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HPFT

Safeguarding Children Policy and Procedures

HPFT Policy and Procedure

Version	5.2
Executive Lead	Executive Director of Quality and Safety
Lead Author	Consultant Nurse Safeguarding Children
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Target Audience	This Policy must be understood by: All HPFT staff working directly or indirectly with children

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Title of document	Safeguarding Children		
Document Type	Policy and Procedure		
Ratifying Committee	Safeguarding Strategy Group		
Version	**Issue Date**	**Review Date**	**Lead Author**
V5.2	02/02/2022	24/02/2024	Consultant Nurse Safeguarding Children
Staff need to know about this policy because (complete in 50 words)	The Trust's duty under Section 11 of the Children Act (2004), is wider than child protection. To be effective it requires staff members to acknowledge their individual responsibility for safeguarding and promoting the welfare of children as well as the commitment of Trust management to support them in this. The Trust will ensure that all staff have access to expert advice, support and training in relation to safeguarding children.		
Staff are encouraged to read the whole policy but I (the Author) have chosen three key messages from the document to share:	Effective safeguarding children and young people arrangements are underpinned by three key principles: • Safeguarding is everyone's responsibility; for services to be effective each professional in every organisation should play their full part. • A child centred approach based on clear understanding of the needs and views of children and young people. • A Think Family approach should be applied by all clinicians, regardless of whether they work in children's or adult services		
Summary of significant changes from previous version are:	Think Family approach COVID Impact Assessment Child Criminal Exploitation Sexual Assault & Referral Centres (SARC) Contextual safeguarding- definition & examples Modern Day Slavery including National Referrals Mechanism Harmful Sexual Behaviour Domestic Abuse- Coercive control, Young People's DASH risk assessment, MARAC Adolescent to Parent Violence & Abuse Definition of forced marriage, forced marriage protection orders & support services		

	Honour Based Abuse Helpline FGM Pathway & FGM Protection Orders Escalation Process for Professional Disagreements Service users as alleged perpetrators of child abuse V5.2: Appendices 1 & 2 updated

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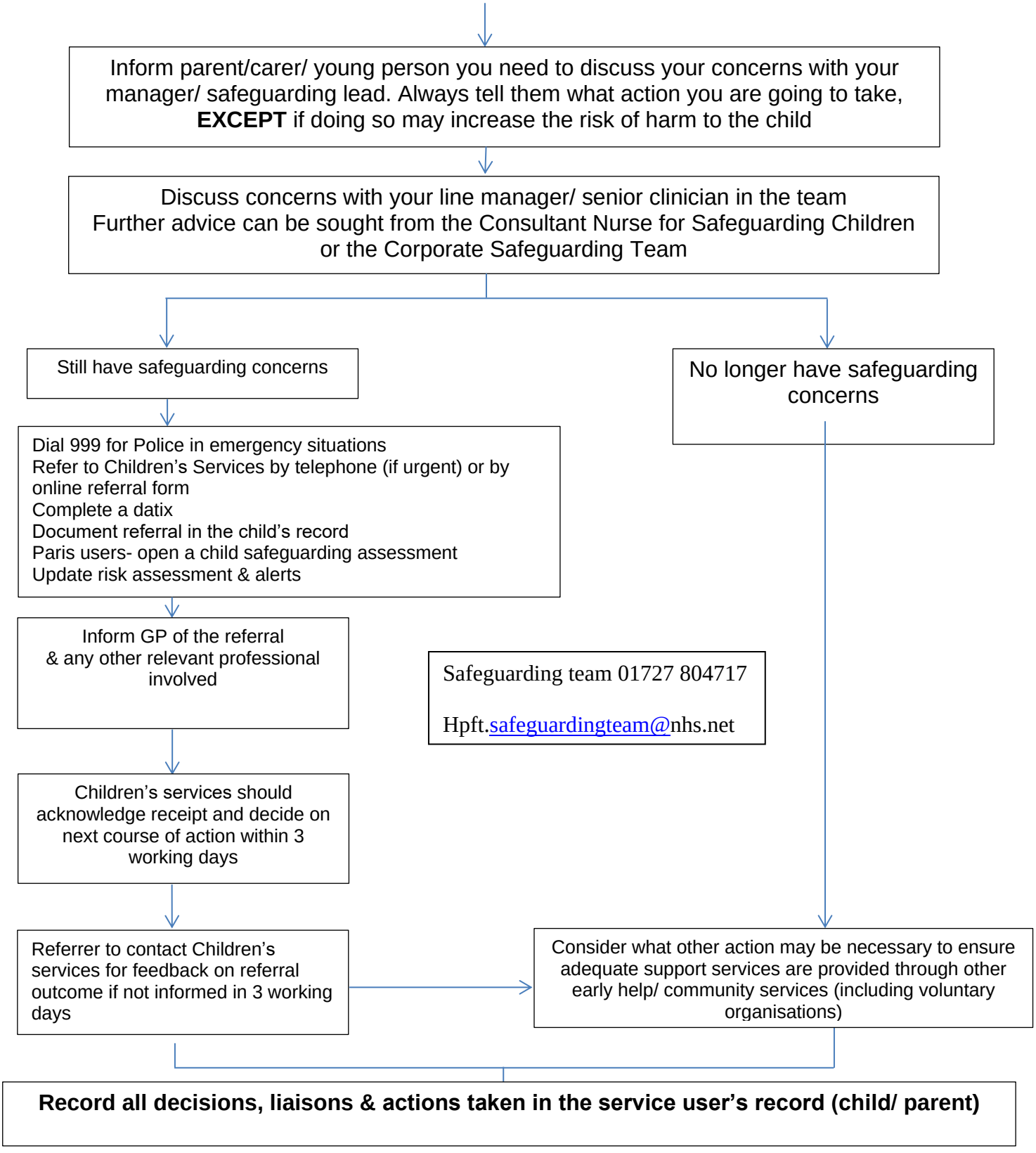
1.0 Safeguarding Children: Referral flowchart

Immediate response to concerns about a child or young person's welfare

Staff member has safeguarding concerns about a child



2.0 Introduction

The aim of this document is to enable HPFT to meet its' statutory requirements to safeguard and promote the welfare of children by ensuring staff have access to policies and practice guidance describing their responsibilities. HPFT also has to

comply with Care Quality Commission (CQC): Regulation 13- Safeguarding service users from abuse and improper treatment.

The principle legislation & guidance underpinning this policy are:

- Children Act 1989
- Children Act 2004
- Children & Social Work Act 2017
- Working Together to Safeguard Children 2018

The Trust's duty under Section 11 is, therefore, wider than child protection. To be effective it requires staff members to acknowledge their individual responsibility for safeguarding and promoting the welfare of children, as well as the commitment of Trust management to support them in this. The Trust will ensure that all staff have access to expert advice, support and training in relation to safeguarding children.

Therefore, effective safeguarding children and young people arrangements are underpinned by three key principles:

- Safeguarding is everyone's responsibility; for services to be effective each professional in every organisation should play their full part.
- A child centred approach based on clear understanding of the needs and views of children and young people.
- A Think Family approach should be applied by all clinicians, regardless of whether they work in children's or adult services. This means considering the health & welfare of all family members and the implications mental illness or a learning disability has upon the functioning or the family unit. Clinicians therefore have a responsibility to safeguard children and or adults in a household, regardless of whether the person at risk is their service user/ patient or not.

The Children Act 2004, as amended by the Children & Social Work Act 2017, strengthens important local duties for three key agencies: the police, clinical commissioning groups (CCGs) & the local authority. Together they lead the local Safeguarding Children Partnerships.

This policy is complimentary to and should be used in conjunction with the safeguarding children policy & procedures of the Hertfordshire, Buckinghamshire, Essex & Norfolk Safeguarding Children Partnerships.

You will find referral forms, guidance and more information on Safeguarding - The Hive

3.0 Scope and Definitions

This policy is aimed at protecting all children:

- who are open to a HPFT service,

- who come into contact with HPFT staff,
- or whom HPFT staff have concerns about

It is applicable to all staff providing healthcare services to children & adults and includes those employed under contractual arrangements, volunteers, students & trainees.

3.1 Definition of a Child:

A 'child' is anyone who has not yet reached their 18th birthday. The fact that a child has reached 16 years of age, is living independently or is in further education, is a member of the armed forces, is in hospital, or in custody, does not change his/her status or entitlement to services or protection under the Children Act 1989 & 2004.

The needs of the unborn child must be considered as well as any child under the age of 18 years as research indicates that the impact of adverse childhood experiences (ACEs) can be life-long; intervention to ensure their future well-being is encompassed within safeguarding children practice.

When safeguarding concerns arise in relation to those aged 18 years and over, the HPFT Safeguarding Adult Policy should be adhered to.

3.2 Definition of Safeguarding Children

Working Together (2018) defines safeguarding & promoting the welfare of as:

- Protecting children & young people from maltreatment
- Preventing impairment of children & young people's health or development
- Ensuring that children & young people are growing up in circumstances consistent with the provision of safe & effective care
- Taking action to enable all children & young people to have the best outcomes

3.3 Safeguarding children includes the following:

- Recognition of the child's needs where they live with the toxic trio (domestic abuse, parental mental health issues and substance/ alcohol misuse) (Brandon et al 2009).
- Assessment of needs, planning and reviewing progress against actions to ensure children are kept safe, utilising a multi-agency 'think family' approach (HM Government, 2007).

3.4 Definition of Child Protection

Child protection refers to the activity which is undertaken to protect specific children who are suffering or are likely to suffer significant harm. This is the threshold that justifies compulsory intervention in family life in the best interests of children and gives the local authority a duty to make enquiries to decide whether they should take action to safeguard and promote the welfare of a child who is suffering or likely to suffer significant harm. There are no absolute criteria for judging what constitutes

significant harm. However, consideration of the severity of ill-treatment may include; the degree and the extent of physical harm, the duration and frequency of abuse or neglect, the extent of premeditation and the presence or degree of threat, coercion, sadism and bizarre or unusual elements. It may constitute a single traumatic event, or more often is a compilation of significant events, both acute and long standing which interrupt, change or damage the child's physical or psychological development.

3.5 Definition of Children in Need

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

3.6 Definition of Early Help

Providing early help is more effective in promoting the welfare of children than reacting later. Early help means providing support as soon as a problem emerges, at any point in a child's life, from the foundation years through to the teenage years. Early help can also prevent further problems arising, for example, if it is provided as part of a support plan where a child has returned home to their family from care, or in families where there are emerging parental mental health issues or drug and alcohol misuse.

Effective early help relies upon local agencies working together to:
• identify children and families who would benefit from early help;
• undertake an assessment of the need for early help; and
• provide targeted early help services to address the assessed needs of a child and their family, which focuses on activity to significantly improve the outcomes for the child.

