# SAFEGUARDING CHILDREN AND YOUNG PEOPLE POLICY

| | | | **POLICY** |
|---|---|---|---|
| **Reference** | CPG-PAED-SgC&YP | | |
| **Approving Body** | Safeguarding Steering Group | | |
| **Date Approved** | 2nd August 2022 | | |
| **For publication to external SFH website** | **Positive confirmation received from the approving body that the content does not risk the safety of patients or the public:** | | |
| | **YES** | **NO** | **N/A** |
| | X | | |
| **Issue Date** | 10th August 2022 | | |
| **Version** | 6.0 | | |
| **Summary of Changes from Previous Version** | Revision of content to align with the Working Together to Safeguard Children 2018 and referral processes | | |
| **Supersedes** | v5.0, Issued 5th March 2019 to Review Date August 2022 (ext2) | | |
| **Document Category** | • Clinical | | |
| **Consultation Undertaken** | Safeguarding Steering Group members | | |
| **Date of Completion of Equality Impact Assessment** | 19/07/2022 | | |
| **Date of Environmental Impact Assessment (if applicable)** | N/A | | |
| **Legal and/or Accreditation Implications** | There is a legal requirement for all NHS Trusts to have in place a Safeguarding Children policy | | |
| **Target Audience** | • All clinical and non-clinical substantive, bank and temporary staff who have contractual obligations to the Trust, including all those working in a voluntary capacity within the organisation.<br>• Trust wide all ward and departments both clinical and non-clinical at Sherwood Forest Hospitals | | |
| **Review Date** | August 2025 | | |
| **Sponsor (Position)** | Chief Nurse | | |
| **Author (Position & Name)** | Lisa Nixon, Safeguarding Lead & Named Nurse Safeguarding Children and Young People | | |
| **Lead Division/ Directorate** | Corporate | | |
| **Lead Specialty/ Service/ Department** | Nursing – Safeguarding Team | | |
| **Position of Person able to provide Further Guidance/Information** | Safeguarding Lead & Named Nurse Safeguarding Children and Young People | | |

| **Associated Documents/ Information** | **Date Associated Documents/ Information was reviewed** |
|---|---|
| Not Applicable | Not Applicable |

# CONTENTS


| Item | Title | Page |
|---|---|---|
| 1.0 | INTRODUCTION | 3 |
| 2.0 | POLICY STATEMENT | 3-4 |
| 3.0 | DEFINITIONS/ ABBREVIATIONS | 4-9 |
| 4.0 | ROLES AND RESPONSIBILITIES | 9-11 |
| 5.0 | APPROVAL | 11 |
| 6.0 | DOCUMENT REQUIREMENTS (NARRATIVE) | 12-24 |
| 7.0 | MONITORING COMPLIANCE AND EFFECTIVENESS | 25 |
| 8.0 | TRAINING AND IMPLEMENTATION | 26 |
| 9.0 | IMPACT ASSESSMENTS | 26 |
| 10.0 | EVIDENCE BASE (Relevant Legislation/ National Guidance) and RELATED SFHFT DOCUMENTS | 26-27 |
| 11.0 | KEYWORDS | 27 |
| 12.0 | APPENDICES | |
| Appendix A | Undertaking a Safeguarding Children Information Management Team (SCIMT) Check | 28 |
| Appendix B | Filing safeguarding children information in medical records | 29 |
| Appendix C | Process for making a children safeguarding referral online | 30-31 |
| Appendix D | Abandoned babies/children process. | 32-33 |
| Appendix E | Missing Child/ Families/ Unborn Child RAPA Alert Process | 34 |
| Appendix F | *PREVENT* Flowchart | 35 |
| Appendix G | Safeguarding Children & Young People Level 3 Training Pathway | 36 |
| Appendix H | Equality Impact Assessment | 37-38 |

## 1.0 INTRODUCTION

Sherwood Forest Hospital NHS Foundation Trust (SFHFT) believes that all children have an equal right not to be abused, neglected or exploited and the right to be happy, healthy, safe and productive in their contribution to society and is committed to safeguarding and promoting the welfare of all children who are cared for or who have contact with the Trust. This statement also encompasses the "unborn child" who, although not legally included within the definition of child is firmly encompassed within safeguarding children practice.

Under the provisions of the Children Act 2004, there is a statutory duty on all agencies to make arrangements to safeguard and promote the welfare of children. The impact that physical, emotional, sexual abuse, neglect and domestic violence can have on a child's development, health and wellbeing should never be under estimated. It is therefore important that all staff who come into contact with children and their families are aware of potential indicators of abuse or neglect, know what action to take and who to contact about any concerns they have in line with Trust guidance and The Nottinghamshire and Nottingham City Interagency Safeguarding Children Procedures (2022).

## 2.0 POLICY STATEMENT

The aim of this policy is to effectively safeguard and promote the welfare of children by:

- Providing guidance and support for all Trust staff, irrespective of role or client group with regards to fulfilling their legal duty to safeguard and promote the welfare of children
- Promoting inter-agency working
- Providing clear procedures regarding concerns about the welfare of a child.

This Safeguarding Children policy is supplementary to the Local Safeguarding Children Partnership/Board (LSCP/B) Procedures and should be used in conjunction with the procedures. This policy is not a replacement for one to one discussion, support or supervision with the practitioners' line manager, divisional leads or with the Named Nurse for Safeguarding Children for the Trust where concerns exist about the welfare of a child.

Government legislation and guidance clearly identifies that safeguarding children is 'everybody's responsibility' emphasising the need for all agencies to work more proactively.

The following documents support the guidance set out within this policy:

Working Together to Safeguard Children (HM Government 2018)

This is the statutory guidance that accompanies the Children Act 2004. This document sets out how organisations and individuals should work together to safeguard children, roles and responsibilities and outlines how to manage individual cases. It identifies "Health Professionals have a critical role to play in safeguarding and promoting the welfare of children ".
The document can be accessed via the Trust safeguarding intranet page.

Children Act 2004

Section 11 of the Children Act 2004 places a statutory duty on organisations to make arrangements to ensure that their functions, including those services contracted out of others, are discharged having regard to the need to safeguard and promote the welfare of children. Arrangements made under section 11 should take account of the Care Quality Commission inspection framework which requires services to be safe, effective, responsive to people's needs, caring and well led.

The Local Safeguarding Children Partnership/Board (LSCP/B) Policies and Procedures

These procedures clarify arrangements in the relevant local authority area as to how all agencies, both statutory and voluntary, should work together to safeguard children and promote their welfare. A copy of the procedures can be accessed via the Trust safeguarding intranet site or via the relevant LSCP/B website. These procedures are supported by multi agency guidance which can be accessed within the procedures.

This clinical policy applies to:

**Staff group(s):**

- All staff directly employed by the Trust whether working on trust premises or in the community. It also applies to staff working at the Trust who are employed by other agencies e.g. primary care staff, staff with honorary contracts, locum and agency staff, students and volunteers.

**Area(s):**

- All areas in the Trust where children and young people are cared for.

**Patient group(s):**

- Children and young people under the age of 18years

**Exclusions:**

- There are no exclusions to this policy

### 3.0 DEFINITIONS/ ABBREVIATIONS

| | |
|---|---|
| **SFHFT** | Sherwood Forest Hospitals NHS Foundation Trust |
| **Trust** | Sherwood Forest Hospitals NHS Foundation Trust |
| **Staff** | All employers of the Trust including those managed by a third party on behalf of the Trust |
| **Designated Professionals:** | A Designated Nurse and a Designated Doctor are individuals who have strategic roles and responsibilities for safeguarding children across a health community. |
| **Named Professionals** | A Named Doctor, Nurse and Midwife who are responsible for Safeguarding Children within their own organisations |
| **CAF** | Common Assessment Framework |
| **EHAF** | Early Help Assessment Form |

| | |
|---|---|
| **LAC or CIC** | Looked After Children or Children in Care |
| **FII** | Fabricated and Induced Illness |
| **CSE** | Child Sexual Exploitation |
| **CCE** | Child Criminal Exploitation |
| **LSCP/B** | Local Safeguarding Children Partnership/Board - A statutory organisation that brings together representatives from agencies and professionals responsible for helping to protect children from abuse and neglect within the Local Authority area. They develop policies and procedures and promote the need to safeguard children as well as monitoring and evaluating what is done. They monitor all child deaths and initiate serious case reviews when required. |
| **NSCP** | Nottinghamshire Safeguarding Children Partnership - A statutory organisation that brings together representatives from agencies and professionals responsible for helping to protect children from abuse and neglect within the Local Authority area. They develop policies and procedures and promote the need to safeguard children as well as monitoring and evaluating what is done. They monitor all child deaths and initiate serious case reviews when required. |
| **DoH** | Department of Health |
| **WNB/DNA** | Was Not Brought / Did Not Attend |
| **CP-IS** | Child Protection Information Sharing |

## DEFINITIONS

A **child** is defined as anyone who has not reached their 18th birthday. The fact that a child has reached 16 years of age is living independently or is in further education, is a member of the armed forces, is in hospital or in custody in the secure estate for children and young people does not change his or her status or entitlement to services or protection, (Working Together 2018). "Children" therefore includes "children and young people" under the age of 18 years. Safeguarding and promoting the welfare of children is defined as:

- Protecting children from maltreatment
- Preventing impairment of children's health or development
- Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care
- Taking action to enable all children to have the best outcomes. (Working Together to Safeguard Children 2018)

**Definitions of categories of abuse:** (HM Government, 2015)

**Physical abuse** a form of abuse which may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning suffocating or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms or deliberately induces illness in a child known as **Fabricated and Induced Illness (FII).**

**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 a child that they are worthless or unloved, inadequate or valued only insofar as they meet the needs of another person. It may include not giving the child opportunities to express their views, deliberately silencing them or 'making fun' of what they say or how they communicate. It may

feature age or developmentally inappropriate expectations being imposed on children and young people. These may include interactions that are beyond the child's capability as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction. It may involve seeing or hearing the ill treatment of another. It may involve serious bullying (including cyber bullying), causing children and young people to feel frequently frightened or in danger, or the exploitation or corruption of children and young people. Some level of emotional abuse is involved in all types of maltreatment of a child though it may occur alone.

