed, designation and name should be written in block letters at the first entry in the notes.

• If joint contacts within health both professionals should sign. Blank lines should not be left at the end of an entry and a single line should be drawn at the end of the entry.

• Where possible the use of abbreviations should be avoided if used they should be compliant to their service agreed glossary.

• Records should not contain information relating to third parties unless it has a direct impact on the child, young person or family member to whom the record relates.

• The child’s records should not refer in detail to the activity another agency has completed (for example a children’s therapist would not write up the details of a social worker’s visit to a family if he/she had not been there).

• A record of dates and times of communications and agreed actions with other professionals should be made in the body of the record. This includes face-to-face discussions, telephone conversations, e-mails and written materials.

• All correspondences should be dated and signed when received and any actions documented in the body of the record in chronological order.

• Pages should be numbered in chronological order.

• All elements of the record including letters, investigations, and results must be secured in the records in chronological order.

• A simple chronology/significant event sheet or patient summary should be filed in the front of the notes relating to the service’s involvement with the child and family.

• All staff should distinguish between observation, what the practitioner has been told, and what actions have been agreed and by whom and include a review date.

• All details of household members and both parents should be recorded even if not in the household.

• The details of who brought a child into hospital and where appropriate who stayed with the child during an inpatient admission should be clearly recorded.

• Once written the records should not be altered. However if the record is inaccurate, misleading or misreported a separate note should be made to this effect (i.e. written in wrong notes, incorrect date). The incorrect entry should be crossed out using a single line, the date and time the alteration was made should be recorded and dated. The deleted entry should remain legible. Correction fluid or self adhesive labels should not be used to alter a record.

**Record-Keeping Guidelines Related To Safeguarding / Child Protection**

• Any injuries should be systematically recorded including diagrams if appropriate. Explanation should be recorded with verbatim comment and any other relevant information. If there is another practitioner present when there has been a disclosure by a child/young person or when injuries have been noticed, the name and status of the witness should be recorded in the notes.

• The chronology should briefly state such issues as A&E attendance, hospital admissions, domestic abuse incidents, failed appointments, episodes of inappropriate parenting and referrals to other agencies. This would also include any concerns about an adult which could not be included in the child’s record.

• Attendance at Case Conferences/Core Groups/Statutory Reviews/Team around the Child (TAC) meetings should be recorded; this should include the agreed action to be undertaken by practitioner’s service, indicating the purpose of that action and intended outcomes.

• All minutes of case conferences core groups TAC meeting should be filed separately within the record.
Failure to comply with record-keeping principles is taken seriously and reported using the on-line incident reporting procedure. Serious breaches will be considered with the practitioner’s line manager and will evoke disciplinary action if necessary.

8. SAFEGUARDING CHILDREN “CAUSE FOR CONCERN” NOTIFICATION

(see also Appendix 2)

Any safeguarding concerns relating to a child or young person must be documented on a “Cause for Concern” form. This will also include concerns relating to the adult’s behaviour /ill health which could impact on the child they are caring for. These are available in all paediatric and ED areas and can be accessed on the Safeguarding Children Microsite. They may be completed by any member of staff in the hospital who has concerns about a child or an adult they are caring for who is a parent/carer.

Wherever possible, parents should be informed of the ‘Cause for Concern’ notification as should adults if it relates to them.

The form should be faxed to the hospital based safeguarding nurse and the original filed in the Child’s notes. If it is regarding an urgent child protection concern, the referring professional must telephone Social Care Tel: 0161 217 6028 or Out of Hours Tel: 0161 718 2118 to make a verbal referral – this must be documented in the medical notes and a Cause for Concern form faxed at their request. This should be followed up within 48 hours by a written referral as stated in Stockport SSCB safeguarding policy which can be accessed at www.safeguardingchildreninstockport.org.uk. The referrer should also make the relevant checks to ensure that children’s social care have received the referral.

9. SAFEGUARDING CHILDREN IN SPECIFIC CIRCUMSTANCES

On the 1st March 2013 Stockport and Tameside Safeguarding Children Boards amalgamated with the Greater Manchester Safeguarding Partnership to have a shared set of policies.

These Greater Manchester Safeguarding Procedures have been developed and implemented through the co-ordination of the Greater Manchester Safeguarding Partnership working with a company named Tri.x. All Stockport policies are accessed through the website: safeguardingchildreninstockport.org.uk and searching using the contents page. There are a number of core policies which are key to safeguarding children including prebirth assessments for the unborn baby and then a number of policies relating to children in specific circumstances. They are updated in line with emerging policy, statutory guidance and local learning therefore policies should not be printed and stored for future reference.

Derbyshire Safeguarding Children Board have their own Multi-Agency Policies and Procedures which are also managed by tri x and can be accessed via the DSCB website.

10. LOOKED AFTER CHILDREN (see appendix 3 for practice guidance)

It is recognised that children in care have significantly higher levels of health needs and often do not have their health needs met. The Department of Health (2009) documents that 45% of Looked after Children (LAC) has been assessed as having a mental health disorder; two thirds have at least one physical complaint. On leaving care these young people are more likely to experience poor health, educational and social outcomes.

Stockport and Tameside have a high number of children placed within Stockport and Tameside from other local authorities. It is essential that there is timely and effective transfer of information and of child health records. If staff become aware that a looked after child is placed in Stockport, Tameside or Glossop and / or is attending a Stockport, Tameside or Glossop school, they should
communicate with the Stockport Community Looked after Children Team on 0161 426 9724 or the Tameside Safeguarding Team tel. no.: 0161 335 2984.

Stockport Foundation Trust’s health professionals have specific roles in promoting the health of looked after children and young people. There is a statutory requirement that all children who are in care will be offered a health assessment annually or bi-annually if they are under 5.

All initial health assessments are completed by a paediatrician. The child’s health records are requested from the health practitioner for this assessment and are returned along with a copy of the completed health assessment and plan.

Review health assessments are requested by the social worker within the placing Local Authority. Once a request is received, the LAC team will send the request along with the BAAF (British Association for Adoption and Fostering) form to the lead practitioner for completion. The review assessment should be completed within 4 weeks and returned to the LAC health team.

The notes of Looked after Children and those in pre-adoptive placements must stay together and are not to be separated from existing family notes. A new set of notes is only generated by child health when a child is given a full adoption order. The notes from the pre-adoptive period are stored in child health. For Tameside & Glossop the pre adoptive period is stored in child health.

Any child who is looked after at home with their parents should remain open to safeguarding supervision as these children remain vulnerable. Any child or young person who is in care but whose behaviour is high risk resulting in safeguarding issues should also remain open to supervision.

Health practitioners can access the Looked after Children’s Team for information and advise on 0161 426 9724 (Stockport) and 0161 335 2984 (Tameside and Glossop).

