Northumbria Healthcare
NHS Foundation Trust

CG29

Northumbria Healthcare NHS Foundation Trust

Clinical Governance Policies and Procedures

Safeguarding and Promoting the Welfare of Children and Young People

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Name of Policy Author	Yvonne Lawrence, Named Nurse, Safeguarding Children Paula Shandran, Head of Safeguarding Children & Adults and Learning Disability Liaison.
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This Policy has been Impact Assessed against the Equality Act 2010

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17/09/2012	19/09/2012	5	01/10/2012	01/10/2015	Jan Hemingway Named Nurse Child Protection
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Statement of changes made from previous version 11

Version	Date	Description
12	02/08/22	Inclusion of updated information around escalation, restraint, thresholds, perplexing presentation, mental health, Domestic Abuse act 2021. Changes of terminology to child to parent violence and abuse, pregnant person, and the use of terms related to a signs of safety approach. Removal of information relevant to Health Visitors and mainstream PHSNs. General update throughout the policy.

Contents

1. Operational Summary

Policy Aim

The overall aim is to ensure that all staff employed by Northumbria Health Care NHS Foundation Trust (NHCFT) know what their duties and responsibilities are with regard to safeguarding and promoting the welfare of children; acting appropriately and in accordance with these policies and procedures when a situation requires them to do so.

These policies apply to all staff employed by Northumbria Healthcare NHS Foundation Trust. Including Northumbria Care who provide domiciliary care into people's own homes (adults).

Policy Summary

This Policy includes information and guidance relating to the sections identified on the contents page, and includes procedures that apply to all staff employed by the Trust.

This policy provides guidance for staff who may have concerns that a child(ren), young person or unborn baby has suffered or is at risk of suffering significant harm from abuse or neglect.

Procedures that apply to specific services only, will be, or have been developed as Standards and Procedures/Pathways within the services they apply to. It is expected that NHCFT Safeguarding Team are consulted within the development of these, and that finalised standards / procedures are implemented and audited by those services. This document does not include the full details of these standards/procedures but may refer to them. Moreover, this document does not include copies of the specific service procedures to be followed; however, these can be obtained via the intranet or by contacting the head of the service they apply to.

All standards and procedures that apply to specific service should:

- Make clear the standard to be achieved
- Highlight the circumstances in which advice will need to be sought from NHCFT's Safeguarding Team / Named Nurse, Midwife or Doctor for Safeguarding Children, including time frames.
- Signs or indicators of concern if relevant
- Actions that should be taken (including time frames).

- How frequently the standard / procedure will be reviewed and audited (where it is realistic to do so). Who (specifying the title of the member of staff within the service) will have responsibility for ensuring any audit(s) are completed.

What it Means for Staff

Managers/Supervisors - All managers are responsible for ensuring that they read, understand and know how to access policies relevant to safeguarding, and for ensuring that all staff who work in their service are:

- Informed of these policies.
- Know how to and are able to access these policies.
- Informed that it is their responsibility to read these policies and seek further clarification from their manager or NHCFT Safeguarding Team, if there is anything they do not understand or if further information is required

All Trust Employees - All staff must ensure that they follow NHCFT safeguarding policies and procedures whilst undertaking their role.

If NHCFT practitioners have concerns about an unborn baby, child or young person they can seek advice from NHCFT Safeguarding Team (contact numbers available on the Intranet). It is expected that all NHCFT who do not regularly deal with Safeguarding Children issues contact NHCFT Safeguarding Team to discuss the case.

If NHCFT staff are unsure of their responsibilities or have concerns that plans in place do not adequately address the safeguarding concerns around a child, young person or unborn baby they must escalate the case to their manager and NHCFT Safeguarding Team.

2. Introduction

The Trust has a responsibility and duty to safeguard the children who access services. This includes children of adults and carers who use our services on a daily basis. Services do not always neatly divide into those for adults and those for children, and there will be circumstances when staff in adult services may become aware of or have reasonable cause to believe that a child is or may be at risk of significant harm; it is crucial that all staff understand their responsibilities to safeguard and promote the welfare of children

This document reflects the principles contained within the United Nations Convention on the Rights of the Child, ratified by the UK Government in 1991 and also the European Convention of Human Rights, in particular Articles 6 and 8.

The Children Act (1989) and (2004), places a duty on all agencies (including health services), to work together to safeguard and promote the welfare of children; ensuring their functions, and any services provided on their behalf, are discharged with regard to this. Working Together to Safeguard Children (2018), describes in more detail the role and responsibilities of professionals and agencies.

Our Local Safeguarding Children Partnerships (LSCPs) utilise a shared North and South of Tyne Safeguarding Children's Partnership Procedures Manual, and this policy (CG29) has been written in alignment to this. North and South of Tyne Safeguarding Children's Partnership Procedures Manual is regularly updated and contains general information relevant to safeguarding children in a wide range of situations. It is an excellent resource for staff. It can be accessed here:
https://www.proceduresonline.com/nesubregion/

3. Purpose

The purpose of this policy is to ensure that staff employed by NHCFT, understand their responsibilities to co-operate and work with other professionals and other agencies to safeguard and promote the welfare of children, and that they know what action to take if they have concerns.

The purpose of this policy is also to ensure that the Trust meets its statutory requirements under current legislation and guidance in relation to Safeguarding Children.

This document describes the responsibilities of the Trust and provides procedures for NHCFT staff regarding how they should work together with other professionals and agencies to safeguard children and young people.

4. Duties

The Executive Director of Nursing, Midwifery and Allied Healthcare Professionals and Director of Nursing are the Trusts Executive Lead/Director Lead for Safeguarding. The Head of Safeguarding is the Trusts specialist lead for Safeguarding and is accountable to the Trust Board to provide safeguarding assurances.

NHCFT has an Assurance Committee and Safety and Quality Committee which report to the Trust's Board. Quarterly reports produced by NHCFTs Head of Safeguarding Children & Adults and are reported to the Trust Board via these committees.

NHCFT has a Named Doctor, Nurse and Midwife in line with Working Together to Safeguard Children (2018), who promote good professional practice, review practice, identify and share learning. They work both with NHCFTs Head of Safeguarding Children & Adults and the Trusts Safeguarding Board to ensure all responsibilities are met. NHCFTs Head of Safeguarding Children & Adults, alongside all of the 'Named' practitioners can be contacted via the Trust Safeguarding Team number (please see intranet / access via switchboard).

NHCFTs Head of Safeguarding Children & Adults, and Named Professionals produce a quarterly report for NHCFT Safeguarding Board. There is representation from the Safeguarding Team at the Board meetings which are held on a monthly basis and any relevant issues (including risks) are discussed and action plans developed to reduce these. NHCFT Safeguarding Team are represented on multi-agency partnership boards, sub-groups, and within audit and practice development work. They also attend and contribute to Safeguarding Children Practice Reviews, Domestic Homicide reviews, and other multi-agency learning processes.

The Safeguarding Team provide staff with advice and supervision as appropriate to role. They also support Trust staff with report writing and court attendance, alongside providing trust wide safeguarding children training and undertaking audit work. The team are core members of MARAC, MAPPA and Channel.

All NHCFT staff who hold a professional registration remain accountable to their regulatory professional body.

All staff are accountable to their manager, and any significant untoward incident must be recorded and reported via the Trusts incident reporting mechanism (Datix). Any datix identified as relevant to safeguarding is reviewed by one of NHCFTs Named Safeguarding Professionals; these are also reported quarterly at NHCFT Safeguarding Board.

There are also Designated Nurses and Doctors for Safeguarding Children covering each Local Authority Area and employed by NHS Clinical Commissioning Group (CCG). The Designated Professionals for Safeguarding Children are a vital source of expertise with regard to safeguarding children and young people.

5. Definitions of Terms Used

Children
For the purpose of this policy, 'children' means persons who have not yet reached their 18th birthday and, includes any reference in this document to 'young people'. The fact that a child has reached 16 years of age does not change his or her status or entitlement to services or protection under the Children Act 1989. However, The Mental Capacity Act applies 16 +, therefore it is important that this is undertaken in line with the legal requirements (RMP 62 Mental Capacity Act and Deprivation of Liberty Safeguards policy).

This policy also applies to unborn children where a practitioner anticipates that prospective parents may require support services to care for their baby or that the baby may be at risk of significant harm following the birth.

Safeguarding and Promoting Welfare of Children
Is defined for the purpose of this policy as:

- protecting children from maltreatment;
- preventing impairment of children's health or development;
- ensuring that children are growing up in circumstances consistent with the provision of safe and effective care.

Abuse and Neglect
Maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting by those known to them or, more rarely, by others. Abuse can take place wholly online, or technology may be used to facilitate offline abuse. Children may be abused by an adult or adults, or another child or children. Working Together to Safeguard Children (2018).

Child Protection
This refers to the activity that is undertaken to protect children who are suffering, or are likely to suffer significant harm. Effective child protection is essential as part of wider work to safeguard and promote the welfare of children. However, all staff should aim to

proactively safeguard and promote the welfare of children so that the need for action to protect children from harm is reduced.

Child in Need (CIN)
A broad definition (under section 17 of the Children Act 1989) spanning a wide range of children and adolescents, in need of varying types of support and intervention, for a variety of reasons. A child is defined as 'in need', where:

- they are unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for them of services by a local authority
- their health or development is likely to be significantly impaired, or further impaired, without the provision for them of such services; or
- they are disabled
  The factors to be considered in deciding whether a child is in need under the Children Act 1989 are:
  - what will happen to a child's health or development without services being provided; and
  - the likely effect the services will have on the child's standard of health and development.

Local Authorities have a duty to safeguard and promote the welfare of children who are in need within their area.

Harm
The Children Act 1989 defines 'harm' as, the ill-treatment or the impairment of health or development, including, for example, impairment suffered from seeing or hearing the ill-treatment of another; 'development' means physical, intellectual, emotional, social or behavioural development; 'health' means physical or mental health; and 'ill treatment' includes sexual abuse and forms of ill-treatment which are not physical.

Significant Harm
The Children Act 1989 introduced the concept of 'significant harm' as the threshold that justifies compulsory intervention in family life in the best interests of children, and gives Local Authorities a duty to make enquiries to decide how they should act to safeguard or promote the welfare of a child who is suffering, or likely to suffer, significant harm.
There are no absolute criteria on which to rely when judging what constitutes significant harm. Consideration of the severity of ill-treatment may include the degree and the extent of physical harm, the duration and frequency of abuse and neglect, the extent of premeditation, and the presence or degree of threat, coercion, sadism and bizarre or unusual elements.

Sometimes, a single event may constitute significant harm, for example, an assault, poisoning, abandonment. However, significant harm can also be a culmination of factors (acute and/or chronic in nature).

Section 47

Section 47 of the Children Act 1989 outlines that Local Authorities have a duty to investigate when they are informed that a child who lives in, or is found, in their area:

- has been made the subject of an Emergency Protection Order (EPO)
- Has been taken into Police Protection (PPO)
- When they have reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm

The purpose of this investigation is to enable a decision to be made as to whether they need to take any action to safeguard or promote the child's welfare.

There is a duty of all NHS health organisations that they assist Local Authorities with these enquiries by providing relevant information.

Risk and Protective Factors

Risk factors are characteristics that may increase the likelihood of experiencing or perpetrating child abuse and neglect. They may or may not be direct causes. Individual, relational, community, and societal factors all contribute to the risk of child abuse and neglect.

Protective factors can reduce the likelihood of a child being abused or neglected. Identifying and understanding protective factors are equally as important as risk factors. These may be individual to the child, the family, the community or in terms of wider support which is being successfully delivered.

5.1 Categories of Abuse

Currently there are four categories of abuse identified in Working Together to Safeguard Children DCSF (2018):

1) Physical abuse:

May involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces, illness in a child.

2) Emotional abuse:
The persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to a child that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person.

It may include not giving the child opportunities to express their views, deliberately silencing them or 'making fun' of what they say or how they communicate. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond a child's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction.

It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying (including cyber bullying), causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.

3) Sexual Abuse:
Involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening.

- The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing.
- They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (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.

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

4) Neglect

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

- provide adequate food, clothing and shelter (including exclusion from home or abandonment);
- protect a child from physical and emotional harm or danger;
- ensure adequate supervision (including the use of inadequate care-givers); or
- ensure access to appropriate medical care or treatment.
- It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

6. Process

6.1 When a child attends hospital

A check should be made whether the child is subject to a Child Protection Plan; for children living in Northumberland and North Tyneside this information is available on PAS as an alert. Therefore, PAS must be checked when a child attends hospital and the alerts reviewed.

Unscheduled care settings: for children who live out of Northumberland and North Tyneside Local Authority areas CP-IS (Child Protection Information Sharing) is used to provide information to staff about children who are subject to Child Protection Plans outside of these local areas (in England). All relevant unscheduled care settings must have a process in place highlighting CP-IS results to the practitioners providing the clinical care.

If the child does not have a Child Protection Plan, this does not mean there are no concerns. If a professional has concerns, action must be taken appropriately.

If the child lives in another area, liaison and appropriate information sharing should take place with the Local Authority in which the child lives. Children in Care (CIC) remain the responsibility of the Local Authority they have been legally placed in the care of even when they are placed in a different geographical area.

If the family do not provide the necessary information to enable the appropriate enquiries and liaison to take place, Children's Services locally should be approached to assist in the first instance.

6.2 Information Sharing:

If a member of staff is asked, or wishes, to share information about a person they must have a good reason or a clear and legitimate purpose to do so. Timey and effective information sharing is essential to keep children safe, with poor information sharing often highlighted in Safeguarding Children Practice Review's (reviews carried out following a child's death or serious injury) as requiring strengthening.

It is always best to share information with consent, however on occasions this may not be possible and it is important that fears about sharing information do not stand in the way of safeguarding and who are children suffering or at risk of suffering abuse or neglect.

Circumstances in which sharing confidential information without consent will normally be justified:

- When there is reasonable cause to believe that the child/young person is suffering or is at risk of suffering significant harm; or that an adult has suffered serious harm.
- To prevent a child/young person from suffering significant harm or to prevent serious harm to an adult.
- When there is a risk to others.

Staff must not seek consent when they have reasonable cause to believe that seeking consent is likely to:

- Place a person (the individual, family member, the professional or a third party) at increased risk of significant harm of a child, or serious harm of an adult or;
- Prejudice the prevention or detection or prosecution of a serious crime; or
- Lead to an unjustified delay in making enquiries about allegations of significant harm to a child or serious harm to an adult.

All staff must read and understand their duties in terms of sharing information when there are safeguarding children concerns.
Consider:

- Necessary and Proportionate- Information sharing must be proportionate to the need and level of risk, so how much information do you need to release?
- Relevant- Only information relevant to the purpose- to allow others to do their job effectively.
- Adequate- Quality information, that is clear and can be understood.

- Accurate: Accurate and up to date, distinguishing between recent and historic information.
- Timely: Shared in a timely fashion to reduced risk of missed opportunities.
- Secure: Organisational policy regarding the safe handling on information should be applied.
- Record: All decisions must be recorded in the record in full- including if consent was obtained (or not), the decision to share (or not), who the information has been shared with. It is important that the person you are sharing the information with understands if it is being shared with consent or not, and if the child / family are aware.

All decisions to share information or to refer a child or young person to Children's Social Care must be fully documented.

The Safeguarding Team can be contacted, and will give advice on individual cases. Out of hours, support should be requested where needed from on-call managers / Children's Social Care.

Further information
- Information sharing- Advice for practitioners providing safeguarding services to children, young people, parents and carers (DFE- 2018) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/721581/Information_sharing_advice_practitioners_safeguarding_services.pdf
- The Trusts information Governance Policy (IG01)
- Clinical/ Social Care Documentation Policy (CG05)

6.3 Responding to Disclosure

A child or adult may choose to confide in or talk to a member of NHCFT staff about experiences of child abuse or neglect; this is commonly known as a disclosure. Disclosures may take the form of a direct statement or an indirect statement, (in writing / drawings, role play or stories). The child / adult making the disclosure may be very anxious and fearful about confiding in someone, or may disclose in a very casual way during an activity in a calm 'matter of fact' way.

- Try not to stop a child / adult who is freely recalling significant events.
- Receive the information, by listening carefully to what is being said.
- Offer reassurance that they have done the right thing by telling you.
- Record what has said been said as soon as possible, using exact words, and making diagrams of any physical marks associated with the allegation.
- Create a safe place to talk, away from other children and adults.

- React to the situation by doing something about it and explain what will happen next, as appropriate to the level of understanding. If you are unsure what needs to happen next contact the Trusts Safeguarding Team (or if out of hours discuss with on-call manager / Children's Social Care).

- **Do not**: Promise to keep the disclosure a secret; you will have to report it.
- **Do not**: Rush off to find someone else to listen or to find a pen/paper
- **Do not**: Display shock or disapproval, anger or disgust
- **Do not**: Ask direct and/or closed questions such as Why? When? Who? Where? How?
  You may ask the child / adult to repeat a statement or say 'is there anything else you want to tell me? or 'Would you like to talk about it?'
- **Do not**: Investigate any allegations.
- **Do not**: Make judgements or say anything about the alleged abuser
- **Do not**: Talk to the parents before discussing a safeguarding children disclosure with NHCFT Safeguarding Children Team/referring to Children's Social Care in the following circumstances;
  - If you think that the child would be threatened or otherwise coerced into silence.
  - If you think that there is a strong likelihood that important evidence would be destroyed (such as in the case of sexual abuse or another police enquiry).
  - If you the child in question does not wish the parent to be involved at that stage and has capacity to make that decision.
  - If you think that it could place you or others at risk of significant harm

If any doubt about what action to take following a disclosure that gives reasonable cause to believe that a child / young person has suffered or is at risk of significant harm, staff must contact NHCFT Safeguarding Team to discuss the case (discuss with the manager on-call or Children's Social Care if outside of normal working hours).