**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 include 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 involve non-contact activities such as involving children and young people in looking at, or in the production of sexual images, watching sexual activities, encouraging children and young people 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 and young people.

**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

**Significant Harm** – Some children are in need because they are suffering or likely to suffer significant harm. This concept was introduced by the Children Act (1989), this is the threshold that justifies compulsory intervention in family life in the best interests of children and gives the local authority a duty to make enquiries (section 47) to decide whether they should take action to safeguard and promote the welfare of a child who is suffering or likely to suffer significant harm. It may constitute a single traumatic event, or a compilation of significant events, which interrupt, change or damage the child's physical or psychological development.

**Child Protection** – is a part of safeguarding and promoting welfare. This refers to the activity that is undertaken to protect specific children who are suffering, or are likely to suffer, significant harm. All agencies and individuals should aim to pro-actively safeguard and promote the welfare of children, so that the need for action to protect children from harm is reduced.

**Child in Need** – Children who are defined as being in need under section 17 of the Children Act 1989, are those whose vulnerability is such that they are unlikely to reach or maintain a satisfactory level of health or development, or their health and development will be significantly impaired without the provision of services plus those children who are disabled.

**The Assessment Framework** – Developed by the DOH in 'The Framework for assessing children in need and their families' (2000) as a multi-agency assessment tool to provide a common language to understand what is happening to a child. Assessing the needs of children requires a systematic and purposeful approach. This involves using the framework to gather and analyse relevant information regarding the three domains:

- Developmental needs of the child
- Parenting capacity (or regular caregiver) to meet the needs of the child
- Impact of the wider family and environmental factors on both parenting opacity and the child's development.

Staff should utilise this assessment tool when:

- Making referrals to Children's Services
- Compiling reports for child protection conferences/core groups/multi-agency meetings etc
- Contributing to a EHAF/CAF (Early help Assessment Form/Common Assessment Framework)

### Early Help Assessment Form/Common Assessment Framework (EHAF/CAF)

An EHAF/CAF should be completed to identify, children's additional needs that are not being met by the universal services they are receiving, and provide timely and co-ordinated support to meet those needs, at the earliest opportunity.

An EHAF/CAF is designed to be used if:

- You are concerned about how well a child is progressing
- The needs are unclear, or broader than your service can address
- An early help or common assessment would help identify the needs, and/or get other services to help them

The Local EHAF/CAF Form is available on the relevant LSCP/B website.

If you are worried that a child is suffering, or is at risk of suffering harm, you should follow the LSCP procedures without delay. Do not stop to do a EHAF/CAF. Contact the Trust Safeguarding Team if you are unsure what to do.

### Children in Care (CIC)

The term *Looked After Child (LAC - Children in Care)* has a specific legal meaning based on the Children Act, 1989. A child is looked after by a local authority if he or she has been provided with accommodation for a continuous period of more than 24 hours, in the circumstances set out in Sections 20 and 21 of the Children Act, 1989, or is placed in the care of a local authority by virtue of an order made under part IV of the Act.

Some other forms of child abuse and child protection concerns with definitions include:

### Female Genital Mutilation (FGM):

Female Genital Mutilation (FGM) is a procedure where the female genital organs are deliberately cut or injured, but where there is no medical reason for this to be done.

## Contextual Safeguarding

This is an approach to understanding, and responding to, young people's experiences of significant harm beyond their families. The relationships young people form outside of their families (whether online or community) can sometimes expose them to violence and/or abuse. These threats can take a variety of different forms and children can be vulnerable to multiple threats, including exploitation by criminal gangs and organised crime groups such as county lines, trafficking, online abuse, sexual exploitation, and the influences of extremism leading to radicalisation.

## Missing. Exploited and Trafficked children

Definition of **Missing** or being **absent**:
To ensure that the appropriate action to promote a child's safety is taken when police receive a concern about a child having gone "missing" the police apply the following categories:

A '**missing'** person is defined as:
"Anyone whose whereabouts cannot be established and where the circumstances are out of character or the context suggests the person may be subject of a crime or at risk of harm to themselves or another"
Those meeting this definition will be actively searched for, with a level of risk and assigned to each case.

An **'absent'** person is defined as a:
"Person not at a place where they are expected or required to be"
People categorised as such should not be perceived to be at any apparent risk. Cases classified as 'absent' will be monitored by the police and escalated to the missing person category if risk increases.

Definition of **Exploitation:**

Exploitation is "the action or fact of treating someone unfairly in order to benefit from their work". (English Dictionary, 2018)

**Child Sexual Exploitation (CSE)** is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology (Working Together 2017).

**Child Criminal Exploitation (CCE)** occurs where an individual or group takes advantage of an imbalance of power to coerce, control, manipulate or deceive a child or young person under the age of 18. The victim may have been criminally exploited even if the activity appears consensual.

Child Criminal Exploitation does not always involve physical contact; it can also occur through the use of technology. Criminal exploitation often happens alongside sexual or other forms of exploitation.

Child Criminal exploitation is broader than just county lines and includes for instance children forced to work on cannabis farms, to commit theft, shoplift or pickpocket, or to threaten other young people.

**Trafficking**

Human trafficking is defined as a process that is a combination of three basic components:

- Movement (including within the UK)
- Control, through harm / threat of harm or fraud
- For the purpose of exploitation (UNHCR 2006)

The Modern Slavery Act (2015) requires public authorities to notify the Home Office when they encounter a potential victim of modern slavery or human trafficking, and for children this is generally done through a referral to the National Referral Mechanism (NRM). Unlike adults, consent is not needed from a child for this referral to be made.

**Children at risk of radicalisation (PREVENT)**

Radicalization is defined as the process by which people come to support terrorism and extremism and, in some cases, to then participate in terrorist activity. Extremism is vocal or active opposition to fundamental British values including democracy, the rule of law, individual liberty and mutual respect and tolerance of different faiths and beliefs.

Health care professionals may treat children who are vulnerable to radicalisation. The key challenge for the health sector is to ensure that, where there are signs that someone has been or is being drawn into terrorism, the health care workers can interpret those signs correctly, are aware of the support that is available and are confident in referring the child for further support (HM Government 2011).

## 4.0 ROLES AND RESPONSIBILITIES

The Trust has and overarching Think Family Safeguarding Strategy, which recognises that neither children nor adults exist or operate in isolation, therefore promoting co-ordinated thinking and delivery of services to children, adults and families. It identifies safeguarding is everyone's responsibility irrespective of roles and looks at how safeguarding is reflected in the Trusts Key Priorities

The Trust has transparent and accountable governance arrangements and organisational structures to ensure effective delivery of safeguarding arrangements. Those working within the Trust are empowered to be confident in their practice through training at the appropriate level and have access to quality management and safeguarding supervision.

Working Together to Safeguard Children (2018) requires that each Trust has identified professionals within the organisation to provide leadership in respect of safeguarding children.

**The Trust Board** will identify a lead member with responsibility for Safeguarding Children within the Trust. The lead member will be responsible for:

- Ensuring regular feedback on Safeguarding Children is provided for the Trust Board.

**The Executive Lead for Safeguarding** holds board level responsibility for safeguarding, providing a strategic leadership for safeguarding across the organisation and chairs the Trust wide Safeguarding Steering Group.

**Safeguarding Lead**
Provides support to the executive lead in exercising their functions in providing strategic leadership for safeguarding across the organisation. Other responsibilities include:

- Ensuring that there is a clear line of accountability and governance within the Trust and the provision of services designed to promote and safeguard the welfare of children.
- Collaborating with Human Resources Department in order to ensure recruitment and human resources management procedures, including contractual arrangements, take account of the need to safeguard and promote the welfare of children and young people.
- Ensuring that there are procedures for dealing with the allegations of abuse against members of staff and volunteers
- Leading the organisation to understand and embed learning from serious case reviews
- Represent the organisation at the Local Safeguarding Children Partnership (LSCP).
- Working collaboratively with partner organisations to grow business and ensure that
- the health economy is an equal partner in all safeguarding delivery.

