journey to change

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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Title: Safeguarding Children Policy

Ref: CLIN-0027-v8.3

Status: Ratified
Document type: Policy

Contents

1 Introduction

Everyone who comes into contact with children and families have a role to play to keep them safe, safeguarding children is everyone's responsibility.

NHS providers have a duty under section 11 of the Children Act 2004 to ensure that they consider the need to safeguard and promote the welfare of children when carrying out their role.

Tees, Esk and Wear Valleys NHS Foundation Trust (referred throughout this document as the Trust) commit to the principles set out in Working Together to Safeguard children (2018) and The Children's Act (2004):

- Protecting children from maltreatment
- 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 action to enable all children to have the best outcomes.

The Trust Safeguarding Public Protection Team has responsibility for safeguarding children and adults, as well as Multi-Agency Public Protection Arrangements (MAPPA), Multi-agency Risk Assessment Conference (MARAC), PREVENT and Potentially Dangerous People (PDP).

This policy should be read in conjunction with local multi-agency policy and procedures which can be accessed via their safeguarding websites

This policy is critical to the delivery of Our Journey To Change and our ambition to co-create safe and personalised care that improves the lives of people with mental health needs, a learning disability or autism. It helps us deliver our three strategic goals as follows:

This policy supports the trust to co- create a great experience for all patients, carers and families from its diverse population by listening to the voice of the child, utilising Early Help to get access to the right support and thinking about the whole family to ensure outstanding care is delivered.

This policy supports the trust to co-create a great experience for our colleagues by ensuring they are well led at all times with regards to safeguarding children.

This policy supports the trust to be a great partner by giving assurance that Trust staff have a shared understanding of local and national safeguarding children polices and guidance, think creatively and work in partnership to meet the needs of the child.

2 Why we need this policy

2.1 Purpose

This policy is to help trust staff protect and safeguard children at risk of abuse or neglect.

It will guide staff to know what to do when they have concerns about a child's welfare or safety. For the purposes of this policy a child is under the age of 18 and includes unborn babies.

This policy will help trust staff to know where to find procedures local to where the child lives.

This policy ensures we adhere to local and national policy and guidance.

To clarify roles and responsibilities of staff and the organisation.

2.2 Objectives

This policy will help staff to :

- notice, ask, listen to the child and family and report concerns to Local Authority Social Care
- know what they need to record and where
- know who to tell if a person who works with children/ young people is potentially harming a child
- follow multi-agency procedures where suspected or actual abuse has occurred
- work with other agencies at all levels of the organisation to protect children from harm
- know how to support families to access Early Help
- 'Think Family' throughout contact with service users
- will help staff identify different forms of abuse both inside and outside of the home

3 Scope

3.1 Who this policy applies to

Safeguarding is everyone's business.

All trust staff including agency staff

Any person working into the trust including volunteers

This policy applies to all children (unborn to 18 years old), they could be a service user or cared for by a service user. It applies to children in the wider community that Trust staff become aware of in the course of their work.

The Safeguarding Public Protection Team use a variety of means to continually inform this policy and its development, including staff feedback and reflections following contact with Team, reflections following Multi-agency processes and inspectorate visits.

This policy aligns with the Trust values by listening to the voice of the child, parents/carers and service users, offering a supportive approach to ensure the family needs are met at the earliest opportunity to safeguard a child and to approach all safeguarding tasks in an open and honest way.

3.2 Roles and responsibilities

Role	Responsibility
Trust Board	• Overall responsibility for ensuring the Trust delivers high quality services that are efficient, effective and safe.
The Chief Executive	• Overall responsibility for the implementation of this policy across the Trust
Chief Nurse	• Responsible for governance systems and the organisational focus on safeguarding. • Ensure the Trust complies with multi-agency safeguarding arrangements and compliance with this policy. • Overall strategic responsibility for safeguarding. • Reports to the Trust Board on all aspects of Safeguarding. • Monitors representation from the Trust on all Safeguarding Boards and associated sub-groups.
The Associate Director of Nursing (Safeguarding)	• Responsible for the operational management of the Safeguarding & Public Protection team. • Ensuring the Safeguarding Children agenda is fully delivered within the Trust and in partnership with other agencies through local Safeguarding arrangements. • Delivering corporate support to the Trust for professional governance and assurance issues relating to nursing and Safeguarding Children. • Providing professional support to the Trust in relation to research and development initiative as they relate to Safeguarding Children • Provides the Quality and Assurance Committee with twice yearly updates on the progress being made and any areas which require further development.
The Medical Director and Local Service Managers & Professional Heads	• Will support the delivery of the wider safeguarding children's agenda across the Trust. • They will ensure staff are aware of this policy and implement Safeguarding Children policies/ procedures throughout their work areas

	• Ensure access and uptake of training and supervision by their staff is made possible. • Disseminate new and relevant information gained at the Trusts Safeguarding and Public Protection group to all staff.
Named Doctor Safeguarding Children Associate Named Doctor Safeguarding Children	• Has an educative role in relation to Doctors and Medical Staff employed by the Trust. • Provides safeguarding supervision to all levels of medical staff dealing with complex cases of a safeguarding nature • Is accountable to Medical Director.
The Named Nurse Safeguarding Children	• Leading the development, implementation and monitoring of Safeguarding Children policy and procedures, in liaison with partner agencies. • Actively participate in Safeguarding Children Board/Partnership multi-agency sub-groups representing the Trust. • Work closely with Named/Designated Professionals for Safeguarding Children to influence the development of policies and procedures developed locally, regionally and nationally. • Provide assurance to Trust Board and external assessors regarding effective and efficient Safeguarding Children strategy/policy implementation. • Provide highly specialised advice and guidance to Trust staff in relation to Safeguarding Adults and Public Protection. • Ensure effective supervision processes are in place for staff managing complex cases. • Responsible for ensuring the provision of safeguarding training that meets the needs of our staff.
Senior Nurse and/or Professional Safeguarding Children	• Support the Named Nurse for Safeguarding Children in delivering the safeguarding children agenda including safeguarding supervision and training to Trust staff.
Safeguarding / MARAC Advisor	• Develop and implement the Trust training strategy. • Deliver specialist safeguarding supervision • Offer advice and support to Trust staff
All employees of the Trust	• To identify and report abuse or suspected abuse • To comply with safeguarding policy and procedures.

4 Policy

4.1 Information gathering

Staff need to 'think family' when working with service users, to know who is in the family and what roles they take on. Names, DOB, address and school details (where relevant) must be recorded in the electronic care record. This includes where a child is a young carer for an adult service user. Family members don't always live together. It is important to consider wider family members/ care givers or significant others who may impact on the family.

Identification of Parental Responsibility is mandatory for all children identified. Staff must check that the adults who present with children have parental responsibility.

4.2 Recognising Abuse

There are different types of abuse staff need to be aware of potential warning signs and take action where required. See appendix 3 for definitions of types of abuse.

All trust staff will attend safeguarding training to be able to identify abuse. The trust training framework uses current policy and guidance. For your required level please see section 7.1.

4.2.1 Types of Abuse

Child abuse can take many forms, this may include the following

- Physical Abuse
- Emotional Abuse
- Sexual Abuse
- Neglect
- Actual or possible Fabricated and Induced illness
- Domestic Abuse
- Radicalisation
- Child exploitation (Criminal and Sexual)
- Exploitation
- Modern Slavery (e.g. county lines, servitude)
- Female Genital Mutilation
- Honour Based Abuse
- Human trafficking
- Hate Crime
- Culture, Religion and Harmful practices

Please see appendix 3 for descriptions of these types of abuse.

4.3 Voice and Lived Experience of the Child

The Voice and lived experience of the child is essential to consider.

'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 electronic care 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.

Staff should consider Advocacy for the child.

4.4 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 of a service user. 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 our service users. 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 use the PAMIC tool to consider the impact of a Parent or Carers mental health on the child and consider actions that can help the child.

4.5 Parental/ Carer Mental Health

Parental / carer wellbeing has an impact on the whole family, including children, so it is essential that staff consider this at every contact with Trust services.

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 electronic clinical record. Impact of parental/carer mental health must be documented in the safety management section (Parental Mental Health and the Impact on Children) on the electronic clinical record. This must include a narrative to evidence the decision made and actions following the outcome of the PAMIC tool. The Childs details must be recorded.

Consideration of the impact of the adult on the child and the child on the adult needs to be included in any assessment.

Staff need to try to understand what life is like for the child/ren

- Names, DOB, parental responsibility, school
- Who else lives in the house
- Any risks associated with others in the household
- Daily life for the family
- Who meets the needs of the child/ren

Caring for children with a range of needs can be a challenge for anyone and especially someone who may be struggling with their mental health so it is important to consider this.

The PAMIC tool is not to be considered a ‘one off’ assessment, it must be reviewed regularly and repeated when a service user’s circumstances or presentation changes. This may include additional children or a change in the impact on the children.

If there is a safeguarding concern about the impact of parental/carer mental health, the Safeguarding Children Concern form in the central index of the electronic clinical record must be completed and the PAMIC tool must be included to evidence the decision making.

Consideration needs to be given to the impact of traumatic life experiences and Adverse Childhood Experience’s with staff following the Trauma Clinical Link Pathway and adopting a trauma informed approach.

All delusional beliefs about children or potential harm to a child as part of a suicide plan must be reported to the Local Authority as a matter of urgency (Rapid Response Report 2009)

In CAMHS, if staff identify a parent / carer who is suffering mental health difficulties, staff must evidence in the young person’s record that they have considered the impact of this and used the PAMIC Tool to identify if any action is required.

