

# Safeguarding Children Policy

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* 1. **Introduction**

**Part A**

**Legal and Organisational Framework**

East London NHS Foundation Trust, as a public sector organisation, has an overall duty to:

* 1. Take all reasonable measures to ensure that the risks of harm to the welfare of children are minimised
  2. Take appropriate actions to address child protection concerns, by working to agreed local policies and procedures, in full partnership with other agencies.
  3. If any member of staff requires advice and support about what action to take having read this policy, they should contact a member of the Safeguarding Children Team.
  4. **Purpose**

The purpose of this policy is to ensure there is an infrastructure in place to equip and support all staff to fulfil their responsibilities for safeguarding and promoting the welfare of children confidently, safely and effectively. This is within the context that risk cannot be completely eliminated.

* 1. **Legal Framework**
     + The Children Act 1989 introduced the concept of significant harm as the threshold that justifies compulsory intervention in family life in order to safeguard children. The local authority has a duty to investigate where it has reason to suspect that a child is suffering or likely to suffer significant harm.
     + The Children Act 2004 requires each local authority, health and partner agencies to make arrangements to promote cooperation between each of the authority’s relevant partners. The arrangements are made to promote the wellbeing of children in their area which includes protection from harm.
     + Section 10 of the Children Act 2004 reinforces and updates the Trust’s existing duty (under the Children Act 1989) to co-operate and share information with local authorities in order to improve children’s well-being and promote positive outcomes for children.
     + Section 17 of the Children Act 1989 considers the provision of services for Children in Need, their families and others; so far as is consistent with that duty, to promote the upbringing of such children by their families, by providing a range and level of services appropriate to those children’s needs.
     + Section 47 of the Children Act 1989 places a duty on any NHS Trust (and other bodies) to help a local authority with its enquiries in cases where there is reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm, unless doing so would be unreasonable in all the circumstances of the case.
     + Under Section 20 of the Children Act 1989, children may be accommodated by the local authority if they have no parent or are lost or abandoned or where their parents are not able to provide them with suitable accommodation and agree to the child being accommodated.
  2. **The Trust’s Statutory Duties**

The Trust’s duties and responsibilities are set out in:

* + - Section 11 of the Children Act 2004;
    - Working Together to Safeguard Children, HM Government Statutory Guidance (2018);
    - Promoting the Health and Well-being of Looked After Children, DfE & DoH Statutory Guidance (2015);
    - Safeguarding Children and Young People: Roles and Competences for Health Care Staff

– Intercollegiate Framework (2019);

* + - Looked After Children: Knowledge, Skills and Competences of Health Care Staff - Intercollegiate Role Framework (2020);
    - Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework. NHSE/I 2022
    - London Safeguarding Children Procedures and Practice Guidance, 7th Edition, London Safeguarding Children Partnership, <https://www.londonsafeguardingchildrenprocedures.co.uk/index.html> (2022)
    - Bedford Borough, Central Bedfordshire and Luton Safeguarding Children Partnership Procedures, <https://bedfordscb.proceduresonline.com/index.html> (2022)
  1. The Children Act 2004 (section 11) places duties on a range of organisations and individuals to ensure their functions and any services that they contract out to others, are discharged with regard to safeguard and promote the welfare of children. These statutory duties require the Trust to have:
* A clear line of accountability for the commissioning and/or provision of services designed to safeguard and promote the welfare of children;
* A senior board level lead with the required knowledge, skills and expertise or sufficiently qualified and experienced to take leadership responsibility for the organisation’s safeguarding arrangements;
* A culture of listening to children and taking account of their wishes and feelings, both in individual decisions and in the development of services.
* Clear whistleblowing procedures, which reflect the principles within Sir Robert Francis’ Freedom to Speak Up Review and a culture that enables issues about safeguarding and promoting the welfare of children to be addressed;
* Clear escalation policies for staff to follow when their child safeguarding concerns are not being addressed within their organisation or by other agencies;
* Arrangements which set out clearly the processes for sharing information, with other practitioners and with Safeguarding Partners;
* Designated Named Professionals for Safeguarding Children. Their role is to support other professionals in their agencies to recognise the needs of children, including protection from possible abuse or neglect. Professionals should be given sufficient time, funding, supervision and support to fulfil their child welfare and safeguarding responsibilities effectively;
* Safe recruitment practices and ongoing safe working practices for individuals whom the organisation will permit to work regularly with children, including policies on when to obtain a criminal record check;
* Appropriate supervision and support for staff, including undertaking safeguarding training;
* Creating a culture of safety, equality and protection within the services they provide.

In addition:

* Employers are responsible for ensuring that their staff are competent to carry out their responsibilities for safeguarding and promoting the welfare of children and creating an environment where staff feel able to raise concerns and feel supported in their safeguarding role;
* Staff should be given a mandatory induction, which includes familiarisation with child protection responsibilities and procedures to be followed if anyone has any concerns about a child’s safety or welfare; and
* All practitioners should have regular reviews of their own practice to ensure they have knowledge, skills and expertise that improve over time.
* Working Together Safeguard Children (2018) makes reference to additional guidance for health services including guidance from the Royal College of Nursing (RCN), General Medical Council (GMC) and the NHS Commissioning Board.

### 5.0 Definition of Safeguarding Children and Child Protection

### The Children Act 2004, as amended by the Children and Social Work Act 2017 places new duties on key agencies in the local area i.e. the Police, Clinical Commissioning Groups and the Local Authority.

Working Together 2018 defines **‘**Safeguarding and promoting the welfare of children’ as:

* + - Protecting children from maltreatment (i.e. abuse or neglect) and
    - Preventing impairment of children’s health and development and
  + Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care and
    - Taking action to enable all children to have the best outcomes.

### Child

A child is defined in the Children Act 1989 and Working Together to Safeguard Children 2018 as any person from birth who has not yet reached their 18th birthday. ‘Children’ therefore means ‘babies, children and young people’ throughout this policy. 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, in prison or in custody in the secure estate, does not change their status or entitlement to services or protection.

### Voice of the Child

Children may be vulnerable to neglect and abuse or exploitation from within their family and from individuals they come across in their day-to-day lives.

A child centred approach is fundamental to safeguarding and promoting the welfare of every child. A child centred approach means keeping in focus when making decisions about their lives and working in partnership with them and their families. All practitioners should follow the principles of the Children Acts 1989 and 2004, which state that the welfare of children is paramount and that they are best looked after within their families, with their parents playing a full part in their lives, unless compulsory intervention in family life is necessary.

When we use the term ‘the child’s voice’ we not only refer to what children say directly, but rather to many ways that children communicate with us, including both verbal and nonverbal communication. It means more than seeking their views, which could just mean the child saying what they want, rather than really being involved in what happens.

Children and young people should have the opportunity to describe things from their point of view. They should be continually involved, and have information fed back to them in a way that they can understand. There should always be evidence that their voice has influenced the decisions that professionals have made.

Key points to gathering the voice of the child are:

* Seeking to understand their story
* Ensuring their views are advocated for
* Picking up on nonverbal cues
* Using our power to influence outcomes on their behalf
* Challenging the use of single stories.
* The child’s lived experience means seeing and understanding their experiences from their point of view.

Practitioners may encounter a number of barriers to eliciting the voice of the child, including lack of engagement from the young person themselves and/or family members. As a result, there is risk that professionals will take decisions that are not informed by the child’s views, feelings and experiences. This can be particularly risky, for example, when taking decisions about case closure where young people may pose a risk of harm to themselves. In cases of non-engagement by children and young people, practitioners are encouraged to make use of partner agency connections to elicit an understanding of the child’s voice in order to inform decision making. This may involve, for example, liaising with other agencies such as school, college, children’s social care, etc to build this understanding.

### Assessment of Needs and Management of Risk

Prevention of harm to children and young people is the purpose of child protection work. To determine if children or young people are at risk or likely risk of harm requires the systematic collection of information to inform a balanced risk assessment. Sound risk assessment assists practitioners to explore more explicitly with children and families what needs to change, especially with regard to the safety and welfare of a child. In the identification of both ‘need’ and ‘risk’ staff should build upon family strengths whilst keeping the needs of the child central. The Framework for the Assessment of Children in Need and their Families (2000, Appendix iii) provides a systematic basis for collecting and analysing information to support professional judgments about how to support children and families in the best interests of the child.

### The Concept of Significant Harm

The Children Act 1989 introduced the concept of significant harm as the threshold that justifies compulsory intervention in family life in the best interests of children/young people, and gives local authorities a duty to make enquiries to decide whether they should take action to safeguard or promote the welfare of a child/young person who is suffering, or likely to suffer, significant harm.

Harm is defined as the “ill treatment of the impairment of the health or development of a child” (Section 31, Children Act 1989). Seeing or hearing the ill-treatment of another person is also a form of harm (Section 120, Adoption and Children Act 2002). Harm can be determined “significant” by comparing a child’s health and development with what might be reasonably expected of a similar child. Although there is no absolute criteria for determining whether or not harm is “significant”, local authorities such as social services, police, education and health agencies work with family member to assess the child, and a decision is made based on their professional judgement using the gathered evidence.

* 1. **Safeguarding versus Child Protection**

Safeguarding is the action that is taken to promote the welfare of children and protect them from harm. Safeguarding means:

* protecting children from abuse and maltreatment
* preventing harm to children’s health or development
* ensuring children grow up with the provision of safe and effective care
* taking action to enable all children and young people to have the best outcomes.

Child protection is part of the safeguarding process. It focuses on protecting individual children identified as suffering or likely to suffer significant harm. <https://learning.nspcc.org.uk/safeguarding-child-protection>

### 5.7 Child in Need

Children who are defined as being in need under section 17 of the 1989 Children Act are those whose vulnerability is such that they are unlikely to achieve or maintain, or have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision by the local authority services. This includes a child whose health or development is likely to be significantly impaired, or further impaired, without the provision of such services. This includes children with disabilities.

Under Working Together to Safeguard Children 2018 in the definition of safeguarding, impairment of children’s health has been changed to “children’s mental and physical health”. Therefore where a child or young person is admitted to a mental health facility they should be considered a child in need - thus clinicians should routinely seek consent to refer all new admissions to Social Care. A referral should only go ahead if consent is provided (either by the competent young person or their parent/carer), unless there are reasons to believe a child is or may be at risk of significant harm as a consequence of the actions or inactions of another – in such circumstances a child protection referral should be made. If consent is refused for the child in need referral this will need to be revisited at key points during admission e.g. CPA reviews. It is also important to understand why the family are not consenting and if it’s possible to address any fears they may have around this process.

### 5.8 Children with Disabilities

Any child with a disability is by definition a 'child in need' under Section 17 of [the Children Act 1989](http://www.legislation.gov.uk/ukpga/1989/41/contents). The Disability Discrimination Act 2005 (DDA) and the Equality Act 2010 define a disabled person as someone who has:

"A physical or mental impairment which has a substantial and long term adverse effect on his or her ability to carry out normal day to day activities"

The [Equality Act 2010](http://www.legislation.gov.uk/uksi/2011/1159/article/1/made) makes it unlawful to discriminate against a disabled person in relation to the provision of services. This includes making a service more difficult for a disabled person to access or providing them with a different standard of service

Research suggests that children with a disability may be generally more vulnerable to significant harm through physical, sexual, emotional abuse and/or neglect than children who do not have a disability. Disabled children may be especially vulnerable to abuse for a number of reasons e.g. they may be at increased likelihood of being socially isolated with fewer outside contacts than non-disabled children.

Where there are concerns about the welfare of a disabled child, they should be acted upon in the same way as with any other child.

### 5.9 Young Carer

A young carer is a person under 18 who provides or intends to provide care for another person (of any age, except generally where that care is provided for payment, pursuant to a contract or as voluntary work). They carry out on a regular basis, significant or substantial caring tasks and assume a level of responsibility, which would usually be associated with an adult. The person receiving care is often a parent but can be a sibling, grandparent or other relative who is disabled, has some chronic illness, mental health problem or other condition connected with a need for care support or supervision.

### 5.10 Parental responsibility

Parental responsibility in the UK is defined by the Children Act 1989 as ‘all the rights, duties, powers, responsibilities and authority which by law a parent of a child has in relation to the child’. This means a parent has the responsibility to maintain and protect the child, make decisions about their education and consent to any medical treatment for the child.

If the parents of a child were not married to each other when the child was born, the mother automatically has parental responsibility, but the father only does (from 1 December 2003) by jointly registering the birth of the child with the mother. He can, however subsequently acquire parental responsibility by various legal means.

If using a surrogate, they will be the child’s legal parent at birth. If the surrogate is married or in a civil partnership, their spouse or civil partner will be the child’s second parent at birth, unless they did not give their permission. Legal parenthood can be transferred by parental order or adoption after the child is born. In the UK, if you have treatment using a donor at a licensed UK clinic, the donor will have no rights or responsibilities to any children conceived. Same-sex partners will both have parental responsibility if they were civil partners at the time of the treatment, e.g. donor insemination or fertility treatment. For same-sex partners who are not civil partners, the 2nd parent can get parental responsibility by either applying for parental responsibility if a parental agreement was made or by becoming a civil partner of the other parent and making a parental responsibility agreement or jointly registering the birth (Gov.uk, Parental Rights & Responsibilities. https://www.gov.uk/parental-rights-responsibilities/who-has-parental-responsibility)

A foster carer does not automatically have parental responsibility. If a child is placed into care under section 20 of the Children Act the parental responsibility remains with the parents. It is therefore important to ensure that the parents/carers have full information about their continuing responsibilities as well as those of the local authority and that this is enshrined in the [Care Plan](https://gbr01.safelinks.protection.outlook.com/?url=http%3A%2F%2Ftrixresources.proceduresonline.com%2Fnat_key%2Fkeywords%2Fcare_plan.html&data=05%7C01%7Ccatherine.jordan2%40nhs.net%7C96e8b1a011cf4c2ef8a108db05fb16dc%7C37c354b285b047f5b22207b48d774ee3%7C0%7C0%7C638110348187237545%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=2Nql9CqsHUWxGmpoCKRxgmdODJkOCmwJVq%2BfxcuL3%2Bo%3D&reserved=0) and a written agreement. This written agreement is called delegated authority. For more detail for delegated authority, please see below link:

<https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1100188/Promoting_the_health_and_well-being_of_looked-after_children_August_2022_update.pdf>

Where a child is made subject to a care order those who have parental responsibility for the child must share this responsibility with the Local Authority. This means that should the Local Authority wish to make a decision relating to the child, they must discuss this decision with the parent(s) and consider the parent’s wishes and views. However, if an agreement cannot be reached, the Local Authority will have final say on the matter. A parent only loses their parental responsibility if/when their child is adopted.

### Child Abuse

Abuse is defined as a form of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting by those known to them or, more rarely, by others. Abuse can take place wholly online, or technology may be used to facilitate offline abuse. Children may be abused by an adult or adults, or another child or children. (Working Together to Safeguard Children 2018) Please see page 37 for guidance on referral to children social care.

### Categories of Abuse

### 5.11.1 Emotional Abuse

Emotional abuse is the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child’s emotional development. It may involve conveying to 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.

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

### Neglect

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

* Provide adequate food, clothing and shelter (including exclusion from home or abandonment)
* Protect a child from physical and emotional harm or danger
* Ensure adequate supervision (including the use of inadequate caregivers)
* Ensure access to appropriate medical care or treatment
* It may also include neglect of, or unresponsiveness to, a child’s basic emotional needs.

### Physical Abuse

Physical abuse is 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 of, or deliberately induces, illness in a child.

### Sexual Abuse

Involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse Sexual abuse can take place online, and technology can be used to facilitate offline abuse. Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse as can other children.

### Allegations of Non Recent (Historical) Abuse

It is not unusual for people to disclose experiences of physical, sexual and / or emotional abuse and / or neglect which constitute significant harm only when they reach adulthood.

Adults may disclose they or others in their family were abused in childhood. Response to allegations by an adult of abuse experienced as a child must be of as high a standard as a response to current abuse because of the likelihood that the perpetrator has continued to abuse children and may be doing so now, criminal prosecution may be possible if sufficient evidence can be collated.

Professionals must inform the adult of the professional duty to safeguard children and try to establish whether the past abuser is in contact with children who could currently be at risk of harm which may need to be referred to children’s social care or police.

