SAFEGUARDING CHILDREN

PROCEDURES FOR HEALTH CARE STAFF

HEALTH & SOCIAL SERVICES DEPARTMENT, JERSEY
&
FAMILY NURSING & HOME CARE (JERSEY) INC

2015

DOCUMENT PROFILE

Document Registration	
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Contact Details	Liz Plastow 01534445471

1. Introduction

Safeguarding is an overarching term that incorporates all activities that protect children and young people from harm, abuse, neglect and exploitation.

Safeguarding and promoting the welfare of children is defined for the purposes of this guidance as:

- Protecting children from maltreatment
- Preventing impairment of children's health or development;
- Ensuring that children grow up in circumstances consistent with the provision of safe and effective care; and
- Taking action to enable all children to have the best outcomes

(Working Together to Safeguard Children, 2015)

1.1. Scope

Safeguarding children and young people is the responsibility of all staffs who work within Health and Social Services and Family Nursing and Home Care, this procedure and associated pathways have been developed to support staff in undertaking this role.

1.2. Limitations

It must be noted that this guidance is specific to the staff of H&SS and FN&HC. It does not include detailed guidance for Social Care staff who have their own detailed procedures and codes of professional practice

This procedure and accompanying pathways are underpinned by the following legislation, guidance and documents:

1.2.1. The Jersey Children's Law (2002) implementation date 01/08/15
1.2.2. The Children's Act 1989 (followed in part as best practice in Jersey)
1.2.3. Department for Education and Skills. Common Core Skills and Knowledge for the Children's Workforce (2014) (www.cwdcouncil.org.uk/commoncore)
1.2.4. HM Govt Working Together to Safeguard Children (2015) (http://medic.education.gov.uk/assets/files/pdf/w/working%together.pdf)
1.2.5. Laming. The Protection of Children in England: A Progress Report. March 2009 (www.publications.everychildmatter.gov.uk)
1.2.6. Child Protection Competency Framework for all clinical staff working in the NHS. (www.nes.scot.nhs.uk/media/370658/child-protection-web.pdf)
1.2.7. All Local Safeguarding Children Boards in Wales. All Wales Child Protection Procedures. Cardiff: WAG 2008.
1.2.8. The Revised NMC Code (2015) (www.nmc-uk.org/the-revised-code)
1.2.9. Safeguarding children and young people: roles and competencies for health care staff Intercollegiate Document Third Edition: March 2014
1.2.10. NICE (2013) When to suspect child maltreatment (http://publications .nice.org.uk/when-to-suspect-child-maltreatment-cq89)

2. Aim and Purpose

2.1. The **Aim** of this procedure is to provide a consistent and evidence based approach to safeguarding children across health in all settings.

2.2. Its **purpose** to:

2.2.1. Provide clarity as to what is required of every individual and how they need to work together
2.2.2. Equip staff throughout the island with the confidence to deal with safeguarding situation involving actual or suspected child abuse.
2.2.3. Provide staff with consistent procedures and pathways relevant to their work area.
2.2.4. Outline safeguarding structures and support mechanisms available for all levels of staff.
2.2.5. Outline education and training requirements for all staff.
2.2.6. Promote active multi-agency and inter-disciplinary working and improved liaison.
2.2.7. Comply with current recommendations and best practice in the protection of children.
2.2.8. Recognise the importance of supervision for all staff.
2.2.9. Outline the governance process to ensure practice is compliant with procedures and that learning from Serious Case Reviews are acted upon.

2.3. Principles

1. The child's needs are paramount
2. The voice of the child should always be listened to and heard
3. All staff who come into contact with children and families are alert to their needs and any risks of harm that anyone may pose to children
4. Information is shared in an appropriate and timely manner
5. All staff should use their professional judgement to put the child's needs first and ensure the right solution can be found for each individual child
6. All staff should contribute to whatever actions are needed to safeguard children
7. All staff should review the outcomes for children against specific care plans and intended outcomes

For the purposes of this document 'child or young person' relates to any person who has not yet reached their 18th birthday. Children means children and young people throughout.

This procedure replaces the previous 'Child Protection' policy published in 2009.

3. Roles and Responsibilities

This procedure and accompanying pathways apply to **all** staff employed by H&SSD and FN&HC, they set out what is expected of all staff who may come into contact with a child or young person who is in need of safeguarding.

