



Aneurin Bevan University Health Board

Guidance for Completion of ‘Cause for Concern’/Child Protection Documentation

N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out of date printed versions of the document. The Intranet should be referred to for the current version of the document.

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1 Executive Summary

This guideline has been produced for use by practitioners when completing Midwifery Cause for Concern/Child Protection documentation.

1.1 Essential Implementation Criteria

All midwives completing Child Protection documentation will be required to follow the guidelines.

2 Responsibilities

The Lead Midwife for Safeguarding Children is responsible for producing the guideline and ensuring updating as necessary.

Midwives have a responsibility to follow the guideline to ensure relevant information is passed on appropriately.

3 Training

Annual updating will be provided for all midwifery staff on aspects of Child Protection/Safeguarding.

This will be delivered via mandatory study days.

Full training records will be kept.

4. References

Healthcare Standards for Wales – Making the connections
Designed for Life

NICE – When to Suspect Child Maltreatment Clinical Guideline 89
– July 0

5. Appendices

Midwifery 'Cause for Concern Report'
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All Gwent Guidance for Completion of 'Cause for Concern'/Child Protection Documentation

1. If information gathered from a Health Visitor/Social Worker or other agency causes concern, or if you are concerned yourself, then activate a **'Midwifery Cause for Concern'** report'.
2. Complete the 'Cause for Concern' report, making sure all details, including DOB are entered on the report. (It is good practice to also record this detail in your midwifery diary and on the IT Protos system using the User Messaging Service.) Check the hospital notes for other relevant information, and place a **'Green Dot' on the outside cover of the notes.** (This will be used as the alert to safeguarding concerns)
- 3 The form should be photocopied and the original **filed in the notes.** A copy is to be placed in the Safeguarding At Risk file in each midwifery clinical area. A copy of this form should also be **sent to the Lead Midwife for Safeguarding Children, and to the Health Visitor and GP** for information. **It is your responsibility to update this form and the hospital notes as necessary.**
- 4 If the circumstances require referral to Social Services this should be done as soon as possible by contacting the Duty Officer at the appropriate Social Service Department by telephone. The telephone call should be supported in writing using the **Multi Agency Referral Form within 48 hours.** Photocopy this form, **and file the original in the notes.** Send a copy of it to the Lead Midwife for Safeguarding Children. It is your responsibility to **chase up any non-responses from Social Services.**
- 5 Share information about the case with your Borough Manager/Lead Midwife and other Team members.
- 6 If a Case Conference is to be held, **inform** the Lead Midwife for Safeguarding Children. If you are unable to attend another team member should attend if possible in your place. You should prepare a written report for the conference using the **'Report for Child Protection Case Conference' form,** which is available on the intranet. Minutes from Case Conferences should be **filed in the notes in a brown envelope marked 'Case Conference Minutes, Confidential'**

- 7 Decisions of Case Conferences should be shared with the Lead Midwife for Safeguarding Children either by telephone or by completing a '**Case Conference Outcome**' form which should then be **sent to the Lead Midwife**. If action is required at the time of birth/discharge (i.e. baby to be removed at birth) ensure that an '**Alert Notice for Child Protection**', is completed. This should explain in detail the steps to be taken when the woman is admitted. **This 'Alert' should be filed in the hospital notes alongside the partogram. A copy should be sent to the appropriate Neonatal Unit for information, and to the Lead Midwife.**
- 8 If you have any concerns regarding a woman's whereabouts, inform the Lead Midwife for Safeguarding Children who may arrange an alert to neighbouring hospitals. NB If there is a risk of flight and a national alert is required this is facilitated by Social Services.
- 9 If there are concerns that the woman may attempt to evade maternity services by birthing at home, inform the Lead Midwife for Safeguarding Children who will inform Welsh Ambulance Service Trust (WAST) Safeguarding Lead.
- 10 Risk assessment should include reference to Health and Safety, Violence and Aggression, Patient/Client safety in the home if applicable.
- 11 **If at any time you are unsure or need advice contact either your Lead Midwife for Safeguarding Children on mobile 07854932695 or your Borough Manager.**

NOTE:

All relevant forms are available on the Intranet. Access policies and forms, type in Child protection which will take you to the Child Protection library.

This policy has undergone an equality impact assessment screening process using the toolkit designed by the NHS Centre Equality & Human Rights. Details of the screening process for this policy are available from the policy owner.

