Captain Cook Primary School

Child Protection Policy

November 2016

Introduction

Captain Cook Primary School fully recognises its responsibilities for child protection and encompasses the five strands set out in the 'Every Child Matters' report. Staff in school are aware of the 'Keeping Children Safe in Education' (September 2016 document) and school safeguarding policies reflect the guidance set out within this.

The health and well being of our children physically, socially and emotionally, their safety and security is of paramount concern. We aim to create an atmosphere where children can enjoy school and achieve their full potential, where they can take an active role in the school community, the local community and prepare to take their place as full citizens in the wider world.
Our PSHE policy follows the guidance provided by the DfE and sets out how we teach children to care for their physical and emotional wellbeing, to develop satisfying social relationships and their rights and responsibilities as citizens. In addition to this we have made explicit links through our curriculum, assembly themes and wider school ethos to the promotion of fundamental British values.

Implementing our Procedures and Policy
Our policy applies to all staff, governors and volunteers working in the school. There are five main elements to our policy:

- Ensuring we practice safe recruitment in checking the suitability of staff and volunteers to work with children.
- Raising awareness of a wide variety of child protection issues including the 4 main types of abuse: physical, emotional, sexual and neglect (See Appendix 1) and equipping children with the skills needed to keep them safe.
- Developing and then implementing procedures for identifying and reporting cases, or suspected cases, of abuse.
- Supporting a pupil who has been abused in accordance with his/her agreed child protection plan.
- Establishing a safe environment in which children can learn and develop.
- Ensuring that all children in school are aware of staff in school who can help them in relation to the different issues or concerns they may have.

We recognise that because of the day-to-day contact with children, school staff are well placed to observe the outward signs of abuse. The school will therefore:

- Establish and maintain an environment where children feel secure, are encouraged to talk, and are listened to.
- Ensure children know that there are adults in the school whom they can approach if they are worried.
- Include opportunities in the PSHE curriculum and beyond for children to develop the skills they need to recognise and stay safe from abuse.

We will follow the procedures set out by Tees Local Safeguarding Board and take account of guidance issued by the Department for Education to:

- Ensure we have a designated senior person for child protection who has received appropriate training and support for this role.
- Ensure we have a nominated governor responsible for child protection.
- Ensure every member of staff (including temporary and supply staff) and governing body knows the name of the designated senior person responsible for child protection and their role.
- Ensure all staff and volunteers understand their responsibilities in being alert to the signs of abuse and responsibility for referring any concerns to the designated senior person responsible for child protection.
- Ensure that parents have an understanding of the responsibility placed on the school and staff for child protection by setting out its obligations in the school prospectus.
- Notify social services on the same day if there is an unexplained absence of a pupil who is subject to a child protection plan; contact EWO within 3 days for any child.
- Develop effective links with relevant agencies and co-operate as required with their enquiries regarding child protection matters including attendance interventions.

- Keep electronic records of concerns through CPOMs secure database about children, even where there is no need to refer the matter immediately.
- Ensure all records relating to child protection referrals/strategy/core or conference reports are kept securely; separate from the main pupil file, and in locked locations to ensure confidentiality is maintained.
- Follow procedures where an allegation is made against a member of staff or volunteer.
- Ensure safe recruitment practices are always followed.

We recognise that children who are abused or witness violence may find it difficult to develop a sense of self worth. They may feel helplessness, humiliation and some sense of blame. The school may be the only stable, secure and predictable element in the lives of children at risk. When at school their behaviour may be challenging and defiant or they may be withdrawn. The school will endeavour to support the pupil through:

- The content of the curriculum.
- The school ethos, which promotes a positive, supportive and secure environment and gives pupils a sense of being valued.
- The school behaviour policy, which is aimed at supporting vulnerable pupils in the school. The school will ensure that the pupil knows that some behaviour is unacceptable but they are valued and not to be blamed for any abuse which has occurred.
- Liaison with other agencies that support the pupil such as social services, Child and Adult Mental Health Service, Education Welfare Services and Educational Psychology Service.
- Ensuring that, where a pupil is subject to a protection plan or child in need category leaves, their information is transferred to the new school immediately and that the child's social worker is informed.

Responsibilities

The designated person for child protection is the Deputy Head Teacher. All concerns must be addressed to her before any further action is taken, and at all stages utmost confidentiality must be observed until decisions can be taken to benefit the child. Any evidence relating to a concern must be kept and given to the Deputy Head Teacher i.e. picture or writing or recording of the spoken word.