A disclosure of sexual abuse, serious physical abuse, or neglect, must be referred to Children's Social Care without delay.

In the case of an allegation against a member of staff**, DO NOT** talk to the member of staff before discussing the allegation with the NHCFT's Safeguarding Children Team or the on-call manger if out of hours.

6.4 Referral to Children's Social Care when there is reasonable cause to believe that a child or young person or unborn baby is suffering or likely to suffer significant harm.

Any member of staff who has reasonable cause to believe that a child / young person is suffering, or may be at risk of significant harm from abuse or neglect must make a referral to Children's Social Care (also see flowchart at the end of this section). This also applies to an unborn baby when there are concerns that the baby may be at risk following the birth. This referral must be made to the Children's Social Care team based in the area the child lives; with the exception of Children in Care (CIC) as this group may include children living in a placement outside of the Local Authority Area who they are in the care of.

Safeguarding Partnerships have useful information regarding Thresholds of Need and such information is useful to assist staff with decision making. However, if in any doubt, advice must be sought from NHCFT's Safeguarding Children Team or the on-call manager / Children's Social Care if outside of normal working hours.

Northumberland:
https://www.northumberland.gov.uk/NorthumberlandCountyCouncil/media/Child-Families/Safeguarding/thresholds-10-2018.pdf

North Tyneside:
https://www.northtynesidescp.org.uk/professional/single-assessment-threshold/

Making a referral to Children's Social Care must not be delayed if there is an immediate risk of harm to a child or young person (consideration must also be given as to if contacting the police is needed- if so, this must not be delayed).

If it is safe to do so, staff must inform parents/carers and or the child / young person (considering their age and understanding), of their concerns and request their permission to refer to Children's Social Care. If the parent(s) or child / young person refuse to give consent, the member of staff will explain that they are required by law and under the organisation's policies and procedures to make the referral, even without their consent due to the level of concern around significant harm.

In the following circumstances staff **will not** seek consent or inform the child/ parents/carers of their intention to make a referral to Children's Social Care:

- If it may place a person (the child, family member, the member of staff or a third party) at increased risk of significant harm (including in cases of suspected Fabricated Induced Illness or Female Genital Mutilation).
- It may prejudice the prevention or detection or prosecution of a serious crime
- It may lead to an unjustified delay in making enquiries about allegations of significant harm to a child or serious harm to an adult.

The referral must be made by initially contacting telephoning Children's Social Care to make a verbal referral, then followed up in writing via the electronic referral form accessed via the safeguarding section on the Intranet (North Tyneside and Northumberland).

Out of hours urgent referrals should still be telephoned through to Children's Social Care at the time of the incident, however those that do not require immediate action from Social Care can be submitted straight away via the electronic referral system, and followed up with a telephone call within office hours. Referrals should include representation and consideration of the voice of the child.

All departments should have an auditable process in place to assure this process, and all contacts and decision making should be clearly recorded in the patient notes.

For children who live in other Local Authority areas, the appropriate from / link should be requested from the appropriate Social Work team at the time of the referral, and a copy stored in the record and also sent to NHCFT Safeguarding Team Safeguarding.Children@northumbria-healthcare.nhs.uk

If the intranet is not available, it is still essential that necessary referrals are completed by telephone with no delay. These will also need to be followed-up in writing at the earliest opportunity. An up to date paper copy of the referral form can be obtained from the Emergency Preparedness file, NHCFT Safeguarding Team or telephoning the relevant children's social care team (all key information is accessible in the Emergency Preparedness files available on departments). This must be completed and sent to both the relevant Local Authority **and** NHCFT's Safeguarding Children Team as soon as possible; a copy must also be stored in the patient record.

It is essential that Children's Social Care are provided with clear, quality information regarding the identified risks, protective factors, plan and also that some thought is given to what types of support might be needed. Social care must also be informed whether or

not the parents / carers are aware of the referral and if not, the reasons why they have not been informed. It is important that NHCFT staff and the social worker re-cap / summarise together at the end of their conversation, to minimize the risk of miscommunication / misinterpretation.

Following making a referral to Children Social Care NHCFT staff should be informed of the next course of action by the Social Work Team, and if they are unhappy / in disagreement with the plan they highlight this. They must then seek immediate advice from NHCFT Safeguarding Team (or on-call manager if out of hours) and a discussion should take place with the manager on-call for the Children Social Care Team to achieve resolution. This should be fully documented in the patient record.

Following the referral, staff must document in the child's / young person or adults health record, the following information:

- The date and time that the referral was made.
- The name of the Social Worker who received the referral.
- Details of the information that was given to the Social Worker, (reference can be made to the written referral).
- Details of the agreed action to be taken.

It is important that case holding staff (Community Midwives, Community Children's Nurses, Primary Mental Health Workers, Community physio / OT, CAMHS staff etc) follow-up on referrals made to Children's Social Care for children on their caseload so that they can contribute to assessment and planning.

If the suspected harm involves an employee of NHCFT, the line manager must be notified and NHCFT's Safeguarding Team contacted immediately (also see section 6.34).

Supporting information can be also be found here:
What to do if you're worried a child is being abused: Advice for Practitioners (DFE-2015)
https://www.gov.uk/government/publications/what-to-do-if-youre-worried-a-child-is-being-abused--2

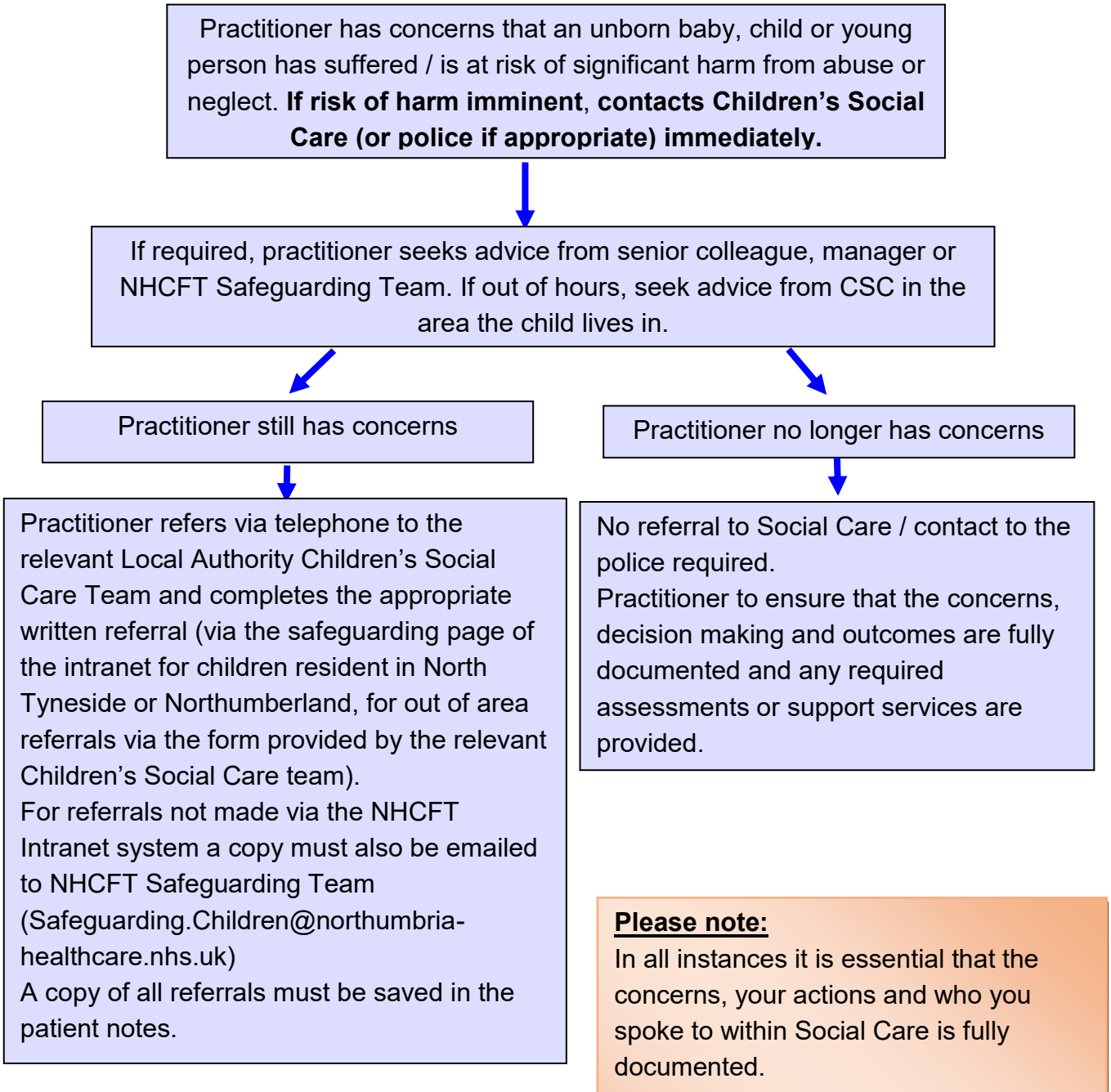
Escalation

NHCFT staff are responsible to ensure the safety of children for whom there are identified safeguarding concerns, and it therefore need to be satisfied with outcomes of any referrals they make, and in agreement with the resulting plans. Should a staff member be unhappy about the responses of other agencies it is essential that they address their concerns effectively.

In the first instance a discussion should take place with the Social Worker / Duty Worker involved to discuss the case and highlight what the concerns are and what the member of staff would like to happen. Should these discussions not resolve the worries, then they should ask for their disagreement with the decision making to be noted and request to speak to the Social Work Team Manager; or inform the worker that they are planning to seek further advice from NHCFT safeguarding Team, (or on-call manager if outside of office hours). All actions should be fully documented in the health record and it is important that any immediate concerns regarding safety are rectified immediately; out of hours there is always a senior manager on duty overseeing children's social care, and their review should be requested via the Social Worker where needed.

NHCFT Safeguarding Team should be contacted to discuss any case where there are concerns that a response to a safeguarding issue has not been appropriate so that an appropriate plan forward can be agreed. Children's Social Care and Safeguarding Partnerships have processes in place aiming to resolve such issues and NHCFT Safeguarding Team will support to progress cases via these processes as required.

Procedure for making a referral to Children's Social Care



Please note:
In all instances it is essential that the concerns, your actions and who you spoke to within Social Care is fully documented.
The Outcome of the referral must also be clear in the record and it is essential that if you are unhappy with a proposed plan you challenge this and seek support from NHCFT Safeguarding Team (or the on-call manager out of office hours) immediately.

Child Protection Medicals

When there is concern that a child has been physically abused or neglected, it may be appropriate that a referral is made to the Consultant Paediatrician 'on call' for child protection for a medical opinion. In these circumstances a medical opinion **must not** be sought from a General Practitioner. It is the social worker's responsibility to make the referral to the paediatrician if it is believed that a medical opinion is necessary. NHCFT always have a Consultant Paediatrician on-call for Child Protection, and they can be contacted via the hospital switchboard.

If a member of staff has concerns that a medical opinion is not being sought and they believe it should be, the member of staff must inform the social worker of their views and ask for the rationale. If they remain unhappy with the plan they should inform the Social Worker of this and contact NHCFT Safeguarding Team immediately to discuss their concerns. If it is out of hours they must discuss immediately with the NHCFT on-call manager and a discussion should take place with the manager on-call for the Children Social Care Team.

6.5 Referral to Children's Social Care when it is believed that a child or young person may be a Child in Need.

Children in Need are defined in the Children Act (1989) as those whose health or development may be impaired without the provision of services, or who are disabled. Section 17 of the Children Act places a duty on Local Authorities to promote and safeguard the welfare of this group by providing access to a range of appropriate services. The Children Act also places a duty on health bodies to co-operate with a Local Authority who may request help identifying what the child requires.

Section 17 states that a child is considered a Child in Need if:

- they are unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision of services by a Local Authority.
- their heath or development is likely to be significantly impaired, or further impaired, without the provision of such services
- is disabled.

Where a child is considered to be a possible Child in Need a referral to Children's Social Care should be made with the consent of the child or parent / carer.
If consent is refused, and professionals are concerned that this results in the child experiencing / being at risk of experiencing significant harm, then the case should be

discussed with NHCFT Safeguarding Team / a referral made to Children's Social Care (see section 6.4).

It is important that case holding staff (Community Midwives, Community Children's Nurses, Primary Mental Health Workers, Community physio / OT, CAMHS staff etc) follow-up on referrals made to Children's Social Care for children on their caseload so that they can contribute to assessment and planning.

6.6 Early help and intervention to support children, young people and families

All staff share responsibility for safeguarding, and also for promoting the welfare of children and young people. From the perspective of a baby / child / young person, it is clearly best if they receive help to reduce / prevent them experiencing adversity. Early Help is collaborative approach with children, young people and families to help them access the right support and the right time by the right person and in a joined up and effective way.

The Early Help process is consent based and is important to enable early and effective assessment of children / young people who need additional services or support from more than one agency. When a member of staff becomes aware of, or suspects that a child/young person has a number of unmet needs, or the parents are struggling to provide the child with appropriate care, they will request permission from the child (if competent) / adult to undertake an assessment using the Early Help Assessment (EHA). A copy of the assessment and subsequent work completed should be clearly recorded in the health record.

NHCFT staff should routinely ask patients / clients whether or not they have any dependents or caring responsibilities, and these questions should be included in all initial health assessments to gain a holistic understanding of need. This includes within adult services.

Early Help arrangements can be somewhat differently across Local Authority Areas- more area specific information will be able to be found on the relevant area website:

Northumberland:https://www.northumberland.gov.uk/Children/Safeguarding/Safeguarding-children-information-for-professional.aspx#earlyhelpinnorthumberland

North Tyneside: https://my.northtyneside.gov.uk/category/500/early-help

Newcastle: https://www.newcastle.gov.uk/services/care-and-support/children/getting-help-children-and-families/early-help-your-family

Training around Early Help can be accessed via the Local Safeguarding Partnership's websites:

North Tyneside: https://www.northtynesidescp.org.uk/professional/ntscb-training/

Northumberland: https://www.northumberland.gov.uk/Children/Safeguarding/NSCB-Multi-Agency-Training.aspx

If the child / parents refuse to give their permission for an Early Help Assessment, the member of staff will need to carefully consider whether or not without the support of services, the child/young person may be at risk of significant harm. If there is felt to be a risk of significant harm then a referral should be made to Children's Social Care (see section 6.4).

6.7 Policy regarding unborn babies and concerns that they may be at risk

It is essential that unborn babies are referred to Children's Social Care to secure their safety when there are concerns or reasonable cause to believe that a baby may be at risk of significant harm. This ensures that there is opportunity for any appropriate assessments and indicated work to take place prior to birth to reduce risk. Therefore, it is a priority that midwives and other staff identify concerns as soon as possible and make appropriate and timely referrals. It is the responsibility of the midwife to, inform children services of any further concerns or escalation of risk during the pregnancy, this should be recorded in the maternity records.

It is important that midwives involved in antenatal and postnatal assessment and support, fully consider the significant role of the father and wider family member who are involved in the care of the baby even if parents are not living together and where possible involve them in the assessment. This should include the father's attitude towards the pregnancy, the mother and the new-born child, his thoughts and feelings and expectations about becoming a parent. Information should also be gathered about the father/partner who are not the biological father but may be caring for the baby at the earliest opportunity to ensure that any risks can be identified. A careful assessment of the role of the person caring for the children in relation to the woman and ay other children in the household as well as their views about the future care of the baby should also be undertaken.

If any doubt about what action to take staff must seek advice from NHCFT's Safeguarding Team (or Children's Social Care if outside of normal working hours).

The NHCFT maternity service must liaise with the Named Midwife (Safeguarding) to have in place up to date standard procedures / pathways outlining when and under what circumstances midwifes must refer to Children's Social Care. These are accessible via the intranet: https://www.northumbria-enyware.com/clinical-document-type/maternityobstetrics-and-gynaecology/

6.7.1 Concealed and Denied pregnancy

Definition of a concealed pregnancy is when

Concealed

- A person knows they are pregnant but does not tell anyone; or tells someone but conceals the fact they are not accessing antenatal care.

Denied

- A person appears genuinely not aware they are pregnant; A denied pregnancy is when a person is unaware of or unable to accept the existence of their pregnancy.

Late booking

- is defined as presenting for maternity services after 20 weeks It is always important to remember that unless the person genuinely has not been aware they are pregnant they have still concealed their pregnancy up until the point they have accessed antenatal care. A booking appointment with a midwife should be around 10 weeks (NICE 2008). A person who presents to antenatal care late in their pregnancy should continue to be assessed with the reasons for the delay in presentation and associated risks as part of the assessment, even once booked and attending for antenatal care.

If a pregnant person presents in pregnancy > 20 weeks gestation with no known social concerns GP records must be thoroughly checked ensuring there are no safeguarding issues.

- Where a child protection concern is identified a referral to children services is required.
- In all cases where a pregnant person presents in labour, have been involved with children social care, or a previous pregnancy has been concealed an immediate referral must be made to children's social care

When a person attends the trust (for example an ED department / MIU) a pregnancy is confirmed, this must be recorded in the discharge notes in a clear and legible way and communicated to the GP.

