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*

Before completing the form please refer to the threshold document to ensure the correct pathways are being followed.

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

I BELIEVE THIS CHILD REQUIRES SOCIAL CARE INTERVENTION	☐

1. About you

Name:			
Job title:			
Organisation:		Police Event No.	
Postal address:			
Email address:		Telephone:	
My relationship to the child concerned is:			

Early Help Assessment

Has there been an Early Help Assessment completed? **Yes** ☐ **No** ☐

If so, by who ______________________

Lead Professional (if known) ______________________

Date completed ______________________

Date closed (if appropriate) ______________________

(Please attached the Early Help Assessment to the referral – if available)

2. About the child/children

Child's name:		Gender:	M	☐	F	☐
Child's address:						
Postcode:		Date of birth / expected birth date:				
The child does ☐ / does not ☐ have a disability						

3. 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?

4. Families ethnicity and language/please refer to appendix 1 guidance, last page of this document

Ethnicity	First Language	Interpreter Required	Religion
		Yes ☐ No ☐	

5. 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)		

6. 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:	

Do you have consent to make the referral from parents/carers.

Yes ☐ **No** ☐

If no consent has been sought, explain the reason why

If the referral does not meet the thresholds for social care intervention, are parents/carers happy for the information to be passed to early help for support and for the information to be shared with relevant agencies.

Yes ☐ **No** ☐

Section two: **A**ssessment and actions *SAFER*

What are you worried about? Outline your concerns. (What have you seen, heard or been told and when did you last see the child and parents)

What are the strengths and protective factors in the family?

What action have you taken to address any concerns?

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

What are the **specific factors** making this child at risk of significant harm? (*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)*

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

Section four: **E**xpected response *SAFER*

What services will **you or your agency** continue to provide for the child / family (if appropriate)?

When did you last see the child and what are his / her views, if known? How have you tried to obtain their views?

If you have made a telephone call in relation to this referral, please record the outcome of the call and any agreed actions.

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	01429284284	08702 402994	N/A	childrenshub@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	01429284284	08702 402994	01642 527756	childrenshub@hartlepool.gcsx.gov.uk
North Yorkshire	0845 0349417	0845 0349410	01609 536993	social.care@northyorks.gcsx.gov.uk
Durham	03000 267979	03000 267979	0191 3835752	First.contact@durham.gcsx.gov.uk
Darlington	01325 406222	08702 402994		childrensaccesspoint@darlington.gcsx.gov.uk

Please sign and date this form

Signature ____

Print Name ____

Date Signed ____

Please list everyone you have shared / discussed this referral with and when.

Name	Title	Agency	Date / Time

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

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