The adult who has disclosed should be asked whether they want a police investigation and must be reassured that the police are able and willing to progress an investigation. They can also be signposted to the National Association for People Abused in Childhood (NAPAC) for support- [www.napac.org.uk](http://www.napac.org.uk)

How to deal with this is included within the Pan London, Bedfordshire and other National Child Protection procedures:

<https://www.londonsafeguardingchildrenprocedures.co.uk/historical_abuse.html?zoom_highlight=historical+abuse>

[https://bedfordscb.proceduresonline.com/p\_recog\_respond.html?zoom\_highlight=historical+abuse#12.-non-recent-/-historical-abuse](https://bedfordscb.proceduresonline.com/p_recog_respond.html?zoom_highlight=historical+abuse%2312.-non-recent-/-historical-abuse)

The guidance states that:

* ‘When an adult discloses childhood abuse, the professional receiving the information should record the discussion in detail. If possible, the professional should establish if the adult has any knowledge of the alleged abuser's recent or current whereabouts and contact with children.
* In view of the potential continuing risk the alleged abuser may pose to children, the professional should make a referral promptly to Local Authority children's social care
* The adult who has disclosed should be asked whether they want a police investigation and must be reassured that the police are able and willing to progress an investigation even for those adults who are vulnerable as a result of mental ill health or learning disabilities.’

For further information, please refer to:

’Guidance document on the management of disclosures of non-recent (historic) child sexual abuse’ (The British Psychological Society 2016)

[https://www.bps.org.uk/sites/bps.org.uk/files/Policy/Policy%20-](https://www.bps.org.uk/sites/bps.org.uk/files/Policy/Policy%20-%20Files/Guidance%20on%20the%20Management%20of%20Disclosures%20of%20Non-Recent%20(Historic)%20Child%20Sexual%20Abuse%20(2016).pdf)

[%20Files/Guidance%20on%20the%20Management%20of%20Disclosures%20of%2](https://www.bps.org.uk/sites/bps.org.uk/files/Policy/Policy%20-%20Files/Guidance%20on%20the%20Management%20of%20Disclosures%20of%20Non-Recent%20(Historic)%20Child%20Sexual%20Abuse%20(2016).pdf) [0Non-Recent%20(Historic)%20Child%20Sexual%20Abuse%20(2016).pdf](https://www.bps.org.uk/sites/bps.org.uk/files/Policy/Policy%20-%20Files/Guidance%20on%20the%20Management%20of%20Disclosures%20of%20Non-Recent%20(Historic)%20Child%20Sexual%20Abuse%20(2016).pdf)

Operation Hydrant - Victim Reporting Factsheet a leaflet for people who would like to speak to the Police [http://napac.org.uk/wp-content/uploads/2016/12/Operation-](http://napac.org.uk/wp-content/uploads/2016/12/Operation-Hydrant-Factsheet-Victim-Reporting-Dec-2016.pdf) [Hydrant-Factsheet-Victim-Reporting-Dec-2016.pdf.](http://napac.org.uk/wp-content/uploads/2016/12/Operation-Hydrant-Factsheet-Victim-Reporting-Dec-2016.pdf)

### Child death

The death of a child is a devastating loss that profoundly affects all those involved. The process of systematically reviewing the deaths of children is grounded in respect for the rights of children and their families, with the intention of learning what happened and why, and preventing future child deaths.

The majority of child deaths in England arise from medical causes. Enquiries should keep an appropriate balance between forensic and medical requirements and supporting the family at a difficult time. When a child dies, in any circumstances, it is important for parents and families to understand what has happened and whether there are any lessons to be learned.

The responsibility for ensuring child death reviews are carried out is held by child death review partners. Child death review partners must make arrangements to review all deaths of children normally resident in the local area and, if they consider it appropriate, for any non-resident child who has died in their area. Child death review partners for two or more local authority areas may combine and agree that their areas be treated as a single area for the purpose of undertaking child death reviews.

The child death review process is outlined in [Working Together to Safeguard Children 2018](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942454/Working_together_to_safeguard_children_inter_agency_guidance.pdf) (Chapter 5).

### Child Safeguarding Practice Reviews

Sometimes a child suffers a serious injury or death as a result of child abuse or neglect. Understanding not only what happened but also why things happened as they did can help to improve our response in the future. The purpose of reviews of serious child safeguarding cases, at both local and national level, is to identify improvements to be made to safeguard and promote the welfare of children. Learning is relevant locally, but it has a wider importance for all practitioners working with children and families and for the government and policy- makers. Understanding whether there are systemic issues, and whether and how policy and practice need to change, is critical to the system being dynamic and self-improving.

The responsibility for how the system learns the lessons from serious child safeguarding incidents lies at a national level with the Child Safeguarding Practice Review Panel (the Panel) and at local level with the safeguarding partners. Serious child safeguarding cases are those in which:

* Abuse or neglect of a child is known or suspected; **and**
* The child has died or been seriously harmed

The safeguarding partners should promptly undertake a rapid review of the case, in line with any guidance published by the Panel. The aim of this rapid review is to enable safeguarding partners to:

* Gather the facts about the case, as far as they can be readily established at the time;
* Discuss whether there is any immediate action needed to ensure children’s safety and share any learning appropriately;
* Consider the potential for identifying improvements to safeguard and promote the welfare of children;
* Decide what steps they should take next, including whether or not to undertake a child safeguarding practice review.

For further guidance practitioners should see [chapter 4](https://www.workingtogetheronline.co.uk/chapters/chapter_four.html#purpose) of Working Together to Safeguarding Children 2018.

### 5.15 Looked After Child

Children/young people who are looked after by local authorities have the same health needs as other children and young people, but their backgrounds and past experiences, and sometimes their experiences while they are “looked after”, make them especially vulnerable. In particular, many Looked After Children have to cope with sadness, distress and trauma which may affect their mental health and cause them to behave in ways that put their health and safety at risk.

In England and Wales the term “looked after” is defined in law under the Children Act 1989.

Looked after children fall into four main groups:

* Children who are accommodated under voluntary agreement with their parents (Children Act Section 20).
* Children who are subject to a care order (Children Act Section 31) or an interim care order (Children Act Section 38).
* Children who are subject to emergency care orders for their protection (Children Act Section 44 and Section 46).
* Children who are compulsorily accommodated; this includes children remanded to the local authority or subject to a criminal justice supervision order with a residence requirement (Children Act Section 21).

The term also applies to children who are:

* Unaccompanied asylum seekers or those trafficked from abroad.
* Children in family and friends placements.
* Children where the agency has the authority to place the child for adoption.

It does not apply to children who have been adopted or who are on a special guardianship order.

The Trust has a statutory role in ensuring that arrangements are in place to meet the health needs of Looked After Children when they are accessing our services. There is a community Looked After Children team in Newham; the team work collaboratively with the Local Authority and the local Integrated Care Board (ICB) to fulfil the Trust’s statutory responsibilities. The team is responsible for statutory health assessments; assessing and ensuring that the health needs of all looked after children and young people from Newham, whether they still live in the Borough or they have moved out of the area, are met. The team is supported by Designated Professionals for Looked after Children from the ICB. The Trust also has embedded Looked after Children teams in Newham and Bedford CAMHS providing support for Looked After Children and Young people known to the service. Care Leavers may have access to additional support and staff should link in with the local authority Care Leavers team, with the consent of the person, to establish any additional support or signposting.

### Transition Planning

The Care Act 2014 places a duty on Health and Social Care to conduct transition assessments for children, children’s carers and young carers where there is a likely need for care and support after the child in question turns 18. The Care Act 2014 and the Children and Families Act 2014 capture the principles of personalisation, inclusion, participation and co-production in law.

The guidance states that in order to fully meet these duties, local authorities should consider how they can identify young people and carers who are not receiving children’s services but are nevertheless likely to have care and support needs as adults. Practitioners working with young people requiring care and support needs should consider how to establish mechanisms and identify young people as early as possible in order to plan for or prevent the development of care and support needs and thereby fulfil their duty relating to ‘significant benefit’ and the timing of assessments

When planning any transition every effort should be made to put the service user and their family/carers at the centre of this process. Particular consideration should be given to the service user’s developmental needs around this time.

### Other Safeguarding Vulnerabilities

**5.17.1 Contextual Safeguarding**

Contextual safeguarding is an approach to understanding, and responding to, young people's experiences of significant harm beyond their families. Contextual Safeguarding, therefore, expands the objectives of child protection systems in recognition that young people are vulnerable to abuse in a range of social contexts. As well as threats to the welfare of children from within their families, children may be vulnerable to abuse or exploitation from outside their families. These extra-familial threats might arise at school and other educational establishments, from within peer groups, or more widely from within the wider community and/or online. 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. Extremist groups make use of the internet to radicalise and recruit and to promote extremist materials. Any potential harmful effects to individuals identified as vulnerable to extremist ideologies or being drawn into terrorism should also be considered.

Practitioners working with children and their families should consider whether wider environmental factors are present in a child’s life and are a threat to their safety and/or welfare. Children who may be alleged perpetrators should also be assessed to understand the impact of contextual issues on their safety and welfare. Interventions should focus on addressing these wider environmental factors, which are likely to be a threat to the safety and welfare of a number of different children who may or may not be known to local authority children’s social care. Assessments of children in such cases should consider the individual needs and vulnerabilities of each child. They should look at the parental capacity to support the child, including helping the parents and carers to understand any risks and support them to keep children safe and assess potential risk to child.

### Child Sexual Exploitation

Child sexual exploitation 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. Child sexual exploitation takes different forms - from a seemingly ‘consensual’ relationship where sex is exchanged for attention, affection, accommodation or gifts, to serious organised crime and child trafficking. Child sexual exploitation involves differing degrees of abusive activities, including coercion, intimidation or enticement, unwanted pressure from peers to have sex, sexual bullying (including cyber bullying), and grooming for sexual activity.

Sexual exploitation is characterised by the following:

* A power imbalance - those exploiting the child/young person have a level of power over them by virtue of their age, gender, intellect, physical strength and/or economic or other resources;
* Limited availability of choice - the child/young person has a limited availability of choice with regard to their participation in exploitative situations (limited choice may also be a result of their social/economic and/or emotional vulnerability).

Sexually exploited children come from a range of backgrounds and may have no additional risk factors or vulnerabilities, therefore, professionals should always keep an open mind to the possibility that a child may be at risk of exploitation. However, children can be at increased risk of sexual exploitation if they have any additional vulnerabilities, as perpetrators may target them and try to exploit these vulnerabilities.

It is important to emphasise that because a child is 16 or 17 and can legally consent to sex, it does not make them less vulnerable to sexual exploitation. A child who is being exploited has not consented to sex regardless of their age. Hence the law regarding the age when a child or young person can consent to sex is only relevant when considering the offences with which a perpetrator may be charged. 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.

For further information, refer to:

Risk Assessment Tool



London Safeguarding Children Procedures, 7th Edition, PG37. Sexual Exploitation, <https://www.londonsafeguardingchildrenprocedures.co.uk/sg_sex_exploit_ch.html?zoom_highlight=sexual+exploitation> (2022)

Bedfordshire Borough, Central Bedfordshire and Luton Safeguarding Children Partnership Procedures, Safeguarding Children from Sexual Exploitation <https://bedfordscb.proceduresonline.com/p_safeg_ch_young.html?zoom_highlight=sexual+exploitation> (2022)

### Children Missing from Care, Home and Education

Children running away and going missing from care, home and education is a key safeguarding issue. There are particular concerns about the links between children running away and the risks of sexual exploitation. Looked After Children missing from their placements are vulnerable to sexual and other exploitation, especially children in residential care.

Children who go missing or run away from home or care may be in serious danger and are vulnerable to crime, sexual exploitation or abduction as well as radicalisation.

Healthcare professionals have a key role in identifying and reporting children who may be missing from care, home and school. Missing children access a number of services provided by a range of health providers including Urgent Care Units, Emergency Departments, Genito-Urinary Medicine Clinics (GUM) and Community Sexual Health Services.

Health professionals should have an understanding of the vulnerabilities and risks associated with children that go missing. Staff should be aware of their professional responsibilities and the responses undertaken by the multi-agency partnership.

A child not being in school is not in itself a safeguarding matter, and there may be an explanation for a child not being on the school roll. However, regular school attendance is an important safeguard and unexplained non-attendance can be an early indicator of problems, risk and vulnerability. It is essential that all services work together to identify and re-engage these children back into appropriate education provision as quickly as possible. It is important to establish the reasons for the child being missing at the earliest possible stage. There should be a ‘child missing from education’ (CME) named point of contact in every local authority and every practitioner working with a child has a responsibility to inform that CME if s/he knows or suspects that a child is not receiving education. If the professional has concerns about the welfare of the child they should refer to Children's Social Care.

### Children exposed to Extreme Ideology (including PREVENT).

Extremism is defined in the Counter Extremism Strategy 2015 as the vocal or active opposition to our fundamental values, including the rule of law, individual liberty and the mutual respect and tolerance of different faiths and beliefs. Extremism goes beyond terrorism and includes people who target the vulnerable – including the young by seeking to sow division between communities on the basis of race, faith or denomination; justify discrimination towards women and girls; persuade others that minorities are inferior; or argue against the primacy of democracy and the rule of law in our society. As a ‘specified authority’, ELFT has a duty placed upon it by Section 26 of the Counter-Terrorism and Security Act 2015 in the exercise of its functions, to have “due regard to the need to prevent people from being drawn into terrorism”. The NHS is a key partner in the successful implementation of the PREVENT agenda particularly as healthcare professionals routinely come into contact with people who may be vulnerable to radicalisation. CONTEST is the Governments counter terrorism strategy. PREVENT is one of the four strands of CONTEST. The health service is a key partner in the delivery of PREVENT. PREVENT aims to stop people becoming terrorists or supporting terrorism. Healthcare staff are well placed to recognise individuals, (patients or staff), who are vulnerable and may be susceptible to radicalisation by extremists or terrorists. This is fundamental to our ‘duty of care‟ and falls within our safeguarding responsibilities.

Children and young people can be radicalised in different ways:

* They can be groomed either online or in person by people seeking to draw them into extremist activity. Older children or young people might be radicalised over the internet or through the influence of their peer network – in this instance their parents might not know about this or feel powerless to stop their child's radicalisation;
* They can be groomed by family members who hold harmful, extreme beliefs, including parents/carers and siblings who live with the child and/or person(s) who live outside the family home but have an influence over the child's life;
* They can be exposed to violent, anti-social, extremist imagery, rhetoric and writings which can lead to the development of a distorted world view in which extremist ideology seems reasonable. In this way they are not being individually targeted but are the victims of propaganda which seeks to radicalise.

A common feature of radicalisation is that the child or young person does not recognise the exploitative nature of what is happening and does not see themselves as a victim of grooming or exploitation.

The harm children and young people can experience ranges from a child adopting or complying with extreme views which limits their social interaction and full engagement with their education, to young children being taken to war zones and older children being groomed for involvement in violence.

PREVENT focuses on working with vulnerable individuals who may be at risk of being exploited by radicalisers and subsequently drawn into terrorism related activity. What is important, if you are concerned that a vulnerable individual is being exploited in this way, you can raise these concerns in accordance with the Trust’s policies and procedures.

Contracts of employment and professional codes of conduct require all healthcare staff to exercise a duty of care to patients and, where necessary, take action for safeguarding and crime prevention. If you have a concern, discuss it with the Safeguarding team and they will advise you regarding your local referral pathway

For further information, please refer to:

[ELFT PREVENT Policy](https://www.elft.nhs.uk/system/files/2022-03/16.04.2020%20Prevent%20Policy%20v2.pdf)

London Safeguarding Children Procedures, 7th Edition, PG12. Extremist Ideology, <https://www.londonsafeguardingchildrenprocedures.co.uk/sg_ch_extremist.html?zoom_highlight=prevent#1.-introduction> (2022)

Bedford Borough, Central Bedfordshire and Luton Safeguarding Children Boards procedures,1.4.13 Safeguarding Individuals Against Radicalisation or Violent Extremism Practice guidance

<https://bedfordscb.proceduresonline.com/files/sg_radical_prevent.pdf?zoom_highlight=extremism#search=%22extremism%22> (2022)

Or contact your local children’s social care.

### Child Criminal Exploitation and County Lines

As set out in the Serious Violence Strategy (2022) published by the Home Office, 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 into any criminal activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial or other advantage of the perpetrator or facilitator and/or (c) through violence or the threat of violence. 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.