When a pregnant person attends the Trust (for example an ED department) and suspicions are raised that a pregnancy may be concealed or a concealed pregnancy is confirmed, this must be recorded in the discharge notes in a clear and legible way and communicated to the GP, community midwife, and NHCFT Safeguarding Team (and the Named midwife/nurse- Safeguarding) made aware for follow up.

Where a pregnant person 20 weeks gestation or over attends ED with a possible obstetric problem she must be transferred to The Birthing Centre / Delivery Suite for care. If the woman refuses to attend The Birthing Centre / Delivery Suite, the Senior Midwife must be informed of this and any documentation must be uploaded onto Badgernet. The Senior Midwife will ensure the community midwife is informed and if contact is not able to be made with the pregnant person a referral to children social care should be made by the community midwife.

It is essential that there is a thorough, clear and safe plan in place following discharge of any newborn and that this is clearly detailed in the records.

6.7.2. Domestic abuse in pregnancy (also see section 6.10):

It is recognised that pregnancy is a risk factor linked to domestic abuse. Domestic abuse can start or escalate during pregnancy, and all staff working with pregnant people should understand that people suffering domestic abuse are more likely to delay seeking care, fail to attend antenatal clinics regularly and to deny and minimise abuse. The perpetrator of the abuse may try to prevent her from attending appointments, likewise they may dominate antenatal appointments.

It is important to provide a supportive and enabling environment, where the issue of abuse is raised with every pregnant person in a confidential environment. This means that pregnant people should be provided with carefully constructed opportunities to be seen alone during their pregnancy. No enquiry should be made about the presence of domestic abuse in front of a partner, ex-partner or any other family member / friend. DASH (Domestic Abuse, Stalking and Harassment) assessments should be used to help explore disclosures / reports of domestic abuse. This assessment can be found on the NHCFT Safeguarding intranet page
http://intranet2.northumbria.nhs.uk/home/safeguarding/

If it is necessary to make a referral into MARAC (see Section 6.11) the appropriate referral form should be fully completed and sent to NHCFT Safeguarding Team who review and submit to MARAC where appropriate. Referrals to other agencies should be made as appropriate, and a completed copy of all documents should be filed in the persons notes.

NHCFT Safeguarding Team include practitioners with specialist knowledge around domestic abuse and sexual violence. The team should be contacted to discuss any cases where advice is needed and also provide a range of training around exploring and managing domestic abuse (see ESR or contact the team for more details).

6.8 Management of challenging behaviour of children or young people in the hospital setting

Some young people and children may present with challenging or abusive/violent behavior. This may be influenced by a number of factors including clinical condition, alcohol and/or drug use and mental health concerns. Young people displaying these behaviors may pose a safety threat to themselves, staff and other patients or visitors.

Some areas (such as Child Health, have their own procedure SOPs form managing challenging behaviour), In all cases, the clinician in charge of the team / department should be made aware that there is potential issue where a child / young person is demonstrating behaviour which may pose a risk to themselves / others.

The healthcare team should seek the advice of, and liaise with the paediatric team, and all routes for de-escalation must have been considered and utilised by staff as appropriate for patient age (including but not limited to, distraction techniques, play techniques and reasoning/understanding techniques). Including the involvement of any parents or carers which are present to attempt to calm the challenging behavior.

Restraint must only be used, where it is necessary to allow clinical management to be provided or if the patient poses a risk of harm to themselves or others. Furthermore, the least intrusive and minimum amount of restraint to achieve the specific outcome / treatment must be employed; the minimum amount of force for the shortest possible time.

A patient can only be restrained by appropriately trained persons (Security or Police) under the direct supervision of a nurse or doctor, to ensure that the patient remains safe at all times.

The decision to restrain the patient must be made by the multidisciplinary team, including input from parent/carer, if appropriate. The rationale and details of the discussion must be documented in the patients notes and include any clinical factors which may impact the patient’s condition and behavior.

There must be a clear documented timeline demonstrating that restraint is necessary including information regarding any de-escalation and also security and/or police intervention if required.

Following an incident which in restraint or de-escalation is required due to challenging behavior, all instances must be documented on the trust Datix system (and flagged as a Safeguarding Incident to ensure that a copy of the Datix is sent to NHCFT Safeguarding Team) and a debrief must be completed with staff involved by the nurse in charge.

Any individual area with a particular local procedure in place must ensure that this is developed in collaboration with NHCFT Safeguarding Team, and reviewed regularly.

Advice must be sought from NHCFT's Lead for Deprivation of Liberty (DOLS) and Mental Capacity Act Lead, and also the relevant Safeguarding Leads should there be any concerns that a person is confined to a restricted place for a non-negligible period of time and least restrictive options MUST be considered at all times. Where restraint is used, it is important to consider whether a deprivation of liberty has occurred, and if so follow the trust policy.

6.9 Suspected Non-Accidental Injuries in babies, children and young people

If any baby / child appears to be seriously unwell as a result of a suspected non-accidental injury then the required care should be provided without delay. If outside of NSECH the member of staff must request an emergency ambulance and ensure ambulance staff are made fully aware of concerns about non-accidental injury and the need for the child and family to be supervised. Once the child has been handed into the care of the ambulance service the NHCFT staff involved must make a referral to Children's Social Care as per process in Section 6.4.

When making a referral regarding concerns in relation to non-accidental injury, the member of staff making the referral must verbally inform Children's Social Care that they are concerned that the mark / bruise / injury may be non-accidental and ensure this view is also documented in their written referral.

Bruising

Bruises are the commonest presenting feature of physical abuse in children. The younger the child, the higher the risk that bruising is non-accidental, especially where the child is under 6 months of age (www.core-info.cardiff.ac.uk/reviews/bruising).

A pre-mobile infant is a child who is not yet crawling, bottom shuffling, pulling to stand, cruising, or walking independently. **All** bruises in a pre-mobile infant **(this includes any**

baby less than 6 months of age), should raise concern about the possibility of non-accidental injury and a referral must immediately be made to Children's Social Care in the area in which the child lives.

When bruising to a pre-mobile baby is noticed by staff at Northumberland Specialist Emergency Care Hospital (NSECH), the Consultant Paediatrician on duty should also be informed.

Babies with bruises should not be left alone with family until the necessary assesments and safety plans are in place, and therefore the family should be asked to wait in the department until this has been done and a plan has been identified by Social Care. Community staff must make the necessary referrals immediately but may need to pay particular attention to their safety while waiting for a Social Worker / police (if appropriate) to arrive.

We would usually expect a social worker to come to the department/clinic/home as a matter of urgency and commence assessments. Pre-mobile babies with bruises will require a paediatric assessment and this will be arranged by the social worker (see section 6.4 Child Protection Medicals).

Blue-Grey Spots ('Mongolian Spots')

These are a type of birthmark which can look blue-grey on the skin like a bruise. They are often on the lower back, bottom, arms or legs**,** are often there from birth (but can appear within the first few months of life), are most common on babies with darker skin and usually disappear before a child reaches 4 years old. The can change in shape and appearance.

If a baby is born with a blue-grey spot it should be recorded on their record (which should be checked if appropriate to assist in differentiating between this and a bruise in future). Midwives should have recorded any birth marks in the child's red book and body map. Any concern that a mark may be a bruise should be managed as per babies with bruising policy. If a second opinion if needed for a birthmark then the oncall Paediatrician can be contacted directly, but if there is a suspicion it is a bruise the bruising policy must be followed.

Oral Injuries in babies

If there is a report or observation of blood or injury in the oral cavity of a non-mobile baby this should prompt full examination, discussion with the paediatrician on call for safeguarding, and consideration of non-accidental injury and referral to Children's Social Care as per bruising pathway.

Other Injuries to babies

Unless there is a clear, credible explanation, injuries to a pre-mobile baby or child should be regarded as unusual and suspicious. Any injuries to a pre-mobile baby (including all babies under 6 months of age) with no clear, credible, witnessed history to explain them should raise concern about potential non-accidental injury and the pathway (as above) for a pre-mobile baby with a bruise, should be followed.

If there is a clear, witnessed and credible history and no other concerns about the child and family, the health visitor should be informed of the attendance as usual but no other safeguarding action may be necessary. Decision making should not be made in isolation regarding infants with injuries **and all** should be discussed with a registrar or consultant prior to discharge. Any decision not to refer should be recorded with a clear explanation of the reason why.

If the injury is unexplained or there are any factors which raise concern about the safety of the infant, then a referral should made to Children's Social Care as per the process above for non-mobile babies with a bruise.

If in any doubt, advice must be sought from NHCFT's Safeguarding Team (or from the on-call manager / Children's Social Care if outside of normal working hours).

'Rough Handling'

It is not unusual to hear of bruises or injuries to babies referred to as being a consequence of 'rough handling', implying that careless or clumsy handling is somehow less concerning as a cause of injury and bruising.

Injuries to babies can be minimised if it is believed they were caused by "rough handling" and review findings indicate that accepting this explanation may leave children at risk.

In all cases:

There needs to be sensitive but clear communication with the parent/carer about the concerns and the referrals which need to be made. Junior staff members should be supported in such discussions with families.

A child for whom there are safeguarding concerns **must not** be discharged from hospital without the permission of the paediatrician in charge of the child's care or a paediatrician as per Laming recommendation. A clearly documented plan for future care and follow-up arrangements must be in place.

The GP must always be informed of the discharge. If the child is not registered with a GP, NHCFT's Safeguarding Team must be must be notified.

6.10 Domestic abuse (including in pregnancy).

Includes psychological; physical; sexual; financial; emotional abuse; 'honour based' violence; forced marriage; Female Genital Mutilation (FGM).

A statutory Legal Definition of domestic abuse is now included in the Domestic Abuse Act: https://www.legislation.gov.uk/ukpga/2021/17/part/1/enacted

Defined as any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are (or have been) intimate partners or family members regardless of gender or sexuality. NHCFT has a policy in relation to Domestic Abuse (PP41) which can be found on the intranet. Domestic Abuse can encompass but is not limited to the following types of abuse:

- Physical or sexual abuse.
- Violent or threatening behavior.
- Controlling or coercive behavior (came into force 2015 as part of Serious Crime Act 2015).
- Financial / economic abuse- any behaviour that has a substantial adverse effect on someone's ability to acquire, use or maintain money / property / goods / services.
- Psychological, or emotional abuse.
- Honor based violence (HBV), female genital mutilation (FGM) and forced marriage are also considered within the sphere of Domestic Abuse. Victims are not confined to one gender, sexuality or ethnic group. Where an adult with care and support needs presents with FGM there is a duty to report to adult services.
- With effect from 29 April 2021, the Domestic Abuse Act 2021 also:
- removed the so-called 'rough sex gone wrong' defense.
- expanded so-called 'revenge porn' to include threats to disclose private sexual photographs and films with intent to cause distress.

Research indicates a strong link between domestic abuse and all types of significant harm to children, and therefore all health assessments should include questions that would promote early identification of domestic abuse. All health professionals who work with children, young people and families should be alert to the strong links between adult domestic violence, substance misuse and child abuse and neglect. Domestic abuse is a complex issue that needs sensitive handling by professionals, and it is important to note that the risks often increase during and after separation.

Domestic violence and abuse may have a long term psychological and emotional impact on children in a number of ways:

- distress by witnessing (or hearing) the suffering of another, or the outcome of any assault;
- children may be pressured into concealing assaults, and may suffer fear / anxiety through living in an abusive environment;
- domestic violence and abuse may impact negatively on an adult victim's parenting capacity;
- children may be drawn into the violence and themselves become victims of physical abuse.

During pregnancy, domestic violence and abuse can pose threats to an unborn child from assaults. It is important to note that;

- In almost a third of cases, domestic violence and abuse begins or escalates during pregnancy
- It is associated with increased rates of miscarriage, premature birth, foetal injury and foetal death.
- The pregnant person may be prevented from seeking or receiving anti-natal care or post-natal care.
- If the pregnant person is being abused this can affect their attachment to their child (particularly if the pregnancy is a result of rape).

Children who witness domestic abuse may benefit from a range of support and services and supporting a non-violent parent may be the most effective way of promoting the child's welfare. The police, Social Care and the Local Authority Housing teams have defined powers and responsibilities that can be used to help those who are subject to domestic abuse.

Risk Assessment (DASH-RIC)

The Domestic Abuse, Stalking and Honor Based Violence - Risk Identification Checklist, (DASH – RIC) was developed by Safelives as a common tool across all agencies to support the identification and assessment of risk from domestic abuse. The primary purpose of the RIC is to identify risk to the adult victim, however if there are children involved this will also help practitioners better understand potential risks to them, and support appropriate safety planning. It is important that referrals are made into Children's Social Care if it is believed that a child is suffering / at risk of suffering significant harm due to domestic abuse (see section 6.4).

The DASH-RIC should be used as a starting point for all disclosures of domestic abuse to support robust assessment and enable an appropriate offer of resources/support to be made. The Safeguarding section of the intranet contains a copy of the DASH-RIC and also information about available services to help support victims. NHCFT Safeguarding Team provide advice, training and support around the use of this tool, and also employ staff with specialist knowledge and experience who can help with identifying options for support for victims. A copy of any completed DASH-RIC should be sent to NHCFT Safeguarding Team for information. Those which when completed identify the individual to be at high risk should also be referred into MARAC (see section 6.11).

Claire's Law

The Domestic Violence Disclosure Scheme (DVDS), also known as "Clare's Law" enables the police to disclose information to a victim (or potential victim of domestic abuse) about their partner's or ex-partner's previous abusive or violent offending. NHCFT can encourage and support people to request this information.

Information can be found on Northumbria Police website, or NHCFT Safeguarding Team can be contacted for more information and support.

Northumbria Police:
https://beta.northumbria.police.uk/advice-and-info/personal-safety/clare-s-law-domestic-violence-disclosure-scheme/

Responding to domestic abuse: a handbook for health professionals (2017)
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/597435/DometicAbuseGuidance.pdf

Child to Parent Violence and abuse (CPVA)- also known as Adolescent to Parent violence and Abuse (APVA) and includes abuse directed towards other guardians

CPVA may be referred to as 'adolescent to parent violence (APV)' 'adolescent violence in the home (AVITH)', 'parent abuse', 'child to parent abuse', 'child to parent violence (CPV)', or 'battered parent syndrome'.

There is currently no legal definition, however CPVA is increasingly recognised as a form of domestic violence and abuse and, depending on the age of the child, it may fall under the government's official definition of domestic violence and abuse. The working definition of Child to Parent Violence and Abuse (CPVA) that has been adopted by Northumbria Police in 2021 is:

"Any harmful act and/or behaviour by a child (aged 10-18) whether physical, psychological, emotional or financial towards a parent, guardian or carer".

CPVA is likely to involve a pattern of behaviour. This can include physical violence and other abusive behaviours such as damage to property, emotional abuse, and economic/financial abuse. Patterns of coercive control can be seen in cases of CPVA, but some families might experience episodes of explosive physical violence from their adolescent with fewer controlling, abusive behaviours. Although practitioners may be required to respond to a single incident of CPVA, it is important to gain an understanding of the pattern of behaviour behind an incident and the history of the relationship between the young person and the parent.

Consideration must be given to the impact on the parent's health and wellbeing as CPVA can be a factor in anxiety, depression, physical injury, self-medicating with drugs and alcohol as a coping mechanism etc. CPVA can be linked to feelings of failure in the parenting role, and experiencing shame / stigma. All staff should seek to identify risk factors early and work together with the family to provide early support to avoid crisis situations.

It is important to use the term 'young person causing harm' as opposed to 'perpetrator' as the violence may be contextualised within existing family problems and some 'perpetrating' the abuse are (or have been) victims of domestic abuse, other forms of child abuse or adversity. There are also concerns about criminalising a young person for their behaviour, and the negative impact that this may have on their future life chances.

The majority of families are seeking a long-term solution whereby they are able to remain safely together, even if the initial request for help is for the removal of the child to ensure safety and provide respite. In this respect, CPVA differs from intimate partner violence. The restoration of healthy, respectful family relationships should be the ultimate goal.

The ’Child/Adolescent to Patient Violence and Abuse Risk Screening Tool’ has been developed to support assessment (sometimes referred to as the CPVA RIC). This can be found alongside lots of helpful further information within the regionally agreed procedures manual:
https://www.proceduresonline.com/nesubregion/p_adolescent_par_vio_abuse.html#

Identified cases of CPVA should always be considered as a safeguarding issue, and therefore staff must ensure they complete a Safeguarding Children Referral for all cases of CPVA via the process outlined in section 6.4. An assessment should be considered by Children’s Social Care in all cases and the subsequent referrals into the relevant locally available programs / services. Local specialist domestic abuse services also offer support

to families experiencing CPVA (please see the domestic abuse information on the Intranet for up to date local services).

In addition, there should always be a process of safety planning put in place for the parent prior to them going home. If the adult is high risk (assessed via the CPVA RIC Screening Tool) and the child is aged 16+ then a MARAC referral should be made. If the child causing harm is aged under 16 the MARAC may still consider the referral but on a case-by-case basis. Please follow MARAC process outlined in Section 6.11)

Where CPVA is happening to an adult who meets the Care Act safeguarding adult definition (see CG77), adult safeguarding procedures should be followed. This will allow multi agency information to be gathered, a shared risk assessment to be collated and a safety plan agreed for the family.

6.11 High Risk victims of Domestic Abuse and Multi Agency Risk Assessment Conferences (MARAC).

MARAC is a regular multi-agency meeting chaired by the police and attended by NHCFT safeguarding team. Here, agencies discuss high risk domestic abuse cases and together develop a safety plan for the victim and any children. Feedback from MARAC is given to relevant staff involved with the family and or children following a MARAC meeting. Any actions required to safeguard the children involved are also be fed back.