**The Named Professionals**
The Trust has a Named Nurse and Named Doctor for Safeguarding Children, who form part of the Safeguarding Team. They carry out their duties in accordance with statutory guidance and work in partnership with the Local Safeguarding Children Partnership/Board and are responsible for:

- Promoting and developing good safeguarding practice throughout the Trust
- Providing expert advice and support on safeguarding issues for the Trust and Trust employees.
- Provide safeguarding supervision as and when required.
- Providing arbitration when professional or agency opinions differ as to whether a child is at risk (if this involves a Named Professional the Designated Professionals will become involved)
- Conducting the Trust's serious case reviews following a child death or serious/life threatening injury to a child through abuse or neglect
- Ensuring recommendations from serious case reviews (both internal and external) are implemented and subsequent learning is disseminated
- Support the organisation in its clinical governance role by ensuring that audits on safeguarding are undertaken and that safeguarding issues are part of the clinical governance systems.
- Defining and with the safeguarding team and NSCP, delivering Safeguarding Children training.

- Producing quarterly and annual Safeguarding Children and Young People Reports for presentation to the Trust Safeguarding Steering Group, Patient Safety and Quality Group and Quality Committee.

**Divisional Heads and all Managers Responsibilities include:**

- Ensuring that all staff are made aware of their roles and responsibilities in relation to this policy.
- Ensuring that all staff have read the policy and are aware of what actions they need to take.
- To identify any additional training and support needs required by their staff to enable them to perform their duties as defined in this policy.
- Monitoring periodically staff awareness of their roles in relation to this policy.
- Following other appropriate Trust procedures, simultaneously where necessary e.g. disciplinary procedures, complaints and incident reporting.
- Ensuring appropriate Divisional representation at the Trust's Safeguarding Steering Group.

**All Trust staff will:**

Undertake Safeguarding Children training as required by the Trust's 'Mandatory Training Policy' *https://www.sfh-tr.nhs.uk/media/7253/lr-ted-mandatory-training-policy-v92-jan-21.pdf*

As appropriate to their role know how to access NSCP Safeguarding Children Procedures and local/national practice guidance via the Safeguarding Children intranet site and understand how, when and where to seek additional support and advice

Respond immediately to any allegations against staff from any source as per the trust's 'Policy for dealing with safeguarding allegations or concerns about individuals undertaking work at the Trust'

It is the responsibility of Trust staff (relevant to their role) to challenge actions/decisions made by other staff members/professionals/agencies if they are felt to be unsatisfactory. Support will be provided by their manager and Safeguarding Team where required. See the Trusts internal interagency escalation policy

Staff must ensure that the relevant documentation is completed in line with Trust policy and Codes of Practice, maintaining up to date and accurate written records.

## 5.0 APPROVAL

This policy has been approved by the Trust's Safeguarding Steering Group.

## 6.0 DOCUMENT REQUIREMENTS (NARRATIVE)

### 6.1 Assessment and Referral Processes

Children's rights to be safeguarded are paramount. Assessments should measure the potential or actual impact of parental health on parenting, the parent/child relationship and the child, as well as the impact of parenting on the adult's health. Appropriate support and ways of accessing it should also be considered in the assessment

Practitioners working with adults must identify and record on admission if:

- They have children or caring responsibilities for children.
- The adult's relationship with any children.
- If there are children, confirm that safe and appropriate child care arrangements are in place.
- Consideration should also be given to whether the adults presenting condition will impact on their ability to care for the children.
- Are there other agencies already involved with the family e.g. social care.

**Risk and Assessment Processes must adopt the "Think Family" approach.**

### 6.2 Children not registered with a GP

If a child is admitted and they are not registered with a GP seek an explanation from the parent/carer and document the answer. Advise parent/carer to register their child ASAP. Consider undertaking a Safeguarding Children Information Management Team (SCIMT) check (see Appendix A)

No child about whom there are concerns about deliberate harm should be discharged without an identified GP. This responsibility rests with the consultant under whose care the child has been admitted.

### 6.3 Checking to see if a child is known to children's social care

Documentation within Paediatric areas of the Trust will ask if there is current social care involvement and if so asks for the Named of the social worker and the reason for their involvement.

Staff within these areas must inform the social worker of the child's attendance/admission and discharge from hospital. Providing a brief overview of the reasons for the admission and any concerns they may have as a result. If there are immediate concerns this contact needs to occur as soon as possible and the child must **not** be discharged until this liaison with social care has taken place and discharged agreed.

If Trust staff have concerns that a child may have a Child Protection Plan or have had previous involvement with children's social care and need to check, then a SCIMT (Safeguarding Children Information Management Team) check can be undertaken. Consent must be asked to undertake this check. *See Appendix A How to undertake a SCMIT check.*

### 6.4 CP-IS Project (Child Protection Information Sharing)

The Child Protection Information Sharing Project (CP-IS) is a system dedicated to developing an information sharing process that will deliver a higher level of protection of children who visit NHS unscheduled care settings. It provides additional child protection information to staff, shares local authority information with the NHS and allows staff to deliver a higher level of child protection.

Sharing information effectively across health and care settings is vital in protecting vulnerable children and young people and preventing further harm.

CP-IS focuses on three specific categories

- Those subject to a child protection plan
- Those with 'looked after child' status (children with full and interim care orders and voluntary care agreements)
- Any pregnant woman whose unborn child has a pre-birth child protection plan

CP-IS has been implemented in the Emergency Department, Newark Urgent Care Centre and Maternity Services. If a child/pregnant women presents at any of these unscheduled care settings and CP-IS identifies that a child/unborn has an allocated social worker, the social worker should be informed of attendance as per routine departmental procedures. If CP-IS does not identify the above three categories, a full risk assessment is still required and actions to safeguard if concerns are identified.

*More information on CP-IS is available on the Trust safeguarding intranet.*

### 6.5 What to do if you suspect a child is at risk

Discuss concerns with line manager/senior colleague and/or safeguarding team. Refer to 'When to Suspect Child Maltreatment' (NICE 2009, 2019) https://www.nice.org.uk/guidance/cg89/resources/child-maltreatment-when-to-suspect-maltreatment-in-under-18s-pdf-975697287109 and relevant multi-agency practice guidance including Children's Social Care referral thresholds (Pathway to Provision, 2021) https://www.nottinghamshire.gov.uk/media/129861/pathwaytoprovisionhandbook.pdf

If necessary undertake a Safeguarding Children Information Management Team (SCIMT) check [Appendix A]. Document all observations and discussions.

If a referral is made to Children's Social Care (see Appendix C - How to make a referral to children's social care) this is normally with the knowledge of the parents/carers and if appropriate the child, unless by doing so would place the child at additional risk i.e. in the cases of FII and sexual abuse, in these instances parents would not be informed of a referral to social care as evidence shows the risk to child is increased by doing so. Confirm the referral in writing within 24hrs (by completing the relevant localities on line referral form (links available on the safeguarding intranet). If the child is admitted follow the Trust's *Policy for Admission and Discharge of Children where there are Safeguarding Concerns* *http://sfhnet.nnotts.nhs.uk/content/showcontent.aspx?contentid=24177*

### 6.6 Children with Disabilities

The available UK evidence suggests that disabled children are at increased risk of abuse, and that the presence of multiple disabilities appears to increase the risk of both abuse and neglect. Disabled children may be especially vulnerable to abuse for a number of reasons:

- Increased risk of being socially isolated with fewer outside contacts than non-disabled children
- Their dependency on parents and carers for practical assistance in daily living, including intimate personal care, increases their risk of exposure to abusive behaviour

### 6.7 Children who are at risk from Domestic Abuse

Domestic abuse is physical, psychological, sexual or financial violence that takes place within an intimate or family type relationship forming a pattern of coercive and controlling behaviour.

The Adoption and Children Act 2002 extended the legal definition of harming children to include harm suffered by seeing and hearing the ill treatment of others. This includes witnessing domestic violence.

If on routine enquiry a patient discloses domestic violence (see Trust Domestic Abuse Policy) the risk to children should always be assessed using the NSCP Safeguarding Procedures *in Relation to Children and Domestic Violence* https://nottinghamshirescb.proceduresonline.com/p_dom_viol_abuse.html and if necessary a referral is made to Children's Social Care. Information on disclosure should also be shared with relevant community health professionals.

If a patient presents for treatment following a domestic assault and they have children or they are pregnant a referral to Children's Social Care should be initiated.

Discussions about the referral should never be held in the presence of the abusing parent/carer nor should they be given any information about the referral as this may put the patient and/or children at increased risk of harm.

