HOSPICE IN THE WEALD

Celebrating Life, Dignifying Death

Safeguarding Children Policy

6.02

Document control sheet

Safeguarding Children Policy

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Contents

Document Summary Sheet

Safeguarding Children: Flowchart:

Recognise

Safeguarding concern identified/disclosed/suspected
If you are unsure, speak to your Line Manager/SafeguardingTeam
If it is a disclosure, do not question, just listen, clarify and
make notes if required and where appropriate to ensure details are not missed

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Respond

Discuss with your Line Manager or Designated Children's Safeguarding Lead:
Is the child safe?
Is medical treatment required?
Does any evidence need to be preserved?
Are parents/carers aware of your concerns?
Has harmed occurred to a child or an allegation been made against an employee?
If yes, contact a Safeguarding Lead
They should be aware of any referrals if it does not place the child, young person or adult at further risk.
In cases of suspected FII, parents/carers should not be informed of our concerns

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Refer

If someone is at risk of immediate harm, call 999
Any injuries need to be referred for a medical assessment
Written referrals should be made to your local social care team
Ensure the Designated Children's Safeguarding Lead is aware of any referrals
If a child, adult or family already has an allocated Social Worker, ensure they are informed
If significant harm to a child has occurred or an allegation has been made against an employee, the Designated Safeguarding Lead or Registered Manager will need to refer to the LADO and/or complete a CQC notification within the expected time frames

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Record

Record all observations, discussions, disclosures and actions – also attach any referral forms and correspondence
Complete an incident form for any incident or injury and ensure the risk grading is at the correct. level

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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 the Designated Children's Safeguarding Lead
Ensure any employees that require a debrief or supervision are supported to access these If concerns are still present or escalating, further or repeat referrals may need to be made
Update the incident progress notes on Vantage.

1. Overview

Policy Intent:
The intent of this policy is to ensure that HITW has a workforce who, whether they work directly with children or not, are aware of their responsibility to safeguard and promote the welfare of all children. It must be used in conjunction with other policies, procedures, and local clinical guidelines.

Policy purpose:
This document emphasises that safeguarding and promoting the welfare of children and those who are 'Looked After' must be an integral part of the care offered to all children and their families by all staff.

It is important that safeguarding concerns be treated at the same level as any clinical concern bearing a child centred culture of listening to children and taking account of their wishes and feelings, both in individual decisions and the development of services.

It sets out what all HitW workforce must do when there are concerns that a child is at risk or has been abused. HitW is required to act to safeguard children and young people from abuse and neglect.

Exclusions: This policy does not cover anyone over the age of 18 years.

If you have any concerns about the content of this document, please contact the policy owner or advise the Policy Coordinator via policy.coordinator@hospiceintheweald.org.uk

2. Scope

This policy applies to any member of the HITW workforce and makes clear the actions that should be taken where concerns arise that puts children at risk. The Safeguarding of children is everyone's responsibility, and every member of the workforce is expected to work in accordance with the guidance contained within this policy.

3. Associated Documents

Children's Services Pressure Ulcer SOP 2.13
Consent Policy 3.01
Deprivation of Liberty Safeguards Policy 6.12
Duty of Candour Policy 6.11
Freedom to Speak Up Guardian Policy 6.03
Incident and Near Mis Reporting and Management Policy 9.08
Mental Capacity Act 2005 Policy 6.09
Privacy and Dignity Policy 6.12
Restraint and Positive Behaviour Support SOP 6.07
Safeguarding Adults Policy 6.01

4. Key terms - abbreviations & definitions

Children	Children and Young People up to the age of 17 are referred to as children in this document.
FGM	Female Genital Mutilation
FII	Fabricated Induced Illness
HitW	Hospice in the Weald
NICE	National Institute for Health and Care Excellence
NMC	Nursing and Midwifery Council

Source of Harm (Previously Perpetrator) The individual/s or organisation suspected of carrying out abuse, or neglect.

Workforce: staff and volunteers employed by or working on behalf of Hospice in the Weald (i.e. agency staff and students on placement).

5. Policy

Hospice in the Weald (HITW) believes that:

- Safeguarding is everyone's responsibility.
- The welfare of children and young people are always paramount
- A child or young person in all situations has a right to feel safe and protected from any situation or practice that results in them being harmed or at risk of harm.

This is based on Working Together to Safeguard Children (HM Government 2018) guidance document which covers the legislative requirements and expectations on individuals and organisations to promote the welfare of children. Section 11 of the Children Act (2004) states that organisations caring for children and Young People have a duty to cooperate with Local Authorities under section 47 of the Children Act (1989).

This policy also reflects the principles contained within the European Convention of Human Rights, in particular Articles 6 and 8 and the United Nations Convention on the Rights of the Child (ratified by the UK in 1991) which states that children live in a safe environment and be protected from harm.

This policy sets out how HITW will work to safeguard and promote the welfare of children. Safeguarding and promoting the welfare of children and those who are 'Looked After' must be an integral part of the care offered to all children and their families by all staff. It is important that safeguarding concerns be treated at the same level as any clinical concern bearing a child centred culture of listening to children and taking account of their wishes and feelings, both in individual decisions and the development of services.

This policy has been developed in line with the principles of Equality and Diversity and is underpinned by the following standards:

- The child's needs come first regardless of who is being presented; the child's welfare and safety is everyone's responsibility, the child's needs are paramount, and the needs, views and wishes of each child, be they a baby or infant, or an older child should be put first, so that every child receives the support they need before a problem escalates
- Staff must work together, understand and appreciate other professionals' roles and responsibilities.

No one should be discriminated against on the grounds of age, race, religion or belief, marriage or civil partnership, pregnancy or maternity, sexual orientation, gender reassignment, sex or disability (the protected characteristics under the Equality Act 2010). In addition, HITW does not permit any discrimination on the basis of a person's culture, cultural background or socio-economic background.

All workforce must read and understand the safeguarding policy and procedures, and be aware of their safeguarding duties, recognise all forms of abuse and neglect and follow procedure in reporting concerns promptly. HitW makes sure that all employees, volunteers and trustees are equipped to embed safeguarding within their day-to-day professional practice. The principles and practices of safeguarding are given a high priority. It is everyone's responsibility to:

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

Working Together to Safeguard Children, 2018 states that effective safeguarding systems is underpinned by the following child centred approach. This child centred approach is fundamental to safeguarding and promoting the welfare of every child. A child centred approach means keeping the child in focus when making decisions about their lives and working in partnership with them and their families.
This approach sits within a whole family culture in which the needs of all members of the family are explored as individuals and how their needs impact on one another is drawn out.

All practitioners should follow the principles of the Children Acts 1989 and 2004 – which states that 'the welfare of children is paramount' and that they are best looked after within their families, with their parents playing a full part in their lives, unless compulsory intervention in family life is necessary.

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

5.1 Legal Framework

Due to the importance of preventing the harm, abuse and neglect of children and promoting their well-being, legislation for safeguarding has always existed at the heart of children's child protection policies, procedures and practices.
There are a number of pieces of legislation for safeguarding of children, including several Acts and statutory guidance documents which are always being amended or updated. This information is the foundation of safeguarding children's policies and procedures for an organisation. These are:

- Children Act 1989 and 2004
- Working Together to Safeguard Children (2018) – statutory guidance
- Working Together to Safeguard Children 2023
- Safeguarding children and young people: roles and competences for health care staff, intercollegiate document, 2019
- Sexual offences Act, 2003
- Counter-terrorism & Border Security, 2019
- General data protection regulation
- Health and Safety at work Act, 1976
- Mental Capacity Act, 2005
- Children Act 2004: Section 11& Section 17
- What to do if you are worried a child is being abused (DfE, 2015)
- Safeguarding Vulnerable People in the NHS - Accountability and Assurance Framework (NHS England, 2015)
- Guidance on Child Maltreatment: When to Suspect Child Maltreatment (NICE 2009, updated 2017)
- Guidance on Child Abuse and Neglect (NICE, 2017)
- Recruiting Safely: Safer Recruitment Guidance helping to keep children and young people safe (CWCD 2009)

6. Procedure

This document outlines signs and indicators of abuse and the actions required when concern.