The responsibility of the designated person is:

- To monitor the well-being and safety of pupils within the school's care;
- To liaise with the appropriate agencies in matters of child protection;
- To collate and submit written contributions for case conferences;
- To establish and collate documentation for pupils subject to child protection plans;
- To inform staff, where appropriate, of relevant developments regarding their pupils;
- To attend courses and disseminate information and establish procedural routes;
- To ensure all adults employed in the school are DBS checked before working with children

The responsibility of staff:

Identification of a concern may include one or more of the following criteria:

- Poor attendance
- Inadequate parenting
- Poor punctuality
- Failure to thrive
- Dirty, inappropriate clothing
- Inappropriate language or behaviour
- Comments by the child, the parents or other agencies
- Obvious physical appearance of abuse and neglect

Further information relating to specific forms of abuse can be found in **Appendices One & Two**: this information has been taken from guidance provided by **Tees Local Safeguarding Board.**

Any staff concerns which may indicate the necessity for possible Child Protection intervention should be reported to the designated person who will contact the appropriate Child Protection Agency via the First Contact Team for Child Protection at Children's Services. Any information obtained relating to children or families should only be shared within a professional context.

If a formal registration is not recommended, but staff concerns remain the same, then observations and any further concerns will be recorded within the school. This may be an invaluable step if future action needs to be taken. All records are locked in a secure cabinet in the School Business Manager's Office; in addition electronic welfare notes are held on a secure online database: CPOMs. This can be accessed by a number of senior member of staff through a security key; security keys are not permitted to be taken off site and must be locked with drawers.

See **Appendices 3 and 4** for guidance notes

Parents/Carers

Staff would like parents and pupils to feel comfortable discussing any concerns with them and would see school as a safe place in times of difficulty.
Staff cannot however guarantee confidentiality if concerns are such that a referral must be made to the appropriate agency.
As a staff we cannot assume a child is not at risk because we know the parents.

Monitoring and Evaluation

It is the responsibility of the Head Teacher to monitor and assess the policy and report to the child protection governor of its effectiveness. It is responsibility of the entire governing body to monitor and review safeguarding across school; it is the responsibility of the governing body to manage any safeguarding allegation against the Head Teacher.

Designated Person	Role	Contact Details
Amy Young	Head Teacher: Safeguarding Lead	CCPS
Victoria Patton	Child Protection Designated Person	CCPS
	Safeguarding Governor	Via School Office
Julia Cairns	Safeguarding Deputy	CCPS
Mary Griksatis	Education Child Protection Officer	First Contact
Lynn Griffiths	LADO	726004/201835

*The policy will be reviewed during the Autumn Term of 2016.

Other related policies:

- Allegations against Staff
- Safeguarding Policy
- E-Safety Policy
- Anti-Bullying Policy
- Promoting British Values and Challenging Extremism Policy

Appendix 1

Signs and Indicators of the four main categories of abuse or neglect. ***Information obtained from Tees Local Safeguarding Children Board.***

Emotional Abuse

Emotional abuse is the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may include not giving the child opportunities to express their views, deliberately silencing them or 'making fun' of what they say or how they communicate. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond the child's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction. It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying (including cyberbullying), 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. Emotional abuse can lead to anxiety, depression, eating disorders, delinquency, aggression, poor social functioning and mental illness.

Neglect

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

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

It may also include neglect of, or unresponsiveness to, a child's basic emotional needs. Neglect is associated with situations where a parent or carer fails to meet the basic needs of the child e.g. by not providing adequate food, warmth, protection from harm, supervision, stimulation or medical care. The maltreatment of children – physically, emotionally, sexually or through neglect – can have major long-term effects on all aspects of a child's health, development and wellbeing.

Neglect may be factor in a number of areas where children may be experiencing difficulty, for example:

- Difficulty with forming attachments
- Impairment with physical and intellectual development
- Impairment of health
- Difficulty in social functioning/forming relationships
- Poor educational progress
- Low self-esteem
- Isolation

- Risky behaviour,
- Running away
- Bullying
- Anti-social behaviour.

Professionals should, therefore, consider whether neglect may be an issue where such difficulties arise.