APPENDIX 1

Midwifery Cause for Concern Report

Date	Team	Planned place of delivery	
Patients Name and DOB			
Address & Tel No.			
EDD Gravida			
Midwife and Tel No.			
GP & Tel No.			
Health Visitor & Tel No.			
Social Worker & Tel No.			
<u>Circumstances Causing Concern</u>			
Action to date:			
GP Informed	YES/NO	Case Conference arranged	YES/NO
Health Visitor	YES/NO	Date.....	
Social Worker Informed	YES/NO	Venue.....	
Case notes updated and Marked with a green dot	YES/NO		
This form should be given to:		1. Lead Midwife Safeguarding Children/Borough Manager	
		2. Health Visitor/GP	

APPENDIX 2



Integrated Children System - Referral and Information Record

SSD 200

The Referral and Information Record gathers together the essential information about a child or young person. There is an expectation that within **one working day** of a referral being received there will be a decision about what response is required (paragraph 3.8, *Framework for the Assessment of Children in Need and their Families, 2001*).

Case Number:		Date referral received:	
Is the Parent/Carer aware of the referral?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Is this a re-referral?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If Yes, does the reason for the re-referral indicate that the response to the original referral did not appropriately address the client's needs:		Yes <input type="checkbox"/> No <input type="checkbox"/>	
Has consent been obtained to make this referral?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If Yes, is consent:	Written <input type="checkbox"/> Verbal <input type="checkbox"/>
In No, give reason:			

CHILD/YOUNG PERSON'S DETAILS

Surname:	Forenames:	Child/Young Person's first language or preferred means of communication:
Alias:	DOB or expected date of delivery:	
Gender: Male <input type="checkbox"/> Female <input type="checkbox"/> Unborn <input type="checkbox"/>	Is an interpreter/signer required? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Address:	Social Services Team:	
Postcode:	Tel:	Responsible Authority:
Current address if different from above:		
Postcode:	Tel:	

CHILD/YOUNG PERSON'S ETHNICITY

Black or Black British	Asian or Asian British	White	Mixed	Other Ethnic Groups
Caribbean African Any other Black Background	<input type="checkbox"/> Indian <input type="checkbox"/> Pakistani <input type="checkbox"/> Bangladeshi <input type="checkbox"/> Any other Asian Background	<input type="checkbox"/> White British <input type="checkbox"/> White Irish <input type="checkbox"/> Any White Background <input type="checkbox"/> White Welsh	<input type="checkbox"/> White & Black Caribbean <input type="checkbox"/> White & Black African <input type="checkbox"/> White & Asian <input type="checkbox"/> Any other Mixed Background	<input type="checkbox"/> Chinese <input type="checkbox"/> Any other ethnic group <input type="checkbox"/> Not given <input type="checkbox"/> If other, please specify:
Further details regarding Child/Young Person's ethnicity:			Child/Young Person's Religion:	
Child/Young Person's Nationality (if not British):			Home Office Registration Number:	
Immigration Status:		Asylum Seeking <input type="checkbox"/>	Refugee Status <input type="checkbox"/>	Exceptional leave to remain <input type="checkbox"/>

CHILD/YOUNG PERSONS MAIN CARERS

Name	Relationship to Child/Young Person	First Language	Ethnicity	Parental Responsibility
				Yes <input type="checkbox"/> No <input type="checkbox"/>
				Yes <input type="checkbox"/> No <input type="checkbox"/>
Parents/Carers First Language:		Is an interpreter/signer required? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Other main Carers: Yes <input type="checkbox"/> No <input type="checkbox"/>		Please specify name:		
Are any of the main Carers disabled? Yes <input type="checkbox"/> No <input type="checkbox"/>		Please specify Carer:		
Name of Disabled Carers Local Authority and SSD Number:		If Yes, please specify name of disabled Carers, main Carer:		

PARENT'S DETAILS IF NOT MAIN CARERS

Mother's name:	SSD Case Number (if appropriate):	DOB:	
Address:	Postcode:	Tel:	
Mother's first language:	Mother's ethnicity:		
Father's name:	SSD Case Number (if appropriate):	DOB:	
Address:	Postcode:	Tel:	
Father's first language:	Father's ethnicity:	Does Father have parental responsibility? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Is either Parent disabled?	Mother <input type="checkbox"/> Father <input type="checkbox"/> None <input type="checkbox"/>	Is an interpreter/signer required?	Mother <input type="checkbox"/> Father <input type="checkbox"/> None <input type="checkbox"/>

Referral Reason:	Priority Level:
Reason for referral/request for services:	
Referred by:	Date:
Address:	Tel:
Agency/relation to Child/Young Person:	Does the referrer wish to remain anonymous? Yes <input type="checkbox"/> No <input type="checkbox"/>

OTHER HOUSEHOLD MEMBERS (including non-family members):

Surname	Forename	DOB	If known to SSD – SSD Case Number	Relationship to Child/Young Person	Tick if also referred to SSD at same time as Child/Young Person
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>