Staff must consider contact with children to inform actual or potential risks to children at every stage of the care pathway including leave and discharge planning.

4.6 Young Carers

Working Together to Safeguard children (2018) defines a young carer as a child (person under the age of 18) who assumes important caring responsibilities for parents and/or siblings who are disabled, have physical or mental ill health problems or drug and alcohol misuse. It is important to remember they may be caring for an adult who isn't their parent, including a grandparent.

Young carers of adult service users need to be taken into consideration in any assessment and support offered, in line with the Think Family ethos.

Young carers and families are experts on their own lives. It is the multi-agency responsibility to include them in personalising the care to meet their needs. This applies whether care needs arise as a result of mental or physical illness or disability, substance misuse and whether a parent, a sibling or a family member is the focus of support.

A whole family approach means making sure the assessment considers and evaluates how the needs of the person being cared for impacts on the needs of the child who is a young carer. Any support offered to the service user needs to try to minimise the role the young carer needs to take.

Where there are concerns about the wellbeing and safety of children, including young carers a full assessment should be requested from the Local Authority.

4.7 Private Fostering Arrangements

A private fostering arrangement is one that is made privately (without the involvement of a local authority) for the care of a child under the age of 16 (under 18, if disabled) by someone other than a parent or close relative with the intention that it should last for 28 days or more (Department of Education and Skills 2005). Staff have a duty to inform the local authority of this arrangement in order for it to be assessed.

4.8 Looked After Child(ren)

A Looked After Child often referred to as LAC is a child in the care of the local authority or given accommodation by them for more than 24 hours. This can be on court orders or an adoption pathway, children who are voluntarily looked after including short term placements, respite placements or those on remand.

Looked after Children experience the same health concerns as their peers, sometimes at a greater degree. All Looked after Children are to have a full health review including emotional and mental wellbeing.

All Looked After Children must be discussed in clinical supervision, please see section 4.25

4.9 Contextual Safeguarding

Contextual Safeguarding highlights 'children may be vulnerable to abuse or exploitation from outside their families' (Working Together 2018). 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.

4.10 Multi-agency meetings regarding Child Exploitation

The Trust participate in a number of multi-agency meetings across the Trusts footprint to safeguard the needs of young people who are potentially being exploited, missing and trafficked.

They are known by a number of names Vulnerable Exploited Missing and Trafficked (VEMT), Educate and Raise Awareness of Sexual Exploitation (ERASE) and Multi-agency Child Exploitation (MACE) groups.

Child and Adolescent Mental Health Services have local arrangements in place for information sharing with their local group. CAMHS Team Managers can provide staff with their local procedures.

Further advice can be sought from the Safeguarding Public Protection Team on 01642 516118.

4.11 Multi-Agency Public Protection Arrangements (MAPPA)

The trust are partner agencies for a number of public protection arrangements.

Children can be heard in Multi Agency Public Protection Arrangements (MAPPA). Staff are required to follow the MAPPA procedure in relation to this. The Safeguarding public Protection Team are involved in MAPPA meetings.

4.12 Domestic Abuse and Multi-Agency Risk Assessment Conference (MARAC)

The Domestic abuse Act 2021 identifies children as victims of domestic abuse by seeing, hearing or experiencing the effects of the abuse. Please follow the Domestic Abuse procedure.

A victim of domestic abuse aged 16 and over can be heard within Multi-Agency Risk Assessment Conference (MARAC), Single point of contacts are in place from the Safeguarding Public Protection Team, staffs are not required to attend. Further information is available in the Domestic Abuse procedure.

Whilst predominantly perpetrators of domestic abuse are heard from age 16 and above, local areas can allow perpetrators under this age to be heard if they deem it appropriate.

Domestic Abuse can occur between family members as well as intimate partners.

Please contact the Safeguarding Public Protection Team for advice on 01642 516118.

4.13 PREVENT

Prevent is one of the Governments Strategies for Counter Terrorism and extremism in the UK. Staff have a key role, please see the PREVENT procedure for roles, responsibilities and expectations as a trust employee.

The Safeguarding Public Protection Team must be made aware of all Prevent related concerns and will have oversight of all cases providing additional support to clinical services.

4.14 Responding to Abuse

Where a child is in immediate danger emergency services need to be contacted

Staff **must** make a referral to Children's Social Care if there are signs that a child under the age of eighteen or an unborn baby:

- Is experiencing or may have already experienced abuse or neglect
- Is likely to suffer significant harm in the future.

Anyone who is worried about a child/ unborn babies' welfare must make a local authority referral, the Trust Intranet Safeguarding Page will direct you to the local authorities within the Trust area, where you will find threshold tools and referral processes.

Local safeguarding children partnerships have multi agency guidance and support available through their websites and must be used alongside this policy.

All referrals made need to be copied to TEAWVNT.safeguardingChildren@nhs.net . A Safeguarding Child Concern form must be completed when staff are worried about a child, including where a referral has been made. An InPhase report must be completed when a safeguarding incident is identified. A copy of the referral must be stored on the electronic clinical record.

Where referrals are made by telephone and not using a form then the above must still be followed but where you would normally send a copy of the referral form to the trust safeguarding team you must still send a copy in an email of the verbal discussion and actions that were agreed from the referral to the team.

Staff must gain consent from those with parental responsibility to make the referral unless this will increase the risks to the child. The referral must clearly indicate why consent has not been sought.

All involved Trust staff must be notified of the referral. Staff should consider whether other agencies working with the family need to be made aware.

When a referral is made verbally it must be confirmed in writing within 48 hours. The Local authority should confirm receipt of a referral within 1 working day. If the referrer has not received this within 3 working days they must contact the Local Authority to confirm it has been received, regardless of whether the person has been discharged or remains open.

Where a crime is suspected to have been committed then the police are to be notified immediately and evidence should be preserved wherever possible. Staff must follow the Criminal Incident Reporting Procedure. Police may require confidential information, the confidentiality and Sharing Information policy must be followed.

A child or adult may make a disclosure of abuse to staff, staff must explain the limitations of confidentiality. Staff must seek the child's view on a referral to Local Authority where possible, however there should be clear professional responsibility to take required action to keep the child safe.

Staff are to make their Line Manager aware of the disclosure made. Further support can be accessed by contacting the Safeguarding Public Protection Team on 01642 516118.

If the abuse relates to a staff member, TEWV or non-TEWV please see section 4.16

Don't delay! Concerns must be raised with the Local Authority Safeguarding Adults team within 24 hours of the concerns being raised. Urgent concerns raised out of hours must be raised with the Emergency Duty Team.

Where a serious incident occurs the Safeguarding Public Protection Team and Patient Safety have oversight. Staff must refer Incident Reporting and Serious Incident Review policy, Complaints policy and Duty of Candour policy for additional information.

4.15 Mental Capacity Act

The Mental Capacity Act 2005, provides a framework to safeguard and empower people over 16 years of age who are unable to make all or some decision themselves.

The Act includes a range of powers and services which must be considered as part of a safeguarding plan where a person lacks capacity.

The Mental Capacity Act Policy offers further guidance.

4.16 Allegations abuse by staff

The Trust Safeguarding & Public Protection team and Human Resources team must be informed of all safeguarding concerns that are made against Trust staff.

TEWV STAFF:

The Senior Nominated Officer (Chief Nurse) and the Safeguarding Public Protection Team must be informed when there is an allegation made against a Trust staff member, that they have harmed or pose a risk to children.

An allegation may relate to a person who works with children who has:

- Behaved in a way that has harmed a child, or may have harmed a child
- Possibly committed a criminal offence against or related to a child
- Behaved towards a child or children in a way that indicates they may pose a risk of harm to children

There are times when a concern relates to behaviour outside of their professional practice that may cause concern about working with children. The Safeguarding Public Protection Team and Human Resources team must be informed alongside the local authority.

The Trust will follow all guidance in relation to Local Authority Designated Officer (LADO) notification where the staff member works with children, for the Local Authority they work within. Where the individual works with Adults instead of Children please follow the Safeguarding Adults Policy

The Safeguarding Public Protection Team will have oversight of all safeguarding concerns involving a staff allegation, and will support services until the safeguarding enquiry closes.

Non-TEWV Staff:

Where the staff member is not a Trust employee staff must gather as much information as possible about the person and their place of work.

The Safeguarding Public Protection Team must be notified, who can support advice and guidance for the LADO process. The employer for the Staff member must be notified alongside the referral to the Local Authority.

Speaking up about any concern you have at work is really important and will help us keep improving services for our patients and the working environment for our staff. Staff can use the Freedom to Speak Up Policy or report to Line Managers.

4.17 Safer Recruitment

The trust follows guidance in relation to Safer Recruitment practices to safeguard children, including the local child protection procedures, ensuring systems are in place to conduct Disclosure and Barring Service checks in accordance with national and statutory guidelines.

For further information refer to the Trust Disclosure and Barring service procedure and Recruitment and Selection procedure.

4.18 Advice and Support

Staff must seek advice and support from their clinical team and/or Line Manager when they are worried about a child.

Clinical Huddles, Report Outs and Multidisciplinary meetings are some of many forums where safeguarding must be discussed.

The Safeguarding Public Protection Team have a duty worker Monday – Friday 9-5 to offer advice and support when a staff member is unsure of what they need to do. The Team can be contacted on 01642 516118. Outside of these times the Emergency Duty Team for the area the child resides in must be contacted.