Local authorities, under section 10 of the Children Act 2004, have a responsibility to promote inter-agency cooperation to improve the welfare of children.

Practitioners should be alert to the potential need for early help for a child who (HM Government, 2018):

• is disabled and has specific additional needs
• has special educational needs (whether or not they have a statutory Education, Health and Care Plan)
• is a young carer
• is showing signs of being drawn into anti-social or criminal behaviour, including gang involvement and association with organised crime groups
• is frequently missing/ goes missing from care or from home
• is at risk of modern slavery, trafficking or exploitation (including forced labour & domestic servitude
• is at risk of being radicalised or exploited
• is in a family circumstance presenting challenges for the child, such as drug and alcohol misuse, adult mental health issues and domestic abuse – TOXIC TRIO
• is misusing drugs or alcohol themselves
• has returned home to their family from care

• is a privately fostered child

4.0 Duties and Responsibilities Within the Organisation

4.1 Lead Directors for Safeguarding Children

The Chief Executive is ultimately responsible for ensuring that the Trust meets its obligations with regard to safeguarding children. The Lead Director for safeguarding is the Director of Quality and Safety, this post-holder is also the Trust's Caldicott Guardian.

4.2 The Head of Social Work & Safeguarding

- Is the strategic lead for safeguarding, responsible for leading the work on safeguarding children & adults across the Trust services, to ensure the Trust meets its statutory responsibilities.

4.3 Consultant Nurse for Safeguarding Children and Named Doctor Safeguarding Children

All NHS Trusts providing services for children should identify a Named Nurse and Named Doctor for safeguarding. The Named Nurse and Named Doctor for Safeguarding Children work in conjunction with the Head of Social Work & Safeguarding and are responsible for:

- Taking the professional lead in safeguarding children matters across the Trust
- Quality assurance of practice and performing audits
- Ensuring a safeguarding children training strategy is in place and delivered within the organisation
- Promoting good professional practice and providing specialist advice and expertise to all staff
- Facilitate safeguarding practice reviews and management reviews and oversea the completion of learning/action plans
- Represent the Trust at sub groups of the local safeguarding children partnership and other multi-agency meetings.

4.4 Heads of services and managers are responsible for ensuring their services meet these requirements.

4.5 The Role of All Staff

It is the role and responsibility of each member of staff to:

- Be alert to the potential indicators of abuse and neglect
- Be alert to the risks of harm that individual abusers, or potential abusers may pose to children
- Identify children in a service user's family who may be suffering or at risk of suffering significant harm from abuse or neglect
- Take action and make a referral to Children's Services when child abuse/ neglect is identified
- Contribute to Section 47 Child Protection investigations, subsequent child protection conferences and reviews
- Contribute to Children's Social Care assessments and planning

- Accept the principle that agencies work together in order to ensure health and social care is appropriately co-ordinated and children are protected from suspected or actual abuse. Staff are expected to maintain close links with all relevant statutory agencies in the pursuit of achieving protection for children
- Provide information for other agencies and Courts where appropriate and necessary
- Identify when the impact of a service users mental illness, substance misuse or learning disability is impairing his / her child's health or development. This will lead to taking action to safeguard the child including adapting the care and treatment plan for the adult
- Contribute to multi agency assessments of children and their families
- Co-operate with safeguarding reviews and with serious incident investigations
- Seek advice from the safeguarding team, Consultant Nurse or the Named Doctor for safeguarding children as required
- Document all liaisons, decisions, supervision and actions taken in relation to safeguarding, in the electronic patient record (EPR)
- Be familiar with the safeguarding children policy and procedures and own role and responsibilities within it
- Ensure mandatory safeguarding training is up to date

5.0 Assessment of Risk During the COVID-19 Pandemic

Children will continue to be abused during pandemics. Even in challenging times, we still have a duty to safeguard children & their families. We must remain vigilant to children & adults who may be experiencing abuse whilst isolated within their homes. We must also identify families in crisis or those at increased risk of domestic abuse.

Those at higher risk may be:

- Children on protection plans/ children in need/ looked after children, as their usual support systems are not available
- Families under additional stress- financial pressures, isolation, home schooling

5.1 Tips for Assessing & Responding to Safeguarding Concerns When Using Online Platforms eg MS Teams include:

- Taking time to prepare before the consultation- review risk assessments/ history/ previous safeguarding concerns/ current status eg child protection/ child in need/ LAC/ care leaver, any known current or historic domestic abuse?
- Ask who else is present in the home
- Consider if anyone could be listening to the consultation
- Ask about current support/ social networks- encourage virtual social contact
- Ask if they feel safe
- Consider asking closed questions (requiring a yes/ no answer) when enquiring about safety
- Signpost to online support- have details readily available to share

PART 2 – Identifying Abuse & Neglect & Other Types of Harm to Children & Young People

6.0 Categories of Abuse (HM Government, 2015).

6.1 Physical abuse

It 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.

Suspected Fabricated or Induced illness (FII) in a Child

Physical harm may also be caused when a parent or carer fabricates the symptoms or deliberately induces illness in a child. Staff should alert the Named Doctor or Nurse if they are concerned about FII. These professionals are responsible for ensuring that HPFT staff works closely with other agencies and professionals in assessing risks to the child and in ensuring that a coordinated response is initiated.

Bruising in pre-mobile babies must be immediately reported to children's services by telephone. All locality safeguarding children partnerships will have a multi-agency policy on physical abuse of babies. Remember that babies that don't cruise, don't bruise. If you see a bruise/ mark on a pre-mobile baby (generally less than 6 months old), you must inform the parent/ carer of your duty to report it to children's services. A child protection medical and a strategy meeting should take place the same day. Inform the parent/ carer the medical examination is to rule out an organic cause for the bruise. It is important to document the reason you are given for the bruise, the location and size. It is impossible to say if it is a new/ old bruise due to differences in skin colouring and bruise presentations.

Management of Suspicious Bruises/Marks in Infants under 6 Months video - The Hive

HSCP Bruising Policy Essex/ Bucks & Norfolk all have similar policies

6.2 Emotional abuse

It 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
- not giving the child opportunities to express their views, deliberately silencing them or 'making fun' of what they say or how they communicate
- imposing age or developmentally inappropriate expectations on children and young people
- overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction
- seeing or hearing the ill treatment of another (domestic abuse)
- serious bullying (including cyber bullying), causing children and young people to feel frequently frightened or in danger
- the exploitation or corruption of children and young people

- emotional abuse is involved in all types of maltreatment of a child though it may occur alone

6.3 Neglect

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

- Provide adequate food, clothing and shelter (including exclusion from home or abandonment);
- Protect a child from physical and emotional harm or danger;
- Ensure adequate supervision (including the use of inadequate care-givers); or,
- Ensure access to appropriate medical care or treatment (please consult the HPFT Did Not Attend/ Not Brought In Policy)
- It may also include neglect of or unresponsiveness to a child's basic emotional needs.

6.4 Sexual Abuse

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

7.0 Children aged under 13 who are sexually active

HPFT professionals are required to make a referral to Children's Services and the Police about all young people aged less than 13 years who are sexually active. Sexual activity between or involving 12 year olds is consider an offence under Sexual Offences Act 2003 (and statutory rape if sexual intercourse has taken place) as legislation holds that a child under 13 does not, under any circumstances, have the legal capacity to consent to any form of sexual activity.

Although the age of consent remains at 16, the law is not intended to prosecute mutually agreed teenage sexual activity between two young people of a similar age, unless it involves abuse or exploitation. Young people, including those under 13, will continue to have the right to confidential advice on contraception, pregnancy and abortion.

The link below is to an NSPCC factsheet about Gillick competence and the Fraser guidelines, regarding consent for young people aged 13-15 years.

https://learning.nspcc.org.uk/media/1541/gillick-competency-factsheet.pdf

8.0 Child Sexual Exploitation

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

Intelligence on suspected perpetrators of abuse or suspected venues where CSE may be taking place can be reported to the police on 101 or in Herts only: HALO Police Reporting Form

9.0 Sexual Assault Reporting Duties

ALL assaults to a child under 13 years old must be urgently reported to the police & children's services (by telephone), as this is a statutory offence
Sexual Offences Act 2003

Sexual abuse/ assaults against children (up to the age of 18 years) are a crime and as such must be reported to the police & children's services. This includes peer on peer assaults and is regardless of whether the child has or can identify the perpetrator. Please note that children's services also have a legal obligation to share information about crime with the police. Information sharing (2018) guidance states; 'If it is thought that a crime has been committed and/or a child is at immediate risk, the police should be notified immediately.' Even if the chances of a criminal conviction are low, it is important the assault is reported and recorded on children's services & police systems, as they may be in possession of additional information with regards to the safeguarding of the child.

In Essex, Bucks & Norfolk report the incident to the police on 101.

In Herts you can either report an incident to the police via 101 or you can email the police safeguarding hub on hqsafeguarding@herts.pnn.police.uk. If there are specific case complexities you wish to discuss with the police to help plan an appropriate response, for example due to the mental health presentation of the child, please phone the Herts Police Safeguarding Hub on 01707 355391 (Mon-Fri 9-5pm).

The child must be signposted to the local Sexual Assault Referral Centre (SARC), for a forensic medical examination (for acute assaults only), advice on their sexual health and to receive support from an Independent Sexual Violence Advisor (ISVA) or to receive counselling. Forensic examinations should occur as soon as possible in the days following an assault, but certainly within 7 days. SARCs can store forensic samples for up to 7 years, allowing the victim time to consider whether they wish to pursue a criminal conviction.

ISVA Service - Herts SARC Essex SARC- Oakwood Place

Sexual Assault | Sexual Health Bucks- Bicester & Slough

The Harbour Centre- Norfolk

If a child declines a referral to the SARC, they must be referred to the GP or a sexual health clinic for consideration of emergency contraception and screening for sexually transmitted infections.

Referral forms and guidance documents can be found on The Hive- Safeguarding Children- SARC

10.0 Child Criminal Exploitation

Child criminal exploitation (CCE, common in county lines) occurs where an individual or group takes advantage of an imbalance of power to coerce, control, manipulate or deceive a child or young person under the age of 18. The victim may have been criminally exploited even if the activity appears consensual. CCE does not always involve physical contact; it can also occur through the use of technology.

CCE is broader than just county lines, and includes for instance children forced to work on cannabis farms or to commit theft. Criminal exploitation of children and vulnerable adults: county lines - GOV.UK

Cuckooing is a term used to describe the situation where gangs/ people take over a person's home to use it as a base for drug dealing. Often it is vulnerable people who are targeted.