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 vulnerable adults to move and store the drugs and money, and they will often use coercion, intimidation, violence (including sexual violence) and weapons.

Potentially a child involved with a gang or with serious violence could be both a victim and a perpetrator. This requires professionals to assess and support his/her welfare and well-being needs at the same time as assessing and responding in a criminal justice capacity.

Professionals should always take what the child tells them seriously.

If a professional is concerned that a child is at risk of harm as a victim or a perpetrator of serious youth violence, gang-related or not, the professional should wherever possible, consult with their line manager or the Safeguarding Children Team and make an immediate referral to Children’s Social Care.

For further information, refer to:

London Safeguarding Children Procedures, Pg17. Gang Activity/Serious Youth Violence <https://www.londonsafeguardingchildrenprocedures.co.uk/gang_activity.html?zoom_highlight=ganga+activity> (2022)

Bedford Borough, Central Bedfordshire and Luton Safeguarding Children Partnership Procedures, Safeguarding Children Vulnerable to Gang Activity <https://bedfordscb.proceduresonline.com/p_safeg_gang.html?zoom_highlight=gang> (2022)

Home Office (2018) Criminal Exploitation of Children and Vulnerable Adults: County Lines Guidance <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/863323/HOCountyLinesGuidance_-_Sept2018.pdf>

### (So Called) Honour Based Abuse

Honour based abuse is the term used to describe incidents of violence, including murder (“honour killings”) that have been committed in the belief that those actions will protect or defend the honour of the family and / or community. Such violence/abuse can occur when perpetrators perceive that a relative has shamed the family and / or community by breaking their honour code.

The victims of such off incidents are predominantly women, perceived to have behaved immorally and deemed to have breached the honour code of a family and / or community, causing shame. For young victims it is a form of child abuse and a serious abuse of human rights.

It can be distinguished from other forms of violence/abuse, as it is often committed with some degree of approval and/or collusion from family and/or community members. Women, men and younger members of the family can all be involved in the abuse.

The Metropolitan Police definition of so-called honour based violence is: 'a crime or incident, which has or may been committed to protect or defend the honour of the family and/or community.

This type of violence and abuse includes physical, emotional, financial and sexual abuse of the victims. Professionals should respond in a similar way to cases of honour violence as with domestic abuse and forced marriage (i.e. in facilitating disclosure, developing individual safety plans, ensuring the child's safety by according them confidentiality in relation to the rest of the family)

For further information, refer to:

London Safeguarding Children Procedures,(2022) Pg21. ‘Honour’ Based Violence, <https://www.londonsafeguardingchildrenprocedures.co.uk/honour_base_viol.html?zoom_highlight=honour+based>

Bedford Borough, Central Bedfordshire and Luton Safeguarding Children Partnership Procedures, (2022) So Called ‘Honour’ Based Abuse, <https://bedfordscb.proceduresonline.com/p_hon_bas_abuse.html?zoom_highlight=honour+basd>

### Forced Marriage

A forced marriage is one where either or both parties do not (or in cases of people with learning disabilities, cannot) consent to the marriage and pressure or abuse is used against them. Forced marriage, as distinct from a consensual 'arranged' one, is a marriage conducted without the full consent of both parties and where duress is a factor. Duress cannot be justified on religious or cultural grounds. It is recognised in the UK as a form of violence against women and men, domestic/child abuse and a serious abuse of human rights. In 2004, the UK Government's definition of domestic abuse was extended to include acts perpetrated by extended family members as well as intimate partners.

The Marriage and Civil Partnership (Minimum Age) Act 2022 came into force on 27th February 2023 and raised the age of marriage and civil partnership to 18 in England and Wales. It is an offence in all circumstances to do anything intended to cause a child to marry before they turn 18. It is therefore now an offence to cause a child under the age of 18 to enter a marriage in any circumstances, without the need to prove that a form of coercion was used. The forced marriage offence will continue to include ceremonies of marriage which are not legally binding, for example in community or traditional settings.

The pressure that is put on people to marry against their will may be physical (including threats, actual physical violence and sexual violence) or emotional and psychological (for example, when someone is made to feel that they are bringing shame on their family). Financial abuse (taking away a person’s wages or not giving them any money) may also be a factor.

If a person does not consent or lacks capacity to consent to marriage, that marriage must be viewed as a forced marriage whatever the reason for it taking place. Capacity to consent can be assessed and tested but is time-and-decision specific. Professionals should respond in a similar way to forced marriage as with domestic violence and honour based violence (i.e. in facilitating disclosure, developing individual safety plans, ensuring the child's safety by according them confidentiality in relation to the rest of the family, completing individual risk assessments, etc.)

For further information, refer to:

London Safeguarding Children Procedures, (2022) PG16. Forced Marriage of a Child

<https://www.londonsafeguardingchildrenprocedures.co.uk/forced_marriage_ch.html?zoom_highlight=forced+marriage>

Bedford Borough, Central Bedfordshire and Luton Safeguarding Children Partnership Procedures, (2022) Forced Marriage

<https://bedfordscb.proceduresonline.com/pr_multi_age_force_marry.html?zoom_highlight=forced+marriage>

### Female Genital Mutilation (FGM)

Female genital mutilation (FGM) is a collective term for procedures, which include the removal of part or all of the external female genitalia for cultural or other non- therapeutic reasons. The practice is medically unnecessary, extremely painful and has serious health consequences, both at the time when the mutilation is carried out and in later life. The procedure is typically performed on girls aged between 4 and 13, but in some cases it is performed on new-born infants or on young women before marriage or pregnancy.

FGM is practised in at least 29 countries across Africa, parts of the Middle East and South East Asia. FGM is usually carried out on young girls between infancy and the age of 15, most commonly before puberty starts. It is estimated that 60,000 girls under 15 are at risk of FGM in the UK, and 137,000 women and girls in the UK have already been subjected to it.

Child protection procedures should be followed when there are concerns that a girl is at risk of, or is already the victim of, FGM. It comprises all procedures that involve partial or total removal of the external genitalia or other injury to the female genital organs for cultural or non-therapeutic reasons. The practice is medically unnecessary and is linked to a number of forms of physical and psychological distress.

There are also mandatory reporting procedures in place for health professionals in relation to FGM. The duty to report applies in specific situations:

Either:

A health professional is informed by a girl under 18 that an act of FGM has been carried out on her

**Or**

A health professional observes physical signs which appear to show that an act of FGM has been carried out on a girl under 18 and they have no reason to believe that the act was necessary for the girl’s physical or mental health or for purposes connected with labour or birth.

All Trust clinicians should refer to and familiarise themselves with the Home Office publication Mandatory reporting of female genital mutilation: procedural information (2015)



For further information, refer to:

FGM pathway – Appendix iii.

London Safeguarding Children Procedures (2022) 7th Edition, PG14 Female Genital Mutilation (FGM)

<https://www.londonsafeguardingchildrenprocedures.co.uk/sg_ch_risk_fgm.html?zoom_highlight=fgm>

Bedford Borough, Central Bedfordshire and Luton Safeguarding Children Partnership Procedures (2022) Female Genital Mutilation (FGM) <https://bedfordscb.proceduresonline.com/p_fgm.html?zoom_highlight=fgm>

### E-Safety: Children Exposed to Abuse through Digital Media

Information and communication technology (ICT) based forms of child physical, sexual and emotional abuse can include bullying via mobile telephones, or online (internet) with verbal and visual messages. Children and young people might experience different types of online abuse such as Cyberbullying (any type of bulling that happens online), emotional abuse, grooming or Sexting.

Children can also be at risk of gaming addictions. Professionals should be curious to the potential use of gaming as a coping strategy for children who are trying to escape the trauma of living in an abusive household, which in itself can lead onto other safeguarding concerns such as self-neglect or school refusal. Gaming disorder is defined by the World Health Organization as a pattern of persistent or recurrent gaming behaviour so severe that it takes “precedence over other life interests”. Symptoms include impaired control over gaming, increased priority to gaming and continuation or escalation of gaming despite negative consequences – such as the impact on relationships, social life, studying and work life or spiralling financial costs.

Some children and young people consider Sexting to mean 'writing and sharing explicit messages with people they know' rather than sharing youth-produced sexual images) or sharing nudes and semi-nudes are terms used when a person under the age of 18 shares sexual, naked or semi-naked images or videos of themselves or others, or sends sexually explicit messages. They can be sent using mobiles, tablets, smartphones, and laptops - any device that allows images and messages to be shared. Sexting may not be criminally motivated and can be consensual but creating or sharing explicit images of a child is illegal, even if the person doing it is a child. A young person is breaking the law if they:

* Take an explicit photo or video of themselves or a friend.
* Share an explicit image or video of a child, even if it's shared between children of the same age.
* Possess, download or store an explicit image or video of a child, even if the child gave their permission for it to be created.

If a staff member were to come across an explicit image, or video of a child, they should not share or forward it to anyone, neither should they ask to be sent it. They should immediately report the image or video to the police, inform their line manager and complete a Datix.

The Trust has a responsibility to:

* Understand e-safety issues
* Know how to help children stay safe on line
* Have procedures in place to support those working with children in knowing how to respond when concerns arise

All Trust staff must have an understanding of the risks, dangers and potential harm, and be aware of the mechanisms which are in place to mitigate any risks and potential dangers; staff are required to recognise, challenge and respond to e-safety concerns. All Trust staff should conduct themselves in a professional manner, adhering to their professional codes of conduct and Trust policies at all times. This includes consideration in the personal use of social media and information technology.

For further information, refer to:

London Safeguarding Children Procedures, 7th Edition (2022) PG22. Information and Communication Technology (ICT) based Forms of Abuse

<http://www.londonsafeguardingchildrenprocedures.co.uk/ict_based_form_ab.html>

Bedford Borough, Central Bedfordshire and Luton Safeguarding Children Partnership procedures, (2022) E-Safety: Children Exposed to Abuse through the Digital Media, <https://bedfordscb.proceduresonline.com/p_esafety_abuse.html?zoom_highlight=online>

In addition to the above, please refer to the Trust’s [Social Media Policy](https://www.elft.nhs.uk/intranet/documents/social-media-policy) on the Trust Intranet.

### Perplexing Presentations & Fabricated or Induced Illness

Fabricated or induced illness is a condition whereby a child has suffered, or is likely to suffer, significant harm through the deliberate action of their parent and which is attributed by the parent to another cause.

There are three main ways of the parent fabricating (making up or lying about) or inducing illness in a child:

* Fabrication of signs and symptoms, including fabrication of past medical history
* Fabrication of signs and symptoms and falsification of hospital charts, records, letters and documents and specimens of bodily fluid
* Induction of illness by a variety of means

The above three methods are not mutually exclusive. Existing diagnosed illness in a child does not exclude the possibility of induced illness. The very presence of an illness can act as a stimulus to the abnormal behaviour and also provide the parent with opportunities for inducing symptoms.

Fabrication of illness may not necessarily result in a child experiencing physical harm, but there may be concerns about the child suffering emotional harm. They may suffer emotional harm as a result of an abnormal relationship with their parent and/or disturbed family relationships. The practitioner has a duty to understand perplexing conditions and challenge other practitioners if medications and treatment plans are not reviewed according to guidelines.

Please refer to the Safeguarding Children section on the Trust Intranet for ‘what to do if you are worried a child is being abused’ guidance.

Where fabricated or induced illness is suspected the parents/carers MUST NOT be informed as this could jeopardise the child/young person’s safety and compromise any Section 47 (Children’s act 1989/2004) enquiries.

Any potential cases of fabricated or induced illness should be discussed with the Trust’s Safeguarding Children Team for advice.

For further information, refer to:

London Safeguarding Children Procedures (2022) PG13. Fabricated or Induced Illness/Perplexing Presentations

#### <https://www.londonsafeguardingchildrenprocedures.co.uk/fab_ind_ill.html?zoom_highlight=fabricated+or+induced+illness>

Bedford Borough, Central Bedfordshire and Luton Safeguarding Children Partnership Procedures (2022) Perplexing Presentations & Fabricated and Induced Illness/Disorders in Children <https://bedfordscb.proceduresonline.com/p_fab_ind_illness.html?zoom_highlight=fabricated+or+induced+illness>

### Royal College of Paediatrician’s and Child Health (2021) Perpelexing Presentations (PP)/Fabricated or Induced Illness (FII) in children – guidance

### <https://childprotection.rcpch.ac.uk/resources/perplexing-presentations-and-fii/>

### Bruising in non-mobile Infants

In September 2022 the Child Safeguarding Practice Review Panel published a briefing paper on [Bruising in Non-mobile Infants](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1106085/14.155_DFE_Child_safeguarding_Bruising_PB1_v3_Final_PDFA.pdf). The panel felt that the most comprehensive summary of the current evidence is contained within the Child Protection Evidence Systematic Review on Bruising (Royal College of Paediatrics and Child Health, 2020). They found that most safeguarding partnerships and NHS trusts have protocols for the assessment and management of bruising in non-mobile infants/children that are typically based on the National Institute for Health and Care Excellence (NICE) clinical guideline 89 – when to suspect child maltreatment (National Institute for Health and Care Excellence, 2009.

They recommend that in all cases of bruising in children who are not independently mobile there is:

* A review by a health professional who has the appropriate expertise to assess the nature and presentation of the bruise, any associated injuries, and to appraise the circumstances of the presentation including the developmental stage of the child, whether there is any evidence of a medical condition that could have caused or contributed to the bruising, or a plausible explanation for the bruising.
* A multi-agency discussion to consider any other information on the child and family and any known risks, and to jointly decide whether any further assessment, investigation or action is needed to support the family or protect the child. This multi-agency discussion should always include the health professional who reviewed the child.

For further information please see

[Pan Bedfordshire Pathway for injuries and bruising in immobile babies and children](https://medicines.blmkccg.nhs.uk/wp-content/uploads/2022/03/injuries_babies_children.pdf)

### Private Fostering

A private fostering arrangement is essentially an arrangement between families/households, without the involvement of a local authority, for the care of a child under the age of 16 (under 18 if disabled) by someone other than a parent or close relative (close relatives are parents, step-parents, siblings, siblings of a parent, and grandparents) for 28 days or more under The Children Act 1989 and The Children (Private Arrangements for Fostering Regulations 2005).

In a private fostering arrangement, the parent retains Parental Responsibility. Children under 16 who spend more than 2 weeks in residence during holiday time in a school, become privately fostered children for the purposes of the legislation during that holiday period (Coram BAAF <https://corambaaf.org.uk/practice-areas/kinship-care/information-kinship-carers/what-private-fostering> ).

Privately fostered children are a diverse, and sometimes vulnerable, group. Groups of privately fostered children include:

* Children sent from abroad to stay with another family, usually to improve their educational opportunities
* Asylum seeking and refugee children
* Teenagers who, having broken ties with their parents, are staying in short term arrangements with friends or other non-relatives
* Children who stay with another family whilst their parents are in hospital, prison or serving overseas in the armed forces
* Language students living with host families.

Private Fostering can place a child in a vulnerable position because checks as to the safety of the placement will not have been carried out if the local authority is not advised in advance of a proposed placement. The carer may not provide the child with the protection that an ordinary parent might provide. In many cases, the child is also looked after away from a familiar environment in terms of region or country.

All Trust staff should confirm with Children’s Social Care that they are aware that a private fostering arrangement is in place. Any private fostering arrangements not already notified to children’s social care will need to be referred in via MASH/Integrated Front Door.

For further information, refer to London Safeguarding Children Procedures, (2022) 7th Edition, PG26. Living Away from Home. 3. Private Fostering

[https://www.londonsafeguardingchildrenprocedures.co.uk/ch\_living\_away.html?zoom\_highlight=private+fostering#3.-private-fostering](https://www.londonsafeguardingchildrenprocedures.co.uk/ch_living_away.html?zoom_highlight=private+fostering%233.-private-fostering)

Bedford Borough, Central Bedfordshire and Luton Safeguarding Children Partnership Procedures, (2022) Private Fostering

[https://bedfordscb.proceduresonline.com/p\_priv\_fost\_policy.html?zoom\_highlight=private+fostering#](https://bedfordscb.proceduresonline.com/p_priv_fost_policy.html?zoom_highlight=private+fostering)

### Trafficking/Modern Day Slavery

The United Nations (Article 3 paragraph A of the Protocol to Prevent, Suppress and Punish Trafficking in Persons) defines Trafficking in Persons as the “recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs”.