3.1. Safeguarding Partnership Board (Children)

The Safeguarding Partnership Board (SPB) has a range of roles and statutory functions including developing local safeguarding policy and procedures and for scrutinising local arrangements. It is made up of representatives from Social Care, Police, Probation, Health, Prison, Education and Voluntary Sector.

3.2. Designated Nurse and Designated Doctor

The Designated Nurse and Designated Doctor are jointly responsible for ensuring that this procedure is implemented and adhered to. They are a **source of advice for all staff** across HSSD and FNHC, if you as an individual or service have any questions or concerns. They are also responsible for providing data and reports to the Safeguarding Partnership Board as required.

You **must** send a copy of **ALL** safeguarding enquiries to Multi Agency Safeguarding Hub (MASH) AND to the Designated Nurse at e.plastow@health.gov.je. For FNHC – send all enquiries to both Designated Nurse and Named Nurse – Michelle Cumming.

3.3. Line Managers and Senior Managers

It is the responsibility of all line managers and senior managers within H&SS and FN&HC to distribute this procedure accordingly to all relevant staff. To be familiar with the content and take action in accordance with the procedures outlined below.

3.4. All Staff

All staff have a duty to undertake the following actions:

- **Alert** an appropriate manager without delay to any concerns, suspicions or evidence of abuse/neglect/exploitation that they observe or hear about.
- Co-operate with any investigation of a safeguarding nature by providing all the evidence that may be known.
- Never prevent or persuade any person from raising concerns, suspicions or presenting evidence
- Record all factual information accurately and clearly within NMC/GMC/HPC Guidelines.
- Follow this procedure and the multi-agency procedure found on http://jerseyscb.proceduresonline.com/index.htm

4. What is the Multi-Agency Safeguarding Hub (MASH)?

The purpose of MASH is to screen all children's safeguarding concerns, a multi-agency group of professionals including social care, health, education and the police research enquiries made into the Hub.

4.1. When should you refer to MASH?

For the majority of vulnerable families their needs can be met through single agency involvement and / or signposting to a range of support services.

However there are occasions when either there is a belief or concern that:

- The child has suffered significant harm
- Is likely to suffer significant harm
- Has a disability which would likely to be further impaired without the provision of services
- Has a developmental need which would likely to be further impaired without the provision of services

On these occasions the practitioner (if necessary) should discuss the case with their line manager or designated safeguarding lead.
Following discussion if it is agreed the child does **not** need safeguarding and that current services can meet their needs, this information should be recorded in the child's records clearly stating the reason for the decision and the package of care for the child. The relevant action or package of care should then be offered to the child and their family.

If the staff member is unsure as to whether a concern would meet the threshold for MASH they should discuss with the Paediatric Liaison Health Visitor and / or Designated Nurse to agree the action to be taken. The outcome of any discussion should be recorded in the Child's records and the rationale for the decision.

4.2. Where a Child is considered at risk of significant harm

If the child is considered to be at significant harm and requires safeguarding the Practitioner must:

4.2.1. Risk is Immediate

- If the child is at immediate risk contact MASH on 01534 519000 between the hours of 8.30 and 17.00 hrs Monday to Thursday and 8.30 to 16.30 hrs on Friday. Outside of these hours Telephone Duty Social Worker on 01534 442000 or contact the Police on 01534 612612 and ask for Public Protection Unit.
- This should be followed up by completing a Multi Agency Safeguarding Hub (MASH) Enquiry Form. The Form can be found on the HSS intranet front page under Safeguarding The Completed Form must be emailed to Enquiries-MASH@gov.je and a copy to the Designated Nurse on e.plastow@health.gov.je and Michelle Cumming named Nurse for FNHC m.cumming@fnhc.org.je

4.2.2. No immediate risk to child

- Where the child is not an immediate risk a Multi Agency Safeguarding Hub (MASH) Referral Form should be completed. The Form can be found on the HSS intranet front page under Safeguarding The Completed Form must be emailed to Enquiries-MASH@gov.je and a copy to the Designated Nurse on e.plastow@health.gov.je

Accurate records must be kept of any discussions either face to face or by telephone and any meetings including strategy meetings undertaken these should be dated, timed and signed by all parties.

