Safeguarding Children Policy and Procedure (N-045)

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Policies should be accessed via the Trust intranet to ensure the current version is used

SAFEGUARDING CHILDREN POLICY AND PROCEDURE

Safeguarding and promoting the welfare of children and protecting them from harm is the responsibility of every member of staff employed or working as a volunteer in Humber Teaching NHS Foundation Trust including bank and agency staff. The Trust shares a commitment to safeguard and promote the welfare of children and young people and for health this is underpinned by a statutory duty or duties. That duty is under Section 11 of the Children Act 2004.

All staff should be aware that age, gender, cultural or religious beliefs, disabilities or social backgrounds may also impact on their ability to access help and support. Staff must give due consideration to these issues at all times when dealing with children, young people and their families. This policy gives due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it.

Safeguarding children and young people is a multi-agency activity and is dependent upon partnership working with other statutory and non-statutory agencies. It is essential therefore that this policy is read in conjunction with Working Together to Safeguard Children 2018 www.gov.uk, procedures and guidance from the East Riding Safeguarding Children Partnership (ERSCP) https://www.erscp.co.uk /, the Hull Safeguarding Children Partnership (HSCP) www.hullcc.gov.uk, and the North Yorkshire Safeguarding Children Partnership (NYSCP) www.safeguardingchildren.co.uk. The guidance set out in Working Together 2018 is statutory and must be followed when responding to welfare concerns and/or where there is or may be an alleged crime.

Contents

1. INTRODUCTION

For the purposes of this policy, the term 'child' refers to any child or young person up to the age of 18 years (Children Act 1989 and 2004). 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 their status or entitlements to services or protection.

Safeguarding and promoting the welfare of children and protecting them from harm is the responsibility of every member of staff employed or working as a volunteer in Humber Teaching NHS Foundation Trust including bank and agency staff.

Safeguarding children and young people is a multiagency activity and is dependent upon partnership working with other statutory and non-statutory agencies. It is essential therefore that this policy is read in conjunction with Working Together to Safeguard Children 2018 www.gov.uk, guidance and procedures from the East Riding Safeguarding Children Partnership (ERSCP) https://www.erscp.co.uk, the Hull Safeguarding Children Board (HSCB) www.hullcc.gov.uk, and the North Yorkshire Safeguarding Children Partnership (NYSCP) www.safeguardingchildren.co.uk. The guidance set out in Working Together 2018 is statutory and must be followed when responding to welfare concerns and/or where there is or may be an alleged crime.

Care Quality Commission (CQC) - Key Lines of Enquiry
This policy supports the compliance with the Care Quality Commission Key Lines of Enquiry investigation framework.

2. SCOPE

The purpose of this policy is to assist all staff (including voluntary and students) within the Trust to be aware of their roles and responsibilities in safeguarding and promoting the welfare of children. The procedures and guidance within the policy will enable the Trust to fulfil its statutory duties as determined by the Children Act 1989 and 2004.

Other organisations working on behalf of the Trust must have policies and procedures in place consistent with this document and be compliant with any other safeguarding children related statutory guidance and legislation, relevant to their organisation.

3. POLICY STATEMENT

The Trust shares a commitment to safeguard and promote the welfare of children and young people and for health this is underpinned by a statutory duty or duties. That duty is under Section 11 of the Children Act 2004.

All staff should be aware that age, gender, cultural or religious beliefs, disabilities or social backgrounds may also impact on their ability to access help and support. Staff must give due consideration to these issues at all times when dealing with children, young people and their families. This policy gives due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it.

4. DUTIES AND RESPONSIBILITIES

Chief Executive
The Chief Executive is accountable and responsible for ensuring that the Trust's contribution to safeguarding and promoting the welfare of children is discharged effectively. The Chief Executive is also responsible for ensuring the Trust is compliant with Section 11 of the Children Act 2004.

The Trust Board and Directors
The Trust Board is responsible for the overall safeguarding of children in the organisation. The Board is responsible for reviewing and maintaining an effective system of internal control, including systems and resources for managing all types of risk associated with safeguarding children.

Executive Director of Nursing, Allied Health and Social Care Professionals
The Executive Director of Nursing is responsible, along with the Chief Executive, for ensuring the Trust discharges its duties in relation to safeguarding children and young people. The Director of Nursing for safeguarding children and young people sits on both the Hull and East Riding Safeguarding Children Partnership Boards

Trust Executive
The support, leadership and authority of the Trust's executive is required to ensure that related policies and documents (whether paper or electronic) used at the point of admission or entry to our services, at review and at the point of discharge or transfer, in all divisions, prompt staff to Think Family and take the appropriate action (National Patient Safety Agency 2009, Care Quality Commission 2009, Monitor 2009, Care Act 2014).

Named Nurse and Named Doctor
The Trust has in post a Named Nurse and Named Doctor in keeping with statutory requirements placed on NHS providers, who have operational and strategic responsibility for implementing the safeguarding of children within the Trust. They provide safeguarding supervision, advice and support to all Trust staff, participate in safeguarding audits as part of the Trust's governance agenda, take responsibility for the Trust's internal case reviews, child death reviews, and work collaboratively with health, other local Safeguarding Children's Partnerships and partners.

All Staff
Achieving good outcomes for children requires all those who work with and have a responsibility for assessment, and the provision of services to work together according to an agreed plan of action. It is the responsibility of all staff including volunteers, students, agency and locum staff working in Humber to:

- Be clear of their roles and responsibilities for safeguarding and promoting the welfare of children in line with current legislation and local Partnership guidance;
- Be clear of the purpose of their activity, what decisions are required at each stage of the process and what are the intended outcomes for the child and their family members;
- Which agency, team or professional has lead responsibility, and the precise roles of everyone else who is involved, including the way in which children and other family members will be involved;
- Know how to contact the key safeguarding professionals in their organisation to seek advice around safeguarding children issues;
- Check record systems relevant to work area to ascertain whether there is a safeguarding alert in place;
- Attend mandatory safeguarding children training in accordance with their role and responsibilities;
- Establish the identities of any other family and household members. Record these in the child's records and share this information with Children's Social Care when making a child protection referral;
- Access child protection supervision as per the Humber Supervision Policy.

