St Wilfrid's Hospice

CHILD PROTECTION & SAFEGUARDING POLICY AND PROCEDURE

Approved by:	**Clinical Governance Board**
Date of approval:	**22 July 2010**
Reviewed:	**2 November 2018**

1. Overarching Policy Statement

St Wilfrid's Hospice recognises that it has fundamental responsibilities in relation to keeping all those who have contact with the organisation safe from harm in the broadest sense. This includes the patients and families, adults and children under the care of the hospice. This also includes staff and volunteers, donors and supporters, the public and our community.

We recognise that keeping safe from harm in the broadest sense requires whole-organisation commitment, underpinned by the organisation's values. Our aim is to foster a broad culture of safe from harm with a focus on prevention and shared awareness, based on sound governance.

2. Our Approach to Safeguarding Children

St Wilfrid's Hospice is committed to and recognises that the welfare of children is paramount. All children without exception have the right to be protected and safeguarded from harm. Any issues or concerns of abuse or neglect (whether alleged, disclosed or witnessed) will be taken seriously by employees and responded to appropriately. This may require a referral to Children's Services and in an emergency to the Police.

In any conflict between the needs of a child and those of parent/carer or professional, the needs of the child must come first. Under no circumstances can any allegation, disclosure or witnessing of abuse or neglect be kept confidential. St Wilfrid's Hospice is committed to safe recruitment and selection, and ensuring all new employees are subject to robust checks before and during employment.

3. Principles and Values

The organisation works in accordance with the key beliefs, principles and values of the Pan Sussex Child Protection & Safeguarding procedures and in particular:

- The needs of the child are paramount
- All children have a right to be safeguarded from harm and exploitation whatever their race, religion, first language or ethnicity, gender or sexuality, age, health or disability, location or placement, any criminal behaviour, political or immigration status
- Our approach will aim to be child-centred and working in partnership with children and families.

4. Related Hospice Policies/Procedures

Accident, Incident and Near Miss Policy and Procedure
Complaints Policy and Procedure
Disciplinary Policy and Procedure

Disclosing and Barring Service (DBS) Policy and Procedure
Ensuring Good Practice Policy and Procedure
Health and Safety Policy Statement and Responsibilities
Information for Patients and Carers Policy and Procedure
Investigation Policy and Procedure
Media and Marketing Confidentiality Policy and Procedure
Patient Confidentiality Policy and Procedure
Pre and Post Employment Checks Policy
Pre and Post Employment Checks Procedure
Recruitment and Selection Policy
Recruitment and Selection Procedure
Senior Nurse On-Call Policy and Procedure
Suspension and Dismissal Procedure

5. Accountability/Responsibility

The **Chief Executive** holds ultimate accountability for adherence to the Child Protection and Safeguarding Policy and Procedure and ensuring there are sufficient resources for the implementation of this document.

The **Registered Manager** is responsible for ensuring this document is compliant with statutory legislation and implemented into practice. The Registered Manager has a duty to report relevant safeguarding events to the CQC.

The Safeguarding Lead is responsible for providing advice, expertise, support and training for hospice staff and volunteers on safeguarding queries and concerns and for promoting a culture within the hospice that encourages staff and volunteers to voice any concerns and provides support for staff and volunteers when concerns are expressed. The Safeguarding Lead is also responsible for ensuring safeguarding concerns are reported to Children's Social Care as relevant and appropriate.

Line Managers are responsible for informing and educating all existing employees of the requirements of the Child Protection and Safeguarding Policy and Procedure and related procedures and respond to any immediate concerns.

All **employees** are responsible for adherence to the Child Protection and Safeguarding Policy and Procedure and associated procedures.

6. Definition

Where the term 'employee' is used in this document it includes, volunteers and contractors with practicing privileges (see Practicing Privileges Policy and Procedures).

7. Scope

This document sets out the hospice's commitment to protecting and safeguarding children whether personally accessing services or associated with patients or carers. The term child or children includes unborn babies, children, and young persons aged 14 to 18 years old.

8. Procedure

8.1 Recognising Abuse and Neglect

Abuse and neglect are forms of maltreatment of a child. Somebody may cause or neglect a child by inflicting harm, or failing to act to prevent harm. Children may be abused in a family, or in an organisational or community setting; by those known to them or, more rarely by a stranger. They may be abused by an adult or adults or another child or children.

There are four broad categories of abuse. These categories overlap and an abused child does frequently suffer more than one type of abuse. For further details regarding these categories, risk indicators and how to recognise these types of abuse see Appendix 1.

8.2 Raising an Alert

Safeguarding children is everybody's business. Anybody may see abuse taking place, be told about alleged abuse or suspect abuse.