### 6.8 Female Genital Mutilation (FGM)

FGM can be carried out on girls of all ages but may be more common between the ages of 5and 10.

The FGM mandatory reporting duty is a legal duty provided for in the FGM Act, 2003 (as amended by the Serious Crime Act, 2015) which requires all regulated healthcare professionals to report FGM in a girl under 18, either through disclosure by the victim or relative and/or are visually confirmed. This is no different from any other obligation on healthcare professionals to report abuse against children. FGM is child abuse so the healthcare professional must make a report to the Police.

Also refer to the Trust FGM policy.

## 6.9 Missing Children/Families, Abandoned or Abducted Children

### 6.9.1 Missing Family Process.

There is a national system used by Children's Social Care Departments for disseminating information about children and unborn babies who go missing from social work caseloads; there are always serious concerns for their welfare and safety.

As part of this system the Trust receives alerts which are actioned through the Re-Admission Patient Alert system (RAPA). So if RAPA identifies a missing child/unborn child the Named Nurse and the Named Midwife for Safeguarding Children will be alerted. Alerts are also placed onto SystmOne in order to obtain 24/7 coverage, this allows Emergency Department staff to be alerted should a missing family present to the department allowing for timely notification to social care and/or police should the family attend out of hours.

See Appendix E for full details of the Missing Child/families/ Unborn Child RAPA Alert Process

### 6.9.2 Abandoned babies/children

In law, child abandonment is defined as the act of leaving of a child alone and having no intention of returning to ensure their health, safety and wellbeing.
Fortunately, child abandonment is rare but when it does occur it can be for a variety of reasons. For some people, it could be the stress and responsibility of being a parent or carer, complicated circumstances in their lives, or mental health issues. Sadly, in an acute hospital trust, people are often at their most vulnerable, or complex family dynamics can reach a crisis point, causing them to abandon their child. This could occur anywhere within the trust, but some areas, such as maternity or the paediatric wards, do have an increased possibility of this occurring.

**Appendix D provides guidance on what to do if a baby/ child was to be abandoned within any area of the hospital.**

### 6.9.3 Abducted Children

Infant and child abductions are rare, however, the trauma and publicity surrounding such events highlights the importance of ensuring that, should an incident occur, the Trust has a comprehensive easy to follow response plan to:

- Ensure that staff are aware of how to raise the alarm quickly as time is critical.
- Ensure that staff are fully aware of their roles and responsibilities.
- Ensure that staff are deployed effectively to conduct a search of the area.
- Ensure effective communication and co-operation between Trust staff, the police and security services.
- Ensure effective communication with other agencies including Social Care.

If a member of staff becomes aware of the unexplained absence they should follow the guidance as set out in the Trust Abduction of a Neonate Policy on the safeguarding intranet page.

### 6.10 Underage Sexual Activity

Sexual relationships and sexual activity are a normal part of life. Although the legal age of consent for sexual activity is 16 years of age, many young people below this age will develop and show an interest in sex and sexual relationships.

This policy recognises the balance, which needs to be drawn between young peoples' access to safe, confidential health services alongside promoting and safeguarding their welfare.

If at any stage, there are concerns that a child/young person may be at risk of sexual exploitation or sexual abuse advice should be sought from the safeguarding team. Please also refer to the NSCP practice guidance relating to this issue. Underage Sexual Activity Practice Guidance.

All staff working with children/young people should be aware of the potential for sexual relationships to be abusive and the need for further action to be taken. Where there are urgent concerns about the welfare of a child/young person an immediate referral should be made to Children's Social Care.

Assessment of risk is essential when thinking about underage sexual activity. It is important to understand the nature of any particular behaviour and the facts surrounding the actual relationships of those involved. In making these judgments, staff should consider the holistic needs of the child/young person and the specific issues outlined below:

- The age and maturity of the children or young people;
- Whether the young person is able to understand, and give informed consent to the sexual activity they are involved in;
- Under the terms of the Sexual Offences Act 2003 children under the age of 13 years old, are not legally capable of giving consent;
- The nature of the relationship between those involved, with particular weight being given to the child/young person's age and the issues outlined relating to the power imbalance;
- Whether overt aggression, coercion or bribery was involved including the use of substances (e.g. alcohol or drugs), as a disinhibitor;
- Whether the young person's own risk-taking behaviours, for example the use of substances, places them in a position where they are unable to make an informed choice about the activity;
- Any attempts to secure secrecy by the sexual partner beyond what would be considered usual in a teenage relationship;
- Whether the sexual partner is known to the agency as having other concerning relationships;
- Whether the child/young person denies minimizes or accepts the concerns for their welfare;
- Whether methods used to silence, secure secrecy and/or compliance by the sexual partner are consistent with behaviours' considered as an act of 'grooming'.

Children/young people under the age of 13 years are not legally capable of giving their consent to any sexual activity (Sexual Offences Act 2003) and are clearly more vulnerable by virtue of their age. Under the Sexual Offences Act, penetrative sex (including oral sex) with a child under 13 is rape. Therefore in these instances a referral to social care must be made.

### 6.11 Where there are concerns about Child Sexual Exploitation (CSE)

CSE is a specific form of child sexual abuse which needs a different approach to take account of its complex nature. CSE involves young people receiving 'something' (eg food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of performing and/or others performing on them, sexual activities. It can occur without physical contact, when children are groomed to post sexual images of themselves on the internet. 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.

Children aged 12-15 years of age are most at risk of child sexual exploitation, although victims as young as 8 have been identified, particularly in relation to online concerns. Equally, those aged 16 or above can also experience child sexual exploitation, and it is important that such abuse is not overlooked due to assumed capacity to consent. Account should be taken of heightened risks amongst this age group, particularly those without adequate economic or systemic support. Though child sexual exploitation maybe most frequently observed amongst young females, boys are also at risk. Child sexual exploitation affects all ethnic groups.

**It is important to remember that:-**

- A child under the age of 13 is not legally capable of consenting to sex (it is statutory rape) or any other type of sexual touching; Sexual activity in older children (i.e. from 13 to 18 years) needs to be considered in relation to both *the giving, and the getting of consent*, with the promotion of mutual negotiation as the norm being an important aspect of preventative activity (Coy *et al*., 2013)

- Sexual activity with a child under 16 is an offence. Practitioners have a responsibility to undertake an assessment of young people aged 13 to 15 years who are engaged in sexual activity following Fraser competencies guidelines, to determine the risk of sexual and other forms of exploitation or coercion including trafficking. This assessment will inform the decision making process relating to the appropriateness of a referral to Children's Social Care and the Police. Risk assessment is a complex process and practitioners are encouraged to discuss concerns with a member of the Safeguarding Children Team whenever they are unsure about the appropriate course of action.

- Those aged 16 and 17 years may be viewed by health professionals and others as being of 'the age of consent' in terms of the Sexual Offences Act (2003), but this age group are particularly vulnerable to CSE being missed precisely because of the legalities of sexual consent in this age group (Powell, 2016).

- It is an offence for a person to have a sexual relationship with a 16- or 17- year old if they hold a position of trust or authority in relation to them;

- Where sexual activity with a 16- or 17- year old does not result in an offence being committed, it may still result in harm, or the likelihood of harm being suffered;

- Non consensual sex is rape whatever the age of the victim; and

- If the victim is incapacitated through drink or drugs, or the victim or his or her family has been subject to violence or the threat of it, they cannot be considered to have given true consent and therefore offences may have been committed.

- No individual, whatever their age, can give consent in a situation where there is intoxication, duress, violence, power imbalances and/or vulnerabilities through age differences, learning difficulties or mental health issues. A child under 18 years of age cannot consent to their own abuse through exploitation (Powell, 2016)

When young people are known to be sexually active (eg when accessing sexual health services), the 'spotting the signs' proforma should always be completed, and the risk factors for sexual vulnerability and grooming considered.

Where there are concerns around CSE an assessment of risk should be made using the CSE Multi Agency Risk Assessment Tool CSE Multi Agency Risk Assessment tool. Also refer to the *Interagency Practice Guidance in relation to Child Sexual Exploitation CSE Practice Guidance.*

### 6.12 Where there are concerns about Fabricated or Induced Illness (FII)

FII concerns may arise where a child or young person is presented for medical attention, possibly repeatedly, with symptoms or signs suggesting significant illness but an appropriate clinical assessment suggests that the child's 'illness' is not adequately explained by any disease.

This might be explained by:

- Simple anxiety or lack of knowledge about illness by carer
- Child's symptoms are misperceived or perpetuated by carer
- Carer actively promotes sick role by exaggeration, non-treatment of real problems, fabrication [lying] or falsification of signs, and/or induction of illness [can include falsification of charts, interference with medical equipment etc.]
- Carer suffers from psychiatric illness which leads them to believe child is ill.
- Unrecognised genuine medical problem (RCPCH, 2009) NB: Illness may also be fabricated or induced in the pregnant mother/unborn child.