- Make referrals to Children Social Work Services in accordance with local authority safeguarding children procedures when they believe a child is in need of safeguarding or protection and follow up any such referrals. Request for Service and Referral Forms links are included in appendix 1. ;
- Share information with other agencies in accordance with local safeguarding children partnerships guidance and procedures and Trust Information Sharing Protocols;
- Participate, where invited and appropriate, in child protection statutory meetings by attending and taking an equal part in the decision making;
- Provide or contribute to a written report where required for the purpose of an initial child protection case conference and or review conference;
- Bring to the attention of the Named Doctor and/or Named Nurse for Safeguarding Children cases where there is a difference of opinion in relation to the diagnosis, safety or welfare of a child;
- Send a representative, in the rare event that staff are unable to attend a case or review conference. A written report must be submitted;
- Ensure staff responsible for the care of adults routinely ask patients whether they have any caring responsibilities for children, so that the impact on the child of any carer ill health can be assessed.

5. CATEGORIES OF CHILD ABUSE

The four definitions below are identified in the Working Together guidance (2018):

- Physical abuse;
- Neglect;
- Sexual abuse;
- Emotional abuse.

Some other forms of child abuse and child protection concerns that sit within the above definitions include:

- Domestic abuse (see Appendix 5);
- Female Genital Mutilation (see Appendix 4);
- Prevent (see Appendix 6).

They should be used to assist in framing a referral to Children's Social Care when the practitioner has a concern that a child is in need, or is at risk, or has suffered significant harm.

5.1. Was Not Brought

Children and young people have a right to receive appropriate healthcare and it is the responsibility of parents/carers to access this on their behalf. It is recognised that non-engagement is a strong feature in domestic abuse, serious neglect and physical abuse in children and families (Working Together 2015).

Parents/carers/young people have a choice to engage with health professionals. However, if there are safeguarding concerns about a child or young person this needs to be assessed on an individual basis as part of a potential risk to a child or young person.

The safeguarding team can be contacted to discuss any concerns raised as a result of missed appointments and multi agency guidance can be found on the Trust intranet.

5.2. Private Fostering

The law requires you to notify Children's Social Care within six weeks if a child is staying with someone who is not a close relative for 28 days or more, or a person going to look after someone else's child for 28 days or more. Please see links below for more information:-

https://www.hullscp.co.uk/parents-and-carers/private-fostering/

https://www.safeguardingchildren.co.uk/professionals/private-fostering/
https://www.eastriding.gov.uk/living/children-and-families/fostering/private-fostering/

5.3. Children looked after

Although children who are looked after have many of the same health issues as their peers, the extent of these is often greater because of their past experience. For example, almost half of children in care have a diagnosable mental health disorder and two thirds have special educational needs. These children and young people therefore remain some of the most vulnerable in society (NSPCC 2019). All staff working with children who are looked after should be aware of the statutory guidance Promoting the health of Looked after children 2015 and Looked after children Roles and competences of healthcare staff 2020.

All children looked after will have an allocated social worker. Children may be living in foster homes, residential homes, residential schools, with connected carers or members of their own family or in secure accommodation.

Humber Teaching NHS Foundation Trust currently has a Named Nurse for Children Looked After based alongside the Children Looked After team

5.4. Early Help

Most children and young people will be best supported, and have their needs met, by universal service provision with additional support provided as required by a single agency or through partnership working. However some children may require the provision of universal, targeted and/or specialist services working together in a co-ordinated way to meet their needs.

Early help is support that is provided as soon as a problem emerges, at any stage in a child or young person's life (Department for Education (DfE), 2018). Addressing a child or family's needs early on can reduce risk factors and increase protective factors in a child's life (Early Intervention Foundation (EIF), 2018).
All Local Safeguarding arrangements have published threshold criteria to help professionals in identifying those who require early help as well as those requiring a Child in Need or Child protection. Referral Advice on thresholds is always available from the Safeguarding Team. Refer to local safeguarding websites for the threshold tools.

If there are concerns that parents do not consent to a Child in Need referral as they do not acknowledge the need for support from other agencies you may discuss this with the Safeguarding Team as this may then mean the threshold for Child Protection has been met.

5.5. Safeguarding Children and Young People: Responding to Concerns

All staff should be aware of the National Institute for Health and Care Excellence (NICE) clinical guidance ; Child Maltreatment – recognition and management, which outlines a range of alerting features that may indicate child maltreatment and should use this to inform their decision making – see link.

https://cks.nice.org.uk/topics/child-maltreatment-recognition-management/

The following factors may impact on parenting capacity and increase concern that a child may have suffered or is at risk of suffering significant harm.

It is important to exercise professional judgement in each situation and recognise that a referral may need to be made even when the following factors are absent.

When a child:

- features within parental delusions or is involved in his/her parent’s obsessive compulsive behaviours;
- might be harmed as part of a suicide plan;

- becomes a target for parental aggression or rejection, neglected physically and/or emotionally by a parent/carer;
- witnesses disturbing behaviour arising from mental illness, e.g. self-harming or suicidal behaviour, disinhibited behaviour, violence or homicide;
- is missing from education;
- is missing or absent from home. For definitions of a missing person for further guidance (see Appendix 2);
- may be at risk of child exploitation. For further guidance (see Appendix 3);
- is at risk of Female Genital Mutilation (FGM). For further guidance (see Appendix 4);
- is at risk of radicalisation. For further guidance (see Appendix 6);
- is in a family where there is domestic violence and abuse. For further guidance (see Appendix 5);
- is unseen/persistently misses routine child health services and/or treatment (consider 'was not brought');
- unexplained injuries and the delay in seeking treatment or exploration of the injury does not fit;
- is in a family where there is misuse of drugs, alcohol or medication;
- is suspected of having **fabricated** or an **induced** illness (FII);
- safety is concerned following a discharge from a mental health inpatient unit when there are Safeguarding Children and Young People concerns;
- when a child has a parent or carer with a learning disability.

This list should not be seen as exhaustive.

All practitioners working with adult service users should record when they see children within the family, their details and appearances of the child(ren) and (in the child's own words) what the child says.

Throughout the process, you should ensure that you keep a comprehensive record of any discussions held and subsequent decisions made in line with standard safeguarding practice and professional relevant standards by your regulatory body.