Where concerns relate to the following areas, the Trust Safeguarding Public Protection Team must be contacted for advice and support:

- Service user being at risk of radicalisation. This will then we escalated to the prevent leads for the locality who are members of the trust Safeguarding Public Protection team see section 4.13
- Professionals working with children who have or have the potential to cause harm to children. A Local Authority Designated Officer (LADO) referral may be required. Where the professional of concern is a staff member of TEWV this must be escalated to the named nurse for safeguarding and subsequently escalated to HR manager and the nominated officer for the trust see section 4.16
- Where staff identify that a service user or their child/ren have undergone FGM or at risk of. there are mandatory reporting requirements and the Trust Safeguarding Public Protection team need to be aware and report on this see section 4.22

Where staff are confident they need to make a referral to the Local Authority, they do not need to seek advice from the Safeguarding Public Protection Team. A copy of the referral must be sent to the trust safeguarding team on TEAWVNT.safeguardingChildren@nhs.net , an InPhase report completed and a Safeguarding Child Concern completed on the electronic clinical record

4.19 Information sharing with other agencies.

Good information sharing practice is at the heart of good safeguarding practice. Serious case reviews have 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.

Staff should use his policy in conjunction with the Confidentiality and Sharing Information Policy and Special Category Data Policy.

All service users will be made aware of the Trust information sharing guidance at the first point of contact. Staff will be proactive in sharing information as early as possible, whether this is when problems are first emerging, or where a child is already known to local authority children's social care.

Staff should consider sharing information on adults outside of the family who may cause harm, with relevant agencies.

Fears about sharing information must not be allowed to stand in the way of the need to promote the welfare, and protect the safety, of children, which must always be the paramount concern.

Where staff need to share special category personal data, they should be aware that the Data Protection Act 2018 contains 'safeguarding of children and individuals at risk' as a processing condition that allows staffs to share information. This includes allowing staff to share information

without consent, if it is not possible to gain consent, it cannot be reasonably expected that staff gains consent, or if to gain consent would place a child at risk. Examples of special category data includes race or ethnic origin, political opinions, religious beliefs, genetic data, data concerning health. For further information please see the Trust Special Category Data Policy.

The reasons for sharing information without consent must be clearly documented on the electronic care record.

Further information on the legal basis for information can be found in Appendix 4

4.20 Professional Challenge

Professional challenge should be seen as a positive activity and a sign of good professional practice, a healthy organisation and effective multiagency working. It is about challenging decisions, practice or actions which may not effectively ensure the safety or well-being of a child or their family.

Staff must follow individual local authority procedures to professionally challenge.

Where a difference of opinion between professionals occurs, the Trust Safeguarding Public Protection team must be contacted for support and advice and where applicable this will be escalated to the Named Nurse for Safeguarding Children and this recorded in the electronic care record.

Many professional challenges will be resolved on an informal basis by contact between the individual raising the challenge (or their manager) and the individual/manager/agency receiving the challenge and will end there.

4.21 Record Keeping

All safeguarding children concerns must be recorded on the electronic clinical case record, as a Safeguarding Child Concern in the Central index, as soon as the concern is being raised.

All records must follow the Trusts Record Management Policy. i.e,

- Be accurate and factual as they may well be relied upon at a later date in court.
- All dates and times must be recorded in sequence and the entry signed.

It is important the follow on actions from the safeguarding child concern form are completed as a safeguarding activity note, this helps other staff see what actions have been taken around the concern.

There are a number of safeguarding activity types available for use including child protection conference, safeguarding supervision, safeguarding discussion and others.

For record keeping in relation to parental mental health and the impact on children refer to section 4.5 for guidance

4.22 Mandatory Reporting Female Genital Mutilation and Forced Marriage Protection Orders

Female Genital Mutilation (FGM) has no health benefits and harms girls and women in many ways. It is a violation of human rights. The Trust has as statutory obligation (Working Together to Safeguard Children 2018) to safeguard children from being abused through FGM.

Mandatory reporting (Serious Crime Act 2015) is required where disclosure of FGM for themselves or relative under the age of 18 is made. The Safeguarding Public Protection Team must be contacted for all cases of FGM regardless of age in order to report nationally.

For under 18's this must be reported to the police via 101 and the Trust Safeguarding Public Protection Team informed. This is an immediate referral to the local authority.

Where the person is over 18 and reporting FGM consider the risks to any children they have and report concerns to the local authority.

The Anti-social behaviour, Crime and Policing Act (2014) made it a criminal offence to force someone to marry, including taking someone overseas to force them to marry, marrying someone who lacks mental capacity to consent and where the person is under duress. Concerns regarding forced marriage must be reported to the Safeguarding Public protection Team on 01642 516118. Additional advice can be sought from the Forced Marriage Protection Unit 020 7008 0151.

4.23 Allegations of Historical abuse

Many of our service users have experienced abuse in childhood which has impacted on their mental health.

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

You should ascertain whether this is the first time the service user has disclosed the abuse. Information should be carefully gathered and documented.

Staff must inform the service user of the professional duty to safeguard children. This includes trying to establish whether the past abuser is in contact with children who could currently be at risk of harm, which may need to be referred to children's social care or police. This is dependent on the amount of information a service user shares.

If a service user does not agree to share information regarding the alleged perpetrator of abuse, professionals should discuss with their line manager, MDT and contact the Safeguarding Public Protection Team on 01642 516118 to discuss and consider next steps.

The adult who has disclosed should be asked whether they want a police investigation and offered support to report the abuse.

Where a crime is suspected of being committed then the Police are to be notified immediately. Staff must follow the Criminal Incident Reporting Procedure.

4.24 Child Protection Processes

To comply with the Trust's statutory duties under the Children Act (2004) attendance at Child Protection Conference, core groups and sharing information on Child Protection reports is essential for effective multiagency working to keep children safe.

Attending the conference or core group must be prioritised. If you are unable to attend a deputy must be identified. Where staff are struggling with this it must be escalated to the line manager for discussion and support to ensure attendance by a TEWV representative. A written report must always be completed in the format requested and by the timescale. A case note entry must be made indicating where the minutes can be located. A template may be provided by the Local Authority , please see Appendix 5 for a ICPC template and Appendix 6 for a RCPC template

The conference report must have Manager oversight prior to being shared. A conference report must be shared with the parents 2 days before the conference. If this cannot happen the Independent Reviewing Officer must be informed of why.

Following Conference assessments and care plans need to be reviewed to reflect the child being made subject to a child protection plan, an alert must be placed on the electronic clinical record to indicate Child Protection Plan is in place.

Minutes must be copied into the electronic care record. An entry must be made to indicate where they can be located within the clinical record. Other agencies must be directed to team email accounts and not individual emails as per Email Procedure.

A copy of the child protection/ child in need plan must be on the electronic clinical record

Where a child is not made subject to a child protection plan following Initial Child Protection Conference (ICPC) the conference attendees must consider plans to support the child. This may take the form of a Child In Need Plan. Professionals involved need to be assured there is a plan to support and monitor the child following the concern. Staff must clearly document any plans and how they will be monitored and multiagency working as part of the electronic care record. Staff must discuss these cases with a line manager or the trust safeguarding team and discussion documented in the electronic record

Please see Appendix 7 for information on writing effective reports for child protection and Appendix 8 for a conference report self assessment aide.

4.25 Supervision

Effective safeguarding supervision helps to provide a clear focus on a child's well-being and supports professionals to reflect on the impact of their decisions on the child and their family. It should provide emotional support for professionals

Safeguarding supervision should enable a review of the child protection or child in need plan for the child and whether the support given is appropriate and is leading to a significant change and whether the pace of that change is appropriate for the child.

A copy of the child protection/ child in need plan must be on the electronic clinical record

Tony Morrison's 4X4X4 is the model used within the Trust for safeguarding supervision. This provides a framework that incorporates:
• 4 Stakeholders (service users / staff / organisation / partners)
• 4 Elements (experience, reflection, analysis & plans / actions)

There is a mandatory requirement for 3 monthly safeguarding children supervision for staff working with children subject to a child protection plan or working with parents or carers caring for a child subject to a child protection plan. This is required to continue for six months after the child protection plan ceases. Wherever possible this must be booked in within 2 weeks of the child being made subject to a CP plan or were we are made aware of the plan.

Where staff are working with multiple individuals (child or parent) staff can access supervision every three months, where they can discuss all cases in one session. At least one case must be discussed in depth using the 4x4x4 model.

Every case discussed must have a record of the supervision discussion on the electronic care record, using the supervision template and saved as a Safeguarding Casenote type. This approach does not prevent staff from requesting further supervision to discuss individual cases where required.

Complex cases must be discussed in Management and clinical supervision as per policy but if required safeguarding supervision can also be requested for other complex cases.

Safeguarding Children Supervision can be offered by a member of the Safeguarding Public Protection team or by a practitioner who has undertaken the specialist Safeguarding Children Supervision training in CAMHS services this is often the Clinical Nurse Specialist.

There are also opportunities for the Trust Safeguarding Public Protection team to offer group supervision where requested. Staff must discuss this with mangers and then contact the Safeguarding Public Protection team.

Specialist Safeguarding Supervision is also required where:

- 3 MARAC meetings in the last 6 months and the individual is open to TEWV
- All organisational abuse
- Any incidents where there is media interest in the case

4.26 Child admitted to an adult ward

The Named Nurse Safeguarding Children is to be informed when a person under the age of 18 years is admitted to an Adult Mental Health Unit :

- To ensure that extra consideration and planning is required about their safety.
- The admission of children onto adult wards needs to be monitored

Please see Young people admitted to Adult In-Patient Policy

4.27 Child Visiting Trust Premises

Please follow the Child Visiting Policy. A child visiting a Trust site is covered by this policy.