Initial concerns about fabricated or induced illness should be discussed with the Trust Named Professionals for Safeguarding Children before a referral to children's Social Care is made unless this would unduly delay the making of a referral.

### 6.13 Children at risk of radicalisation (PREVENT)

### PREVENT – The Government's Counter Terrorism Strategy

The Government's counter terrorism strategy called CONTEST aims to reduce the risk to the United Kingdom and its interests overseas from international terrorism, so that people can go about their lives freely and with confidence. These forms of terrorism include Far Right Extremists; Al-Qa'ida influenced groups, English Defence Leagues, environmental and animal rights extremists.

CONTEST has four work streams. These Pursue (to stop terrorist attacks), Protect (to strengthen our protection against terrorist attack), Prepare (where an attack cannot be stopped, to mitigate its impact) and Prevent (to stop people becoming terrorists or supporting terrorist activities)

Staff may meet and treat children and young people who are vulnerable to radicalisation. Working Together to Safeguard Children 2015 states *"Experience suggests that young people from their teenage years onwards can be particularly vulnerable to getting involved with radical groups through direct contact with members, or increasingly, through the internet. This can put a young person at risk of being drawn into criminal activity and has the potential to cause significant harm".*

All staff must escalate any concerns about patient's, parents/carers or staff as per the Trust PREVENT flowchart (see Appendix F): to the Trust's nominated Prevent lead (contact details on the Prevent Intranet page) each issue will be taken seriously and handled appropriately.

### 6.14 Historic abuse allegations

The term 'historical abuse' is commonly used to refer to disclosures of abuse that were perpetrated in the past. It is normally used when the victim is no longer in circumstances where they consider themselves at risk of the perpetrator and more commonly used when adults disclose abuse experienced during childhood.

Allegations of child abuse are sometimes made by adults and children many years after the abuse has occurred. There are many reasons for an allegation not being made at the time including fear of reprisals, the degree of control exercised by the abuser, shame or fear that the allegation may not be believed. The person becoming aware that the abuser is being investigated for a similar matter or their suspicions that the abuse is continuing against other children may trigger the allegation.

Cases may be complex as the alleged victims may no longer be living in the situations where the incidents occurred or where the alleged perpetrators are also no longer linked to the setting or employment role. It is important to ascertain as a matter of urgency if the alleged perpetrator is still working with, or caring for children.

### Action to Safeguard following a disclosure of historical abuse

The professional receiving the disclosure or the victim may not be aware of the perpetrators present circumstances and therefore are not able to assess whether they pose a current risk to a child, children or other adults at risk person.

Consideration must be given to whether the alleged perpetrator presents a current risk to children or vulnerable people through having contact within a family setting, as a professional or by their behaviour.

The professional to whom the disclosure was made should:

- Clarify whether there are any children who may currently be at risk from the Perpetrator.
- If it has been ascertained that the alleged perpetrator has or may have contact with a known child/ children, a referral should be made to Children's Services.
- If there are concerns that the alleged perpetrator has contact with children but the names of the children are not identifiable, the police should be contacted to enable further investigation
- If there are concerns that the adult making the disclosure is at risk, consideration to refer to adult social services and police will be required
- Advise and support the adult that they are able to make a formal complaint to the Police.
- Provide the victim with information about relevant support services – these are available on the Trust Safeguarding Intranet.

### 6.15 Discharging a child and/or a parent/carer from your service when there are Safeguarding Child and/or adult concerns.

Before any decision is made around discharging a child and/or a parent/carer from hospital where there are safeguarding concerns staff must hold a discharge planning meeting, including all relevant agencies. At this meeting a clear safe plan for discharge must be agreed. If a safe discharge plan cannot be agreed upon then staff should discuss this with the safeguarding team who will support in decision making around next steps and any necessary escalation required.

Discharge should not occur until a clear safe discharge plan is agreed.

*Admission and Discharge Where There Are Safeguarding Concerns Policy*

### 6.16 Outcome of Referral to Children's Social Care

Children's Social Care departments are expected to acknowledge a written referral confirming their intended course of action to the referrer (NSCB 2015).

If a referrer is not informed of the outcome of their referral they should contact Children's Social Care and request this information.

If the referrer is unhappy with the outcome from children's social care they should contact the Trust Safeguarding team who will review the case and escalate accordingly.

### 6.17 Resolving disagreements (escalation process):

Disagreements are most likely to arise around thresholds for referrals, roles and responsibilities and the need for action.

Professional disputes potentially increase the risk to children so it is important that they are resolved quickly and openly.

If there is a professional or inter-agency disagreement over whether a child or young person is at risk of harm and resolution cannot be achieved between practitioners this should be escalated to the Named Professionals for advice, support and arbitration. Refer to the Policy for the Escalating Safeguarding Children Inter-agency Disagreements
*http://sfhnet.nnotts.nhs.uk/content/showcontent.aspx?ContentId=31682*

### 6.18 Safeguarding Children Supervision

Safeguarding Children supervision will be provided in accordance with the trust Safeguarding Children Supervision Policy
*http://sfhnet.nnotts.nhs.uk/content/showcontent.aspx?contentid=27506*

Safeguarding Children Supervision training will be provided for all Safeguarding supervisors and will be regularly updated.

### 6.19 Child Deaths

The Specialist Nurse for Child Death and Named Professionals are notified of all child deaths within the Trust.

If the death is unexpected i.e. not anticipated as a significant possibility 24hrs before the death the joint Nottingham City and Nottinghamshire Safeguarding Children Partnership multi-agency rapid response procedures/processes are initiated -
*http://sfhnet.nnotts.nhs.uk/content/showcontent.aspx?contentid=17979*

### 6.20 Serious Case Reviews

Serious Case Reviews are initiated by the Local Safeguarding Children Partnership/Board for the area within which a child is/was resident. Individual organisations undertake individual management reviews (IMR).

The author of the IMR will be a Named Professional or member of the Trust safeguarding team. Arrangements will be made to allow the IMR author sufficient time for the IMR to be undertaken.

All IMR authors will be appropriately trained.

The IMR process will be undertaken and written in accordance with NSCP/Ofsted prescribed format and timescales.

The Trust Board will be made aware of the content and recommendations arising from the IMR.

Recommendations arising from action plans will be completed within the prescribed timescales and any learning from outcomes will be disseminated appropriately and in a timely fashion.

### 6.21 Dissemination of Safeguarding Children Information

Safeguarding Children information/resources will be made available via the Safeguarding intranet site, and as new information is shared, will also be disseminated via Trust Safeguarding Children Champions and Safeguarding Steering Members.

Staff wil be made aware of the contact details of the Named Professionals via the Safeguarding Children Information Card (carried in their ID badge holder), the Safeguarding Children intranet site and training.

The Trust's expectations of staff, parents and carers behaviour where children are cared for will be made explicit and displayed.

Children and young people will have information displayed on confidentiality, the limits to confidentiality and organisations they can contact for help and support.

### 6.22 Confidentiality and Sharing Information

The decision to share or not to share information about a child/young person should always be based on professional judgement, supported by the cross-governmental guidance Information *Sharing: Advice for practitioners providing safeguarding services to children, young people, parents and carers* (HM Government, 2015).

Information sharing must be done in a way that is compliant with the General Data Protection Regulation, the Human Rights Act and the common law duty of confidentiality. However, a concern for confidentiality must never be used as a justification for withholding information when it comes to safeguarding a child/young person. The welfare of the child must always be of paramount consideration.

Effective information sharing is an essential element of Safeguarding Children. The Children Acts 1989 and 2004 state we have a duty to co-operate with other agencies to safeguard and promote the welfare of children. Sharing information to protect children is in the public interest.

Written Trust guidance on information sharing will be available to staff and will comply with statutory legislation/guidance, multi-agency information sharing agreements and trust information governance policies.

### 6.23 Children and Young People who are not brought to appointments (WNB/DNA)

Every child has the right to health and healthcare – United Nations Convention on the Rights of the Child, Article 24, 1989. We must ensure a Trust wide approach in proactively following-up non-attendees and sharing this information with other known professionals who are involved with the child and family, on a multi-agency basis.

Failed attendance of a child or young person may be due to several factors, for example incorrect contact details, inappropriate referral/problem resolved, fear & anxiety or multiple appointments at diverse locations on consecutive days or they have just forgotten about the appointment. Many parents/ carers will telephone the hospital to rearrange or cancel appointments but a significant number just fail to turn up.

However, professionals need to also consider the issue that failure to attend can be an indicator of a family's vulnerability, potentially placing the child's welfare in jeopardy. Younger children in particular are reliant on their parent/carer accompanying them to appointments. There may be a perfectly acceptable reason for a child not being brought to an appointment, however, it is also possible that the parent/carer does not share our concerns, may be hiding injuries or signs of neglect or is just unable to put their child's needs first.

Where there could be child protection concerns, sharing information regarding failure to attend can be vital in protecting the child and the opportunity to safeguard children and young people should not be missed. Sharing information on missed appointments may contribute to timely interventions in children whose needs are not being met or who are experiencing abuse.