Severe neglect of young children has adverse effects on children's ability to form attachments and is associated with major impairment of growth and development. Persistent neglect can lead to serious impairment of health and development, and long-term difficulties with social functioning, relationships and educational progress. Neglected children may also experience low self-esteem, and feelings of being unloved and isolated. Neglect can also result, in extreme cases, in death. The impact of neglect varies depending on how long children have been neglected, the children's age, and the multiplicity of neglectful behaviours children have been experiencing.

Physical Abuse

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

Physical abuse can lead to neurological damage, injury and, in extreme situations, death. Although physical abuse can be particularly dangerous for babies and young children – e.g. shaking a child can cause major injury or death – its impact, both in terms of physical and emotional wellbeing is of major concern for children and young people of all ages. Physical abuse is a traumatic experience to any child who is victim of it or who witnesses physical abuse within their family environment.

Physical abuse may be particular prevalent in households where there are issues of domestic violence or drug and alcohol abuse.

Physical abuse of children has been linked to aggressive behaviour, emotional and behavioural problems and educational difficulties.

Sexual Abuse

Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing.

They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet). Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.

It is important to differentiate between contact and non contact offences for example contact offences include sexual touching and sexual activity with a child and non contact offences would include sexual activity in the presence of a child and children made to view indecent material. Children could be groomed or in sighted to commit sexual acts remotely, eg. via webcam

Appendix 2

Female Genital Mutilation

Female Genital Mutilation (FGM) is a term used to refer to any practice which includes the removal or alteration of the female genitalia. FGM is illegal in the UK but is seen as an acceptable custom within certain cultures and communities.

Definition and overview

Even though FGM is a child protection issue which has a major impact on the health and wellbeing of the child – it can take place within otherwise loving and caring families, who genuinely believe there are acting in the best interest of the child. FGM must always be regarded as causing significant harm.

Legal position

FGM is a criminal offence under the Female Genital Mutilation Act 2003. The act also makes if offence for UK nationals or permanent residents to carry out, or aid, abet, counsel or procure the carrying out of FGM abroad – including for countries in which the practice is legal.

Prevalence

FGM is carried out in parts of Africa, and the Middle and Far East. It is also found in Western Europe – primarily amongst immigrant and refugee communities. It is estimated that 24,000 females under the age of 15 are at risk of FGM in England (see Dorkenoo et al 2007. Available from Forward UK). FGM is most commonly performed on females aged between 4 and 13 but can also be carried out on babies, younger children and older children.

Impact on children

FGM is carried out on children who cannot understand the full implications or exercise informed choice. The practice is painful and can have serious health implications (including death in some circumstances through blood loss or infection) both at the time of procedure and in later life. FGM can cause the following:

- Shock Bleeding
- Extreme pain
- Infection Spread of HIV and hepatitis (through the instruments used)
- Damage to the vaginal area
- Abscesses and tumours
- Infertility
- Scarring
- Bladder and kidney damage
- Pain during intercourse/increased risk of infection from intercourse
- Tearing/bleeding during childbirth (some women will need to be recut to allow birth to occur)
- Decreased sexual pleasure/fulfilment
- Feelings of humiliation and betrayal

A child may be considered to be at risk if it is known that older girls in the family have been subject to the procedure. Pre-pubescent girls of 7 to 10 are the main subjects, though the practice has been reported amongst babies.

It should also be remembered that FGM can be the "norm" with specific communities and may play a part of acceptance and fulfilling the role of a female within the community expectations. Where that community is a minority within a wider society there may be immense psychological impact of a person who has been/will be subject to FGM, as they are caught between the specific expectations of their community and the wider cultural expectations of the wider society.

Parents and others who have subjected daughters or plan to subject daughters to FGM do not intend it as an act of abuse; they believe it is in the girl's best interest to conform to their prevailing custom. Agencies should work together to promote a better understanding of the damaging consequences to physical and psychological health of FGM. Wherever possible the aim must be to work in partnership with parents, families and communities to protect children through parents awareness of the harm caused to the child.

Potential indicators that FGM may have/could occur

- Belonging to a community where FGM is practiced
- Planned holidays/absence from school
- Changes in behaviour or avoiding certain activities e.g. school PE following the procedure
- Child referring to a "special procedure"

Where a professional or agency believes a child is likely to suffer of has suffered FGM a child protection referral must be made.