Most children are trafficked and exploited for financial gain. Some trafficking is by organised gangs, in other cases individual adult’s traffic children to and around the UK for their own personal gain. Exploitation includes children being used for sex work, domestic servitude, sweatshop and restaurant work, drug dealing and credit card fraud, begging or pickpocketing, benefit fraud, drug mules or decoys for adult drug traffickers, forced marriage, trade in human organs, and, in some cases, ritual killings. There are a number of circumstances that could indicate a child may have been trafficked to the UK, and may still be controlled by the traffickers or receiving adults.

The National Referral Mechanism is a process set up by the Government to identify and support all victims of modern slavery following the implementation of the Modern Slavery Act (2015). The mechanism through which the [**Modern Slavery and Human**](http://www.nationalcrimeagency.gov.uk/about-us/what-we-do/specialist-capabilities/uk-human-trafficking-centre)[**Trafficking Unit (MSHTU)**](http://www.nationalcrimeagency.gov.uk/about-us/what-we-do/specialist-capabilities/uk-human-trafficking-centre)collects data about victims. This information aims to help build a clearer picture about the scope of human trafficking in the UK. <https://www.ecpat.org.uk/national-referral-mechanism>

For further information, refer to:

London Safeguarding Children Procedures, (2022) 7th Edition, PG43. Safeguarding Trafficked and Exploited Children

[https://www.londonsafeguardingchildrenprocedures.co.uk/sg\_trafficked\_ch.html?zoom\_highlight=trafficking#](https://www.londonsafeguardingchildrenprocedures.co.uk/sg_trafficked_ch.html?zoom_highlight=trafficking%23)

Bedford Borough, Central Bedfordshire and Luton Safeguarding Children Partnership Procedures, (2022) Children from Abroad, including Victims of Modern Slavery, trafficking and Exploitation

[https://bedfordscb.proceduresonline.com/p\_modern\_slavery.html?zoom\_highlight=modern+slavery#](https://bedfordscb.proceduresonline.com/p_modern_slavery.html?zoom_highlight=modern+slavery%23)

In cases where a staff member suspects that a child may have been trafficked and exploited an immediate referral must be completed and sent to Children’s Social Care in the Local Authority where the child resides.

### Spiritual, Cultural and Religious Beliefs

Where parents, families and the child themselves believe that an evil force has entered a child and is controlling them, the child is likely to suffer significant harm. The belief includes the child being able to use the evil force to harm others. This evil is also known as black magic, kindoki, ndoki, the evil eye, djinns, voodoo, and obeah. Children are called witches or sorcerers.

Parents can be initiated into and/or supported in the belief that their child is possessed by an evil spirit by a privately contacted spiritualist/indigenous healer, or by a local community faith leader. The task of exorcism or deliverance is often undertaken by a faith leader, or by the parents or other family members.

A child may suffer emotional abuse if they are labelled and treated as being possessed with an evil spirit. In addition, significant harm to a child may occur when an attempt is made to “exorcise“ or “deliver“ the evil spirit from the child. Staff need to remember that while recognising that child rearing practices are highly diverse, and that all differences are to be valued and understood, it is also important that any judgements about the care and protection of children are based on objective assessment of facts. Sensitivity to parental behaviours, culture, religion, or ideology, whilst being important in the provision of care, must not mean that children from any background receive a lower level of care or protection.

For further information, refer to London Safeguarding Children Procedures (2022) PG39. Spiritual, Cultural and Religious Beliefs

<https://www.londonsafeguardingchildrenprocedures.co.uk/spirit_possession.html?zoom_highlight=spiritual#4.-professional-response>

Bedford Borough, Central Bedfordshire and Luton Safeguarding Children Partnership Procedures. Section 3.4.5

### Parenting Capacity and Mental Illness

Some situations cause additional stress within families, such as social isolation, poverty, homelessness and racial harassment. Parental factors such as mental health, substance misuse (drugs and alcohol), domestic violence, learning/physical disability or difficulty, and teenage parents may also have a negative impact on a child/young person’s health, development and well-being, either directly, or because they affect the capacity of the parents to respond to the child/young person’s needs. This is particularly the case when there is no other significant adult who is able to respond to the child/young person’s needs.

Parental mental illness does not necessarily have an adverse impact on a child's developmental needs, but it is essential to always assess its implications for each child in the family. Many children whose parents have mental ill health may be seen as children with additional needs requiring professional support.

Where a parent has enduring and / or severe mental ill-health, children in the household are more likely to suffer significant harm; this could be through physical, sexual or emotional abuse, and / or neglect.

Adult mental health professionals must identify those service users who are pregnant and those who are parents or who have regular access to children, whether they reside with children or not. Professionals should consider the needs of all children as part of their [**Care Programme Approach (CPA)**](http://www.nhs.uk/CarersDirect/guide/mental-health/Pages/care-programme-approach.aspx) assessments. When adult mental health services and LA children's social care are both involved with a family, joint assessments should be carried out to assess the support parents need and the risk of harm to the child/ren.

The most effective responses to children and families affected by mental ill health comes through agencies adopting a “**Think Family”** approach. Whilst mental illness can be compatible with good parenting, some parents with severe mental illness are at risk of harming their children; very serious risks may arise if their illness incorporates delusional beliefs about the child, and/or the potential for the parent to harm the child as part of a suicide plan.

NSPCC ‘Parental Mental Health: Learning from case Reviews, 2015’ advises that when a parent discloses suicidal feelings that ‘as well as leading to a referral to mental health services, disclosure of suicidal feelings should lead to full consideration of child protection issues in relation to a suicidal parent. Children should never be considered a protective factor for parents who feel suicidal. In some cases, professionals inappropriately viewed the child as a protective element who could help to reduce the parent’s risk of self -harm. This belief significantly increases the risk to the child.’ In short, Children can’t be held to account to risk manage the adult in their life. Please see briefing below for full details.



For further information, refer to:

London Safeguarding Children Procedures (2022) 7th Edition, PG27. Mental Illness (Parenting Capacity)

[https://www.londonsafeguardingchildrenprocedures.co.uk/par\_cap\_ment\_illness.html?zoom\_highlight=mental#](https://www.londonsafeguardingchildrenprocedures.co.uk/par_cap_ment_illness.html?zoom_highlight=mental)

Bedford Borough, Central Bedfordshire and Luton Safeguarding Children Partnership Procedures (2022) Children of Parents with Mental Ill Health [https://bedfordscb.proceduresonline.com/p\_ch\_par\_ment.html?zoom\_highlight=mental#](https://bedfordscb.proceduresonline.com/p_ch_par_ment.html?zoom_highlight=mental)

### Parental Substance Misuse

Although there are some parents who are able to care for and safeguard their child/ren despite their dependence on drugs or alcohol, parental substance misuse can cause significant harm to children at all stages of development. A thorough assessment is required to determine the extent of need and level of risk of harm for each child in the family. Where a parent has enduring and / or severe substance misuse problems, children in the household are likely to suffer significant harm primarily through emotional abuse and neglect. The child/ren may also not be well protected from physical or sexual abuse.

Maternal substance misuse in pregnancy can have serious effects on the health and development of the child before and after birth. Many factors affect pregnancy outcomes, including poverty, poor housing, poor maternal health and nutrition, domestic abuse and mental health.  Assessing the impact of parental substance misuse must take account of such factors. Pregnant women (and their partners) must be encouraged to seek early antenatal care and treatment to minimise the risks to themselves and their unborn child.

Professionals must identify those adults who are parents, or who have regular care giving access to children, and share the information with local authority children's social care as early as possible.

For further information, refer to:

London Safeguarding Children Procedures (2022) 7th Edition, PG32. Parents who Misuse Substances

[https://www.londonsafeguardingchildrenprocedures.co.uk/par\_misuse\_subtance.html?zoom\_highlight=substance#](https://www.londonsafeguardingchildrenprocedures.co.uk/par_misuse_subtance.html?zoom_highlight=substance)

Bedford Borough, Central Bedfordshire and Luton Safeguarding Children Partnership Procedures, (2022) Children of Parents who Misuse Substances [https://bedfordscb.proceduresonline.com/p\_ch\_misuse\_subs.html?zoom\_highlight=substances#](https://bedfordscb.proceduresonline.com/p_ch_misuse_subs.html?zoom_highlight=substances)

### Domestic Abuse

Domestic abuse is the most frequent form of abuse among adults. However, it is known nationally that one in seven children and young people under the age of 18 will have lived with domestic abuse at some point in their childhood. Police in England and Wales made an average 669 child protection referrals a day to social services in the 2021/22 (NSPCC). Children can experience both short and long term cognitive, behavioural and emotional effects as a result of witnessing domestic abuse. There is an increased risk to children’s welfare where there is domestic abuse, mental ill health and substance/alcohol abuse.

Domestic abuse has a devastating impact on children and young people that can last into adulthood. Children’s responses to the trauma of witnessing domestic abuse may vary according to a number of factors, which may include, age, race, sex and stage of development. Domestic abuse can co-exist with child abuse, through direct abuse of children in addition to their exposure to the abuse of their parent or the risk of being caught in the cross-fire of physical violence. Anyone can be affected by domestic abuse – regardless of age, disability, sex, sexual orientation, gender identity, gender reassignment, race, religion or belief. In addition, domestic abuse can manifest itself in different ways within different communities.

The definition of domestic abuse according to the [The Domestic Abuse Act 2021](https://www.legislation.gov.uk/ukpga/2021/17/pdfs/ukpga_20210017_en.pdf) is:

Behaviour of a person (“A”) towards another person (“B”) is “domestic abuse” if— (a) A and B are each aged 16 or over and are personally connected to each other, and the behaviour is abusive.

Behaviour is “abusive” if it consists of any of the following:

(a) Physical or sexual abuse.

(b) Violent or threatening behaviour.

(c) Controlling or coercive behaviour.

(d) Economic abuse

(e) Psychological, emotional or other abuse.

And it does not matter whether the behaviour consists of a single incident or a course of conduct. The Act recognises children as victims in their own right and they should be referred to the local MASH to assess risk and offer support. Types of domestic abuse include intimate partner abuse, teenage relationship abuse, abuse by family members and child to parent abuse.

There is a specific DASH risk assessment which can be used with victims age 16-18. Click [here](https://safelives.org.uk/sites/default/files/resources/YP%20RIC%20guidance%20FINAL%20%281%29.pdf) for access.

#### For further information, please see:

London Safeguarding Procedures, Pg 11. Domestic abuse.

<http://www.londonsafeguardingchildrenprocedures.co.uk/sg_ch_dom_abuse.html>

Bedford Borough, Central Bedfordshire and Luton Safeguarding Children Partnership Procedures (2022)- Safeguarding Children and Adults from Domestic Abuse Practice Guidance

<https://bedfordscb.proceduresonline.com/files/sg_ch_dom_abuse.pdf>

#### ELFT Domestic Abuse Pathway



The [Trust Domestic Abuse and Harmful Practices policy i](https://www.elft.nhs.uk/system/files/2022-03/Domestic%20Abuse%20%20and%20Harmful%20Practices%20Policy%203.0.pdf)s also available on the Intranet.

* 1. **Scope**

This policy applies to all trust staff, including agency staff, and volunteers and relates to the following children and young people up to their 18th birthday:

* + - Unborn children of service users who are pregnant or who have a pregnant partner.
    - All children and young people who are service users of CAMHS and Children’s Community Health Services and their siblings.
    - Children of service users whether living in the same household or not.
    - Children who are related to service users – e.g. as grandchildren, nephews, nieces, siblings, step-children, foster children.
    - Children who live in households shared with, or visited by, service users.
    - Any child who may have contact with a perpetrator about whom a service user has disclosed past abuse.
    - Any other children not covered above who may be at risk from a service user e.g. service users in contact with children through paid employment or voluntary work.
    - Children of staff members who have child abuse allegations made against them.

The fact that a child has become 16 years of age, is living independently, is in further education, is a member of the armed services, is in hospital or in custody in the secure estate for children and young people, does not affect his or her status or entitlement to services or protection under the Children Act 1989.

1. 1. **Responsibilities**

#### The Trust Board

The Trust Board has responsibility for ensuring that there is an effective framework in place for assisting staff to safeguard children and for ensuring contractors are aware of their responsibilities.

#### The Executive Lead for Safeguarding

The Trust has identified the Chief Nurse as the Executive Lead for Safeguarding Children on the Trust Board, as required by Working Together to Safeguard Children, 2018. The Executive Lead has overall responsibility for the effective implementation of this policy. He/she is the Named Senior Officer and is responsible for the management of allegations against staff in the Trust.

#### The Operational Lead Director for Safeguarding

The Trust has identified a Director of Nursing to provide professional leadership and, in liaison with managers and safeguarding leads in locality services, to provide operational oversight of safeguarding children activity and the work of the Safeguarding Teams to ensure action plans are progressed and implemented.

#### The Associate Director for Safeguarding Children

The Associate Director for Safeguarding Children is responsible for providing a strategic lead for safeguarding children and promoting a co-ordinated approach to the development, implementation, management and monitoring of relevant national guidelines and standards in respect to safeguarding children. They ensure that the Trust systems for safeguarding children including education and training, risk and assurance frameworks, annual board report are in place and responsive to relevant guidance. This entails working closely with the Associate Director for Safeguarding Adults where there are overlapping issues. They are to be in regular communication with the Designated leads in the ICB’s where ELFT has its footprints. The Associate Director reports to the Operational Lead Director for Safeguarding.

#### Named Doctor, Safeguarding Children

The Clinical Director for Children Services is the Named Doctor for children safeguarding and the Medical Director has also been identified as the Named Doctor (children safeguarding) for Adult Mental Health Services. The function of Named Doctors includes:

* Promoting good practice and effective communication within and between Trust’s and all agencies on matters related to the safeguarding and protection of children and young people.
* Being a source of advice and expertise on safeguarding and child protection matters to all staff at the point of need.
* Co-ordinating and monitoring medical input into cases of abuse and/or neglect.
* Co-ordinating and participating in safeguarding training for medical staff.
* Providing safeguarding supervision for medical staff (see [Safeguarding Supervision Policy](https://www.elft.nhs.uk/intranet/documents/supervision-policy) on the Trust Intranet)
* Participating and contributing to Internal Management and Serious Case Reviews.
* Contributing to an effective system of child protection audits to monitor the application of agreed child protection standards.
* Contributing to the work of Local Safeguarding Partners and attend relevant safeguarding board and committee meetings.
* Representing the Trust at the Child Death Overview Panels in the Boroughs the Trust serves when required.

#### Named Professionals for Safeguarding Children

The Trust has a number of staff fulfilling the statutory responsibilities of this role within the organisation. Named professionals have direct lines of communication with specific boroughs and are responsible for:

* Promoting good practice and ensuring the Trust is kept up-to-date about safeguarding children issues.
* Working with all clinical and corporate services to promote a ‘Think Family’ approach to safeguarding children.
* Delivering a regular Safeguarding Children training programme for clinicians at Level 3.
* Carrying out regular checks on Electronic Patient Record Systems as to whether service users are involved in multi-agency child protection or domestic abuse processes for information sharing purposes.
* Working with partner agencies, particularly Children’s Social Care, to strengthen interface arrangements and resolving difficulties.
* Working with the Governance and Risk Management Department on the management of Incident Reviews, audits and performance data.
* Working with the Caldicott Guardian and Associate Director of Governance and Risk Management regarding information sharing and information governance arrangements.
* Contributing to the work of Local Safeguarding Partners.
* Carrying out and contributing to Local Safeguarding Practice Reviews and Learning Reviews.
* Overseeing and leading Trust involvement in multi-agency case audits.
* Ensure that the Safeguarding information on the Trust intranet is up to date.
* Providing performance information to the Trust Board and Commissioners.
* Contributing to coroners’ inquests as required.
* Advising HR on staffing matters that have a safeguarding children component, including child protection allegations against staff.