5.6. Making a referral to Children's Social Care

If any member of staff believes the child is **at risk of or has suffered significant harm**, they should seek agreement from the parent/carer where possible and then make a timely referral to Children's Social Care (see Appendix 1: Flowchart).

However, in the following circumstances, a referral should be made without making parents/carers aware:

- increase the risk of harm to the child;
- increase the level of risk to the practitioner;
- jeopardise a potential police investigation.

A record must be made of whether or not agreement has been obtained together with reasons for overriding the agreement.

All consultations and subsequent decisions must be recorded between health and Children's Social Care about the appropriateness of a referral.

Professionals are required to telephone and discuss concerns with the relevant local authority prior to submitting the written confirmation via email or using an electronic portal. The referral must clearly identify all risks to the child, any protective factors and the expected response.

A response from the child protection referral should be expected within 3 working days. A copy of the referral form and any associated actions for, e.g. interventions, telephone calls, must be

recorded within the child's or parents records (as appropriate). All staff must complete a Datix with a copy of EVERY referral and must forward a copy of the referral to the Trust Safeguarding Team.

You should be clear about any need for **URGENT** action to make the child safe from harm.

All Trust employees involved with the case must be informed of the referral.

N.B. If any member of staff has a concern about a child outside of normal office hours then the practitioner should contact the local Emergency Duty Team (see Appendix 1: Flowchart)

If a strategy meeting is convened the referrer should be invited to attend - this must be seen as a priority. The professional will be supported by their line manager and where attendance is not possible by either the referrer or a member of their team, the Humber safeguarding team should be made aware so that alternative arrangements can be made.

5.7. Escalation Process

If feedback from a referral is not received, the practitioner should contact social services for an outcome within three working days. If this is still not successful, they should use the escalation form, requesting information to the local authority child care team manager and send a copy to Humber safeguarding team with this request.

If a member of staff is still dissatisfied with the response, they receive following a referral, in the first instance they may discuss the matter with the Trust Safeguarding Team at the earliest opportunity. This process must also be followed if at any time a practitioner is not satisfied with any aspect of a case where there are safeguarding concerns. This should be in line with Trust policy (see Appendix 8 for template) and ERSCP/HSCP/NYSCP procedures

5.8. Parental Mental Health

As a Trust providing mental health services to both adults and children, we are committed to the Think family agenda SCIE Publication - Guide 30
https://www.scie.org.uk/publications/guides/guide30/files/guide30.pdf

When working with any of our service users it is essential that we think about the whole family. For parents/carers who are accessing services we must ensure that we have recorded details of all children whom they have caring responsibility for. The impact of this on our service user and the impact of the Parental Mental Health on the children is important to consider. The PAMIC tool can be used to evidence the impact upon the child

https://www.safeguardingchildren.co.uk/tool-for-assessing-and-responding-to-the-impact-of-parental-mental-ill-health-on-children/

It is essential to consider the impact of parental mental health on unborn babies during pregnancy, labour and following the birth of the child. At these times a referral could be considered to the perinatal mental health teams across the Trust. On occasion where there are significant safeguarding concern's and the plan is for the baby to be removed after birth the perinatal mental health team can still be contacted for advice and consultation. All pregnant mothers with severe and complex mental health problems would have a mental health birth plan which compliments the maternity services birth plan.

5.9. Parental Learning Disability

Parents with learning disabilities may need additional support to develop the understanding, resources, skills and experience to meet the needs of their children. Such support is particularly important when parents experience additional stressors such as having a disabled child, domestic abuse, poor physical and mental health, substance misuse, social isolation, poor housing, poverty and a history of growing up in care. It is these additional stressors when combined with a learning disability that are most likely to lead to concerns about the care and safety of a child.

6. GUIDANCE

6.1. Supervision and Supporting Staff Involved in Safeguarding Children matters

The Trust recognises that children and young people's safeguarding issues and decision making can be complex, difficult and emotive. The Trust supports staff through providing mandatory training, safeguarding supervision access at least 3 monthly and access to Named Nurse, Named Doctor and the Trust safeguarding team who are available for advice and support to all staff.

The Trust has a supervision policy and guidance in place which should be followed. This clearly identifies supervision arrangements and expectations for all staff including the supervision of safeguarding children issues.

Supervision Guidelines

All safeguarding children supervision needs to be recorded using the relevant template on the system used within the service area.

6.2. Consent and the Sharing of Information

Consent and the Mental Capacity Act (MCA)

The Mental Capacity Act applies to anyone over the age of 16. Decisions about a young person's capacity and best interests can be made in the same way as for any adult. Young people over 16 years old are presumed to have capacity to consent to surgical, medical or dental treatment and to associated procedures, such as nursing care (Family Law Reform Act 1969).

Some procedures are not covered by this, but by an assessment of 'Gillick competence'. This assessment is used with people under 16 It is reflective of the capacity test and assesses if the young person has the intelligence, maturity and understanding to comprehend what is proposed.

The person proposing any treatment or care needs to be clear about the young person's capacity/competency to make the decision. If the young person can't make the decision because of an impairment of or disturbance in the functioning of the mind or brain, then the assessment and process of MCA will apply.

Young people aged 16 or 17 are presumed in UK law, like adults, to have the capacity to consent to medical treatment. However, unlike adults, their refusal of treatment can, in some circumstances be overridden by a parent, someone with parental responsibility or a court. This is because we have an overriding duty to act in the best interests of a child. This would include circumstances where refusal would likely lead to death, severe permanent injury or irreversible mental or physical harm

If a young person does not have capacity/competency to make a decision, the decision could be made following MCA processes or could be made by the person with parental responsibility. The method by which the decision is made will depend on whether the decision is in the 'zone of parental control' and who is exercising parental responsibility.

Further information can be found in the Trust Mental Capacity Act and Best Interests Decision Making Policy. Mental Capacity Act and Best Interest Decision Making Policy

Information Sharing

Sharing of information amongst practitioners working with children and their families is essential. In many cases it is only when information from a range of sources is put together that a child can be seen to be in need or risk of harm.