4.3. Medical Assessment

Where there is injury or assault to a child a referral **must** be made to the On Call Paediatrician, a paediatric medical assessment should be undertaken as a matter of urgency. Where this examination is undertaken by a Paediatric staff Grade it must be signed off by the On Call Paediatrician.

Where relevant the On Call Paediatrician may request a second opinion from a Forensic Medical Examiner. A report should be completed by the medical officer undertaking the examination within one working day.

In the Community, the point of contact for referral to assault / injury would be ED, the referring practitioner should inform both ED and On Call Paediatrician of the Referral.

Where the child is a Looked After Child it may be more appropriate for the LAC Doctor to undertake the medical examination.

In cases of suspected sexual abuse the Child Sexual Abuse Pathway should be followed.

4.4. What to include in the MASH Enquiry Form

When making an Enquiry into MASH you should:

- Identify clearly your concerns
- Why you are concerned and what is the evidence
- If there is urgent action required to protect the child and /or siblings /other children

4.4.1. Minimum Additional Information required on MASH Enquiry Form:

- Name, age, DOB, Address, Ethnicity
- Family composition and any details known
- Current location of the child
- Who has parental responsibility , if known
- Child's GP, Health Visitor. School Nurse, Nursery, School
- Any other agencies involved and their contact details if known.
- Any significant medical history
- The child's feelings /wishes

Practitioners should include ALL relevant information they hold.

4.4.2. Completing Enquiry Forms

There are a number of basic principles to follow when completing any Enquiry form, further advice on referral/report writing can be found in **Appendix 4.**

- Keep to the point stating facts and why they are relevant.
- Language needs to mean the same to everyone so if using medical jargon explain it.
- Abbreviations should be avoided
- The clear purpose for including information needs to be clear
- The information on the Enquiry form should flow and avoid repeating information. .
- Include both facts on the cause for concern but also evidence to support it.

- Referrals/ reports should NEVER include assumptions.
- Agencies should not comment on other agencies practice merely state their engagement if known.
- The principle of partnership working through sharing of professional information should be the premise of all referrals.

5. Consent

Wherever possible, consent should be sought from parents /guardians to disclose information to other agencies.

FNHC routinely seek written consent and advise parents on their first contact that all information shared is confidential except where a child may be considered to be at risk/harm. However even though this is an agreed position all staff must make parents /guardians aware of any referral of a safeguarding nature.

The parent/guardian's response to the sharing of information should be recorded on the Enquiry form and in the Records.

The ability for a young person to make their own decisions about their own care and treatment and rights to confidentiality may be based upon Gillick competence or the Fraser guidelines. It is however good practice to seek consent from competent children and to encourage competent children to involve their families or carers when consenting to share information.

6. Information Gathering

When MASH receive an enquiry the Police and Social Care will check whether the family is already known to social care. If the case is already open, all new information is made available to the allocated social worker.

Each case referred to MASH is assessed as to whether the case meets MASH Thresholds.

If the case is accepted by MASH the partner agencies in MASH i.e. health, FNHC, education and police will be asked to research any relevant information they may hold. The Decision Maker in MASH will then decide the outcome of the case.

7. Chronologies

7.1. Purpose of Chronology

Vulnerable children are best protected if agencies supporting them, work together and effectively share information. Single incidents seen in isolation can appear insignificant or harmless but incidents when seen together can show an escalating pattern of concern.
It is for this reason for those agencies who work with families on a continuing basis keep a chronology of significant events as they occur.

It is good practice to keep a chronology of significant events in all children's records. So that when asked for they are easily extricated from the Childs records and can contribute to multi-agency chronologies.

Practitioners should exercise professional judgement as to what events are considered **significant** and included within a chronology. **Appendix 5** provides a generic list as to what information **may** be considered **significant.**

7.2. Exemptions

For Health Departments who see children on a one /off incident e.g. Emergency Department (ED) and Ambulance Services it is not a requirement they complete a chronology. However for those children with multiple use of emergency services this information should be easily identified and collated, by ED. Where necessary these attendances must be followed up by the paediatric liaison health visitor.

8. Outcome of MASH Enquiry

The aim is for you to receive within 24 hours the initial decision on what action is to be taken, following MASH enquiry.
This may be:

1. Referral to the children's Initial Response Team (CIRT) for further assessment
2. Signposting to another agency for further support – early help
3. No further services involvement at this stage (the enquiring agency to continue to monitor)
4. No further action required

8.1. Process in Social Care on Receipt of Referral

On occasions it may be necessary for the social worker and police to undertake a child protection investigation.