11. MANAGING ALLEGATIONS AGAINST INDIVIDUALS WORKING WITH CHILDREN

In addition to safer recruitment practices, the Foundation Trust has a responsibility to ensure procedures are in place to deal with any allegations against any staff working with children and young people. Guidance related to “Allegations Management” is outlined in “Working Together to Safeguard Children” (2013, Chapter 6). This guidance should be followed in respect of any allegation that a person who works with children has:

- Behaved in a way that has harmed a child, or may have harmed a child;
- Possibly committed a criminal offences 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.

These can be in connection with a person’s employment or voluntary activity or in regard to their own children and family.

A summary of this guidance and training is available for all managers within the Trust via the “Safeguarding children” microsite or the SSCB website (www.safeguardingchildren instockport.org.uk) Advice can also be sought from the Safeguarding team or HR lead for allegations management.

12. DOMESTIC ABUSE/VIOLENCE

The Government (2013) defines domestic violence as:

The cross-government definition of domestic violence and abuse is:
any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to;

- psychological
- physical
- sexual
- financial
- emotional

**Controlling behaviour**

Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

**Coercive behaviour**

Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

This is not a legal definition.

It does however includes issues of concern to black and minority ethnic (BME) communities such as so called 'honour based violence', female genital mutilation (FGM) and forced marriage.

An adult is defined as any person aged 18 years or over. Family members are defined as mother, father, son, daughter, brother, sister, and grandparents, whether directly related, in laws or stepfamily.

Prolonged and/or regular exposure to domestic abuse can have a serious impact on a child's development and emotional well being, despite the best efforts of the victim parent to protect the child. Domestic abuse has an impact in a number of ways. It can pose a threat to an unborn child, because assaults on pregnant women frequently involve punches or kicks directed at the abdomen, risking injury to both mother and foetus. Older children may also suffer blows during episodes of violence. Children may be greatly distressed by witnessing the physical and emotional suffering of a parent. Both the physical assaults and psychological abuse suffered by adult victims who experience domestic abuse can have a negative impact their ability to look after their children. The negative impact of domestic abuse is exacerbated when the abuse is combined with alcohol or drug misuse; children witness the abuse; children are drawn into the abuse or are pressurised into concealing the assaults. Children’s exposure to parental conflict, even where violence is not present, can lead to serious anxiety and distress among children. Appendix 4 details the suggested responses required from the school nursing services on receipt of the referral they receive from the police. A standalone domestic abuse policy (including adult and children’s services) hosted on the safeguarding microsite is to be used alongside this brief guidance and includes the recognition and response to domestic abuse by all members of staff.

13. PRIVATE FOSTERING

Private Fostering is a private agreement between a parent and another adult, who is not a close family member (i.e. brother, sister, grandparent, uncles or aunts, step-parent - care by this list of adults would not be deemed a private fostering arrangement) to care for a child or young person for 28 days or more in their home. It applies to children under 16 or under 18 if the young person is disabled.
Private fostering is arranged and agreed by a child’s parents and the person or family who will be caring for the child. The other adult has no parental responsibility for the child.

Any person who becomes aware of a private fostering arrangement has a legal obligation to inform children’s social care who will undertake an assessment to ensure the child is being cared for adequately.

See [www.privatefostering.org.uk](http://www.privatefostering.org.uk) for further information.

14. GUIDANCE FOR WORKING WITH SEXUALLY ACTIVE YOUNG PEOPLE UNDER THE AGE OF 18 YEARS

There is a comprehensive GM tri-x process entitled Working with Sexually active young people under the age of 18 accessed at [www.safeguardingchildreninstockport.org.uk](http://www.safeguardingchildreninstockport.org.uk). (4.36) Staff working with young people should familiarize themselves with this information. The guideline highlights that practitioners working with young people will wish to provide a safe, accessible and confidential service whilst remaining aware of their duty to safeguard them and promote their well-being.

Whist the legal age of sexual consent is 16, it is well recognized that some young people become sexually active before this age. All known sexual activity involving young people under the age of 16 should be taken seriously by agencies involved to promote sexual health and crucially to ensure that a young person is not being abused or exploited.

There is a risk assessment proforma to use with young people under 18 years old presenting to a service who report to be sexually active or who intend to be sexually active. (See appendix 5 and 6). This tool must be used to inform an assessment for all young people under 13 and for young people under 18 accessing health services about whom the practitioner has concerns. Sexual health services use a full assessment tool for all children and adults presenting to their services which incorporates the Bichard questions.

Other practitioners outside the sexual health services (for example school nurses), must use the tool with all young people under 18 presenting as being engaged in or considering a sexual relationship. Concerns may be around the nature of a relationship including an age difference, power imbalance and coercion. (The tool is based on the recommendations from the Bichard 2004 report into the events leading up to the deaths of Jessica Chapman and Holly Wells).The tool is used in conjunction with Fraser guidelines, also previously known as the Gillick competency test. These are used to ensure that young people under 18, are fully able to understand what is proposed and it implications and are competent to consent to medical treatment regardless of age - Fraser guidelines are explored in more detail in the multiagency policy.

A child under 13 is not legally capable of consenting to sexual activity (Sexual Offences Act 2003). Under this act, penetrative sex with a child under 13 including oral and anal sex is classed as rape. There would always be reasonable cause to suspect that a child, whether a girl or a boy, is suffering or is likely to suffer significant harm if engaging in sexual activity below the age of 13. There is a presumption that a discussion with children’s social care will take place and then if necessary a strategy discussion held to discuss appropriate next steps (Working Together 2010 sec 5.27). Whilst this discussion may initially anonymise the child, practitioners will be asked to identify themselves to children’s social care. If a decision is made not to refer/discuss with children’s social care, the practitioner’s records must identify clearly why the decision has been made not to share.

All cases involving children under 13 and indeed any child under 18 years old about whom there is concern should always be discussed with the practitioner’s line manager and with the Named Nurse or a Specialist Nurse from the Vulnerable Children Unit. It must be considered that information held on the child/young person is likely to be incomplete. Information may be missing about the experience of the child if a decision is made not to consult with other agencies.

15. MULTIAGENCY SEXUAL EXPLOITATION PROCESS (MASE)
Sexual exploitation of children and young people is a hidden form of child abuse. However, over recent years there has been increasing awareness about the extent and scale of children who have been sexually exploited.

The primary concern of anyone who comes into contact with a child or young person who is vulnerable to being sexually exploited must be to safeguard and promote the welfare of that child. All professionals who work with children and young people should be alert to signs of possible abuse or neglect including sexual exploitation.

