**Policy:** **Safeguarding Children and Young People**
**Policy number:** **6.02**

## 1. *Policy Statement*

Child safeguarding is the action that is taken to promote the welfare of children and protect them from harm. This can include both proactive and reactive interventions to support health and wellbeing.

Hospice in the Weald is committed to supporting children and their families, as well as respecting and valuing all staff members, trustees, and volunteers. Every member of staff and volunteer (the workforce), as well as the trustees, has a duty to protect any child or young person who encounters the organisation and who is, or could become a victim of abuse of any kind.

Safeguarding children and promoting the welfare of children is defined by Working together to Safeguard Children 2018 as:

- protecting children from maltreatment and significant harm
- preventing impairment of children's health or development
- ensuring that children grow up in circumstances consistent with the provision of safe and effective care
- taking actions to ensure children have the best outcomes

Every member of the workforce has a duty to protect any child or young person who encounters the organisation: safeguarding is everyone's responsibility.

This policy provides guidance on how to act if you think a child or young person may be at risk.

*Related policies, guidelines, and procedures*

### *Internal Policies*

Risk Management & Incident Reporting (including Near Misses) (9.08)
Safeguarding Vulnerable Adults (6.01)
Comments and Complaints (6.04)
Health and Safety (9.01)
Employment (8.01)
Health Records (4.02)
Recruitment and Selection (8.23)
Confidentiality (8.19)
Whistleblowing (6.03)
Mental Capacity & Deprivation of Liberty Safeguards
Consent to Care Children and Young People

### *Legal Framework*

Children's Act 1989 2004
The United Nations convention on the Rights of the Child 1992
The Care Act 2014
The Equality Act 2010
The Children and Families Act 2014
The Human Rights Act 1998
The Mental Capacity Act 2005
Children and Social work Act 2017
Working Together to Safeguard Children 2018
Keeping Children Safe in Education 2020

The key principles from the legislation are:

Safeguarding is **everyone's** responsibility: for services to be effective each professional and organisation should play their full part.
A child centred approach: for services to be effective they should be based on a clear understanding of the needs and views of children.

### *Other Related Guidance*

Safeguarding disabled children: practice guidance
Child maltreatment: when to suspect maltreatment in under 18s NICE
Child sexual exploitation: definition and guide for practitioners (Department of Education 2017)
Care of unaccompanied migrant children and child victims of modern slavery (Department of Education 2017)
Multi agency statutory guidance on female genital mutilation: procedural information
PREVENT duty guidance Home Office 2021
Thinkuknow Supporting Children to stay safe online
NICE guideline on child abuse and neglect

## 2. *Responsibility and Accountability*

| | |
|---|---|
| Policy formulation and review: | Lead Nurse Childrens Service |
| Approval: | CEO (via HLT) |
| Compliance: | All Staff and volunteers. Managers have a responsibility to ensure volunteers in their service or department are aware of the detail in this policy and have the necessary information and training to carry out their roles in line with this. |

## *3. Relevant Dates*

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|---|---|
| Policy originated: | August 2022 |
| Date of last review: | N/A |
| Date of this review: | N/A |
| Date of next review: | April 2025 |

## *4. Aim of the Policy*

- Provide protection for the children and young people who receive our services, and for their siblings and children connected to adult patients.
- To provide staff and volunteers with guidance on procedures they should follow if they suspect a child or young person may be at risk of harm.
- To provide clear guidance on action to be taken if an allegation of abuse is made against a member of staff or a volunteer or if the behaviour of anyone gives cause for concern.
- To have a clear understanding of the principles of safeguarding children

## *5. Designated Safeguarding Lead:*

The Designated Safeguarding Lead at Hospice in the Weald is Tracy Smith (Head of Children and Young People's Service) and can be contacted on 0735 503 5185

The deputy designated safeguarding lead is Jan Thirkettle (Clinical Director) and can be contacted on 0735 503 5160

Both have responsibility for:

- Receiving information from anyone who has concerns about a child or young person
- Deciding whether the parents of a victim need to be informed, and/or agreement sought from, to contact the relevant local authority
- Deciding what action is required and contacting the relevant agency or the police or the NSPCC for advice

## *6. Definitions of safeguarding and abuse*

Safeguarding is the action taken to promote the welfare of children and young people from harm. Safeguarding means protecting children from maltreatment and significant harm. Preventing impairment of a child's health or development and ensuring children grow up in a safe and consistent environment.
Child protection is part of the safeguarding process and sets out specific procedures to follow when dealing with a concern about a child.

Abuse is where someone causes harm or distress.
There are 4 broad categories of abuse recognised by national frameworks and agencies

- Physical
- Sexual
- Emotional/psychological
- Neglect

These categories overlap and an abused child typically suffers form more than one type of abuse.

*Appendix 2 Description of categories*
*Appendix 3 Indicators of abuse*

## *7.* ***Commitment to Safeguarding***

All staff and volunteers have a responsibility for the safety of children, young people, and adults. All staff must read and understand the safeguarding policies and procedures and be aware of their safeguarding duties. Staff will be equipped to recognise potential indicators of abuse or neglect and follow procedure in reporting concerns without delay. It is everyone's responsibility to:

• Recognise
• Respond
• Refer
• Record
• Review (Follow up)

Hospice in the Weald ensures all employees, volunteers and trustees embed safeguarding within their day-to-day professional practice. All employees, volunteers and trustees will receive mandatory safeguarding training in keeping with Safeguarding Children and Young people: Roles and Competencies for Healthcare Staff Intercollegiate Document (2019). See appendix 4: training matrix.

It is the duty of a health care organisation to provide the following to staff as appropriate:

- Safeguarding/child protection training
- Learning opportunities
- Safeguarding/child protection supervision
- Support to facilitate the understanding of child wellbeing and information sharing

Registered Children's Nurses will be able to access Safeguarding Supervision through the specialist children's safeguarding nurses, at the integrated care board. Group supervision will be provided, with additional 1;1 opportunity if the individual has an urgent child protection concern. Mandatory safeguarding supervision will be provided quarterly. Safeguarding supervision will form part of the regular 1:1 discussions and team meetings.