Usually once all the information has been gathered from all agencies within MASH the MASH decision maker decides whether or not the child should be considered as 1) Child in Need (CIN); 2. Child Protection (CP); or 3. No Further Action (NFA) required.

For CIN and CP the social worker aims to complete an Initial Assessment within ten days. As part of the Initial Assessment a Professional Meeting may take place. If the concerns around the child are significant the Court process may also begin.
If the child is deemed at risk of immediate Significant harm (as assessed by the Social Worker), there may be an agreement to place the child in care under an Emergency Protection Order (EPO). In this situation the Initial Assessment must be completed within 24 hours of placement (this also applies to out of hours admissions).

If the Child meets the criteria for further assessment they may be considered a Child in Need CIN) or in need of Protection (CP)

If CIN the case will be transferred to the CIN Under 11 years Social Work team, or the CIN Adolescent Social Work team.
If they are Child Protection they will be transferred to the Statutory Social Work team.

8.2. Child Protection

The Statutory Social Work team complete a Core assessment within eight weeks, and an Initial Child Protection Case Conference is called within 15 days of Children's Initial response Team requesting it.

Following the Initial Child Protection Case Conference (ICPC), if the child is made subject of a Child Protection Plan, if not already under the Statutory Social work team they will be transferred to them at this point.

The first Core Group is called within 10 working days of the ICPC and these are held monthly.

A Review of the Case is undertaken at 3 months and again at 6 months.

Children who have been on the Child Protection Register on 3 or more occasions their case will be reviewed by the Head of Safeguarding in Social Care.

The MASH must report the outcome of all health related MASH enquiries to the Designated Nurse and Referrer within two weeks of Enquiry.

See Appendix 3. Jersey MASH Process

9. Escalation Policy and Resolution Pathway

Ultimately, it is the responsibility of staff within H&SS and FNHC to alert MASH to any safeguarding concerns. The MASH team will make the decision as to whether the Referral meets their criteria.

From time to time staff from partner agencies have differing views as to the level of risk and action to be taken.

If you disagree with the outcome of action taken, you should initially contact your line manager who will attempt to resolve any disagreement and if this is not possible you must follow the Escalation Policy and Resolution Pathway http://www.gov.je/Government/Pages/StatesReports.aspx?ReportID=1129

10. Information Sharing

An Information Sharing Protocol has been agreed and signed by Chief Officers of Education Sport and Culture, Health & Social Services, States of Jersey Police, Probation, Housing and Family Nursing and Home Care to ensure that for the purposes of safeguarding, information will be shared between agencies.

11.1 Vulnerable Adults

When identifying safeguarding concerns you identify vulnerable adults you have a duty to safeguard the adult and should refer to Single Point of Referral if appropriate. Similarly if in the course of work you see an Adult and their presentation gives concern for the welfare of their children you have a duty to safeguard the child even though it is the Adult presenting for Treatment.

11. Dealing with Disclosure & Confidentiality

An allegation by a child who report that they have been abused must be listened to and heard whatever form their attempts to communicate takes. You must listen and on no account should suggestions be made to children as to alternative explanations for their worries. A written, dated record should be made of the allegations at the time and signed by the member of staff to whom the allegation was made.

Members of staff should make it clear to a child who confides in them that, in some circumstances, they would be bound to pass on what they were told.

11.1. Rules to Remember when Listening to an Allegation:

- Ask no leading questions
- Err on the side of caution
- Elicit just as much information as you need in order to ascertain that there is a child protection issue which needs following up
- Log your conversation as soon after the event as possible and ensure that the words used are accurate
- Provide a signed, dated copy of your disclosure record to the designated named child protection health professional immediately

You can reassure the child they have done the right thing to share their worries and they will be helped and supported

12. Allegations about Staff

There may be an occasion when a child or a parent accuse staff of abusing them. Such an allegation should be dealt with as a matter of urgency through the complaints and child protection procedures ensuring the following principles are adhered to:

- The welfare of the child is the paramount consideration - The designated nurse / doctor must be informed immediately
- It is not advised to discuss this further with the complainant, if they wish to continue talking, listen without questioning. Interviewing the complainant is the responsibility of a professional with the specific role to investigate.
- Professionals should be informed of allegations against them as soon as possible but with due regard to protecting evidence and disclosure of information.
- It is not up to the recipient of the allegation to determine its validity, it is their role to pass this on to the appropriate manager ensuring they follow this with a written account of the incident which is dated, timed and signed.
- The senior / line manager or deputy in their absence, should be informed immediately so this is addressed as a matter of urgency for the benefit of all concerned.
- The manager who is informed must follow child protection procedure.
- Where the matter is referred to the police their investigation must take priority over an internal investigation.

13. Education and Training for Health Care Staff

To protect children from harm all healthcare staff must have the competences to recognise child maltreatment and to take effective action as appropriate to their role. It is the duty of their employers to facilitate access to training and education which enable the organisation to fulfil its aim to effectively protect children on the Island of Jersey.

Safeguarding competencies are the set of abilities that enable staff to effectively safeguard, protect and promote the welfare of children.

Different staff groups require different levels of competence depending on their role and degree of contact with children and families.
There are five levels of competence all staff across Health and FNHC should be competent in one of the five levels:

- Level 1. – All staff including non-clinical managers and staff working in health care settings
- Level 2 – Minimum level required for non-clinical and clinical staff who have some degree of contact with children
- Level 3. – Clinical staff working with children and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child and parenting capacity where there are safeguarding concerns
- Level 4 – Named Professionals
- Level 5 – Designated professionals.

The designated nurse will undertake an annual Training Needs Analysis of all staff in H&SS, the named nurse in FNHC will undertake the same activity across FNHC. Data from this will determine the Single Agency training programme, in addition:

- The Safeguarding Partnership Board provide Multi-Agency Training programme and all staff should be familiar with the programme content and access relevant programmes commensurate with their level of Practice.
- As a minimum all H&SS and FNHC staff should undertake multi-agency children safeguarding foundation training and be updated on an annual basis.
- The Designated Nurse and Doctor will undertake annual audit of all training undertaken by staff across H&SS and FNHC.
- All staff would be expected to meet the competencies as outlined in the Safeguarding children and young people: roles and competences for health care staff Intercollegiate Document Third Edition: March 2014.

14. Supervision Policy

All staff should refer to their Supervision Policy and access safeguarding supervision to meet their clinical need.

15. References

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States of Jersey (2011) Jersey Strategic Framework for Children and Young People. Available at: http://www.gov.je/Government/Pages/StatesReports.aspx?ReportID=668

United Nations Convention on the Rights of the Child (1989) Available at: http://www.unicef.org.uk/UNICEFs-Work/Our-mission/UN-Convention/

16. Consultation Schedule

PERSON CONSULTED	WHEN
Dr Mark Jones (Paediatrician)	August 2015
Dr Catherine Howden (LAC Doctor)	(April- August 2015)
Dr Kate Wilson (GP Lead)	August 2015
Dr Nicola Charles (ED)	(April- August 2015)
Dr Dawn O'Sullivan (FME)	(April- August 2015)
Michelle Cumming (FNHC)	(April- August 2015)
Glynis Collier (PLHV)	(April- August 2015)
Jane Long (LAC Nurse)	(April- August 2015)
Sally Gebhardt (Lead Nurse Children)	(April- August 2015)
Anne Patterson (Maternity)	July 2015
Linzi Gilmour (Named Nurse Children)	(April- August 2015)
Dr Carolyn Coverely (CAMHS Consultant)	(June – August 2015)
Natalie Spooner (MASH)	(April- August 2015)
Shane Jennings (MASH)	August 2015
Julia Wise St Leger (Childrens Services)	July 2015
Jo Ollson (Director Children's Services)	July 2015
Glynis Johnson (Chair, SPB)	July 2015
Stewart Gull (Police)	August 2015
Peter Gavey (Ambulance)	August 2015
Isobel Hamon (ED)	(April- August 2015)
Jane Ferguson (CAFCASS)	August 2015