Stockport services:

The full multiagency policy can be read at www.safeguardingchildreninstockport.org.uk Chapter 10.22 Child Sexual Exploitation Procedure. This details the work of the multiagency forum which has been in place since October 2012; health are represented to inform the risk assessment around these vulnerable children is sought from a range of health partners; CAMHS/Mosaic/Sexual Health Services/Acute Health/School Nursing. Where practitioners have concerns around possible sexual exploitation, the first point of contact is through the MASE co-ordinator on 474 5657. This discussion will establish whether any other agency has raised concerns and decide on how to refer in to social care for assessment on a CAF- signed or unsigned to request an initial assessment. Practitioners must ensure that they have shared their own risk assessments for the MASE process to be most effective (see appendix 6 for an example).

Child sexual exploitation is not under age peer sexual relationships and in the event of two children under the age of 13 years being involved in a sexual relationship; this would be discussed with children’s social care.

Tameside services:

In Tameside the Phoenix Team are co-located at Ashton Police Station. The team has been set up to safeguarding young people at risk of CSE and address any CSE in the Borough. The team link with partner agencies, including health professionals involved in safeguarding these young people. The team can be contacted by e-mail: childsexualexploitation@gmp.police.uk or by phone: tel. no. 0161 856 5880 / 9218.

Derbyshire CSE Policies and Procedures are available at www.derbyshirescb.org.uk.

16. IMPLEMENTATION

The Trust Safeguarding Committee will monitor the overall implementation and effectiveness of the policy

- The SOP will be approved at Patient Experience and Workforce Assurance Committee.
- The Director of Nursing and Midwifery will disseminate to Heads of Nursing and Assistant Directors.
- Heads of Nursing/Service Managers and Assistant Directors will disseminate and obtain signatures on receipt.
- The SOP will be published on the intranet / Children’s Safeguarding Microsite.

The SOP will be discussed and reviewed where necessary at monthly operational safeguarding meetings.

17. MONITORING
Policy authors must outline how the implementation of the policy will be monitored i.e. through audit review of incidents etc. This must also include the frequency of arrangements and the reporting of the results and actions as outlined in the “SOP on policy, standard operating procedure, guidelines and protocol development”.

**Monitoring template for Trust Approved Documents**

<table>
<thead>
<tr>
<th>Process for monitoring e.g. audit</th>
<th>Responsible individual/group/committee</th>
<th>Frequency of monitoring</th>
<th>Responsible individual/group/committee for review of results</th>
<th>Responsible individual/group/committee for development of action plan</th>
<th>Responsible individual/group/committee for monitoring of action plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal Monitoring</td>
<td>Line Managers and Governance Leads</td>
<td>Monthly</td>
<td>Patient Experience and Workforce Assurance Committee</td>
<td>Department Manager and Governance Lead</td>
<td>Departmental Manager and Governance Leads</td>
</tr>
<tr>
<td>Checking that all staff are aware of the SOP and the messages are embedded in practice</td>
<td>Named Nurse</td>
<td></td>
<td>Operational Safeguarding Meeting Named Nurses</td>
<td>Named Nurses</td>
<td>Named Nurses</td>
</tr>
</tbody>
</table>

If you would like this document in a different format, e.g. in large print, or on audiotape, or for people with learning disabilities, please contact PCS.

Your local contact for more information is Patient and Customer Services at Poplar Suite, SHH, Tel: 0161 419 5678 or [www.stockport.nhs.uk](http://www.stockport.nhs.uk)
REFERENCES


## Glossary

### Children
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 or in custody in the secure estate, does not change his/her status or entitlements to services or protection.

### Safeguarding & promoting the welfare of children
Defined for the purposes of this guidance as:
- protecting children from maltreatment;
- preventing impairment of children's health or development;
- ensuring that children are growing up in circumstances consistent with the provision of safe and effective care; and
- taking action to enable all children to have the best life chances.

### Child protection
Part of safeguarding and promoting welfare. This refers to the activity that is undertaken to protect specific children who are suffering, or are likely to suffer, significant harm.

### Abuse
A form 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 others (e.g. via the internet). They may be abused by an adult or adults, or another child or children.

### Physical abuse
A form of abuse which 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.

### Emotional abuse
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 a child 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 a 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.
| **Sexual Exploitation** | Sexual exploitation of children and young people under 18 involves exploitative situations, contexts and relationships where young people (or a third person or persons) receive 'something' (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of them performing, and/or another or others performing on them, sexual activities. Child sexual exploitation can occur through the use of technology without the child's immediate recognition; for example being persuaded to post sexual images on the internet/mobile phones without immediate payment or gain. In all cases, those exploiting the child/young person have power over them by virtue of their age, gender, intellect, physical strength and/or economic or other resources. Violence, coercion and intimidation are common, involvement in exploitative relationships being characterised in the main by the child or young person’s limited availability of choice resulting from their social/economic and/or emotional vulnerability. |
| **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. |
| **Neglect** | 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. |
### Significant Harm

Some children are in need because they are suffering, or likely to suffer, significant harm. The Children’s Act 1989 introduced the concept of significant harm as the threshold that justifies compulsory intervention in family life in the best interests of children, and gives local authorities a duty to make enquiries to decide whether they should take action to safeguard or promote the welfare of a child who is suffering, or likely to suffer, significant harm.

A court may make a care order (committing the child to the care of the local authority) or supervision order (putting the child under the supervision of a social worker or a probation officer) in respect of a child if it is satisfied that:

- The child is suffering, or is likely to suffer, significant harm; and
- The harm, or likelihood of harm, is attributable to a lack of adequate parental care or control (section 31).

There are no absolute criteria on which to rely on when judging what constitutes significant harm, consideration of the severity of ill-treatment may include the degree and the extent of physical harm, the duration and frequency of abuse and neglect, the extent of premediation, and the presence of degree of threat, coercion, sadism and bizarre or unusual elements. Each of these elements has been associated with more severe effects on the child, and or relatively greater difficulty helping the child overcome the adverse impact of the maltreatment. Sometimes a single traumatic event may constitute significant harm, for example a violent assault, suffocation or poisoning. More often, significant harm is a compilation of significant events, both acute and long standing, which interrupt, change or damage the child’s physiological development. Some children live in family and social circumstances where their health and development are neglected. For them it is the corrosiveness of long term emotional, physical or sexual abuse that causes impairment to the extent of constituting significant harm. In each case it is necessary to consider any maltreatment alongside the child’s own assessment of his or her safety and welfare, the family’s strengths and support, as well as an assessment of the likelihood and capacity for change and improvements in parenting and the care of children and young people.

To understand and identify significant harm, it is necessary to consider:

- The nature of harm, in terms of maltreatment or failure to provide adequate care;
- The impact on the child’s health and development;
- The child’s development within the context of their family and wider environment;
- Any special needs, such as medical condition, communication impairment or disability, that may affect the child’s development and care within the family;
- The capacity of parents to meet adequately the child’s needs; and
- The wider and environmental family context.
The child’s reactions, his or her perceptions, and wishes and feelings should be ascertained and the local authority should give them due consideration, so far as is reasonably practical and consistent with the child’s welfare and having regard to the child’s age and understanding.