4.28 Child Safeguarding Practice Reviews

The purpose of reviews of serious child safeguarding cases, at both local and national level, is to identify improvements to be made to safeguard and promote the welfare of children.

Understanding not only what happened but also why things happened as they did can help to improve our response in the future. Understanding the impact that the actions of different organisations and agencies had on the child's life, and on the lives of his or her family, and whether different approaches or actions may have resulted in a different outcome, is essential to improve our collective knowledge.

A Rapid Review is established promptly to gather facts about the case, consider immediate actions to ensure a child's safety, identify improvements to safeguard children and plan next steps such as whether a Child Safeguarding Practice Review is undertaken.

The Trust are required to consider whether a referral for a Child Safeguarding Practice Review is required. The Safeguarding Public Protection Team offer services support and have oversight of this.

Learning is shared through a variety of routes including the Safeguarding Public Protection Bulletin, through clinical governance arrangements and safeguarding training.

4.29 Child Death Process and Child Death Overview Panels (CDOP)

Children Act (2004) requires Clinical Commissioning Groups (CCG's) and Local Authorities, known as child death review partners, to make local arrangements to undertake statutory Child Death Review (CDR) processes.

The death of a child is a devastating loss that profoundly affects all those involved. A child death review has the intention of learning what happened and why and preventing future child deaths.

The CDR process relies on inter-agency cooperation and information sharing.

A Child Death Overview Panel (CDOP) reviews the deaths of all children (under the age of 18 years and for all children regardless of the cause of death), who are normally resident in the relevant Local Authority area, and if they consider it appropriate the deaths in that area of non-resident children.

The review should then be carried out by a CDOP, on behalf of CDR partners, and should be conducted in accordance with Child Death Review: Statutory and Operational Guidance 2018 and Working Together to Safeguard Children Statutory Guidance 2018.

The Trust Safeguarding Public Protection team are involved with this process.

5 Definitions

Types of Abuse are defined in Appendix 3

Term	Definition
Abuse *(Working Together to Safeguard Children 2018)*	A form of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting by those known to them or, more rarely, by others (e.g. via the internet). They may be abused by an adult or adults, or another child or children
Adverse Childhood Experiences	highly stressful, and potentially traumatic, events or situations that occur during childhood and/or adolescence hey can be a single event, or prolonged threats to, and breaches of, the young person's safety, security, trust or bodily integrity." (Young Minds, 2018)
Child/Children *(Working Together to Safeguard Children 2018)*	Anyone who has not yet reached their 18th birthday. The fact that a child has reached 16 years of age, is living independently or is in further education, is a member of the armed forces, is in hospital or in custody in the secure estate, does not change the child's status or entitlements to services or protection.
Child Exploitation *(Working Together to Safeguard Children 2018)*	Child Sexual Exploitation (CSE) -Someone taking advantage of you sexually, for their own benefit. Through threats, bribes, violence, humiliation, or by telling you that they love you, they will have the power to get you to do sexual things for their own, or other people's benefit or enjoyment (including touching or kissing private parts, sex, taking sexual photos) Child criminal exploitation (CCE) where an individual or group takes advantage of an imbalance of power to coerce, control, manipulate or deceive a child or young person under the age of 18 into any criminal activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial or other advantage of the perpetrator or facilitator and/or (c) through violence or the threat of violence. The victim may have been criminally exploited even if the activity appears consensual. Child criminal exploitation does not always involve physical contact; it can also occur through the use of technology.
Child in Need *(Children Act 1989)*	Under Section 17 (10) of the Children Act 1989, a child is a Child in Need if: •the child is unlikely to achieve or maintain, or have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him/her of services by a local authority

	• the child's health or development is likely to be significantly impaired, or further impaired, without the provision for him/her of such services • the child is disabled
Child In need of Protection *(Children Act 1989)*	Under section 47 of the Children Act 1989, where a local authority has reasonable cause to suspect that a child (who lives or is found in their area) is suffering or is likely to suffer significant harm, it has a duty to make such enquiries as it considers necessary to decide whether to take any action to safeguard or promote the child's welfare.
Core groups	the Interagency Forum for achieving the outcomes of a child protection plan. It is comprised of the professionals responsible for delivering particular aspects of the plan, and is attended by parents and children, where appropriate
Domestic Abuse *(Domestic Abuse Act 2021)*	The Domestic Abuse Act (2021) definition: Behaviour of a person ("A") towards another person ("B") is "domestic abuse" if — A and B are each aged 16 or over and are personally connected to each other, and the behaviour is abusive. Behaviour is "abusive" if it consists of any of the following — physical or sexual abuse; violent or threatening behaviour; controlling or coercive behaviour; economic abuse; psychological, emotional, or other abuse; and it does not matter whether the behaviour consists of a single incident or a course of conduct. A's behaviour may be behaviour "towards" B despite the fact that it consists of conduct directed at another person (for example, B's child).
Early Help	Early help means providing support as soon as a problem emerges, at any point in a child's life, from the foundation years through to the teenage years.
Female Genital Mutilation	A collective term (also known as genital cutting and female circumcision) for all procedures that involve partial or total removal of the external female genitalia or other injury to the female genital organs for cultural or non-medical reasons. Female Genital Mutilation is a criminal offence in the United Kingdom. It is also a criminal offence for UK nationals or permanent UK residents to carry out Female Genital Mutilation abroad, or to aid, abet, counsel or procure the carrying out of Female Genital Mutilation abroad, even in countries where the practice is legal.
Forced Marriage	A marriage in which one or both spouses do not (or in the case of some adults with learning or physical disabilities or children, cannot) consent to the marriage and duress is involved. Duress can include physical, psychological, financial, sexual and emotional pressure. The Anti-social Behaviour, Crime and Policing Act 2014 made it a criminal offence (which can result in a sentence of up to 7 years in prison) to force someone to marry This includes: • Taking someone overseas to force them to marry (whether or not the forced marriage takes place).

	• Marrying someone who lacks the mental Capacity to consent to the marriage (whether they're pressured to or not). • The civil remedy of obtaining a Forced Marriage Protection Order through the family courts continues to exist alongside the criminal offence, so victims can choose how they wish to be assisted. • Breaching a Forced Marriage Protection Order is also a criminal offence, which can result in a sentence of up to 5 years in prison.
Initial Child Protection Conference (ICPC)	An initial child protection conference brings together family members (and the child where appropriate), with the supporters, advocates and staffs most involved with the child and family, to make decisions about the child's future safety, health and development. If concerns relate to an unborn child, consideration should be given as to whether to hold a child protection conference prior to the child's birth.
Local Authority Designated Officer (LADO) *(Working Together to Safeguard Children 2018)*	County level and unitary local authorities should ensure that allegations against people who work with children are not dealt with in isolation. Any action necessary to address corresponding welfare concerns in relation to the child or children involved should be taken without delay and in a coordinated manner. Local authorities should, in addition, have designated a particular officer, or team of officers (either as part of multi-agency arrangements or otherwise), to be involved in the management and oversight of allegations against people who work with children. Any such officer, or team of officers, should be sufficiently qualified and experienced to be able to fulfil this role effectively, for example qualified social workers. Any new appointments to such a role, other than current or former designated officers moving between local authorities, should be qualified social workers. Arrangements should be put in place to ensure that any allegations about those who work with children are passed to the designated officer, or team of officers, without delay.
Looked After Child (LAC)	A Looked After Child (sometimes referred to as 'LAC') is a child who is Accommodated by the local authority, a child who is the subject to an Interim Care Order, full Care Order or Emergency Protection Order; or a child who is remanded by a court into local authority accommodation or Youth Detention Accommodation. In addition, where a child is placed for Adoption or the local authority is authorised to place a child for adoption - either through the making of a Placement Order or the giving of Parental Consent to Adoptive Placement - the child is a Looked After child. Looked After Children may be placed with parents, foster carers (including relatives and friends), in Children's Homes, in Secure Accommodation or with prospective adopters
Neglect *(Working Together to Safeguard Children 2018)*	The persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during

	pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to: • Provide adequate food, clothing and shelter (including exclusion from home or abandonment) • Protect a child from physical and emotional harm or danger • Ensure adequate supervision (including the use of inadequate care-givers) • Ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.
Parental Responsibility *(Government- Parental Rights and Responsibilities)*	A mother automatically has parental responsibility from birth. A father has parental responsibility if he is married to a child's mother or if not married but is named on the birth certificate (only since December 2003). People who have applied to the court to obtain a 'parental responsibility order' for example: civil partners.
PAMIC	Potentiality for the Adult's Mental Ill Health to Impact on the Child. The PAMIC check is a tool to support you when considering the likelihood and severity of the impact of an adult's parental mental ill health on a child
Private Fostering	A private fostering arrangement is one that is made privately (that is to say without the involvement of a local authority) for the care of a child under the age of 16 (under 18, if disabled) by someone other than a parent or close relative with the intention that it should last for 28 days or more (Department of Education and Skills 2005)
Review Child Protection Conference (RCPC)	A review conference is about bringing the family and professionals working with them back together to review progress to date and how the plan is working, with a view to continuing to safeguard and promote the welfare of the child(ren)
Significant Harm	The Children Act 1989 introduced the concept of significant harm as the threshold that justifies compulsory intervention in family life in the best interests of children, and gives local authorities a duty to make enquiries to decide whether they should take action to safeguard or promote the welfare of a child who is suffering or likely to suffer, significant harm. 'Harm' means ill-treatment or the impairment of health or development. Where the question of whether harm suffered by a child is significant turns on the child's health and development, his health or development shall be compared with that which could reasonably be expected of a similar child.