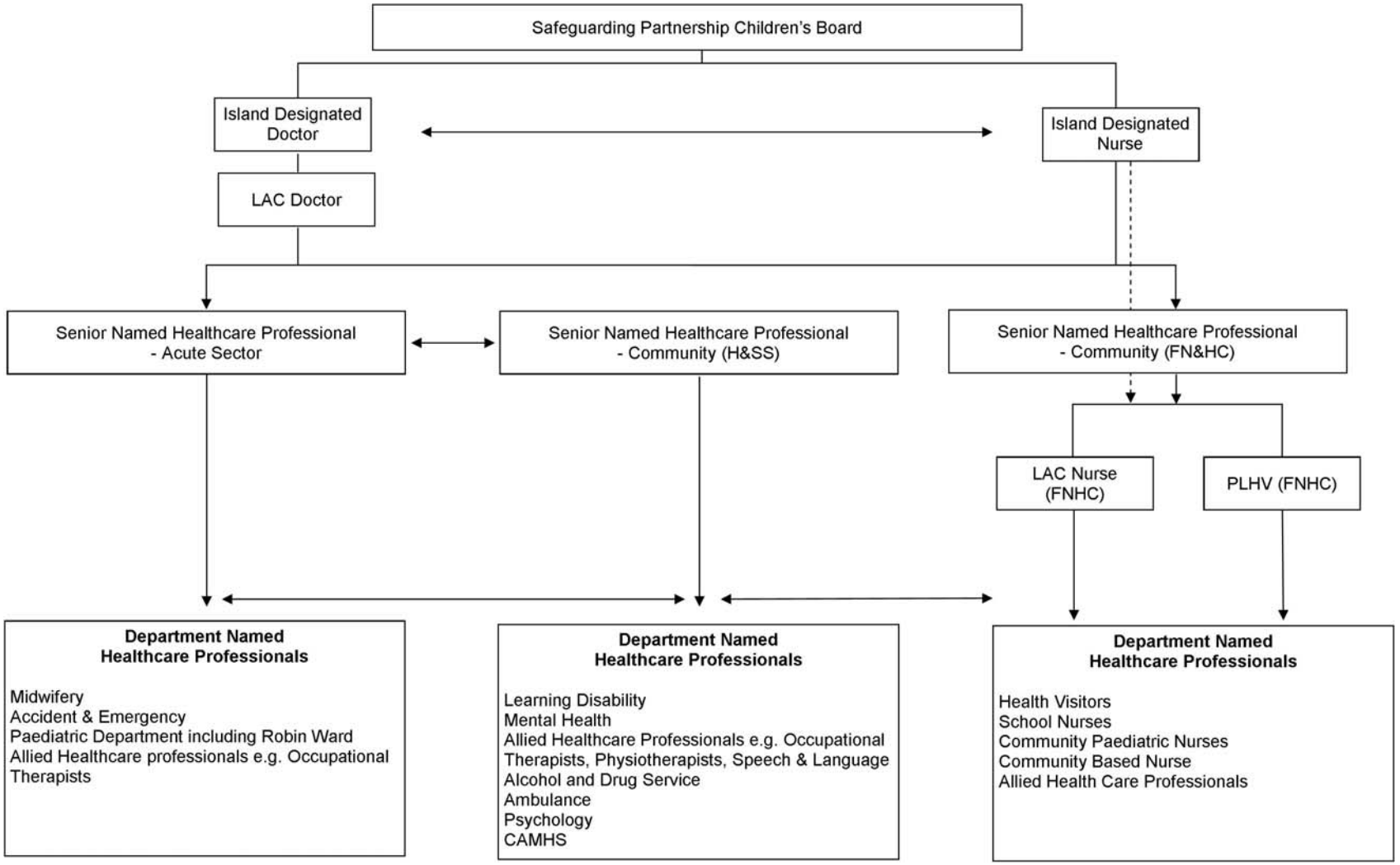
17. Implementation Plan

Action	Responsible Officer	Timeframe
Purchase of appropriate camera and log book. Identify secure storage in Robin Ward.	Lead Nurse Children. Robin Ward Manager	By November 2015
Training by department • MASH Process • Enquiry Form and Report writing	Designated Nurse, LAC Doctor and Children's Community of Practice	Upon ratification of pathway As required
Communication existence of pathway: Targeted presentations to: • Paediatricians • Neonatal unit • Maternity • Robin Ward • Emergency Department • EAU • Senior Nurses • Clinical Directors • Senior Health professionals for Safeguarding Group Cascade through team meetings and email Upload onto HSSnet	Designated Nurse LAC Doctor Lead Nurse for Children Clinical Directors and Senior Nurses Designated Nurse	Upon ratification of pathway Upon receipt of ratification of policy.
Audit	LACDoctor; Designated Nurse Named Nurse FNHC	6 months from implementation