11.0 Contextual safeguarding (HM Government, 2018)

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. Contextual safeguarding refers to these extra-familial threats that may arise at school and other educational establishments, from within peer groups, or more widely from within the community/ neighbourhood 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 (child criminal exploitation)
- trafficking
- online abuse
- sexual exploitation
- the influences of extremism leading to radicalisation. Extremist groups make use of the internet to radicalise & 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

12.0 Counter Terrorism/Radicalisation – PREVENT Strategy

Radicalisation is the process through which a person comes to support or be involved in extremist ideologies. It can result in a person becoming drawn into terrorism and is in itself a form of harm.

Extremism is vocal or active opposition to fundamental British values, including democracy, the rule of law, individual liberty and mutual respect and tolerance of different faiths and beliefs. It includes calls for the death of members of the British armed forces.

Prevent is one element of the counter terrorist strategy. It works with individuals who are identified as potential victims of radicalisation, before they may go on to commit any criminal offences.

Please refer to the HPFT Prevent Policy for details of how to make a Prevent referral.

A one off mandatory e-learning training must be completed- see Discovery.

13.0 Modern Slavery

The Modern Slavery Act 2015 includes the following offences:

- **Slavery, servitude & forced labour**- holding another person in slavery or servitude or requiring someone to perform compulsory labour (applies to children & adults)
- **Human Trafficking**- arranging or facilitating the travel of another person with a view to them being exploited (travel can be international or regional)

Exploitation includes slavery & forced labour, sexual exploitation, removal or organs, securing services by force, threats or deception & securing services from children & vulnerable people.

This Act may be used to prosecute offenders in cases of child criminal exploitation or child sexual exploitation. Spot the Signs of Modern Slavery and Exploitation | Unseen

Actions required if you **suspect** a child is a victim of modern slavery (very low threshold for referral- you only need to suspect):

1. Call 999 if the child is in imminent danger/ at immediate risk or significant harm or going missing- stay with the child & take advice from the police on next steps
2. Complete a child safeguarding referral- if urgent telephone children's services & follow up with a written referral. If you suspect family members/ care givers are the perpetrators, then do not under any circumstances discuss your concerns with them
3. Intelligence can be report to the police by telephoning 101
4. Complete a Datix & update risk assessment & alerts on the record

The National Referral Mechanism (NRM) is a framework for identifying and referring potential victims of modern slavery and ensuring they receive the appropriate support. The police & children's services can make a NRM referral, at present NHS

staff are unable to do so. A referral must be made for all victims known or suspected to be under the age of 18 years, their consent is not required. They must be safeguarded prior to being referred to NRM.

Resources:

- Operation Tropic (Hertfordshire Constabulary Modern Slavery Unit): RModernSlavery@herts.pnn.police.uk (for advice on a case)
- Modern Slavery Helpline: **08000 121 700** (+ translation support)
- Independent Child Trafficking Guardian Service advice line: **08000 43 43 03**
- Herts Victim Referral Pathways (Child & Adult)
- HSCP Modern Slavery Multi-Agency Procedures

14.0 Harmful Sexual Behaviours

Harmful sexual behaviour (HSB) is developmentally inappropriate sexual behaviour which is displayed by children and young people, which may be harmful or abusive. It may also be referred to as sexually harmful behaviour or sexualised behaviour.

HSB encompasses a range of behaviour, which can be displayed towards younger children, peers, older children or adults. It is harmful to the children and young people who display it, as well as the people it is directed towards.

Technology assisted HSB

Technology assisted HSB (TA-HSB) is sexualised behaviour which children or young people engage in using the internet or technology such as mobile phones. This might include:

- viewing pornography (including extreme pornography or viewing indecent images of children)
- sexting

(NSPCC, 2020)

Research indicates that many children and young people charged with criminal offences relating to harmful sexual behaviour, had previously been referred to children's services, but their sexual behaviour was either not recognised or dismissed. Data indicates that children and young people with learning disabilities are over-represented among those in the criminal justice system. HSB can be an expression of other problems or underlying vulnerabilities. Harmful sexual behaviour among children and young people | Guidance | NICE (2016)

15.0 Domestic Abuse

Domestic violence is a pattern of controlling behaviour against a family member, an intimate partner or ex-partner, that includes but is not limited to physical assaults, sexual assaults, emotional abuse, isolation, economic abuse, threats, stalking and intimidation. It is important to recognise coercive control as a complex pattern of overlapping and repeated abuse, perpetrated within a context of power and control.

Victims are aged 16 years and above. It can happen to anyone regardless of their social group, class, age, race, disability, gender, sexuality or lifestyle.

Domestic Abuse impacts children significantly. Witnessing the abuse of others has a psychological and physiological impact on children's development.

It is important to understand the links between domestic abuse, substance misuse and parental mental health issues (toxic trio), as they are often found in cases where children have suffered significant harm.

The Serious Crime Act 2015 made controlling or coercive behaviour in an intimate or family relationship an offence. Consider reporting controlling or coercive behaviour to the police on 101 if there are risks of serious harm or domestic homicide.

When working with a young person who is experiencing relational abuse, you can complete a Domestic Abuse Stalking & Harassment (DASH) risk assessment. You can only refer victims aged 16 years & over to the Multi-Agency Risk Assessment Conference (MARAC), if you have 14 ticks on the form or on professional judgement of risk of significant harm or death. You would also need to do a child safeguarding referral & seek consent to refer them to an Independent Domestic Violence Advocate (IDVA). Victims aged 15 years & younger can only be referred to children's services Young people's Dash risk checklist | Safelives

Please refer to The Hive – Domestic Abuse of Service Users Policy v1for details on how to make MARAC & IDVA referrals & further domestic abuse advice. Paris users can add 'a risk of domestic abuse' alert to the record.

The link below has details of HM government responses to domestic abuse and support networks for clients. Domestic abuse: get help during the coronavirus (COVID-19) outbreak – GOV.UK

24-hour National Domestic Violence- Free phone Helpline 0808 2000 247

16.0 Adolescent to Parent Violence & Abuse

In 2015, the Home Office published the first guidance document on adolescent to parent violence and abuse (APVA), following an increase in reported incidents. There is no legal definition of APVA, but it is recognised as a form of domestic abuse. The government's official definition of domestic abuse applies to those aged 16 years and older, hence the need for distinct terminology to define abuse perpetrated by children aged less than 16 years. APVA is likely to involve a pattern of behaviour where the adolescent may display physical violence, damage to property, emotional abuse (threats, belittling, humiliating) economic abuse (stealing from parents) and heightened sexualised behaviour towards a parent. Patterns of coercive control may also be seen. Siblings are also at risk of abuse. Domestic abuse (historic or current) may also be present between the parents/ carers of the adolescent.

A child safeguarding referral should be made for all cases of AVPA, as the child & family may require additional services. Consideration should also be given towards making a safeguarding adult referral, if the parent/ carer has care & support needs (eg. Learning/ physical disability, mental illness etc). Please refer to the HPFT Safeguarding Adult policy for further guidance.

Forced Marriage, Honour Based Violence and Female Genital Mutilation are all forms of Domestic Abuse- see HSCP Domestic Abuse Policy (HBA, FM, FGM)

17.0 Forced Marriage

A forced marriage is where one or both people do not (or in cases of people with learning disabilities or reduced capacity, cannot) consent to the marriage as they are pressurised, or abuse is used, to force them to do so. It is recognised in the UK as a form of domestic or child abuse and a serious abuse of human rights.

The pressure put on people to marry against their will may be:

- physical: for example, threats, physical violence or sexual violence
- emotional and psychological: for example, making someone feel like they are bringing 'shame' on their family
- financial: for example taking someone's wages from them

The Anti-social Behaviour, Crime and Policing Act 2014 made it a criminal offence in England, Wales and Scotland to force someone to marry.

This includes:

- taking someone overseas to force them to marry (whether or not the forced marriage takes place)
- marrying someone who lacks the mental capacity to consent to the marriage (whether they are pressured to or not)

Forcing someone to marry can result in a prison sentence of up to 7 years.

Victims or those at risk can apply for a Forced Marriage Protection Order (FMPO). As a civil law measure, an application for a FMPO would be made in the family court.

The Forced Marriage Unit (FMU) is a joint Foreign and Commonwealth Office and Home Office unit which leads on the government's forced marriage policy, outreach and casework. It operates both inside the UK (where support is provided to any individual) and overseas (where consular assistance is provided to British nationals, including dual nationals).

The FMU operates a public helpline to provide advice and support to victims of forced marriage as well as to professionals dealing with cases. The assistance provided ranges from safety advice, through to helping a forced marriage victim prevent their unwanted spouse moving to the UK ('reluctant sponsor' cases). In extreme circumstances the FMU will assist with rescues of victims held against their will overseas.

Telephone: 020 7008 0151 Email: fmu@fco.gov.uk

Forced Marriage Training

The Forced Marriage Unit (FMU) has also developed free forced marriage e-learning for professionals. Please email fmu@fco.gov.uk if you have problems registering.

18.0 Honour Based Violence

The concept of 'honour' is deemed to be extremely important for some communities. To compromise a family's 'honour' is to bring dishonour and shame and this can have severe consequences. The punishment for bringing dishonour can be emotional abuse, physical abuse, family disownment and in some cases murder. If a victim is aged less than 18 years, a referral should be made to children's services.

In most honour-based abuse cases there are multiple perpetrators from the immediate family, sometimes the extended family and occasionally the community at large. Mothers, sisters, aunties and even grandmothers have been known to be involved in the conspiring of honour crimes.

Honour crimes are most prevalent within diaspora communities from South Asia, the Middle East, and North and East Africa. Reports come from Muslim, Sikh, Hindu, Orthodox Jewish and occasionally traveller communities. Honour Abuse is not determined by gender; both perpetrators and victims can be male or female. (Karma Nirvana, 2020)

Forced marriage is a form of honour based abuse.

Karma Nirvana are one of many organisations offering support to victims of forced marriage and honour based abuse. They have a UK helpline: Helpline – Karma Nirvana

19.0 Female Genital Mutilation

Female Genital Mutilation (FGM) is a crime that affects some of the most vulnerable girls and women in societies across the world and increasingly in the UK. It is a procedure where the female genitalia are deliberately injured, cut or changed, there is never a medical reason for this to be done. FGM should be considered and dealt with as significant child abuse. Health professionals have a pivotal role in identifying, sharing information and reporting girls at risk of FGM.

Mandatory reporting of FGM:
The Serious Crime Act (2015) amended the FGM Act (2003) & introduced a mandatory reporting duty for statutory agencies, including the NHS. This means:

- Dial 999 for the police- if you believe a child is imminently being taken to have FGM performed
- Dial 101 for the police- if you believe a child has recently undergone FGM

The mandatory reporting duty does not apply to women aged over 18 years, who disclose they had FGM as a child

The police will liaise with children's services.