Fabricated or Induced Illness

Introduction

Fabricated or Induced Illness by parents or carers (FII) can cause significant harm to children. FII involves a well child being presented by a parent/carer as ill, or a disabled or ill child being presented with more significant problems than he or she has in reality. This may result in extensive, unnecessary medical investigations being carried out in order to establish the underlying causes for the reported signs and symptoms. The child may also have treatments prescribed or investigations, procedures or operations which are unnecessary. These interventions can result in children spending long periods of time in hospital and some, by their nature, may also place the child at risk of suffering from harm or even death.

There are particular challenges for all professionals in terms of recognising and responding to possible FII. This procedure aims to support professionals from all agencies to recognise and respond in order to effectively safeguard the child.

Definition of FII

FII is a spectrum of disorders rather than a single entity. At one end of the spectrum less extreme behaviours may include a genuine belief that the child is ill or an exaggeration of existing symptoms. At the other end of the spectrum the behaviour of carers includes them deliberately inducing symptoms in the child. For the purpose of this

procedure the behaviours can be broadly divided into the following areas, whilst recognising they are not mutually exclusive:

- Exaggeration of existing symptoms to an extent which leads to potential harm to the child or significantly impacts on their day to day life.
- Fabrication of signs and symptoms.
- Falsification of hospital charts and records, and specimens of bodily fluids.
- Induction of illness by a variety of means.

Examples of behaviours associated with FII

- Exaggerating symptoms, which may cause professionals to undertake investigations and treatments.
- Claiming the child has symptoms which are unverifiable unless observed directly, such as observing signs of pain, frequency of passing urine, vomiting or fits.
- Fabrication of past medical history.
- Falsification of letters and documents.
- Providing specimens reported to be from the child which have been tampered with or other substances added or are from another person.
- Interfering with treatments by overdosing, not administering them or interfering with medical equipment such as infusion lines.
- Obtaining specialist treatments or equipment for children who do not require them.
- Alleging psychological, emotional or behavioural disorders.
- Deliberately inducing symptoms in children by administering medication or other substances or by means of intentional suffocation

FII can cause death, disability and physical illness. It can also lead to emotional difficulties for the child and confusion over their own health status. Professionals must remain focused on the impact of FII on the child's health and development, this is crucial to ensure an appropriate safeguarding response.

Professionals may have concerns because parents are describing a child's illness or health needs which are not witnessed by the professionals. If they remain concerned or have heightened concerns they should discuss the child with the Safeguarding Lead. If concerns remain, then the child should be discussed with the School Nurse or Health Visitor. Consent from the parents to do this should be sought on the grounds that that this is usual practice where a child has an illness which is impacting on their health or development. At this stage the concern about possible FII should not be disclosed to the parent/carer. If parents refuse consent for a discussion with the School Nurse or Health Visitor then this should be discussed with the Safeguarding Lead to consider whether refusal increases the level of concern. When a parent/carer reports restrictions/limitations for normal school activities it is important this is verified with the reported source of the advice.

Professionals should keep careful and secure records of absences and reasons given by parents for absences so that these can be corroborated. The professionals should listen to the child and document what they are saying.

All discussions, including those with parents/carers, must be documented and kept in a secure record.

Appendix 3

Child Protection Guidelines For Staff

Teachers are the identifiers
Other agencies are the investigators

Remember see Head Teacher or Deputy, before consulting parents/guardians or other members of staff if you have concerns of a sexual nature about a child.

Try to have 2 teachers present when talking to a child involving child protection issues.

Always keep evidence of a sexual nature and do not give to parents until a decision has been made by the Head Teacher and Deputy Head Teacher.

Don't tell parents if sexual abuse is suspected. **Don't put yourself or the child in danger.**

Be cautious about people who come into school to talk about a child e.g. solicitor – particularly if the child is the subject of a court order. Don't speak to the above directly, pass any relevant information to the Head Teacher/Deputy Head Teacher.

Parents are only allowed to see attendance and academic records.

The Attendance Assistant (Rachel Lake) can be involved with families who are continually late.

Parents of a child will be informed if their child is isolated through issues such as 'smelly clothes' and then if there is no improvement a referral may be made to social services.

The Head Teacher will ensure any concerns are passed on to future schools.

Narratives from the child must be reported using the child's EXACT language and references.

The Head/Deputy Head Teacher has a list of children who are subject to Child Protection intervention. She will inform staff as appropriate.

Contact names and telephone numbers can be found in the Head Teacher's office.

Only share information relating to children or families within a professional context and with permission from the designated CP lead.

Provide phase leaders with regular welfare updates for vulnerable pupils so that they can be raised and discussed during the half termly welfare meetings held in school.