### 8.1 ***Recognise***

All staff and volunteers should be trained to recognise indicators of abuse and neglect. This includes being able to recognise a change in a pattern or behaviour that could suggest something isn't right in a child's life. Research suggests that children with disabilities are at a greater risk and more vulnerable to abuse and the presence of multiple disabilities appears to increase the risk of both abuse and neglect, yet they are underrepresented in safeguarding systems. Children with disability can be abused in ways that other children cannot, and early indicators can be more complicated. The Disability Discrimination Act 2005 defines a

disabled person as someone who has ‘a physical or mental impairment which has a substantial and long-term adverse effect on his or her ability to carry out normal day to day activities’

**Increased vulnerabilities can include:**

- Communication barriers and impaired capacity to avoid or resist abuse.
- Increased isolation physically/socially from mainstream services
- Increased level of dependency on others
- Inadequate support
- Discriminated against by society’s attitudes
- Subjected to increased power inequalities
- May have multiple carers
- May rely on others for intimate/personal care
- Can’t distinguish between types of touch

**Signs and indicators**

- Rough handling
- Lack of equipment
- Lack of stimulation
- Pressure sores, poor skin integrity
- Confined to a chair/room
- Over protection
- Misuse of medication
- Inappropriate restraint
- No explanations prior to an intervention
- Lack of privacy and dignity
- Force feeding or no support with feeding
- Missed medical appointments
- Lack of engagement with services

## 8.2 ***Respond***

It takes a lot of courage for children or young people to talk to an adult about their abuse. They often fear there will be negative consequences if they speak out, you must reassure them that they have done the right thing by speaking to an adult. It is important to consider that not all children can speak out verbally therefore it is essential that you are able to recognise possible indicators of abuse or neglect.

If a child or young person talks to you about their abuse, you should:

- remain calm, accessible, and receptive
- listen carefully and actively without interrupting
- communicate with the child in a way that is appropriate to their age, understanding and preference
- Only ask questions for clarification and do not ask leading questions (leading questions may elicit answers, which could compromise evidence)
- be aware of the non-verbal messages you are giving
- make it clear that you are taking them seriously
- acknowledge their courage and reassure them that they are right to tell
- reassure them that they should not feel guilty and say that you're sorry that this has happened to them
- let them know that you are going to do everything you can to help them and what may happen as a result
- make a note of what was said and who was present, using the child's actual words wherever possible

- Talk to your Line Manager or, if they are not available, contact the Designated Safeguarding Lead

Do not:

- probe for more information than the child offers
- speculate or make assumptions
- make negative comments about the alleged abuser
- Never promise to keep a secret or confidentiality
- delay getting emergency help if needed – e.g., medical help

8.3 ***Refer***

All practitioners who work with children, young people and families must know how and when to refer children to statutory services. They have a duty to refer to Children's social care under section 11 of the Children Act 2004.
Everyone who works with children and young people have a duty to keep them safe. Anyone who has concerns about a child's welfare and believes or suspects that a child:

- Has suffered significant harm
- Is likely to suffer significant harm
- Has a disability, developmental and welfare needs those needs would only likely be met with the provision of family support services (with consent from the child's parent)
- Is a child in need whose development would likely be impaired without intervention of services.

should make a referral to local authority children's social care without delay. The referrer should provide information about their concerns and any information they may have gathered in as assessment that may have been undertaken before making the referral.

The local authority and its social workers have a statutory responsibility to lead on the assessment of children in need (section 17, Children Act 1989) and to lead Child protection enquires (section 47, Children Act 1989*).*

*If a concern is recognised:*

- Ring 999 if a child is in immediate danger or emergency services if the child is suffering from a serious injury.
- Complete the Safeguarding Children alert form (Appendix 5)

If there is no immediate danger:

- Discuss concern and whether a social services referral should be made with your line manager or designated safeguarding lead
- If safe to do so and would not put the child or young person at risk, parents should be made aware of the referral
- Contact the relevant Safeguarding Children Board ASAP
- East Sussex Local Safeguarding Children Board on 01323 464222 or out of hours 01273 335905 email 0-19.SPOA@eastsussex.gov.uk
- Kent Safeguarding Children Multi-Agency Partnership Front Door Team on 03000 41 11 11 or out of hours 03000 41 91 91
- Complete an incident form which is on the Hospice Web (from policy 9.8)
- Complete the safeguarding children alert form on the Child/ young person's Electronic Care Record (ECR) (Appendix 6)

The timing of referrals should reflect the level of perceived harm, no longer than 24 hrs of identification or disclosure of risk or harm. A response should be received in writing within 48 hours

### *8.4* ***Record***

It is important that all concerns are recorded at the time or soon after the event. Records of concerns may reveal patterns which may indicate child abuse or identify unmet needs. Record as soon as possible after any concern and make sure that the date and time on the record corresponds to the actual 'event'.

The record needs to be accurate and factual. It should clearly differentiate between facts and a professional's judgement or opinion which may be crucial, however must be recorded as an opinion and supported by setting out the facts and observations upon which the opinion was based. Records pertaining to issues of child protection may be accessible to third parties, such as social services, police, the courts, and solicitors.

Where a disclosure has been made records should be documented using the child or young person's own words.

Concerns and agreement to make a referral to social services should be discussed with the child or young person and their parent/carer. Constructive working relationships between staff and family members and between professionals themselves are essential to enable effective practice and respond to situations where a child or young person is at risk or have suffered abuse. A caveat to raising concerns with a parent/carer would be if it placed the child or young person at risk of significant harm through either delay, or the parents/carers possible actions or reactions, for example circumstance's where a serious crime has been committed such as sexual abuse or fabricated induced illness. This should be clearly documented with the rationale on the safeguarding alert form in the ECR and within the social service referral.