Alerting refers to the duty of all employees to inform their line manager of a concern that a child:

- Has been harmed, abused or neglected or
- Is being harmed, abused or neglected
- Is at risk of being harmed, abused or neglected.

A concern may arise from a:

- A direct disclosure by the child
- A concern raised by others using the service, a carer or a member of the public
- An observation of the behaviour of the child or of the behaviour of another person towards the child.

8.2.1 Responsibilities of the Person Raising the Alert

8.2.1.1 Taking Immediate Action to Ensure Safety

All employees must take immediate action if they witness an actual incident of abuse.

They must make an immediate evaluation of risk and take steps to ensure that the child is not in or removed from immediate danger.

There may be an urgent need for medical treatment, or where there is immediate risk of harm urgent action may be needed to protect the person. Depending on circumstances, this may involve calling the police and/or an ambulance. It may be necessary to remove the child to a safe place or encourage the perpetrator to leave the premises.

As far as possible any such actions should be taken in consultation with and with support by line managers and other senior staff.

It may be possible to challenge the person who is abusing the child but staff and volunteers should not put themselves in any danger.

Where relevant, any evidence of e.g. the child's physical condition, their clothing or property should be preserved.

8.2.1.2 Acting on a Concern or Disclosure

Actual incidents of abuse in the presence of employees are extremely rare in the hospice context. Far more frequently staff and volunteers will be told of behaviour that might be abuse and/or they will pick up on other clues (as per Appendix 1).

When responding to a child making a disclosure, staff and volunteers should:

- Assure the child that they are being taken seriously, listen carefully and get as clear a picture as possible (NB: employees are not expected to undertake an investigation, however, they may ask some very basic clarifying questions - e.g. "when did you say this happened?")
- Offer reassurance about how (s)he will be kept safe

- Give support and reassurance to the child that they have done nothing bad and it is not their fault
- Ensure the child understands that secrets cannot be kept
- Explain to the child that senior members of staff will need to be told and what action will be taken
- If the child is thought to be able to understand the significance and consequences of making a referral to Children's Social Care, (s)he should be asked her/his view (NB: regardless of the child's expressed view, it remains the responsibility of the organisation to take whatever action is required to ensure his/her safety)
- Establish with the child who they trust to support them
- If possible communicate/contact their chosen support to be with them (being mindful of confidentiality issues)
- Conserve and protect any evidence that indicate abuse has occurred.

Employees must act on all disclosures and concerns, however vague.

8.2.1.3 Informing a Manager

Disclosures and concerns should be reported to a line manager or relevant senior members of the multi-disciplinary team without delay. This includes concerns regarding a colleague (staff or volunteer) having abused a child.

8.2.1.4 Making a Record

Incidents, disclosures and concerns must be clearly recorded at the earliest opportunity on the Patient Electronic Record and if appropriate through the incident reporting process. With regards to relatively vague concerns in particular, recording must be factual, not speculative (e.g. record behaviour observed or quote what has been said). Follow-through action (e.g. report to line manager) and any further plans must be recorded. Staff and volunteers with no access to the patient Electronic record should write a paper record. This needs to be dated and signed and then scanned onto the electronic database.

8.2.2 <u>Responsibilities of the Person Receiving the Alert</u> (Line Managers and Senior Members of the Multi-Disciplinary Team (MDT))

8.2.2.1 Follow-Through by the MDT and Decision to Make a Referral to Children's Social Care

Line managers or relevant senior members of the multi-disciplinary team receiving a report of an incident, disclosure or concern, however vague and uncertain, must ensure that the matter is discussed at the earliest opportunity by the multi-professional team or appropriate members of it.

This discussion should lead to a decision regarding the most appropriate follow-through. This may range from 'no action at this point but keep under review' for vague concerns to supporting immediate needs or a decision to make a safeguarding referral to Children's Social Care.

The hospice Social Worker (or in their absence, the Hospice Safeguarding Lead) should be involved in all such MDT discussions.

The Hospice Safeguarding Lead (or in their absence the Registered Manager or out of hours the Senior Nurse On-Call) needs to be consulted regarding all safeguarding decisions and before action is taken, unless, on reflection by the MDT (including the social worker), a concern is deemed minor, unfounded and clearly not requiring any follow through other than keeping the matter under review.

Guidance states that a referral to Children's Social Care must be made if there are signs that a child under the age of 18 years or an unborn baby is:

- Suffering or has suffered 'significant harm' or
- Likely to suffer 'significant harm'.