When parents or children frequently miss health appointments then the professional must review their case and determine if there are any issues of neglect or abuse.

Refer to the Trust's Access Policy for the management of children who are not brought to or fail to attend appointments (WNB/DNA)

Children in hospital for 3 months Section 85 (Children's Act 1989)
All children who are resident in hospital for 3 months must be referred to Social Care for an assessment under the Framework for the Assessment of Children in Need and their families, and follow up of their welfare (Section 85, Children Act, 1989). This form does not need to be completed in full; only the information immediately available is required.

### 6.24 Documentation

All Safeguarding Children information should be filed within the hospital record as per trust practice (Appendix B)

### 6.25 Managing Allegations

Despite all efforts to recruit safely there will be occasions when allegations of abuse against children are raised. The allegations may relate to the person's behaviour at work, at home or in another setting. All allegations of abuse of children by those who work with children must be taken seriously. Allegations against people, who work with children, whether in a paid or unpaid capacity, cover a wide range of circumstances.

If you are aware of a person who works with children and has:

- Behaved in a way that has harmed a child, or may have harmed a child
- Possibly committed a criminal offence against or related to a child
- Behaved towards a child in a way that indicates he/she is unsuitable to work with children

All such allegations made against adults working with children must be referred to the Local Authority Designated Officer (LADO) who provides advice and guidance to employers and voluntary organisations, liaises with the police and other agencies and monitors the progress of cases to ensure that they are dealt with as quickly as possible consistent with a thorough and fair process.

See allegations against staff policy for full guidance on how to manage allegations.
http://sfhnet.nnotts.nhs.uk/departments/clinicalguidelines/deptbrowse.aspx?recid=7317&homeid=2471

## 7.0 MONITORING COMPLIANCE AND EFFECTIVENESS

| **Minimum Requirement to be Monitored**<br><br>**(WHAT – element of compliance or effectiveness within the document will be monitored)** | **Responsible Individual**<br><br>**(WHO – is going to monitor this element)** | **Process for Monitoring e.g. Audit**<br><br>**(HOW – will this element be monitored (method used))** | **Frequency of Monitoring**<br><br>**(WHEN – will this element be monitored (frequency/ how often))** | **Responsible Individual or Committee/ Group for Review of Results**<br>**(WHERE – Which individual/ committee or group will this be reported to, in what format (eg verbal, formal report etc) and by who)** |
|---|---|---|---|---|
| Safeguarding documentation audit | Named Nurse Safeguarding | Audit | Yearly | Safeguarding Steering Group and patient safety and quality committee |
| Training Compliance | Named Nurse Safeguarding | Monthly compliance rates from Training and Education Dept. reported via Quarterly safeguarding assurance report | Quarterly | Safeguarding Steering Group and patient quality and safety committee |
| Safeguarding Activity and audit programme against locally agreed priorities | Named Nurse Safeguarding | Audit programme and Quarterly assurance reports | Quarterly | Safeguarding Steering Group. Patient Quality and safety committee. |
| Number of Childrens safeguarding referrals made by the Trust | Named Nurse Safeguarding | Record of number of referrals made by the trust is collated by the safeguarding team and reported on via the safeguarding quarterly assurance report. | | Safeguarding Steering Group, Patient Quality and Safety Committee |
| Compliance with NSCP Marker of Good Practice section 11 self-assessment tool | Named Nurse Safeguarding | Monitored through safeguarding children workplan and compliance rag rating system | Monitored internally quarterly with the self-assessment tool being submitted externally every 2 years. | Safeguarding Steering Group, Patient Quality and Safety Committee and NSCP |

## 8.0 TRAINING AND IMPLEMENTATION

Staff will undertake Safeguarding Children Training in accordance with the Trust's Mandatory Training Policy.

## 9.0 IMPACT ASSESSMENTS

- This document has been subject to an Equality Impact Assessment, see completed form at Appendix H

## 10.0 EVIDENCE BASE (Relevant Legislation/ National Guidance) AND RELATED SFHFT DOCUMENTS

**Evidence Base:**

- Adoption and Children Act 2002 http://www.legislation.gov.uk/ukpga/2002/38/contents
- Children Act 1989 http://www.legislation.gov.uk/ukpga/1989/41/contents
- Children Act 2004 http://www.legislation.gov.uk/ukpga/2004/31/contents
- HM Government [2018] *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children,* Stationery Office, London
- HM Government [2015] *Information sharing,* DfE, London
- HM Government [2008] *Safeguarding Children in whom illness is fabricated or induced: Supplementary guidance to Working Together to Safeguard Children,* DCSF Publications, London
- National Institute for Health and Clinical Excellence [2009 – updated 2017] *Child Maltreatment: When to suspect maltreatment in under 18's* *http://www.nice.org.uk/guidance/cg89/chapter/1-recommendations*
- Nottinghamshire and Nottingham City Safeguarding Children Boards [2021] *Safeguarding Children Procedures*
- Nottinghamshire and Nottingham City Safeguarding Children Boards [2014] *Inter-agency practice guidance in relation to children and domestic violence,*
- Royal College of Paediatrics and Child Health [2009] *Fabricated or Induced Illness by Carers: A practical guide for Paediatricians, RCPCH Publications, London*

**Related SFHFT Documents:**

- Policy for the admission and discharge of children where there are child protection concerns
- Policy for dealing with safeguarding allegations or concerns about individuals undertaking work at the Trust.

- Safeguarding Children Supervision Policy
- Holding Still and Restraining Children undergoing Health Interventions
- Policy for the management of children who fail to attend appointments [DNA]
- Guideline for Disclosure of Forced Marriage
- Guideline for the management of women who have undergone female genital mutilation
- Policy and Procedure for Dealing with Criminal Records Checks
- Policy for escalating Inter-Agency Safeguarding Children Disagreements
- Mandatory Training Policy

## 11.0 KEYWORDS

Domestic violence
Child maltreatment
Child protection
Child abuse

## 12.0 APPENDICES

Appendix A – Undertaking a Safeguarding Children Information Management Team (SCIMT) Check

Appendix B – Filing safeguarding children information in the medical records

Appendix C – Process for making a children safeguarding referral online

Appendix D – Abandoned babies/ children process

Appendix E – Missing Child/ Families/ Unborn Child RAPA Alert Process

Appendix F – *PREVENT* Flowchart

Appendix G – Safeguarding Children and Young People Level 3 Training Pathway

Appendix H – Equality Impact Assessment

## Appendix A – Undertaking a Safeguarding children information management team (SCIMT) check

Safeguarding Children Information Management Teams (SCIMT) are responsible for holding information on children who are judged to be at continuing risk of significant harm and are subject to an active Child Protection Plan.

When to make a SCIMT check
If after initial assessment and discussion with the parents/carers concerns remain that a child or young person may be known to Childrens Social Care a SCIMT check can be undertaken.

A SCIMT check should also be considered if a child:
- Presents for treatment and lives out of area (and is not on holiday).
- Is not registered with a GP
- Parents/carers remove the child from Emergency Department/Minor Injuries Unit &Urgent Care Centre/ward without the child being seen

NB: If possible always inform the parent/carer a SCIMT check is being made.

SCIMT Process
When an agency other than Children's Social Care contacts the SCIMT (or Emergency Duty Team out of hours) to make an enquiry, the procedure is that:
- The details of the enquiries are always requested
- All calls are dealt with on a call back basis to verify the identity of the caller
- A series of questions will be asked in order to establish whether there is sufficient concern to warrant an enquiry being made
- If the child is known and/or there is a child protection plan in place the enquiry is logged on the Children's Social Care electronic recording system and the caller will be given the name and contact details of the social worker for that child.
- If the enquiry is about a child at the same address as a child subject to a child protection plan this information is given to the social worker involved.
- If the child is not known the call will be recorded on Children's Social Care electronic recording system, together with any advice given to the caller

**SCIMT telephone numbers are available on the Safeguarding Children Intranet**

## Appendix B – Filing safeguarding children information in medical records

All safeguarding children information is filed within the child's medical record, for an unborn child within the mother's record until baby is born and then a set of records should be made for the baby and all copies of the safeguarding information are then filed in baby's records. This includes hospital alerts and reports or minutes of meetings etc. from Children's Social Care.

For the ongoing safety of the child it is important that safeguarding information is easily identified and accessible. To ensure this the following process is followed:

1. White Safeguarding Children Sticker: At the front of the notes behind the "Patient Identification Sheet" is the "alert notification" divider (this has a red boarder). Place a white sticker in section 3 of this divider. (NB. This is not the same as the red safeguarding divider.) This sticker says, "Sensitive 3rd party information contained. Do not disclose without consulting with a Paediatrician or Safeguarding Lead".