### *8.5* ***Review***

Follow up any referrals with a phone call or email. Provide care and support to the individual/family as required. Document any follow up correspondence or attempts to follow up. If you are having issues obtaining external updates, please speak to your line manager or the designated safeguarding lead. Staff should be supported to access debriefs or supervisions if required. If concerns are still present or escalating, further or repeat referrals may need to be made.

## *8.* ***Recruitment of staff and volunteers***

We follow stringent recruitment procedures to minimise any risk of abuse by a member of staff or a volunteer. Those who are likely to have unsupervised contact with children or young people in the course of their work will undergo a DBS check at Enhanced level to confirm that there are no previous convictions, cautions or warnings relating to child abuse, sexual offences, or violence. Further details are in our Recruitment and Selection Policy (8.23) and in appendix item 4. However, we all need to report behaviours we see in anyone that concern us if the concern relates to safeguarding children and young people.

## *9.* ***Professional Curiosity***

People affected by abuse or neglect rarely tell us so directly – they may be frightened or ashamed, and often they don't realise that their lives are different to anyone else's. This makes it difficult for professionals to

identify people who are experiencing or at risk of abuse – to do so we need to be curious about their lives, observant of their behaviour and to really listen to what they are saying to us.

Professional curiosity means exploring every possible indicator of abuse or neglect and trying to understand what the life of that adult is like on a day-to-day basis – their routines, thoughts, feelings, and relationships with family members/carers.

A professional may have the opportunity to identify abuse and neglect even if they meet a family for an unrelated reason. To be truly curious about a child/ young person's or adult's life, professionals also need to maintain an attitude of respectful uncertainty. This means applying a critical eye to the information given by family members or carers rather than just accepting things on face value:

- Does the explanation given make sense?
- Is there other information which sheds doubt on their account?
- Is it possible to independently verify the information given?

It is important to acknowledge that we all work in an environment of uncertainty. Nobody can see into the future or know what happens behind closed doors and therefore practitioners need to adjust their understanding of the persons situation to consider changing information and different perspectives.

## *10.* ***Information Sharing***

Sharing of information is an intrinsic part of a professional's role. Effective information sharing between practitioners and local organisations and agencies is paramount for early identification of need, assessment, and service provision. It could ensure that the child or young person receives the right service at the right time preventing the need to escalate to an acute more difficult to manage situation or indeed a fatality. Data from serious case reviews has highlighted that missed opportunities to record, understand the significance of and share information in a timely manner can have severe consequences for the safety and welfare of children. Fears about sharing information cannot be allowed to stand in the way and professionals should be proactive and effective and not make assumptions that information is already known.

Concerns about abuse covers a broad spectrum, from the immediate risk of significant harm (where a referral to Police or Local Authority Children's Social Care would be required) to 'lower level' indicators, that may require action, such as a plan for further monitoring or referral to Early Help Services. It is important to understand that these indicators could form part of a wider picture, and will need to be promptly shared with other agencies.

Lower-level concerns can also become more significant if they occur frequently, over a period. It is therefore, important to make an informed, professional judgement, acting to promote early assessment and intervention. This should be done in consultation with a Safeguarding Lead, other agencies and children and young people themselves.

## *11.* ***Accidents and Injury.***

All accidents or incidents that occur at HitW children's service or whilst in the care of Hospice in the Weald's workforce are recorded as per the risk management incorporating incidents/near misses reporting policy 9.08.
An incident/near miss form should be submitted via the Hospice Web as soon as possible after the incident/near miss has occurred. An incident or near miss investigation will allow patterns to be identified, lessons learnt and changes to protocols and procedures if required.

The Designated Safeguarding Lead must be informed of any injury that a child has sustained as notifications may need to be sent to external agencies such as the Care Quality Commission (CQC) and the Local Authority Designated Officer (LADO). The Head of Children's Service and Lead Nurse must have oversight of all Children's Service incident forms.
Parents must be notified of all incidents and near misses as soon as possible after the event. All health care professionals have a duty of candour to be open honest and transparent when things go wrong, (NMC 2014)
Parents will be asked to inform staff of any existing injuries or bruising that has occurred outside of HITW. A body map will be completed, and this will be clearly documented on the child/young person's care records Body Map (appendix item 5).

## *12. **Allegations towards a staff member or volunteer or if behaviour of anyone gives cause for concern.***

We recognise that any allegation of abuse against a member of staff or volunteer is deeply distressing and difficult to handle. However, it is crucial that, if you have any concerns about the behaviour of another member of staff or volunteer, you raise this immediately with the Designated Safeguarding lead, or their Deputy or the Head of Personnel who will make sure that this is investigated appropriately, and that confidentiality is maintained.

If a child or young person makes an allegation against a member of staff or volunteer, you must raise this with the Designated Safeguarding lead, or the Deputy or the Personnel Director immediately.

## *13. **Other types of Abuse***

### *19.01 **Child sexual exploitation***

Child sexual exploitation (CSE) is a form of sexual abuse. The definition of CSE is:

- Child sexual exploitation is a form of 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 either in exchange for something the victim wants or needs and or for the financial advantage or the increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. CSE does not always involve physical contact. It can also occur using technology.

- CSE is a complex form of abuse and can often be difficult for those working with children and young people to identify. The indicators for CSE can sometimes be mistaken for normal adolescent behaviour. It requires knowledge, skills professional curiosity and an assessment that highlights risk factors and personal circumstances of individual children to ensure that signs and symptoms are being interpreted correctly and support is given.

- The new electronic CSE partner information sharing form (eINTEL) has been created to enable an effective multi-agency information sharing by any staff involved in the child or young person's care about CSE. The information shared may be important and relevant for the Multi-Agency Child Sexual Exploitation Team (CSET) to build intelligence about CSE and better target the response to prevent and disrupt it. It must be emphasised that this form is NOT a referral to Local Authority Children's Social Care or to Early Help but is an information gathering exercise and will inform further assessments and actions.

- If a sexual assault is disclosed or suspected, a referral will need to be made to a Sexual Assault Referral Centre (SARC) to ensure specialist care and examination.