The Children Act 1989 provides the legal framework for defining situations in which a local authority has a duty to make enquiries about what, if any, action to safeguard or promote a child's welfare. The threshold for Local Authority involvement is actual or suspected 'significant harm'. There are no absolute criteria on which to rely to determine what constitutes 'significant harm'. It is often a compilation of significant events, both acute and longstanding, which impact on the child's physical and psychological development.

If in doubt a safeguarding referral to Children's Social Care must always be completed. It is *not* St Wilfrid's role to determine whether the alert meets safeguarding thresholds. Children's Social Care is the lead agency in relation to safeguarding. They will decide whether criteria are met. This means it is to be expected that some referrals will not be followed through by Children's Social Care as active safeguarding cases.

The responsibility for decisions whether to make a referral lies with the MDT in consultation with the Hospice Safeguarding Lead.

8.2.2.2 Recording of Follow Up and Decisions

Any discussions or decisions by the MDT, or following consultation with the hospice Safeguarding Lead, rationale for decisions and subsequent plans must be recorded on the Patient Electronic Record.

8.3 Making a Safeguarding Referral to Children's Social Care

A safeguarding referral is the direct reporting of an allegation, concern or disclosure to the local authority who acts as the lead agency with regards to safeguarding.

8.3.1 Timeframe for Referrals

The timing of referrals must reflect the level of perceived risk, but should usually be within one working day of the recognition of risk.

8.3.2 Parental Consultation Regarding Referrals

Where practicable, concerns should be discussed with the family and agreement sought for a referral to Children's Social Care unless this may:

- Place the child at risk of significant harm or by leading to an unreasonable delay
- Place others at risk
- Lead to the risk of losing evidential material.

A decision by any professional **not** to seek parental consent before making a referral to Children's Social Care must be recorded and the reasons given.

Where a parent has agreed to a referral, this must be recorded and confirmed in the referral to Children's Social Care. Referrals from named professionals cannot be treated as anonymous, so the parent will ultimately become aware of the identity of the agency making the referral.

Where the parent refuses to give consent for the referral, further advice should, unless this would cause undue delay, be sought from the Hospice Safeguarding Lead and outcome fully recorded.

If, having taken full account of the parent's wishes, it is still considered that there is a need for a referral:

- The reason for proceeding without parental agreement must be recorded
- Children's Social Care must be told that the parent has withheld consent
- The parent should be contacted to inform him/her that after considering her/his wishes a referral has been made (unless this action may increase the risk of harm to the child).

8.3.3 How to Make Referral

The Social Worker can make referrals on behalf of the MDT or advise MDT colleagues how to go about doing so. It is often helpful if the person most directly involved (the person who has witnessed abuse or spoken directly to the child) makes the call to Social Services as accurate and detailed information is crucial. This can be decided on a case by case basis.

Referrals should be made to the Children's Social Care office where the child is living (NB: for children visiting the hospice this may be outside the hospice local area). In urgent situations outside office hours, referrals should be made to the relevant Emergency Duty Service/Out of Hours Team.

Referrals can be made verbally initially but must be confirmed in writing using the Interagency Referral Form (use mail merge from on Crosscare). If there is no acknowledgement by Children's Social Care of a written referral sent within 24 hours, hospice staff should contact Children's Social Care to establish the current status of the referral.

In addition, matters may need to be reported to the police where a crime has been committed or is suspected. Social Services are usually able to advise whether this will be necessary or not.

Every safeguarding referral to Social Services and/or the police also needs to be reported to the CQC by the Registered Manager. It is the responsibility of the Hospice Safeguarding Lead to make the Registered Manager aware in each instance.

8.4 Information Sharing

Information sharing between organisations is essential to safeguard children. St Wilfrid's Hospice will share information with other relevant agencies in line with the data protection act and relevant hospice policy and procedure. The following principles must apply:

- Information will only be shared on a 'need to know' basis when it is in the interest of the child
- Confidentiality must not be confused with secrecy
- Staff and volunteers must not give assurances of absolute confidentiality
- Decisions about what information is shared and with whom will be taken on a case-by-case basis and in line with guidance given in the Pan Sussex Child Protection and Safeguarding Procedures Manual https://sussexchildprotection.procedures.org.uk/pkpq/information-sharing-and-confidentiality/information-sharing

8.5 Employees' Responsibility to Themselves

Employees need to protect themselves from allegations of abuse. If working in a patient's home, employees should ensure they are not left alone in a room with a child or that they are visible through a glass door or window.

When a referral is made to work with a child, the first meeting should be with the parent or guardian and subsequent meetings in a room with a glass door/window enabling the child to be visible.