To do this depends on communicating effectively with children and young people, including those who find it difficult to do so because of their age, impairment or their particular psychological or social situation. This may involve using interpreters and drawing upon the expertise of early years, workers or those working with disabled children. It is necessary to create the right atmosphere when meeting and communicating with children, to help them feel at ease and reduce any pressure from parents, carers or others. Children will need reassurance that they will not be victimised for sharing information or asking for help or protection; this applies to children living in families as well as those in institutional settings, including custody. It is essential that any accounts of adverse experiences coming from children are as accurate and complete as possible. Accuracy is key, for without it effective decisions cannot be made and, equally, inaccurate accounts can lead to children remaining unsafe, or to the possibility of wrongful actions being taken that affect children and adults.

(The Children Act 1989)
# SAFEGUARDING CHILDREN CAUSE FOR CONCERN FORM

*PLEASE NOTE THIS FORM DOES NOT REPLACE AN URGENT SOCIAL CARE REFERRAL*

<table>
<thead>
<tr>
<th>NAME OF CHILD:</th>
<th>PARENTS / CARERS DETAILS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>DATE OF BIRTH:</td>
<td>AGE:</td>
</tr>
<tr>
<td>HOSPITAL NUMBER:</td>
<td></td>
</tr>
<tr>
<td>ADDRESS:</td>
<td></td>
</tr>
<tr>
<td>POSTCODE:</td>
<td></td>
</tr>
<tr>
<td>PHONE NO:</td>
<td></td>
</tr>
<tr>
<td>SCHOOL:</td>
<td></td>
</tr>
<tr>
<td>G.P.</td>
<td></td>
</tr>
</tbody>
</table>

| WHO HAS PARENTAL RESPONSIBILITY: (e.g. any parental/family restrictions) |
| ADDRESS IF DIFFERENT: |
| ANY OTHER SIBLINGS/FAMILY MEMBERS AT HOME: |
| NAMES AND AGES OF SIBLINGS: |

<table>
<thead>
<tr>
<th>DOES THE CONCERN RELATE TO AN ADULT?</th>
<th>YES/NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>RELATIONSHIP TO THE CHILD:</td>
<td></td>
</tr>
<tr>
<td>SURNAME:</td>
<td></td>
</tr>
<tr>
<td>FORENAME:</td>
<td></td>
</tr>
<tr>
<td>D.O.B:</td>
<td></td>
</tr>
</tbody>
</table>

**GIVE FULL DETAILS OF CONCERN - CONTINUE OVERLEAF IF NECESSARY**

DATE SEEN:

SEEN BY: REFERRED BY: DESIGNATION:

HAS REGISTRAR OR CONSULTANT BEEN INFORMED OF REFERRAL YES/NO
CHILD’S NAME: 

DATE OF BIRTH:

Does the child have a child protection plan? YES/NO 

Is the child a ‘Looked After Child’ YES / NO 

Does the child have a Social Worker? YES / NO. 

If yes, have they been informed of admission? YES / NO 

Name: 

Contact no: 

Has a referral been made to social care? YES / NO 

If yes give Date? ______________ Time ___________

If a referral has been made to Social Care? Name of social worker: 

Have parents been informed of the referral? YES / NO 

If no give reason ______________________________________________________________________________ 

_____________________________________________________________________________________________

ALL REFERRALS TO SOCIAL CARE MUST BE GIVEN VERBALLY BY PHONE AND FOLLOWED UP IN WRITING 
( CAUSE FOR CONCERN OR CAF FORM) 

CONTACT DETAILS: STOCKPORT CHILDREN’S SOCIAL CARE TEL: 0161 217 6028 

OUT OF HOURS TEL: 0161 718 2118 FAX NO TO SCANNING ROOM: 0161 476 3504 

FOR OTHER LOCAL AREAS, SEE CHILDREN’S SAFEGUARDING MICROSITE 

OTHER KEY CONTACTS & TELEPHONE NUMBERS WHO HAVE BEEN INVOLVED WITH FAMILY: (e.g. Doctors, 

social workers, school nurses, health visitors etc 

DISCHARGE INFORMATION 

Admitted to paediatric ward 

Discharged home 

Transferred to other hospital 

Referral to other agency e.g. CAMHS 

ANY FURTHER INFORMATION / ACTION OR RECOMMENDATIONS / OUTCOME 

IMPORTANT: This information MUST be completed: 

HAVE PARENTS/CARERS BEEN INFORMED THAT INFORMATION WILL BE SHARED WITH 
OTHER PROFESSIONALS VIA THIS CAUSE FOR CONCERN FORM? YES/NO 

IF NO STATE REASON: 

__________________________________________________________________________________________ 

PERSON COMPLETING FORM (Print clearly) . 

SIGNATURE_____________________________________________________DATE_________________________ 

DESIGNATION___________________________________________________CONTACT NO. ________________ 

*PLEASE NOTE* THIS FORM SHOULD BE FAXED TO 2180 

For the attention of the Safeguarding Children Team and Paediatric Liaison Nurse. Original to be filed in case notes. 

For further advice contact: 

Safeguarding Team: Tel: 0161 419 2136 

Julie Parker - Named Nurse Child Protection Tel: 0161 426 9622 

VCT (Vulnerable Children’s Team) Community Tel: 0161 426 9622 

NB: Receipt of Social Care Referrals should be Faxed to 0161 419 2180 or Telephoned to 0161 419 2136
Appendix 2 (cont’d)

**Rationale for Completing a Cause for Concern Form**

This form is used for:

- Information sharing purposes amongst health professionals ONLY. *(Option 1)*
  
  The Child/Young Person may require follow up assessment and support.
  
  The information may inform a more detailed picture of what life is like for this Child or Young Person.

- Information sharing with Children’s Social Care if Child/Young Person has a known allocated social worker. *(Option 2)*

- To request further assessment as the evidence is that this is a Child in need of support. *(Under section 17 Children’s Act 1989-2004) (Option 3)*

An Urgent Referral to Children’s Social Care *(Option 4)*

Please complete the form as fully as possible. The quality of information provided at point of contact with other health professionals and children’s Social Care Services is critical to safeguarding vulnerable children. Remember other professionals will base their initial risk assessment on the information you provide. **All** sections of the form should be completed. Please make sure handwriting is legible so that faxed copies can be clearly read. All forms **MUST** be signed and dated as they form part of the medical records. Be clear in your plan what you are asking for-what needs to happen- the rationale for that. This is your assessment at a crucial point of contact with the child/family/Parent.

Your assessment is evidence that the child or young person is at risk of significant harm (Under section 47 of Children’s Act 1989/2004) You are requesting that children’s social care undertake a comprehensive further assessment within a timeframe

This form does **NOT** replace an urgent social care referral.