Appendix 4

Disclosure Guidelines For Staff

If a child alleges abuse or neglect:

Take the child to a private place and listen to what is being said.

Accept what is said.

Try to take notes.

Reassure the young person but only so far as is honest and reliable.

Do not make promises that you cannot keep.

Do not promise confidentiality.

Do reassure the young person only as far as is necessary for you to establish whether or not you need to do a referral. **DO NOT INTERROGATE.**

Do not ask leading questions e.g. "What did he do next?" (this assumes something else did happen) "Did he touch your private parts?" Such questions may invalidate your evidence and the child's if the case goes to court.

Ask open-ended questions like, "Anything else you would like to tell me?"

Do not criticise the perpetrator, the young person might love him/her.

Do not ask the pupil to repeat it for another member of staff.

Make some brief notes at the time if you are able and write the notes up as soon as possible.

Do not destroy the notes in case they are required in court.

Record the time and date of the disclosure and if the child uses 'pet' sexual words record the actual words the child uses and do not translate them into 'proper' words.

A 'body map' must be completed if there are signs of physical injury. Record only observable or factual things – do not interpret. All reports and body maps must be dated and signed.

Tees Multi Agency SAFER Referral Form

SAFER i.e. **S**ituation, **A**ssessment, **F**amily, **E**xpected response**, R**ecording.

Section one: **S**ituation *SAFER*

For additional guidance on contacting children's services, please refer to individual local authority websites

I am completing this referral because: (please tick as appropriate):

I BELIEVE THIS CHILD IS AT RISK OF SIGNIFICANT HARM	
I BELIEVE THIS CHILD IS IN NEED OR VULNERABLE	
THIS CHILD HAS BEEN ASSESSED THROUGH THE COMMON ASSESSMENT FRAMEWORK AND I BELIEVE MAY BENEFIT FROM ADDITIONAL SUPPORT	
I BELIEVE THIS CHILD MAY BENEFIT FROM SUPPORT THROUGH THE COMMON ASSESSMENT FRAMEWORK *(For use only by those agencies who would not normally complete a CAF)*	
I BELIEVE THIS CHILD MAY BE VULNERABLE TO CHILD SEXUAL EXPLOITATION	

1. About you

This is *(your name)*:			
I am a *(job title)*:			
from *(organisation)*:		Police Event No.	
Postal address:			
Email address:		Telephone:	
My relationship to the child concerned is:			

Common Assessment Framework (CAF)

- The CAF process has/has not been followed
- If the CAF **has** been followed when was it completed and sent to the CAF Co-ordinator *(date)*? _____.

Please attach a copy of the latest assessment and go to Section 4.

- If it **has not** been followed, please outline why and complete the following sections;

2. About the child

I am calling about a male / female child called:			
Child's address:			
Postcode:		Date of birth/ expected birth date:	
The child does/does not have a disability			

3. Child's ethnicity and language

White ☐ White British ☐ White Irish ☐ Gypsy/Roma ☐ Traveller of Irish heritage ☐ Any other White background	Black or Black British ☐ African ☐ Caribbean ☐ Any other Black background Please state ……	Asian or Asian British ☐ Bangladeshi ☐ Indian ☐ Pakistani ☐ Any other Asian background Please state ……..
Mixed/dual background ☐ White and Asian ☐ White and Black African ☐ White and Black Caribbean ☐ Any other mixed background Please state……	Chinese and other ☐ Chinese ☐ Any other ethnic group Please state …….. ☐ Not given	Religion …….. First Language ……..

4. Other services involved with the child are:

Service	**Details (e.g. name, address)**	**Telephone**
☐ GP		
☐ Early years		
☐ School		
☐ Other (specify)		
☐ Other (specify)		
☐ Other (specify)		
☐ Other (specify)		

5. Details of parents/guardians

- **Parent/guardian 1**

Name:		D.O.B.	
Relationship to child concerned:		Do they have parental responsibility?	☐ Yes ☐ No ☐ Don't Know
Address:			
Postcode		Telephone:	

- **Parent/guardian 2**

Name:		D.O.B.	

Relationship to child concerned:		Do they have parental responsibility?	☐ Yes ☐ No ☐ Don't Know
Address:			
Postcode		Telephone:	

The child's parents/guardians are/are not aware of the referral

- If the parent(s) or guardian(s) **are** aware of this referral, what are their views?