8.6 Safeguarding Concerns Involving Alleged Abusers known to the Child in a Professional Capacity

Where safeguarding concerns are identified involving alleged abusers known to the child in a professional capacity as employees in the service of St Wilfrid's, the Registered Manager must be informed at the earliest opportunity.

An initial internal review will be conducted. The first responsibility to act lies with the employing organisation as provider of the service, i.e. St Wilfrid's Hospice. The Hospice Safeguarding Lead must be consulted regarding appropriate action to protect the child. All discussions and decisions must be documented.

Where the internal review concludes that concerns are serious, the referral process will be followed. The referral to Children's Social care will be made by the Hospice Safeguarding Lead and/or Registered Manager.

Where concerns arise regarding alleged abuse by professionals from any health or social care agency external to St Wilfrid's Hospice, the Hospice Safeguarding Lead together with relevant MDT staff and/or Directors will consider appropriate action, including possible safeguarding referrals.

8.7 Training for Employees

St Wilfrid's Hospice will ensure that all employees receive appropriate induction, training and continuing support in dealing with safeguarding matters. Training will be appropriate to their level of responsibility and role.

Training will include face-to-face group training delivered by St Wilfrid's staff with particular expertise in safeguarding (the St Wilfrid's Lead for Safeguarding and the social worker). It will include e-learning and also attendance at external adult safeguarding courses available through the local authority.

The mandatory attendance at training will be overseen by the Patient Safety Group.

9. Governance Structure for Children Safeguarding

St Wilfrid's has a designated Safeguarding Lead who will formally report, on an annual basis, to the Clinical Governance Committee. All incidents will be reported and managed through St Wilfrid's Hospice Accident, Incident and Near Miss Policy and Procedure.

The Registered Manager will act as a deputy to the Safeguarding Lead in the Lead's absence.

10. Monitoring and Compliance

This policy and procedure will be monitored through the Accident, Incident and Near Miss Reporting Policy and Procedure and reported to the Clinical Governance Committee.

11. Policy Review

The document will be reviewed every 2 years or following introduction of any new legislation or significant changes within the organisation.

12. Compliance with Statutory and Other Requirements

Children's Act 1989
Children's Act 2004, amended by Children and Social Work Act, 2017
Data Protection Act 1998
Information Sharing: Guidance for Practitioners and Managers (Department of Education 2008)
Working Together To Safeguard Children 2018
Pan Sussex Child Protection and Safeguarding Procedures (updated 2018)
https://sussexchildprotection.procedures.org.uk/

Appendix 1

Types of Abuse and How to Recognise Abuse

There are **four broad categories of abuse** which are used for the purposes of recognition:

- Physical abuse
- Emotional abuse
- Sexual abuse
- Neglect.

Abuse could also include exploitation by criminal gangs and organised crime groups; trafficking; online abuse; sexual exploitation and the influences of extremism leading to radicalisation. Whatever the form of abuse or neglect, practitioners should put the needs of children first when determining what action to take.

Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child.

It may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces illness in a child. This unusual and potentially dangerous form of abuse is described as fabricated or induced illness in a child.

Emotional abuse involves the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development.

It may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may include not giving the child opportunities to express their views, deliberately silencing them or 'making fun' of what they say or how they communicate. It may feature age or developmentally inappropriate expectations being imposed on children.

These may include interactions that are beyond the child's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction. It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying causing children frequently to feel frightened or in danger, or the exploitation or corruption of children.

Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.

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 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 their children.

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 and development.

Neglect may occur during pregnancy as a result of maternal substance misuse. Once the child is born, neglect may involve a parent or carer failing to: provide adequate food and clothing, 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-takers; ensure access appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

Severe neglect of young children is associated with major impairment of growth and intellectual development. Persistent neglect can lead to serious impairment of health and development, long-term difficulties with social functioning, relationships and educational progress. Neglect can also result, in extreme cases, in death.

Risk Indicators

The factors described in this section are frequently found in cases of child abuse. Their presence is not proof that abuse has occurred, but must be considered as indicators of possible significant harm.

In an abusive relationship the child may:

- Appear frightened of the parent(s);
- Act in a way that is inappropriate to her/his age and development (though full account needs to be taken of different patterns of development and different ethnic groups).

The parent or carer may:

- Persistently avoid child health services and treatment of the child's illnesses;
- Have unrealistic expectations of the child;
- Frequently complain about / to the child and fail to provide attention or praise (a high criticism / low warmth environment);
- Be absent;
- Be misusing substances;
- Be involved in domestic violence;
- Be socially isolated.

Recognising Physical Abuse

Watch out for injuries not typical of the normal bumps and scratches of a child's/young person's activities. Look out for bruising, bite marks, burns scalds and scars.