Sexual Exploitation can have links with other types of crimes these include

- Child trafficking
- Domestic Abuse
- Grooming (including online grooming)
- Gang related offences
- Immigration related offences

*19.02* ***Fabricated Illness***

Fabricated or induced illness (FII) and perplexing presentation: Fabricated or induced illness (FII) and perplexing presentation are rare forms of child abuse. It occurs when a parent or carer, usually the child's biological mother, exaggerates or deliberately causes symptoms of illness in the child. FII was previously known as Munchausen's Syndrome, where a person pretends to be ill or causes illness or injury to themselves or Munchausen's by proxy, where a person fakes illness in another, usually their child. FII can involve children of all ages, but the most severe cases are usually associated with children under 5 years. Clinical experience and research indicate that the mother is nearly always involved or the instigator. There have however, been cases where the father, foster parent, grandparent, guardian, or healthcare/childcare professional was responsible. In cases where the mother is responsible, it could be that she enjoys the attention and the status of playing the role of a "caring mother". Many mothers involved in FII have borderline personality disorders, characterised by emotional instability, impulsiveness, and disturbed thinking. FII is a child safeguarding issue and if suspected, should be initially discussed with a Designated Safeguarding Lead. Staff who suspect FII must contact the child's medical professionals and liaise with Local Authority Children's Social Care and the Police and must follow local safeguarding procedures. A chronology should be kept/completed. If a member of staff or volunteer suspects that someone may be fabricating or inducing illness in their child, they should not confront them directly or elude that they have concerns about FII. It is unlikely to make the person admit to wrongdoing, and it gives them the opportunity to dispose of any evidence of abuse and disengage with services involved. (Perplexing presentation(pp)/Fabricated or induces illness (FII) in Children RCPCH guidance. 2021)

*19.03* ***Disguised compliance***

Disguised compliance is when a parent/carer appears to be cooperating with health professionals and agencies when in fact they are avoiding compliance. This can present in the form of avoiding meetings or last-minute cancellations, missed health appointments, not seeking advice or help, incorrect reporting of issues or situations or changing staff that they will or will not work with. Often what appear to be legitimate excuses are given which is why it is difficult to recognise. Disguised compliance is used to avoid professional involvement, multi-agency communication and escalation of concerns

*19.04* ***County Lines***

The Home Office Serious Crime strategy 2018 states the NPCC definition of a County Line is a term used to describe gangs and organised criminal networks involved in exporting illegal drugs into one or more importing areas (within the UK) using dedicated mobile phone lines or other form of 'deal line'. They are likely to exploit vulnerable adults and Children to move and store the drugs and money and will often use coercion intimidation and violence (including sexual) and weapons.

19.05 ***Cuckooing***

Cuckooing is where professional criminals target homes of vulnerable adults to take control of the persons home and use it to facilitate exploitation. The criminal usually befriends their victim and establishes a relationship with the vulnerable person to access their home. The term takes the name from cuckoos who take the nests of other birds. There are different types of cuckooing

- Using the property to deal or store drugs
- Using the property for sex work
- Taking over the property for somewhere to live

19.06 ***Modern Slavery and Human trafficking***

The term 'modern slavery' is an umbrella term under which human trafficking, slavery, sexual and criminal exploitation, forced labour and domestic servitude are encompassed. The current offences for which are spread across several pieces of legislation. Human trafficking as defined by the United Nations Office on Drugs and Crime as:

*"The act, recruitment, transportation, transfer, harbouring or receipt of persons by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation."*

The Modern Slavery Act (2015) is intended to provide the police with stronger legal powers to stamp out modern slavery, ensuring that the perpetrators receive suitably severe punishment, while enhancing the protection of, and support for, all victims.

Children and young people can be subject to trafficking, and they may stand out from other children or young people because:

- They have money or possessions they cannot account for
- They don't seem to live with their parents or guardians
- They are emotionally unstable (for example, they are aggressive, withdrawn, or anxious)

If you suspect someone is a victim of trafficking

- Try to find more out about their situation and speak to the person in private without the adult who accompanied them.
- Reassure the person that it is safe to speak
- Do not make promises you can't keep
- Ask relevant non-judgemental questions
- Allow the person to share their experiences in their own time.
- Do not let concerns you may have about challenging cultural practices and beliefs stand in your way of making professional assessments about the safety of a child or young adult.

See the RCN resources: Recognising the signs and help direct people on what to do for those they suspect are victims of modern slavery.

*19.07* ***Radicalisation (PREVENT)***

Children and young people can be radicalised in different ways:

- They can be groomed either online or in person by people seeking to draw them into extremist activity. Older children or young people might be radicalised over the internet or through the influence of their

peer network. In this instance, their parents might not know about this or feel powerless to stop their child's radicalisation.

- They can be groomed by family members who hold harmful, extreme beliefs, including parents/carers and siblings who live with the child and/or person(s) who live outside the family home, but have an influence over the child's life.
- They can be exposed to violent, anti-social, extremist imagery, rhetoric and writings, which can lead to the development of a distorted world view in which extremist ideology seems reasonable. In this way, they are not being individually targeted but are the victims of propaganda which seeks to radicalise. A common feature of radicalisation is that the child or young person does not recognise the exploitative nature of what is happening and does not see themselves as a victim of grooming or exploitation. The harm children and young people can experience ranges from a child adopting or complying with extreme views, which limits their social interaction and full engagement with their education, to young children being taken to war zones and older children being groomed for involvement in violence.

PREVENT is a government strategy which forms part of a wider counter terrorism strategy and aims to prevent people from supporting terrorism or becoming a terrorist. CHANNEL is an early intervention and is part of the PREVENT strategy and is a multi-agency approach to identifying, supporting, and safeguarding young people at risk of being encouraged into terrorism through radicalisation. There are 3 criteria for a referral to the Channel programme; engagement with an extremist group, cause or ideology, intent to cause harm and capability to cause harm.