Appendices

Appendix 1

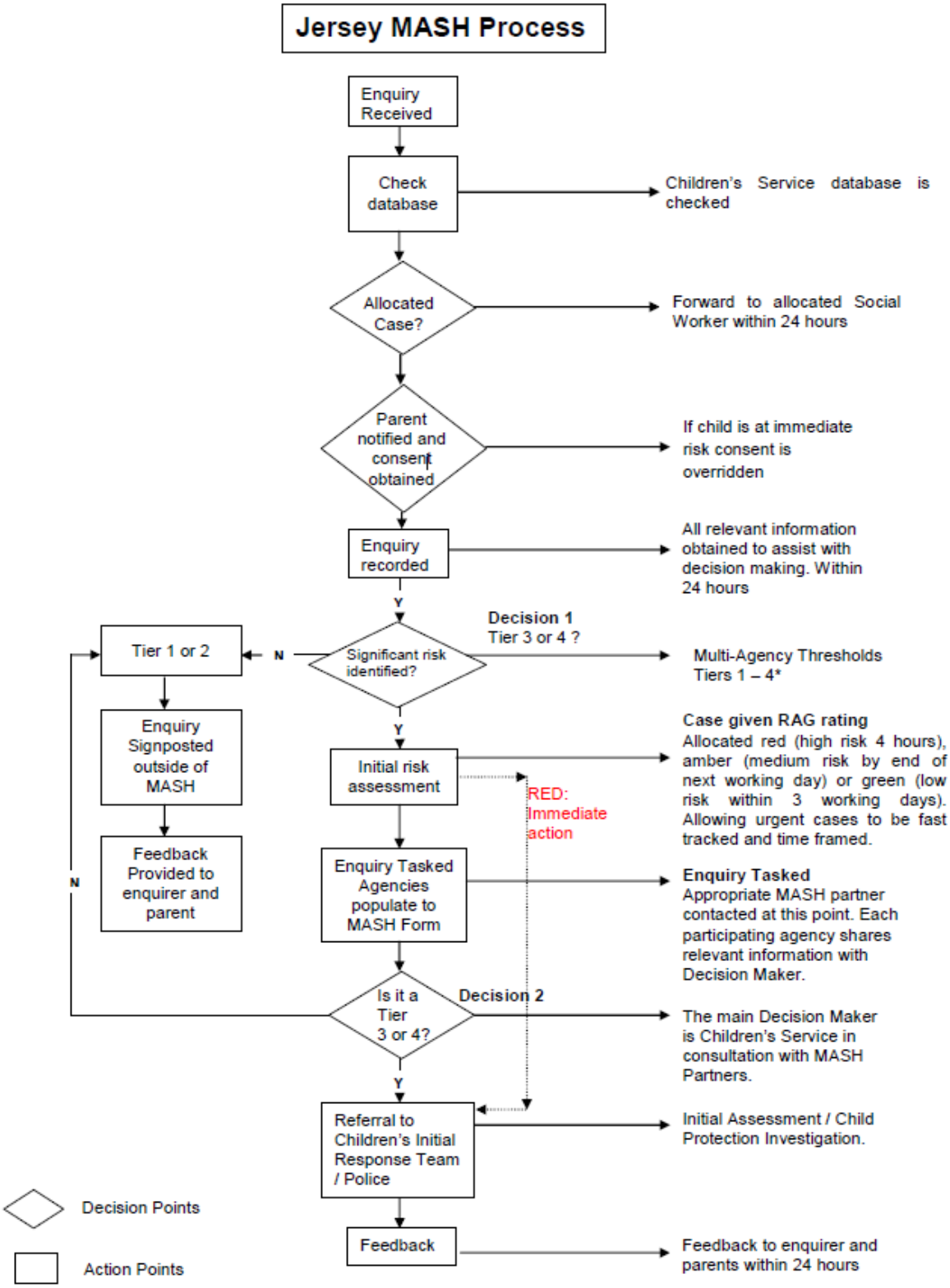
Structure Diagram of Communication and Responsibilities for Child Protection



Appendix 2 - Definitions of Abuse

Type of Abuse	Definition
Physical	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	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	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.