There are 4 categories of abuse recognised by child protection agencies and national frameworks and all employees and volunteers need to familiarise themselves through the mandatory training provided.
The 4 categories are:

- Physical abuse
- Sexual abuse
- Emotional abuse
- Neglect

Further, detailed information can be found in Appendix 1

6.1 Recognise

Recognising the signs and indicators of abuse poses challenges for most professionals, especially those professionals whose job role has a more limited involvement with the families and children on a day-to-day basis.

6.1.1 Children with disabilities:
Research indicates that disabled children are on average 3-4 times more vulnerable to abuse and neglect than other children. This may be due to a number of issues such as:

- Having impaired capacity to avoid or resist abuse
- Fewer outside contacts (than other children) yet more intimate care from a number of carers, sometimes in isolation, which may increase risk of abusive incidents
- Having communication difficulties that might make it difficult to disclose to others what is happening
- The lack of acceptance by some families of appropriate medication or equipment needs, and ways of coping which may conflict with the needs of the child
- Professional denial of harm occurring

6.1.2 The spectrum of concerns:
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 of time. 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, as outlined in the principles of Signs of Safety® (Appendix B)

6.1.3 Accidental injury and pressure areas:

- It is HitW's policy to report to a senior team member and complete an incident form on Vantage for any: accidental injury, causing harm to a child whilst in the care of HitW
- all pressure areas (grade 2 and above), irrespective of how or where the pressure sore occurred.

A Safeguarding Lead must be informed of any child injury as notifications may need to be sent to external agencies such as the Care Quality Commission (CQC), the Local Authority Designated Officer (LADO) and the Health and Safety Executive (HSE)

6.2 Our response

Respond to concerns, allegations, or suspicions of abuse:

If any person in HitW becomes aware of the signs and indicators of abuse, suspects, or is told that a child, young person or adult is being, has been, or is likely to be abused or neglected, they must act, as set out in this procedure.

6.2.1 Responding to an immediate risk of harm:

If as an employee or volunteer, you believe that a child is at immediate risk of harm or abuse, you must take immediate steps to protect the child. If the law has been, or is being broken, the Police must be contacted immediately:

- Employees or volunteers must contact the Police immediately by calling 999 and then contact their Line Manager within 2 hours of the concern being raised.

- The Line Manager must then consult with the Designated Safeguard Lead within 3 hours of the incident – they will advise on other steps that may be required. A safeguarding referral must be completed to Local Authority Children's Social Care within 4 hours after informing relevant agencies and personnel.

If an emergency arises outside of normal working hours (i.e., between 5pm and 8am on weekdays, or on weekends and statutory holidays), all workforce must use the emergency out of hours contact number of the relevant Local Authority Children's Social Care to discuss the concern and notify them of the referral to the Police.

Kent or Medway please call the 24 hour emergency number on 03000 41 91 91

For further contact information when raising a concern follow: **Kent and Medway contact information.**

East Sussex out of hours emergency number on 01273 335905 / 6

For further contact information when raising a concern follow: East Sussex contact information

6.2.2 Responding to a child or young person when abuse is alleged, or signs and indicators are seen or heard:

When responding to a disclosure of abuse from a child or young person, an employee or volunteer should:

Listen carefully and actively to what is said and allow the child or young person to talk at their own pace.

Remain calm and reassure the child that they have done the right thing by talking to an adult. Find an appropriate opportunity in the discussion to explain the likelihood that information will need to be shared with other responsible people. •

- Never promise to keep a secret or confidentiality.
- Call the Police if there is an immediate risk of significant harm.
- Only ask questions for clarification and do not ask leading questions (leading questions may elicit answers, which could compromise evidence).
- Make sure the child understands what will happen next with their information. It is best to say something like "'I feel pleased that you have told me about what is upsetting you, to make sure that you are safe and happy I am going to……'.
- Consider the potential for any forensic evidence, relevant time frames and preservation of any potential evidence. This can involve anything that may contain DNA such as clothing. Forensic evidence may be contained at home so any potential perpetrator should not be made aware of concerns before the police. The police can advise further on this.
- Talk to your Line Manager, the Designated Children's Safeguarding Lead.

6.2.3 Low level concerns:

If any situation, conversation, observation or event causes you to have a concern about a child, young person or adult, you have a responsibility to discuss this with your Line Manager or Designated Children's Safeguarding Lead and this needs to be documented. Low level concerns can lead to early identification of safeguarding situations and help to build a wider picture of what may be happening for an individual or family. Early identification leads to early help, to ensure situations have an opportunity to improve before they escalate and this in turn can improve the outcomes for those involved.

6.2.2.4 The Signs of Safety® Framework (Appendix 2)

Constructive working relationships between professionals and family members, and between professionals themselves are at the heart of effective practice in responding to situations where children and young people are at risk of or have suffered abuse. In simple terms, the Signs of Safety® framework has four domains of inquiry:

1. What are we worried about? (Past harm, future danger and complication factors)

2. What is working well? (Existing strengths and safety)

3. What needs to happen? (Future Safety)

4. Where are we on the scale of 0 to 10, where 10 means there is enough safety for the Local Authorities to close the case and 0 mean that the child will be (re) abused? (Judgement)

6.3 Record

As soon as possible after the discussion, employees must make notes as a written record of the conversation with the child, or what was observed. Ideally, this documentation should be made directly onto the child's ECR on EMIS as well as notify the Designated Safeguard lead in writing in an email. Factually record what the child or young person has said, in their own words or what has been observed, including time, date and any other witnesses

6.4 Refer

6.4.1 Making a referral:

If the circumstances justify making a referral, this must be made to the Local Authority Children's Social Care following the multi-agency partnership procedures. This must always be confirmed in writing and documented in the child's ECR on EMIS.

The timing of such referrals must reflect the level of perceived risk of harm but must not be longer than within 1 working day of identification or disclosure of harm or risk of harm. If concerns arise out of hours, referrals must be made to the Local Authority Children's Social Care's out of hours service. Any sensitive information sent outside of HitW must be sent using the NHD secure email. The 'Signs of Safety' (Appendix 2), 'Continuum of Need' (Appendix 3) and the Assessment Framework Triangle (Appendix 4) can assist you in writing a concise referral using shared professional terminology.

6.4.2 Consent:

Where a decision not to seek parental agreement before making a referral to Local Authority Children's Social Care is made, the decision must be discussed with the Designated Safeguarding Lead and recorded in the child's ECR on EMIS, with the reasons why. This should also be confirmed in the referral to Local Authority Children's Social Care.

Concerns should be discussed with the child or young person and their parent/carer, and agreement should be sought for a referral to the Local Authority Children's Social Care. This conversation would be led by a Nursing and Care or Family Services professional and applies to all situations, unless the seeking of agreement is likely to place the child at risk of significant harm through either delay, or the parent/carer's possible actions or reactions.