In general the law will not prevent practitioners from sharing information with other practitioners if:

- Those likely to be affected consent;
- The public interest in safeguarding the child's welfare overrides the need to keep the information confidential;
- Disclosure is required under a court order or other legal obligation.

The law also recognises that disclosure of confidential information without consent or a court order may be justified in the public interest to prevent harm to others.

The amount of confidential information disclosed without consent should be proportionate. If a practitioner needs to establish whether a child has a Child Protection Plan or whether they are known to Children's Social Care, this information can be requested from the local Children's Social Care team, or the Emergency Duty Team if outside of normal office hours. If this information is not forthcoming then they should contact the Trust safeguarding team who will access this information on their behalf. If a practitioner has a concern about a child's welfare then being unable to access this information should not prevent them from making a referral to Children's Social Care.

All information sharing should be consistent with the Humber Information Sharing Charter (formerly Sharing Information between Agencies Protocol).
Information sharing: advice for practitioners (publishing.service.gov.uk)

6.3. Death of a Child

The Child Death Review process is a statutory function of Child Death Review Partners (Local Authority and Clinical Commissioning Groups). Further information regarding this process is available in Child Death Review Statutory and Operational Guidance (England) (HM Government 2018).
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/859302/child-death-review-statutory-and-operational-guidance-england.pdf

Any member of staff who becomes aware of the death of a child on their caseload, or for whom they are providing services should ensure the named nurse (child) is notified as soon as possible. The named nurse (child) will then ensure the LSCP child death review co-ordinator is notified and that the relevant health service response and contribution to the multi-agency child death review process takes place.

6.4. Record Keeping

Well-kept records are essential to safeguarding children. The purpose of record keeping is to provide accurate, current, comprehensive and concise information, which reflect a chronology of events.

In line with the recommendations from the Climbié Inquiry (2003) practitioners should ensure that the following information is recorded in relation to each child and young person, with whom they are working:

- The child's name, age and address;
- The name of the child's primary carer, parent/carer names and who has parental responsibility;
- The name of the child's general practitioner;
- The child's school;
- The child's ethnic background.

This information should be confirmed at each 'new contact'.

Any interviews or conversations with a child suspected or known to be at risk of harm must be recorded in the child's health record immediately and practitioners must ensure that all information held on health records should clearly differentiate between fact and opinion.

6.5. Serious Incidents/Safeguarding Children Serious Incidents

If any adverse incidents occur involving children, or which have safeguarding child implications, these should be reported via Datix and managed through the Trust's Serious Incidents and Significant Events Policy and Procedure. Any meeting the criteria for a Serious Incident (SI) will also be reported to the Designated Nurse within two working days by the Named Nurse child.

6.6. Child Safeguarding Practice Reviews

When a child dies or is seriously harmed as a result of abuse or neglect, a review is conducted to identify ways that professionals and organisations can improve the way they work together to safeguard children and prevent similar incidents from occurring. These are referred to as child safeguarding practice reviews.

In England, child safeguarding practice reviews should be considered for serious child safeguarding cases where:

- abuse or neglect of a child is known or suspected;
- and a child has died or been seriously harmed.

This may include cases where a child has caused serious harm to someone else.

There are two types of reviews; local reviews – where safeguarding partners consider that a case raises issues of importance in relation to their area, and national reviews where the Child Safeguarding Practice Review Panel considers that a case raises issues which are complex or of national importance.

6.7. Safeguarding Children Training

It is essential that all staff, irrespective of whether or not they work directly with children, receive training at the appropriate level, in accordance with the organisation's Statutory and Mandatory Training policy and the Intercollegiate Document 2018. All training can be accessed via the training and development centre.

Level 1 Training (Intercollegiate Document 2018) is undertaken within the induction programme for all new staff and is relevant for staff who do not work with a clinical caseload. This should be refreshed every three years and is available electronically.

Level 2 Training (Intercollegiate Document 2018) is undertaken by clinical staff who do not work with families or adults with child caring roles. This should be refreshed every three years and is available electronically.

Advanced Safeguarding Children's Training (Level 3 Intercollegiate Document 2018) is mandatory, for staff that have a regular caseload of children and/or contribute to multi-agency working on behalf of children and carers. Training should be undertaken every three years. This group should have a higher minimum level of expertise, and a greater understanding of how to work together to identify and assess concerns and to plan, undertake and review interventions (Working Together 2018, Intercollegiate Document 2018).

7. IMPLEMENTATION

This policy will be disseminated by the method described in the document control policy

8. MONITORING, AUDIT AND COMPLIANCE

Information regarding monitoring and compliance with this policy will be included in an annual performance report from the Safeguarding Team to the Trust Quality and Patient Safety Group and the Trust Safeguarding Forum. This will include:

- Training uptake;
- Information arising from the Child Death Review process;
- Patient safety incidents and allegations against staff;
- Any new or ongoing Child Safeguarding Practice Reviews or other statutory reviews;
- Quality of and any risk areas associated with child protection referrals;
- Any relevant audits undertaken within the time period;
- Impact of new guidance and legislation relating to safeguarding children.

Numbers of safeguarding referrals and information on reported categories of abuse are reported to the Quality and Patient Safety Group every month.

9. REFERENCES/EVIDENCE/GLOSSARY/DEFINITIONS

References

- ERSCP, HSCP and NYSCP Safeguarding Children Procedures
- Care Quality Commission The five Key Questions we Ask. [Accessed online 2022] https://www.cqc.org.uk/what-we-do/how-we-do-our-job/five-key-questions-we-ask
- Definition of Child Sexual Exploitation (CSE) (Department for Children, Schools and Families, 2009)
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- Department of Health (2005). Mental Capacity Act. London, HMSO.
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- Information sharing. Advice for practitioners providing safeguarding services to children, young people, parents and carers. March 2015 www.gov.uk
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- Serious Crimes Act 2015. London. The Stationary Office
- Social Care Institute 2012 Think Child, think parent, think family. London
- The Children Act 1989, HMSO The Children Act 2004, London. The Stationery Office
- The Victoria Climbié Inquiry Report (January 2003)
- United Nations Convention on the Rights of the Child 1990 Unicef. London
- United Kingdom: Human Rights Act 1998 [United Kingdom of Great Britain and Northern Ireland], 9 November 1998, available at: https://www.refworld.org/docid/3ae6b5a7a.html [accessed 20 June 2022]
- What to do if you're worried a child is being abused; advice for practitioners (March 2015)
- Working together to safeguard children: A guide to inter-agency working to safeguard children (March 2018)