Appendix 3 - Jersey MASH Process



*Please refer to Multi-Agency Safeguarding Procedures

11th February 2015 – **Version 2**

Appendix 4 - Tips for Completing Enquiry Forms

When completing MASH Enquiry Forms there are a number of considerations that may help you:

1. Stick to the facts
2. If opinion is included it should be clearly stated this is a professional/expert opinion and justified in the evidence that supports the opinion and the reason why the person writing it has the expertise to write that opinion.
3. State who the information in any Report has been taken from

4. Avoid statements like 'I believe' because it suggests you are not sure find out fact and state it.
5. Avoid use of adverbs like 'very' e.g. very poorly/ naughty/ autistic etc. it does not mean anything to the reader.
6. If using adjectives to describe someone include evidence to support the statement.
7. Ensure grammar is correct and remains in 3rd person and past tense throughout.
8. Ensure the content of each section includes the relevant information for that section, so in section that relates to the child's view only include their views not the relatives or care staff. It just muddles the Report
9. If a child meets the criteria for an adult at risk state how you have come to that conclusion and what is the evidence to support this.
10. If using criteria to measure an injury, bruise, etc state what criteria is used and how the injury meets the criteria. If you have this information third hand state so. E.g. If a bruise is 3cms by 4 cms on inner thigh state who has seen it and who measured it to be that size;
11. When stating where information was obtained clarify difference between discussion and information. Where can the evidence of such discussion / information be found?
12. If you state an action has taken place be clear what you are saying the child attended nursery regularly, or the child's behaviour was typical of a teenager both are meaningless statements; state how often, what does regularly mean? What does a typical teenager look like?
13. Do not diagnose unless you are a doctor, paramedic or nurse practitioner with advanced diagnostic skills
14. If you state that something is comparable with another area, practice region etc provide evidence.
15. Do not state third party information unless the person stating it sees the Report and either countersigns it or confirms in writing they are happy for their statement to be included.
16. If you are going to make a conclusion of any sort it must make sense
17. If you make a statement about someone's parenting capacity be explicit what you mean by this and the evidence of why you have come to that conclusion.
18. Do not make statements that have clearly come out of a text book – its obvious!
19. **Never** make a judgement call on another agencies actions, you can if you have the evidence state the consequences of their actions.
20. **Never be subjective** if you believe an action resulted in harm you need to evidence it or state how it may be a contributory factor.
21. Never give opinion in an area that is not your expertise

22. Do not repeat information already provided ensure the information is in the right place in the context of the whole document rather than repeat.
23. Always read through the Referral Form and if possible get someone in your team to read it who does not know the case, to ensure it makes sense.

All staff completing forms should work to their professional codes of conduct and should seek supervision as required. The ultimate aim is to safeguard children and adults.

Appendix 5

Guidance on what may be considered Significant and Included in a Chronology

All staff should exercise professional judgement in deciding what is significant, however the list below although not exhaustive, provides a Guide

- Family history, birth, marriages, separations and bereavement
- Changes in household composition
- Employment/unemployment, homelessness
- Changes in Child Protection status, legal status
- Referral history and outcomes
- Education, behaviour, exclusions, admissions, absences, and school changes
- Changes in child's physical health, mental health and/or emotional wellbeing
- Domestic Abuse Incidents
- Substance misuse issues
- Criminal justice activity for parents, carers, young people
- Periods subject to Looked After Child process
- Missing episodes for child or family member
- Concerns around specific issues e.g. Child Sexual Exploitation, Trafficking
- History of convictions or violence
- CP enquiries and outcomes
- Court appearances and orders
- MAPPA, MARAC or sex offender registration
- Disability, illness, mental health
- ED and hospital admissions
- Vulnerable adult concerns
- Any key management decisions and brief reasons
- Relocation
- Any concerns and positive improvements.

It is essential when completing a chronology that all information is accurate.

Appendix 6

GLOSSARY

1. **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.

2. **YOUNG CARERS -** Are children and young people who assume important caring responsibilities for parents or siblings, who are disabled, have physical or mental ill health problems, or misuse drugs or alcohol

3. **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.

4. **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.