	To understand and identify significant harm, it is necessary to consider: • The nature of harm, in terms of maltreatment or failure to provide adequate care; • The impact on the child's health and development; • The child's development within the context of their family and wider environment; • Any special needs, such as a medical condition, communication impairment or disability, that may affect the child's development and care within the family; • The capacity of parents to meet adequately the child's
Young Carer *(Working Together to Safeguard Children 2018)*	A young carer is a person under 18 who provides or intends to provide care for another person (of any age, except generally where that care is provided for payment, pursuant to a contract or as voluntary work).

6 Related documents

This policy should be read in conjunction with local multi-agency policies and procedures on Safeguarding Children Partnership websites.

Trust policies and procedures references within this policy are listed below and can be found within the **policies and procedures section of the Trust intranet**.

- Allied Health Professionals Professional and Clinical Supervision
- Child Visiting Policy
- Clinical Supervision Policy
- Complaints Policy
- Confidentiality and Sharing Information Policy
- Criminal incident Reporting Procedure
- Domestic Abuse Procedure
- Duty Of Candour Policy
- Email Procedure
- Freedom to Speak Up Policy
- Human Rights, Equality and Diversity policy
- Incident Reporting and Serious Incident Review Policy
- Information Governance Policy
- MAPPA procedure
- Mental Capacity Act Policy
- PREVENT procedure
- Rapid Response Report 2009 National Patient Safety Agency RR003
- Records Management Policy
- Recruitment and Selection Procedure
- Safeguarding Adult's Policy

- Safeguarding Toolkit
- Special Category Data Policy
- Was Not Brought Policy
- Young People admitted to Adult In-patient Wards Policy

7 How this policy will be implemented

- This policy will be published on the Trust's intranet and external website
- This policy will be communicated to all Trust staff to implement

7.1 Implementation Action Plan

Activity	Expected outcome	Timescale	Responsibility	Means of verification/ measurement
Inclusion within safeguarding and public protection e-bulletin	Communicate the new policy to all Trust staff	1 month	Safeguarding Public Protection Team	Confirmation within Safeguarding Public Protection e-bulletin
Inclusion within the policy e-bulletin	Communicate the new policy to all Trust staff	1 month	Policy Department	Conformation within policy e-bulletin
Inclusion within the Trust e-bulletin	Communicate the new policy to all Trust staff	1 month	Safeguarding Public Protection Team and Communications Team	Conformation within Trust e-bulletin
Shared with members of the Safeguarding Public Protection sub-group	Cascade into clinical services via local quality assurance and improvement meetings	1 month	Safeguarding Public Protection team sub-group	Agenda item/ email communication with Safeguarding Public Protection team sub-group members. Minutes of the local quality assurance and improvement meeting.

7.2 Training needs analysis

The Trust has the following training packages in place which follows the guidance set within the **Royal College of Nursing (2018) Adult Safeguarding: Roles and Competencies for Health Care Staff**, **Royal College of Nursing (2018) Safeguarding Children and young People: Roles and**

Competencies for Healthcare Staff and **Royal College Of Nursing (2020) Looked After Children: Roles and Competencies for Healthcare staff**.

Staff/Professional Group	Type of Training	Duration	Frequency of Training
All non-clinical staff i.e., corporate, housekeeping	Safeguarding Level 1	e-learning	Every 3 years
All Clinical band 4 and below who have contact with service users of any age.	Safeguarding Level 2 including PREVENT	e-learning – 4 hours	Every 3 years
All clinical staff Band 5 and above including Medics and Allied Health Professionals	Safeguarding Level 3	e-learning – 3 hours pre-reading material – 2 hours face to face training - 3 hours Additional 4-8 hours to be achieved and evidenced by appraisal	Every 3 years
Safeguarding Public Protection Professionals including Named Doctor	Safeguarding Level 4	24 hours	Over 3-year period
All clinical staff Band 5 and above including Medics and Allied Health Professionals	PREVENT	Mental health approved e-learning	3 yearly

8 How the implementation of this policy will be monitored

	Auditable Standard/Key Performance Indicators	Frequency/Method/Person Responsible	Where results and any Associate Action Plan will be reported to, implemented and monitored; (this will usually be via the relevant Governance Group).
1	The following Key performance Indicators will be monitored: • Training compliance • Safeguarding Child Concerns • Safeguarding Child concerns referred to Local Authority	Quarterly through data collection, by the Safeguarding Public Protection Team Bi-annually through data collection, by the Safeguarding	Safeguarding Public Protection Sub-Group of the Quality and Assurance Committee. Clinical Quality Review Group/ Quality & Performance Meeting.

	• Safeguarding Child concern by types of abuse • Staff allegations • Specialist Safeguarding Supervision		
2	Safeguarding Children Casefile Audits for CAMHS and Adult Mental Health	Annual audit by the Safeguarding Public Protection Team	Safeguarding Public Protection Sub-group of the Quality and Assurance Committee.
3	Safeguarding Children Referral Audit	Annual audit by the Safeguarding Public Protection Team	Safeguarding Public Protection Sub-group of the Quality and Assurance Committee.
4	Parental Mental Health Audit	Annual audit by the Safeguarding Public Protection Team	Safeguarding Public Protection Sub-group of the Quality and Assurance Committee.

9 References

Information sharing advice for practitioners providing safeguarding services to children, young people, parents and carers (2018) HMSO.
Anti-social Behaviour, Crime and Policing (2014) HMSO
The Children and Families Act (2014) HMSO
Contextual safeguarding and Policy Development (2020) Contextual Safeguarding network.
Data Protection Act (2018) HMSO.
General Data Protection Regulations (2018) HMSO
Serious Crime Act (2015) HMSO
Think Child, Think Parent, Think Family (2009) SCIE Publication Guide 30.
Working Together to Safeguard Children (2018) Department of Education.

10 Document control (external)

To be recorded on the policy register by Policy Coordinator

Date of approval	20 December 2023
Next review date	20 July 2025
This document replaces	Safeguarding Children Policy CLIN-0027-v8.2
This document was approved by	Deputy Chair's Action of Safeguarding Public Protection Group (Deputy Chief Nurse) (v8.3) 11 Dec 2023
This document was approved by	Safeguarding Public Protection Group (v8.3) pending retrospective approval on minutes of February 2024 Meeting

This document was ratified by	Management Group
This document was ratified by	20 December 2023
An equality analysis was completed on this policy on	28 April 2022
Document type	Public
FOI Clause (Private documents only)	N/A

Change record

Version	Date	Amendment details	Status
V2	November 2018	Safeguarding Children Supervision Procedure	Withdrawn
V7	28 August 2019	Safeguarding Children policy	Withdrawn
V8	20 July 2022	Safeguarding Children Policy- full review of the policy, ensuring the voice of the child, think family, contextual safeguarding, Domestic Abuse Act (2021) and Working Together to Safeguard Children are fully incorporated. The policy also now captures the supervision requirements for staff instead of a stand-alone procedure.	Withdrawn
v8.1	25 May 2023	Section 3.2 – Changed The Named Doctor to Named Doctor Safeguarding Children Associate Named Doctor Safeguarding Children Section 8 – changed Contract Management Board to Quality & Performance Meeting. Appendix 9 – added a link to the PAMIC tool Appendix 10 – renamed and amended the link to poster on the T drive.	Withdrawn
v8.2	21 Jun 2023	Job title 'Executive Director of Nursing and Governance' updated to 'Chief Nurse' in body of policy. N.B. this change requested Management Group 21 June 2023	Withdrawn
v8.2	11 Dec 2023	"ALERT – Links!" message added to title page	Withdrawn
v8.3	20 Dec 2023	References on page 13 to "a DATIX must be completed when a safeguarding referral is made" has been changed to "an InPhase report must be	Ratified

		completed when a safeguarding incident is identified." Reference to "a DATIX" on page 16 amended to "an InPhase report".	

Appendix 1 - Equality Analysis Screening Form

Please note: The Equality Analysis Policy and Equality Analysis Guidance can be found on the policy pages of the intranet

Section 1	Scope
Name of service area/directorate/department	Safeguarding Public Protection Team Nursing and Governance Directorate
Title	Safeguarding Children Policy
Type	Policy
Geographical area covered	Trust wide
Aims and objectives	To ensure that all staff can respond to a child safeguarding issue/concern
Start date of Equality Analysis Screening	04/01/2022
End date of Equality Analysis Screening	28/04/2022

Section 2	Impacts
Who does the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?	This benefits all service users, families and staff To support staff in safeguarding and promoting the welfare of children To provide staff with a point of reference in relation to their duty to safeguarding and promote the welfare of children and to promote best practice
Will the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups?	• **Race** (including Gypsy and Traveller) **NO** • **Disability** (includes physical, learning, mental health, sensory and medical disabilities) **NO** • **Sex** (Men, women and gender neutral etc.) **NO** • **Gender reassignment** (Transgender and gender identity) **NO** • **Sexual Orientation** (Lesbian, Gay, Bisexual and Heterosexual etc.) **NO**