Circumstances where there has been a serious crime committed such as a parent fabricating their child's illness or perpetrating sexual abuse would be the exception. If there is not agreement from parents/carers, this should not stop a referral being made, but advice should be sought from a Safeguarding Lead in advance of submission.

6.4.2 Chronologies and safeguarding:

The use of chronologies as a means of analysing progress, patterns, themes and trends within a safeguarding case has long been recognised as extremely useful. It is therefore strongly advised to utilise the chronologies process as soon as there is a safeguarding concern raised.

It is especially important to outline the impacts on the child or young person's health (for example, the child remaining in bed for prolonged periods of time will make him/her more vulnerable to complications such as pressure marks and/or chest infections).

6.4.3 Referrals when working with a partner organisation or within schools:

When working with children or young people in schools (e.g. music therapy) it is important to liaise with the school's named Safeguarding Professional and/or SENCO at the outset of the direct work to establish the lines of reporting and safeguarding accountabilities.

If a safeguarding concern arises within the context of HitW working with partner organisations or with children in schools, these should be raised with the host organisation and a decision made as to whom refers on to Local Authority Children's Social Care. This needs to be clearly documented on EMIS.

If there are conflicting views between agencies with regards to any concerns, HitW employees must speak to the Designated Safeguarding Lead for Children for further discussion and action planning.

6.4.4 Referral responses: What to expect from the Local Authority Children's Social Care

A Local Authority Social Worker should decide about the type of response that is required within 1 working day of receiving a referral and acknowledge receipt to the referrer, but this can take up to 10 days if further information is required.

If this does not occur within 5 working days, the employee making the referral, or the Designated Safeguarding Lead must contact the Local Authority Children's Social Care to establish progress. If the employee is not satisfied with the response by the Local Authority or believes it does not adequately address the risk of abuse, this must be raised with the Designated Safeguarding Lead on the same day that this conclusion is reached. The Designated Safeguarding Lead will review the details of the case on the same day and decide whether further escalation is required to the Local Authority Children's Social Care or the Police.

6.4.5 Making referrals to access Child in Need or Early Intervention Services:

When decisions are made by Local Authority Children's Social Care that a child or young person is not at risk of abuse, a decision is made if other services are required to be offered.

- Early Help Assessments should identify why the child and family require further support and what services are needed to prevent the concerns from escalating.
- Each Local Authority will have local agreements in place for Early Help Assessments, in principle a Lead Practitioner should undertake the assessment, provide help to the child or young person and their family, act as an advocate on their behalf and co-ordinate the delivery of support services.

Kent Early Help: Kent County Council Early Help: Early Help (support for families) - Kent County Council

East Sussex Early Help: Supporting families with complex needs | Family hubs

- Following acceptance of a referral by the Local Authority Children's Social Care, a Social Worker should lead a multi-agency assessment under Section 17 of the Children Act (1989). These assessments take up to 45 working days to complete, but services can be commissioned before the end of the assessment.

- Local Authorities have a duty to ascertain the child's wishes and feelings and take account of them when planning the provision of services. Assessments should be carried out in a timely manner reflecting the needs of the individual child or young person.

- Any referral or signposting to other agencies, for help and support, for a child and family must be recorded on the child's ECR on EMIS.

6.5 Sharing Information

No single practitioner can have a full picture of a child's needs and circumstances so effective sharing of information between practitioners, local organisations and agencies is essential for early identification of need, assessment, and service provision to keep children safe. Rapid reviews and child safeguarding practice reviews have highlighted that missed opportunities to record, understand the significance of, and share information in a timely manner can have severe consequences for children

All members of the workforce must recognise that sharing information is vital for early intervention to ensure that children are protected from abuse and neglect. They need to be aware of when, why and how information should be shared so that they can do so confidently and appropriately as part of their day-to-day practice.

The member of workforce should consider and discuss with the child and/or parent confidentiality, consent and information sharing at the outset including the duty to share information where there are concerns about a child's welfare. Should a concern or allegation take place these must be discussed and if a referral to children's social care is to be made, the child and/or parent/carer must be informed unless to do so would place the child at increased risk of significant harm.

Professionals must use their judgement but should also be aware that failure to pass on information that might prevent a tragedy could expose them to criticism in the same way as an unjustified allegation. The safeguarding of children is paramount and must override any duty of confidence.

The law will not prevent you from sharing information with others if:

- Consent has been obtained.
- The public interest in safeguarding the child's welfare overrides the need to maintain confidentiality.
- Information is being shared to inform a Sect.47 assessment being undertaken by Children's Social Care. The Children Act 1989 places an obligation on health professionals to share information when an assessment is being undertaken.
- Disclosure is required under a court order or other legal obligation.
- Under these circumstances, staff have a responsibility to share appropriate information about a child or young person with other professionals /agencies in accordance with Information Sharing Guidance for Practitioners and Managers (HM Government 2008) and GMC Guidelines.
- If at any time you are unsure as to whether information can be shared, further advice must be sought from the Information Governance Team or the Safeguarding Team.
- All decisions taken as to whether to share/not share information must be documented in the child's clinical record.

6.6 HitW contribution to a Section 47 inquiry

6.6.1 Initial Strategy Meeting:

When a Local Authority decides that they have identified that a child or young person has suffered, or is likely to suffer significant harm, they will convene an initial strategy meeting or discussion, which instigates the Section 47 inquiry. This must take place within 3 days of the strategy meeting. A Section 47 Inquiry is given a maximum of 45 working days from point of referral to completion.

It is unlikely that HitW will be directly involved in strategy meetings, as it is usually Local Authority Children's Social Care, the Police and relevant health professionals who contribute, although we may be asked to attend if we have regular or significant involvement. If an employee or volunteer is invited to participate, or is asked to report into such a meeting, the Designated Safeguarding Lead must be informed by the employee on the same working day that the invitation has been made. If invited, someone must attend.

The Designated Children's Safeguarding Lead will review the child or young person's clinical records and make sure that a designated employee is appropriately prepared to contribute to the meeting. The employee must make a full record of decisions made at the meeting on the child's ECR on EMIS.

Often agency checks are made by telephone and the information shared must be confirmed in writing to the Local Authority within one working day of the initial agency check call. It is important to verify that the call is legitimate before divulging information. Please take a name and number and phone the person back to confirm their identity; the call needs to be a main reception, not a mobile.

6.6.2 Section 47 Inquiry outcomes:

At the end of the Section 47 Inquiry there are a number of possible outcomes including:

- A decision to take no further action.
- A decision to provide other support services.
- Concerns are substantiated and the child is assessed to be at risk of significant harm. In these cases, there must be a Child Protection Conference within 15 working days of the strategy discussion.

6.6.3 HitW employee role when attending a Child Protection Conference:

When HitW is invited to a child protection conference, the Designated Children's Safeguarding Lead will decide on the best person to attend, but attendance is mandatory.

6.6.1.4 Preparing a report:

Reports will be prepared for the meeting or conference and the local authority template must be used – these are provided in advance. Written reports will be agreed with and countersigned by the Designated Children's Safeguarding Lead at least 5 days before the meeting (some local authorities may require them 10 days in advance). The written report must include details of:

- HitW's involvement with the child or young person and their family, to include dates, times and frequency.
- Information, knowledge and concerns regarding the child or young person's presentation, behaviour, development and their medical needs.
- A professional view, with reference to the Signs of Safety ® (Appendix 2), regarding the capacity of the child or young person's parents to meet their needs. If there is any doubt about whether to include a

piece of information in a report, the advice of a Safeguarding Lead must be sought prior to the report being shared with the family members or other agencies

6.6.5 Sharing the report:

In most cases, the author of the report will share it with the child or young person and/or their family before the meeting, unless to do so would put the child or young person at further risk of harm or would jeopardise any on-going investigation.