All referrals to Children’s Social Care (Social Services) must be made verbally by phone (Date /Time recorded) and followed up in writing using this Cause for Concern form (or CAF) no later than 48hrs (Working Together 2013). Ensure that you record the name of the social worker and details of all discussions included all actions agreed in your agency record. By completing this referral form as comprehensively as possible you will be helping Children’s Social care make an informed decision on further action within the requirements of Working Together 2013 and in line with the time scales set. You will also help determine whether the level of need meets the LSCB approved threshold for statutory social work intervention. *(Level of need document and guidance)*.

Parents should be informed that information will be shared in line with Working Together to Safeguard Children (DCSF March 2013). There is a strong expectation that the permission of parents/carers/children/young people (as appropriate to age and understanding should have been sought. The only exception to this expectation is where such discussion and agreement seeking would place a child at further risk of significant harm or prejudice enquires under Section 47 of Children Act 1989, or police investigation. Please complete with the family and where possible gain their signatures for consent to share.

Please indicate who has parental responsibility under the Children Act 1989.

This Form can be completed if there is a Concern for an Adult who has contact with a child or has parental responsibility for them. The Language of the Parent child needs to be documented.

This form should **ALWAYS** be faxed as well to the Safeguarding Team/Paediatric liaison on EXT 2180 for information sharing with community staff and safeguarding purposes. All Cause for Concern forms are reviewed by the safeguarding team. They may require further information from you or refer your information to Children’s Social Care. On receipt and consideration of your referral you will receive feedback, confirmed in writing within one working day about the decision/rationale,
and within the limits of confidentiality, the actions being undertaken. This information is usually sent to the Safeguarding Team. It is then logged on the database and Evolve then copied. The first copy is kept with the cause for concern form and the second sent to the main case holder to be kept with the child’s community health records. If you as the referrer have not received and acknowledgement within 3 working days you could contact Children’s Social Care Contact Centre 0161 217 6028 or the Safeguarding Team in the Treehouse.

For further advice please contact The Safeguarding Team at the Treehouse on 0161 419 2136/2122/2087. If the safeguarding team need to contact you please be specific about your contact details, especially if you work part-time or work from different locations at different times. You may require advice from the Safeguarding team.

To contact Social Care 0161 217 6028 (OUT OF HOURS 0161 718 2118) Fax 0161 476 3504.

**Indicators For Taking a More detailed History** *(This list is not exhaustive use as examples)*

- A Child is subject to a Multi-agency child protection Plan (macpp) or have a history of being subject to a child protection plan.
- A Child has an allocated Social worker/key worker.
- A Child is in the team around the child process. (TAC PROCESS)
- A Child is Looked After.
- Unusual History-Explanation of injury inconsistent with History. Change in History.
- The Childs tells you a different account of the event.
- Late Presentation - Time Frame for seeking medical assessment/ – with no explanation or unreasonable explanation. Consequent delay in treatment/investigations.
- Time of attendance in relation to history/injury.
- Place/situation circumstance-unusual.
- Safety of the child has been compromised- i.e. lack of supervision or failure of a parent/main carer to protect the child. (Direct-intent or indirect omission of care)
- Frequent hospital A/E/Clinic attendances. Patterns of attendance seeking medical advice/screening/pregnancy testing is concerning.
- Non-attendance at hospital appointments /clinic. Consequently child has not been assessed or received appropriate health care. regular defaulters
- Sought medical attention but parents did not wait for child to be appropriately assessed and treated. No plan was made or followed through.
- Parents have not agreed to assessment/treatment.
- Child not brought by a parent (may be a relative why? friend? carer? LAC child, NWAS) Who?
- Risky behaviour- Alcohol, Drug misuse, fighting/bullying.
- Sustained injury whilst witness to Domestic Violence.
- Disturbed emotional behaviour - Anorexia, obesity, self-harm, depression.
- Unusual social interaction or ability to process information which may result in increased vulnerability.

If an Adult (A Parent or has contact with a child). This pertains to either parent.
- Self-neglect/presentation
- Behaviours of Concern
- Engaging in Risky Behaviours/Drug/Alcohol Misuse.
- Mental Health Issues.
- Domestic Violence-Injury emotional impact.
- Physical Illness —unable to parent (temporarily)
- Disability Physical/learning which may affect parenting capacity/functioning.
- Known Chaotic Lifestyle.

For further advice please contact The Safeguarding Team at the Treehouse on 0161 419 2136/2122/2087. If the safeguarding team need to contact you please be specific about your contact details, especially if you work part-time or work from different locations at different times. You may require advice from the Safeguarding team.

**Recording Keeping Guidance for Completing a Cause for Concern form**

Structure to Complete Cause for Concern Form (STAR)

**SITUATION**
- Reason for Attendance /who is with the child
- DOB names of siblings/Carers with parental responsibilities
- First Language
- Reason For Admission (Current Concerns if admitted)
- History (Background)

**TASK**
Assessment.
The child/young person’s history/account of events must inform this assessment as far as possible. The child/young person should always have the opportunity to “tell their story”. Record verbatim what was said.
It is essential that your direct questioning –what was said by whom- who was present is accurately recorded.

Record your observations

Your examination

Rationale for not completing a clinical examination or to request a further paediatric medical assessment.

Risks identified in the assessment.

Rationale for Competing Cause for Concern Form

**ACTION**
What Needs To Happen
Plan
RESULT
Do you need confirmation of RECEIPT of your action?
CAUSE FOR CONCERN OPTIONS

OPTION 1

CAUSE FOR CONCERN IS RAISED

INFORMATION SHARING AMONGST HEALTH PROFESSIONALS: - FORM FAXED TO:

SAFEGUARDING CHILDREN’S TEAM FAX: 0161 419 2180

OPTION 2

CAUSE FOR CONCERN RAISED, CONSENT GAINED FROM PARENTS TO SHARE INFORMATION

FAXED TO CHILDREN’S SOCIAL CARE (0161 476 3504)
INFORMATION SHARING PURPOSES (ALLOCATED SOCIAL WORKER)

FAXED TO CHILDREN’S SAFEGUARDING TEAM (LIAISON)

SENT TO LEAD HEALTH PROFESSIONAL
**OPTION 3**

CAUSE FOR CONCERN IS RAISED

FAXED TO SOCIAL CARE

SOCIAL CARE TO REQUEST SOCIAL CARE FURTHER ASSESSMENT/SUPPORT SERVICES UNDER SECTION 17 CHILDREN’S ACT

CHILDREN’S SAFEGUARDING TEAM

**OPTION 4**

CAUSE FOR CONCERN IS RAISED BY ASSESSMENT UNIT, WARD, E.D. CONSENT GAINED TO SHARE INFORMATION FROM PARENTS

FAXED TO SOCIAL CARE WITHIN 48 HRS THEN TELEPHONED TO SOCIAL CARE 0161 217 6028

URGENT SOCIAL CARE REFERRAL – CHILD AT RISK OF SIGNIFICANT HARM – SECTION 47 CHILDREN’S ACT

FAXED TO CHILDREN’S SAFEGUARDING TEAM

SENT TO VULNERABLE CHILDREN’S TEAM

SENT TO HEALTH PROFESSIONAL LEAD WORKER
Appendix 3A

What To Do If You’re Worried a Child is Being Abused

Child Protection Flowchart For Referral

Social Care
For referrals phone 0161 217 6028 Contact Centre

Emergency Duty Team
Out of Hours Social Care 0161 718 2118

Greater Manchester Police
General Police Switchboard 101
Child Protection Unit 0161 856 9931