	• **Age** (includes, young people, older people – people of all ages) **NO** • **Religion or Belief** (includes faith groups, atheism and philosophical beliefs) **NO** • **Pregnancy and Maternity** (includes pregnancy, women who are breastfeeding and women on maternity leave) **NO** • **Marriage and Civil Partnership** (includes opposite and same sex couples who are married or civil partners) **NO** • **Armed Forces** (includes serving armed forces personnel, reservists, veterans and their families **NO**
Describe any negative impacts	
Describe any positive impacts	Disability – this policy has considered and taken into account the additional vulnerabilities of children who are disabled or young carers. It has also considered the additional vulnerabilities to children who have parents who have disabilities or mental health difficulties. Age – this policy has considered age, example of this is the inclusion of pre-birth and the impact of safeguarding on unborn and new born children. In addition the vulnerabilities of adolescent children in different areas of safeguarding. Religion/belief – this policy has considered and taken into account the additional vulnerabilities in terms of safeguarding issues in some religions. Beliefs, these include FGM, Forced marriage and Honour based violence. Gender- The transgender community experience higher levels of abuse and discrimination when compared to the general population. It is estimated that a transsexual teenager is eight times more likely to attempt suicide, than their peers. It is anticipated the policy will have a positive impact on trans service users under the age of 18 by supporting staff to protect them from harm and respond effectively to safeguarding risks that are identified. Sex- It is anticipated the policy will have a positive impact on service users of all sexes under the age of 18 by supporting staff to protect them from harm and respond effectively to safeguarding risks that are identified. Sexual orientation- The lesbian, gay, bisexual and transgender community experience higher levels of abuse and discrimination when compared to the general population. It is estimated that they are four times more likely to be bullied than their peers. It is anticipated the policy will have a positive impact on service users of all sexual orientations under the

	age of 18 by supporting staff to protect them from harm and respond effectively to safeguarding risks that are identified Pregnant service users- It is anticipated the policy will have a positive impact on pregnant service users under the age of 18 by supporting staff to protect them from harm and respond effectively to safeguarding risks that are identified.

Section 3	**Research and involvement**
What sources of information have you considered? (e.g. legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.)	The Children's Act 1989 The Children's Act 2004 Working Together to Safeguard Children 2018 Safeguarding Children: Roles and Competencies for Healthcare Staff 2019 London Child Protection Procedures 2019 Health and Social Act 2008 (regulated Activities) Regulations (2014) Care Quality Commission Regulation 13: Safeguarding Service Users from abuse and improper Information sharing advice for practitioners providing safeguarding services to children, young people, parents and carers (2018) HMSO. Anti-social Behaviour, Crime and Policing (2014) HMSO The Children and Families Act (2014) HMSO Contextual safeguarding and Policy Development (2020) Contextual Safeguarding network. Data Protection Act (2018) HMSO. General Data Protection Regulations (2018) HMSO Serious Crime Act (2015) HMSO Think Child, Think Parent, Think Family (2009) SCIE Publication Guide 30. Working Together to Safeguard Children (2018) Department of Education
Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the protected groups?	Yes
If you answered Yes above, describe the engagement and involvement that has taken place	Consultation with staff Consideration to Expert by Experience groups.

If you answered No above, describe future plans that you may have to engage and involve people from different groups	

Section 4	**Training needs**
As part of this equality analysis have any training needs/service needs been identified?	No
Describe any training needs for Trust staff	
Describe any training needs for patients	
Describe any training needs for contractors or other outside agencies	

Check the information you have provided and ensure additional evidence can be provided if asked

Appendix 2 - Approval checklist

	Title of document being reviewed:	Yes/No/ Not applicable	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Yes	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
2.	**Rationale**		
	Are reasons for development of the document stated?	Yes	
3.	**Development Process**		
	Are people involved in the development identified?	Yes	Safeguarding Team
	Has relevant expertise has been sought/used?	Yes	
	Is there evidence of consultation with stakeholders and users?	Yes	Ongoing discussions with TEWV staff have informed this policy. This policy will be put out for six-week standard trust wide consultation.
	Have any related documents or documents that are impacted by this change been identified and updated?	Yes	Safeguarding Toolkit Safeguarding Children Supervision Policy v2 -to be withdrawn on implementation of this policy.
4.	**Content**		
	Is the objective of the document clear?	Yes	
	Is the target population clear and unambiguous?	Yes	
	Are the intended outcomes described?	Yes	
	Are the statements clear and unambiguous?	Yes	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Yes	
	Are key references cited?	Yes	
	Are supporting documents referenced?	Yes	
6.	**Training**		

	Title of document being reviewed:	Yes/No/ Not applicable	Comments
	Have training needs been considered?	Yes	
	Are training needs included in the document?	Yes	
7.	**Implementation and monitoring**		
	Does the document identify how it will be implemented and monitored?	Yes	
8.	**Equality analysis**		
	Has an equality analysis been completed for the document?	Yes	
	Have Equality and Diversity reviewed and approved the equality analysis?	Yes	
9.	**Approval**		
	Does the document identify which committee/group will approve it?	Yes	Safeguarding Public Protection Group (virtual) for approval and then to MG
10.	**Publication**		
	Has the policy been reviewed for harm?	yes	
	Does the document identify whether it is private or public?	yes	Public
	If private, does the document identify which clause of the Freedom of Information Act 2000 applies?	N/a	

Appendix 3 - Categories of Abuse

Working Together to Safeguard Children 2018, defines the following categories of abuse.

Abuse
A form of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting by those known to them or, more rarely, by others (e.g. via the internet). They may be abused by an adult or adults, or another child or children.

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.

Emotional abuse
Emotional abuse is the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to a child that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may include not giving the child opportunities to express their views, deliberately silencing them or 'making fun' of what they say or how they communicate. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond a child's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction. It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying (including cyber bullying), causing children frequently to feel frightened or in danger, or the exploitation or corruption of children.
Some level of emotional abuse is involved in all types of maltreatment of a child, although it may occur alone

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.

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 care givers)

- • Ensure access to appropriate medical care or treatment.
- • It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

Other forms of abuse:

Child Sexual Exploitation (CSE) Home Office (2013) Tackling Child Sexual Exploitation Home Office March 2015

Child sexual exploitation is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology. Child Sexual Exploitation – Definition and a guide for practitioners, local leaders and decision makers working to protect children from child sexual exploitation. February 2017

Some of the following signs may be indicators of sexual exploitation:

Children who appear with unexplained gifts or new possessions

Children who associate with other young people involved in exploitation

Children who have older boyfriends or girlfriends

Children who suffer from sexually transmitted infections or become pregnant

Children who suffer from changes in emotional well-being

County Lines exploitation?

(Criminal exploitation of children and vulnerable adults: county lines 2018)

County lines is a major, cross-cutting issue involving drugs, violence, gangs, safeguarding, criminal and sexual exploitation, modern slavery, and missing persons; and the response to tackle it involves the police, the National Crime Agency, a wide range of Government departments, local government agencies and VCS (voluntary and community sector) organisations. The UK Government defines county lines as:

County lines is a term used to describe gangs and organized 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 impact on young people, vulnerable adults and local communities.

Child criminal exploitation is increasingly used to describe this type of exploitation where children are involved, and is defined as:

Child Criminal Exploitation is common in county lines and occurs where an individual or group takes advantage of an imbalance of power to coerce, control, manipulate or deceive a child or young person under the age of 18. The victim may have been criminally exploited even if the activity appears consensual. Child Criminal Exploitation does not always involve physical contact; it can also occur through the use of technology. Criminal exploitation of children is broader than just county lines, and includes for instance children forced to work on cannabis farms or to commit theft.

One of the key factors found in most cases of county lines exploitation is the presence of some form of exchange (e.g. carrying drug or in return for something). Where it is the victim who is offered, promised

or given something they need or want, the exchange can include both tangible (such as money, drugs or clothes) and intangible rewards (such as status, protection or perceived friendship or affection). It is important to remember the unequal power dynamic within which this exchange occurs and to remember that the receipt of something by a young person or vulnerable adult does not make them any less of a victim. It is also important to note that the prevention of something negative can also fulfil the requirement for exchange, for example a young person who engages in county lines activity to stop someone carrying out a threat to harm the child's family.

Child Victims of Trafficking and/or Modern Slavery

Modern slavery' is a form of organised crime in which individuals including children and young people are treated as commodities and exploited for criminal and financial gain. It encompasses human trafficking, slavery, servitude and forced labour. The Modern Slavery 2015 provides better protection for victims and increases the sentences for committing these offences.

Grooming methods are often used to gain the trust of a child and their parents, e.g. the promise of a better life or education, which results in a life of abuse, servitude and inhumane treatment.

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

'Exploitation' for modern slavery purposes is defined, as a minimum, to include: sexual exploitation, forced labour, domestic servitude and organ trafficking.

Trafficked victims are coerced or deceived by the person arranging their relocation, and are often subject to physical, sexual and mental abuse. The trafficked child or person is denied their human rights and is forced into exploitation by the trafficker or person into whose control they are delivered.

Children are not considered able to give 'informed consent' to their own exploitation (including criminal exploitation), so it is not necessary to consider the means used if you suspect a child or young person may have been trafficked.

Domestic Abuse

The Domestic Abuse Act (2021) identifies children as victims of domestic abuse, where a perpetrator of abuse is present in their lives. Domestic Abuse includes psychological, physical, sexual, emotional, financial, economical and controlling and coercive behaviours. There is an increase in teenage abuse in relationships from the age of 16 a victim can be heard within Multi-Agency Risk Assessment Conference (MARAC). For further advice see the Domestic Abuse Procedure.

Culture, Religion and Harmful Practices including Witchcraft

Harmful traditional practices are forms of violence which have been committed, primarily against women and girls, in certain communities and societies for so long that they are considered, or presented by perpetrators, as part of accepted cultural practice. They have often been embedded in communities for a long time and are born out of community pressure.