If the child or another family member disagrees with something in the report and, after discussion, a difference of opinion remains, this must be brought to the attention of the Chair of the conference (either verbally or in writing). This may be documented in the report in the section for parents' views. The Designated Children's Safeguarding Lead must also be informed of this disagreement, and this should be documented in the child's ECR on EMIS.

The Child Protection Conference report must be made available to the Child Protection Conference Chair at least 2 working days in advance of an initial conference and 5 days in advance of a review conference (please note that Local Authorities have different timelines for submission, but this will be detailed on the request letter).

6.6.6 Attending the Child Protection Conference:

Employees who have been directly involved with the child or young person and their family would usually be expected to attend the conference. The Designated Children's Safeguarding Lead will provide appropriate support to the employee. For employees with minimal experience of such meetings, the Designated Children's Safeguarding Lead, will accompany them to the conference, with the prior agreement of the Child Protection Conference Chair.

Every effort must be made to ensure attendance by a representative of HitW. On any occasion when attendance is not possible, apologies must be sent in advance to the Child Protection Conference Chair and a written report must be submitted. This will need to be saved on the child's ECR on EMIS.

At the conference, employees will be invited to speak about their report. They will be expected to:

- Be open regarding any risks and/or concerns they have.
- Form and express a view from the contributions and reports at the conference.
- Respond to the question, 'Has the child suffered significant harm?'
- Respond to the question, 'Is the child likely to suffer significant harm in the future?'
- Respond to the question, 'Should the child have a child protection plan?'

6.6.7 Child Protection Conference Outcomes - Child Protection Plan:

If a decision is taken that the child or young person has suffered, or is likely to suffer, significant harm and therefore needs a Child Protection Plan, the Child Protection Conference Chair will often ask the professionals involved which category of abuse or neglect the child has suffered, or is likely to suffer: physical, emotional, sexual abuse, or neglect. This may be asked within the previous question: 'should the child have a child protection plan, and if so, under which category?' At the end of the conference, if agencies agree that a child or young person requires a Child Protection Plan, HitW's representative may be asked to:

- Contribute to the plan through the provision of services or monitoring and reporting.
- Become a member of the Core Group, who will work with the family on the plan.

6.6.8 Child Protection Conference Outcomes - No Child Protection Plan:

If the conference decides that a child has not suffered, or is not likely to suffer, significant harm, it may not make the child the subject of a Child Protection Plan. The Child Protection Conference Chair, in their role as the Independent Reviewing Officer (IRO), has the overall decision and may go with the minority view. The child or young person may nevertheless require services to promote his or her health or development. In these circumstances, the conference should consider the child or young person's needs and make recommendations for further help to assist the family in responding to them. Again, HitW's representative can be asked to contribute to providing these services.

6.6.9 Recording the Child Protection Conference outcome

Whatever the outcome of the conference, HitW's representative is responsible for making a record of their attendance and ensuring that the minutes of the meeting and any Child Protection Plan are recorded on the child's ECR on EMIS. The Designated Children's Safeguarding Lead are responsible for ensuring that Child Protection Conference minutes are received and checked and shared with the employees who attended the meeting. Any amendments must be agreed with the Designated Children's Safeguarding Lead and submitted to the Child Protection Conference Chair within the locally stipulated timeframe.

6.6.10 Disputing the Child Protection Conference outcome:

If the HitW's representative does not agree with a decision or recommendation made at a Child Protection Conference, their professional dissent will be recorded in the record of the conference. The Local Authority procedures to apply the escalation process for professional disagreements should be implemented as soon as practicable after the conference has concluded, and the Lead Nurse should be informed on the same working day.

6.6.11 Working with Local Authority Children's Social Care:

There may be times when there are safeguarding concerns about a child or young person, where the child or young person already has a Child Protection Plan, is a Child in Care, or is in receipt of other services from the Local Authority. In these instances, Local Authority Children's Social Care will often not accept a formal safeguarding referral, despite employees at HitW feeling that current provisions are not adequate to deal with a new concern. If this occurs, the following steps must be taken:

- The new safeguarding concerns must be shared with the Local Authority within 1 working day and be confirmed in writing to the allocated Social Worker (or in their absence, their Manager or the Duty Social Worker) on the same working day.
- If the safeguarding concern is not fully addressed within the existing Child Protection Plan, this must be reported to the Social Worker, in line with the plan, and confirmed in writing in the same timescales as above.

Receiving a response: The allocated Social Worker will inform the employee of their response to the new concern within 2 working days of the information being shared. If the employee is not satisfied with the response or believes it will not adequately address the risk of abuse or neglect, this must be raised with a HitW representative

on the same day of this conclusion being reached. The Designated Children's Safeguarding Lead will review the details of the case on the same day before deciding and acting regarding any escalation required

6.7 Governance

Failure to follow safeguarding children processes must be recorded as an Incident.

All safeguarding related incidents must be investigated and managed by a relevant line manager.

There will be occasions where the Safeguarding Team will contact the relevant manager to follow up local investigations. The Safeguarding Team is also available for managers and staff to discuss investigations and recommendations.

All near misses, incidents, or serious incidents as well as complaints in relation to safeguarding children will be reported to HITW Clinical Risk Managers, monitored and reported to the Risk and Quality Committee to highlight any issues which might require further organisational action or indicate a training and development need.

The Safeguarding subgroup is the operational vehicle for implementing Safeguarding governance at the Hospice.

The Director of Quality Governance chairs the Safeguarding subgroup and reports to the Board.

6.8 Safe Recruitment

Safe recruitment practices for individuals whom the organisation will permit to work regularly with children, including policies on when to obtain a criminal record check.

The Hospice must ensure there are in place safe recruitment policies and practices, including Disclosure and Barring Service (DBS) checks and checks against the ISA vetting and barring scheme for all staff, including agency staff, students and volunteers, working with children, in accordance with The Hospice Selection and Recruitment Policy. It is an offence to knowingly employ a person who has been barred by the Independent Safeguarding Authority (ISA) from working in posts which involve caring for or treating children. Information about whether a person is barred will be given an enhanced DBS check.

7. Roles & Responsibilities

Where teams, groups or individuals have specific roles and/or responsibilities specifically relating to this policy, they should be listed in this section.

Trustee Board Lead for Safeguarding

HitW's Trustee Board Lead for Safeguarding has safeguarding oversight, on behalf of Trustee Board. The role not only supports the Hospice Leadership Team (HLT) but also provides an important mechanism for critically evaluating the information presented to Trustee Board and, where necessary, challenging this.

The Trustee Board Lead for Safeguarding has specific responsibility for:

- Safeguarding oversight, in order to ensure that the appropriate systems and procedures are in place to cover all aspects of the safeguarding agenda and that the Trustee Board's statutory responsibilities in this respect are fulfilled.
- Liaising with the CEO, Director of Quality Governance and the Designated Safeguarding Lead about child protection issues within the organisation, ensuring that information and reports are provided to the Trustee Board as necessary.

Chief Executive Officer (CEO)

The Chief Executive holds ultimate accountability for adherence to the policy and procedure, ensuring that reasonable resources are made available for its implementation.