The PREVENT practice guidance summarises the responsibility of professionals and volunteers to intervene effectively to prevent the grooming of children for involvement in extremist activity.

Effective information sharing is essential to the delivery of PREVENT as this enables multi-agency professionals to take appropriate and informed action in a timely manner and is integral to providing appropriate support to those who are vulnerable to radicalisation. Information shared should be necessary and proportionate and informed consent should be sought when possible and safe to do so

19.08 ***Female genital mutilation (FGM)***

Female genital mutilation involves the partial or total removal of the external female genital organs or any other injury to the female genital organs for non-medical purposes. It can also be referred to as cutting, female circumcision, initiation, sunna and infibulation. It is most often carried out on young girls aged between infancy and 15 years old. Religious, social, or cultural reasons are sometimes given for FGM however it is extremely dangerous, harmful, and illegal. FGM constitutes to physical and emotional abuse. There are no medical reasons to carry out FGM. It doesn't enhance fertility and it doesn't make childbirth safer. It is used to control female sexuality and can cause severe and long-lasting damage to physical and emotional health. It is estimated that 65,00 girls aged 13 and under are at risk of FGM in the UK. Girls living in communities that practice FGM are most at risk, these include Kenyan, Somalian, Sudanese, Sierra Leonean, Egyptian, Nigerian, and Eritrean. Non- African countries that practise FGM include Yemen, Afghanistan, Kurdistan, Indonesia, Malaysia, Turkey, Thailand (South) and Pakistani. (This list is not exhaustive*) NHS England.*

The world Health Organisation (WHO) differentiates between four different types of female genital mutilation:

- Type 1: Excision of the clitoris prepuce (sunna circumcision) and of the clitoris or parts thereof.
- Type 2: Excision of the clitoris prepuce, the clitoris and the inner lips and parts thereof.
- Type 3: Excision of all parts of the external genitals (infibulation) Afterwards the reaming parts of the outer lips are sewn together leaving a small hole for urine and menstrual flow. The Scar needs to be opened before intercourse or labour, causing additional pain. It is the most severe form of FGM

- Type 4: Any other procedure which injures or circumcises the female genitalia. This may involve, pricking, piercing, cutting, burning, scarring the genitals.

FGM can happen anywhere in the UK. However, there are large populations of practicing communities in several specific regions including London. Of note, girls are more at risk if FGM has been carried out on their mother, sister, or a member of their extended family (HM Government, 2011). Families who practice FGM don't consider it as abuse, they view it as a routine cultural or religious practice. Professionals need to give families advice and information that is sensitive to their culture and beliefs, but they need to make it clear that FGM is illegal in the United Kingdom.

A girl at immediate risk of FGM may not know what's going to happen. But she might talk about, or you may become aware of:

• A long holiday abroad or going 'home' to visit family
• An older female relative visiting the UK, a special visitor, relative or 'cutter' visiting from abroad
• A special occasion or ceremony to 'become a woman' or get ready for marriage
• A female relative being cut - a sister, cousin, or an older female relative such as a mother or an aunt.

A girl who has been a victim of FGM may display signs such as:

- Having difficulty walking, standing, or sitting
- Spending longer in the bathroom or toilet
- Appearing anxious or upset
- Acting different after an absence from school or college
- Reluctant to go the doctors for routine medical examinations
- Asking for help though they might not be explicit about the problem because they are too scared or embarrassed.

Staff should always be aware and alert to vulnerabilities and any signs or indicators of abuse. This should be discussed with your line manager, designated safeguarding lead and refer to external partners.

*19.09* ***Domestic abuse***

Domestic abuse can be defined as any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence and abuse between those aged 16 and over, who are or have been intimate partners or family members regardless of gender and sexuality. The abuse can encompass, but not limited to

- Psychological
- Physical
- Emotional
- Sexual
- Financial

Within such patterns of behaviour, the following must also be considered:

**Controlling behaviour**: A range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance, and escape, and regulating their everyday behaviour.

**Coercive behaviour:** An act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

Domestic abuse most certainly has a harmful impact on children. Being exposed to this is child abuse. Children may experience abuse directly, but they can also experience it indirectly by:

- Hearing the abuse from another room
- Seeing someone they care about being injured or distresses
- Finding damage to their home such as furniture
- Being hurt from being caught up in or trying to stop the abuse
- Not getting the support they need from their parents or carers because of the abuse.

If a disclosure is made to a member of staff or volunteer, it should be recognised that this may be the first or only time that the child, young person, or adult has disclosed this, and employees must never assume that other people or agencies are aware of it and addressing the issue. A disclosure will enable an assessment of the risks of harm, to the person making the disclosure and/or others around them, to be undertaken. It is imperative that staff take into consideration that 'low level' incidents of known domestic abuse may only be a small part of what is taking place, and that such incidents have a long-term accumulative impact upon a child within the household.

*19.10* ***Grooming***

Grooming is a 'process by which a person prepares a child, significant adults and the environment for the abuse of a child' (Craven 2006) Grooming can happen anywhere including

- Online
- In organisations
- In public spaces

Grooming techniques can be used to prepare a child for sexual abuse, exploitation, radicalisation and criminal exploitation**.**

As with any form of abuse children who are disabled, or those who have already experienced abuse are particularly vulnerable to grooming. Other high-risk factors include, mental health problems, loneliness, social isolation, family problems, children in care, those experiencing difficulties with peers, children with low self-esteem, children with limited awareness, those who may be exploring their sexuality and identity online, those whose online activity is not appropriately monitored or supervised.