The DASH-RIC should be used to support any referrals made into MARAC, and even if the assessment doesn't generate enough ticks on the assessment to flag as high-risk cases can still be considered on professional judgement.
All DASH-RICs completed within Northumbria Healthcare should be emailed to NHCFT Safeguarding Team for review.

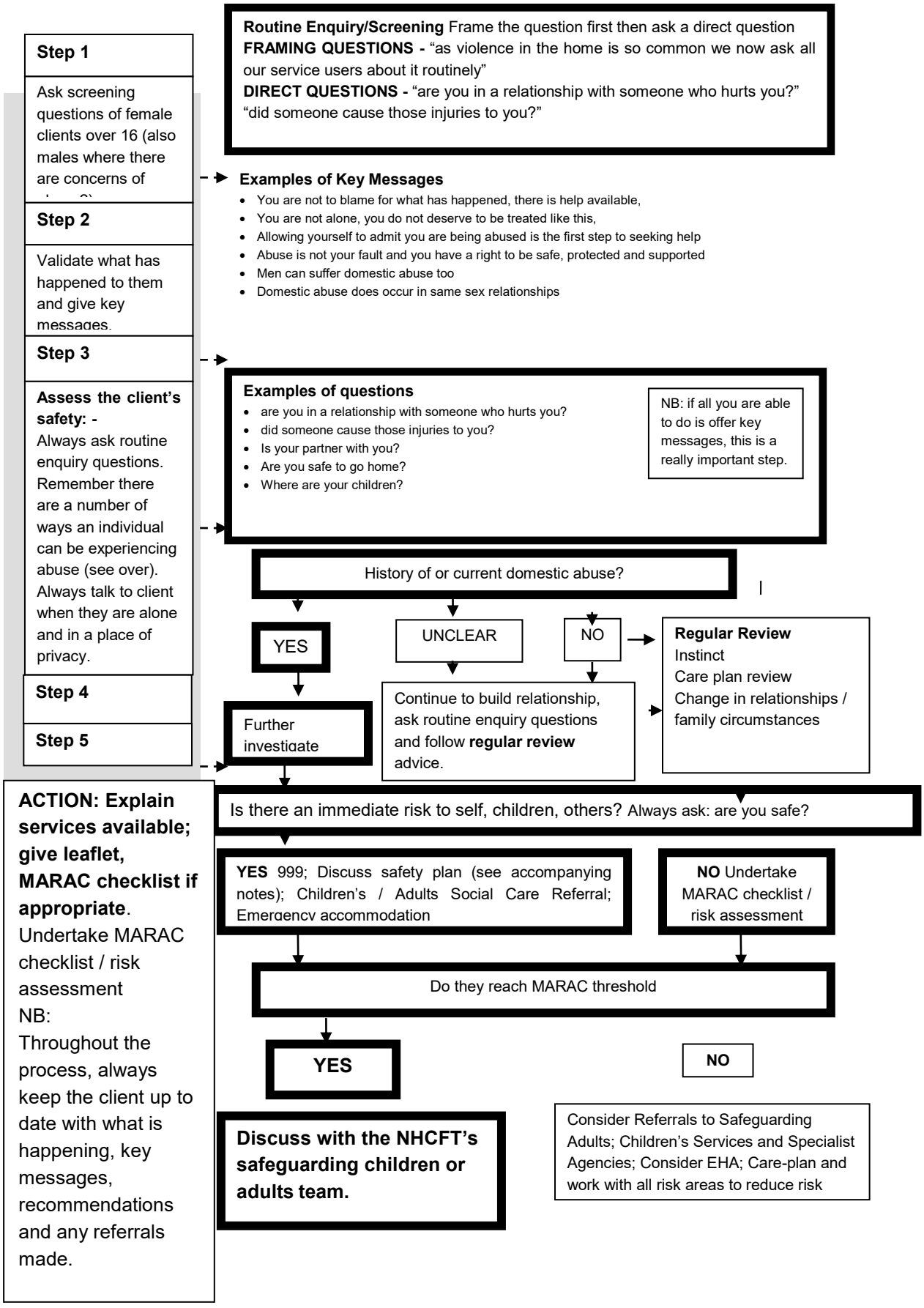
All MARAC referrals should be sent to NHCFT Safeguarding Team alongside the DASH-RIC where they will be reviewed and submitted to MARAC as appropriate.
Practitioners must always refer to Children's Social Care if they are concerned that domestic abuse is occurring and an unborn baby or children in the home is suffering or at risk of suffering significant harm (regardless of the completion of a MARAC referral). It is important that staff are aware that there may be some time between the incident of abuse and the case being heard in MARAC, and therefore the completion of a DASH-RIC or MARAC referral does not override safety planning.

Situations should be explored in depth, and re-referrals made into Children's Social Care as appropriate, when it becomes known that a relationship has reconciled (or child contact resumed) in situations where there were previous significant risks from domestic

abuse which were addressed via support to separate or contact stopping. This applies whether or not the perpetrator is living in the household.

Staff must seek advice if any doubt about what action to take from NHCFT's Safeguarding Team (or NHCFT Manager on-call / Children's Social Care if outside of normal working hours).

Procedure for identifying and managing domestic abuse with Clients and the referral process into MARAC.



6.12 Child Sexual Abuse and Child Sexual Exploitation.

Please see section 5.1 for definition of sexual abuse. Children from birth onwards may be subjected to sexual abuse. Sexual abuse can have a long-term impact on emotional, social and educational development and is linked to the development of mental health issues in later life. Sexual abuse often occurs in conjunction with the other categories of child abuse especially emotional abuse in order to maintain control and secrecy. Sexual abuse is not solely perpetrated by adult males, women can commit acts of sexual abuse, as can other children.

People who have been sexually abused are more likely to suffer with depression, anxiety, eating disorders and post-traumatic stress disorder (PTSD). They are also more likely to self-harm, become involved in criminal behaviour, misuse drugs and alcohol, and to commit suicide as young adults.

Sexual abuse within families often remains hidden and is the most secretive and difficult type of abuse for children and young people to disclose. Children may not see themselves as victims of sexual abuse or understand what is happening.

Children may disclose sexual abuse both directly or by non-verbal means. This requires staff to focus not just on the behaviour but also why the behaviour may be happening. There may be a significant delay between the onset of the abuse and any disclosure.

Barriers to disclosure include fear of not being believed, embarrassment and shame and fear of the consequences. Some groups of young people will have additional challenges to disclose due to communication, religious, language, cultural or sexuality issues. Disabled children are at increased risk of experiencing sexual abuse especially due to communication and developmental issues.

Whenever they chose to disclose, it is important that they are believed, that they are told what will happen next and kept informed and that they are provided with emotional support.

Sexual abuse is linked to a range of signs. Further information can be found in the Regional Manual: https://proceduresonline.com/nesubregion/contents.html#

It is important to remember that children under the age of 13 can never legally give consent for any type of sexual activity. Any member of staff who has reasonable cause to believe that a child less than 13 years of age is engaging in sexual activity of any type, must make a referral to Children's Social Care (for the area the child lives in) and a report will need to be made to the police.

Any member of staff who has reasonable cause to believe that a child or young person is suffering or is likely to suffer significant harm from sexual abuse or sexual exploitation must make a referral to Children's Social Care for the area the child lives in (and the police as appropriate). NHCFT Safeguarding Team can be contacted for advice and support via switchboard or details on Intranet (out of hours contact on-call manager / Children's Social Care).

Whenever a child reports that they are suffering or have suffered sexual abuse staff should listen carefully, and observe the child's behaviour and circumstances. Staff should respond as per information detailed within 'responding to a disclosure' (section 6.3). The child must not be pressed for information, led or cross-examined or given false assurances of absolute confidentiality, as this could prejudice police investigations, especially in cases of sexual abuse.

Children's Social Care and police will carefully consider and plan any child protection medical assessment in order to secure any forensic evidence (as judged to be appropriate); liaising as required with the appropriate Forensic Service.

Child Sexual Exploitation (CSE).

CSE is a form of sexual abuse that can include both contact and non-contact sexual activities. It occurs both in person and on-line, and involves an individual (or group) taking advantage of an imbalance of power to coerce, manipulate or deceive someone 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.

(Working Together to Safeguard Children 2018). Victims of CSE can be exploited by both adults and other children.

Power imbalance may include age, gender, sexual identity, intellect, strength, status and access to resources. The victim may have been sexually exploited even if the sexual activity appears consensual and CSE is never the victim's fault (even if they have received something in exchange). Some victims may be being exploited by people they feel they have a relationship with, and may also travel (or be moved) from one place to another for the abuse to take place.

All staff must remember that any child can be a victim of CSE regardless of gender, age, culture, sexuality, background or wider circumstances. Although some children may have particular vulnerabilities (e.g. those with special needs, children in / leaving care, involved in gangs).

CSE can seriously harm both physical and mental health, and can have wider family impacts (including placing the siblings of victims at risk). CSE has links to other crimes (e.g. grooming, the distribution of abusive images of children, criminal exploitation and child trafficking) and perpetrators are often well organised and use sophisticated tactics. They may target areas where children and young people gather, use parties to create networks for abuse or use technology. It is important that agencies consider who else in a child's circle of contacts may also be at risk.

It is important to try and identify children at risk of harm from sexual exploitation at the earliest opportunity. Victims rarely report their abuse due to the nature of the grooming involved and many not recognising they are being abused. Threats can also be made by abusers so that children are fearful of repercussions or of being blamed for what has happened to them. It is important that any disclosure is treated sensitively (see section 6.3).

Staff must be aware of the key indicators of child sexual exploitation but also understand CSE can occur without any being obviously present. Further information about these signs and indicators can be found in the Regional Manual: https://proceduresonline.com/nesubregion/p_ch_sexual_exploit.html#

Some factors to remember in relation to consent:

- Sexual activity with a child under 16 years is an offence and consideration of the child's full situation is important (maturity / understanding, wider circumstances, age imbalance, aggression or power imbalance, coercion or bribery, familial child sex offences, behaviour of the child, alcohol /substances use, attempts to secure secrecy beyond what might be considered normal in a teenage relationship, grooming methods, risks known about partner).
- A child cannot consent to their own abuse;
- Sexual Activity with a child under 16 is an offence;
- Sexual activity with a 16 or 17-year-old may still result in harm;
- Non-consensual sex is rape whatever the age of the victim;
- If a victim is incapacitated through drink or drugs they cannot be considered to have given true consent;
- If a victim (or their family / people they care about) has been subject to violence or the threat of it, they cannot be considered to have given true consent;
- Children under the age of 13 can never legally give consent for any type of sexual activity;
- It is an offence for a person to have a sexual relationship with a 16 or 17-year-old if they hold a position of trust or authority in relation to the child;

Practitioners must also consider other factors which might influence the ability of the person to give consent, e.g. learning disability / mental ill health.

Whenever a practitioner has concerns that a child or young person is being sexually exploited, or is at risk of sexual exploitation, they should make a referral to Children Social Care (see section 6.4). If a crime has been committed a report will need to made to the police. Any member of staff who has reasonable cause to believe that a child less than 13 years of age is engaging in sexual activity of any type, must make a referral to Children's Social Care (for the area the child lives in) and make a report to the police. NHCFT Safeguarding Team can be contacted for advice and support via switchboard or details on Intranet (out of hours contact on-call manager / Children's Social Care).

Children's Social Care and police will carefully consider and plan any child protection medical assessment in order to secure any forensic evidence (as judged to be appropriate); liaising as required with the appropriate Forensic Service.

Further reading:
https://nwgnetwork.org/
https://www.gov.uk/government/publications/child-sexual-exploitation-definition-and-guide-for-practitioners

6.13 Female Genital Mutilation (FGM)

FGM is where a female's genital organs are deliberately cut, injured or changed and there is no medical reason for this. It is a traumatic and violent act and can cause severe pain alongside both immediate and/or long-term significant health consequences (pain, infection, mental health problems, difficulties in childbirth and/or death).

FGM is a deeply rooted practice, widely carried out among specific ethnic populations in Africa and parts of the Middle East and Asia. The age at which FGM is carried out varies enormously according to the community; sometime to new-born infants, during childhood, adolescence, just before marriage or during a first pregnancy. UNICEF estimates that over 200 million girls and women worldwide have undergone FGM.

FGM is often carried out by a family who believe it is beneficial and is in a girl or woman's best interests and is a complex and sensitive issue. Good communication is essential when speaking to women and families, sensitive language should be used, and the girl's wishes, culture and values are recognised and respected.

'Known' cases of FGM are those where either a girl informs the person that an act of FGM (however described) has been carried out on her, or where the person observes

physical signs on a girl appearing to show that an act of FGM has been carried out and the person has no reason to believe that the act was necessary for the girl's physical or mental health or for purposes connected with labour or birth.

Under the Female Genital Mutilation Act 2003, FGM is a criminal offence and it is:

- illegal to practice FGM in the UK;
- illegal to take girls who are British nationals or permanent residents of the UK abroad for FGM whether or not it is lawful in that country;
- illegal to aid, abet, counsel or procure the carrying out of FGM abroad;
- punishable with up to 14 years in prison and/or, a fine.

The Serious Crime Act (2015) amends this to also include:

- An offence of failing to protect a girl from the risk of FGM
- Female Genital Mutilation Protection Orders ("FGMPO"). Breaches carrying up to 5 years in prison.
- Allowing for the lifelong anonymity of victims of FGM
- Extra-territorial jurisdiction over offences of FGM committed abroad by UK nationals and those habitually (as well as permanently) resident in the UK;
- Mandatory reporting which requires specified professionals to report known cases of FGM in under 18s to the police (see process below).
- FGM is illegal unless it is a surgical operation deemed necessary for the physical or mental health of the female, or where the woman is in labour or just given birth, for purposes connected with the labour or birth.

Data recording

This is mandatory for all women who have been identified as having FGM

- Document FGM diagnosis in medical records (even if FGM is not the reason for presentation)
- Genital examination should be performed and type of FGM identified
- Document further details in accordance with HSIC FGM Enhanced Dataset
- Explain to the woman that her personal data will be transmitted to the HSCIC for the purpose of FGM prevalence monitoring. All personal confidential data is removed from the final report before it is published or used.

This Mandatory reporting duty means that all regulated health and social care professionals in England and Wales have a duty to report to the police 'known' cases of

FGM in under 18s which they identify in the course of their professional work. Staff identifying a known case of FGM in an under 18 should therefore:

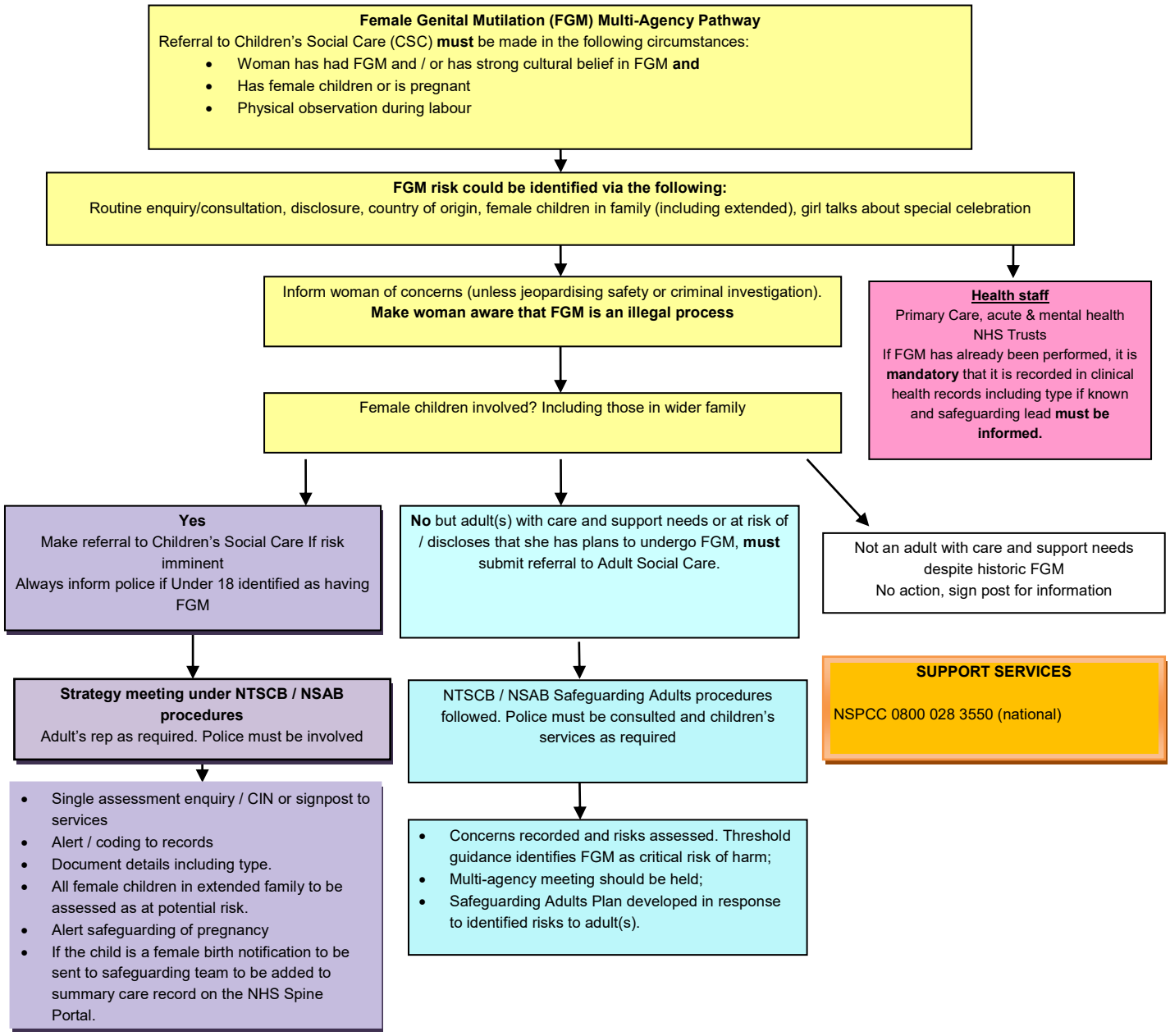
- Report to police using the non-emergency 101 telephone number.
- Refer to Children Social Care (as per section 6.4).
- All cases must also be reported to NHCFT Safeguarding Team (who will support with the completion of an Enhanced Data Set- information collected by NHS England on behalf of the Department of Health).
-

Staff should consider the safety of self / child (any relevant other) and decide if it is safe to inform the family of the actions detailed above at the time. Any decision not to inform the family should be communicated to the Police, Children's Social Care and fully documented in the record. If unsure advice can be sought from NHCFT Safeguarding Team (out of office hours on-call manager / Children's Social Care).