Director of Quality Governance

The Director of Quality Governance is the executive officer responsible for safeguarding in the organisation and is responsible for ensuring this document is compliant with statutory legislation and implemented into practice. They will provide strategic direction and provide assurance to the Board; embedding appropriate arrangements to enable safe and effective safeguarding processes are implemented and embedded in the organisation. They will ensure that senior management receive regular information and reports to inform decision-making and to provide assurance that this policy is being implemented across the organisation. Takes responsibility for coordinating risk management and investigation where the person alleged to be causing harm is employed (paid or unpaid) in a Position of Trust with children.

They must ensure the organisation is up to date with all levels of training; and that the workforce is compliant in accordance with the Adult Safeguarding: Roles and Competencies for Health Care Staff (July 2024)

Director of Care (DoC)/Registered Manager
Has overall responsibility for ensuring that HiTW workforce understand their safeguarding roles, ensure that safeguarding processes are embedded. Responsible for managing safeguarding risks. The Registered Manager has a duty to report relevant safeguarding events to the CQC.

Designated Children's Safeguarding Lead
This role involves championing the importance of safeguarding, promoting the welfare of children throughout the organisation an ensure that systems and processes are in place and that any concerns about the welfare of children are taken seriously and acted upon appropriately.

Provides support directly to operational staff in relation to safeguarding adult issues, providing safeguarding advice and supervision. Be a mentor to the Safeguarding champions.

Safeguarding Champions

- Act as a resource and a point of contact for colleagues who require support and guidance with safeguarding issues, however, it is not the role of the Safeguarding Champion to be responsible for the submission of referrals on behalf of the service area.
- To cascade/disseminate safeguarding information received to colleagues within their teams.
- To maintain safeguarding as a standing agenda item at team meetings
- To maintain an awareness of HitW's policy and procedures in relation to Safeguarding including the referral processes to be followed internally within the organisation.
- To encourage colleagues to recognise and be aware of trends and themes within their area and communicate these as appropriate to line manager and safeguarding leads.

Heads of Services'

- Managers have a responsibility to ensure their workforce are aware of and comply with this policy.
- Managers have a responsibility to ensure that their respective workforce groups have attended mandatory safeguarding training at the level applicable to their job role.
- Managers may be required to raise concerns with the Local. As part of this, the manager will be required to liaise with the Designated Children's Safeguard Lead who will support/oversee the process and submit the respective response. On occasion, enquiries raised externally are submitted to the Safeguarding Team and require the support of managers to formulate a response.
- Recruiting Managers must follow the HitW Recruitment and Selection Guidelines to ensure that the recruitment process includes the appropriate checks and references have been received and that gaps in employment are verified to enable a workforce that is safely recruited.

Workforce responsibilities

- Workforce at all levels, from strategic to operational, have a part to play in the safeguarding of children who come into contact either directly or indirectly with our services. Staff should ensure that they complete the appropriate level of mandatory training appropriate to their job role.
- Workforce should remain alert to the possibilities of abuse or neglect and report any concerns immediately in line with this policy. Professional curiosity should be always exercised.
- Workforce must ensure a copy of any safeguarding children's referral form is placed within the patient's ECR on EMIS.

8. Training

At the commencement of employment all employees and volunteers undertake a mandatory induction programme, which includes Safeguarding Children and Prevent Training, to be completed within 6 weeks of employment. Safeguarding Children Refresher training is undertaken every three years in accordance with mandatory training requirements and based on the Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff Intercollegiate Document (RCPCH 2019)

	Staff groups	**Refresher training**
Level 1 and 2 Within 4 weeks of starting: Have a local/organisational safeguarding induction and complete relevant Level 2 learning	All staff working at the hospice, including receptionists, administrative staff, catering, housekeeping and maintenance staff.	Suggested 3 hours training per 3 years. Can be delivered using participatory, face to face, online, e-learning or hybrid methodology.
Level 3 Within 4 weeks of starting: Have a local/organisational safeguarding induction and complete relevant Level 3 learning	All staff who are working with children who are engaged in assessing, planning, delivering care and/or evaluating the needs of children where there are safeguarding concerns (as appropriate to role). This includes safeguarding professionals, medical staff, registered nurses, councillors and allied health professionals along with HitW's safeguarding champions.	Suggested 8 hours training over 3 years.50% of the learning should be delivered/met through participatory opportunities (where discussion can take place with colleagues with sufficient safeguarding experience). Participatory learning includes face to face, online virtual classrooms, hybrid methodology. E-learning should not be the primary or sole delivery method at this level.
Level 4 Within 6 weeks of starting: Have a local/organisational safeguarding induction and complete relevant Level 4 learning	Specialist roles This includes Safeguarding leads, lead doctors, registered manager or hold sufficient seniority/authority within the organisation.	Suggested 24 hours training per 3 years. 50% of the learning should be delivered/met through participatory opportunities where discussion can take place with colleagues with sufficient safeguarding experience. Participatory learning includes face to face, online virtual classrooms, hybrid methodology. E-learning should not be the primary or sole delivery method at this level
Board level Within 6 weeks of starting: Have a local/organisational	Board of Trustees	Suggested 2 hours training during 3-year refresher period. Can be delivered using participatory, face to face, online, e-learning or hybrid methodology

safeguarding induction and complete relevant Level 1 learning.		

9. Monitoring Effectiveness

9.1 Key standards: 100% of Safeguarding Concerns will be recorded in ECR on EMIS
'100% staff will complete Safeguarding Children training as per Training Matrix

9.2 Method(s)*: Review of training attendance.
Annual audit on record keeping

9.3 Responsibility for monitoring: Designated Safeguarding Lead for Children

9.4 Frequency of monitoring: Annually

9.5 Process for reviewing results and ensuring improvements: Annual Safeguarding audit and review of compliance with training and record keeping will be submitted to the Safeguarding Sub-group and reported to the Quality Governance Sub-committee.

10 References

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- What to do if you're worried a child is being abused (HM Government, 2015)
- The Children Act 1989
- The Children Act 2004
- HM Government (2015) Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children. London;
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- HM Office (2015) Controlling or Coercive Behaviour in an Intimate or Family Relationship Statutory Guidance Framework, London;
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- London Safeguarding Children Board (2017) London Child Protection Procedures Part A & Part B. London;
- Department for Education and Skills (2015) What to do if you are worried a child is being abused. London;
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- Department of Health (2015) Promoting the Health and Wellbeing of Looked-After Children. London;
- Home Office & AVA (Against Violence Abuse) (2013) Information for Local Areas on the change to the Definition of Domestic Violence and Abuse, London;
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- Children's Workforce Development Council (2010) The Common Core of Skills and Knowledge. London;
- General Medical Council (2012) Protecting children and young people - The responsibilities of all doctors. Manchester;
- Home Office (2010) The Vetting & Barring Scheme. London;
- Home Office (2015) Policy Counter-terrorism. London;
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- HM Government (2009) The Protection of Children in England: A Progress Report. London;
  Mental Capacity Act (2005)
- NHS England (2015) Safeguarding Vulnerable People in the NHS – Accountability and Assurance. London; and
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- NHSE (2015) Safeguarding Vulnerable People in the NHS: Accountability and Assurance Framework, London.
- HM Government (2018) Serious Violence Strategy, London
- HM Government (2019) Transforming the Response to Domestic Abuse: Consultation and Draft Bill, London.
- Trix 164 Briefing (2016) Breast Ironing, Signis Group, UK
- Working Together to safeguard children, 2023
- Signs of Safety: Home - Signs of Safety

11 Guidance for the Policy Co-ordinator

Must be fully completed by the author prior to publication.