If you need advice please contact:

Julie Parker
Named Nurse, Safeguarding Children 0161 426 9622

Claire Woodford
Head of Children’s Services 0161 419 2031

Safeguarding Children Team Stepping Hill Hospital
0161 419 2136/07786702234

Community Based Vulnerable Children Team
0161 426 9622

Named Midwife
0161 419 5455

Looked after Children Specialist Nurses
0161 426 9724

Dr Louise O’Connor
Named Doctor Child Protection 0161 419 2098

Dr Ian Mecrow
Designated Doctor Child Protection 0161 419 2086

Dr Erica Houston
Designated Doctor Looked after Children 0161 419 2084

After Hours Contact
Consultant Paediatrician On-Call
Via Stepping Hill switchboard on 0161 483 1010

Immediate Strategy discussion between LA Children’s Social Care, Police and other agencies

Immediate Safety

Concerns about child’s immediate safety

Initial assessment required

Social worker and manager acknowledge receipt of referral and decide on next course of action within one working day

Feedback to referrer on next course of action

Initial assessment required

No further social care involvement at this stage, although other action may be necessary, eg. onward referral

No further child protection action, although may need to act to ensure services provided

Still has concerns

Practitioner refers to social care, following up in writing within 2 working days.

Practitioner discusses with manager and/or other senior colleagues as they think appropriate

PRACTITIONER HAS CONCERNS ABOUT CHILD’S WELFARE

Still has concerns

No longer has concerns
Community Healthcare Tameside and Glossop

What To Do If You’re Worried a Child is Being Abused

Child Protection Flowchart For Referral

PRACTITIONER HAS CONCERNS ABOUT CHILD’S WELFARE

Practitioner discusses with manager and/or other senior colleagues as they think appropriate

- Still have concerns
- No longer have concerns

Practitioner refers to social care, following up in writing within 2 working days.

Social worker and manager acknowledge receipt of referral and decide on next course of action within one working day

Assessment required

Concerns about child’s Immediate safety

Immediate Strategy discussion between LA Children’s Social Care, Police and other agencies

No further social care involvement at this stage although other action may be necessary, for example, onward referral.

Feedback to referrer on next course of action

Social worker and manager acknowledge receipt of referral and decide on next course of action within one working day

- No further child protection action, although may need to act to ensure services provided

If you need advice please contact:

Safeguarding Team
0161 335 2984/5

Named Nurse for Safeguarding Children, Looked after Children & Adults
07833038869

Specialist Nurse Safeguarding Children
07867787373

Specialist Nurse Safeguarding Adults
07810658173

Specialist Nurse Looked After Children
07770544664

For further information, guidance, policies and procedures please access:

Microsite: Tameside & Glossop Community Healthcare business group, Safeguarding

Tameside Safeguarding Children’s Board
www.tamesidesafeguardingchildren.org.uk

Derbyshire Safeguarding Children’s Board
www.derbyshirescb.org.uk

Out of Hours Social Care
Tameside
Tameside Public Service Hub
0161 342 4222
Call Derbyshire
Tel: 01629 532 500

Greater Manchester Police
General Police Switchboard 101
Public Protection Investigation Unit
0161 856 9314
Derbyshire Police
Tel: 0300 122 8719

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Flowchart of action by school nurse/staff nurse on receipt of domestic abuse notification

School Nurses receive a copy of DA notification for all children involved together with child health records.

What type of incident is it?

High risk
• Child directly involved in a physical episode of DA.
• Child witnesses a physical episode of DA.
• Excess of 3 verbal episodes in last 6 mths with child present
• DA incident involving a weapon regardless of whether child present or not.

Action on receipt of DA
• Contact Health Visitor if younger children in the home and any other health professional working closely with the child
• Contact centre or supporting families pathway or social worker
• See the young person in school with parental consent, if appropriate
• Consider referral to MARAC and analyse information known by social care

Document Actions
• Sign notification and date
• File in appropriate section of records
• Enter on chronology
• Document any actions in main body of records

Lower risk
• 3 or less verbal episodes of DA when children are present within a 6 mth period
• DA incident when Children are not present

Action on receipt of DA
Sign notification and date
• File in appropriate section of records
• Enter on chronology

• If SN is concerned with the response or uncertain how to proceed, they should immediately contact VCT for supervision
• SN to discuss with VCT which cases to open to vulnerable families supervision
APPENDIX 5

Prompt for School Nurses for the completion of the Bichard assessment proforma

Rationale

The primary concern of anyone working with sexually active young people under the age of eighteen years must be to safeguard and promote the welfare of the young person. The purpose of this guideline is to provide clear operational guidance for all practitioners where the processes of assessment and decision making are required.

The assessment provides:

- Actions to be taken in order to ensure sexually active young people are safeguarded
- A means of ensuring the obligation in relation to recommendation 12 of Michael Bichard’s report is met (Bichard Inquiry, 2004).

School nurses to complete the Bichard assessment proforma for all young people requesting sexual health advice (not including enquiries re puberty and growing up).

To be used in conjunction with the flow chart entitled ‘Flow chart for professionals working with sexually active under 18’s’ (Available on sharepoint, see below)

Prompt

Accompanied by

Please include name of person accompanying as although third party information it may integral to the risk assessment

Sexual activity

Has the young person had sex, do they know what sex is.

Age of first sexual intercourse

Was this at an acceptable age (see legalities section) any worries about previous sexual abuse.

Current partner

Are they age appropriate, how do you know how old they are, Where did you meet them. Any worries?

Name of partner as may be integral to risk assessment

Length of relationship and previous partners

May need to give advice re sexually transmitted infections or offer Chlamydia screen (two weeks following unprotected sexual intercourse)

Also if numerous partners consider CSE/abuse

Assessment for Child Sexual Exploitation (CSE)

Discuss rationale for sexual activity, did they freely chose to have sex, was it appropriate or in an appropriate place. EG did you have sex because you wanted to? were you offered any rewards? has your partner been violent, aggressive or controlling towards you? Have you been asked to take or pose for sexual photographs?

Support from friends and family

Have your family or friends met your partner? If not why not? Do you tell anyone where you are going? Does any one have any worries about you?