Mandatory reporting of female genital mutilation: procedural information - GOV.UK

Agencies in Hertfordshire have worked together to develop a **Herts FGM Pathway**, containing useful information and risk assessment templates.

Multi-Agency FGM Pathway| Hertfordshire County Council

FGM Protection Orders

FGM Protection Orders (FGMPOs) offer a legal means to protect and safeguard victims and potential victims of FGM. They are granted by a court and are unique to each case. They contain conditions to protect a victim or potential victim from FGM. This could include, for example, surrendering a passport to prevent the person at risk from being taken abroad for FGM or requirements that no one arranges for FGM to be performed on the person being protected.

FGM protection orders: factsheet - GOV.UK

20.0 Child abuse linked to spirit possession and witchcraft

The belief in 'possession and witchcraft' is widespread although the number of known child abuse cases linked to accusations of 'possession' or 'witchcraft' is small. In possession cases, the parent/carer views the child as different due to disability, illness, bedwetting, disobedience, independence or having nightmares. Attempts may be made to exorcise the child, which may involve beating, burning, starvation, cutting/stabbing and or isolation within the household.

'Witchcraft' is the belief that a child is able to use an evil force to harm others. There is a range of terminology connected to such beliefs including black magic, Juju, kindoki, ndoki, the evil eye, voodoo, obeah, and child sorcerers. In all known cases, families, carers and the children can hold genuine beliefs that evil forces are at work. Families and children can be deeply worried by the evil that they believe is threatening them. There may also be an element of the adult gaining some advantage through the ritualistic abuse of the child which may even result in the death of the child.

Such beliefs are not confined to particular countries, cultures or religions. Nor are they confined to new immigrant communities in the UK.

While the number of known cases of abuse related to spiritual or religious belief is small, agencies should be alert for possible indicators and should apply basic safeguarding principles to prevent it. Where it occurs, the impact on the child is substantial and distressing. The child is at risk of significant harm.

Key considerations are:

- Child abuse is never acceptable in any community or culture, under any circumstances.
- Child abuse linked to a belief in spirit possession usually stems from a child being used as a scapegoat, the underlying reasons for the abuse is often kinked to family stress, deprivation, domestic abuse, substance misuse and or mental illness.
- Links, where they exist, between individual cases of such child abuse and wider belief, faith or community practices should be identified. Where connections are identified and appropriate action taken, the risk that other children will be similarly abused can be greatly reduced.
- Standard child safeguarding procedures apply and must be followed in all cases where abuse or neglect is suspected including those that may be related to a belief in spirit possession or witchcraft.

- Practitioners need to have an understanding of religious beliefs and cultural practices in other to help gain the trust of the family or community. Practitioners should seek advice if dealing with a culture or set of beliefs that are unfamiliar.

PART 3 – Assessment of Needs, Referral Processes, Escalation, Information Sharing & Consent

21.0 **Assessment Framework**

The Assessment Framework – 'The framework for assessing children in need and their families' (2000)

Developed by the Department of Health *'The Framework for assessing children in need and their families'* (2000) is a multi-agency assessment tool to provide a common language to understand what is happening to a child. Assessing the needs of children requires a systematic and purposeful approach.

Staff should utilise this assessment tool when:

- Completing a safeguarding risk assessment
- Making referrals to Children's Services
- Compiling reports for child protection conferences/core groups/multiagency meetings etc
- Contributing to an early help assessment

Framework for the Assessment of Children in Need

22.0 Adult Service Users with Caring Responsibilities for Children (Think Family)

The Trust endeavours to minimise the potential effects of parental mental illness on children by implementing Government guidance and using an evidence based approach to underpin training and practice.

All staff who work with adult service users are obliged to consider the potential effects that mental illness/learning disabilities may have on children.

The following points may impact negatively upon the parent's ability to meet the needs of children who they may care for or have significant contact with:

- Toxic trio- mental illness, substance misuse & domestic abuse (red flag)
- Problematic and chaotic substance/alcohol misuse
- Did Not Attend/ Not Brought In appointments and disengagement from services
- Complex mental health needs including poor compliance, unstable mental health, symptomology, effects of prescribed medication
- Learning disability
- Aggression/violence (especially domestic abuse)
- Self-neglect/poor motivation
- Adults who may pose a risk to children or have a history of offending against a child

23.0 Pregnant Women and Expectant Parents

HPFT provides Peri-natal Services for service users with moderate to severe mental illness. The service includes direct specialised care for pregnant women and will ensure that safeguarding children is an integral part of operational procedures.

HPFT staff should consider the needs of pregnant service users, and all expectant parents or other service users who are in close contact with a pregnant woman.

The holistic needs of pregnant women and their unborn child should be considered at the earliest opportunity, irrespective of whether there are obvious concerns regarding the welfare of an existing or unborn child.

A referral to Local Authority Children's Services should be made if concerns regarding the welfare of a baby or unborn baby exist. Factors that may initiate a referral include:

- Concerns regarding the parent/carers ability to provide adequate levels of self -care and care for a child/unborn child – e.g. failure to access medical advice and services, neglect, learning disability
- Disclosure of domestic abuse
- Substance or alcohol misuse (TOXIC TRIO= mental illness, domestic abuse & substance misuse)
- Sibling previously removed from care of parent/carer
- Sibling subject to Child Protection Plan/ Child In Need plan
- A parent/carer known to have committed an offence against a child/known to pose a risk to children
- Previous unexplained death of a child whilst in the care of parent/carer
- The degree to which parental mental impairment/substance misuse is likely to significantly impact on the safety, health and development of the baby.
- Concerns regarding the baby being at risk of significant harm - e.g. fabricated or induced illness, violence and aggression.

- The need for a pre-birth planning meeting for pregnant women and expectant fathers with mental ill health should also be discussed with Children's Services.

- Consideration must be given to any risks posed by mentally ill parents to a new baby and/or the carers and the impact that the birth may have on their wellbeing and family dynamics.

24.0 Private Fostering

A private fostering arrangement is a private arrangement made by a parent/ carer for someone outside of their immediate family to look after a child under the age of 16 (under 18, if disabled), with the intention the arrangement should last for 28 consecutive days or more. A person who is a relative under the Children Act 1989 i.e. a grandparent, brother, sister, uncle or aunt (whether of the full or half blood or by marriage) or step-parent will not be a private foster carer. A private foster carer may be from the extended family, such as a cousin or great aunt, or a friend of the family, the parent of a friend of the child, or someone previously unknown to the child's family who is willing to privately foster a child.

Always ask who the adult is accompanying a child to an appointment, or ask the adult service user if they have caring responsibilities for any children. If you suspect private fostering please make a child safeguarding referral following the usual process.

25.0 Making a referral to Children's Services

Staff should seek advice as stated on the Safeguarding referral flow chart (page 4)

Refer to the flowcharts in the appendices, for local information. Always consult the Continuum of Need Document/ threshold document of the local authority you are referring to.

The referral process has been simplified and you know longer need to decide the level of risk/ need- all safeguarding referrals (whether thought to be child protection/ child in need or early help) are made through the online children's services referral form.

- Dial 999 for the police, if the child is at immediate risk of harm/ threats to life/ risk of abduction/ trafficking/ imminently being taken for FGM etc
- All child safeguarding referrals should be made to the local authority children's services **in the area the child resides,** by telephone (if urgent) or by completing an online referral form. The referral must be uploaded onto the child/ parent's electronic patient record (EPR). If a reference number is provided for the referral, then this must be clearly recorded in the records, as it will be required for follow up liaisons
- Telephone referrals should be followed up in writing within 48 hours, using the appropriate referral form for the local authority of the area in which the child is living.
- The child (if appropriate) and the parent/carer, should be informed why the

referral has been made. **However, there may be circumstances where referrals are made without the child's/ parent's knowledge**, if it may place the child at greater risk of harm. This may be the case with acute sexual abuse (due to potential forensic evidence may be destroyed) or in the case of suspected fabricated or induced illness (FII). The reason for not informing the child/ parent, must be recorded in the EPR and the reason must be explicit on the referral form

- Inform the police if a crime has been committed. Please note that children's services also have a legal duty to report crime to the police and they do share information about referrals they receive with the police.
- Complete a datix
- Document all concerns & liaisons in the child/ parent's EPR.
- Paris users must open a child safeguarding assessment (care document), to record details of the referral
- Update the risk assessment
- Add a 'child safeguarding referral made' alert to the EPR (Paris). This alert should remain on the record and should only be removed if the child is subsequently placed on child protection/ child in need plan or is made a Looked After Child, to alert all professionals there is a history of safeguarding concerns
- Add/ update any other alerts on the EPR
- Children's services should notify the referrer of the outcome of the referral in 3 working days. If this does not occur, it remains the responsibility of the referrer to contact children's services to enquire as to the outcome of the referral & document this on the child safeguarding assessment/ EPR
- All referrals must be discussed in safeguarding supervision & the actions recorded on the child/ parent's EPR

26.0 Allegations against Staff or Concerns about Suitability to Work with Children and Young People

Any disclosures about an adult who works directly with children (paid or voluntary employment), must be reported to the Local Authority Designated Officer (LADO) within 1 working day, if the adult has:

- Behaved in a way that has harmed or may have harmed a child
- Possibly committed a criminal offence against or related to a child, the police should be contacted by the appropriate senior manager
- Behaved towards a child or children in a way that indicates he or she is unsuitable to work with children and young people

LADO referral forms are found on your local safeguarding children partnership website. A children's services referral and a Datix are also required. Do not include the staff member's name on the Datix.

When an allegation is made about a member of HPFT staff, the following staff should be immediately notified:

- the senior manager responsible for the service- they need to contact the SBU HR business partner
- Consultant Nurse Safeguarding Children or Corporate safeguarding team

Only personnel who need to manage the Trust's internal procedures should be informed, as well as those who are directly involved in co-operating with the child protection investigations. Consideration must be given to whether it is safe for the staff member to remain at work whilst investigations are pending and when the last Disclosure & Barring check was made on the employee.

If the allegation is regarding a member of staff at a different organisation, the LADO will be responsible for deciding whether to inform the employer of the allegation.

It is in everyone's interest to resolve cases as quickly as possible, with a fair and thorough investigation.

27.0 Service Users as Alleged Perpetrators of Child Abuse

Staff have a duty to report any disclosures or allegations of child abuse, made against a service user, to the police. All cases should be discussed within the multi-disciplinary team and advice sought from the Consultant Nurse Safeguarding Children/ corporate safeguarding team as required. This includes service users who may be aged under 18 years and are indeed a child themselves. If information is reported to police then a Datix must also be completed.

Indecent Images

Taking, making, sharing and possessing indecent images and pseudo-photographs of people under 18 is illegal, even if the person doing so is aged under 18 too.