Keywords & phrases	Safeguarding Children Policy
Document review arrangements	Review will occur by the author, or a nominated person, within three years or earlier should a change in legislation, best practice, or other change in circumstance dictate.
Special requests	All of HitW workforce

12 Equality impact screening tool

Section 1	
Protected Characteristic	**If the proposal/s have a positive or negative impact, please give brief details**
Age	Loss of capacity from illness and trauma. Progressive diseases e.g. dementia. A serious Learning Disability diagnosis.
Disability	This can impact on individuals' ability to understand situation and impact of their actions but it is important that people with disabilities can make certain decisions for themselves or supported in understanding.
Gender reassignment	No impact
Marriage or civil partnership	No impact
Pregnancy and maternity	No impact
Race	People with a language barrier may need an interpreter.
Religion or belief	Some of the abuse referred to in this policy may be seen by certain cultures as part of religion or belief
Sex	No impact
Sexual orientation.	No impact
Other underserved communities (Including Carers, Low Income,	The policy must be applied case by case. With people who are victims of abuse advice may be needed.

Section 2

Will implementation of this policy / procedure have a <u>significant</u> <u>adverse</u> impact for people with protected characteristics or otherwise listed above, in relation to <u>any</u> of the following six categories? Please mark in the yes/no checkbox below, as appropriate.

NB: In this context 'significant' means that potential adverse impacts of implementing the policy cannot be mitigated against within the policy / procedure itself.

1. Adversely affect patient safety or clinical effectiveness
2. Adversely affect compliance with statutory/regulatory requirements e.g. NICE requirements, CQC, Equality Act, Care Act etc.
3. Adversely affect the experience of a patient or their loved one(s)
4. Adversely affect the experience of staff or volunteers
5. Adversely affect access to Hospice services

Yes		No	
High risk: Complete further Equality Impact Assessment (EqIA) tool, available from the Policy Co-ordinator policy.coordinator@hospiceintheweald.org.uk	[ ]	Low risk: Go to section 3.	[X]

Section 3

If this proposal is low risk, please give evidence or justification for how you reached this decision:

Signed by Policy / Procedure Lead Author		**Date**	
Sign off that this proposal is low risk and does not require further EqIA			

Signed by EDI Lead		Date	

13 Appendices

Appendix 1

1. Categories of abuse

There are four categories of abuse:

1.1 Physical abuse:
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. Physical abuse also includes Female Genital Mutilation.

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

Emotional abuse also includes radicalisation or exploitation by a radical group.

1.3 Sexual abuse:
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 abuse also includes sexual exploitation

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

- Provide adequate food, clothing and shelter (including exclusion from home or abandonment.

- Protect a child from physical and emotional harm or danger.
- Ensure adequate supervision (including the use of inadequate caregivers); or
- Ensure access to appropriate medical care or treatment.
- It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

(Working Together to Safeguard Children, 2015)

Children may be abused in a family or in an institutional or community setting, by those known to them or, more rarely, by a stranger for example, via the internet. They may be abused by an adult or adults, or another child or children.

Other Abuse threats can take a variety of different forms, including:

- Exploitation by criminal gangs and organised crime groups
- Trafficking
- Online abuse
- Sexual exploitation and the influences of extremism leading to radicalisation.

Whatever the form of abuse or neglect, practitioners should put the needs of children first when determining what action to take.

Everyone working with children should see and speak to the child; listen to what they say, take their views seriously; and work with them and their families collaboratively when deciding how to support their needs. Special provision should be put in place to support dialogue with children who have communication difficulties, unaccompanied children, refugees and those children who are victims of modern slavery and/or trafficking. (See appendix 3 on the voice of the child)

Everyone who works with children has a responsibility for keeping them safe. No single practitioner can have a full picture of a child's needs and circumstances and, if children and families are to receive the right help at the right time, everyone who encounters them has a role to play in identifying concerns, sharing information and taking prompt action.

In order that organisations, agencies and practitioners collaborate effectively, it is vital that everyone working with children and families, including those who work with parents/carers, understands the role they should play and the role of other practitioners. They should be aware of, and comply with, the published arrangements set out by the local safeguarding partners.

2. Fabricated or Induced Illness/Perplexing Presentations

Fabricated or induced illness is a condition clinical situation where a child is, or is very likely to be, harmed due to parents'/carers' behaviour and action, carried out in order 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).

There are three main ways of the parent fabricating (making up or lying about) or inducing illness in a child: They are not exclusive

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

Perplexing presentations indicate possible harm due to fabricated or induced illness which can only be resolved by establishing the actual state of health of the child. Not every perplexing presentation is an early warning sign of fabricated illness, but professionals need to be aware of the presence of discrepancies between reported signs

and symptoms of illness and implausible descriptions of illnesses and the presentation of the child and independent observations of the child.

2.1 Impact on the child

Fabricated or induced illness is most commonly identified in younger children. Although some of these children die, there are many that do not die as a result of having their illness fabricated or induced, but who suffer significant long term physical or psychological health consequences.

Fabrication of illness may not necessarily result in a child experiencing physical harm, but there may be concerns about the child suffering emotional harm. They may suffer emotional harm as a result of an abnormal relationship with their parent and / or disturbed family relationships

Clinical evidence indicates that fabricated or induced illness is usually carried out by the child's mother or a female carer, usually the child's mother (**Safeguarding children in whom illness is fabricated or induced**, DCSF 2008). Aspects of their behaviour may include: - *[Fabricated or Induced Illness by Carers (Royal College of Paediatricians and Child Health, 2009)]*

- Not as concerned about the child as medical personnel;
- Remaining with child on ward constantly;
- Investing significant emotional / intellectual effort in the illness;
- Having a history of conduct or eating disorders / contact with mental health agencies;
- Other carer uninvolved in child care;
- Reports of distant passive father.

2.2 Response

All professionals who have concerns about a child's health should discuss these with their line manager, Designated Safeguarding Lead for Children and the GP or paediatrician responsible for the child's health. If the child is receiving services from local authority children's social care, the concerns should also be discussed with them.

If any professional considers that their concerns are not taken seriously or responded to appropriately, they should discuss this as soon as possible with the designated doctor or nurse for child protection at the ICB.

If any concerns relate to a member of staff, discuss this with line manager and Designated Safeguarding Lead for Children. (See Managing allegations against the workforce policy)

All concerns and discussions must be recorded contemporaneously by both parties in their agency records for the child, dated and signed.

3. Voice and Lived Experience of the Child

'The child's voice' not only refers to what children say directly, but to how they behave and how this could be an expression of their feelings. We need to consider what could their behaviour tell us. This means listening to them, observing them and seeing their experiences from the child's point of view.

Children should have a say when decisions are made which may affect them, staff need to understand the lived experience of the child. When staff are working with an adult who is a parent or has caring responsibilities for a child staff must capture the voice of the child as part of their assessment and keep the lived experience of the child at the fore of their work.

Staff must evidence in the record that the voice of the child and their lived experience has been considered and subsequent action taken as a result of this. Wherever possible staff should ensure they are sharing the voice and lived experience of the child with other agencies, as appropriate. See appendix 3 for Voice of the child

4. Think Family

Think family is an approach to help staff consider the parent (carer), the child and the family as a whole when assessing the needs of and planning care. It is essential that when we are working with parents/carers of children we are considering the impact of parental mental health on the children but also the impact of the parental role on the patient. This supports better outcomes for the child, adult and family.