KEY AGENCIES

Agency	Name	Address including Postcode	Telephone	Parental Consent	Date of Consent
General Practitioner				<input type="checkbox"/>	
Health Visitor				<input type="checkbox"/>	
Nursery or School				<input type="checkbox"/>	
Other Agencies (please specify)				<input type="checkbox"/>	

CHILD/YOUNG PERSON AND FAMILY NETWORKS

Significant family members who are not members of the Child/Young Person's household						
Surname	Forename	DOB	Relationship	Address	Postcode	Tel

Other Social Services cases associated with the Child/Young Person

Name:	SSD Case No:
Name:	SSD Case No:

FURTHER DETAILS ABOUT THE CHILD/YOUNG PERSON AND FAMILY

Disabled – The Child/Young Person referred is disabled: Yes <input type="checkbox"/> No <input type="checkbox"/>		The Child/Young Person referred is on a disability register: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Child Protection – The Child/Young Person referred is on the Child Protection Register of another Local Authority: Yes <input type="checkbox"/> No <input type="checkbox"/>		The Child/Young Person referred has been registered previously by any Local Authority: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Name of Local Authority:		Category:	
Date of Registration:		Date of De-Registration:	
Looked After – Is the Child/Young Person referred Looked After by another Local Authority? Yes <input type="checkbox"/> No <input type="checkbox"/>		Child/Young Person referred has been Looked After previously by any Local Authority: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Name of Local Authority:		Start Date:	End Date:
Relevant information: Other Child(ren)/Young Person(s) in the family is/has been on a Child Protection Register: Yes <input type="checkbox"/> No <input type="checkbox"/>			
Name:	Date of Registration:	Date of De-Registration:	
Name:	Date of Registration:	Date of De-Registration:	
Name:	Date of Registration:	Date of De-Registration:	
Other Child(ren)/Young Person(s) in the family(s) is/has been Looked After by a Local Authority:			
Name:	Start Date:	End Date:	
Name:	Start Date:	End Date:	
Name:	Start Date:	End Date:	
Person Completing Form:	Signature:	Date:	

Further Action – For Social Services Use Only			Practice note: ensure this referral is collated with previous referrals or files
No further action <input type="checkbox"/>	Provision of information and advice <input type="checkbox"/>	Referral to other agencies <input type="checkbox"/>	
Initial Assessment <input type="checkbox"/> (please specify other):		(to be completed within 7 working days)	
Referrer informed of action taken:	Yes <input type="checkbox"/> No <input type="checkbox"/>	If no, date this be done:	
Parent's informed of action taken:	Yes <input type="checkbox"/> No <input type="checkbox"/>	If no, date this be done:	
Child/Young Person informed of action taken:	Yes <input type="checkbox"/> No <input type="checkbox"/>	If no, date this be done:	
Other action(s) (please specify):			
Name of Social Worker:	Signature:	Date:	
Name of Team Manager:	Signature:	Date:	

APPENDIX 3

ANEURIN BEVAN HEALTH BOARD

MIDWIFERY REPORT FOR CHILD PROTECTION CONFERENCE

NAME OF MOTHER:	ADDRESS:
ESTIMATED DATE OF DELIVERY/OR INFANTS DOB:	GP:
DATE OF CONFERENCE:	HV:

1. COMPLIANCE WITH ANTENATAL/POSTNATAL CARE

2. INVOLVEMENT WITH OTHER AGENCIES E.G. MENTAL HEALTH/LEARNING DISABILITIES

3. SUBSTANCE MISUSE CONCERNS

4. SPECIFIC EVENTS/INCIDENTS/CONCERNS INCLUDING REASON FOR REFERRAL TO SOCIAL SERVICES AND OTHER AGENCIES

5. FUTURE PLAN OF CARE

6. **SIGNATURE**

DESIGNATION:

DATE:

APPENDIX 4

ANEURIN BEVAN HEALTH BOARD				
CASE CONFERENCE OUTCOME				
DATE & TIME OF CONFERENCE				
SOCIAL SERVICES				
INITIAL/REVIEW				
CHILDREN'S NAME				
D.O.B.				
FAMILY ADDRESS				
SCHOOL				
SHN				
CHILDREN'S CURRENT ADDRESS IF DIFFERENT				
DECISION OF CONFERENCE				
CATEGORY				
ATTEND BY CNS/HV/SHN				
DATE OF NEXT CONFERENCE				
ACTION PLAN				

APPENDIX 5

Alert Notice for Child Protection Action Plan	
Name and Address	
EDD.....	
Child Protection Concerns, and relevant background details	
Action to be taken when admitted in labour	
Instruction for discharge	
Contact name/numbers for Social Services	
Day.....	Night.....
Name of Midwife completing this form	
	Date.....
Community Team	
Named Midwife	
GP	

Alert notice child protection June 2004
JB