*19.11* ***Online abuse***

Information technology has made it very easy for us to communicate quickly, share experiences, views opinions and beliefs. It is an essential part of life and can be a valuable tool for children to learn, play and connect. It can however put children at risk of online abuse which can happen anywhere online including

- Social media
- Text messages
- Emails
- Online gaming
- Live streaming

Types of inline abuse include:

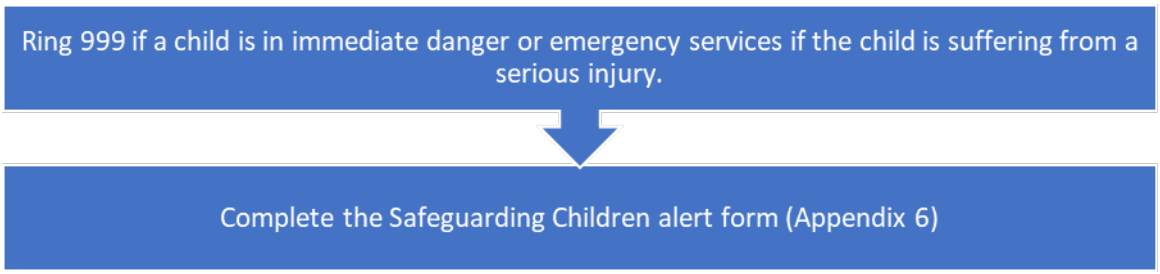
- Cyber bullying
- Emotional abuse
- Grooming
- Sexting
- Sexual abuse
- Sexual exploitation**.**

If a member of staff or volunteer has a safeguarding concern that a child or young person is being, or has been, subjected to abuse using information and communication technology (ICT), which can include bullying via mobile telephones or online (internet) with verbal and visual messages, they must make a safeguarding referral to Local Authority Children's Social Care. If the concern is regarding the sexual abuse or grooming of a child online, a referral should be made to Child Exploitation and Online Protection Command (CEOP), part of the UK's National Crime Agency. https:///www.ceop.police.uk/ceop-reporting/. The Police will often be interested in securing any evidence of online abuse. Take advice before deleting content or taking steps to preserve or record evidence of online harm. If a member of staff or volunteer has concerns about a child or young person's online behaviour, where the behaviour does not warrant a referral to Local Authority Children's Social Care the information about the child or young person must be shared with their parent/carer. All concerns and discussions should be recorded on the child's clinical records. This must include a record of the basis on which a referral to Local Authority Children's Social Care is not made, and how this is to be kept under review.

## Appendix 1

## Safeguarding Flow Chart

**If a concern is recognised:**




**If no immediate danger see the next page**

**If there is no immediate danger**

## Appendix 2 Description of the categories of Abuse

| | |
|---|---|
| Physical | Hitting, shaking, throwing, poisoning, drowning, suffocating, strangulation, deliberately inducing an illness, any action that results in the physical impairment of a child. |
| Emotional | The persistent emotional maltreatment of a child. It may involve telling a child they are unloved, worthless unwanted, inadequate. It may include not giving the child opportunities to express themselves, to silence them, or make fun of them. It may include limiting a child's experiences and interactions socially. Bullying causing a child to feel in danger and frightened. Over protection not allowing a child to experience age-appropriate exploration and learning. |
| Sexual | The involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, and for which the child is not developmentally prepared. It covers a range of illegal sexual activities including possessing images of child sexual abuse, forcing a child to undress or masturbate, engaging in any type of sexual activity in front of a child including watching pornography, not taking measures to protect a child from witnessing sexual activity or images, encouraging a child to perform sex acts on a webcam, inappropriate touching either clothed or unclothed, penetrative sex. |
| Neglect | Failure to meet a child's most physical, social, emotional and psychological needs that will likely result in an impairment of a child's health and development. Neglect may occur in pregnancy as a result of substance abuse. |

**Appendix 3**

**Safeguarding Children and young people - Examples of indicators of abuse**

| **Type of abuse** | Physical Indicator | Behavioural Indicator |
|---|---|---|
| Physical | • Frequent or unexplained bruising, marks, or injury<br>• Bruises which reflect hand marks or shapes of articles, e.g. belts<br>• Cigarette burns<br>• Bite marks<br>• Unexplained broken or fractured bones<br>• Scalds | • Fear of parent being contacted<br>• Behavioural extremes – aggressive/ angry outbursts or withdrawn<br>• Fear of going home<br>• Flinching when approached or touched<br>• Depression<br>• Keeping arms/legs covered<br>• Reluctance to change clothes<br>• Panics in response to pain<br>• Report's injury caused by parents |
| Emotional | • Delays in physical development or progress<br>• Sudden speech disorders<br>• Failure to thrive | • Neurotic behaviour<br>• Sleeping disorders, unable to play<br>• Fear of making mistakes<br>• Sucking, biting, or rocking<br>• Inappropriately adult or infant<br>• Impairment of intellectual, emotional, social, or behavioural development. |
| Sexual | • Pain/itching in genital area<br>• Bruising/bleeding near genital area<br>• Sexually transmitted disease<br>• Vaginal discharge/infection<br>• Frequent unexplained abdominal pains | • Inappropriate sexual behaviour or knowledge for the child's age<br>• Promiscuity<br>• Sudden changes in behaviour<br>• Running away from home<br>• Emotional withdrawal through lack of trust in adults |

| | | |
|---|---|---|
| | • Discomfort when walking/sitting<br>• Bed wetting<br>• Excessive crying | • Unexplained sources of money or “gifts”<br>• Inappropriate sexually explicit drawings or stories<br>• Bedwetting or soiling<br>• Overeating or anorexia<br>• Sleep disturbances<br>• Secrets which cannot be told<br>• Substance/drug misuse<br>• Reports of assault |
| Neglect | • Constant hunger<br>• Poor hygiene<br>• Weight loss/underweight<br>• Inappropriate dress<br>• Consistent lack of supervision/ abandonment<br>• Unattended physical problems or medical needs<br>• Frequently missed hospital appointments<br>• Faulty or lack of specialist equipment | • Begging/stealing food<br>• Truancy/late for school<br>• Constantly tired/listless<br>• Regularly alone/unsupervised<br><br>• Poor relations with care giver<br>• Increase in symptoms for example seizures<br>• Pressure sores from faulty or ill-fitting equipment |