2. Red Safeguarding Divider: Insert the red "safeguarding divider" behind the red boarded alert divider in the patient medical records. Tick the "Safeguarding Children" box (the divider is multi-purpose and is also used for "Adults and Risk" and "Multi-Agency Public Protection Risk Assessments")

3. Chronology Sheet: Place a Safeguarding Children "chronology sheet" directly behind the red safeguarding divider. Document the date of each admission where safeguarding concerns are identified (this provides a reference guide for finding safeguarding information within the main body of the record).

NB: File copies of written referrals to social care, child protection reports, case conference/strategy minutes etc. behind the red safeguarding divider and chronology sheet. (If your ward/department is currently using yellow safeguarding front/continuation sheets these should also be filed here.)

For midwives: Midwifery Social and Domestic alerts are placed behind the obstetric referral letter for the current pregnancy and are filed in chronological order. A copy of the social and domestic alert must also be filed in a set of baby notes when baby is born.

Adult patients who are parent/carers may have health issues that impact on their children/unborn child e.g. substance use, mental health problems, domestic violence. Where there are any concerns about safeguarding children these should always be addressed. Safeguarding children information should be documented and filed in their medical record as outlined above.

It is the responsibility of all staff dealing with safeguarding children information to ensure this process is followed.

**NB**: There should only be one safeguarding divider in use. When volume 2 of a patient record is started all safeguarding information should be transferred into this volume.

If you require further advice please contact:

Safeguarding Lead & Named Nurse Lead Safeguarding Children and Young People ext. 4636
Named Midwife for Safeguarding Children ext: 3357
Named Doctors for Safeguarding Children via switch
Specialist Nurse Safeguarding Children ext. 3357

- Social & Domestic Alerts and Chronology sheets are available to download from the Safeguarding Children intranet site in "Documentation" folder.
- Dividers/ Stickers are available from Case Note Store ex: 2517

**Appendix C**

# Process for making a children safeguarding referral online

1. Follow the link for safeguarding referral on the children safeguarding intranet page. http://www.nottinghamshire.gov.uk/care/safeguarding/childrens-mash/report-a-new-concern-about-a-child

2. Click on the green 'Report a Concern' button now. (Screen shot of referral page below)

**3**. If the child is in immediate danger you will need to contact the police and social care directly to share your concerns.

**4**. If the child is not in immediate danger click no and complete the online form. (Screen shot below)

Children's Safeguarding

**When to use this form**

Please use this form to make a childrens safeguarding referral which is **not** urgent.

If you believe a child urgently needs specialist support from Children and Young Peoples Services, based on the Children's Social Care Policies, visit the Multi-Agency Safeguarding Hub (MASH) website

For you information

- after 60 minutes your form will time out, to ensure that you do not lose any completed information, please save your form and follow the instructions on screen

Is the child in immediate danger? *
- Yes
- No (selected)

Does the child normally reside in Nottinghamshire (excluding Nottingham City)?
- Yes (selected)
- No

Are you contacting us as: *
- A member of the public or family member
- A professional (selected)

**5**. When populating the form with the email address you **MUST** use – sfh-tr.safeguardingchildren@nhs.net

## Referrer Details

| | |
|---|---|
| Your name * | |
| Organisation * | |
| Job role * | |
| Enter a postcode search for an address * | Work address |
| Select address | Select... |
| Your preferred method of contact: * | ☑ Telephone<br>☐ Mobile |
| Telephone number * | work telephone number |
| Alternative number (optional) | |
| Email address | sfh-tr.safeguardingchildren@nhs.net |
| Is this form a follow-up to a telephone referral? | ○ Yes<br>○ No |
| Are you aware of any risks to children's social care staff visiting the child/ren at home? | |

**6**. Complete all the form. Please ensure you give as much information as possible to enable social care to assess the risk to the child.

**7**. When you have completed the form click the submit button (see below) you will then get an option to print as a PDF copy. Print a copy to put in the patient record and send a copy to the GP, health families team (address and contact details are available on the safeguarding intranet) and the safeguarding team (either through the post or electronically via the safeguarding team email sfh-tr.safeguardingchildren@nhs.net).

Save | ✔ Submit

**9**. Social care will send an outcome letter electronically to the safeguarding team email and the safeguarding team will forward this on to the staff member.

**Any questions or queries please contact the safeguarding team on Ext. 3357**

**Appendix D**

**Abandoned babies/children Process:**

**Definition:**

In law, child abandonment is defined as the act of leaving of a child alone and having no intention of returning to ensure their health, safety and wellbeing.
Fortunately, child abandonment is rare but when it does occur it can be for a variety of reasons. For some people, it could be the stress and responsibility of being a parent or carer, complicated circumstances in their lives, or mental health issues. Sadly, in an acute hospital trust, people are often at their most vulnerable, or complex family dynamics can reach a crisis point, causing them to abandon their child. This could occur anywhere within the trust, but some areas, such as maternity or the paediatric wards, do have an increased possibility of this occurring.

***Maternity:***

There should not be any anticipated circumstances where a baby or child is abandoned on Sherwood Birthing Unit, Maternity Ward or any other area within maternity services.
Occasionally there are such significant concerns within a family that Children's Social Care may apply for an Interim Care Order. This means that the baby will be placed into foster care. UK law states that this process cannot commence until the baby is born, and therefore the court hearing cannot take place until after birth. It must be made clear to mothers, their families, and their allocated social workers that the Maternity Unit are not able to care for babies unattended for ***any reason***, (including court hearings), and therefore there must be an approved adult able to supervise the baby in the family's absence. It is preferable that the mother remains with the baby at all times.

Unfortunately there are also times where new mothers abandon their babies following birth for a variety of reasons and in any event that a baby is abandoned on the Maternity Unit, staff will:

- Escalate to ward leader
- Discuss with Named Midwife for Safeguarding Children or the Safeguarding Team (ext 3357)
- Contact the allocated Social Worker or the Children's Social Care Emergency Duty Team
- In some cases it may be necessary to call for Police assistance
- Complete a 'Datix' form.

***Neonatal Unit (NNU)/Ward 25***

Babies being cared for on the NNU will be assessed on a case by case basis as we are aware that sometimes babies are staying for considerable periods of time. Sadly there are occasions where parents will choose to abandon their babies for a variety of reasons. Therefore if families or carers have not made any contact and staff are concerned, in the first instance every attempt should be made to contact the family/carers. If these efforts to contact are unsuccessful, or the response causes further concern, staff will:

- Escalate to ward leader
- Discuss with Safeguarding Team (3357)
- If necessary refer to the relevant Children's Social Care team for the area of the child's normal residence; or contact the allocated Social Worker, (or the Children's Social Care Emergency Duty Team if out of hours) if applicable
- Complete a 'Datix' form.

***All other areas:***

It is highly unlikely that a baby or child (anyone under 18) would be abandoned in a clinical area, therefore in the event that a child is found to be abandoned all attempts must be made to contact the parent or carer. The staff should use professional judgement based on the circumstances, regarding how long or how often these attempts to contact parents/carers are made.

If parents/carers are contacted and the response raises safeguarding concerns, then a referral to Children's Social Care must be made.

If contact is unsuccessful then staff must contact the police and the relevant children's social care team. Staff will:

- Escalate to ward leader
- Discuss with Safeguarding Team (3357)
- Complete a 'Datix' form.

## Appendix E Missing Child/Families/Unborn Child Alerts Process

**The Safeguarding Team are notified of a "missing child/family/pregnant woman" via the local Missing family process.**

The Safeguarding Team place a Safeguarding children alert (Purple Dot – see below) on the patient SystmOne record and a RAPA alert is generated.

Safeguarding Alert

**A 'missing child/family/pregnant woman' presents at KMH ED** or **Newark UCC**

The SystmOne alert (will display on the ED whiteboard – when staff hover over the alert it advises staff they must retrieve the patient record on systmOne.

Once ED/UCC staff have retrieved the record, they will click on the specialist nurse tab (see below) on the left hand side of the record.

This will contain the information regarding the missing alert – advising of the professionals to contact e.g., police and social worker (contact details will be available).

ED /UCC staff are to contact the named professionals and advise of the missing person/family attendance, police and social care will then advise on next steps.

The child/family/pregnant woman/ are not to be made aware of the above actions [these individuals are deliberately avoiding Children's Social Care and may flee again if alerted and put their child[ren]/unborn child at further risk]

The Trust children safeguarding team should also be contacted. In hours they will support and advise. (it is important that the team are informed out of hours by leaving a message on the secure answerphone so that follow up can be undertaken the next working day.