Supporting Documents

- Humber Information Sharing Charter (formerly Sharing Information Between Agencies Protocol)
- Police Information Sharing Procedure https://intranet.humber.nhs.uk/police-information-sharing-procedure.htm
- Records Management and Information Lifecycle Policy
- Safeguarding Supervision Adult and Children Guidance
- Safeguarding Children Allegations against Staff Policy
- Safeguarding Children Fabricated Illness Guidelines
- Safeguarding Domestic Violence and Abuse Guidelines
- Supervision Policy
- Risk Management Strategy (including Adverse Incidents and Serious Untoward Incidents)

Appendix 1: Safeguarding Children; How to Act On Your Concerns

Where there are concerns a child may be suffering significant harm then a referral MUST always be made to Children's Social Care OR call 999 for immediate concerns

If targeted early help is required, the early help process should be followed. See section 6.4 of Safeguarding Children Policy

Any member of staff who has current or historic concerns about a child can also contact Humber Teaching Foundation Trust safeguarding team on 01482 335810

If they are CURRENT concerns:

ADDRESS CONCERNS WITH PARENT/CARER AND INFORM PARENT/CARER OR YOUNG PERSON OF YOUR INTENTION TO CONTACT CHILDREN'S SOCIAL CARE **UNLESS**:

- **Informing them would place the child at greater risk**
- **Informing them would place yourself at greater risk**
- **Informing them may jeopardise a potential police investigation.**

Where parents/carers are not informed, the practitioners should record the grounds for this decision.

If they are HISTORIC concerns:

If you are confident and clear that you need to share this information, a referral to Children's Social Care can be made using the number below or, if the information is about a potential perpetrator, the Protection of Vulnerable People Unit (PVPU) can be contacted on tel: 101. The Humber Safeguarding Team should be made aware of this.

Verbal referral to children's social care

Referral form to be sent to children's social care, within 24 hours. Complete Datix and attach copy of referral send to Humber Safeguarding Children's Team. Referral forms available on the Humber intranet page

NORTH YORKSHIRE
www.safeguardingchildren.co.uk

CONTACT THE NAMED PROFESSIONALS or The Children & Families Service through the Customer Contact Centre on: 01609 780780 (same number for Out of Hours Duty Team)
Email: Children&families@northyorks.gcsx.gov.uk

Hull
hscb@hullcc.gov.uk

CONTACT THE NAMED PROFESSIONALS or Early Help and Safeguarding Hub 01482 448879
EHASHgc@hullcc.gcsx.gov.uk

Out of office hours: 01482 300304

EAST RIDING of YORKSHIRE

https://www.erscp.co.uk
CONTACT THE NAMED PROFESSIONALS or SAPH: 01482 395500

Out of office hours: Emergency Duty Team: 01377 241273

An outcome response should be received from Children's Social Care within one working day.

If this does not happen, the practitioner is to contact Social Services for outcome within three working days.

If a member of staff is still dissatisfied with the response they receive following a referral, in the first instance they may discuss the matter with the Trust Safeguarding Team at the earliest opportunity. This process must also be followed if at any time a practitioner is not satisfied with any aspect of a case where there are safeguarding concerns. This should be in line with Trust Escalation Process (see Appendix 7 for template) and ERSCP/NYSCP/HSCP procedures.

Appendix 2: Missing Child/Family/Child Abduction

In cases where a child is at risk and missing from the family/carer a referral to police and children's social care should be made immediately. For further advice; refer to the ERSCP/HSCP/NYSCP procedures and guidance.

The tracing and notification of missing families where child welfare concerns exist or children are subject to a Child Protection Plan (CPP) is as follows:

- The practitioner completes the following checks:
    - General practitioner
    - Visit to the last known address
    - Children's Social Care Services (ER/Hull/North Yorkshire)
    - Housing if appropriate
    - Other Professionals involved
- If unable to locate, inform the Trust's Safeguarding Team. If child/family is not found after further checks a Missing Child/Family Alert is issued;
- If the family are believed to be in another area of the country an alert will also be sent via the Safeguarding Team in those areas;
- The Practitioner must put an alert on SystmOne and contact the Safeguarding Team if an address becomes known to them, Children's Social Care should also be informed;
- The case should remain open on SystmOne on a Specialist Case Load for 12 months as an ongoing review.

In the event of the whereabouts of the family becoming known, the Trust's Safeguarding Team should be notified and a 'traced family' notification will be issued. Children's Social Care should also be informed.

Child Abduction
If a member of staff becomes aware of the unexplained absence of a child or young person from Trust's premises, they must take the following action

- Immediate search of the area;
- Immediately identify the child's last known whereabouts with the missing child/young person's family/carer and revisit those areas;
- If child still has not been located, alert the Police on 999;
- Take action to ensure that the family/carers are supported, for example a private room with an allocated member of staff;
- Alert the Trust's Safeguarding Team and complete a Datix form in a timely manner and inform Children's Social Care.

Appendix 3: Alerting Signs of Child Exploitation and Abuse

The exploitation of children and young people under 18 involves exploitative situations, contexts and relationships where young people (or a third person or persons) receive 'something', (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of them performing, and/or another or others performing on them, sexual or criminal activities. Criminal exploitation of children and adults with additional needs is a geographically widespread form of harm that is a typical feature of county lines activity.

County Lines
County lines is a term used to describe gangs and organised criminal networks involved in exporting illegal drugs into one or more importing areas within the UK, using dedicated mobile phone lines or other form of "deal line". They are likely to exploit children and adults with additional needs to move (and store) the drugs and money. They will often use coercion, intimidation, violence (including sexual violence) and weapons (Serious Violence Strategy, HO 2018).

Gangs establish a base in the market location, typically by taking over the homes of local adults with additional needs by force or coercion in a practice referred to as 'cuckooing'.

County lines is a major, cross-cutting issue involving drugs, violence, gangs, safeguarding, criminal and sexual exploitation, modern slavery, and missing persons. The response to tackle it involves the police, the National Crime Agency, a wide range of Government departments, local government agencies and VCS (voluntary and community sector) organisations.