Where cases of FGM are identified in adults, consideration must be given to any female children of the woman and their potential for being at risk of FGM; these cases must also be referred to Children's Social Care for further assessment and NHCFT Safeguarding Team notified so that the Enhanced Data Set can be completed.

All female births should be reported to the safeguarding team/named midwife, a copy of the birth notification should be attached which will then be updated in the FGM-IS tab on the Summary Care record of the NHS Spine Portal. Where an adult with care and support needs presents with FGM there is a duty to report to adult services.

See flowchart below:



6.14 Safeguarding Disabled Children

Evidence suggests that disabled children are at increased risk of abuse and that the presence of multiple disabilities appears to increase the risk of both abuse and neglect. Disabled children may be especially vulnerable to abuse, some may:

- Have fewer outside contacts than other children;
- Receive intimate personal care, possibly from a number of carers- potentially increasing their risk of exposure to abusive behaviour and presenting challenges to set and maintain physical boundaries;
- Have impaired capacity to resist or avoid abuse;
- Have difficulty understanding and recognising what abuse is;
- Have communication difficulties making it difficult to tell others, or have their development inhibited by not having their communication needs met;
- There may be concerns that complaining could result in loss of services;
- Are especially vulnerable to bullying and intimidation, may have poor body image or low self-esteem;
- Be more vulnerable to abuse by peers or targeted by abusers who believe the abuse if less likely to be detected;
- Have parents whose own needs and ways of coping conflict with theirs;
- Have signs and indicators of abuse inappropriately linked to their disability;
- Be particularly vulnerable to over-medication, poor basic care, feeding and toileting, suffer from inappropriate management of challenging behaviour or a lack of stimulation and emotional support.

In addition to the universal indicators of abuse/neglect, the following abusive behaviours must be considered:

- Force feeding;
- Unjustified or excessive physical restraint;
- Rough handling;
- Extreme behaviour modification including the deprivation of food medication, or clothing;
- Misuse of medication, sedation, heavy tranquillisation;
- Invasive procedures against the child's will;
- Deliberate failure to follow medically recommended regimes;
- Non- compliance with programmes or regimes;
- Failure to address ill-fitting equipment e.g. callipers, sleep boards which may cause injury or pain, inappropriate splinting;
- Misappropriation/misuse of a child's finances;
- Being denied access to education, play and leisure opportunities.

Children with disabilities should not be left in situations where there is a high level of neglect or other forms of abuse, because a practitioner feels that the parent, carer or service "is doing their best". Carers will need to be challenged in the same way as carers of non-disabled children.

All staff involved with disabled children should pay particular attention to helping them make their wishes and feelings known and to making best use of appropriate resources which includes staff with specialist skills in communication.

All disabled children fit the criteria of 'Child in Need' and are entitled to an appropriate package of support to enable them to be safe and achieve their full potential (see section 6.5). All staff should highlight any unmet needs identified with relevant partners so that these can be adequately addressed.

Any member of staff who has reasonable cause to believe that a disabled child / young person is suffering, or may be at risk of significant harm from abuse or neglect must make a referral to Children's Social Care. This referral must be made as per section 6.4, and if in any doubt, advice must be sought from NHCFT's Safeguarding Children Team (on-call manager / Children's Social Care if outside of normal working hours).

Additional resources:
https://webarchive.nationalarchives.gov.uk/ukgwa/20141107030924/http://www.ofsted.gov.uk/resources/protecting-disabled-children-thematic-inspection
https://www.gov.uk/government/publications/safeguarding-disabled-children-practice-guidance

6.15 Fabricated and Induced Illness (FII) and Perplexing Presentations (PP)

FII refers to situations when a parent/career's behaviors attempt to convince doctors that the child's state of physical and/or mental health or neurodevelopment is impaired (or more impaired than is actually the case). It is a relatively rare but potentially lethal form of abuse. FII results in physical and emotional abuse and neglect because of these parental actions, behaviours or beliefs and from doctors' responses to these.

The parent may not necessarily intend to deceive, and their motivations may not be initially evident, however Illness induction is a clear form of physical abuse. It is important that the focus is on the impact on the child's health and development and not initially on attempts to diagnose the parent or carer.

Parents / carers may fabricate or induce illness in a child by one / a combination of the following;

- Fabricating signs and symptoms, including past medical history;
- Fabricating signs and symptoms and falsifying hospital charts, records, letters, documents and specimens of bodily fluids;
- Exaggerating symptoms/real problems;
- Inducing illness by a variety of means.

Behaviors may include:

- Deliberately inducing symptoms in children by administering medication or other substances, or by means of intentional suffocation
- Interfering with treatments by over dosing, not administering them or interfering with medical equipment such as infusion lines
- Claiming the child has symptoms which are unverifiable unless observed directly, such as pain, frequency of passing urine, vomiting, or fits;
- Exaggerating symptoms, thereby causing professionals to undertake investigations and treatments which may be invasive, are unnecessary and therefore are harmful and possibly dangerous;
- Obtaining specialist treatments or equipment for children who do not require them;
- Alleging psychological illness in a child.

Indicators may include:

- Reported symptoms and signs found on examination are not explained by any medical condition from which the child may be suffering; or
- Physical examination and results of medical investigations do not explain reported symptoms and signs; or
- There is an inexplicably poor response to prescribed medication and other treatment; or
- New symptoms are reported on resolution of previous ones; or
- Reported symptoms and found signs are not observed in the absence of the carer; or
- Over time the child is repeatedly presented with a range of symptoms to different professionals in a variety of settings; or
- The child's normal, daily life activities, such as attending school, are being curtailed beyond that which might be expected from any known medical disorder from which the child is known to suffer;
- Excessive use of any medical website or alternative opinions.

There may be a number of explanations for these circumstances and each requires careful consideration and review.

Perplexing Presentation (PP) refers to a term introduced to describe the commonly encountered situation when:

- there are alerting signs of possible FII (not yet amounting to likely or actual significant harm) when the actual state of the child's physical, mental health and neurodevelopment is not yet clear;
- BUT
- there is no perceived risk of immediate serious harm to the child's physical health or life.

PP indicates possible harm due to FII which can only be resolved by establishing the actual state of health of the child. However, not every case of PP is an early warning sign of fabricated illness. Professionals need to be aware of any discrepancies between reported signs and symptoms of illness (and implausible descriptions of illnesses) and the presentation and independent observations of the child.

In situations of possible induced or fabricated illness practitioners should **not** discuss their concerns with the parents/carers. This is because such discussion may increase the risk of significant harm to the child.

In any case where an NHCFT staff members suspects FII they should discuss the case with NHCFT Safeguarding Team and the Named Doctor for Safeguarding Children (contactable via switchboard or NHCFT Safeguarding Team). In some cases, it may be appropriate first to have a health professionals meeting to enable all health information about the child to be shared and better understood. At this meeting a decision should be made as to whether the child may be at risk of significant harm and if so a referral should be made to Children's Services. However, if there are imminent concerns about the safety and wellbeing of a child due to FII and it is out of office hours then an urgent referral should be made to Children's Social Care clearly outlining the concerns. The Named Dr for Safeguarding Children should also be notified, who will link in with relevant Designated Dr as appropriate.

Decisions about what discussions are to take place with the parents/carers are to be made on an inter-agency basis, following referral to Children's Social Care.

In all cases of suspected FII a chronology may need to be prepared to support assessment and intervention but this should not delay intervention if this would put the child at increased risk of harm. When a single organisational chronology is needed, the

Responsible Pediatric Consultant will co-ordinate this on behalf of NHCFT but a number of professionals may be asked to contribute.

RCPCH (2021)
https://childprotection.rcpch.ac.uk/wp-content/uploads/sites/6/2021/03/Perplexing-Presentations-FII-Guidance.pdf

6.16 Concern that a child or young person has been left unsupervised.

When there is reasonable cause to believe that a child or young person is at risk of significant harm because they have been left at home or anywhere else unsupervised and attempts to locate an appropriate adult have been unsuccessful, the member of staff must telephone the police by calling 999 to inform them.

The member of staff should use all reasonable and safe measures to gain the attention of the parent/carer e.g. telephone parent/carer using mobile, telephone house landline number if available, knock loudly.

If there is suspicion that the carer is in the home but not responding, the member of staff should make attempts to inform the parent/carer that the police will need to be called if they do not respond.

The member of staff must remain at the address until the police or Children's Social Care arrives.

If in any doubt, advice should be sought from NHCFT's Safeguarding Children Team, or Children's Social Care if outside of normal working hours.

6.17 Concerns that a child/young person or a pregnant person is 'missing'

Estimates from research are that 25% of children who go missing are likely to suffer significant harm. There are links between children running away and risks of exploitation. Children in Care who are missing from placements are vulnerable to sexual and other exploitation, especially those from a residential care setting.

The College of Policing defines 'missing' as:
Anyone whose whereabouts cannot be established will be considered as missing until located, and their well-being or otherwise confirmed. All reports of missing people sit within a continuum of risk from 'no apparent risk (absent)' through to high-risk cases that require immediate, intensive action.

https://www.app.college.police.uk/app-content/major-investigation-and-public-protection/missing-persons/

Health professionals have a key role in identifying and reporting children (and pregnant persons) who may be missing. The member of staff must make reasonable enquiries regarding the child or pregnant person's whereabouts including contacting the General Practitioner, Health Visitor or Public Health School Nurse/School Health Advisor before making a referral to Children's Social Care.

If the child / pregnant persons whereabouts are not able to be established and there is a Social Worker involved, the NHCFT member of staff must notify the key social worker immediately. If the social worker is not available, they must inform a duty social worker. If there is not a social worker involved, the member of staff must contact NHCFT Safeguarding Team to discuss further. They should also inform NHCFT Safeguarding Team (details on intranet / via switchboard) who will consider the need for a Regional Missing Alert to be completed and distributed. If a wider National Alert is required then this should be completed in collaboration with Children's Social Care.

Remember: if there are concerns that the child/young person or unborn baby maybe at risk of immediate significant harm, a referral must be made to Children's Social Care in the area the child/young person or pregnant woman lives in without delay (and the police contacted as appropriate).

Further Reading:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/307867/Statutory_Guidance_-_Missing_from_care__3_.pdf

6.18 Action to be taken when a child was not brought for a health appointment.

The following NHCFT services must have in place a Standard Procedure/Pathway for all staff to follow regarding non-attendance for health appointments, Staff should document in records "the child was not brought" rather than did not attend as this prompts the practitioner to consider safeguarding issues of neglect.

- Medical services/appointments with doctors.
- Maternity Services, particularly Community Midwives.
- Child Health settings.

Any member of staff who has any concerns that a that a child is suffering or may be at risk of significant harm from abuse or neglect must make a referral to Children's Social

Care in the area the child lives in (as per section 6.4). This also applies to an unborn baby for whom there are concerns following the birth.

If in any doubt, advice should be sought from NHCFT's Safeguarding Team (or on-call manager or Children's Social Care if outside of normal working hours).

6.19 Action to be taken if a child or pregnant person is not registered with a GP

The following services must have in place a Standard Procedure/Pathway regarding action to be taken if a child or pregnant person is not registered with a GP.

- Maternity services, particularly community midwives.
- Child Health Settings

If in any doubt, advice should be sought from NHCFT's Safeguarding Team (or on-call manager or Children's Social Care if outside of normal working hours).

6.20 Safeguarding children at risk of radicalisation and extremism: Prevent and Channel Process.

The aim of prevent is to reduce the threat to the UK from terrorism by stopping people becoming terrorists or supporting terrorism. Delivery of Prevent is grounded in early intervention and safeguarding. The Prevent Lead for the Trust is based in the Safeguarding service. If anyone in the Trust has concerns about someone being radicalised the Trust have a duty to report a prevent concern.

Prevent has 3 objectives:

- Tackle the causes of radicalisation and respond to the ideological challenge of terrorism.
- Safeguard and support those most at risk of radicalisation through early intervention, identifying them and offering support.
- Enable those who have already engaged in terrorism to disengage and rehabilitate.

Radicalisation is defined as the process by which people come to support terrorism and extremism and, in some cases, to then participate in terrorist groups.

Radicalisation is an abusive process. Radicalising children can involve encouraging the development of extreme views (political, religious, sexist or racist), or steering them into a rigid, narrow ideology intolerant of diversity.

Healthcare professionals will meet and treat people who may be vulnerable to being drawn into terrorism. Being drawn into terrorism includes not just violent extremism but also non-violent extremism, which can create an atmosphere conducive to terrorism and can popularise views which terrorists exploit. NHCFT have a Preventing Radicalisation: Prevent Strategy Implementation Policy (RMP64).

Indicators of vulnerability can include:

- Identity Crisis- e.g. distancing from heritage, uncomfortable with society around them
- Personal Crisis- e.g. low self-esteem, family / social tension, isolation, questioning belonging.
- Personal Circumstances – e.g. migration, local tensions, events affecting region of origin, grievance triggered by personal experience of racism or discrimination, aspects of Government policy;
- Unmet aspirations – e.g. feeling of injustice, failure.;
- Criminality – e.g. imprisonment, involvement with criminal groups.

Changes in behaviour may be noticeable such as:

- Changes of mood, behaviour, secrecy;
- Changes of friends or way of dress;
- Use of language;
- Possession of extremist literature;
- The expression of extremist views;
- Making plans to take long term holidays and visits out of the UK;
- Advocating violent actions and means;
- Association with known extremists;
- Seeking to recruit others to an extremist ideology.

It is important that responses are proportionate and the emphasis is on supporting vulnerable children and all cases should be discussed with NHCFT Safeguarding Team (unless there is evidence of more active involvement in extremist / terrorist related activities which may mean that referrals to police and children's social care are needed urgently). However more generally, the NHCFT designated lead will consider the information and refer into the Channel Programme where appropriate.

Channel focuses on providing support at an early stage to people who are identified as being vulnerable to being drawn into terrorism. In North Tyneside and Northumberland there are monthly Channel Panel meetings which the trust Prevent Lead attends. The

meetings are statutory under law and cover both children and adults. It is essential that the trust attend to share information and assess ongoing vulnerability, risk and support needs. Via the trust Prevent lead, we have a statutory responsibility to refer into the Channel Process and respond to any new referrals

The Trust's Head of Safeguarding also reports quarterly on the prevent referrals and training figures via mandated reporting to NHS England.

Please see Appendix 2 for PREVENT flow chart.

Further reading:
https://www.gov.uk/government/publications/protecting-children-from-radicalisation-the-prevent-duty
https://www.nspcc.org.uk/keeping-children-safe/reporting-abuse/dedicated-helplines/protecting-children-from-radicalisation/

6.21 Modern Slavery, Trafficking of Children and Criminal Exploitation.

Modern Slavery is an international crime and a global problem, affecting an estimated **29.8 million slaves** around the world. It can include child victims that have been brought from overseas as well as vulnerable children targeted in the UK, who are forced to illegally work in many different sectors, including brothels, cannabis farms, nail bars and agriculture.

Child Trafficking is where children are tricked, forced or persuaded to leave their homes and are then moved or transported and then exploited, forced to work or sold. Children are trafficked for:

- Sexual exploitation
- Criminal exploitation- including county lines, theft, begging
- Benefit fraud
- Forced marriage
- Domestic servitude
- Forced labour

The organised crime of child trafficking into (and within) the UK is an issue of considerable concern and any form of trafficking children is an abuse.

Criminal groups (normally led by adults for whom involvement in crime is for personal gain) exploit vulnerable children to move and sell drugs and money across the country (County Lines). Most children are trafficked for financial gain and this can include

payment from or to the child's parents. Child criminal exploitation is typified by some form of power imbalance in favour of those perpetrating the exploitation, and it is important to remember that child criminal exploitation constitutes abuse even if the child appears to have readily become involved / has received some form of payment.

Child victims of criminal exploitation are at a high risk of violence, intimidation, threats towards their family members / people important to them. They may go missing while they travel to undertake the criminal groups wishes (sometimes far from their home).

They may have unexplained increases in money or possessions, be in receipt of an additional mobile phones and receive excessive texts or phone calls. Any child can be targeted, and gangs can try to exploit those they perceive as most likely to evade police detection, including very young children. The young people involved may not recognise themselves as victims of any abuse, and can be used to recruit other young people. Children can be become indebted to the gang/groups and then exploited in order to pay off debts

If a child is a long way from home with no obvious reason or means of getting home, this should trigger questions about their welfare and they should potentially be considered as victims of child exploitation and trafficking. There are a wide range of indicators of criminal exploitation and useful further information can be found here: https://proceduresonline.com/nesubregion/contents.html#

Any agency or practitioner who has concerns that a child may be at risk of harm as a consequence of modern-day slavery / trafficking / gang activity including child criminal exploitation should refer to Children's Social Care as per section 6.4 (and police as appropriate). Practitioners should not do anything which would heighten the risk of harm to the child, such as consulting with or trying to obtain the consent to the referral by anyone suspected of potential involvement in the exploitation / trafficking.