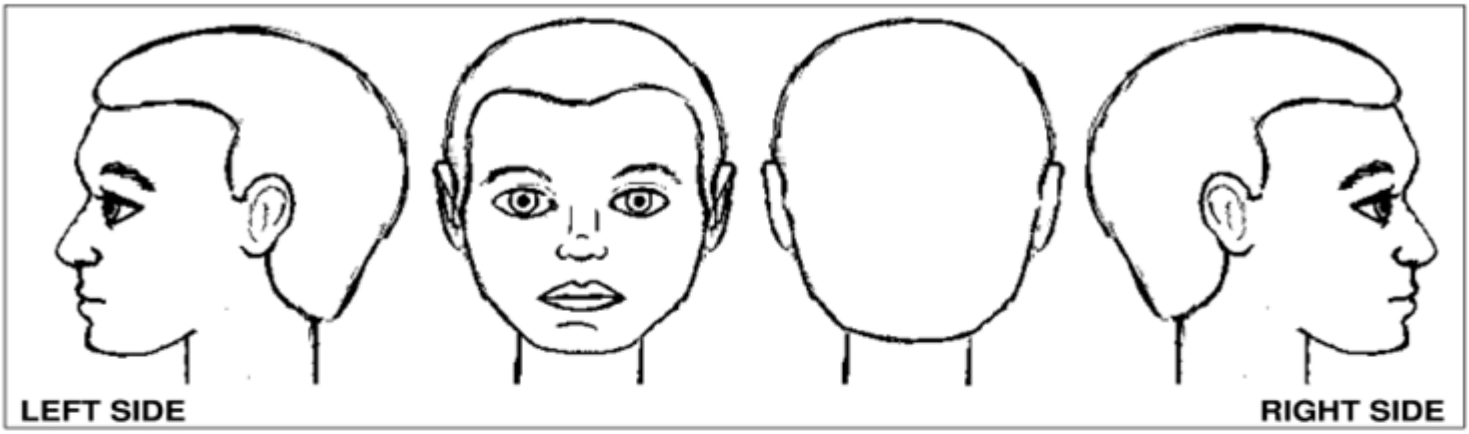
**Appendix 4 training Matrix**

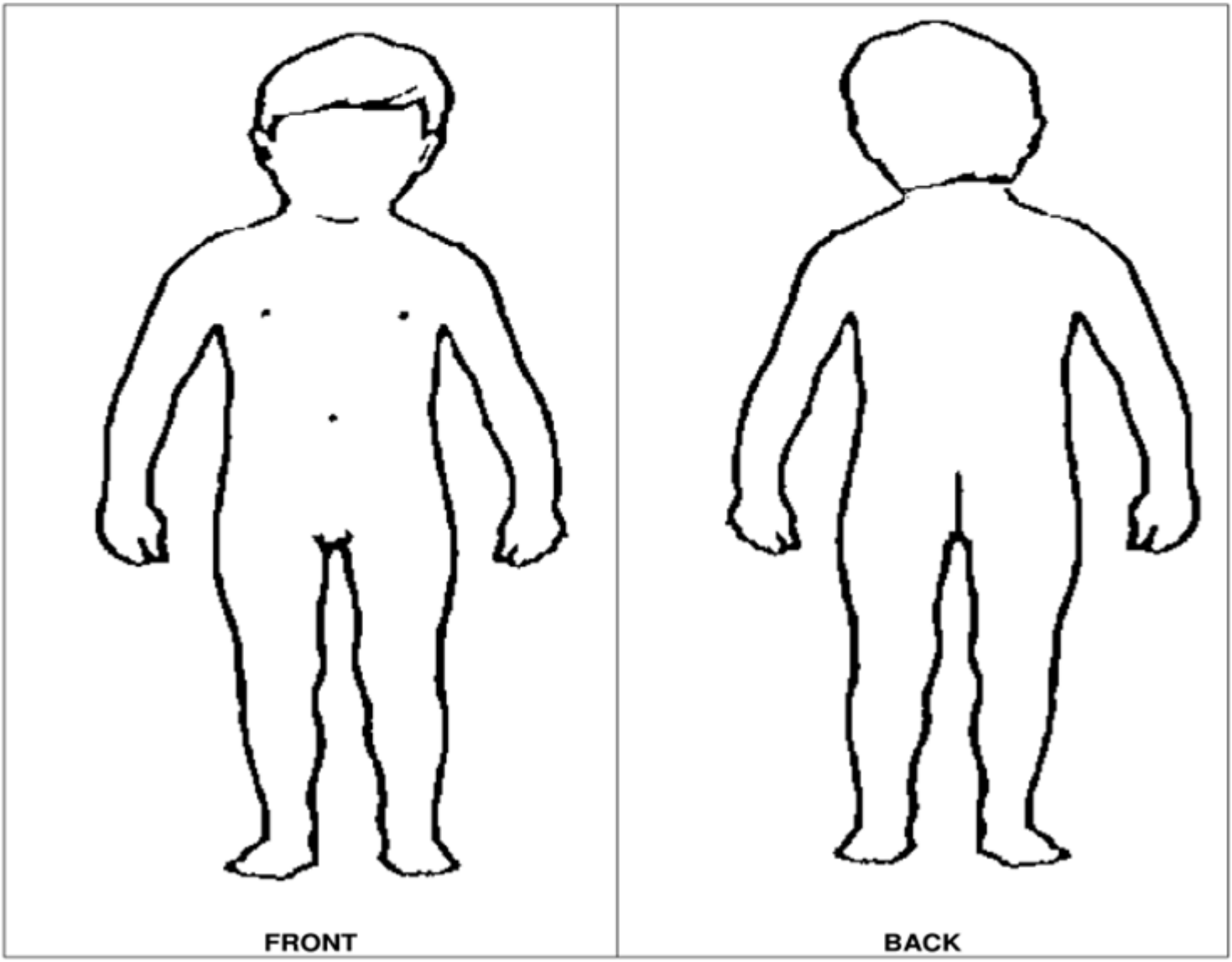
| Job/Role Title | Safeguarding Training Level | Training Frequency | DBS Level |
|---|---|---|---|
| All Workforce Members (including Trustees) | Level 1 – Adults & Level 1 - Children's | Yearly | Standard – Adult & Child |
| Workforce who work in Pembury building (including Hospice Outreach Service) or Cottage Hospice<br><br>(including Retail Managers) | Level 2 – Adults & Level 2 – Children's | Yearly | Standard – Adult & Child |
| Doctors, ANPs, CNS, ACNS, Registered Nurse, Hospice Paramedic, Nursing Associate | Level 3 – Adults & Level 3 - Children | Every 3 Years | Standard – Adult & Child |
| Heads of:<br>- Hospice Outreach Service<br>- Cottage Hospice<br>- In-Patient Ward<br>- Counselling & Support Service<br>- Living Well Service<br>- Children's Service<br><br>Directors:<br>- Care<br>- Clinical<br>- Development and Communications | Level 3 – Adults & Level 3 - Children | Every 3 Years | Standard – Adult & Child |
| All registered staff in Children's Service. | Level 3 – Adults & Level 3 - Children | Every 3 Years | Enhanced - Adult & Child |
| Register Managers (CQC) | Level 4 training | Every 3 Years | Enhanced - Adult & Child |