A pseudo-photograph is an image made by computer-graphics or otherwise which appears to be a photograph.
This can include:

- photos
- videos
- tracings and derivatives of a photograph
- data that can be converted into a photograph

For further information see: Indecent images of children: GOV.UK

28.0 Escalating Cases Where There is Professional Disagreement

Professional disagreements may arise from difference in opinions with the outcome of safeguarding referrals, stepping a child up or down from child protection or from the management of a case, particularly if there is drift in decision making.

In the first instance, you must discuss your concerns with your line manager/ clinical lead & liaison should take place with a manager in children's services.

If the issue remains unresolved at an operational level, please inform the Consultant

Nurse Safeguarding Children/ corporate safeguarding team (hpft.safeguardingteam@nhs.net) for formal escalation of the case to children's services.

If the disagreement is not resolved at this stage, the Consultant Nurse Safeguarding Children, must escalate the case within children's services. If the issue is still not resolved, it will be further escalated to the Designated Nurse for Safeguarding Children in the CCG, who can raise the issue with the Safeguarding Children Partnership/ Board.

Please refer to Multi-Agency Escalation Process | Hertfordshire County Council, contained within the CIN Multi-Agency Protocol & Procedure.

29.0 Attending Child Protection Conferences and Core Group Meetings

- Attendance at a child protection conference is a clinical priority. Should an invited professional be unable to attend, this must be discussed with their line manager/senior staff and a suitable deputy found.

- If attendance is not possible, an apology must be sent to the chair of the conference. It is essential that a written report which details the involvement of the service and an ***analysis of concerns; any risks, protective factors and professional actions*** is produced and submitted to the conference chair, ***48 hours in advance of the conference***.

- Information contained in the report should be routinely shared with family members prior to the conference. Any concerns about sharing information with parents or carers should be discussed with the conference chair prior to the conference taking place.

- If the health professional has not been able to share their report with the family, reasons for this should be clearly stated on the report before submission.

- Where a practitioner is identified as a member of a core group for a child who is made subject to a child protection plan at the conference, they must prioritise attendance at core group meetings.

- Multi-agency meetings must be recorded on the child safeguarding assessment on Paris- including the type of meeting, whether anyone attended, if a report was sent, the outcome of the meeting and the date of the next meeting.

- Alerts must be updated on the EPR, following any change to the child's status at a child protection conference or other multi-agency meeting

30.0 Section 47/ Section 17 Children Act 1989 Requests for Information from Children's Services

Children's services make Section 47 enquiries when a child living in their area is subject to an emergency protection order, is in police protection or is suspected

or known to have suffered from significant harm. Therefore requests for information are urgent and must be returned within **24 hours.**

Children's services make Section 17 enquiries when a child living in their area is thought to be in need of additional services, without which their health or development will be significantly impaired. These requests for information should be returned within **48 hours**.

Requests for information may also be received from the Multi-Agency Safeguarding Hub (MASH), in response to a child safeguarding referral being made by an agency concerned about the child's welfare. These requests for information need to be returned the same day, in order for MASH to decide the outcome of the referral.

The request for information is received by the Single Point of Access (SPA), who will forward the form to the service the child/ family member is currently or was most recently open to. Therefore you must provide a summary of the care received within HPFT. All requests for information should include:

- Dates the child/ family member were open to HPFT
- Diagnosis & treatment plans
- Any safeguarding child or adult concerns
- How they engaged with the service/ treatment plan- include information about did not attend (DNA) appointments or appointments cancelled at the last minute
- Risk formulation – risk to self/ others/ children
- Date they were last seen, or when they are next due to be seen

If information is not received in the above timescales, children's services will escalate the issue to the corporate safeguarding team, who will contact the clinician and service manager to ensure information is shared in a timely manner.

31.0 Child Death Review Processes

Process for Notifying the Child Death Review Partners of a Child Death

In the unlikely event that a member of HPFT staff believes they are first person to be informed of a death, they have the responsibility of completing the 'Notification Form' (previously known as form A) and submitting it to the child's local child death overview panel (CDOP) administrator. See the relevant Safeguarding Children Partnership/ Board website for further details. The notification form is usually completed by Emergency Departments, Hospices or GPs.
If you complete a notification form, you must also:

- Complete a datix to report the child death within the Trust
- Update the electronic patient record (EPR) and record the child as deceased

How are HPFT Staff Notified of a Child Death?

The majority of notifications of a child death will come via the HPFT Corporate Safeguarding team. If a child or family member is known to HPFT, then the corporate safeguarding team will contact the team manager. Occasionally, the

team may be contacted directly, by other agencies. If this happens, please let your manager know and also email the corporate safeguarding team on hpft.safeguardingteam@nhs.net.

You will also need to complete a datix, to report the death and you need to record the child as deceased on the electronic patient record.
The Corporate Safeguarding team shares information with CDOP, via the computer database e-CDOP.

Child Death Review Meetings

Following the publication of 'Working Together to Safeguard Children' (2018) and 'Child Death Review: Statutory and Operational Guidance' (2018), all child deaths will now have a local review, within 3 months of the child's death. These reviews are called child death review (CDR) meetings. This will be for unexpected and expected deaths.

The purpose of the meeting is for the frontline practitioners who were working with the child or family member, to come together:

- To understand the events leading up to the death,
- Understand the circumstances of the death,
- Identify any immediate learning, identify any potential abuse or neglect that may have contributed to the death
- Plan bereavement support for the family

These meetings will take place in different formats:

- Joint agency response meetings (rapid response) following some unexpected child deaths
- Hospital-based mortality meeting
- Perinatal mortality review meeting
- A meeting at a hospice or other setting

HPFT staff will be invited and are expected to attend these meetings, if they were working with a child or family member at the time of the death.
It is important that it is the frontline staff, who knew the child/ family member best placed that attends, as they will be expected to share detailed information about their agency's involvement. For example:

- How long the child/ family member was known to the service?
- How often were they seen by the service?
- When was the last appointment?
- What was their diagnosis?
- What was the treatment plan?
- Were they engaging with the service?
- Were there any safeguarding concerns?
- Were there any gaps in your service provision?

Information about the circumstances of the death, including resuscitation attempts, may be discussed (if relevant) by the ambulance service/ emergency department staff or police. This can be distressing information, which is why it's important staff have support from their manager and the Corporate Safeguarding team as required.

As these meetings can involve many agencies, they can have a large number of people in attendance. Therefore, only 2 members of staff from each agency can attend. For this reason, if the child was known to multiple teams & clinicians, a discussion must take place about who the most appropriate 2 people are, to attend and represent HPFT. If you feel extra staff should attend, please discuss this with the chair of the meeting in advance. An Analysis Form is completed during the meeting and this is submitted to CDOP.

If it is felt that abuse or neglect may have contribute to the death, the local child safeguarding practice review panel (formerly known as serious case review panel) will be notified.

Child Death Overview Panel (CDOP)

CDOP will ultimately discuss all local child deaths, once every other process has been finalised eg. post mortem examination, serious incident investigations or child safeguarding practice reviews etc. The strategic panel anonymously discuss the deaths and scrutinise the issues and learning identified at the CDR meeting. They may identify wider public health or safety issues, requiring a local campaign or further exploration by agencies. CDOP categorise the deaths and make recommendations, this data is submitted to the National Child Mortality Database, to inform national learning about infant and child mortality.
If any further advice or support is required regarding child deaths, staff can contact the corporate safeguarding team on hpft.safeguardingteam@nhs.net or 01727 804717**.**

For further guidance see:
Child Death Review Process: Guidelines for What to do Following the Death of a Child, Where the Child or a Family Member is Known to HPFT - The Hive

32.0 Child Safeguarding Practice Reviews (Formerly Known as Serious Case Reviews)

Child safeguarding practice reviews should be considered for serious child safeguarding cases where:

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

Child Safeguarding Practice Reviews | Hertfordshire County Council

If you suspect a case meets this criteria, please contact the Consultant Nurse Safeguarding Children or Corporate Safeguarding Team to discuss how a referral can be made to your local safeguarding children partnership.

33.0 Information Sharing

The Children Acts, Working Together to Safeguarding Children (2018), Information sharing (2018) & Data Protection Act GDPR (2018) all outline the legal duty of NHS professionals to share information with statutory agencies (local authority & police) when they have concerns for a child's safety or welfare.

The Information sharing (2018) guidance states; 'If it is thought that a crime has been committed and/or a child is at immediate risk, the police should be notified immediately.'

GDPR guidance advises that information should be shared with consent where possible. However, the GDPR does allow for safeguarding data to be disclosed without consent:

1. When relevant information is shared to 'keep a child or individual at risk, safe from neglect or physical, emotional or mental harm, or if it is protecting their physical, mental or emotional well-being' and
2. If the practitioner is unable to, or cannot reasonably be expected to, gain consent, or if gaining consent could put the child at risk (this would include a refusal to consent to a referral)

Where there is no consent to share information, practitioners must:

- Identify how much information to share (information must be necessary, proportionate, relevant and adequate for the purpose)
- Distinguish fact from opinion
- Ensure the right information is given to the right individual
- Share information securely
- Where possible, be transparent with the child/ parent/ carer and inform them that the information has been shared, as long as this does not create or increase risk of harm to the child
- Record the reasons for their decision to share information

Practitioners must weigh up the risk to the child's safety of sharing or not sharing information. The guidance states that 'whatever the form of abuse or neglect, practitioners should put the needs of children first when determining what action to take.'

Guidance on information sharing for complex cases must be sought from line managers/ clinical leads/ corporate safeguarding team or the information governance team. All discussions and decisions must be recorded in the EPR.

34.0 Confidentiality & Consent

Confidentiality is never absolute. Children & their parents' carers should be informed of this at the first and subsequent contacts within HPFT. Our duty to safeguard the welfare of a child is paramount. 16 & 17 year olds are presumed to have capacity to consent to medical treatment, unless there is evidence to suggest otherwise (Mental Capacity Act, 2005). It is advisable to liaise with the person with parental responsibility, unless there are specific documented reasons not to.

35.0 Gillick Competency & Fraser Guidelines

Gillick competency is used to help assess whether a child aged under 16 years, has the maturity to make their own decisions and to understand the implications of those decisions. The Fraser guidelines specifically apply to contraceptive advice- see factsheet for further information:

https://learning.nspcc.org.uk/media/1541/gillick-competency-factsheet.pdf

36.0 Refusal of Treatment/ Referrals

A child (under 18 years) cannot refuse treatment. Their refusal can be overridden by a person with parental responsibility, it may be necessary to go through the courts depending on the circumstances of the case.