If in any doubt, advice should be sought from NHCFT's Safeguarding Team (or on-call manager or Children's Social Care if outside of normal working hours).

6.22 Children attending Emergency Department or other acute setting following Alcohol/Substance misuse.

This term substance misuse includes the misuse of prescription drugs, use of illicit drugs, alcohol and solvents.

Substance misuse can have major implications for children, families and communities. Alcohol and drugs are linked to a number of diseases in adulthood including cancers and

cirrhosis, and as such are major contributors to the burden of disease in the UK. Children who misuse drugs and alcohol can experience negative impacts on their education, friendships, relationships and within peer dynamics. It can also be associated with other risks such as those from unprotected (or later regretted) sexual activity, involvement in anti-social behaviours and crime, and mental health (including anxiety, depression, self-harm, thoughts of suicide and psychosis).

It is important that staff make every contact count and the exploration of potential drug / alcohol use in under 18's is sensitively explored within young people's assessments. It is recognised that children presenting in emergency care settings due to substance and alcohol issue are at risk of harm from their substance misuse. Health professionals will provide an assessment, intervention and signposting to address the young person's health needs. Any assessments should also include consideration of their physiological health. If there are mental health needs, the agreed protocols and pathways for accessing the appropriate child and adolescent mental health services should be implemented.

Staff should check PAS (Patient Administration System) to identify if an alert is in place to indicate a child presenting as intoxicated has a Child Protection Plan or Special Guardianship Order in place, and if so their Social Worker should be notified of their attendance.

A referral to children's social care should be made for all children who attend due to intoxication from drugs or alcohol, and this should also be sent to SORTED for children resident in Northumberland via ticking the box on the last page of the electronic children's social care referral, see section 6.4). SORTED IS Northumberland Substance Misuse Service for children and young people).

For children not attending due to intoxication (e.g. those who disclose alcohol / drug misuse within assessments), careful assessment regarding the level of risk due to the substance misuse must take place. Following this, appropriate health promotion activities, safety planning and onwards referrals for support (including to Children's Social Care is there are concerns that the child is at risk of significant harm see section 6.4) should be made. All decision making should be clearly documented in the patient record. If in any doubt, advice should be sought from NHCFT's Safeguarding Team (or on-call manager or Children's Social Care if outside of normal working hours).

6.23 Children Presenting with Mental Health Concerns, or Self Harm.

- Deliberate self-harm is self-harm without suicidal intent, resulting in non-fatal injury;
- Attempted suicide is self-harm with intent to take life, resulting in non-fatal injury;
- Suicide is self-harm, resulting in death.

(Mental Health Foundation, 2003).

Self-harm is a sign of emotional distress and poorly developed coping skills, and can be a precursor to suicide; in addition, children who self-harm may kill themselves by accident. Self-harm can include a wide range of behavior's (including cutting, burning, banging, self-poisoning, hair pulling). A wide range of mental health problems are associated with self-harm, including borderline personality disorder, depression, bipolar disorder, schizophrenia, and drug and alcohol-use disorders.

The initial reactions received by a child who self-harms can have a significant impact on if they access support. Any child or young person, who self-harms or expresses thoughts about this or about suicide, must be taken seriously and appropriate help and intervention, should be offered at the earliest point. Practitioners must talk with the child without delay to ensure appropriate assessments, clinical care, safety planning and onward referrals are made without delay.

Professional judgement must be exercised to determine whether a child or young person in a particular situation is competent to consent or to refuse consent to sharing information. Consideration should include the child's chronological age, mental and emotional maturity, intelligence, vulnerability and comprehension of the issues.

Informed consent to share information should be sought if the child is competent unless:

- The situation is urgent and delaying in order to seek consent may result in serious harm;
- Seeking consent is likely to cause serious harm to someone or prejudice the prevention or detection of serious crime.

If the child refuses consent to share information, or consent cannot be sought, information should still be shared if:

- It is believed that not sharing information is likely to result in serious harm or is likely to prejudice the prevention or detection of serious crime; and
- The risk is sufficiently great to outweigh the harm; and
- There is a pressing need to share the information.

Parents/carers are likely central to safety plans and should be involved fully wherever possible, however if a competent child wants to limit the information given to their parents the child's wishes should be respected (unless the conditions for sharing without consent apply). Where a child is not competent, a parent with parental responsibility should give consent unless the circumstances for sharing without consent apply.

Acute and non-specialist mental health settings

Where a child or young person requires care in relation to self-harm special attention should be given to:

- Confidentiality;
- Consent (including competence) of child and parent;
- Safeguarding issues- Referrals to Children's Social care must be made if there are concerns that a child is suffering or at risk of suffering significant harm;
- Use of the Mental Health Act and the Children Act;
- Admission.

Acute care settings are unlikely to have access to full information about the child's wider context, background and other professional involvement or concerns. Therefore, it is important that checks are done with Children's Social Care in the area the child lives to find out if there are any current issues of concern, and that any previous attendances within the Trust are reviewed and considered.

All children attending acute settings for unplanned care due to self-harm (such as ED / Urgent Care Centers / Minor Injury Units / Children's Unit) should be referred to PLT (Psychiatric Liaison Team) for assessment and reviewed prior to discharge. Assessments and discharge / follow-up plans should be clearly recorded in the record.

For other non-specialist mental health settings in the community consideration should be given to the most appropriate source of support:

- Is hospital assessment needed
- Support from GP
- Local mental health crisis services
- Local mental health support services

In all cases, safety plans need to address issues such as:

- If parents / carers are able to adequately safeguard the child and that they have appropriate information to do so.
- If a safeguarding referral to children's social care is needed
- Access to easily accessible such as medication / drugs / household items (e.g. chemicals, knives, razors) is prevented to reduce risk of harm from impulsive actions.
- Potential risks from self-harm should be considered when prescribing medication- certain medication may pose a greater risk of harm, or death, and this should be considered when prescribing to at risk young people and others in the household.
- Other children in the household
- Appropriate follow-up

Referral must be made to Children's Social Care should there be concerns that the child is suffering or at risk of suffering significant harm (see section 6.4), or support required via section 17 (see section 6.5). Clear rationale for decision making should be evident in the patient record.

If in any doubt, advice should be sought from NHCFT's Safeguarding Team (or on-call manager or Children's Social Care if outside of normal working hours).

Specialist Children's Mental Health Settings (CAMHS and Primary Mental Health)

These services should have standard pathways in place to ensure that there are specialist assessments and care planning undertaken in respect of children for whom there are concerns around self-harm.

These assessments must be timely and fully address needs and risks for the child and family; including any medical care which is indicated. There must be full consideration of the family and social situation surrounding the child and assurance that robust and appropriate safety plans are in place whilst care is being progressed.

Referrals must be made to Children's Social Care should there be concerns that the child is suffering or at risk of suffering significant harm (see section 6.4), or when support is required via section 17 (see section 6.5). Evidence of full decision making should be evident in the record. If in any doubt, advice should be sought from NHCFT's Safeguarding Team (or on-call manager or Children's Social Care if outside of normal working hours).

Further reading:

National Panel:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/984767/The_Child_Safeguarding_Annual_Report_2020.pdf

NICE
https://www.nice.org.uk/guidance/qs34/chapter/Introduction-and-overview

6.24 Private Fostering

A private fostering arrangement is essentially one that has been made without an assessment of the appropriateness of the placement having been undertaken by a court or Children's Social Care. The term applies to a child under 16 years (or less than 18 years if the child has a disability), who has been placed in the care of someone other than a parent or close relative, with the intention that it should last 28 days or more.

Close relatives are defined under the Children Act 1989 as a grand-parent, sibling, uncle or aunt (whether by blood or marriage) or a step parent (and therefore these groups will NOT be considered private foster carers).

Under the Children Act 1989, private foster carers (and those with parental responsibility) are required to notify the local authority of their intention to privately foster; or to have a child privately fostered.

All NHCFT staff who become aware of a private fostering arrangement (which they are not confident has been notified to Children's Social Care), must inform Children's Social Care themselves immediately. If in any doubt, advice should be sought from NHCFT's Safeguarding Team.

6.25 Supplementary guidance on safeguarding and promoting the welfare of children

A range of supplementary guidance relevant to safeguarding and promoting the welfare of children can be found within statutory documentation (such as Working Together to Safeguard Children) and within the North and South of Tyne Safeguarding Children Partnership Procedures Manual:

https://www.proceduresonline.com/nesubregion/#

6.26 Child Protection Conferences; attendance, report submission and core groups.

A Child Protection Conference is a meeting which is held when it is believed that a child(ren) may be at risk of / suffering significant harm. The meeting is chaired by an Independent Reviewing Officer (IRO) and attended by all relevant involved professionals, the family (and the child where appropriate). Information will be shared and a collaborative decision will be reached clarifying what the concerns are and if it is felt the threshold has been met to provide support via a Child Protection Plan. This plan will detail the input everyone agrees to have in order to improve things for the child and secure their safety and wellbeing. Even if the threshold for a Child Protection Plan is not met, there will usually be an alternative support plan agreed (under Child in Need processes for example).

When a Child Protection Conference is convened it is expected that all relevant agencies provide relevant information in advance of the meeting, and attend and take part in meeting and the decision making (Working Together to Safeguard Children 2018).

It is expected that NHCFT staff invited to conference because they have relevant involvement with the child / family, provide a typed report in advance of the conference using the Trust template (available from NHCFT Safeguarding Team and Intranet). This report should include representation and consideration of the voice of the child. If staff are not familiar and competent completing reports for conference they should contact NHCFT Safeguarding team at the earliest opportunity and support with the process will be provided.

When invited to conference NHCFT staff are expected to make arrangements to share their report directly with the child / family in advance of the meeting, and with the other relevant professionals as per the information sharing process outlined within the invite (if in doubt NHCFT Safeguarding Team should be contacted). The parents should be given the option to discuss the report with the health professional in advance of the meeting and the member of staff should ensure sufficient time is allowed, taking account of the parents/carer's communication needs. If a staff member has concerns about their own safety they should contact their line manager or NHCFT Safeguarding Team, to agree an alternative option.

All reports for conference should follow good record keeping and information sharing principles and staff must submit reports which are factual and distinguish between fact, observation, allegation and opinion. Addresses are not used within these reports, this is a control measure to prevent the risk of 'protected addresses' being disclosed inadvertently. Addresses are usually protected due to the very high-risk nature of

concerns and the consequences could be severe if an address was inadvertently disclosed.

All staff must write reports that give an accurate account of their involvement with a child or family and include the consideration both of the concerns and also the protective factors and what is working well. Staff should use their professional judgement to analyse impact for the child and support forward planning. The initial report must include both relevant historical and current information regarding the involvement and the child's health and development. For review conferences information only needs to be supplied from the time of the last conference (and the last report submission).

Reports must be submitted for the following meetings:

- Initial Child Protection Conferences
- Review Child Protection Conferences

The report must include and demonstrate that the member of staff has made reasonable attempts when working with child/young person to:

- ascertain the child's wishes and feelings regarding the provision of support and services or any action that has been taken; and
- Has given due consideration (with regard to the child's age and understanding) to those wishes and feelings.

NHCFT medical staff must have in place a report writing proforma for Child Protection Medical Assessments and this must be used by all medical staff completing these assessments. The Named Doctor must have in place a Standard for Writing Child Protection medical reports.

NHCFT Safeguarding Team must have in place a standard for writing reports for child protection conferences. Trust templates can be obtained from the Intranet or NHCFT Safeguarding Team.

Core Groups take place monthly in between conferences to monitor the progression of the Child Protection Plan, and it is important that practitioners identified as a core group member prioritise attendance at these and plan them into their diary.

6.27 Strategy Meetings, Care Team (Child in Need) Meetings and Reviews.

Strategy meetings are called by Children's Social Care (often at short notice), due to concerns that a child may be suffering or at risk of suffering significant harm, and it is

important that professionals prioritise attendance at these meetings. If a professional is invited to a strategy meeting they are unable to attend they must liaise with their manager to request support to find cover if possible. If there is still no representative able to attend then;

- The social worker should be contacted to discuss concerns and information.
- A written report (on the NHCFT strategy meeting proforma) should be provided to the social worker outlining agency information and analysis. This proforma can be found on the intranet or by contacting NHCFT Safeguarding Team, and a copy of the completed document should be stored in the record.
- The social worker should be contacted following the strategy to discuss the meeting outcome and plan any required actions.

All of these actions must be fully documented in the health record.

Care Team meetings and Child in Need Reviews**:** These meetings are held regularly to monitor the progress and impact of support provided via a Child in Need Plan. It is important that attendance is prioritised by professionals involved, and that attempts are made to source an appropriate deputy if the key worker is unable to attend. There is no requirement to provide written reports for these meetings, and updates can be given verbally.

If NHCFT staff are unable to attend then the Social Worker and family should be contacted prior to (and following) the meeting to share information.

All of these actions must be fully documented in the health record.

6.28 Requests from Courts, Solicitors, Police and Coroner related to Safeguarding children.

Court and Legal Requests related to Safeguarding Children.

Clinical staff (apart from medical staff), who are requested to provide a statement for Court must inform NHCFT Safeguarding Team as soon as possible who will provide and support with the completion of a court statement, and also with attendance.

Staff will inform the Safeguarding Children Team if they are requested to meet with a Guardian /Children and Family Court Advisor, as soon as possible of the request being received. The case will then be discussed prior to the meeting and a member of NHCFT's Safeguarding Team will be available to attend the meeting with them.

If staff are approached by solicitors to provide information for private law proceedings, for example, residence or contact orders, staff must first discuss this with the NHCFT's Safeguarding Team prior to agreeing to share any information.

If a staff member receives requests for copies of records from a solicitor, they must inform their manager, the Access to Records Team and NHCFT Safeguarding Team.

Requests from the Police and Coroner related to Safeguarding Children.
When a staff member receives requests for copies of records from the Police or Coroner they must inform the Information Governance Team, their line manager and NHCFT Safeguarding Team. Copies of health records would not normally be given to the Police without a Court Order or the written consent of person to whom the information relates to, or their parent if a child is unable to consent.

If a member of staff is asked to attend a meeting with the Police or Coroners officer, they must be accompanied by a member of staff from NHCFT's Safeguarding Team. It may also be necessary to instruct the trusts legal team. If attendance is required at coroner's court, this be will formally requested via the trusts Inquest Team.

6.29 Visiting patterns when a child is subject of a Child Protection Plan

Visiting a child and family at home can assist understanding of the child and family context and support robust assessment and appropriate care planning. It is essential that this is considered by health professionals who are part of Core Groups. Children should also be routinely offered the opportunity to be seen alone in clinic, home or school (13 and over).

In the case of an unborn, the family should receive a home visit during the pregnancy by the Midwife this is to ensure that the home is suitable for a newborn and that preparations have been made for the birth. Following delivery, a pre-discharge planning meeting will take place, this will outline a robust safety plan providing details of the MDT who will carry out postnatal daily visits for the first ten days. Assessment of care, home, family and environmental context should be taken at each visit and detailed in the record. Key health information (such as Safe Sleeping and Coping with Crying / ICON) should be covered at visits, with all adults involved in baby's care, and reflected in the record. Documentation of who is present at each postnatal visit should be clearly noted in the postnatal records stating name and relationship.

All professionals actively involved in the core group should be regularly seeing the child.

Home visits should only take place if it is safe to do so, if there are any concerns about visiting the home you must discuss this immediately with your line manager and NHCFT Safeguarding Team.

Where a child is subject to a child protection plan and the professional cannot gain access to the home they should document this fully in the child's records, inform the social worker and NHCFT safeguarding team.

6.30 Supervision of staff in relation to Safeguarding Children

Health practitioners are well placed to identify safeguarding concerns, and it is important that they are confident to address these appropriately. This requires an understanding of risk factors, protective factors and the ability to analyse effectively and communicate and share information to keep children safe. Effective safeguarding supervision play's a critical role in ensuring a clear focus on a child's welfare, hearing their voice and understating their lived experience. Effective supervision support's practitioners to reflect critically on the impact of their decisions. The aim of safeguarding supervision is to have a positive influence on practice and outcomes for babies, children and vulnerable adults; this is achieved by ensuring that practitioners are clear about their purpose, role and responsibilities.

NHCFT staff working with children and families must receive pro-active supervision and support specifically in relation to Safeguarding Children. The model and level of supervision will be dependent on their professional role. This model of pro-active supervision must be supplemented by additional sessions as required and depending on the need identified by the practitioner, the supervisor or based on the individual circumstances relating to a particular case. Additional supervision can be requested from any member of staff at any time by contacting NHCFT Safeguarding Team (who also operate a duty system during office hours).

A supervision agreement must be drawn-up between the practitioner / group and the supervisor. The boundaries regarding confidentiality must be specified in the Supervision Agreement.