- If the parent(s) or guardian(s) **are not** aware of this referral please explain why

6. Current family and home situation

Who else lives with the child or plays a significant role in their life, e.g. siblings or grandparents

Name	Date of birth	Relationship to child	Living with child?

Section two: **A**ssessment and actions	***SA****FER*

Tick the appropriate statement and provide further details below

☐ I have assessed the child personally and the specific concerns are…

☐ I am concerned for the child's safety / wellbeing because…

☐ I have not been able to assess the child but I am concerned because…

(Provide specific facts – what you have seen, heard and/or been told and when you last saw the child and parents)

There has been a change since I last saw the child ___ days/weeks/months ago

The child is now *(describe current conditions and whereabouts)*:

I have taken the following actions to make the child safe:

Section three: **F**amily factors	***SAFER***

Specific family factors making this child at risk of significant harm are as follows: (*please include any information with regard to the incidence of substance misuse, domestic abuse, parental mental health, learning difficulties or any other factors and how they impact on parenting)*

Additional factors creating vulnerability are:

The strengths in the family situation are:

There might be risks to staff visiting the child's family, they are:

Section four: **E**xpected response	***SAFE****R*

In line with Working Together to Safeguard Children, NICE guidance and the Children Act 1989, I recommend that the following action is taken:

☐ An urgent assessment as a child in need of protection.

☐ For further assessment as a child in need.

☐ For further support under Common Assessment Framework.

☐ For information sharing purposes.

What services do you think will make things better / safer for the child?

What services will **you** continue to provide for the child?

If you have made a telephone call regarding this referral, record outcome of the discussion here:

7. About the member of staff taking the referral

Their name is:	
Their job title is:	

Section five: **R**eferral and recording	***SAFER***

All referrals to Children's Services must be followed up in writing using the Safer Referral template. Urgent child protection referrals must be made via a telephone call and followed up in writing within 24 hours. For less urgent situations it will be expected that the information is recorded in writing prior to any contact with Children's Services. At any stage, however, Children's Services can be contacted for advice and guidance with regard to how to progress referral.

Once a referral is accepted by Children's Services the person making the referral will receive a feedback letter detailing the action taken.

Children's Services	Office hour	Out of hours	Fax	Email
Hartlepool	01429 284284	08702 402994	N/A	fcsh@hartlepool.gcsx.gov.uk
Middlesbrough	01642 726004	08702 402994	N/A	firstcontact@middlesbrough.GCSX.gov.uk
Redcar & Cleveland	01642 771500	08702 402994	01642 771535	firstcontact@redcar-cleveland.gcsx.gov.uk
Stockton-on-Tees	01642 527764	08702 402994	01642 527756	First.contact@stockton.gcsx.gov.uk
North Yorkshire	0845 0349417	0845 0349410	01609 536993	social.care@northyorks.gov.uk
Durham	03000 267979	03000 267979	0191 3835752	First.contact@durham.gcsx.gov.uk

Please sign and date this form

Signature _____

Print Name _____

Date Signed _____

For Health Professionals Only please copy to: -

Health Professional	Date Sent	Tick
Midwife		
Health Visitor		
Family Nurse Practitioner		
School Nurse		
GP		
SNSC		
Other		

Confidentiality Notice – This information is shared in accordance with Tees LSCB's Information Sharing Protocol, if received in error please contact the referring organisation.

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Middlesbrough
TS7 8DU

Tel: 01642 315254
Fax: 01642 315277
Email: ckcaptaincook@mcschools.org.uk
Website: www.captaincookprimary.co.uk

Transfer Form for Child Protection Records between Educational Establishments

(Please print all information)

Name of Child .....

Date of Birth .....

Unique reference number (schools only) .....

Home address .....

Name of originating establishment .....

Address of originating establishment .....

Name of current Child Protection Lead .....

Date file exchanged by hand .....**OR**

Date file posted by special delivery .....**OR**

Date information received electronically .....

Name of receiving establishment .....

Address of receiving establishment .....

Name of receiving Child Protection Lead .....

Date file received by hand .....**OR**

Date received by recorded delivery .....**OR**

Date information received electronically .....

Signature of receiving Child Protection Lead .....Date.....

Upon receipt, the receiving setting should

- **Sign this form and keep a copy with the child's CP records**

- **Ensure the original form is returned to the originating establishment without delay**
- **The originating establishment should keep the returned form securely in line with the Transfer and Retention of Child Protection Records**