General behaviour

How does the young person present? Are they anxious, withdrawn, self harm evident, ask if they are drinking alcohol or misusing substances (if so consider SN alcohol tool or mosaic referral) have they stayed away from home without telling their parents and where did they go to? What is school attendance like? How well do they engage with you. Are you concerned about the young person for any reason. Are they known to you?

Fraser competence

Refer to Fraser guidelines to make assessment (available on Sharepoint; see below) Discuss consent and what it means, not acceptable if other person too drunk to consent or under the influence of substances.

Always encourage discussing sexual health with parents or an appropriate adult.
Legalities and Confidentiality
Discuss age limits and the law sensitively.
Discuss under 13 never acceptable.
If aged under 13 and sexually active a discussion with social care/vulnerable children’s team is necessary.
Discuss confidentiality policy.
Actions taken.
Be specific about actions taken and if any further action/follow up is required.
Document if Chlamydia screen is offered and if accepted put sticker on pro-forma.
Record batch number and expiry date of pregnancy tests if applicable.
Expiry date and number of Condoms given.
Follow CSE risk assessment if concerned. Contact team leader of VCT for further advice if necessary (available on sharepoint, see below)
Any concerns contact
Liz on 078815527257 or Fran on 0782485772
Sexual Health Services 426 9696

All guidance available on Sharepoint; community health Stockport/safeguarding children, child protection, looked after children/sexual health and exploitation

NB School nurses should have copies of these available to them at their clinics prior to start of their school health clinic.
## BICHARD RISK ASSESSMENT FOR CLIENTS ACCESSING SEXUAL HEALTH SERVICES UNDER THE AGE OF 18 YEARS

<table>
<thead>
<tr>
<th>Clients Name:</th>
<th>D.O.B:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date:</td>
<td>Time:</td>
</tr>
<tr>
<td>School:</td>
<td>Gender: F / M</td>
</tr>
</tbody>
</table>

**Reason for Contact:**

<table>
<thead>
<tr>
<th>Accompanied?</th>
<th>Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>If yes, by whom?</td>
<td>Yes / No</td>
</tr>
</tbody>
</table>

**Sexual Activity:**

<table>
<thead>
<tr>
<th>E.g. intends to have sex, already has</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Age of first Sexual Intercourse (if applicable)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Current partner</th>
<th>Male / Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age:</td>
<td>Name:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Length of relationship</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Previous partners if relevant</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Pressure</th>
<th>Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coercion</td>
<td>Yes / No</td>
</tr>
<tr>
<td>Threat</td>
<td>Yes / No</td>
</tr>
<tr>
<td>Bribery</td>
<td>Yes / No</td>
</tr>
<tr>
<td>Secrecy</td>
<td>Yes / No</td>
</tr>
<tr>
<td>Violence</td>
<td>Yes / No</td>
</tr>
<tr>
<td>Posting Sexual Images/use of internet/mobile phone devices.</td>
<td>Yes / No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Support from:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parents/carers aware</td>
</tr>
<tr>
<td>Parent / Guardian</td>
</tr>
<tr>
<td>Family / Friends</td>
</tr>
<tr>
<td>Social Care Agencies</td>
</tr>
<tr>
<td>Other, give details</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>General behaviour of client</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxious / withdrawn</td>
</tr>
</tbody>
</table>

If yes, give details
<table>
<thead>
<tr>
<th>Minimizes / denies concerns</th>
<th>Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk taking behaviour</td>
<td>Yes / No</td>
</tr>
<tr>
<td>Attending school regularly</td>
<td>Yes / No</td>
</tr>
<tr>
<td>Alcohol / substance misuse</td>
<td>Yes / No</td>
</tr>
<tr>
<td>Missing from Home</td>
<td>Yes / No</td>
</tr>
<tr>
<td>Self-Harming</td>
<td>Yes / No</td>
</tr>
</tbody>
</table>

**Fraser Competence**

<table>
<thead>
<tr>
<th>Does client understand concept of consent?</th>
<th>Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parents / Carer / another trusted adult aware</td>
<td>Yes - If yes, give name and contact details if possible</td>
</tr>
<tr>
<td>Without treatment / advice the young persons physical / mental health is likely to suffer</td>
<td>Yes / No</td>
</tr>
<tr>
<td>FRASER COMPETENT?</td>
<td>Yes / No</td>
</tr>
</tbody>
</table>

**Discussed:**

<table>
<thead>
<tr>
<th>Legalities</th>
<th>Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>of underage sex</td>
<td>Yes / No</td>
</tr>
<tr>
<td>Confidentiality</td>
<td>Yes / No</td>
</tr>
</tbody>
</table>

**Action Taken**

| Give Details: | |

CAF Completed

| Yes / No (if yes give details) |

Referral to safeguarding/MASE following assessment

| Yes/No (if yes give details) |

(MASE – Multi-agency Sexual Exploitation)

**Printed name, signature & role of practitioner**

**Date:**

If concerns highlighted regarding sexual exploitation with this assessment, consider proceeding to full CSE risk assessment in section 10.22 Child Sexual Exploitation Procedure Appendix 1 – page 19 www.safeguardingchildreninstockport.org.uk
INITIAL OR ONGOING CONTACT WITH THE YOUNG PERSON

INITIAL ASSESSMENT OF RISK
(based on information available)
Complete “Bichard Assessment for clients under the age of 18 years”
As per service specific guidelines

Does this assessment leave you with?

Immediate/imminent concern
(to young person or risk of young person abusing someone else)
Seek immediate advice from Safeguarding Children Lead / Caldicott Guardian / Named/Designated clinician and Line Manager, or in exceptional circumstances, go straight to next step

Some uncertainty
Obtain more information on specific concerns & reassess

Is further Guidance Needed?
Discuss with Safeguarding Children Lead / Caldicott Guardian/ Named/Designated Clinician/ or Line Manager & document the discussion

Concerns
After discussing the matter with the child and taking due account of their opinions, activate multi-agency Safeguarding Children procedures as per safeguarding children policy and Team around the Child procedures

No Concerns

Is he/she under 13 (or do you believe they are)

Yes
No

No concerns
Offer advice, support & treatment; document discussion

Referral to Social Care / Initial Assessment / safeguarding Children Team/MASE
APPENDIX 7

Guidance for health professionals completing review health assessments meeting the health needs of Looked After Children

Meeting the needs of the child or young person residing in your area is of paramount importance. Providing continuity of healthcare is emphasised within the statutory guidance (Statutory Guidance on promoting the Health and Well-being of Looked After Children, 2009). The Stockport Designated Doctor and Nurse have overall responsibility for ensuring high quality, timely health assessments are carried out for all our LAC, wherever they are placed.

A local Lead Health Professional needs to be identified, who will ensure the health assessments are undertaken, work with the SW to coordinate the health care plan and ensure actions are tracked and act as a key contact point for the child, carers and other professionals involved. This includes attending or providing updated health information for the Review process.