**Appendix 5**

## GROWING SAFETY – INJURY BODY MAP

| NAME OF CHILD | | DATE OF BIRTH | |
|---|---|---|---|




| NAME OF WORKER | | DATE RECORDED | |
|---|---|---|---|

## Appendix 5 continued - Completing a Body Map

Record using the template on EMIS or a hard copy form:

The date and time of when the injury was recorded.
Mark clearly on the body map where the injury is on the body.

Note the details of the injury- the colour, shape, size, and condition.

Note any information you are given about the injury from the child or parent: date, time, and place of occurrence; any actions taken.

Behaviour of child, is the injury causing pain? Are there any changes to care plan as a result of the injury?

If completing a hard copy of the form, add your name and signature

**Appendix 6**
**HOSPICE IN THE WEALD**

**SAFEGUARDING CHILDREN ALERT FORM**

This form should be used to report concerns where a child or young person is believed to have suffered harm, abuse or neglect or is at risk of harm, abuse or neglect by the actions or omissions of another person(s).
Once completed, please upload to the child/ young person's records on EMIS and email the Children's Safeguarding Lead and Deputy

| **1.** | **INITIAL DETAILS** |
|---|---|
| **Child/Young Person Forename** | |
| **Child/Young Person Surname** | |
| **Any Alternative Name** | |
| **Date of Birth** | |
| | |
| **1a. Parent/ Carer Details** | |
| **Name** | |
| **Home Address** | |
| **Post Code** | |
| **Telephone Numbers** | |
| **Relationship to Child/Young Person at Risk** | |
| | |
| **1.b FORM COMPLETED BY** | |
| **Name:** | |
| **Role:** | |
| **Date:** | |
| **Contact Details:** | |
| | |
| **2.** | **INCIDENT DETAILS** |
| **Date and Time of Incident** | |
| **Location incident Occurred** | |
| **2a. Details of the allegation, incident of concern.** | |
| *Factual account of allegation (who/where/when/what). Details of witnesses. Details of alleged harm, abuse or risk, or potential of any. Any other support information:* | |

| **2b. Are there any concerns of immediate risk to the child/ young person or any other adult or children** | YES: | NO: |
|---|---|---|
| *If yes, further details and action taken:* | | |

| | | |
|---|---|---|
| **2c. Do you have reason to believe a crime has been committed? If yes, in emergencies, consult with the Police on 101 or 999. If not an emergency, please contact Kent KSCB Front Door Team on 03000 41 11 11 or out of hours 03000 41 91 91 (Ensure you complete the ON LINE FORM )** | YES: | NO: |
| *Outcome of Consultation with Police) if applicable) – Crime Reference No. (if available):* | | |

| | | |
|---|---|---|
| **2d. Are the parent's/ carers aware of the referral?** | YES: | NO: |
| **2e. Consent should always be obtained from the parent/carers unless this was to pose further risk to the child/ young person.** | YES: | NO: |
| *If NO, provide reasons:* | | |

| |
|---|
| **3.Essential information about the child/young person at risk's current social situation which is relevant to these concerns** |
| |
| **4.Is there anything that you know of that would affect the child, young person, parent or carer's ability to make decisions in respect of this concern? (Either temporary or permanent)** |
| *Details of any involvements such as MCA, DoLS, IMCA, LPA:* |

| | | | |
|---|---|---|---|
| **5. Has a Mental Capacity Assessment been completed?** | YES | NO | DO NOT KNOW |

| | | | |
|---|---|---|---|
| **6.Other significant Family Members? Adults/Children or young people you are aware of** | | | |
| **Name** | **Relationship** | **Date of Birth / Age** | **Contact Details** |
| | | | |
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| **7.Professionals known to the child/ young person, for example, Community Children's Nurse, Paediatrician, O/T, Physio, Dietician,** | | | |
| **Name** | **Role** | **Address** | **Telephone Numbers** |

| | | | |
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|---|---|---|---|
| **3.** | **Details of any medical attention sought** | | |
| | | | |
| **4.** | **PERSON ALLEGED TO BE RESPONSIBLE (if identified)** | | |
| **Name of person or service believed to have cause alleged abuse, harm, or neglect** | | | |
| **Is the person alleged to be responsible also considered at risk?** | | YES | NO |
| **Does person have capacity in relation to the allegations** | Yes | No | Do Not Know |
| **Date of Birth /Age** | | **Gender** | |
| **Address & Post Code** | | **Telephone / Email** | |
| **Is the child/ young person at risk dependent, on the person alleged to be responsible, to support them** | | Yes | No |
| If yes, in what capacity: | | | |
| **Does the person alleged to be responsible, care for others?** | YES | | NO |
| Details: | | | |
| **11.Signature of person completing this form (Accepted as signed when sent electronically/uploaded to EMIS)** | | | |
| Signature | | Date:<br>Time: | |