The most common forms of Harmful Practices are

- forced or early marriage
- so called 'honour' based violence
- female genital mutilation or cutting (FGM).

Other less common forms include:

- Spirit Possession
- Son preference
- Bride kidnapping
- Acid Attacks
- Breast Ironing

Appendix 4 - Legal Framework and Trust Statutory Duties underpinning this policy

Legal framework

• The Trust has a statutory duty outlined in Section 11 of the Children's Act 2004, which places responsibility on the trust to make arrangements to ensure that it has regard in exercising its functions to the need to safeguard and promote the welfare of children.

• Section 10 of the Children Act 2004, requires each local authority, health and partner agencies to make arrangements to promote cooperation between the authorities, each of the authority's relevant partners. The arrangements are made with a view to improving the wellbeing of children in the authority's area – which includes protection from harm or neglect alongside other outcomes.

• Section 27 of the Children Act 1989 introduced the concept of significant harm as the threshold that justifies compulsory intervention in family life in order to safeguard children. The local authority has a duty to investigate where it has reason to suspect that a child is suffering or likely to suffer significant harm.

• Section 47 of the Children's Act 1989 places a duty on any NHS Trust (other agencies) to help a local authority with its enquiries in cases where there is reasonable cause to suspect that a child is likely to suffer or is suffering from significant harm, unless doing so would be unreasonable in all circumstances of the case.

• The Equality Act 2010 puts a responsibility on public authorities to have due regard to the need to eliminate discrimination and promote equality of opportunity. This applies to the process of identification of need and risk faced by the individual child and the process of assessment. No child or group of children must be treated any less favourably than others in being able to access effective services which meet their particular needs.

• The United Nations Convention on the Rights of the Child (UNCRC). This is an international agreement that protects the rights of children and provides a child-centred framework for the development of services to children. The UK Government ratified the UNCRC in 1991 and, in doing so, has recognised children's rights to expression and receiving information

The Trust's Statutory Duties

Duties and responsibilities for the Trust are set out in the following:

• Section 11 of the Children Act 2004

• Working Together to Safeguard Children, HM Government Statutory Guidance (2018)

• Promoting the Health and Well-being of Looked After Children, DofE & DoH Statutory Guidance (2015)

• Safeguarding Children and Young Peoples: Roles and Competences for Health Care Staff – (Intercollegiate Document) (2019)

• Looked After Children: Knowledge, Skills and Competences of Health Care Staff-Intercollegiate Role Framework (2015)

Requirements as outlined in Section 11, Children's Act 2004

The Trust has a statutory duty to provide;

• A clear line of accountability for the commissioning and/or provision of services designed to safeguard and promote the welfare of children;

• A senior board level lead to take leadership responsibility for the organisation's safeguarding arrangements;

• 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;

• A culture of listening to children and taking account of their wishes and feelings, both in individual decisions and in the development of services;

• Arrangements which set out clearly the processes for sharing information with other professionals and with the Local Safeguarding Children Partnership;

• Named Professionals for Safeguarding Children. Their role is to support other professionals in their agencies to recognise the needs of children, including rescue from possible abuse or neglect. Professionals should be given sufficient time, funding, supervision and support to fulfil their child welfare and safeguarding responsibilities effectively;

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

• Appropriate supervision and support for staff, including undertaking safeguarding training;

• Employers are responsible for ensuring that their staff are competent to carry out their responsibilities for safeguarding and promoting the welfare of children and creating an environment where staff feel able to raise concerns and feel supported in their safeguarding role;

• Staff should be given a mandatory induction, which includes familiarisation with child protection responsibilities and procedures to be followed if anyone has any concerns about a child's safety or welfare.

• All professionals should have regular reviews of their own practice to ensure they improve over time.

• Clear policies in line with those from the Local Safeguarding Children Partnerships (LSCP) for dealing with allegations against people who work with children. An allegation may relate to a person who works with children who has:

- Behaved in a way that has harmed a child, or may have harmed a child;
- Possibly committed a criminal offence against or related to a child; or
- Behaved towards a child or children in a way that indicates they may pose a risk of harm to children.

- Additional guidance for health services including from the Royal College of Nursing (RCN), General Medical Council (GMC) and the NHS Commissioning Board.is also made reference to in Working Together makes reference.

Communication with stakeholders - working in partnership

The Trust is a statutory partner of Local Safeguarding Children Partnerships (LSCPs) and shares responsibility for safeguarding children

The Trust will work closely with Local Safeguarding Partnerships in their quality assurance, monitoring and safeguarding children arrangements.

The Trust's Local Child Safeguarding leads attend work groups and forums on behalf of the trust, and report on this to the Trust safeguarding children committee.

Appendix 5 - Initial Child Protection Conference Template

Please note this template should only be used where the Local Authority have not provided a template.

Initial Child Protection Report

Name of Professional / Designation/ Team Completing the Report.

Conference Date:	
Conference Time:	
Conference Venue:	

Name of Child:	DOB:	NHS No:	Address:

Name of Mother:	DOB:	NHS No:	Address:

Name of Father:	DOB:	NHS No:	Has father got PR? Does father have contact with the child?

Name of Mother's/ Father's Partner (If applicable):	DOB:	NHS No:	Address:

Any significant others related to the child / family:

Name:	DOB:	Relationship to the child:	Address:

Brief Details of the Referral and Concerns expressed at Strategy that led to conference

Significant Safeguarding chronological events including dates (Include Domestic Abuse incidents, significant missed appointments, risk taking behaviours, parental risk taking behaviours, poor home conditions, previous children services involvement, over attendance at appointments, contextual safeguarding, impact of Parental Mental Health etc)

Has the child previously been subject to a child protection plan or ever been a child looked after? **If so please provide date(s) and reason(s)**

When was the *child/parent* last seen by our service?

What is the voice of the child? Life through the eyes of the child?

What is the risk to the child and what is needed to make them safe?

What is the cumulative (growing) risk and how does this impact / potentially impact upon the child?

Has Parental Mental Health impacted on the child? What are the child's caring roles if any?

What is the single agency recommendation regarding the need for a child protection plan? Please explain the rationale for the recommendation.	

Signature **Date Report completed.**	

Report submitted in timescales? (2 working days for ICPC & 7 working days for RCPC)	

Date the report was shared with parents	

Appendix 6 - Review Child Protection Conference Report

Please note this template should only be used where the Local Authority have not provided a template.

Review Child Protection Report

Name of Professional / Designation/ Team Completing the Report.

Conference Date:	
Conference Time:	
Conference Venue:	

Name of Child:	DOB:	NHS No:	Address:

Name of Mother:	DOB:	NHS No:	Address:

Name of Father:	DOB:	NHS No:	Has father got PR? Does father have contact with the child?

Name of Mother's/ Father's Partner (If applicable):	DOB:	NHS No:	Address:

Any significant others related to the child / family:

Name:	DOB:	Relationship to the child:	Address:

Brief Details of the Referral and Concerns expressed at Strategy that led to conference

Date of the child protection plan being implemented and the category of risk:

What is our role within the child protection process and in safeguarding the child?

Significant Safeguarding chronological events including dates (Include Domestic Abuse incidents, significant missed appointments, risk taking behaviours, parental risk taking behaviours, poor home conditions, previous children services involvement, over attendance at appointments, contextual safeguarding, impact of Parental Mental Health etc)

Has the child previously been subject to a child protection plan or ever been a child looked after? If so please provide date(s) and reason(s)

When was the *child/parent* last seen by our service?

What is the voice of the child? Life through the eyes of the child?

What are you worried about?

What is working well?

What is the risk to the child and what is needed to make them safe?

What is the cumulative (growing) risk and how does this impact / potentially impact upon the child?

Has Parental Mental Health impacted on the child? What are the child's caring roles if any?

What services are being provided / will be provided to minimise / reduce the risk to the child and family?

Has the concerns from the Initial conference improved, stayed the same or increased?	

What is the single agency recommendation regarding the need for a child protection plan? Please explain the rationale for the recommendation.	

Signature **Date Report completed.**	

Report submitted in timescales? (2 working days for ICPC & 7 working days for RCPC)	

Date the report was shared with parents	

Appendix 7 - Writing effective reports guide

Writing effective reports for Child Protection processes

A guide for staff

Introduction

This guide has been produced to help staff who are responsible for submitting reports for child protection case conferences and child protection legal processes to write clear effective reports that contribute the safety and welfare of children.

Background

No one agency can effectively safeguard a child on their own. Whilst the local authority are the lead agency in safeguarding and promoting the welfare of children at risk of abuse or neglect our staff has a key part to play. The information and insights into a child's world from direct work undertaken with children and families form the basis of all our work. For that direct work to effectively contribute to multiagency safeguarding processes it must be recorded, analysed and shared.

Why write a report for a child protection case conference?

Safeguarding Children's Partnership's are the statutory multiagency organisation that is responsible for arrangements to safeguard and promote the welfare of children. The partnership procedures for Child protection conferences and core groups can be found on their website.

What does a good report look like?

Reports come in a range of shapes and sizes. Different area's will use different proforma Reports from different agencies can look very different depending on the role of the practitioner involved and the information that needs to be communicated.

However there are a range of things that good reports share whatever the agency format

At this point you are probably thinking that some of these are potentially contradictory and you would be right. There will also be a degree of subjectivity in judging the quality of reports. There is no 'right length' for example, but a report that details every single contact with a family where there is nothing specific or concerning is likely to be too long.