The Children Acts do not distinguish between young people who are aged 16-17 years old and therefore the same safeguarding principles must be applied to all children aged under 18 years old. This means that safeguarding referrals can be made to statutory agencies against the wishes of 16 & 17 year olds, though open transparent conversations should always take place to inform a child of the actions you are taking and why.

PART 4 – Children & Young People as Service Users in HPFT – Admission to Discharge

37.0 Mental Health Act Assessments For Children

The Mental Health Act assessment must consider any safeguarding concerns for the child and a referral made to children's services as required, following the usual processes.

38.0 Mental Health Act Assessments For Adults

Mental Health Act assessments of adults, must take into consideration the needs of any child for whom the service user has caring responsibilities. A joint planning discussion should be held with Children's Services (where the child resides) if safeguarding children concerns are identified, prior to the assessment.

Children and young people should receive appropriate information regarding the care of their parent/carer and where appropriate, have the opportunity to share information and concerns regarding the parent/carer's illness.
HPFT staff must ensure that children and young people are not left unattended if a parent/carer is hospitalised.

In the event of a delay in Mental Health Act Assessment, HPFT staff should ensure that the child's welfare is not compromised and that adequate support is available for the family.

39.0 Admissions for Children

The Child and Adolescent Mental Health Services (CAMHS) has a child and young person centred culture operating in suitable environments that are safe and minimise the risks to the young people who utilise services. CAMHS are responsible for ensuring that there are appropriate and up to date operational procedures available for staff.

It is the policy of the Trust that the mental health needs of children and young people are best met within the CAMHS structures. A number of adult services accept clients aged 16 upwards – these services should make specific arrangements to review if this client group has additional needs and what action may be required in order to meet these needs.

Where it is not possible to provide care for a young person aged 16-18 years old in a CAMHS environment and the young person requires admission to an adult in patient service, this should only be considered on a case by case basis. A robust risk assessment should occur, the safeguarding team should be consulted and the 'best available' option agreed in collaboration with CAMHS Service Line Leads and partner agencies including Children's Services.

Young People under the age of 16 should not be admitted to adult in-patient wards. If an appropriate facility is not available, then an out of area placement must be considered.

40.0 Safeguarding Children – An integral part of the Care Programme Approach (CPA)

40.1 Documentation

As part of the Care Programme Approach (CPA) documentation, health care professionals are obliged to consider whether there are any safeguarding children concerns within the family unit.

It is best practice to document the names and dates of birth of all adults in or connected to the family home. In line with recommendation 12 of the Laming Report, it is essential that basic demographic information is obtained for all children connected to an adult service user, as follows:

- Child's first name and surname
- Address (even if not residing with service user)
- Name of child's primary carer and relationship to child
- Date of birth
- General Practitioner and Health Visitor (for children aged 5 and under)
- Name of school (if appropriate)
- Expected Date of Delivery (EDD) for pregnant women
- Any disability the child has and how this impacts them
- Ethnicity
- First language (if this is not English)

HPFT staff are required to ascertain the above information where there is any likelihood of contact with children, whether or not the child resides with the adult concerned.

40.2 Care Planning

The needs of children, including any unborn, should be considered when formulating a plan of care. This may include:

- Consideration of the impact the child's mental health is having on other members of the household, particularly considering siblings/ other children
- Consideration as to whether the plan may impact on the parent/carer's ability to provide safe and consistent levels of care to a child.
- Whether the needs of the adult/service user may have a negative impact on children who they may have significant contact with.
- Do any restrictions need to be in place to safeguard and promote the wellbeing of a child?

The multi-disciplinary team must ensure that any concerns are clearly recorded within the service user's records and is information shared with other agencies/professional as and when required.

41.0 Risk Assessment

Staff should have open and honest discussions with Service Users regarding any safeguarding concerns that arise whilst under our care. Specific consideration should be given to level of insight shown by the service user regarding the actual or potential impact that their illness/ difficulties may have upon a child/ other family members.

Referrals to other agencies should be discussed with parents and carers prior to the referral being made, unless to do so would increase the risk of harm to the child.

When completing the Risk Assessment, it is essential that staff give consideration to the following points:

- Actual/potential risk posed by the service user either as part of a delusional state or as a consequence of mental ill health;
- Diagnosis, symptoms and relapse indicators;
- Age and developmental stage of the child - children aged under 5 and especially infants are particularly vulnerable;
- Impact of situation on child's emotional wellbeing;
- Neglect (unresponsiveness to both physical and emotional needs);
- Contact with children in the family and wider community, either presently or in the future;
- Protective factors and areas of concerns (strengths and weaknesses) of the family including access to formal or informal support networks;
- Any risk of injury, aggression or dangerous behaviour (including domestic abuse, FGM or any other harmful cultural practices).

Assessed risks, whether to the child, siblings, or other adults including staff, should be clearly recorded in the service user's records and shared with partner agencies as appropriate. Please refer to Clinical Risk Assessment and Management for Individual Service Users Policy v9 - The Hive

42.0 Contingency and Emergency Planning

Staff should ensure that details regarding the care arrangements for children are an integral part of emergency and contingency planning. This information should be clearly recorded within the service user's records and communicated to relevant agencies and professionals. This may include the use of Advance Directives where appropriate.

Staff must ensure that any proposed arrangements safeguard and promote the wellbeing of the child.

Relevant information regarding the care of the parent/carer should be provided to children and alternative carers in a way that they can understand.

If there is no appropriate family carer available, staff should immediately telephone children's services to make emergency arrangements for the child.

If mother's on the mother & baby unit need to be transferred to an acute hospital or other mental health bed, contact must be made with person (s) with parental responsibility to arrange the safe discharge of the baby out of the unit. If no-one other than the mother has parental responsibility, or the person with PR cannot be contacted within a reasonable timescale, staff should telephone children's services to make emergency arrangements for the baby.

43.0 Leave Arrangements for Clients

Consideration should be given to the advantages and disadvantages of granting leave for a service user and the potential or actual risks to a child or young person; this information should be clearly recorded in the service user's records. Additional support may also be required to facilitate the parent/carer role whilst on leave. Where possible, HPFT staff should ensure any arrangements are in place prior to leave commencing.

The multi-disciplinary team should consider the possibility of suspending leave arrangements for a service user if any risk of harm is identified to a child or other adult.

HPFT staff must ensure that any decisions regarding leave are compliant with Child Protection Plans and Children's Social Care should be informed of changes to leave arrangements where relevant.

HPFT staff must ascertain details regarding leave, whether there are any children or young people present at the address and any associated risks or concerns.

Refer as necessary to: Absent Without Leave (AWOL) and Managed Exit and Entry (MEEP) Policy v6.1 - The Hive

44.0 Did Not Attend/ Not Brought In to Appointments

This section should be read in conjunction with the Did Not Attend (DNA) Policy v4.1 - The Hive

The responsibility for assessing the situation of a child not brought to appointments with a health professional, rests with the practitioner to whom the child has been referred (Laming, 2003).

All DNA/NBI appointments should be followed up to find out why the child/ parent did not attend. An alternative appointment should always be offered. Consideration must be given to liaising with the referrer/ GP/ social worker or other involved professional following a DNA/ NBI appointment.

For children on child protection plans, child in need plans or looked after children, the social worker must be informed immediately of all DNA/ NBI appointments and reason for non-attendance. This also applies if the parent of a child on a plan does not attend an essential appointment.

Consider making a child safeguarding referral if a child/ parent frequently does not attend appointments, or cancels appointments with very short notice and there are safeguarding concerns for the child, as this may be a form of disguised compliance.

45.0 Internal or External Transfer of a Child from Hospital to Hospital (when there is a safeguarding concern)

- Transfer documentation must be completed that ensures that nursing and medical staff at the receiving hospital are aware of the safeguarding concerns and any ongoing support that the child/family are receiving. This may include detailed information about the named social worker, any current child protection plan, CIN and lead professional involvement
- The child should be transferred via ambulance accompanied by a member of the nursing and or medical team to the receiving hospital
- This information should also be transferred via telephone conversation with the receiving medical and nursing staff
- If the child is an inpatient, then the senior nurse and the named nurse for safeguarding at the receiving hospital must be informed
- If there is no current children social care service involvement and there is a safeguarding concerns, then a child safeguarding referral should be made following the usual process
- All conversations must be documented in the patient notes and copies of referrals and transfer documentation filed in the patient's medical records

The Transporting of Service User's policy should be referred to if HPFT transport is used to convey a service user to an appointment within HPFT

46.0 Transferring a Case Within HPFT

Prior to the transfer of a case to another worker/service, staff must ensure that the relevant documentation has been completed, the demographic information is accurate and the Risk Assessment has been adequately completed. Concerns regarding a child's welfare should be clearly documented and communicated to new workers. Providing a chronology of events and a verbal handover is considered good practice.

Please refer to Transition of care from Child and Adolescent Mental Health Services (CAMHS) to Adult MH Services v4 - The Hive

47.0 Discharge

Discharge plans must consider the impact on children and young people within the household, family and wider community, in particular any specific needs and/or support required by the family. Discharge planning meetings should routinely include a representative from Children's Social Care where they are or will be involved in supporting the family. Consider inviting other relevant agencies as required eg health visitor, school nurse or school etc

Discharge letters should be copied, with the service user's/ parent/ carer's knowledge, to the relevant professionals involved with the family. The letter should highlight any safeguarding concerns, including safeguarding referrals made and the outcome and indicate whether a child is currently on a child protection plan/ child in need plan or if they are a looked after child or care leaver.

It is essential that liaison takes with the child's social worker, prior to being discharged from HPFT, to ensure a robust plan of support is in place for the child and family.

PART 5 – Mandatory Safeguarding Training

48.0 **Training**

The safeguarding children training framework and requirements are stipulated in the intercollegiate document: roles and competences for healthcare staff (2019). The framework recognises that safeguarding training is a mandatory requirement and that staff groups will have different training needs depending on their degree of contact with children and families as well as their level of responsibility.

The framework recognises that a range of learning opportunities will be available, including in-house face to face, e-learning and multiagency approaches.

Safeguarding training compliance will be recorded through the Learning and Development (L&D) team.