Safeguarding Supervision is available in different formats dependant on practitioner's roles and needs, but should take place 6 monthly. It is the responsibility of managers and practitioners to ensure that they are accessing regular supervision appropriate to their role:

- Individual Safeguarding Supervision from NHCFT Safeguarding Team: This form of supervision should be accessed by practitioners (Band 6 and above) who are providing on-going care for pregnant persons, babies and children and are regularly case-holders attending and contributing to safeguarding processes. Such processes include Child in Need and Child Protection processes. This group includes all community midwives. Other clinical staff may also require individual supervision directly from NHCFT Safeguarding Team and this will be agreed by the Named Doctor, Nurse or Midwife (safeguarding) and the manager of the service involved.
- Group Safeguarding Supervision facilitated by NHCFT Safeguarding Team: This form of supervision is for practitioners who provide episodes of care / oversee such care for pregnant persons, babies, children and vulnerable persons but who do not regularly have roles within Child Protection and Child in need processes.
- Group or Individual Safeguarding Supervision facilitated by senior colleague: This form of supervision should be accessed by staff who may contribute to the care of pregnant persons, babies and children, but on an infrequent basis. This should be conducted by a senior member of the team who has oversight of the practitioners safeguarding work, and who engages regularly in Individual Safeguarding Supervision from NCFT Safeguarding Team themselves. This group should have the written agreement of the Named Doctor, Nurse or Midwife (Safeguarding) for the arrangements, and processes agreed to assure that the supervisor is appropriately skilled and supported to deliver effectively.
- Peer Review facilitated by the Named Professional. This form of supervision is applicable to the community paediatric teams.

In all cases it remains the practitioner's responsibility to request any ad-hoc supervision or advice from NHCFT Safeguarding Team when they have concerns about a child or young person.

6.31 Multi Agency Public Protection Arrangements meetings (MAPPA)

Public protection arrangements exist to manage the risks from potentially dangerous individuals. If an individual is considered to be a potentially dangerous person, whether or not s/he has a relevant conviction, information sharing should be facilitated through the Safeguarding Trust Lead for MAPPA as soon as possible.

MAPPA meetings are statutory multi-agency meetings which are held to develop plans to reduce the risks posed to the public and or specific individuals, from sexual or violent offenders who have been assessed as posing a high risk of harm.

NHCFT Safeguarding Team are a core member on MAPPA Panels and are responsible for ensuring appropriate information is shared and the required actions are undertaken on behalf of the Trust.

Link to MAPPA Guidance 2014:
https://www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa-guidance

6.32 Child Safeguarding Practice Reviews (formally known Serious Case Reviews).

When a child dies or suffers serious harm as a result of abuse or neglect, local safeguarding partnerships will collect information and meet to identify if there are ways that organisations could improve the way they work together to prevent similar incidents from occurring.

NHCFT named professionals are responsible for securing the records at the time of the incident and supporting the subsequent review of the case. This allows the

- gathering of facts about the case
- discussion of whether there is any immediate action needed to ensure children's safety and share any learning appropriately
- consideration of the potential for identifying improvements to safeguard and promote the welfare of children
- decisions about what steps should be taken next, including whether or not to undertake a child safeguarding practice review

During this process the person leading in the review for the Trust may need to interview key staff who have been involved with the child or the family members. Staff may also be invited to practitioner's events to discuss the case and help identify local learning. The focus is on learning not blame, and NHCFT Safeguarding team will fully support staff through this process.

The Head of Safeguarding and Named Nurse (or midwife) will have responsibility for co-ordinating and ensuring the recommendation(s) from the Action Plans are implemented. These plans must be agreed and addressed through Governance meetings and presented at board level assurance meetings.

Child safeguarding practice review panel: practice guidance - GOV.UK (www.gov.uk)

6.33 Child Death Overview Panel (CDOP)

CDOP refers to a multi-agency process which reviews of all unexpected child deaths. The remit of the meetings is to look at whether or not there are any lessons to be learnt with regard to improving practice and improving the health and safety of children, and to ensure the family receive appropriate support.

Staff who are involved with a child who dies unexpectedly are expected to participate in the multi-agency meeting to discuss the life of the child, the circumstances leading to their death and what support or services the family/parents may benefit from. The initial meeting is usually held soon after the child death, and if the allocated practitioner is unable to attend then a deputy should be provided in their place. The death of a child is often incredibly sad for those who knew the child and family and it is important that NHCFT Safeguarding Team are contacted should any additional support be required by staff.

NHCFT Safeguarding team must attend all initial CDOP Rapid Review meetings, and ensure that any issues relevant to safeguarding are identified and addressed.

6.34 Allegations and Concerns Regarding Staff (including the role of the Local Authority Designated Officer).

Please read in conjunction with RMP77 Managing Safeguarding Concerns and Allegations against staff policy.

There may be occasions when abuse is alleged against an employee working in the Trust, regardless of whether they are made in connection to duties with NHCFT or if they fall outside of this such as in their private life or any other capacity. This may also include safeguarding in their own lives if they have children or are pregnant.

This must be reported immediately to a Senior Manager. Consideration should be given to whether a crime has been committed and the duty to report to the Police. If your concerns relate to your immediate manager then you should discuss this with a more senior member of the team, e.g. OSM or on call General Manager

Staff raising an alert or who make an allegation regarding a member of staff will be supported via the Trust's freedom to speak up policy (IG07 and PP10 Dignity at Work Policy).

When a complaint or allegation has been made against a member of staff the Trust Head of Safeguarding OR Team Lead Safeguarding Adults and the HR Manager with responsibility for Safeguarding should be notified of the concerns for advice and support.

Disciplinary procedures must not be operated in isolation from Safeguarding Children and Adults procedures. A Safeguarding Children and/or Adults referral must be made if it is an allegation against a member of staff. Consideration must also be given to reporting to the police.

The Trust will also adhere to the Disclosure and Barring Service (DBS) processes and professional registration bodies, for staff found to be unsuitable to work with vulnerable adults and children.

Allegations against staff

All allegations of abuse by those who work with children (paid or unpaid) must be taken seriously and can cover a wide range of situations. These situations may be connected to allegations made about staff both within and outside of their employment (or unpaid roles), and may include (NHS England 2019);

- the commitment of a criminal offence against, or related to, a child, young person or adult at risk;
- a failure to work collaboratively with social care agencies when an issue about the care of a child, young person or adult at risk for whom they have caring responsibilities, is being investigated;
- behaving towards a child, young person or adult at risk in a way that suggests they are unsuitable to work with them;
- the commitment of domestic violence or abuse, or the failure to ensure that a vulnerable individual is protected from the impact of such violence or abuse; and
- abuse against someone closely associated with a member of staff, such as a partner, or a member of the family or household.

This also includes:

- Having a sexual relationship with a child under 18 if in a position of trust in respect of that child (see ss16-19 Sexual Offences Act 2003);
- 'Grooming', i.e. meeting a child with intent to commit a relevant offence (see Section 15 Sexual Offences Act 2003);
- Other 'grooming' behaviour giving rise to concerns (e.g. inappropriate text / on-line communication, images, gifts, socialising);
- Possession of indecent photographs / pseudo-photographs of children.

NHCFT Head of Safeguarding will inform the Local Authority Designated Office (LADO) that an allegation has been made.

Every effort must be made to maintain confidentiality, and manage communications effectively, whilst an allegation is being investigated, and it may be necessary for restrictions to be placed on the staff members role / consideration of exclusion while this takes place. Occupational Health support should also be considered.

Child Safeguarding Concerns

Safeguarding issues transcend all pockets of society and therefore NHCFT staff will also be directly impacted by a range of safeguarding issues (e.g. domestic abuse, child to parent violence and abuse, sexual abuse, historical allegations of child sexual abuse, exploitation, mental health and substance misuse issues).

Staff can seek advice from a range of sources to support their own well-being (Managers, Occupational Health, HR, via staff wellbeing portal). NHCFT Safeguarding Team are also available to support with any concerns of a safeguarding nature and should be utilised by managers and relevant areas (e.g. occupational health) to highlight and discuss any issues of concern. The NHCFT Safeguarding Head of Service can be contacted by contacting the Trust safeguarding team and asking to discuss a staff concern.

Every effort must be made to maintain confidentiality, and manage communications effectively.

6.35 VIPs Visits on Trust Premises

The Trust may, on occasions, arrange for external persons to visit trust sites and meet patients when appropriate. For example, players from Newcastle United or Newcastle Eagles visiting the Children's Ward at Christmas time, or VIP visits from local members of parliament or national dignitaries.

When this does occur, all persons must be accompanied at all times by a member of the communications team who will also make necessary arrangements to ensure that staff are fully briefed about the visit. A member of the communications team will also co-ordinate all media activity related to the visit (see IG11 Social Media Policy / IG109 Media Policy.

Any such persons would not be left unsupervised with patients/service users or allowed to undertake any duties or responsibilities in relation to patients without fully complying

with the selection, clearances, and vetting processes, required of either an employee or a volunteer as appropriate.

Please read in conjunction with RMP57 Patients, Carers and Visitors Policy.

6.36 Safeguarding Adults at Risk (CG77)

When working with children it is important to “Think Family” and consider any risks to adults. All staff within the Trust have a duty to:

- Raise any concern, suspicion or allegation of abuse of an adult at risk when suspected, disclosed or discovered, and
- To maintain patient safety and contact the emergency services if required.

An Adult at Risk is defined as a person who:

- Has needs for care and support (whether or not the local authority is meeting any of those needs) and;
- Is experiencing, or at risk of, abuse or neglect; and;
- As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

This definition is often referred to as the three-part test and a person has to meet all three parts to be defined as an Adult at Risk under Safeguarding Adults.

7. Safeguarding Children Training

All managers must ensure that all staff within their department complete and are up to date with their required level of safeguarding children training. This will be monitored by ESR (Electronic Staff Record) and compliance will be reported regularly at Safeguarding Board. The level of training staff are required to complete is aligned with the Intercollegiate Document; Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff
https://childprotection.rcpch.ac.uk/resources/intercollegiate-roles-and-responsibilities/

https://www.rcn.org.uk/professional-development/publications/pub-007366

The aim of NHCFT is to ensure their staff are equipped and have the required levels of competency to carry out their responsibilities, work effectively on their own and with those from other agencies with regard to safeguarding and promoting their welfare. Training can be booked via ESR or the Local Safeguarding Partnership Safeguarding

Training Programmes. Specific guidance on the appropriate level of safeguarding children training staff require is available to all staff and managers from NHCFT's Safeguarding Team. The Named professionals (Named Dr, Nurse and Midwife) are also available for advice and can be contacted via NHCFT Safeguarding Team.

Staff may need to attend more in-depth safeguarding children training in addition to the mandatory courses, for example when training needs are identified through new legislation or best practice guidance, recommendations from Safeguarding Practice Reviews, trends emerging from the Child Death Overview process, the internal Incident Reporting process and via identified individual need.

Training Levels:

The statutory guidance *Working Together to Safeguard Children* (2018) and the Intercollegiate Document, (RCPCH 2018) identify the level of competency health staff require, (depending on their role), with regard to Safeguarding Children.

Level	Policy – criteria	Staff groups	Method	Criteria
Safeguarding Children & Young People - **Level 1**	**Trust Policy - CG29** This should provide key safeguarding/child protection information, including about vulnerable groups, the different forms of child maltreatment, and appropriate action to take if there are concerns	**ALL STAFF WORKING IN HEALTH CARE SETTINGS** Board level Executives and non- executives, receptionists, administrative, caterers, domestics, transport, porters, community pharmacist counter staff and maintenance staff and volunteers.	~ Trust Induction - DVD ~ e-Learning/ Work Book Appraisal process	**3 Yearly** (alternating between e learning and work book to ensure local and national learning incorporated in to training)
Safeguarding Children & Young People - **Level 2**	**Trust Policy - CG29** This should include all Level 1 competencies with additional learning around identification of exploitation, FGM, Trafficking, Documentation of concerns, How to respond to concerns about colleagues NB. All clinical	**ALL NON- CLINICAL AND CLINICAL STAFF WHO MAY HAVE CONTACT WITH CHILDREN, YOUNG PEOPLE AND OR PARENTS OR CARERS** Includes administrators for looked after children and safeguarding teams, health care students, clinical laboratory staff, phlebotomists, pharmacists, dental care professionals,	~ e-Learning / Work book Acute clinical staff (hospital based) - National programme (CSBU) - Virtual College Programme Appraisal process Revalidation	**3 Yearly** (alternating between e learning and work book to ensure local and national learning incorporated in to training)

Level	Policy – criteria	Staff groups	Method	Criteria
	staff who require Level 3 training should complete level 2 as a one off in preparation for Level 3 Training	audiologists, adult physicians, surgeons, anaesthetists, radiologists, nurses working in adult acute/community services, allied health care practitioners and all other adult orientated secondary care health care professionals, including technicians.		
Safeguarding Children & Young People - **Level 3**	**Trust Policy CG29** Staff who work predominantly with children and their parents and / or carers and are likely to contribute to assessing, planning, implementing and reviewing the needs of a child and/or parenting capacity where there are safeguarding / child protection concerns.	All clinical staff • working with children, young people and/or • their parents/carers and/or • any adult who could pose a risk to children and • who could potentially contribute to assessing, planning, intervening and/or evaluating the needs of a child or young person and/or parenting capacity (regardless of whether there have been previously identified child protection/safeguarding concerns or not)	Face to Face Training via NHCFT SG Team (or equivalent) or through Safeguarding Partnership Offer. Guided learning Appraisal process Revalidation	8 hours minimum. There are additional specialist specific requirements, and therefore additional hours (12-16 total) for the following roles (as per the Intercollegiate Doc, 2019, p.27-49): https://www.rcn.org.uk/professional-development/publications/pub-007366 - Paediatricians - Children's nurses - Midwives - School Nurses - CAMHS staff - Perinatal psychiatrists - Adult mental health psychiatrists and mental health nurses in adult mental health service - specialist paediatric dentists - diagnostic radiographers undertaking imaging for suspected physical abuse - radiologists - paediatric surgeons - urgent and unscheduled care staff - obstetricians - neonatologists - paediatric intensivists - lead anaesthetists for safeguarding/child protection. 3 Yearly

7.1 Training and Support

Training, support and advice on any aspects of the policy can be accessed via the NHCFT's Safeguarding Team.

8. Monitoring and Audit Arrangements

Datix reporting

All significant incidents / Clinical incidents involving harm to a child or young person should be reported using the Datix system. These should be reported using the on-line electronic incident reporting form. This form is available via the Trusts intranet site. (For further information on incident reporting see Reporting and management of incidents RMP03).

Monitoring/audit arrangements	Methodology	Reporting		
		Source	Committee	Frequency
Failure to adhere to policy				
Audit	Review of practice where procedure has not been followed via Datix process.	Reports from Datiix system	Appropriate Business Unit and manager. Safeguarding Board	Immediately Quarterly
Risks identified				
Risk Register	Review of risk register action plans	Policy Author	Safeguarding Board	Quarterly and summary in annual report

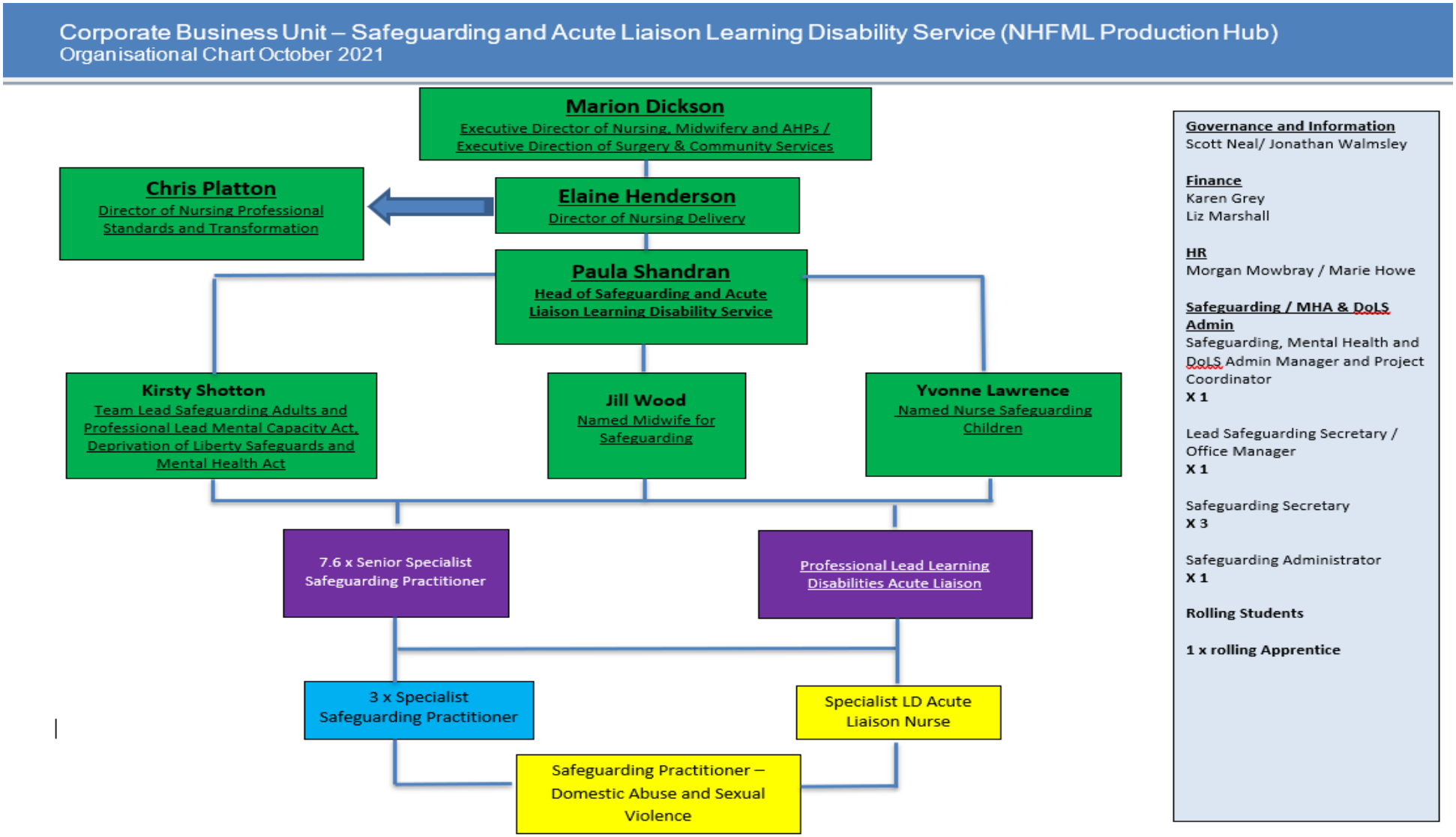
9. References

- North and South of Tyne Safeguarding Children Partnership Procedures Manual: https://www.proceduresonline.com/nesubregion/index.html#
- Working Together to Safeguard Children: https://www.gov.uk/government/publications/working-together-to-safeguard-children--2
- The Children Act 1989: https://www.legislation.gov.uk/ukpga/1989/41/contents
- The Children Act 2004: https://www.legislation.gov.uk/ukpga/2004/31/contents
- Sexual Offences Act 2003: https://www.legislation.gov.uk/ukpga/2003/42/contents
- Intercollegiate Document 2019: https://www.rcn.org.uk/professional-development/publications/pub-007366