It is preferable to say

'I have visited the family on five occasions since the last case conference. All but one occasion no concerns were raised in relation John. However on my planned visit of 1 June I was concerned that …..'

Than to give extensive detail of four unremarkable visits.

Provenance

The source of information included in a good report is clear to those who read it. This is particularly important for families who may feel very upset if they feel things are being said about them without basis. It is also important should a conference report ever be submitted to court. You may know now why you said something but will you remember in 6 months or 6 years' time? Being clear about source is actually easier than many people think. Just think to yourself 'how do I know that?' always bearing this in mind immediately improves the accuracy of your report too.

'John fell down the stairs and bruised his forehead'

How do I know that? Either I was present or someone told me. A better way of putting this would therefore be

'at my home visit on 1 June I saw John fall down the stairs from a few steps up. This was also seen by his mother who was present. She reacted appropriately comforting John and checking if he had any injuries. She found he had a slight bruise to his forehead.'

At my home visit on 1 June John's mother told me had had fallen down five stairs that morning and now had a bruise to his forehead.

Balance

It is important that reports are balanced. This is in line with your duties under the NMC code to

'Treat people as individuals and uphold their dignity' and

'act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment'

Families have the right to expect that the areas of their lives that are positive and contribute to the promotion of their children's wellbeing are acknowledged. Additionally it is important that these aspects are protected and built upon where appropriate in a protection plan.

An example might be

Carrie has a very strong fear of injections but with support from David has now managed to take Charlie for his MMR immunisation on time. This is in contrast to his primary immunisations which were all delayed.

Or

Rebecca tells me she provides the children with a varied and healthy diet. At a home visit on 1 October they were eating lunch of homemade Sheperd's pie with two vegetable. The children then shared a banana.

Voice of the Child

Children should be central to everything that we do. Children's right to be heard is enshrined in the UN convention on the Rights of the Child.

Some professionals struggle with the term 'voice of the child' when a child is pre or nonverbal. But the voice of the child goes far beyond what a child says, how often do we know that someone is upset, annoyed or worried not through what they say but through their behaviour, body language, facial expression? All of a child's behaviour and presentation

contributes to their 'voice'. The 'How Can you Hear my Voice' document is also very helpful in portraying the voice of the child and is available in bases. Crucially, the voice of the child means seeing their experiences through their eyes. It is now 20 years since Lord Laming said of Victoria Climbie *'no-one could describe a day in her life'*

Analysis

The analysis is arguably the most important part of any report. Essentially the analysis considers all the information in your report and answers the question

'what does this mean for this child'

However, understanding how human beings think is important in relation to analysis. You will no doubt have heard that 'first impressions last'. Eileen Murno reviewed public inquiries into child abuse to see if typical errors in human reasoning identified in psychology explained at least in part why things go wrong in safeguarding children practice. She found 'professional's based assessments of risk on a narrow range of evidence. It was biased towards the information readily available to them'

'The range was also biased towards the more memorable data, that is, towards evidence that was vivid, concrete, arousing emotion and either the first or last information received.'

Importantly she found

'A critical attitude to evidence was found to correlate with whether or not the new information supported the existing view of the family. A major problem was that professionals were slow to revise their judgements despite a mounting body of evidence against them.'

This is known as confirmation bias. This is the tendency to search for, interpret, give me weight to, and recall information in a way that confirms or supports our beliefs, sometimes known as our hypothesis.

Guarding against confirmation bias in your analysis is challenging. Two good ways are

- To ask yourself 'Is there another way of thinking of this?' and
- To look for ways that don't find with your view.

The analysis pulls together the information, shared in your report. It presents your professional opinion of what the information means for the child. Your analysis should help the conference decide if the child needs a protection plan to be safeguarded.

Sharing reports

Child protection processes are much more likely to successfully protect and promote a child's welfare where the adults caring for the child feel consulted, listened to, respected and able to take part in the process. Having reports shared with them prior to conference is an important part of how we do this and is a TEWV requirement.

1 in 6 adults in England, have literacy levels at or below Level 1. Level 1 is equivalent to GCSE grades D-G. Adults with skills below Level 1 may not be able to read bus or train timetables or understand their pay slip (www.LiteracyTrust.org). This highlights why it is important that practitioners actually go through reports rather than just expecting parents to read them. Obviously some parents will refuse this offer and want to read reports in private.

Where you are leaving a copy of a report with a parent it is must be marked 'Parents copy'. This can be done using a highlighter.

Where both parents play a role in a child's life both can expect that reports are shared with them. In general reports would be shared with the parent with whom the child resides however, any non-resident parent who asks should be afforded the same opportunity to have the report shared with them prior to conference.

Presentation

As we said above 'First impressions last'. A report that is badly laid out, with poor attention to detail, spelling mistakes and multiple fonts gives a poor impression of the report, the author and the service. The report itself is likely to be seen as unreliable and less weight placed on its contents as a result of its presentation.

Ask yourself:

Are all the child's and family demographic details complete and correct?

Are names spelt correctly?

Have I spell checked, used one font and avoided underlining?

Is my name and designation included and is the report dated?

Does the report give a professional impression of me and my service?

Would a 'critical friend' (colleague, manager or safeguarding team) be useful to review this report

If you need additional support as a result of specific learning need, ensure you ask a manager or the safeguarding team to help.

A word on court reports

Many of the same principles apply to court reports as to case conference reports. There is an expected layout of court reports which will be provided to you by legal services when a report is requested, in addition legal services are likely to pose specific questions or area of care that they wish you to focus on. Remember to think about the purpose of the report. In the same way a conference report provides conference members with information to reach a decision on how best to protect a child, a court report will help the court do the same thing.

Whilst all reports are formal and it is common to use first names in conference reports, court reports should use Mr/Mrs/Miss/Ms (as appropriate) through out for adults, it is usual however to use a child's name. You will be expected to provide details of your qualifications and professional registration including your NMC number.

Just as with a case conference, provide clear and succinct information. Just as with case conference reports there is no need to provide a blow by blow account of every contact with

a family. Ask yourself, ‘how does this information in my report help the court?’ Reports that are overly long with irrelevant detail risk losing the attention of the reader. Additionally consider ‘is everything in my report explained and understandable by a person who is not a nurse or a doctor?’ If you think something in your report is likely to raise a question make sure you answer it, otherwise you may find you are asked to attend court to explain.

There is no need (and often no time) to share reports with families. Parents will have reports shared via their legal representatives prior to court. You should only provide court reports at

- the request of the local authority legal services
- In response to a court order.
- At the specific request of the Safeguarding Team

If a parent asks you for a report (for example as part of divorce proceedings) you must decline. The parent would need to make a formal request.

Conclusion

This guide has taken you through the elements of an effective report for a child protection case conference and discussed how the same principles apply to providing a report for the court system.

Remember as with all your practice in relation to children at risk of abuse or neglect the Safeguarding Children Team is here to support you and you can contact us about a conference report. All court report requests must be discussed with the team

Document gratefully shared by City of York Safeguarding Healthy Child Service and modified to a guide for TEWV employees.

Appendix 8 - Conference Report Self-Assessment

WHEN YOU HAVE COMPLETED A REPORT FOR A CHILD PROTECTION CASE CONFERENCE ASK YOURSELF SEVEN QUESTIONS:

Question	How will I know this?
Are the Basics right?	The service users demographic details are completed . The family demographic details are included and correct to the best of my knowledge. Father/male care givers are included if not the service user. Any gaps in agency knowledge are made clear I have spell checked, used one font and avoided underlining My name and designation are included. The report is dated I am happy the report gives a professional impression of me and my service.
Have I made the Voice of the child the centre of my report	The voice of the child is threaded through my report I give a clear picture of the child I reported not only what the child says verbally but behaviour and presentation.
Does my report give a good overview of this family and my work with them?	There is a succinct overview of my involvement with the child/parent The chronology is limited to significant events for the child/parent. The chronology has not been 'cut and paste' from the record. It does not contain unnecessary detail, it does contain details of incidents or omissions in care such as failed appointments and how I have tried to adjustment my approach in order for the service to engage the family
Is my report clear about what is working well and what needs to improve?	All the issues I am worried about are included in the report and I have explained why I am worried about these aspects of the child's life My report fairly reports what's working well too it considers the strengths and progress made by the family. The impact/potential impact of these factors on the child is made clear
Is my unique contribution as a health professional clear?	I have shared information about the service users needs I have explained the potential impact on the child of parents not seeking or following advice in terminology that can be understood by parents and non health professionals

Have I explored parent's health and lifestyle as it impacts of their ability to safely parent the child?	I have discussed known risk factors such as parental conflict, domestic abuse, substance and alcohol abuse as well as mental illness and made clear the impact or potential impact on the child of living in this environment. I have included any young carer responsibilities for the child and how this may impact on their wellbeing, hat the service has done to explore reducing their responsibilities. Where the parent is my service user I have included the impact of parental mental health on the child
Conclusion: Have I drawn together all my information and analysed it.	My report concludes with a statement pulling together the information shared and analysing the information. The conclusion does not include any information not found elsewhere in the report. The analysis presents my professional opinion of what the information means for the child. My report will help the conference decide if the child needs a protection plan to be safeguarded and what might need to be in that plan. ***'What it is like being this child and what it will be like if nothing changes'.***

Appendix 9 – PAMIC Tool

You can find the PAMIC tool here:
T:\Safeguarding and Public Protection\RESOURCES\PAMIC TOOL .pdf

Appendix 10 – Safeguarding Team Poster

See T:\Safeguarding and Public Protection\RESOURCES