See below safeguarding children training eligibility criteria:

Level of Training	Method of Training	Number of Hours	Staff Groups
Level 1	E-learning	2 hrs every 3 years	All NHS staff who do not have direct contact with patients Administration, HR, Finance, porterage and cleaning etc Bespoke level one training is offered to the Executive Team
Level 2	E-learning & face to face	4 hrs every 3 years	All patient facing staff Patient facing receptionists, reception managers, nursing/ allied health prof students, patient advocates, phlebotomists, pharmacists,
Level 3-Core	• Face to face • E-learning • Supervision • Case discussions Reflections of learning from: • Articles/ research • Attending multi-agency meetings etc child protection conferences Not an exhaustive list 50% of hours must be face to face	8 hrs every 3 yrs	All staff with direct contact and healthcare responsibilities for patients and families All clinical staff in Older Adults Teams Medical doctors in training Adult learning disability teams Psychiatrists Psychologists Nurses Social Workers Allied Health Profs etc
Level 3 - Enhanced		12-16 hrs 3 yearly	CAMHS Community Peri-natal Team Thumbswood Adult community & inpatient MHLT CATT Forensic physicians
Level 4		24 hrs every 3 years	Consultant Nurse Safeguarding Children Consultant Social Worker Safeguarding Adults Specialist Safeguarding Practitioners Named Doctor for Safeguarding Children

49.0 **Prevent**

Training is provided by The Home Office and is approved by NHS England. Staff need to complete the specific training for NHS Mental Health Organisations.

All staff accessing the training will need to send a copy of the certificate to L&D, to be recorded as compliant.

50.0 New Employees

If new employees have completed safeguarding children training in other organisations, they should send the training certificates to L&D, for their compliance matrix to be updated accordingly. Otherwise, they are given 3 months to complete all mandatory training.

51.0 Monitoring of Mandatory Safeguarding Children Training

L&D monitors registers and updates training compliance, from all internal courses. Compliance with mandatory training will be monitored by Line Managers, at supervision and through the staff appraisal and performance review process.

Safeguarding training compliance is also monitored quarterly via each SBU and overall Trust compliance, at the Safeguarding Strategy Group meetings.

PART 6 – Monitoring, Document Control & Standards Information

52.0 Process for monitoring compliance with this document

This policy may be used to demonstrate compliance with safeguarding children and young people standards set by the Care Quality Commission, National Health Service Litigation Authority and Local Safeguarding Children Partnerships.

The effectiveness of this policy will be assessed in a number of ways; through planned organisational and service level audits and through the investigation of serious incidents, complaints and allegations that are undertaken by HPFT or other authorised bodies. The policy will be amended in response to safeguarding legislative changes and as necessary in the light of learning from such reviews.

Action:	Lead	Method	Frequency	Report to:
Annual Report	Head of Social Work and Safeguarding	Review safeguarding strategy and practice governance	Annually	Safeguarding Strategy Group
Audit of cases	Consultant Nurse Safeguarding Children	Sample specified number of cases	Quarterly	
Updating Safeguarding Children Policy	Consultant Nurse Safeguarding Children	Make amendments to policy in response to local and national changes	As required	

53.0 Embedding a culture of equality and respect

The Trust promotes fairness and respect in relation to the treatment, care and support of service users, carers and staff.

Respect means ensuring that the particular needs of 'protected groups' are upheld at all times and individually assessed on entry to the service. This includes the needs of people based on their age, disability, ethnicity, gender, gender reassignment status, relationship status, religion or belief, sexual orientation and in some instances, pregnancy and maternity.

Working in this way builds a culture where service users can flourish and be fully involved in their care and where staff and carers receive appropriate support. Where discrimination, inappropriate behaviour or some other barrier occurs, the Trust expects the full cooperation of staff in addressing and recording these issues through appropriate Trust processes.

Access to and provision of services must therefore take full account of needs relating to all protected groups listed above and care and support for service users, carers and staff should be planned that takes into account individual needs. Where staff need further information regarding these groups, they should speak to their manager or a member of the Trust Inclusion & Engagement team.

Where service users and carers experience barriers to accessing services, the Trust is required to take appropriate remedial action.

Service user, carer and/or staff access needs (including disability)	The HPFT safeguarding children policy and the Safeguarding children board policies for Hertfordshire, Norfolk, Buckinghamshire and Essex are concerned for the safety of all children. All investigations into child abuse would be sensitive to age, ethnicity, gender, disability and religion but would also consider the need to protect children from abuse. The needs of the child are paramount a statement enshrined in child care legislation and this policy.
Involvement	Children are involved and consulted with in the safeguarding process depending on their age and the nature of the safeguarding concern.
Relationships & Sexual Orientation	HPFT services respond sensitively to relationships and sexual orientation. The CAMHS service staff are also trained to work with individual service users where there are personal and family conflicts.
Culture & Ethnicity	Interpreters are arranged where required when there are language difficulties that affect communication. All staff are trained to ask questions and respond to ethnic and cultural needs.
Spirituality	All staff respond to spiritual needs as described above.
Age	This policy is for all children under the age of 18 years
Gender & Gender Reassignment	Transgender issues are responded to sensitively by all staff.
Advancing equality of opportunity	The principles of safeguarding children apply to all children regardless of their age. The youth council listens to the views of young people accessing HPFT services.

54.0 Version Control

Version	Date of Issue	Author	Status	Comment
V1	August 2008	Lead Nurse, Safeguarding Children	Superseded	Archived
V1.1	August 2009	Lead Nurse Safeguarding Children	Superseded	Archived
V1.2	December 2009	Lead Nurse Safeguarding Children	Superseded	Archived 30.6.2010
V2	July 2010	Lead Nurse Safeguarding Children	Superseded	Approved by the safeguarding strategy group 24.4.2010
V3	December 2012	Head of Social Work & Safeguarding	Superseded	
V3.1	9th December 2013	Safeguarding Practitioner/named Nurse Safeguarding Children	Superseded	Updated with Appendix 9
V3.2	14th February 2014	Safeguarding Practitioner/named Nurse Safeguarding Children	Superseded	Page13 Child Sexual Exploitation has been moved to this page Page 18 Child pornography & Historical abuse Page 19 Safeguarding Supervision Page 24 Record Keeping
V4	15TH December 2015	Safeguarding Practitioner/named Nurse Safeguarding Children	Superseded	Full review

V4.1	24th May 2018	Safeguarding Practitioner/named Nurse Safeguarding Children	Superseded	Reviewed under GDPR
V4.2	2nd October 2019	Consultant Nurse for Safeguarding Children (Interim)	Superseded	Updated with Early Help Processes and Bucks, Essex and Norfolk child safeguarding poster following recommendations from Serious Incident 2018 28339
V4.3	20th Nov 2019	Consultant Nurse for Safeguarding Children (Interim)	Superseded	Herts SG Children Referral Process
V5	January 2021	Consultant Nurse for Safeguarding Children	Superseded	Full review
V5.1	25/02/2021	24/02/2024	Consultant Nurse Safeguarding Children	
V5.2	02/02/2022	24/02/2024	Consultant Nurse Safeguarding Children	Updated referral flowcharts

55.0 Supporting HPFT Policies

- Safeguarding Adult Policy
- Domestic Abuse The Hive - Domestic Abuse of Service Users Policy v1
- Clinical Risk Assessment and Management for Individual Service Users Policy v9 - The Hive
- Absent Without Leave (AWOL) and Managed Exit and Entry (MEEP) Policy v6.1 - The Hive
- Did Not Attend (DNA) Policy v4.1 - The Hive
- Transporting of Service Users Policy
- Transition of care from Child and Adolescent Mental Health Services (CAMHS) to Adult MH Services v4 - The Hive
- Operational policies for all HPFT services

56.0 Consultation

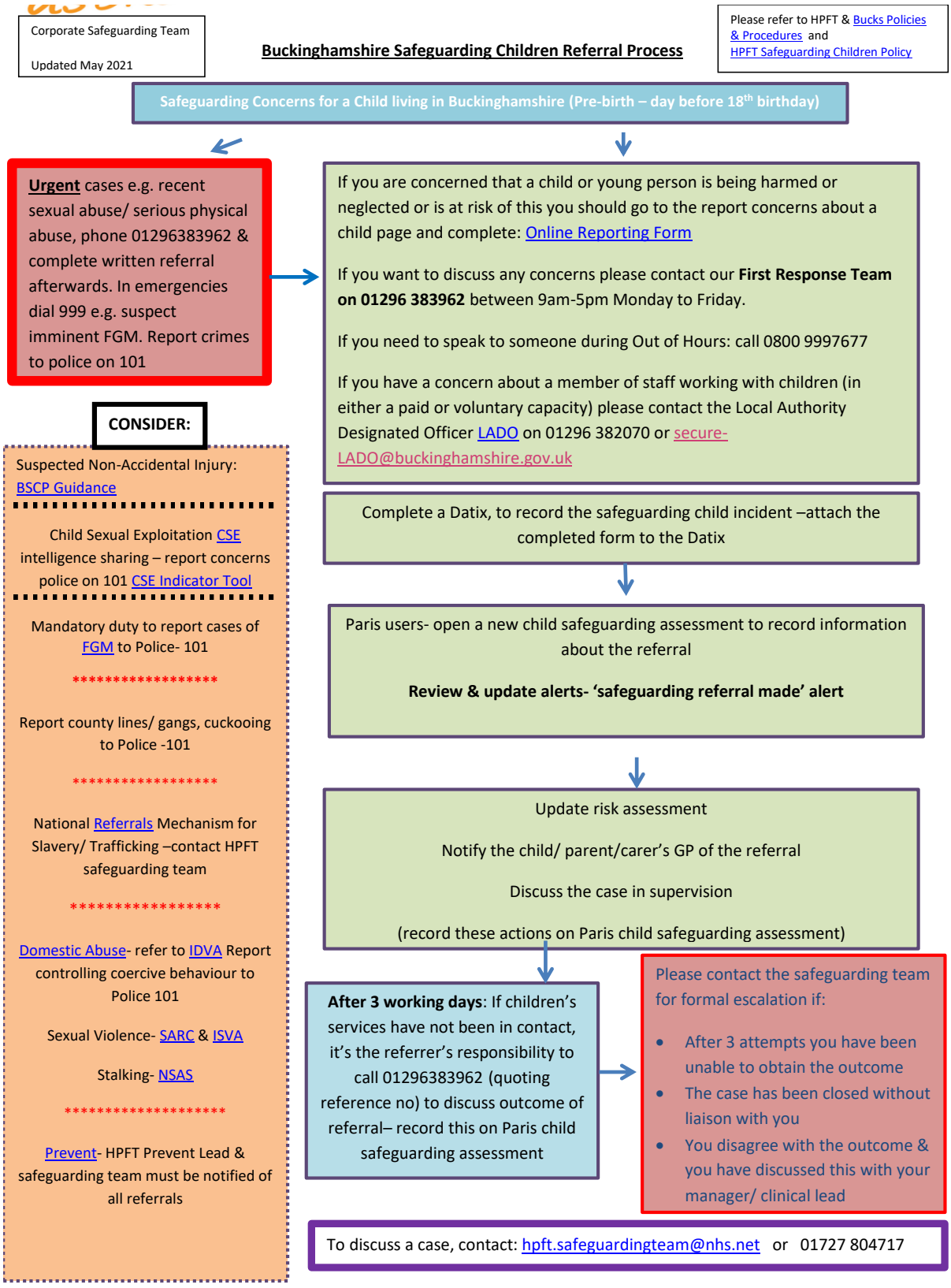
Job Title of person consulted
Executive Director of Quality and Safety
Head of Social work and Safeguarding
Consultant Social Worker for Safeguarding Adults
Named Doctor Safeguarding Children
Professional Lead CAMHS
Designated Nurse Safeguarding Children CCG

