



Aneurin Bevan University Health Board

Guidance for Completion of Safeguarding Documentation

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1 Executive Summary

This guideline has been produced for use by practitioners when completing Safeguarding documentation.

1.1 Essential Implementation Criteria

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

2 Responsibilities

The Lead Midwife for Safeguarding 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 Safeguarding. This will be delivered via mandatory study days. Full training records will be kept.

All staff will need to complete safeguarding adult and children online training (E-Learning via the ESR Portal)

All staff will need to complete Group 1 awareness-raising training on Violence against Women, Domestic Abuse and Sexual Violence (VAWDASV)

4 Appendices

Integrated Children System- Referral and Information Record
Midwifery Report for Child Protection Case Conference
Case Conference Outcome Form
Alert Notice

5. References

Healthcare Standards for Wales – Making the connections Designed for Life

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

Guidance for Completion of Safeguarding Documentation

1. If the circumstances require referral to the Local Authority (Children's Services) this should be done as soon as possible by contacting the Duty Officer at the appropriate department by telephone.

Complete an electronic copy of the **Multi Agency Referral Form** within 48 hours of the telephone call and email a copy to : -

- Local Authority
- Lead midwife for safeguarding
- Upload a copy to "**documents**" on Clinical Work Station
- An alert should be placed on the maternity data system CSC

It is your responsibility to chase up any non-responses from Children's Services.

2. Share information about the case with your Borough Manager/Lead Midwife and other Team members.
3. If a Case Conference is to be held, **inform** the Lead Midwife for Safeguarding. 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.
4. 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**' is completed on CSC. This should explain in detail the steps to be taken when the woman is

admitted. **This 'Alert' should be uploaded to "documents on Clinical Workstation" A copy should be sent to the Lead Midwife.**

5. **All birth plans will be added to CWS by the Lead Midwife for Safeguarding. The alert will read 'safeguarding see documents'**
6. If you have any concerns regarding a woman's whereabouts, inform the Lead Midwife for Safeguarding 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 Children's Services.
7. If there are concerns that the woman may attempt to evade maternity services by birthing at home, inform the Lead Midwife for Safeguarding who will inform Welsh Ambulance Service Trust (WAST) Safeguarding Lead.
8. Risk assessment should include reference to Health and Safety, Violence and Aggression, Patient/Client safety in the home if applicable.
9. **If at any time you are unsure or need advice contact either the Lead Midwife for Safeguarding on mobile 07854932695 or your Borough Manager.**

NOTE:

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

APPENDIX 1
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 <input type="checkbox"/> African <input type="checkbox"/> 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

HEALTH PROFESSIONALS CASE CONFERENCE REPORT

Name of Health Professional:

Designation:

Date of conference:

Initial/Review:

(Prior to 3rd review case conference seek supervision with Lead Nurse for Safeguarding Children)

UNBORN	E.D.D.	MOTHER'S NAME DATE OF BIRTH ADDRESS	FATHER'S NAME DATE OF BIRTH ADDRESS	GP	PLACE OF BIRTH	PARENTAL RESPONSIBILITY

CHILD'S NAME DATE OF BIRTH ADDRESS	MOTHER'S NAME DATE OF BIRTH ADDRESS	FATHER'S NAME DATE OF BIRTH ADDRESS	GP	NURSERY/SCHOOL	PARENTAL RESPONSIBILITY

Health Professional involvement with family:

UNBORN

Health and development of pregnancy:

FAMILY ANALYSIS

Positive factors:

Key harm factors:

Complicating factors:

Grey areas:

Summary - needs of unborn:

Signature:

Date:

CHILD

Child's Name:	Date of birth:
Health and development:	

Child's Name:	Date of birth:
Health and development:	

Child's Name:	Date of birth:
Health and development:	

FAMILY ANALYSIS

Positive factors:

Key harm factors:

Complicating factors:

Grey areas:

Summary:

Signature:

Date:

Appendix 4

SAFEGUARDING CHILDREN PROFESSIONAL MEETING COMMUNICATION REPORT

INITIAL/REVIEW

Case Conference/Core Group/Professional Meeting (*Delete as appropriate)

DATE:

TIME:

VENUE:

NAMES OF CHILDREN	D.O.B	SCHOOL	SHN/HV	GP / SURGERY
NAME OF MOTHER	D.O.B	E.D.D	MIDWIFE	GP / SURGERY

HOME ADDRESS:

CURRENT ADDRESS IF DIFFERENT:

DECISION & CATEGORY:

ACTION PLAN:

SOCIAL WORKER TELEPHONE NUMBER:

DATE OF NEXT CC/CORE GROUP/PROF MEETING:

COPY SENT TO GP'S
YES/NO

COPY SENT TO SAFEGUARDING SUPERVISOR
YES/NO

**COPY SENT TO ANY OTHER HEALTH PROFESSIONAL INVOLVED BUT NOT IN
ATTENDANCE YES/NO**

APPENDIX 5

ALERT NOTICE FOR CHILD PROTECTION	
ACTION PLAN	
NAME	DOB:
	EDD:
ADDRESS	
Child protection concerns and relevant background	
Action to be taken when admitted in labour	
Instruction for discharge	
Contact name/numbers for Social Services	
DAY	NIGHT – via EDT 0800 328 4432
Name of midwife completing this form	
	Date
Community Team	
Named Midwife	
GP	