County lines activity and the associated violence, drug dealing and exploitation have a devastating impact on young people, adults with additional needs and local communities.

Exploitation
Child exploitation can occur through the use of technology without the child's immediate recognition; for example being persuaded to post sexual images on the internet/mobile phones without immediate payment or gain. In all cases, those exploiting the child/young person have power over them by virtue of their age, gender, intellect, physical strength and/or economic or other resources. Violence, coercion and intimidation are common, involvement in exploitative relationships being characterised in the main by the child or young person's limited availability of choice resulting from their social/economic and/or emotional vulnerability.(See appendix 7)

For further guidance, please refer tohttps://www.erscp.co.uk
www.hullcc.gov.uk and www.safeguardingchildren.co.uk.

Appendix 4: Safeguarding Children at Risk of Female Genital Mutilation (FGM)

Female Genital Mutilation (FGM) constitutes “significant harm”, it is child abuse. The Department of Health (DOH) and NHS England are committed to caring for FGM survivors, protecting girls from FGM, and preventing future generations from having to undergo FGM. The fact that FGM is a traditional cultural practice in some countries does not negate the fact that it is illegal in the UK and has extremely damaging after effects.

FGM is a collective term for procedures, which include the removal of part or all of the external female genitalia for non-medical purposes.

It is **mandatory** for health professionals to record in the patient’s healthcare record (**and inform the safeguarding team data administrator**) if an adult patient has had FGM, whenever it is identified in the course of NHS treatment (DOH Dec 2014 FGM Prevention Programme: requirements for NHS staff). If the adult patient is pregnant, a referral to the local authority should be made.

The FGM mandatory reporting duty is a legal duty provided for in the FGM Act 2003 (as amended by the Serious Crime Act 2015). This reporting duty came into effect in England on the 31st of October 2015. The legislation requires regulated health and social care professionals in England and Wales to make a report to the police where, in the course of their professional duties, they believe a child has undergone FGM either via disclosure by the child, other or by examination.

The duty is a personal duty which requires the individual professional who becomes aware of the case to make a report; the responsibility cannot be transferred.

Failure to do so may lead to prosecution of the professional.

How do I know if a girl/unborn child is at risk?
These indicators are not exhaustive and whilst the factors detailed below may be an indication that a child is facing FGM, it should not be assumed that is the case simply on the basis of someone presenting with one or more of these warning signs. These warning signs may indicate other types of abuse such as forced marriage or sexual abuse that will also require a multi-agency response.

The following are some signs that the child may be at risk of FGM:

- The family belongs to a community in which FGM is practised;
- Maternal or other family member disclosure;
- An awareness by a midwife or obstetrician that the procedure has already been carried out on a mother, prompting concern for any daughters, girls or young women in the family;
- Any child whose older sibling has undergone FGM;
- Any female living in the same household as the child;
- The family makes preparations for the child to take a holiday, e.g. arranging vaccinations, planning an absence from school;
- The child talks about a ‘special procedure/ceremony’ that is going to take place.

Consider whether any other indicators exist that FGM may have or has already taken place, for example:

1. The child has changed in behaviour after being absent from school; or
2. The child has health problems, particularly bladder or menstrual problems

Mandatory Reporting
Professionals have a legal duty to report FGM **mandatory** verbally by **calling 101** and where concerns relate to a child or young person a safeguarding referral to Children’s Social Care should

also be made in line with local safeguarding arrangements. For ER SAPH please contact 01482 395500 or Hull EHASH 01482 448879 and North Yorkshire Customer Services 01609 780780.

If you are unsure, seek advice from safeguarding children lead professionals in your service, the named nurse, or the named doctor for safeguarding. The safeguarding team is also available to offer support and advice. Reports under the duty should be made as soon as possible after a case is discovered, and best practice is for reports to be made by the close of the next working day.

A comprehensive record of any discussions held and subsequent decisions made should be maintained in line with standard safeguarding practice. This includes the circumstances surrounding the initial identification or disclosure of FGM, details of any safeguarding actions taken, and when and how the case was reported to the police (including the case reference number). You should also ensure that your organisation's designated safeguarding lead is kept updated as appropriate.

For more detail, please refer to the government and safeguarding partnership guidance:

https://www.erscp.co.ukand www.hullcc.gov.uk and www.safeguardingchildren.co.uk

www.gov.uk/government/publications/female-genital-mutilation-guidelines

www.gov.uk/government/publications/fgm-mandatory-reporting-in-healthcare

Appendix 5: Safeguarding Children in Domestic Violence and Abuse

The term 'domestic violence and abuse' is used to mean: any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or are family members.

This includes: psychological, physical, sexual, financial and emotional abuse. It also includes 'honour'-based violence and forced marriage. A perpetrator of domestic violence or abuse themselves may be a young person or a child.

Routine enquiry refers to asking all women (aged 16 years and over) about their experience of domestic abuse, regardless of whether or not there are any signs of abuse, or whether abuse is suspected. Also commonly known as ‘screening’, this approach particularly helps to increase the rates of identification within vulnerable groups and very much aligns to the principles of the early help and intervention model.

A child or a young person seeing, hearing or being aware of the ill-treatment of another is at risk of emotional and physical abuse. Practitioners must consider the impact of exposure to domestic violence and abuse in their risk assessment – the effect on a child and young person’s development. There is an absolute requirement to consider the elements of harm. The younger the child the greater the dependency the more significant the effects of living in a home where domestic violence and abuse is a feature. The CAADA-DASH risk assessment (see Safeguarding Domestic Violence and Abuse Trust policy) will assist front line practitioners identify high risk cases of domestic abuse, stalking and ‘honour’ based violence. The risk assessment once completed will also help those practitioners in deciding which cases should be referred to MARAC, and the support that may be required.

Domestic violence and abuse is a consistent feature of child protection cases and serious case reviews. **Domestic violence and abuse, parental substance misuse and parental mental ill health are all identified significant risk factors in relation to safeguarding children when occurring together**. Statistically, children are most at risk in family circumstance presenting these three challenges.