Family members don't always reside together, and it is important to consider wider family members or significant others who may impact on the family. Considering support for the whole family is important, referrals to other services should be made, with consent, where it can help a family situation. Staff should consider the impact of a Parent or Carers mental health on the child and consider actions that can help the child.

5. Parental/ Carer Mental Health

It is essential that assessments include consideration of impact of parental/carer mental health on children that they have any caring responsibility for, this includes

- Parents
- Stepparents or partners of parents
- Grandparents
- Any service users who have any caring responsibility for children Staff must document that the whole family have been considered, including the impact of parental mental health on the child(ren) on the clinical record. This must include a narrative to evidence the decision made and actions.

6. Contextual Safeguarding

Contextual Safeguarding highlights 'children may be vulnerable to abuse or exploitation from outside their families' (Working Together 2023). This may occur at school and other educational establishments, from within peer groups, within the wider community and/or on-line. It is sometimes referred to as extra-familial harms. The threats can include exploitation by criminal gangs and organised crime groups such as county lines; trafficking, online abuse; sexual exploitation and the influence of extremism leading to radicalisation.

It is important for staff to recognise places, groups and people who may be involved in causing harm to children. It is essential this is recorded on the electronic care record and shared within the multi-agency as stated in local safeguarding information sharing procedures. All local Safeguarding Children Partnerships have guidance that staff must follow. Please see the local partnership websites for further information.

6.1 County Lines:

Is a term used to describe gangs and organised criminal networks involved in exporting illegal drugs into one or more importing areas within the UK, using dedicated mobile phone lines or other form of 'deal line'. They are likely to exploit children and vulnerable adults to move and store the drugs and money, and they will often use coercion, intimidation, violence (including sexual violence) and weapons.

County lines activity and the associated violence, drug dealing and exploitation has a devastating impact on young people, vulnerable adults and local communities.

6.2 Child 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 (HM Government, 2018).

Hitw Safeguarding team must be informed immediately the disclosure is made.

6.3 Child Criminal Exploitation:

Is defined as where an individual or group takes advantage of an imbalance of power to coerce, control,

manipulate or deceive a child or young person under the age of 18 into any criminal activity

- in exchange for something the victim needs or wants, and/or
- for the financial or other advantage of the perpetrator or facilitator and/or
- through violence or the threat of violence.

The victim may have been criminally exploited even if the activity appears consensual. Child criminal exploitation does not always involve physical contact; it can also occur through the use of technology.

6.4 Missing

Anyone whose whereabouts cannot be established will be considered as missing until located, and their well-being or otherwise confirmed.
Staff have a key role in identifying and reporting children who may be missing from care, home and school. Staff understand the vulnerabilities and risks associated with children that go missing and be aware of their professional responsibilities and the responses undertaken by the multi-agency partnership. Risks include sexual exploitation, trafficking, forced marriage and female genital mutilation.

7. Domestic Abuse

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

- Psychological
- Physical
- Sexual
- Financial
- Emotional

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.

7.1 Intervention principles:

Three key imperatives of any intervention for children living with domestic violence and abuse must be considered, in this order:
• to protect children and young people, including unborn children, living in the home
• to empower adult victims to protect themselves and their children
• to hold the abuser accountable for the abuse and provide opportunities for them to change their behaviour.

If a disclosure is made to an employee, 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 employees, volunteers and line managers 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.

Adults experiencing abuse will usually, though not always, be well placed to predict the risks faced and the likelihood of further abuse,and must therefore be encouraged and supported to complete a personal risk

assessment. It should be noted that pregnancy provides a heightened risk of domestic violence, even when there has been no previous history of domestic violence.

7.2 Raising concerns

When employees or volunteers become aware that a child, young person or adult family member they are working with is experiencing, or has experienced, domestic violence or abuse (whether as a victim, bystander or perpetrator) they must discuss this concern on the same working day with their Line Manager. The exception to this is when the concerns present an immediate threat to the safety and welfare of the child, where in such instances, employees or volunteers must take care not to put themselves at risk.

- A child who is within the household where there is domestic abuse may be considered a child in need, and therefore a referral for such services must be made (see section 3.6).
- If at any time a view is reached that an incident, or an accumulation of incidents, may be placing a child at risk of significant harm, a referral must be made (see Appendix A).
- The Line Manager will record of such discussions, including decisions on actions that are to be taken, and by whom. Considerations when referring When assessing harm and the needs of a child living with domestic violence and abuse, the following points must be considered:
- The frequency and severity of the abuse, how recently and where the abuse took place
- Whether the child was or has ever been present when abuse has occurred.
- The age and vulnerability of the child (ability to self-protect).
- What the child does while the abuse is happening.
- Whether the child ever intervened, or if are they likely to (try to) intervene in the future.
- Whether the child been physically threatened or sustained any injury.
- The child's description of the effects upon themselves, their siblings and their parent or carer.
- Whether the child is being made to participate in, or witness, acts of abuse against a parent/carer or sibling. • Whether the non-abusing parent/carer can meet the child's immediate and long-term needs.
- Whether any weapons have been used, or if there has ever been a threat to use a weapon.
- Whether actual or threatened ill-treatment of animals has been used to control the child and/or a parent or carer.
- Whether physical abuse has been directed or threatened towards a pregnant woman and her unborn child.
- Whether the child or the adult victim(s) have been locked in the house or prevented from leaving it.
- Whether the abuse relates to any other factors that undermine parenting capacity (such as alcohol or substance misuse or mental health issues).

8. Disguised compliance

Disguised compliance is when a parent/carer appears to be cooperating with health professionals and agencies when they are actually 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 employees 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. https://learning.nspcc.org.uk/research-resources/learning-from-case-reviews/disguised-compliance

9. Female Genital Mutilation Female genital mutilation (FGM)

is the partial or total removal of external female genitalia for nonmedical reasons. It's can also be known as female circumcision, cutting, gudniin, halalays, tahur, megrez, khitan or sunna.
Religious, social or cultural reasons are sometimes given for FGM. However, FGM is deemed as child abuse. It's dangerous and a criminal offence. 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.

The World Health Organisation (WHO) estimates that over 200 million girls and women have been subjected to FGM in the 30 countries in Africa, the Middle East and Asia where FGM is concentrated. In the UK it is estimated that around 137,000 women have undergone FGM and 60,000 girls under 15 years old are at risk.
The prevalence of FGM varies between countries and regions, countries with the highest prevalence are; Somalia, Egypt, Sudan, Sierra Leone, Eritrea, Gambia and Ethiopia (Public Health England, published 31/8/14, updated 13/9/21. Female genital mutilation – migrant health guide)

The term FGM covers all harmful procedures to the female genitalia for non-medical purposes. There are four types - all are illegal and have serious health risks
Type 1 (clitoridectomy) – removing part or all of the clitoris
Type 2 (excision) – removing part or all of the clitoris and inner labia
Type 3 (infibulation) – narrowing of the vaginal opening
Type 4 (other harmful procedures) - pricking, piercing, cutting, scraping or burning the genital area.

FGM ranges from "pricking" or cauterizing the genital area, through to partial or total removal of the clitoris, cutting the labia and narrowing the vaginal opening. Even partial removal or 'nipping' can risk serious health problems for girls and women. FGM is usually performed by someone with no medical training. Girls are given no anaesthetic, no antiseptic treatment and are often forcibly restrained. The cutting is made using instruments such as a knife, pair of scissors, scalpel, glass or razor blade.