#### Named Nurse and Named Doctor for Children in Care

* Raising awareness to all Trust employees that because children are in care they are not necessarily safe from harm and should be protected as with any other child.
* Providing appropriate advice and support to promote good professional practice specifically relating to children in care and their carers.
* Promoting, influencing and participating in policy and procedure development ensuring it reflects the requirements of children in care and meeting statutory requirements.
* Supporting the Trust in its clinical governance role to ensure services and issues regarding children in care are part of the governance system.
* Ensuring that all Trust staff working directly with children in care and those who come into contact with them through their work are fully aware of their complex health needs, vulnerability and legal status.
* Working in partnership with other statutory and third sector organisation who are responsible for meeting the needs of children in care.
* Contributing to the training strategy for safeguarding to ensure children in care are an integral part.

#### The Director of Human Resources

Responsible for ensuring safer recruitment standards are maintained as set out in the London Child Protection Procedures and the Pan Bedfordshire Child Protection Procedures:

* Ensuring Job Descriptions include a statement regarding safeguarding children.
* Ensuring Disclosure and Barring Scheme (DBS) checks are carried out in line with national and statutory guidelines.
* Ensuring allegations against staff regarding the welfare of children, at work or in personal life, are addressed in accordance with Trust policy and national/statutory guidelines.
* Ensuring all HR policies incorporate safeguarding children requirements where necessary.
* Ensuring Job Descriptions include a statement regarding safeguarding children.

#### Clinical and Service Directors

Borough and Service Directors and Clinical Directors are responsible for ensuring their services meet safeguarding children requirements. This should occur through an identified operational lead manager for safeguarding children in each directorate, working closely with the Safeguarding Children Team.

They have responsibility for ensuring that all their clinical practitioners are adequately trained and skilled in incorporating safeguarding children considerations into assessment, care planning and care management and that they have fulfilled their minimum training requirements as specified in the Training Needs Analysis. In addition to this, Service Directors are responsible for ensuring that clinical staff are receiving regular supervision and oversight of their clinical work and that this includes monitoring of compliance with the principles and requirements of this policy and any associated documentation.

#### All ELFT staff, irrespective of discipline or role

All staff whether permanent, temporary or contracted have a duty to ensure that children are protected from harm and comply with the principles laid down in the legislation (described above)

This includes recognising and reporting concerns and to always follow up oral communication in writing to ensure the message is clear. All clinical staff must ensure all relevant clinical documentation is completed and reviewed in order to ensure the on-going safeguarding of children.

All ELFT employees have a duty to undertake relevant mandatory safeguarding training.

For all staff, the welfare of the child is paramount. This implies that when there is actual, or potential, conflict between the needs of a child and adult (for example, an adult client of ELFT) the child’s needs must be prioritised.

#### Clinical Practitioners – additional responsibilities

All practitioners have a responsibility for ensuring that they are adequately trained and skilled to incorporate safeguarding children considerations into assessment, care planning, care management, and have fulfilled their training requirements as specified in the Training Needs Analysis.

Practitioners also have a duty to ensure they carry out clinical risk assessments and management planning as part of their clinical work, in line with the principles contained within this policy and using the Trust’s most up-to-date tools and templates available on the intranet.

Practitioners must be aware of local procedures for reporting concerns about a particular child and refer to local authority children’s social care if there are signs that a child or unborn baby is experiencing or may already have experienced abuse or neglect, or is likely to suffer significant harm in the future.

Practitioners must be able to recognise whether a child is in need of additional services (because they are unlikely to achieve or maintain a satisfactory level of health or development, or their health and development will be significantly impaired, without the provision of services; or a child with disability) and make a decision about referral to children’s social care or early help services. This might include children whose parents are in hospital or prison, and for asylum seeking children. Children and young people who have been admitted to a mental health inpatient unit should be considered children in need. A DATIX needs to be completed for any under 18 admitted to an adult mental health ward.

Referrals to partner agencies should be coordinated so that the child and family experience a clear process and a single plan of action.

Practitioners must also consider:

* The needs of parents/carers who may require additional support or extra help in caring for their children, and know where to refer for help.
* The impact a parents/carers condition and symptoms may have on their own or other children, and whether this merits referral to children’s social care. This includes risk of physical abuse, sexual abuse, emotional harm or neglect.
* Identify young carers and provide information to them about their right to request an assessment of their own needs as a ‘child in need’ and as a carer.

Staff must consider these issues at all stages throughout the episode of care and documentation and risk assessments should be regularly reviewed. There should be clear written evidence of consideration of the safeguarding needs of children. For example, GP discharge letters and ward summaries must address any actions taken or concerns expressed regarding the needs of children.

Staff must ensure that they seek information from relevant services about a service user’s history. This needs to include information from other agencies such as children’s social care and other health agencies especially if they have moved or recently transferred into the area.

All staff working with current service users must contribute to multi-agency assessments, child protection investigations and subsequent child protection conferences and reviews.

#### Safeguarding record keeping on Rio

Alerts- There are numerous safeguarding alerts on ELFT Rio. When a practitioner becomes aware that a child is made subject to a child protection plan or child in need plan a red alert triangle must be added to their record to state “child in need” or “child protection”, and consequently removed when the plan is de-escalated. If a child is open to early help or Team Around the Family (TAF) then the “vulnerable child” alert would be the most appropriate to use in this instance. If a practitioner becomes aware that a child is being discussed at MACE (multi agency child exploitation conference) then the alert “at risk of sexual exploitation” must be added to their record. If anyone over the age of 16 is discussed at MARAC (multi agency risk assessment conference) then the MARAC alert should be selected. There are also alerts for looked after children, domestic abuse in the household, drug and alcohol use, FGM identified and risk of FGM which should be used when appropriate.

Family Management- Any service user living with a child under 18 should have this child linked to them via the “household and child contact” form on Rio. Please see document below for in depth instructions on how to record this.



Children’s social care referrals- All referrals made to children’s social care should be uploaded either to the child’s record if they are the service user, or the adult’s if they are the service user and the child is not an open patient to ELFT. Please also write a progress note to say what you have made a children’s social care referral to (insert name of council) and click the “significant event” box. Record any referrals made on the safeguarding form in the case record menu, see below for in depth instructions on how to complete this.



Rio document list- Any meeting minutes (such as case conferences, professionals meetings, strategy meetings, TAF, child in need meetings, core group meetings, discharge planning meetings etc) and copies of plans from these meetings should be uploaded to Rio documents on the service user’s case record. Any reports you write for these meetings should also be uploaded.

#### Think Family approach

The Think Family initiative was introduced by the Department for Children, Schools and Families (DCSF) in 2008 following the Cabinet Office’s 'Families at Risk' Review. ‘At risk’ is a term used to describe families who are experiencing multiple and complex problems, which frequently lead to poor outcomes for children within those families.

The basis of a Think Family approach is to co-ordinate the response to families in order to:

* Identify families at risk of poor outcomes to provide support at the earliest opportunity.
* Meet the full range of needs within each family they are supporting or working with.
* Develop services which can respond effectively to the most challenging families.
* Strengthen the ability of family members to provide care and support to each other.
* Develop a corporate responsibility for families incorporating a culture shift at all levels.

The intention is to ensure that the Think Family approach underlies all our core services to children and adults, particularly to those experiencing multiple and complex problems, and that services and partner agencies are wholly co-ordinated to maximise their effectiveness.

On a practical level this means staff working with adults need to be asking if they have caring responsibilities for anyone under the age of 18 or are residing with anyone under the age of 18 (For example, older people may live in the same home as their adult child & grandchildren) and document the child/ren’s details on Rio family management. Any physical or emotional health issue that the adult is presenting with may well impact on their parenting capacity or pose a risk to children and a further assessment of risks and protective factors for any children in the home will need to be completed.

#### Representation at Multi-Agency Meetings

The Trust has a responsibility to ensure it is represented at an appropriate level at the following bodies:

* Local Safeguarding Children Partnerships including sub groups.
* Multi-Agency Risk Assessment Conferences (MARAC) – regarding domestic abuse.
* Multi-Agency Sexual Exploitation (MASE) Panels/Multi-Agency Child Exploitation (MACE) Panels.
* Any other panels as are convened e.g. Channel Panel.

#### Data Protection and Confidentiality (GDPR)

The Data Protection Act (2018) and the General Data Protection Regulation (GDPR) sets the legal framework by which the Trust can process personal information. It applies to information that might identify any living person. The common law duty of confidentiality governs information given in confidence to a health professional (about a person alive or deceased) with the expectation it will be kept confidential. The GDPR is not a barrier to sharing information but provides a framework to ensure that personal information about living persons is shared appropriately.

The General Data Protection Regulations (GPDR), implemented through the Data Protection Act 2018 identifies:

*“That it is no longer necessary to seek consent to share information for the purposes of safeguarding and promoting the welfare of a child (i.e. removing the distinction between information sharing for the purposes of assessing need or child protection). It does, of course, continue to be good practice to inform parents/carers that you are sharing information for these purposes and to seek to work cooperatively with them. Agencies should also ensure that parents/carers are aware that information is shared, processed and stored for these purposes.”*

It is therefore important to be open and honest with the child and their parents/carers where appropriate from the outset about why, what, how and with whom information will, or could be shared, and seek their informed consent, unless it is unsafe or inappropriate to do so.

The information shared should be necessary, proportionate, relevant, accurate, timely and secure. Ensure that the information shared is necessary for the purpose for which you are sharing, it is shared only with those people who need to have it, is accurate and up-to-date, is shared in a timely fashion, and is shared securely. Reference can be made to the [Trust’s Data Protection and Confidentiality Policy](https://www.elft.nhs.uk/information-about-elft/trust-policies-procedures) on the Intranet.

The child's best interest must be the overriding consideration in making any such decision of sharing information.

#### Information Sharing

“The duty to share information can be as important as the duty to protect patient confidentiality”. (Caldicott 2 principle 7).

Effective sharing of information between professionals and local agencies is essential for safeguarding and promoting the welfare of children and young people. Early sharing of information is the key to providing effective early help where there are emerging problems. At the other end of the continuum, sharing information can be essential to put in place effective child protection services. Safeguarding Children Practice Reviews (SCPRs) have shown how poor information sharing has contributed to the deaths or serious injuries of children.

Fears about sharing information cannot be allowed to stand in the way of the need to promote the welfare and protect the safety of children. To ensure effective safeguarding arrangements no professional should assume that someone else will pass on information which they think may be critical to keeping a child safe. If a professional has concerns about a child’s welfare and believes they are suffering or likely to suffer harm, then they should share the information with local authority children’s social care.

[Information Sharing: Guidance for practitioners and managers (2018)](https://www.gov.uk/government/publications/safeguarding-practitioners-information-sharing-advice) provides guidance about sharing personal information on a case by case basis.

Please refer to the [Trust Data Protection and Confidentiality Policy](https://www.elft.nhs.uk/information-about-elft/trust-policies-procedures) on the Intranet which provides additional support and guidance.

Where sharing concerns with parents could increase the risks to a child, for example sexual abuse within the family when there is a danger of the parents silencing the child; you should make the referral without informing the parents and record this in the notes.

Children have a right to be told what is going on. They should not be given promises that cannot be kept. Their views and wishes should be taken into consideration, in accordance with their age and developmental status.

Clients and children should be made aware that confidentiality can never be absolute, as staff have a duty to ensure they are protected from harm.

Information should be shared with the parent or carer and with the child appropriate to their age and understanding. This includes all reports for child protection conferences and some planning meetings, which should always be shared with the family before any meeting.

There will be circumstances in which it will not be in the child’s best interests for information to be shared immediately.

Nevertheless, health professionals should not disclose without consent any information obtained in confidence, unless it is necessary to ensure the protection of a child at risk, or is necessary as part of a multi-agency comprehensive assessment to determine the level of risk.

The child’s welfare should always be considered whenever a practitioner is communicating via email or post; for example to a GP/referrer, summarising involvement with a patient who is a parent or carer. This may include copying the letter to the relevant Local Authority Children Social Care where there are concerns. Cases should not be declined or closed without the original referrer and other key agencies being advised that this is the proposed plan so that they can either question this decision or take over the responsibility for support and monitoring, where this is required. This is particularly important where a child is subject of a child protection plan or already known to children’s social care.

Generally, if children’s social care request information as part of a section 47 (child protection) assessment, practitioners have a duty to pass on information with or without client/parental consent. If the requested information is part of a section 17 (child in need) assessment, then information should only be given with service user or parental consent. Therefore, staff should clarify with children social care which section of the Children Act 1989 the assessment is being conducted under, in-order to know the level of client consent required.

Where a child in the family is subject of a child protection plan or where there are safeguarding concerns, services should ensure copies of letters sent to GPs summarising involvement in the case are copied to children’s social care.

#### Caldicott Guardian

For further guidance on information sharing please contact the Trust Caldicott Guardian. A Caldicott Guardian is a senior person for an organisation which processes health and social care personal data. They make sure that the personal information about those who use the organisation’s services is used legally, ethically and appropriately, and that confidentiality is maintained. Caldicott Guardians should be able to provide leadership and informed guidance on complex matters involving confidentiality and information sharing.

#### Consent

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 there are reasons to believe a child aged 16 or over lacks capacity, an assessment of capacity to consent should be conducted and recorded in their notes. Please note-The Mental Capacity Act 2005 generally applies to people 16 and above, however there are some exemptions which apply to people age 18 and above. This policy needs to be read in line with ELFT Mental Capacity Act 2005 policy and associated standard operating procedures.

Children under the age of 16 can consent to their own treatment if they have sufficient understanding and intelligence to fully understand what is involved in a proposed treatment. This includes its purpose, nature, likely effects, risks, and chances of success and the availability of other options. This is known as being Gillick competent. There is no presumption of Gillick competence. However, as with adults, this consent is only valid if given voluntarily and not under undue influence or pressure by anyone else. Additionally, a child may have the capacity or Gillick competence to consent to some treatments but not others as assessment is decision specific and time specific. The understanding required for different interventions will vary and can fluctuate. Therefore each individual decision requires assessment of Gillick competence.

If a child is assessed as not being Gillick competent or as lacking mental capacity to consent to particular treatment/intervention, then the consent of a person with parental responsibility, or in some circumstances the courts, is needed in order to proceed with the treatment. This could be:

* the child's mother or father (however not every father will have a parental responsibility)
* the child's legally appointed guardian
* a person with a child arrangement order with the live with component
* a local authority designated to care for the child
* a local authority or person with an emergency protection order for the child

Where a health professional accepts the consent of a Gillick competent child it cannot be overruled by the person with parental responsibility. However, where the same child refuses consent then they may obtain it from another person with parental responsibility who can consent to treatment on the child's behalf.

For more guidance on seeking consent for medical examination in children and young people see the [General Medical Council's 0-18 years: Ethical Guidance for all Doctors.](https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/0-18-years/making-decisions)

Clinicians are required any complex cases or matters involving significant risk, especially when the child who is Gillick competent or who has mental capacity declines relevant treatment or intervention, to the attention of the ELFT Mental Capacity Act Lead via email: [elft.mentalcapacity@nhs.net](mailto:elft.mentalcapacity@nhs.net) for the case to be discussed and all legal avenues to be explored.

Additionally, in cases where child lacks mental capacity or is assessed as not being Gillick competent to consent to particular treatment/intervention and parents decline to provide such consent, practitioners should immediately seek advice from ELFT Mental Capacity Lead as above.

Furthermore, the advice should be sought in cases where the child is looked after by the Local Authority, as in some cases the local authority will not be in position to give consent to the treatment/intervention, especially if the care plan would amount to the deprivation of child’s liberty.

#### Training

Mandatory training requirements are set out in the Safeguarding Children Training Needs Analysis which has been developed in accordance with the Safeguarding Children and Young People: Roles and Competences for Health Care Staff, Inter- collegiate framework (2019).

As part of the Trust Training Needs Analysis and depending on role, staff are mapped to their highest compliance level. Therefore, they are required to access appropriate training for their role in line with the [Safeguarding Children and Young People; Roles and Competencies for Healthcare Staff (RCN, 2019).](https://www.rcn.org.uk/professional-development/publications/pub-007366) All staff are expected to complete the safeguarding children training (whichever level they are mapped to) within 12 months of commencing employment.