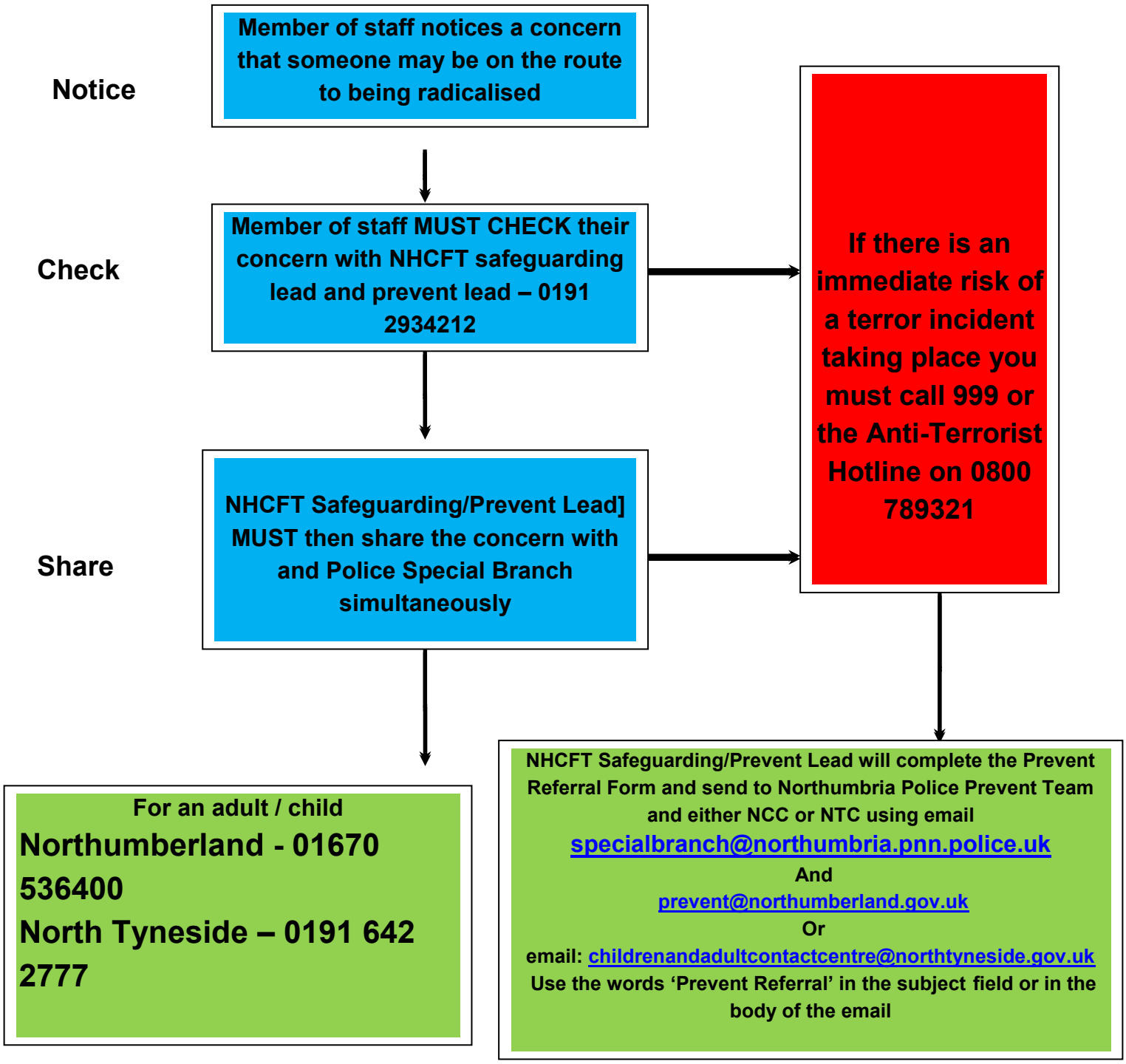
10. Associated Documentation - Contacts

Agency/Individual	**Telephone Number**	**E-mail**
NHCFT Safeguarding Teams	0191 282 8900	nhc-tr.safeguardingchildrensteam@nhs.net
North Tyneside Children and Adult Social Care joined Services:	0345 2000 109 Or (0191) 200 6800 (evenings and weekends).	childrenandadultcontactcentre@northtyneside.gcsx.gov.uk
Northumberland Children's Social Care Teams: 01670 536400 during office hours, or 0345 6005252 out of hours		
NHCFT Children in Care Team	01670 564 052, 0191 643 8369 or via switchboard	
Designated Doctor North Tyneside	Contact via switchboard	
Designated Doctor Northumberland	Contact via switchboard	
Named Doctor North Tyneside & Northumberland	0191 282 8915 or via switchboard	
Named Nurse	0191 282 8900 or via switchboard	
Named Midwife	0191 282 8900 or via switchboard	

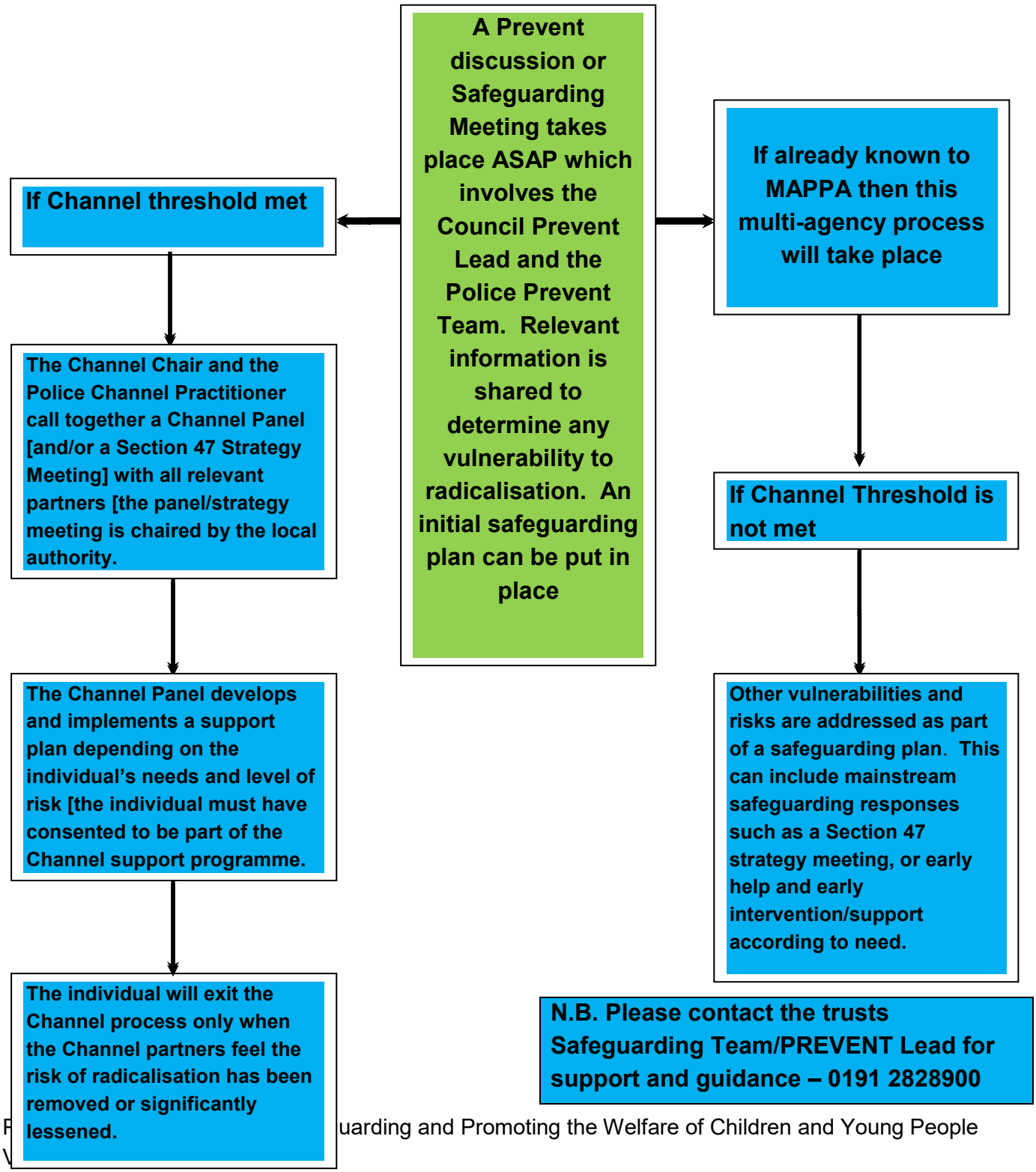
Appendix 1 – Organisational Chart



Appendix 2 – PREVENT Flowchart



Next Steps


A Prevent discussion or Safeguarding Meeting takes place ASAP which involves the Council Prevent Lead and the Police Prevent Team. Relevant information is shared to determine any vulnerability to radicalisation. An initial safeguarding plan can be put in place
If Channel threshold met
The Channel Chair and the Police Channel Practitioner call together a Channel Panel [and/or a Section 47 Strategy Meeting] with all relevant partners [the panel/strategy meeting is chaired by the local authority.
The Channel Panel develops and implements a support plan depending on the individual's needs and level of risk [the individual must have consented to be part of the Channel support programme.
The individual will exit the Channel process only when the Channel partners feel the risk of radicalisation has been removed or significantly lessened.
If already known to MAPPA then this multi-agency process will take place
If Channel Threshold is not met
Other vulnerabilities and risks are addressed as part of a safeguarding plan. This can include mainstream safeguarding responses such as a Section 47 strategy meeting, or early help and early intervention/support according to need.
N.B. Please contact the trusts Safeguarding Team/PREVENT Lead for support and guidance – 0191 2828900

Appendix 3- Equality Impact Assessment

To be completed for all key policies. Cite specific data and consultation evidence wherever possible.

Duties which need to be considered:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act
- Advance equality of opportunity between people who share a protected characteristic and those who do not
- Foster good relations between people who share a protected characteristic and those who do not

PART 1 – Overview

Date of equality impact assessment:

02.08.22

Name(s) and role(s) of staff completing the assessment:

Yvonne Lawrence (Named Nurse- Safeguarding Children)

Overall, what are the outcomes of the policy?

The outcome of the policy is that all staff act appropriately and in accordance with these policies and procedures to be able to effectively safeguard children.

PART 2 – Relevance to different Protected Characteristics

Answer these questions both in relation to people who use services and employees as appropriate

Protected Characteristic	Does this characteristic have specific relevance to this policy?	If No –	If Yes –						
		Please state why:	What do you know about usage of the services affected by this policy by people in this protected group, about their experiences of it, and about any current barriers to access?	Could people in this protected group be disproportionately advantaged or disadvantaged by the policy?	Could the policy affect the ability of people in this protected group participate in public life? (e.g. by affecting their ability to go to meetings, take up public appointments etc.)	Could the policy affect public attitudes towards people in this protected group? (e.g. by increasing or reducing their presence in the community)	Could the policy, change make it more or less likely that people in this protected group will be at risk of harassment or victimisation?	If there are risks that people in this protected group could be disproportionately disadvantaged by the policy are there reasonable steps or adjustments that could be taken to reduce these risks?	Are there opportunities to create positive impacts for people in this protected group linked to this policy?
Disability *Note: "disabled people" includes people with physical, learning and sensory disabilities, people with a long-term illness, and people with mental health problems.*	No	The policy is applicable to all staff members deemed able to perform their role by Occupational Health.							
Sex *Note: all policies should be gender neutral and use pronouns such as them, their and they, not he/she; her/him*	No								
Age	No								

Protected Characteristic	Does this characteristic have specific relevance to this policy?	If No –	If Yes –						
		Please state why:	What do you know about usage of the services affected by this policy by people in this protected group, about their experiences of it, and about any current barriers to access?	Could people in this protected group be disproportionately advantaged or disadvantaged by the policy?	Could the policy affect the ability of people in this protected group participate in public life? (e.g. by affecting their ability to go to meetings, take up public appointments etc.)	Could the policy affect public attitudes towards people in this protected group? (e.g. by increasing or reducing their presence in the community)	Could the policy, change make it more or less likely that people in this protected group will be at risk of harassment or victimisation?	If there are risks that people in this protected group could be disproportionately disadvantaged by the policy are there reasonable steps or adjustments that could be taken to reduce these risks?	Are there opportunities to create positive impacts for people in this protected group linked to this policy?
Race *Note: For the purposes of the Act 'race' includes colour, nationality and ethnic or national origins.*	No								
Religion or belief *Note: In the Equality Act, religion includes any religion. It also includes a lack of religion. Belief means any religious or philosophical belief or a lack of such belief.*	No								
Sexual Orientation *Note: The Act protects bisexual, gay, heterosexual and lesbian people.*	No								

Protected Characteristic	Does this characteristic have specific relevance to this policy?	If No –	If Yes –						
		Please state why:	What do you know about usage of the services affected by this policy by people in this protected group, about their experiences of it, and about any current barriers to access?	Could people in this protected group be disproportionately advantaged or disadvantaged by the policy?	Could the policy affect the ability of people in this protected group participate in public life? (e.g. by affecting their ability to go to meetings, take up public appointments etc.)	Could the policy affect public attitudes towards people in this protected group? (e.g. by increasing or reducing their presence in the community)	Could the policy, change make it more or less likely that people in this protected group will be at risk of harassment or victimisation?	If there are risks that people in this protected group could be disproportionately disadvantaged by the policy are there reasonable steps or adjustments that could be taken to reduce these risks?	Are there opportunities to create positive impacts for people in this protected group linked to this policy?
Gender Reassignment *Note: The Act provides protection for transsexual people. A transsexual person is someone who proposes to, starts or has completed a process to change his or her gender.*	No								

Protected Characteristic	Does this characteristic have specific relevance to this policy?	If No –	If Yes –						
		Please state why:	What do you know about usage of the services affected by this policy by people in this protected group, about their experiences of it, and about any current barriers to access?	Could people in this protected group be disproportionately advantaged or disadvantaged by the policy?	Could the policy affect the ability of people in this protected group participate in public life? (e.g. by affecting their ability to go to meetings, take up public appointments etc.)	Could the policy affect public attitudes towards people in this protected group? (e.g. by increasing or reducing their presence in the community)	Could the policy, change make it more or less likely that people in this protected group will be at risk of harassment or victimisation?	If there are risks that people in this protected group could be disproportionately disadvantaged by the policy are there reasonable steps or adjustments that could be taken to reduce these risks?	Are there opportunities to create positive impacts for people in this protected group linked to this policy?
Pregnancy and Maternity *Note: the law covers pregnant women or those who have given birth within the last 26 weeks, and those who are breast feeding.*	No								
Marriage and Civil Partnership *Note: This applies to changes, decisions or proposals impacting on employees only. The Act protects employees who are married or in a civil partnership.*	No								

Protected Characteristic	Does this characteristic have specific relevance to this policy?	If No –	If Yes –						
		Please state why:	What do you know about usage of the services affected by this policy by people in this protected group, about their experiences of it, and about any current barriers to access?	Could people in this protected group be disproportionately advantaged or disadvantaged by the policy?	Could the policy affect the ability of people in this protected group participate in public life? (e.g. by affecting their ability to go to meetings, take up public appointments etc.)	Could the policy affect public attitudes towards people in this protected group? (e.g. by increasing or reducing their presence in the community)	Could the policy, change make it more or less likely that people in this protected group will be at risk of harassment or victimisation?	If there are risks that people in this protected group could be disproportionately disadvantaged by the policy are there reasonable steps or adjustments that could be taken to reduce these risks?	Are there opportunities to create positive impacts for people in this protected group linked to this policy?
Human Rights	**Could the policy impact on human rights? (e.g. the right to life, the right to respect for private and family life, the right to a fair hearing)**								
	no								

PART 3 - Course of Action

Based on a consideration of all the potential impacts, tick one of the following as an overall summary of the outcome of this assessment:

☒	The equality analysis has not identified any potential for discrimination or adverse impact and all opportunities to promote equality have been taken.
☐	The equality analysis has identified risks to equality which will not be eliminated, and/or opportunities to promote better equality which will not be taken. Acceptance of these is reasonable and proportionate, given the objectives of the policy and its overall financial and policy context.