Following Ofsted/CQC recommendations we are now auditing the quality of health assessments and plans. This supports the responsible commissioning arrangements in ensuring all Looked After Children receive the health care they need locally.

Completing the statutory health needs assessment, summary and plan (using the BAAF form)

Child Details

i) Please make every attempt to access the Community Records (Health Visitor Record/ School Nurse Record) and if possible GP information, before the assessment.

ii) Please complete the BAAF form legibly and in black ink, and include your details at the end of Part B and C. **Part C needs to be completed by the health professional carrying out the Health Assessment** (as normally agreement from the young person should be gained regarding what is included in the health plan).

iii) Part A will have been completed by the Social Worker, this includes consent. If any details have changed or are incorrect please amend as necessary and inform Stockport LAC team so we can update our records.

iv) GP registration for all children (even if only a temporary placement) needs to be FULL registration as otherwise the GP does not have historical records for the child.

v) A date will be included with the request which reflects the statutory timeframe; the health professional should prioritise completing the assessment by this date. In those cases where the requests are outside of the statutory timeframe, then the health professional should complete within 4 weeks

Health Issues

Immunisations- IMPORTANT

- Please ensure that all immunisations are up to date and recorded on the child health system.

| Any immunisations given locally, please record ALL on BAAF form and/or attach immunisation print out, when returning BAAF form (including for those LAC aged 16-18 years) | 35 |
A plan detailing which immunisations are missing and a ‘catch-up’ plan should be included in the health needs plan (Part C).

Medication: The summary forms the only medical information available to the social worker and GP. Within the summary record any medical conditions, including diagnosis and treatment, with planned follow up/review in the summary and the plan.

Need to clearly state

Either - No medication currently taken
Or - Medication, formulation (cream, tablets, liquid) dose and frequency.

Please record who responsible for prescribing and reviewing the medication (e.g. Methylphenidate prescribed/monitored by a consultant psychiatrist, CAMHS etc).

CAMHS/Mental Health Needs

Mental health issues are particularly common in the LAC population. Please record any such concerns on the health plan and how they are being addressed.

Dental Checks

Looked after children have high levels of dental decay and neglect. It is important that children have access to dental care, and attend regularly for checks which include hygiene advice. All children from 6 months of age should attend at least annually or according to their dentist’s advice. Children from 6 months need to be introduced to a mouth examination and carers receive advice on sugar avoidance, hygiene, pacifiers, and thumb sucking etc. Many children/YP have never been taken to the dentist or have had difficult experiences and may be fearful and anxious.

On the back page of the BAAF form there is a sticker included for date of last dental assessment. It is essential that this is filled in. If the child has not been seen or seen more than 6 months ago then need for a dental check should be an action on the health plan (part C).

For children placed outside Stockport local pathways to access dental care should be followed but looked after children should be prioritised so that no unnecessary delays occur.

Family Health Issues

Parental/personal lifestyle issues may include the risk of blood borne infection. Please consider these, seek further information e.g. antenatal results and carry out investigations if necessary. For further information, contact Stockport LAC team to discuss 0161-426-9724 or Tameside & Glossop LAC team on 0161 335 2984.

Completion of form: What should be included in the health needs plan:

Please be sensitive about how information is written as this may be shared in a public forum at Looked After Child Review. The summary is copied to GP, Social Worker and Independent Reviewing Officer, with the plan also being sent to carer, birth parent and young person if aged over 10 years.
The needs identified and actions required on the health plan should be written clearly in bullet points avoiding technical jargon and abbreviations as far as possible. Indicate the source of the information in the summary- e.g. from records, carer or Social worker.

The summary and plan should be clearly linked and always include information about immunisations, dental health, vision, emotional and mental health, and lifestyle/sexual health for those aged over 10 years.

If the LAC/young person does not wish certain information to be shared ie included in Part C, please try to ensure health needs are met and with permission add to the plan in a non-specific way such as ‘personal health or lifestyle issues under appropriate review’.

If Review Health assessment- please indicate what has happened with issues identified on previous plan, so can track that health needs are indeed being fully met.

All Health assessments are now audited to ensure the quality of health care plans is consistent for children placed in Stockport and out of area. Any Health assessment not meeting the standards will be returned to the health professional for updating.

**Non-attendance for Health assessment**

- If the child / young person does not attend the appointment, the social worker should be contacted to check the details of the placement are correct and any known reasons for non-attendance. Please offer a further appointment.

- If this is also not attended or the young person refuses a health assessment, there needs to be a telephone discussion with carer and Social worker re current health concerns along with review of records to see what previously identified but unmet health needs continue. The health plan should then include this information and highlight that a health assessment has not be carried out directly with young person.

**Referrals**

- Please ensure you have appropriate consent for referrals, investigations and immunisations. This may be identified as an action to be obtained by the social worker from the birth parents or service manager.
## Section 47 Child Protection Medical - Operational Flow Chart

### STEP ONE:
To arrange a S47 medical examination

Social Worker contacts the on-call Paediatric ‘Registrar/2nd on call’ at Stepping Hill Hospital between 09.00 to 15.30 hrs via switchboard on 0161 483 1010.

If a GP needs to arrange a child protection medical directly, to contact the on-call Paediatric ‘Registrar/2nd on call’ in the same way. G.P is required to make a child protection referral to Children’s Social Care, backed up in writing. The registrar taking the G.P call to check that the referral process has/is being implemented with Duty Social Work team.

The registrar / 2nd on call discusses the case with the ‘hot week’ Paediatric Consultant and arranges the necessary medical examination.

### STEP TWO:

The Paediatric Registrar takes details (names, date of birth, address, family structure, reason for request etc) and negotiates the urgency of the medical with Social Worker based on child’s needs.

An appointment will be made at Stepping Hill Hospital with a Registrar and Consultant Paediatrician.

**Hours of service are:**

*Monday to Friday:*

The service is available to 17.00hrs.

To allow time for appointments booked to arrive —no bookings will be taken after 15.00hrs for that day.

The Appointment Time & Venue will be confirmed.

If the need for a S47 medical is identified by the Emergency Duty Social Worker Team (EDT) which cannot wait until the following day, this is deemed as urgent and contact with the on-call Registrar is made in the same way as above.

Please note; in this situation an appointment time is unable to be given however, the venue will be confirmed and the Registrar will complete the medical as acute medical priorities and the child’s needs for examination allow. There may be a long wait and consideration needs to be made about whether this is in the best interests of the child.

### STEP THREE:

- The Social Worker arrives with child at the allotted time.
- The Registrar completes the medical and summary report.
- The Doctor signs and dates the summary agreement.
- Copy of the summary agreement is given to the Social Worker.
- The full medical report to follow.

**N.B.** Any medical investigations required will be carried out at Stepping Hill Hospital. However, if photographs are needed these are carried out at Wythenshawe Hospital (office hours only). Where photographs required out of hours these are completed by police.