* All staff will receive the level 1/level 2 joint adults & children’s safeguarding training induction booklet on commencing in post.
* Non-clinical staff are required to maintain Level 1 competence and refresh no longer than every 3 years.
* Non–clinical and clinical staff who in their role have contact (however small) with children, young people and/or parents/carers or adults who may pose a risk to children are required to undertake Level 2 Training. They are required to maintain Level 2 competence and refresh within every 3 years.
* All clinical staff working with children, young people and/or their parents/carers and or any adult who could pose a risk to children and who could potentially contribute to assessing, planning, intervening and or evaluating the needs of a child or young person and/or parenting capacity (regardless of whether there have been previously identified child protection/safeguarding concerns or not) are required to maintain competence at Level 3 and refresh within every 3 years.
  + Safeguarding Children Named Professionals/Doctors are required to attend Level 4 Training and maintain competence and refresh within every 3 years.
  + All staff are required to attend Safeguarding Adults Training which incorporates the impact on children within domestic abuse, radicalisation and PREVENT.
  + Other training may be required from time to time in view of Government priorities.

Staff and managers are responsible for keeping a record of individual training requirements and attendance in their Personal Development Plan. The Learning and Development team keeps a corporate record of attendance at safeguarding children training and provides a monthly compliance report to managers. Compliance with training requirements is closely monitored by the Safeguarding Committee.

### 8.0 Internal Monitoring, Compliance and Review

**8.1 Safeguarding Committee**

The Trust joint adults and children’s Safeguarding Committee meets quarterly and oversees all issues relating to the Trust’s statutory responsibilities for safeguarding children, safeguarding adults and domestic abuse. It feeds into other committees and groups in the Quality Framework. The Safeguarding Committee is accountable to the Quality Assurance Committee.

It is chaired by the Director of Nursing who is the delegated operational Lead for Safeguarding Children, the vice-chair is the Medical Director (Named Doctor for Safeguarding Children – adult mental health) and its safeguarding children work is led by the Associate Director for Safeguarding Children. Each service directorate has a senior clinical/management lead for safeguarding children who is a member of the committee. This individual is responsible for ensuring that safeguarding children issues are raised at appropriate directorate committees, for taking up operational issues with managers and staff and for ensuring that action plans from practice review recommendations are implemented.

The Safeguarding Committee receives a quarterly performance report which includes information on:

* Training compliance.
* Reported incidents.
* Trust Serious Incident Reviews.
* Local Safeguarding Practice Reviews and Local Learning Reviews.
  1. **Reporting to the Trust Board**

The Trust Board receives an Annual Report and Work Plan from the Safeguarding Committee. The Annual Report is also submitted to the Local Safeguarding Children Boards and to the Clinical Commissioning Groups.

* 1. **Training Compliance**

Compliance with mandatory training is closely monitored by the Safeguarding and Quality Committee via a regular Performance report. Service managers receive monthly mandatory training compliance figures.

* 1. **Incident Reporting and Monitoring**

The electronic incident report (Datix) form has five compulsory fields asking for information regarding children, parents and pregnant women once “Yes” is selected under the heading “Does this incident have safeguarding children implications?”.

These are:

* Was a person under 18 years old directly involved/indirectly affected?
* Was any action necessary to ensure the safety and wellbeing of a person under 18 years old?
* Is the primary person involved in this incident a service user with parenting responsibilities for under 18s?
* Was a pregnant woman involved?
* Was a referral made to, or information shared with, Children’s Social Care?

If any of the fields are completed the form is automatically forwarded to the Safeguarding Children Team for review and follow up where necessary.

Incident categories can also flag up children at risk, missing children and child deaths.

* 1. **Serious Incident Review Monitoring**

Serious Incident and Serious Case Review action plan monitoring is carried out at Service Level Governance Committees, the Trust Safeguarding Committee and the Trust Serious Incident Committee.

* 1. **Clinical Audit**

The Trust carries out audits relating to safeguarding children in a number of ways:

* + - Through involvement in Local Safeguarding Children Board thematic audits where staff are involved in auditing identified cases and attending multi-agency case discussions.
    - Through audits carried out by the Safeguarding Children Team regarding Trust involvement in child protection, supervision and Referrals to Children’s Social care and attendance at Child Protection Conferences. These themes may change to reflect local and national interests. Through Directorate audits into clinical practice which impacts on identifying risks to, and needs of children.
    - They are used as a measure of compliance with the principles in this policy and associated procedures and action plans are developed in response to areas in need of development. Audit results and action plans are monitored by Clinical teams and Service Directorate governance groups, the Safeguarding Committee and the Quality Committee.
  1. **Supervision**

The Trust’s [Safeguarding Supervision Policy](https://www.elft.nhs.uk/system/files/2022-08/Safeguarding%20Children%20Supervision%20Policy%205.0.pdf) requires safeguarding children issues to be addressed in supervision. The Safeguarding Children Team provides advice and support to staff and safeguarding supervision to agreed groups of staff.

* 1. **Complaints**

Feedback, including complaints, from Child Protection Conference Chairs, Children’s Social Care and other partner agencies is followed up and acted upon.

* 1. **Safer recruitment**

All organisations which employ staff or volunteers to work with children should adopt a consistent and thorough process of safe recruitment in order to ensure that those recruited are suitable. This includes ensuring that safe recruitment and selection procedures are adopted which deter, reject or identify people who might abuse children or are otherwise unsuitable to work with them. The Trust has several policies in place relating to safe recruitment, including the Disclosure and Barring Policy and the Management of Allegations Policy. Please see Trust Intranet for further information.

* 1. **Management of Allegations Against Members of Staff and Contractors**

Allegations against members of staff and contractors may be a safeguarding children issue. When there is an allegation that any person who works with children, in connection with their employment or voluntary activity, has:

* Behaved in a way which has harmed, or may have harmed, a child or vulnerable adult.
* Possibly committed a criminal offence against or related to a child or vulnerable adult.
* Behaved in a way that indicates he/she is unsuitable to work with children or vulnerable adults.

Or

* Has behaved in a way in their personal life that raises safeguarding concerns. These concerns do not have to directly relate to a child but could, for example, include arrest for possession of a weapon;
* As a parent or carer, has become subject to child protection procedures;
* Is closely associated with someone in their personal lives (e.g. partner, member of the family or other household member) who may present a risk of harm to child/ren for whom the member of staff is responsible in their employment/volunteering.

Then the incident should be reported to their Line Manager and the Service/Borough Director and the Associate Director for Safeguarding Children (or in their absence the Chief Nurse). The Service/Borough Director and Associate Director for Safeguarding Children (or in their absence the Chief Nurse) both will ensure it is reported to the appropriate Local Authority Designated Officer (LADO) within one working day.

Staff should refer to [Trust’s Management of Allegations against Staff Policy](https://www.elft.nhs.uk/sites/default/files/2022-09/Management%20of%20Allegations%20against%20Staff%20Policy%203.0.pdf) available on the Trust Intranet for full details of the process to follow and who to contact.

VIP/celebrity visits will be handled and managed by the communications team. One‐off or very short‐term approved official (VIP, celebrity or media) visitors are to always be accompanied throughout their visit to the Trust where there is a possibility of contact with lone staff or vulnerable patients/visitors and a risk assessment will be done prior the visit. If the celebrities and VIP escort or any staff member becomes concerned with the behaviour of the visitor during their visit then the escort must stop the visit and notify the nominated communications team staff member responsible for the visitor immediately. If the concerns are of a safeguarding nature then the Borough Director and Associate Director for Safeguarding Children must be informed as soon as possible seeking advice on further actions required.

Further information is available at: London Safeguarding Children Procedures (2022) 7th Edition, CP7. Allegations against Staff or Volunteers (People in Positions of Trust), who work with Children [https://www.londonsafeguardingchildrenprocedures.co.uk/alleg\_staff.html?zoom\_highlight=allegations+against+staff#](https://www.londonsafeguardingchildrenprocedures.co.uk/alleg_staff.html?zoom_highlight=allegations+against+staff%23%20)

Bedford Borough, Central Bedfordshire and Luton Safeguarding Children Partnership Procedures, (2022) Allegations and Concerns regarding Staff, Carers and Volunteers Working with Children and Young People, [https://bedfordscb.proceduresonline.com/p\_alleg\_staff\_wk\_ch\_yp.html?zoom\_highlight=allegations+against+staff#](https://bedfordscb.proceduresonline.com/p_alleg_staff_wk_ch_yp.html?zoom_highlight=allegations+against+staff)

1. **External Monitoring, Compliance and Review**
   1. **Commissioners**

The Trust submits quarterly performance reports (dashboards) to the ICB’s and Local Authority commissioners. The Safeguarding Children Named Professionals are supervised by the Designated Nurses in the ICB’s.

* 1. **Local Safeguarding Children Partnership Section 11 Organisational Audit**

Local Safeguarding Children Boards have a statutory duty to monitor the arrangements that member agencies make for safeguarding children under Section 11 of the Children Act 2004. The Trust completes and submit Section 11 audits to the City & Hackney, Newham, Tower Hamlets, Bedford Borough, Central Bedfordshire and Luton Safeguarding Children Boards as required.

* 1. **Care Quality Commission (CQC) Inspections and Review**

The Trust is inspected by the CQC in relation to a wide range of standards which may include safeguarding children as part of an inspection or as a single issue inspection or review.

* 1. **Safeguarding and Looked After Children Inspections - Ofsted and Joint Targeted Area Inspection (JTAI)**

In addition to single agency inspections of health trusts by the CQC, the Government has developed multi-inspectorate inspections of borough wide partnership arrangements for safeguarding children. The inspections are led by the Office for Standards in Education, Children’s Services and Skills (Ofsted), and also include the Care Quality Commission (CQC), HM Inspectorate of Constabulary (HMIC) and HM Inspectorate of Probation (HMIP). The Trust is inspected, alongside all other relevant agencies in each of our seven local boroughs, and other local authority areas if required, in relation to single and multi-agency safeguarding children arrangements.

1. **Child Was Not Brought/Did Not Attend**

It is not acceptable to discharge a child/young person from a service for non-attendance without a reassessment or liaison with the original referrer being undertaken. For guidance and procedures to be followed when a child, young person and/ or family fail to attend/ was not brought to an appointment please refer to the management of non- attendance of health care appointments in Children, Young People and CAMHS services on the [Trust intranet](https://www.elft.nhs.uk/sites/default/files/WNBDNA%20Management%20of%20Non-Attendance%20of%20Healthcare%20Appts%20in%20CAMHS%20and%20SCYPS%205.0.pdf).

1. **Making a Referral to Children’s Social Care**

#### See embedded flowcharts below. Click on the relevant link for the area where the child resides for information about how to make a referral:

East London boroughs (City, Hackney, Newham, Tower Hamlets)



Bedfordshire and Luton CSC (Bedford Borough, Central Beds, Luton)



Telephone the relevant Children’s Social Care / MASH team if referral is urgent. If non-urgent then complete relevant online referral form for the borough the child resides in. If you have made an urgent telephone referral then the online referral form needs completing after the call. Upload referral form to Rio document list. Agree with the recipient of the telephone referral what the child and parents will be told, by whom and by when.

Children’s Social Care should acknowledge your referral within one working day.

If you have not heard back within 3 working days, contact Children’s Social Care again to find out if/how it is being acted upon.

If you are not happy that the response will safeguard the child and you are unable to resolve it, discuss with your manager or clinical lead.

The Trust’s Safeguarding Children Teams are available to support staff about making a referral or if concerns need to be escalated.

As part of their risk assessments of adults or children, staff should assess any risks to children and whether a referral should be made to Children’s Social Care. Staff should use their clinical judgement regarding risk but there are some situations which must always be referred to Children’s Social Care.

Referrals must be made to Children’s Social Care if:

* + - A parent or other adult in significant contact with children has delusional thinking involving a child.
    - A parent or other adult in significant contact with children has suicidal thoughts involving a child.
    - There are concerns that a female under 18 has undergone or may undergo FGM.
    - There are concerns a child or young person is at risk of Child Sexual Exploitation.
    - There are concerns that a child or young person is at risk of radicalisation.
    - There are concerns that a child may be subject of Fabricated or Induced Illness.
    - A child has been in hospital or a psychiatric unit (including private and voluntary sector units) for any continuous period exceeding and/or likely to exceed 12 weeks (section 85 of the Children Act 1989).
    - Where an unborn baby is considered to be at risk of harm or likely to be in need of services from Children’s Social Care when born.

Following triage of the referral to children’s social care, the outcome could be:

* + - * Delegated to Early Help.
      * ‘Mash’ process.
      * Single Agency Statutory Assessment.
      * Closed.

Services should keep a list of children at risk/who are subject to child protection plans or who are looked after and alerts should be placed on the service user’s Rio record. If the service user is a child then the details of the people who have parental responsibility for them should be linked via family management on Rio, likewise is the service user is an adult, any children who they have parental responsibility for should be linked via family management.

#### 12.0 Managing Multi-agency Disagreement and Escalation

It is important that all those working with children and families feel able to air their views and constructively challenge the decisions and actions, or lack of actions of others.

Concern or disagreement may arise over another professional's decisions, actions or lack of actions in relation to a number of issues; referral, an assessment or an enquiry, the implementation of the child protection plan (including the timing, quoracy or decision-making of core group meetings), progress of the plan or professional practice.

There must be respectful challenge whenever a professional has concern about the action or inaction of another, or with regard to any response about concerns and referrals for children perceived to be at risk or in need.

This challenge should initially be the responsibility of the member of staff who has concerns, and the other agency or professional involved.

If the practitioner(s) are unable to resolve differences within an appropriate timescale, or anticipate they will be unable to do so, they should contact a member of the Trust’s Safeguarding Children Team and follow the local Safeguarding Board conflict resolution procedures.

Escalation of concerns relating to any aspect of safeguarding or child protection work is essential; it is clearly stated within the:

London Child Protection Procedures 2022, Part PA4, Resolving Professional Differences.

<http://www.londonsafeguardingchildrenprocedures.co.uk/profess_conflict_res.html>

Pan Bedfordshire Child Protection Procedures May 2022, Multi Agency Disagreement and Escalation Procedure.

<https://bedfordscb.proceduresonline.com/p_resolution_disagree.html>

#### 13.0 References and Associated Documents

The Care Act 2014

<https://www.legislation.gov.uk/ukpga/2014/23/contents/enacted>

The Children Act 1989

<https://www.legislation.gov.uk/ukpga/1989/41/contents.htm>

The Children Act 2004

<https://www.legislation.gov.uk/ukpga/2004/31/contents>

The Children and Families Act 2014 <http://www.legislation.gov.uk/ukpga/2014/6/contents/enacted>

Education and Adoption Act 2015 https://services.parliament.uk/bills/2015-16/educationandadoption.html

[Mental Capacity Act 2005 (legislation.gov.uk)](https://www.legislation.gov.uk/ukpga/2005/9/contents)

[Mental Capacity Act Code of Practice - GOV.UK (www.gov.uk)](https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice)

Serious Crime Act 2015 <http://www.legislation.gov.uk/ukpga/2015/9/part/5/crossheading/female-genital-mutilation/enacted>

Children and Social Work Act 2017 <http://www.legislation.gov.uk/ukpga/2017/16/contents/enacted.htm>

Counter-Terrorism and Security Act (2015)

<https://www.legislation.gov.uk/ukpga/2015/6/contents/enacted>

HM Government (2018) Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children, Crown Copyright

NICE Clinical Guidance (89) 2016: Child Maltreatment: When to suspect maltreatment in Under 18s

NICE Guidelines (NG76) 2017: Child Abuse and Neglect

RCPCH (2019) Safeguarding Children and Young people: roles and competences for health care staff, Intercollegiate document,

HM Government (2015), What to do if you’re worried a child is being abused: advice for practitioners. Crown copyright

HM Government Guidance on Forced Marriage 2013 updated 2018

HM Government (2009), *The Right to Choose: multi-agency statutory guidance for dealing with forced marriage.* Forced Marriage Unit: London

HM Government (2008), *Safeguarding children in whom illness is fabricated or induced.* DCSF Publications.

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\_dat](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/277314/Safeguarding_Children_in_whom_illness_is_fabricated_or_induced.pdf) [a/file/277314/Safeguarding\_Children\_in\_whom\_illness\_is\_fabricated\_or\_induced.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/277314/Safeguarding_Children_in_whom_illness_is_fabricated_or_induced.pdf)

National Audit Office (2015), Care Leavers’ transition to adulthood

https:[//www.gov.uk/government/uploads/system/uploads/attachment\_data/file/39764](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/39764) 9/CA1989\_Transitions\_guidance.pdf

Skills for Health (2013), UK Core Skills Training Framework Subject Guide Trust-wide Care Programme Approach (CPA) Policy.