FGM has been a criminal offence in the UK since 1985. In 2003 it also became a criminal offence for UK nationals or permanent UK residents to take their child abroad to have female genital mutilation. Anyone found guilty of the offence faces a maximum penalty of 14 years in prison. From July 2015, anyone can apply to the court for an FGM Protection Order if they are concerned that someone is at risk of FGM. Breaching an FGM Protection Order is a criminal offence with a maximum of 5 years' imprisonment.

Further information:

FGM_Risk and Safeguarding.pdf

FGM_Mandatory_Reporting_-_procedural_ir

10. Breast ironing (pressing)

Breast ironing or pressing is a practice that originates from Africa. The process involves hot stones or implements being pressed against a young girl's breast tissue to restrict the breast growth. Some may use binding or belts to compress the breast tissue. Families believe this will allow the child to maintain a childlike appearance and reduce the risk of unwanted sexual attention, forced marriage, kidnapping and unwanted pregnancy. This practice is usually performed by a female relative on girls aged 9-15 years old. Breast ironing is physical abuse and has been condemned by the United Nations and classified as gender-based violence. This practice exists in the UK within African communities and was first raised a safeguarding concern in parliament in 2016. For more information visit http://nationalfgmcentre.org.uk/breast-flattening/

11. Modern Slavery/Human Trafficking

In brief, the term 'modern slavery' encompasses: human trafficking, slavery, sexual and criminal exploitation, forced labour and domestic servitude. The current offences for which are spread across several pieces of legislation.

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.

The new act consolidates and updates the existing criminal legislation on human trafficking, slavery, forced labour and domestic servitude and increases the maximum custodial sentence for the most serious offences from 14 years to life. In addition, the legislation creates the post of Anti-Slavery.

Commissioner and places a duty on specified public authorities, including local authorities, to report potential victims of trafficking to the National Crime Agency. This act can now be used to support victim of CSE.

Referral – Human Trafficking If employees or volunteers suspect human trafficking, they should follow the principles of reporting a safeguarding concern (see Appendix A). If the concern is immediate, employees and volunteers must call the Police on 999 or 101, if it is not urgent, Crimestoppers (tel: 0800 55511) will also accept referrals.

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) https://www.modernslaveryhelpline.org/about/spot-the-signs

12. Faith abuse

Abuse linked to faith or belief is where concerns for a child's welfare have been identified, and could be caused by, a belief in witchcraft, spirit or demonic possession, ritual or satanic abuse features; or when practices linked to faith or belief are harmful to a child. Significant harm (including murder) can occur because of concerted efforts to 'excise' or 'deliver' evil from a child (or vulnerable adult). Witchcraft beliefs are used to blame a person (rather than circumstances) for misfortune that happens in life. Faith buse can include physical, sexual, emotional abuse and neglect. Child abuse linked to faith or belief is not confined to one faith, nationality or ethnic community.

Indicators of child abuse linked to faith or belief include the following:
physical injuries, such as bruises or burns (including historical injuries/scaring)

- a child reporting that they are or have been accused of being 'evil', and/or that they are having the 'devil beaten out of them'
- the child or family may use words such as 'kindoki', 'djin', 'juju' or 'voodoo' - all of which refer to spiritual beliefs • a child becoming noticeably confused, withdrawn, disorientated or isolated and appearing alone amongst other children
- a child's personal care deteriorating (e.g. rapid loss of weight, being hungry, turning up to school without food or lunch money, being unkempt with dirty clothes)
- it may be evident that the child's parent or carer does not have a close bond with the child
- a child's attendance at school or college becomes irregular or there is a deterioration in a child's performance
- a child is taken out of a school altogether without another school place having been arranged
- wearing unusual jewellery/items or in possession of strange ornaments/scripts. (Metropolitan Police, 2020)

The witchcraft and Human Rights information network: http://www.whrin.org/
Government guidance: https://www.gov.uk/government/publications/national-action-plan-to-tacklechild-abuse-linked-to-faith-or-belief

13. Online abuse or digital safeguarding

HitW recognises that the use of information technology is an essential part of life, particularly an intrinsic part of the experience of children and young people that can be greatly beneficial. However, technology also presents challenges in terms of responsible use, and if misused, it can be harmful.
HitW has comprehensive IT policies and procedures for employees and volunteers, which applies to all users including contractors, temporary employees, volunteers, service users (i.e. children) parents/carers and partner

organisations.
HitW can only ensure that content accessed online is safe if the technology is owned by HitW and is connected to the HitW WIFI, and this should be encouraged.
Employees must be aware that close monitoring is still required when children and young people are using the internet.
Parents and carers are made aware of the WIFI situation and risks when bookings are confirmed and upon admission, the information given is as follows; "Whilst on our premises, connection to the HitW WIFI is recommended. HitW WIFI will block internet searches and inappropriate content being accessed or downloaded via the internet. However, the way your device is set up and managed (i.e. with parental controls), will dictate what your child or young person is able to view, access or download to the device and the HitW WIFI would not block this. If you want your child to remain using their own data, you should be aware that no content can be blocked by our IT system." All new digital equipment donated to, or purchased for HitW must be reviewed by the IT department before use. This includes any device that can be connected to the internet.

13.1 Incel Ideology

'Incel' describes a growing online subculture of predominately men or boys who define themselves as unable to get a romantic or sexual partner despite desiring one. Incel refers to 'internationally celibate'. This ideology was growing in popularity prior the COVID-19 pandemic, however there are very real fears that this has been exacerbated due to the increasing amount of time that already socially isolated individuals with little stake in society have spent online during lockdown restrictions. Involuntary celibates or the Incel communities are radical, mainly online forums populated by disaffected young men and centered on violent misogyny. Some incels believe that women's political empowerment and ability to select their sexual partners has severely degraded men's social status thus preventing them from having romantic relationships with the opposite sex. Incels may share similarities with extreme rightwing groups. Both groups attribute society's ills to social liberalism, women and ethnic minorities. Racial hatred and far right extremism are also common in some online Incel forums (Pan Sussex 2021

13.2 Raising an online safeguarding concern
If an employee or volunteer finds or suspects that a fellow employee or volunteer is conducting online activity that is inappropriate or illegal, they must immediately report it to their Line Manager within 1 hour of the concern being noted. Out of hours, a call must be made to the senior employee on-call for their area.

They must not inform the employee or volunteer of the concern.
See the Managing Allegations Policy against workforce for further information.

Appendix 2

Signs of Safety ®

Signs of Safety® approach was originally designed in the 1990s in Western Australia and is now widely recognised internationally as the leading participative approach to safeguarding, having been developed to provide a more constructive culture around safeguarding children and child protection work.

Completing the Signs of Safety assessment and planning is a process of creating a map of the circumstances surrounding a vulnerable child. This mapping process should ensure rigorous, sustainable and everyday child safety in the family home and in place where the child lives.

Constructive working relationships between professionals and family members, and between professionals themselves are at the heart of effective practice in responding to situation where children and young people are at risk of or who have suffered abuse.

The Signs of Safety® assessment and planning framework incorporates the risk assessment analysis, in simple

terms, the Signs of Safety® framework has four domains of inquiry:
1. What are we worried about? (Past harm, future danger and complication factors)

2. What is working well? (Existing strengths and safety) 3. What needs to happen? (Future Safety)
4. Where are we on the scale of 0 to 10, where 10 means there is enough safety for child protection authorities to close the case and 0 mean that the child will be (re) abused? (Judgement)

"Signs of Safety Assessment and Planning form" available: https://sofs.s3.amazonaws.com/downloads/SofS-Assessment-and-Planning-Form-Normal.pd

Further information can be found here: Home - Signs of Safety