When working with service-users living in households where there is domestic violence and abuse, staff will need to also consider the possibility that the child may also be being abused by the same perpetrator. A risk assessment must be undertaken in all cases where there is suspicion of or known domestic violence. A referral to Children’s Social Care may need to be made after discussion with the line manager/supervisor.

Further guidance and assessment tools are available in the Trust policy – Safeguarding Domestic Violence and Abuse, on the intranet. Domestic Abuse (humber.nhs.uk)

Appendix 6: Prevent

The Trust, as with all other NHS bodies, has a statutory duty to ensure that it makes arrangements to safeguard and promote the welfare of children and young people, to protect adults at risk from abuse or the risk of abuse and support the Home Office's Counter Terrorism strategy CONTEST, which includes a specific focus on Prevent (preventing violent extremism/radicalisation). Throughout this document, safeguarding children, young people and adults at risk includes those vulnerable to violent extremism/radicalisation.

A concern that an individual may be vulnerable to radicalisation does not mean that the practitioner believes the person is a terrorist. It means that they have concerns that the person is potentially vulnerable to exploitation by others, and therefore have a safeguarding concern.

Prevent is about:

Noticing – Vulnerability to radicalisation, changes in behaviour, ideology and other signs of extremist exploitation.
Checking – Your concerns out with your line manager and Humber Safeguarding team to offer support and help and determine proportionate response.
Sharing – Your concern, where appropriate with partner agencies and as far as possible being open and honest with the individual around your duty to share concerns.

If a member of staff has a concern that someone is being radicalised, then they should:

- Discuss their concerns with their immediate line manager and contact the Trust Safeguarding team/Prevent lead;
- Complete a Datix (ensure that the Prevent box is highlighted);
- The Safeguarding team will discuss the case with the Prevent police link.

The Safeguarding Team/Prevent lead will support you through the process and co-ordinate all referrals.

The Trust Prevent Policy (available on the intranet) should be referred to throughout. Prevent Policy

Appendix 7: Online Safety and Exploitation

The rapid growth of the internet, social networking and of electronic technologies generally, has opened up a new world of opportunities for many children and young people. Through the internet and mobile technology, it is possible for them to have access to almost unlimited information worldwide, to be entertained and, through social networking sites, to contact and socialise with other young people. Alongside the benefits there are also significant risks, and whilst many children and young people are very competent in using such technologies, their knowledge, as well as their parents/carers of the risks should be strengthened.

Staff should be aware of possible risks to children and young people using social media:

- Sexual exploitation
- Bullying, including cyber based or prejudiced based bullying
- Impact of technologies on sexual behaviour
- Radicalisation and extremism
- Substance misuse
- Self-harm
- Eating disorders

Further information can be accessed at the UK Council for Internet Safety
www.gov.uk/government/organisations/uk-council-for-internet-safety

Appendix 8: Practice Escalation Form

Escalation of Concerns

To: (Team Manager & Social Worker)

Name of Child:	**DOB:**
Practitioner:	**Service:**

Summary of concern(s)

Requested Action

Response by Team Manager/Social Worker

Date:

When Concerns Persist (Escalation Process)

Professionals making referrals to Children's Social Care should receive feedback (see flowchart). If feedback is not received, the practitioner should contact social services for an outcome within three working days. If this is not successful, they should write requesting information and send a copy to the child care team manager and the safeguarding team.

If a member of staff is still dissatisfied with the response, they receive following a referral, in the first instance they should discuss the matter with the Trust's Safeguarding Team at the earliest opportunity. This process must also be followed if at any time a practitioner is not satisfied with any aspect of a case where there are safeguarding concerns. This should be in line with Trust policy (see Appendix 8 for template) and ERSCP/HSCB/NYSCP procedures.

N.B. Urgent concerns may need a more rapid escalation.

The practitioner must make a note of the discussion within the relevant client record.

The safeguarding team must also make a note of the concern, with sufficient detail to be able to identify the case and follow up professional concerns to seek resolution.

The escalation process also applies when there is a disagreement on ongoing active cases.

This process should also be used if the practitioner becomes aware that they have not been consulted when Children's Social Care have completed an initial or pre-birth assessment.

If the issues/concerns are not resolved with Humber Safeguarding Team, please refer to:

HSCP – Resolving Inter Agency Disagreements

ERSCP – Resolving Inter Agency Disagreements

NYSCP – Professional Inter Agency Disagreements
https://www.safeguardingchildren.co.uk/professionals/procedures-practice-guidance-and-one-minute-guides/professional-resolutions/

Appendix 9: Contacts

Safeguarding Team for Humber Teaching NHS Foundation Trust
Email HNF-TR.SafeguardingHumber@nhs.net

Hull Early Help and Safeguarding Hub (01482) 448879

Hull out of hours Immediate Help Team (01482) 300304

Hull Local Authority Designated Officer (01482) 790933

Police Public Protection Unit 101

Hull Safeguarding Children Partnership (01482) 379090

Hull Safeguarding Children and Looked After Team CHCP (01482) 617839/75

Safeguarding Team Hull University Teaching Hospital Trust (HUTH) (01482) 675103

ER Early Help and Safeguarding Hub (01482) 395500
Email childrens.socialcare@eastriding.gcsx.gov.uk

ER out of hours Emergency Duty team (01377) 241273

ER Local Authority Designated Officer (01482) 395500

ER Safeguarding Children Partnership (01482) 396999

North Yorkshire Customer Resolution Centre (01609) 780708
Email Children&families@northyorks.gcsx.gov.uk

North Yorkshire Safeguarding Children Partnership
Email www.safeguardingchildren.co.uk/aboutus/contact-us

Humber Teaching NHS Foundation Trust has a Children Looked After health team based at Beverley Health Centre. The Named Nurse (Children Looked After) can be contacted during normal office hours for advice, support and information on 01482 347320