Department of Health (2008), Refocusing the Care Programme Approach: Policy and Positive Practice Guidance.

Department of Health and Social Care Institute for Excellence (2008), Care Programme Approach Briefing: Parents with Mental Health Problems and their Children.

Royal College of Psychiatry (2017), Parental mental illness: the impact on children and adolescents: for parents and carers.

The Government Drug Strategy (2017), Tackling the complex issue of drug misuse House of Parliament Post note; Parental Alcohol Misuse and Children, February 2018.

Social Care Institute for Excellence (2012), Think Child, Think Parent, Think Family: a guide to parental mental health and child welfare.

### Child Protection Procedures

Health professionals involved in the care of a child and young person are required to attend child protection case conferences or meetings and make specific contribution due to their knowledge of the child and family or their expertise relevant to the case.

For further information, see appendix iv (Guidance on preparation at a child protection conference and other child protection meetings)

Trust staff who work in London must familiarise themselves, and comply, with the London Child Protection Procedures.

The London Safeguarding Children Procedures and Practice Guidance can be found at: [http://www.londoncp.co.uk](http://www.londoncp.co.uk/)

Trust staff who work in Bedford Borough, Central Bedfordshire or Luton must familiarise themselves, and comply, with the Bedford Borough, Central Bedfordshire and Luton Safeguarding Children’s Boards Procedures

The Bedford Borough, Central Bedfordshire and Luton Safeguarding Children’s Boards Procedures can be found at: https://bedfordscb.proceduresonline.com/index.html#

In both sets of procedures can be found:

* Definitions of abuse and neglect.
* Guidance on acting on concerns and making referrals to Children’s Social Care.
* Guidance on information sharing and consent.
* Guidance on resolving professional disagreements.

In addition, the Safeguarding Children Partnerships in London and Pan Bedfordshire have local guidance which can be found on their websites.

This includes local information about:

* Threshold guidance
* How to make referrals to Children’s Social Care and Multi-agency Safeguarding Hubs (MASH)
* Escalation processes
* Joint protocols
* Training courses

#### City and Hackney Local Safeguarding Children Partnership

<https://chscp.org.uk/>

#### Newham Local Safeguarding Children Partnership

https://www.newhamscp.org.uk/

#### Tower Hamlets Local Safeguarding Children Partnership

<http://www.childrenandfamiliestrust.co.uk/the-lscb/>

#### Luton Safeguarding Children Board

<http://lutonlscb.org.uk/>

**Central Bedfordshire Safeguarding Children Board**

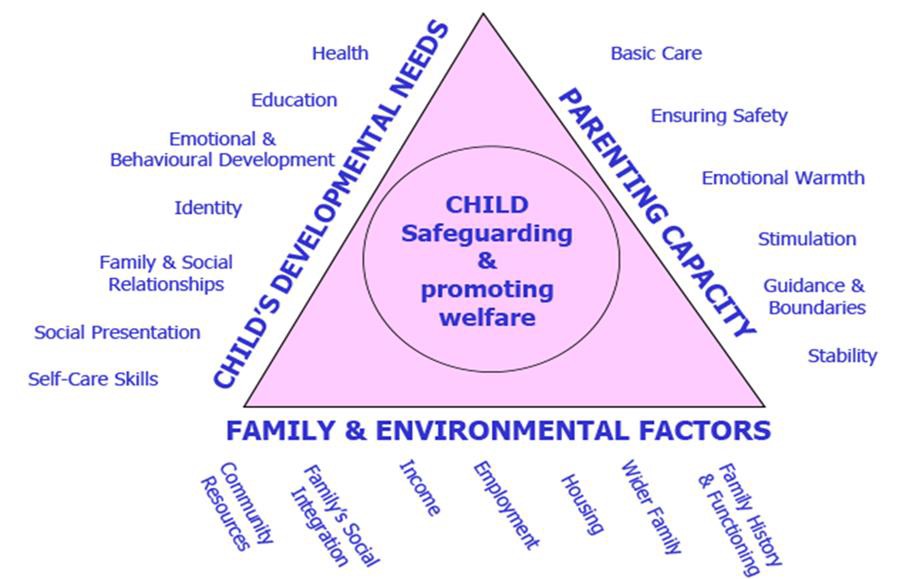
<https://centralbedfordshirelscb.org.uk/lscb-website/about-us/welcome-to-the-central-bedfordshire-safeguarding-children-board-website>

**Bedford Safeguarding Children Partnership**

<https://www.bedford.gov.uk/social-care-and-health/children-and-families/safeguarding-children-partnership>

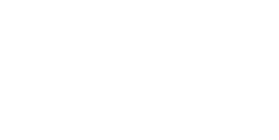
### Appendix i

**Triangle chart for the Assessment of Children in Need and their Families**

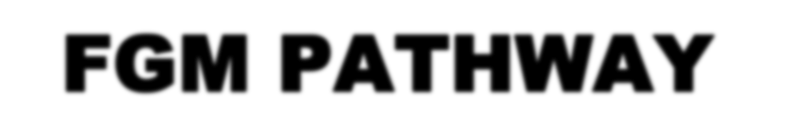


**Appendix ii**





**Appendix iii**

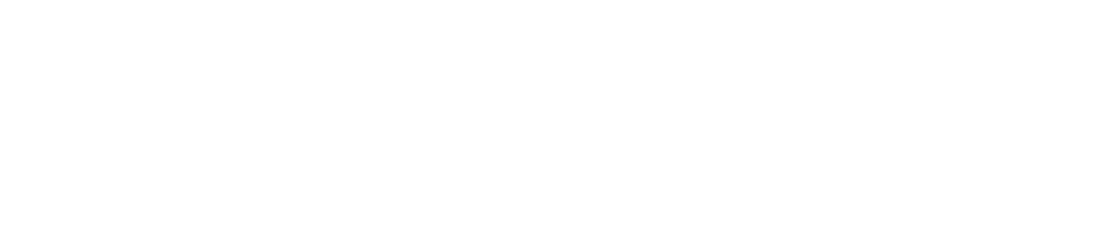


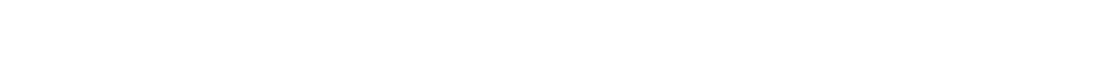






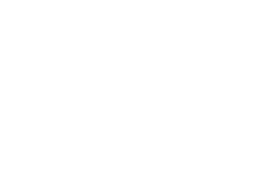
#### Has FGM occurred or been identified?

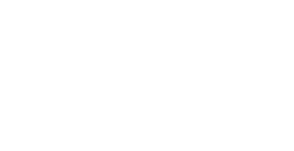


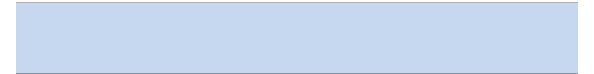










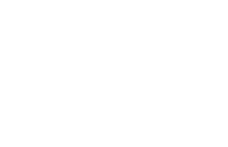




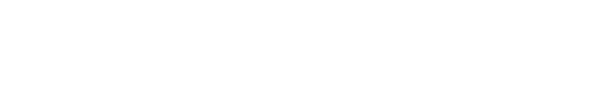








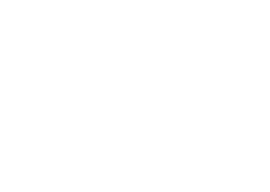




**Is there an imminent risk that FGM is going to occur?**

**YES NO**

**YES**





**NO**

**No Further**

**Action (NFA)**

**Document on RIO**

**Report to Police on 101 Non- emergencies**

**No Further Action**

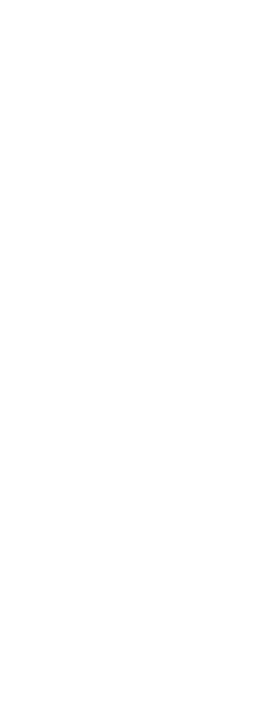
**Document on**

**RIO**

**Dial Police on 999 Immediately**

**Mandatory Reporting Duty applies**

**Complete referral to Children’s Social Care immediately**



**NB:**

**For further assistance contact your line manager in first instance.**

**For further clarification contact Safeguarding Team**

**Place FGM Alert on RIO records in Safeguarding page using the child FGM form**

**For CAMHS and Children’s Community Health teams document on Female Child’s Progress notes/ Electronic Patients’ records**

**For Adult Mental Health and Community services, document on the Parent’s Progress notes/ Electronic Patients’ records**

**Add date of Disclosure Including Police CAD No. (if applicable)**

**Complete Datix**

**Inform GP & Sign Post to FGM support agency**

**Appendix iv**

*y 2019*



**Guidance for the preparation and attendance at Child Protection Conferences and other Child Protection meetings**

Date: December 2018

### Introduction

* 1. It is essential that information provided to the child protection conference and other meetings is relevant, useful and fulfils the requirement of the conference/meeting in order to safeguard the welfare of children. Therefore, all child protection conference/meetings must be attended by the key health professional who must also submit a report in the approved format.
  2. All reports for child protection conferences and meetings submitted by health professionals must follow this agreed format. The only exception is medical examinations which will follow the report format for medical examinations.

### Purpose

* 1. To support staff in their day to day work, improve communication and promote safe outcomes for children
  2. To ensure that all Trust procedures conform to an agreed standard for preparation and attendance at child protection conferences and report writing
  3. To establish clear standards against which the process of attendance at conference and written reports can be audited.

### Objectives of the procedure

* 1. To outline the expected process and format for attendance at child protection conferences.

### Responsibilities

* 1. Health professionals have a responsibility to adhere to this procedure.
  2. Line managers and named safeguarding professionals have a responsibility to support supervisees in relation to this procedure, monitor practice and inform the practitioner’s manager when there are areas for development identified.

### Definitions

* 1. A child protection conference is a multiagency meeting which brings together the child, family and significant others, key professionals involved with the family in order to share information to:
     + Make a judgement on the likelihood of the child/children suffering significant harm
     + Decide what future action is needed to safeguard the child/children and promote their welfare.

### Representation at Child Protection Conferences

* 1. Health representation must be made at all child protection conferences and meetings by key professionals who have a specific contribution to make due to their knowledge of the child and family or their expertise relevant to the case.
  2. The aim of the discussion is to share and plan health input for the family. Subsequent case discussions would be organised in response to additional needs. Either practitioner could request this.
  3. Core group meetings/review child protection conference:
  4. The key health professionals will form the core group and review child protection plan, for the family and child/ren, unless he / she informs the chair and named social worker who will be replacing them providing name, job title and contact details. This will be recorded in the RiO progress notes for each child.
  5. If there is no health representation, the chair of the conference will inform the Safeguarding Children Team who will raise the issue with the individual’s line manager for action.

### Preparation for Child Protection Conferences

* 1. If a health professional is unable to attend a child protection conference, they must ensure a colleague from their own service represents them and presents their report.
  2. There may be occasions when a health professional may request support at a child protection conference due to the complexity of the case or inexperience of the health professional in attending conferences. The health professional should negotiate this with their line manager and/or their Child Protection Supervisor.

### Writing Reports for Child Protection Conferences and other Child Protection Meetings (see Intranet page)

* 1. The report must be typed on the template sent from social care.
  2. A separate report should be produced for each child within the family for which the professional has responsibility.
  3. Where information in the report is either the assessment of other professionals or comes from another source, this must be clearly identified.
  4. Where the health professional’s client is an adult e.g. antenatal or in mental health, then their report will focus more on parenting capacity and family and environmental factors. The report should include an explanation of their condition and care where this has an impact on their ability to care for their children and/or outline what support they will require to care for their children.
  5. Contents of the report must be shared with the parent/carer and child (depending on age and understanding) prior to the conference. The report must be sent to the chair of the conference at least 48 hours prior to the conference.

### Heath Professionals’ responsibility at a Child Protection Conference

* 1. All health professionals attending child protection conferences will share information about their involvement with family or children.
  2. Health professionals will be expected to provide an opinion on whether child/ren discussed is in need of a child protection plan including which category is most suitable based on the information provided at the child protection conference.

### Dissent to the decision regarding the need for a Child Protection Plan

* 1. When a health professional disagrees with the decision regarding the need for a Child Protection Plan, they must clearly state their dissent and request that this and their reason for dissent is documented in the minutes.

### Record Keeping and Minutes

* 1. Attendance at a Child Protection Conference must be recorded in each child’s records by the health professional that attended the conference and should include the following:
     + Date, time and venue of the conference
     + Type of conference attended (initial /review/transfer-in/pre-birth);
     + The decision of the conference including the category if a child protection;
     + Date, time and venue of the next conference (or child in need meeting);
     + Date, time and venue of the Core Group Meeting, if relevant;
     + The main issues/concerns;
     + An outline of the health care plan and the health professional’s responsibilities under the Child Protection Plan.
  2. Child protection conference minutes must be checked for accuracy. If inaccurate they must be amended and returned to the conference chairperson within 7 days of receipt. Failure to do so will result in acceptance of minutes as a true reflection of conference.
  3. Child protection conference minutes must be uploaded to RiO Documents for each child by the health professional. Where the health professional is working with the adults the conference minutes must be uploaded to the adult’s records.
  4. Failure to comply with the agreed child protection plan by any party should be notified to the social worker within 48 hours.

## References

Working together to safeguard children: Statutory guidance on inter-agency working to safeguard and promote the welfare of children (March 2018).

<https://www.gov.uk/government/publications/working-together-to-safeguard-children--2>

London Safeguarding Children Procedures (October 2022).

<http://www.londonsafeguardingchildrenprocedures.co.uk/index.html>

Bedford Borough, Central Bedfordshire and Luton Safeguarding Children Partnership Procedures (November 2022)

<https://bedfordscb.proceduresonline.com/>

# 



## Appendix v

**Protocol for safeguarding sexually active children and young people**

Date: December 2018

### Introduction

* 1. This document is based on the core principle that the welfare of the child is paramount and emphasises the need to accurately assess to what extent there may be a risk of significant harm when a child is engaging in sexual activity. The purpose of this document is to help health professionals identify where children and young people’s sexual relationships may be abusive, and how to take the appropriate action.

### Legal context

* 1. The Sexual Offences Act (2003) introduced a range of offences specifically focusing on the protection of children from sexual exploitation. This legislation prevents the following;
     + Sexual activity with a child.
     + Causing or inciting a child to engage in sexual activity.
     + Engaging in sexual activity in the presence of a child.
     + Causing a child to watch a sexual act.
  2. The legal age of consent to sexual activity is16 years. The law is not intended to prosecute mutually consenting teenage sexual activity between two young people of a similar age unless there is evidence of abuse or exploitation.
  3. A child under the age of 13 is not legally capable of consenting to sexual activity.
  4. Young people under the age of 18 are protected under the ‘Sexual Offences Act’ from sexual abuse by adults who are in positions of trust or authority.

### Indicators of risk

* In order to determine whether a relationship presents a risk of significant harm to a young person, the following factors should be considered:
* Whether the child/young person is competent to understand, and consent to, the sexual activity they are involved in (children under 13 are not legally capable of consenting to sexual activity);
* What the child or young person in the relationship's living circumstances are, whether they are attending school, whether they or their siblings are receiving services from LA Children's Social Care or another social care agency etc.;
* The nature of the relationship between those involved, particularly if there are age or power imbalances
* Whether overt aggression, coercion or bribery was or is involved including misuse of alcohol or other substances as a disinhibition;
* Whether the child/young person's own behaviour, for example through misuse of alcohol or other substances, places him/her in a position where he/she is unable to make an informed choice about the activity; and
* Any attempts to secure secrecy by the sexual partner beyond what would be considered usual in a teenage relationship;
* Whether methods used to secure a child or young person's compliance and trust and/or secrecy by the sexual partner are consistent with grooming for sexual exploitation.
* Whether the sexual partner is known by one of the agencies as having or having had, other concerning relationships with children/young people (which presupposes that checks will be made with the Police);
* Whether the child/young person denies, minimises or accepts the concerns held by professionals.