57.0 Appendices

Appendix 1 – Safeguarding Children Referral Process in Bucks, Essex and Norfolk

Appendix 2 – Safeguarding Children Referral Process in Hertfordshire

Appendix 1


Corporate Safeguarding Team
Updated May 2021
Buckinghamshire Safeguarding Children Referral Process
Please refer to HPFT & Bucks Policies & Procedures and HPFT Safeguarding Children Policy
Safeguarding Concerns for a Child living in Buckinghamshire (Pre-birth – day before 18th birthday)
Urgent cases e.g. recent sexual abuse/ serious physical abuse, phone 01296383962 & complete written referral afterwards. In emergencies dial 999 e.g. suspect imminent FGM. Report crimes to police on 101
If you are concerned that a child or young person is being harmed or neglected or is at risk of this you should go to the report concerns about a child page and complete: Online Reporting Form
If you want to discuss any concerns please contact our First Response Team on 01296 383962 between 9am-5pm Monday to Friday.
If you need to speak to someone during Out of Hours: call 0800 9997677
If you have a concern about a member of staff working with children (in either a paid or voluntary capacity) please contact the Local Authority Designated Officer LADO on 01296 382070 or secure-LADO@buckinghamshire.gov.uk
CONSIDER:
Suspected Non-Accidental Injury: BSCP Guidance
Child Sexual Exploitation CSE intelligence sharing – report concerns police on 101 CSE Indicator Tool
Mandatory duty to report cases of FGM to Police- 101
****
Report county lines/ gangs, cuckooing to Police -101
****
National Referrals Mechanism for Slavery/ Trafficking –contact HPFT safeguarding team
****
Domestic Abuse- refer to IDVA Report controlling coercive behaviour to Police 101
Sexual Violence- SARC & ISVA
Stalking- NSAS
****
Prevent- HPFT Prevent Lead & safeguarding team must be notified of all referrals
Complete a Datix, to record the safeguarding child incident –attach the completed form to the Datix
Paris users- open a new child safeguarding assessment to record information about the referral
Review & update alerts- 'safeguarding referral made' alert
Update risk assessment
Notify the child/ parent/carer's GP of the referral
Discuss the case in supervision
(record these actions on Paris child safeguarding assessment)
After 3 working days: If children's services have not been in contact, it's the referrer's responsibility to call 01296383962 (quoting reference no) to discuss outcome of referral– record this on Paris child safeguarding assessment
Please contact the safeguarding team for formal escalation if:
After 3 attempts you have been unable to obtain the outcome
The case has been closed without liaison with you
You disagree with the outcome & you have discussed this with your manager/ clinical lead
To discuss a case, contact: hpft.safeguardingteam@nhs.net or 01727 804717

Corporate Safeguarding Team

Updated February 2022

Essex Safeguarding Children Referral Process

Please refer to HPFT & SET Policies & Procedures and HPFT Safeguarding Children Policy

Safeguarding Concerns for a Child living in Essex (Pre-birth – day before 18th birthday)

Urgent cases e.g. recent sexual abuse/ serious physical abuse, phone 0345 603 7627 & complete written referral afterwards. In emergencies dial 999 e.g. suspect imminent FGM. Report crimes to police on 101

If you are concerned that a child or young person is being harmed or neglected or is at risk of this you should go to the report concerns about a child page and complete a: Request for Support

If you need to speak to someone during Out of hours: (Mon-Thurs 5.30pm-9am. Fri & Bank Holidays 4.30pm-9am) call 0345 606 1212 and/or email: Emergency.DutyTeamOutOfHours@essex.gov.uk

The single point of contact for all Safeguarding queries is: 01245 315130

Report allegations of child abuse about people working with children to LADO –found under Managing Allegations in the Workforce

Complete a Datix, to record the safeguarding child incident –attach the completed form to the Datix

For Paris users- open a new child safeguarding assessment to record information about the referral

Review & update alerts- add 'safeguarding referral made' alert

PCMIS users- document your concerns & actions

Update risk assessment

Notify the child's GP of the referral

Discuss the case in supervision

(record these actions on Paris child safeguarding assessment/ PCMIS)

CONSIDER:

SET Suspicious/Unexplained injury or Bruising in Children Multi-agency Protocol

Child Sexual Exploitation intelligence sharing – report concerns police on 101

Mandatory duty to report cases of FGM to Police- 101

Duty to Report

****

Report county lines/ gangs, cuckooing to Police -101

****

National Referrals Mechanism for Slavery/ Trafficking –contact HPFT safeguarding team

****

Domestic Abuse- refer to IDVA Report controlling coercive behaviour to Police 101

Sexual Violence- SARC- ISVA

Stalking- ISAC

****

Prevent - HPFT Prevent Lead & safeguarding team must be notified of all referrals

After 3 working days: If children's services have not been in contact, it's the referrer's responsibility to call 0345 603 7627 (quoting reference no) to discuss outcome of referral– record this on Paris child safeguarding assessment/ PCMIS

Please contact the safeguarding team for formal escalation if:

- After 3 attempts you have been unable to obtain the outcome
- The case has been closed without liaison with you
- You disagree with the outcome & you have discussed this with your manager/ clinical lead

To discuss a case, contact: hpft.safeguardingteam@nhs.net or 01727 804717

Corporate Safeguarding Team

Updated May 2021

Norfolk Safeguarding Children Referral Process

Please refer to HPFT & Norfolk Policies & Procedures and HPFT Safeguarding Children Policy

Safeguarding Concerns for a Child living in Norfolk (Pre-birth – day before 18th birthday)

Urgent cases e.g. recent sexual abuse/ serious physical abuse, phone 0344 800 8021 & complete written referral afterwards. In emergencies dial 999 e.g. suspect imminent FGM. Report crimes to police on 101

If you are concerned that a child or young person is being harmed or neglected or is at risk of this you should go to the report your concerns to the Children's Advice and Duty Service: How to Raise a Concern

If you need to speak to someone during Out of Hours phone 03448008020

Children's Advice and Duty Service (CADS): Professionals Guide

If you have concerns about an adult working with a child under the age of 18 report to the Local Authority Designated Officer (LADO): LADO Referrals

CONSIDER:

Suspicious or unexplained injury in non-mobile babies (<6 months)- Guidance

Child Sexual Exploitation intelligence sharing – report concerns police on 101 -CSE Resources

Mandatory duty to report cases of FGM to Police- 101

Duty to Report

****

Report county lines/ gangs, cuckooing to Police -101

****

National Referrals Mechanism for Slavery/ Trafficking –contact HPFT safeguarding team

****

Domestic Abuse- refer to IDVA Report controlling coercive behaviour to Police 101

Sexual Violence- SARC & ISVA

Stalking- NSAS

****

Prevent -HPFT Prevent Lead & safeguarding team must be notified of all referrals

Complete a Datix, to record the safeguarding child incident –attach the completed form to the Datix

Paris users- open a new child safeguarding assessment to record information about the referral

Review & update alerts- add 'safeguarding referral made' alert

Update risk assessment

Notify the child's GP of the referral

Discuss the case in supervision

(record these actions on Paris child safeguarding assessment)

After 3 working days: If children's services have not been in contact, it's the referrer's responsibility to call 0344 800 8021 (quoting reference no) to discuss outcome of referral– record this on Paris child safeguarding assessment

Please contact the safeguarding team for formal escalation if:

- After 3 attempts you have been unable to obtain the outcome
- The case has been closed without liaison with you
- You disagree with the outcome & you have discussed this with your manager/ clinical lead

To discuss a case, contact: hpft.safeguardingteam@nhs.net or 01727 804717

Appendix 2

Corporate Safeguarding Team

Updated May 2021

Hertfordshire Safeguarding Children Referral Process

Please refer to HPFT & HSCP Policies & Procedures and HPFT Safeguarding Children Policy

Safeguarding Concerns for a Child living in Herts (Pre-birth – day before 18th birthday)

Urgent cases e.g. recent sexual abuse/ serious physical abuse, phone **0300 123 4043** & complete written referral afterwards. In emergencies dial 999 e.g. suspect imminent FGM. Report crimes to police on 101

If you believe the child is at immediate risk of significant harm/ child in need complete a Child protection contact form (**This includes referrals to all of the safeguarding services eg. IFFST, SASH, 0-25 Team etc**)

1. Register for a personal account
2. When the form is completed, create a PDF to upload the referral onto Datix & the Paris child safeguarding assessment care document or PCMIS
3. Note the unique reference number (you will need this if following up a referral)
4. Also report allegations of child abuse about people working with children to LADO within 1 working day, for referral refer to Section 3 of 5.1.5 Managing allegations against Adults working with Children

Complete a Datix, to record the safeguarding child incident (*this notifies the safeguarding team of the referral- no need to email us separately*)

For Paris users- open a new child safeguarding assessment to record information about the referral

Review & update alerts- add 'safeguarding referral made' alert

PCMIS users- document your concerns & actions

Update risk assessment

Notify the child's GP of the referral

Discuss the case in supervision

(record these actions on Paris child safeguarding assessment/ PCMIS)

After 3 working days: If children's services have not been in contact, it's the referrer's responsibility to call **0300 123 4043** (quoting reference no) to discuss outcome of referral– record this on Paris child safeguarding assessment/ PCMIS

Please contact the safeguarding team for **formal escalation** if:

- After 3 attempts you have been unable to obtain the outcome
- The case has been closed without liaison with you
- You disagree with the outcome & you have discussed this with your manager/ clinical lead

Section 6- HSCP Escalation Policy

To discuss a case, contact: hpft.safeguardingteam@nhs.net or 01727 804717

CONSIDER:

Bruising Policy- for babies <6 months

CSE intelligence sharing - HALO police referral form hqsafeguarding@herts.pnn.police.uk

****

Mandatory duty to report cases of FGM to Police- 101 - HSCP FGM Pathway

****

Report county lines/ gangs, cuckooing to Police -101

****

National Referrals Mechanism for Slavery/ Trafficking –contact HPFT safeguarding team

Child Victim Pathway Herts

****

Domestic Abuse- refer to IDVA. Report controlling coercive behaviour to Police 101

Sexual Violence- SARC- ISVA

Stalking- ISAC

****

Prevent - HPFT Prevent Lead & safeguarding team must be notified of all referrals

Our Values

Welcoming Kind Positive Respectful Professional