Appendix 10- Document Control Sheet

Document Type	Policy – Safeguarding Children Policy and Procedure (N-045)		
Document Purpose	The purpose of this policy is to assist all staff (including voluntary and students) within the Trust to be aware of their roles and responsibilities in safeguarding and promoting the welfare of children. The procedures and guidance within the policy will enable the Trust to fulfil its statutory duties as determined by the Children Act 1989 and 2004.		
Consultation/Peer Review:	Date:	Group/Individual	
list in right hand columns consultation groups and dates	June 2022	Division Groups	
		Safeguarding children supervisors	
		Designated Nurses	
		HR, IG, Safeguarding Team	
		Safeguarding Children Partnership	
	Aug-22	QPaS	
Approving Committee:	EMT	Date of Approval:	*19-Sept-22*
Ratified at:	Trust Board	Date of Ratification:	*28-Sept-22*
Training Needs Analysis: *(please indicate training required and the timescale for providing assurance to the approving committee that this has been delivered)*	None	Financial Resource Impact	None
Equality Impact Assessment undertaken?	Yes	No [ ]	N/A [ ] Rationale:
Publication and Dissemination	Intranet [✓]	Internet [ ]	Staff Email [ ]
Master version held by:	Author [ ]	HealthAssure [✓]	
Implementation:	*Describe implementation plans below*		
	• Dissemination to staff via Global email • Teams responsible for ensuring policy read and understood		
Monitoring and Compliance:	See section 8 of policy		

Document Change History:			
Version Number/Name of procedural document this supersedes	*Type of Change i.e. Review/Legislation*	*Date*	*Details of Change and approving group or Executive Lead (if done outside of the formal revision process)*
2.03	*Minor review*	*Oct 10*	*Policy ratified*
2.04	*Minor changes*	*Mar 11*	*Minor changes*
2.05	*Review*	*Nov 11*	*Reviewed, changed to the terms of reference of the safeguarding committee*
2.06	*Review*	*Feb 13*	*Reviewed with minor changes* *- Making the escalation process section 5.4 more explicit* *- additional paragraph in section 5.8 re training (Appendix 2)* *- emergency duty team out of hours telephone number changed*
2.07	*Review*	*Jun 13*	*Inclusion of Practice Escalatin Form where the are continuing concerns regarding a family*
2.08	*Review*	*Mar 14*	*Inclusion of procedure in the event of child abduction from Trust premeise* *Addition of escalation flowchart* *Addition of app – HSCB guidance, resolving inter-agency disagreements*
2.09	*Review*	*Nov 15*	*Amendments to flowchart sdafeguarding children how to act on your concerns* *Addition of guidance of FGM and CSE*
2.10	*Minor changes*	*July 17*	*Amendment Flowchart Appendix 1 the inclusion of North Yorkshire referral details*
2.11	*Review*	*July 19*	*Policy reviewed and amended*

			• *Child sexual exploitation appendix amended to widen reference to child exploitation incorporating criminal exploitation* • *Addition of online safety (Appendix 7)* • *Addition of MCA guidance* • *Was not brought guidance included* • *Amendment of terminology in line with legislation changes* • *Addition of North Yorkshire contact details* • *Reference to the forthcoming CAMHS inpatient service* • *Reference to the development of the Integrated Specialist Public Health Nursing Service (ISPHNS)*
3.0	*Review with major amendment*	*June 2022*	*Policy reviewed and amended (Major amendments)* • *Updated staff responsibilities* • *Updated Trust staff titles* • *Removal of specific work areas across the Trust. Now referred to as all staff* • *Update of Early Help* • *Updated referral guidance* • *Updated Assessment Tool used to measure impact of parental mental health* • *Updated partnership titles and contacts* • *Additional links to relevant documents* *Approved QPaS 18-Aug-22* *EMT 19-Sept-22 nd ratified at Board 28-Sept-22*
3.1	*Review*	*Oct-22*	*Minor amend to add additional infomration, in relation to injuries to non-moble babies for clarity* *Approved by Director signed off 3-Oct-22*

Appendix 11: Equality Impact Assessment (EIA)

For strategies, policies, procedures, processes, guidelines, protocols, tenders, services

1. Document or Process or Service Name: **Safeguarding Children Policy and Procedure**
2. EIA Reviewer (name, job title) **Kerry Boughen. Named Nurse Safeguarding Children,**
3. Is it a Policy, Strategy, Procedure, Process, Tender, Service or Other? **Policy**

Main Aims of the Document, Process or Service To assist all staff (including voluntary and students) within the Trust to be aware of their roles and responsibilities in safeguarding and promoting the welfare of children. The procedures and guidance within the policy will enable the Trust to fulfil its statutory duties as determined by the Children Act 1989 and 2004.		
Please indicate in the table that follows whether the document or process has the potential to impact adversely, intentionally or unwittingly on the equality target groups contained in the pro forma		
Equality Target Group 1. Age 2. Disability 3. Sex 4. Marriage/Civil Partnership 5. Pregnancy/Maternity 6. Race 7. Religion/Belief 8. Sexual Orientation 9. Gender re-assignment	Is the document or process likely to have a potential or actual differential impact with regards to the equality target groups listed? Equality Impact Score Low = Little or No evidence or concern (Green) Medium = some evidence or concern(Amber) High = significant evidence or concern (Red)	How have you arrived at the equality impact score? a) who have you consulted with b) what have they said c) what information or data have you used d) where are the gaps in your analysis e) how will your document/process or service promote equality and diversity good practice

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Age	Including specific ages and age groups: Older people Young people Children Early years	**Low**	This policy relates to the safeguarding of children up to 18 years of age.
Disability	Where the impairment has a substantial and long term adverse effect on the ability of the person to carry out their day to day activities: Sensory Physical Learning Mental Health (including cancer, HIV, multiple sclerosis)	**Low**	
Sex	Men/Male Women/Female	**Low**	
Marriage/Civil Partnership		**Low**	
Pregnancy/ Maternity		**Low**	
Race	Colour Nationality Ethnic/national origins	**Low**	
Religion or Belief	All religions Including lack of religion or belief and where belief includes any religious or philosophical belief	**Low**	
Sexual Orientation	Lesbian Gay Men Bisexual	**Low**	

Gender Reassignment	Where people are proposing to undergo, or have undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attribute of sex	**Low**	

Summary

A child's age, gender, cultural or religious beliefs, disabilities or social backgrounds may impact on their ability to access help and support. Due consideration must be given to these issues at all times when dealing with children, young people and their families. This policy gives due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it.	
EIA Reviewer: **Kerry Boughen**	
Date completed: *18-August-2022*	Signature: **K Boughen**