### Assessment tool

* 1. The process of assessment must be undertaken in a consistent and comprehensive manner by practitioners who have the relevant knowledge and skills.
  2. The Risk Assessment Tool (See Appendix 1) is designed to assist practitioners to identify and assess the risk of abuse when delivering sexual health services to children and young people in order to identify the appropriate response.

Practitioners should also be familiar with the accompanying guidance in Appendix 2 prior to using the Risk Assessment Tool.

* 1. Once completed the Risk Assessment Tool should supplement any other records generated by the practitioner for the child/young person.
  2. The Risk Assessment Tool is not substitute for the practitioner’s professional judgement or supervision from their manager and/or from the Named Nurse or Doctor for Child Protection.

### Referral to Children’s Social Care

* 1. The decision whether or not to make a formal referral to Children’s Social Care must be made within the supervision arrangements within an agency for making such a decision.
  2. Whenever there is reasonable cause to suspect that a child is suffering, or is likely to suffer significant harm a referral should be made to Children’s Social Care of the Borough in which the child resides.

### Where there are no concerns

* 1. Where the practitioner knows that a young person 13 or over is sexually active but the practitioner’s assessment does not raise concerns that the young person’s sexual relationship is abusive, the practitioner should continue to make arrangements for the young person to receive confidential advice and support.

### Children under the age of 13

* 1. A child under 13 is not legally capable of consenting to sexual activity.
  2. Under the Sexual Offences Act 2003, penetrative sex with a child under 13 is classed as rape. A referral should be made to Children’s Social Care and be reported to the police. All cases involving under 13s should be fully documented, including giving detailed reasons where the decision is taken ‘not’ to share information.

### Children aged 13 years to their 16th birthday

* 1. Young people below the age of consent have a right to access sexual health services and to have their rights to confidentiality respected (FPA 2016)
  2. However, sexual activity with a child under 16 is also an offence. Where it is consensual, Practitioners should consider whether they should initiate a discussion with Children’s Social Care about the risk of harm to the child and whether a referral should be made. Where a decision is made not to refer to Children’s Social Care and /or the police has made the rationale for this decision, then this decision must be documented in the young person’s records.

### Young people from the age of 16 until their 18th birthday

* 1. Sexual activity involving a 16 or 17 year old, though unlikely to involve an offence, may still involve harm or the risk of harm. Professionals should still bear in mind the considerations and processes outlined in this document in assessing that risk, and should share information as appropriate.
  2. 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.

### Record keeping

* 1. The completed Risk Assessment Tool should supplement any other records generated by the practitioner for the child / young person.
  2. Any decision made by the practitioner with regard to potential risk of harm should be recorded in the child /young person’s records accompanied by their rationale for that decision.

### References

Department of Health (2004). Best practice guidance for doctors and other health professionals on the provision of advice and treatment to young people under16 on contraception, sexual and reproductive health. Crown Copyright

Sexual Offences Act (2003). London: HMSO [online] Available at: <http://www.legislation.gov.uk/ukpga/2003/42/contents>

Rogstad K, & Johnson G. (2014) Spotting the signs: A national proforma for identifying risk of child sexual exploitation in sexual health services. Brook & BASHH

London Safeguarding Children Board: London Child Protection Procedures 2022 Available at: <https://www.londonsafeguardingchildrenprocedures.co.uk>

Pan Bedfordshire Safeguarding Children Board: Pan Bedfordshire Child Protection Procedures 2022 available at <https://bedfordscb.proceduresonline.com/>

HM Government (2018) Working together to Safeguard Children Available at: [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\_data/file/7](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/729914/Working_Together_to_Safeguard_Children-2018.pdf) [29914/Working\_Together\_to\_Safeguard\_Children-2018.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/729914/Working_Together_to_Safeguard_Children-2018.pdf)

The Children’s Act (2004) London: HMSO [online] Available at: <http://www.legislation.gov.uk/ukpga/2004/31/contents>

### Section a of Appendix v Risk Assessment Tool

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Risk Assessment (sexually active young person)** | | | | | | | | |
| Family name: | First name: | | | | Date of birth: Age: | | Address: | |
| School: | Clinic number: | | | | NHS number: | |
| **Age and competency** | | | | | | **Notes** | | **Level of concern** |
| Is the child/young person competent to understand, and consent to, the sexual activity they are involved in? | | No | Unsure | Yes | |  | |  |
| Age of young person | | Under 13 years | 13-15  years | 16-17  years | |  | |  |
| **Young person’s circumstances** | | | | | | **Notes** | | **Level of concern** |
| Are the living circumstances of the child or young person secure and supportive? | | | Yes | No | |  | |  |
| Does the young person attend school? | | | Yes | No | |  | |  |
| Does the young person live with their parents? | | | Yes | No | |  | |  |
| Has the young person experienced domestic violence? | | | Yes | No | |  | |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Does the young person or their siblings receive services from local authority children’s social care or another social care agency? | Yes | No |  |  |
| Is the young person looked after by the local authority? | Yes | No |  |  |
| Is the young person homeless, living in a hostel or staying temporarily somewhere? | Yes | No |  |  |
| Is the child or young person in any way disabled or learning disabled or does s/he have a communication difficulty? | Yes | No |  |  |

**Notes Level of concern**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Experience of sexual / intimate relationships** | |  |  |  |
| Age of first sexual experience? | Under 13 13-15 16-17  years years years | |  |  |
| Age of partner |  |  |  |  |
| **Relationship details** | | |  |  |
| Are you having sexual contact with anyone? | | |  |  |
| How old is the person you are having sexual contact with? | | |  |  |
| Where did you meet this person? | | |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| How many people have you had sexual contact with in the past three months? | | |  |  |
| Where do you spend time together? | | |  |  |
| Is the age differential greater than 5 years? | Yes | No |  |  |
| Is the relationship between those involved equal and consensual or are there power imbalances? | Yes | No |  |  |
| Are coercion or seduction / bribery involved including misuse of alcohol or other substances as a disinhibitor? | Yes | No |  |  |
| Has the sexual partner made attempts to secure secrecy beyond what would be considered usual in a teenage relationship? | Yes | No |  |  |
| Are the methods used to secure a child or young person’s compliance and trust and/or secrecy by the sexual partner consistent with grooming for sexual exploitation? | Yes | No |  |  |
| Is the sexual partner known by one of the agencies as having or having had, other concerning relationships with children/young people? | Yes | No |  |  |
| Does the child/young person deny, minimise or accept the concerns held by professionals? | Yes | No |  |  |
| Does the child/young person’s own behaviour, for example through misuse of alcohol or other substances, place him/her in a position where he/she is unable to make an informed choice about the activity? | Yes | No |  |  |

**Plan** (see guidance that accompanies this risk assessment tool)

Staff name: Signature

Date of assessment:

|  |  |  |  |
| --- | --- | --- | --- |
| Appendix 2 – Practitioner Guidance for the Risk Assessment Tool for (sexually active child or young person) | | | |
| 1. The indicators for concern should be assessed using professional judgement and individually rated as HIGH, MEDIUM or LOW risk. 2. A single occurrence of HIGH would be sufficient to generate a referral to police and LA children’s social care. 3. Two or more occurrences of MEDIUM would be sufficient to generate a referral to police and LA children’s social care. 4. Assessments of risk below these thresholds may also be referred to the police and LA children’s social care. 5. Confidentiality is never absolute and, in most cases, competent professionals will be able to articulate the need for information from the police in a manner that does not undermine the integrity of the agency. 6. Decisions not to refer to the police and LA children’s social care must be made within the agency’s supervision arrangements and at first line manager level or above. | | | |
| Age and competency | Considerations for assessment | | |
| Is the child/young person competent to understand, and consent to, the sexual activity they are involved in? | Competence is relative to the seriousness of the situation. The less a child or young person is able to appreciate the risks involved in their sexual relationship the less s/he is likely to be able to protect her/himself. | No | Seek advice from a Named Professional for safeguarding children |
| Unsure | Document any concern and consider seeking advice from the safeguarding team |
| Yes | Continue to provide a confidential service to the young person. |
| Age of young person | Children under 13 years old are not legally capable of consenting to sexual activity (Sexual Offences Act 2003). Where a practitioner is concerned that a child is involved with penetrative sex, or other intimate sexual activity, there will always be reasonable cause to suspect that a child, whether girl or boy, is suffering or is likely to suffer significant harm. | Under 13  years old | Seek advice from a Named Professional for safeguarding children regarding referral to children’s social care and/or the police. |
| 13-15 years old | Document any concern and consider seeking advice from the safeguarding team. |
| 16-17 years old | Document any concern and consider seeking advice from the safeguarding team. |
| Young person’s circumstances | Considerations for assessment | | |
| Are the living circumstances of the child or young person secure and supportive? | Children and young people whose home / social / school circumstances  are not robust are likely to have lower self-esteem and less resilience and are therefore more vulnerable to coercion. They are less likely to be able to resist forceful or seductive sexual advances. | | Document, including level of concern and consider seeking advice from a Named Professional for Child Protection. A high level of concern should always result in consultation with a Named Professional for Child Protection. |
| Does the young person attend school? |
| Does the young person live with their parents? |
| Has the young person experienced domestic violence? |

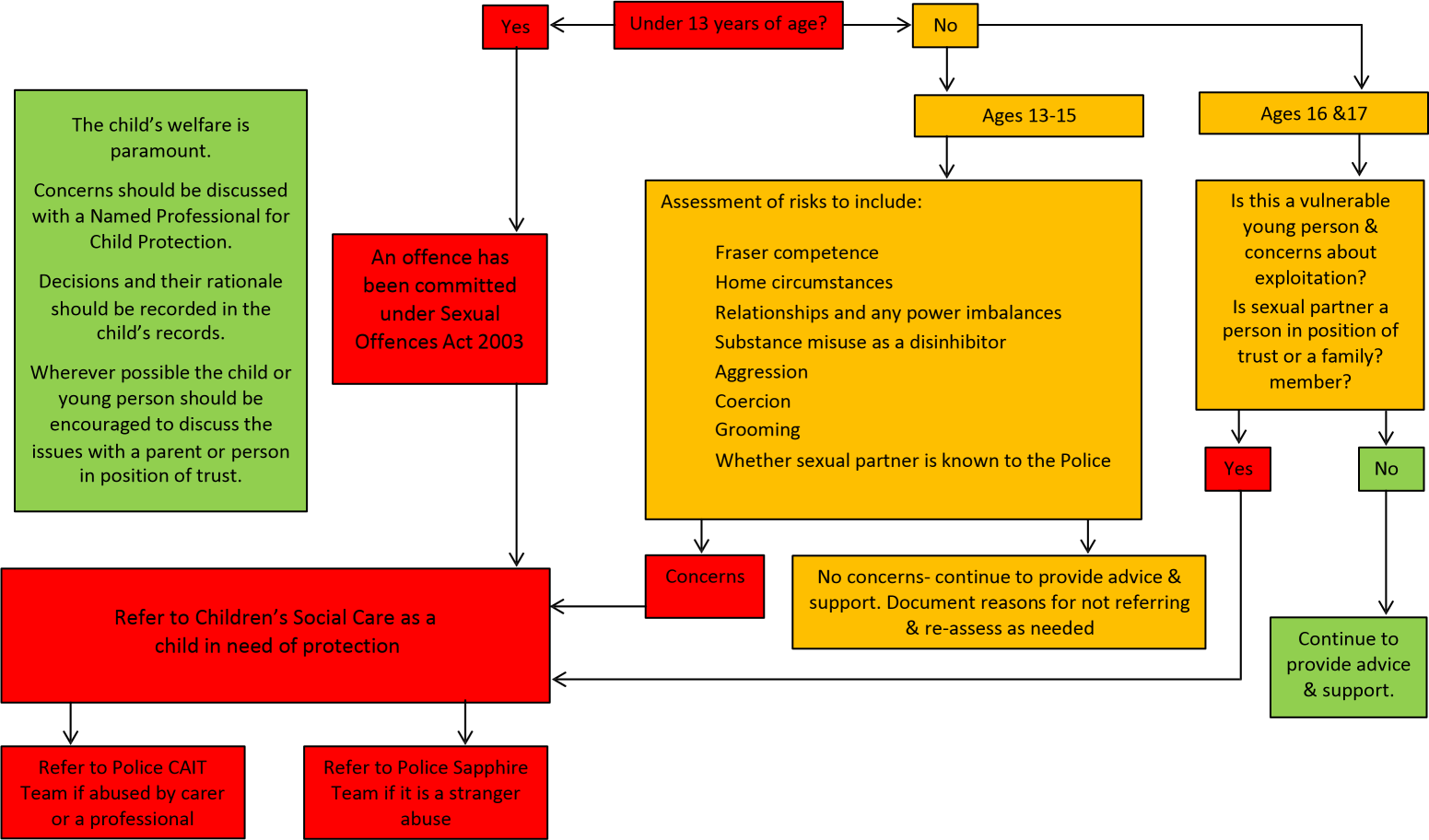
|  |  |  |
| --- | --- | --- |
| Does the young person or their siblings receive services from local authority children’s social care or another social care agency? |  |  |
| Is the young person looked after by the local authority? |  |  |
| Is the young person homeless, living in a hostel or staying temporarily somewhere? |  |  |
| Is the child or young person in any way disabled or learning disabled or does s/he have a communication difficulty? | Disabled children and young people are more likely to be abused than non-disabled children. |  |

|  |  |  |
| --- | --- | --- |
| **Experience of sexual / intimate relationships** | **Considerations for assessment** |  |
| Age of first sexual experience? | See section on age and competency |  |
| Is the relationship between those involved equal and consensual or are there power imbalances? | These can result from differences in size, age, material wealth and/or psychological, social and physical development. In addition gender, sexuality, race and levels of sexual knowledge can be used to exert power. A large age differential could be a key indicator (e.g. 5 years or more) There can also be bullying present where the children and young people are in a similar age relationship. There may also be instances when the sexual predator is a woman or girl and the victim is a boy. A child or young person is considered unable to give consent if the sexual partner is in a position of trust or is a family member (Sexual Offences Act 2003; and/or any pre-existing legislation). | Document, including level of concern and consider seeking advice from a Named Professional for Child Protection. A high level of concern should always result in consultation with a Named Professional for Child Protection. |
| Is coercion or seduction / bribery involved including misuse of alcohol or other substances as a disinhibitor? | A child or young person may not see the activities of another as aggressive, coercive or seductive. Similarly they may be unaware and reluctant to recognise that drugs and alcohol are offered to facilitate sex or sexual exploitation. |  |
| Has the sexual partner made attempts to secure secrecy beyond what would be considered usual in a teenage relationship? | Practitioners should seek advice and supervision about what would be considered a usual degree of secrecy in a teenage relationship, if they are unsure. |  |

|  |  |  |
| --- | --- | --- |
| Are the methods used to secure a child or young person’s compliance and trust and/or secrecy by the sexual partner consistent with grooming for sexual exploitation? | Adults and young people who are paedophiles are extremely adept at presenting themselves as benevolent (gifts, help, money) and trustworthy (friend of the family or responsible older friend).  Adults and young people who are pimps may develop the relationship with the young person first, including by offering them money or drugs, before coercing them into prostitution.  Children and young people who begin taking illegal substances are likely to need protection irrespective of their views. |  |
| Is the sexual partner known by one of the agencies as having or having had, other concerning relationships with children/young people? | In cases of concern, when sufficient information is known about the sexual partner/s, the agency concerned should check with other agencies, including the police, to establish whatever information is known about that person/s. |  |
| Does the child/young person deny, minimise or accept the concerns held by professionals? | Protecting a child or young person from harm depends on a practitioner scrupulously assessing the child or young person’s true position – rather than a possible position by the child or young person as a line of least resistance or in order to avoid the involvement of other agencies. |  |
| Does the child/young person’s own behaviour, for example through misuse of alcohol or other substances, place him/her in a position where he/she is unable to make an informed choice about the activity? | Anyone who takes advantage of a child or young person’s temporary disinhibition or incapacity for sexual purposes, whether by accident or design, does so without consent. The sexual activity is always unlawful. |  |

*ELFT Safeguarding Children Policy February 2023*

#### Section b of appendix v - Safeguarding Sexually Active Children & Young People



*ELFT Safeguarding Children Policy February 2023*