The following are often regarded as indicators of concern: an explanation which is inconsistent with an injury, several different explanations provided for an injury; parents/carers who are uninterested or undisturbed by an accident or injury; reluctance to give information regarding injury.

Caution should be used when interpreting an explanation by parents/carers that an injury was self-inflicted or caused by a sibling.

Recognising Emotional Abuse

Emotional abuse may be difficult to recognise, as the signs are usually behavioural rather than physical. Recognition of emotional abuse is usually based on observations over time.

Watch out for parent/carer relationship factors such as: - persistent negative comments about the child or 'scape-goating' within the family; inappropriate or inconsistent expectations of the child such as over-protections or limited exploration.

Watch out for how the child presents: - behavioural problems such as aggression or attention seeking; frozen watchfulness; low self-esteem, lack of confidence, fearful, distressed, and anxious.

Consider parent / carer related issues: - dysfunctional family relationships including domestic violence; parental problems that may lead to lack of awareness of child's needs such as mental illness, substance misuse, learning difficulties; parent or carer emotionally distant.

Recognising Sexual Abuse

Boys and girls of all ages ma be sexually abused and are frequently scared to say anything due to guilt and/or fear. This is particularly difficult for a child to talk about and full account needs to be taken of the cultural sensitivities of any individual child/family.

Recognition can be difficult, unless the child discloses and is believed. There may be no physical signs and indications are likely to be emotional / behavioural.

Some examples of behavioural indicators to watch out for: - inappropriate sexualised conduct; sexually explicit behaviour, play or conversation, inappropriate to the child's age; anxious unwillingness to remove clothes when e.g. room temperature high.

Recognising Neglect

Neglect covers different aspects of parenting.

Child related indicators include for example:- an unkempt, inadequately clothed, dirty or smelly child; a child frequently hungry; a child observed to be listless, apathetic, displaying anxious attachment, aggression or indiscriminate friendliness.

Indicators in the care provided include:- failure to meet basic essential needs; a dangerous or hazardous home environment; lack of opportunities to play and learn; child left with adults who are intoxicated or violent; child abandoned or left alone for excessive periods.

For further information: https://sussexchildprotection.procedures.org.uk/qkpz/recognition-and-referral-of-abuse-and-neglect/recognition-of-abuse-and-neglect

Appendix 2

Referral Form - CONFIDENTIAL

THIS FORM SHOULD ONLY BE COMPLETED FOLLOWING A CONVERSATION WITH A DUTY SOCIAL WORKER AND SHOULD BE RETURNED WITHIN 24 HOURS OF CONTACT

1

To: _____ _____ at Children's Social Care

Initial date of contact _____ Today's date _____

Are you aware if a CAF form may have already been completed? Yes/No/Do not know

2

FAMILY/CLIENT DETAIL				
Are family aware of referral?	Yes ☐		No ☐	
Re-referral	Yes ☐		No ☐	
CHILD/YOUNG PERSON'S FULL NAME(S) _____				
DATE OF BIRTH/Expected date of delivery _____		GENDER:	M ☐	F ☐
ADDRESS: _____				
PHONE:				

3

ETHNICITY					
☐African	☐Bangladeshi	☐ Caribbean	☐Chinese	☐ Indian	☐ Pakistani
☐White British	☐ White & Asian	☐ Other Asian	☐ White & Black African	☐ White & Black Caribbean	
☐White Irish	☐ Other White	☐Other Black	☐ Other Ethnic Group	☐Other Ethnic Group	
☐ Not given					

4

OTHER HOUSEHOLD MEMBERS/CHILDREN			
NAME	**DOB**	**RELATIONSHIP**	**Parental Responsibility**
			Y ☐ N ☐
			Y ☐ N ☐
			Y ☐ N ☐
			Y ☐ N ☐
			Y ☐ N ☐
			Y ☐ N ☐

5

OTHER SIGNIFICANT ADULTS/PEOPLE (LIVING ELSEWHERE)			
Name	**Relationship**	**Address**	**Telephone No**

6

REFERRER DETAILS	
These should include information on:	The presenting issue, with evidence and facts Summary of previous involvement Expectations of referrer (what you feel needs to happen Family's views of referral CAF/Framework of Assessment where possible Are there any indications that the child/young person may be at risk of Child Sexual Exploitation?

Please continue on separate sheet if necessary and attach any supporting documents.

7

OTHER KEY AGENCIES			
Name/Role	**Address**	**Telephone Number**	**E-mail**

8

REFERRER DETAILS

Name: Agency:

Address:

Signature: Date:

Tel No:

Fax No:

E-mail: