ALLEGATIONS AGAINST STAFF REFERRAL FORM

On completion this form is to be returned to:
professionalallegations@derbyshire.gov.uk

PERSON MAKING THIS REFERRAL ON

Name:

Address:

Job Title:

Telephone No: E mail:

COMPLAINANT

Name:

Address:

Date of Birth:

What is the connection with the person complained about:

Does the child have a disability? Yes/No

DETAILS OF PERSON COMPLAINED ABOUT

Name:

Home Address:

Date of Birth: Telephone No:

Employer/Place of Work:

Job Title:

ANY OTHER INVOLVED PARTIES

Name:

Address:

Date of Birth: Telephone No:

How involved:

Name:

Address:

Date of Birth: Telephone No:

How involved:

Is this event being described as a physical intervention or restraint? **YES/No**

BRIEF DETAILS OF THE ALLEGATION

(includes times, dates, potential witnesses etc, where known)

RISK ASSESSMENT AND INTERMEDIATE SAFEGUARDING PLAN

(include details of what, if anything has been done to secure the immediate safety of the young person potentially at risk)

ACTION TAKEN SO FAR

(include what, if anything has been done by way of talking to any of the people involved, whether medical advice has been sought etc)

INVITEES FOR ALLEGATION/STRATEGY MEETING

(Please include full contact details for all Professionals/Individuals)

	√	CONTACT NAME/DETAILS
POLICE		

CHILDREN'S SOCIAL CARE		
HEALTH		
SCHOOL		
SAFEGUARDING MANAGER		
MENTAL HEALTH		
EARLY YEARS		
PRIVATE AGENCY		
OFSTED		
ADULT SOCIAL CARE		
HUMAN RESOURCES		
COUNTY TRANSPORT		
PROBATION		
OTHER (please specify)		