**A Missing Child/family/pregnant women presents elsewhere in the Trust**

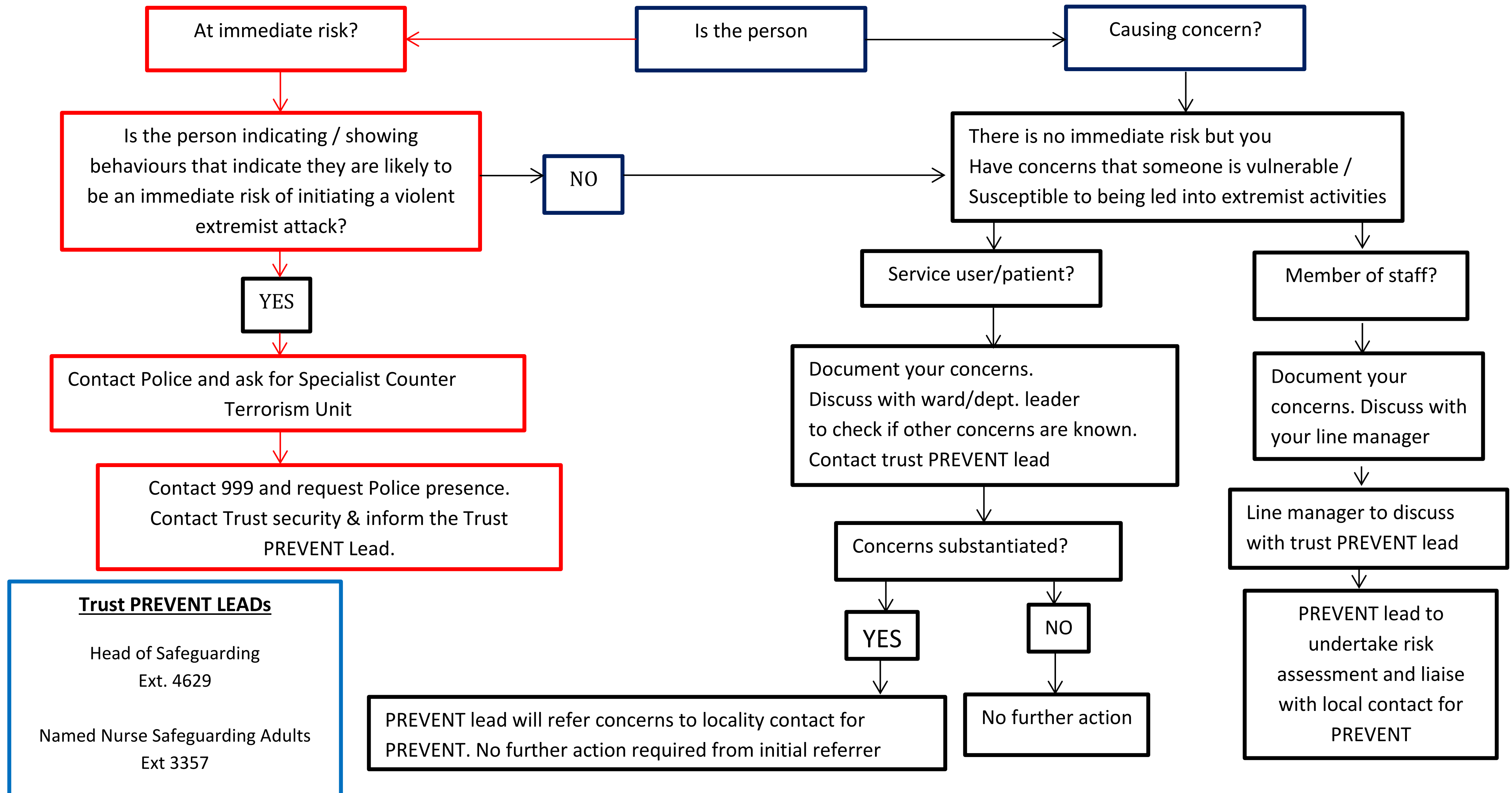
The RAPA alert is triggered – this alert will automatically trigger a notification to the safeguarding team who in hours will liaise with the relevant department where the missing person/child/family have presented to advise on next steps and will liaise directly with the relevant professionals.

The child/family/pregnant woman/ are not to be made aware of the above actions [these individuals are deliberately avoiding Children's Social Care and may flee again if alerted and put their child[ren]/unborn child at further risk]

**"Missing Child Alerts" must be:**

Removed from systems on the specified expiry date (usually 3 months after receipt of the alert) or when notification is given that the child or pregnant woman has been found. This will be undertaken by the Safeguarding team.

## Appendix F – *PREVENT* Flowchart



## Appendix G

# Safeguarding Children and Young People Level 3 Training Pathway

**Level 3 Competency**

Includes all clinical staff working with children, young people and/or their parents/carers and those who could potentially contribute to assessing, planning, intervening and evaluating the needs of children & young people or parenting capacity where there are safeguarding/child protection concerns

**New Staff to SFHT**

Follow the New starter pathway

**Existing Staff Needing to Maintain Level 3 Competency**

**Think Family Safeguarding (level 2) E-Learning Package undertaken prior to commencement (HR send this our automatically for new starters to complete)**

**Safeguarding Think Family Induction session ( Level 3 ) this is a 2 hour face to face (E-Learning for Medical staff) session included in the Trust wide induction programme.**

Booked via HR on commencement to the Trust

**NSCB: (Multi-agency) Working Together to Safeguard Children – Level 3**

Book via the NSCB website

https://nscp.nottinghamshire.gov.uk/training/wtsclevel3-20july2022/

**Level 3 Refresher Training**

Competency gained through the Trust mandatory training programme – yearly.

This includes:

1 Hour Face to Face Think Family Safeguarding session

MCA E-Learning

PREVENT update – E-Learning

**Other Level 3 Safeguarding Children Training Available**

**External Training - Other Safeguarding children level 3 training is available through the Nottinghamshire Safeguarding Children Partnership (NSCP). https://nscp.nottinghamshire.gov.uk/training/**

**This is free training for NHS staff with E-Learning and Face to Face sessions available.**

**You will need to register on the site to access training using SFH's unique code – this is available by contacting the Safeguarding team on ext 3357.**

**In House Seminars**

Themed in-house seminars will be advertised as topics arise

## APPENDIX H – EQUALITY IMPACT ASSESSMENT FORM (EQIA)

| Name of service/policy/procedure being reviewed: Safeguarding Children and Young People Policy | | | |
|---|---|---|---|
| New or existing service/policy/procedure: Existing | | | |
| Date of Assessment: 19/07/2022 | | | |
| For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas) | | | |
| **Protected Characteristic** | **a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider?** | **b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?** | **c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality** |
| **The area of policy or its implementation being assessed:** | | | |
| **Race and Ethnicity** | This policy provides equitable care for all patients irrespective of race or ethnicity | This policy replaces the previous Safeguarding Children and Young People policy | None |
| **Gender** | This policy provides equitable care for all patients irrespective of gender | This policy replaces the previous Safeguarding Children and Young People policy | None |
| **Age** | This policy provides equitable care for all patients under the age of 18 years. Other Policies are in place to meet the safeguarding needs and safe discharge of adult patients. | This policy replaces the previous Safeguarding Children and Young People policy | None |
| **Religion** | This policy provides equitable care for all patients irrespective of religion | This policy replaces the previous Safeguarding Children and Young People policy | None |
| **Disability** | This policy provides equitable care for all patients irrespective of disability | This policy replaces the previous Safeguarding Children and Young People policy | None |
| **Sexuality** | This policy provides equitable care for all patients irrespective of sexuality | This policy replaces the previous Safeguarding Children and Young People policy | None |
| **Pregnancy and Maternity** | Patients who are pregnant or postnatal will receive the same standard of care as non-pregnant patients. | This policy replaces the previous Safeguarding Children and Young People policy | None |
| **Gender Reassignment** | This policy provides equitable care for all patients irrespective of gender | This policy replaces the previous Safeguarding Children and Young People policy | None |
| **Marriage and Civil Partnership** | This policy provides equitable care for all patients irrespective of marital status or civil partnership | This policy replaces the previous Safeguarding Children and Young People policy | None |

| Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation) | This policy provides equitable care for all patients irrespective of socio-economic status | This policy replaces the previous Safeguarding Children and Young People policy | None |
|---|---|---|---|

**What consultation with protected characteristic groups including patient groups have you carried out?**

- This policy acknowledges the needs of patients under 18 years admitted to an acute hospital where there are safeguarding concerns. To ensure that it is complaint with all legislation it has been shared with senior divisional staff for consultation and feedback to ensure that it effectively meets the needs of this client group.

**What data or information did you use in support of this EqIA?**

- HM Government [2018] Working Together to Safeguard Children,
- HM Government [1989] Children Act 1989,
- HM Government [2004] Children Act 2004,
- National Institute for Health and Clinical Excellence [2009 updated 2019] When to suspect child maltreatment,
- National Institute for Health and Clinical Excellence [2008] Antenatal Care
- Nottinghamshire and Nottingham City Safeguarding children Partnership [2019]
- Laming (2003). The Victoria Climbe inquiry .
- Laming WH (2009) The protection of children in England: a progress report.

**As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments?**

- No

**Level of impact**

From the information provided above and following EQIA guidance document Guidance on how to complete an EIA (click here), please indicate the perceived level of impact:

Low Level of Impact

**Name of Responsible Person undertaking this assessment: Lisa Nixon**

**Signature:**

**Date: 19/07/2022**