St Wilfrid's Hospice

CHILD PROTECTION & SAFEGUARDING POLICY AND PROCEDURE

Approved by:	**Clinical Governance Committee**
Date of approval:	**22 July 2010**
Reviewed:	**September 2021**

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 and 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

Disclosure and Barring Service (DBS) Policy and Procedure
Duty of Candour Policy and Procedure
Raising Concerns (Whistle Blowing) Policy and Procedure
Health Record Keeping Policy and Procedure
Patient Confidentiality Policy and Procedure
Pre and Post Employment Checks Policy and Procedure
Recruitment and Selection Policy and Procedure
Senior Clinical Manager On-Call Policy and 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 Chief Executive takes responsibility for ensuring that policies, procedures and processes are in place (Whistleblowing Policy, Freedom to Speak Up Guardians) that support staff and volunteers reporting concerns at work, and that staff are entitled to protection under the Public Interest Disclosure Act 1998.

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 Steering Group**:

- Provides strategic oversight and make recommendations to the Board on children's safeguarding matters
- Provides assurance to the Board that safeguarding policies and procedures are up to date and are being adhered to
- Identifies organisational risks with regards to safeguarding and escalate these appropriately
- Acts as a central point on behalf of St Wilfrid's to receive national and local updates and reports and implement any changes required
- Raises the profile of safeguarding to ensure it is embedded in all aspects of hospice business, ensuring that lessons learnt are disseminated
- Fosters effective working relationships with external agencies and others including the Sussex Hospice Collaborative on safeguarding matters.

The Safeguarding Lead is responsible for:

- Providing advice, expertise, and support for hospice staff and volunteers on safeguarding queries and concerns
- 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
- Oversight of learning from practice and implementation of any relevant follow through
- Making recommendations regarding training for staff and volunteers with regards to safeguarding children at risk and ensuring training is in place and monitored
- Keeping abreast of national and regional changes in policy and procedure relating to children at risk and amending and updating the hospice policy accordingly
- Reporting to the Chief Executive, Safeguarding Steering Group, Governance Groups and Trustees any concerns, risks and actions plans, relating to the effective implementation of this policy.
- Leading on the hospice's approach to preventing radicalisation under the Prevent Duty.

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. They are responsible for ensuring their staff undertake safeguarding training as required.

Human Resources are responsible for:

- Ensuring relevant policies, procedures and checks are in place (such as references, professional registration and DBS checks), so that only staff and volunteers that are suitable to work with vulnerable groups are recruited
- Ensuring that appropriate HR procedures are in place to allow comprehensive investigation to be undertaken should an allegation be made against a member of staff or the organisation with respect to safeguarding. These must follow guidance contained within the Pan Sussex Child Protection and Safeguarding Procedures.

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 hospice patients or carers, on hospice premises and in the community. It includes bereaved children. 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 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 is 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 they 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, they should be asked their view (NB: regardless of the child's expressed view, it remains the responsibility of the organisation to take whatever action is required to ensure their 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. Out of hours the senior clinical manager on-call needs to be informed.

This includes concerns regarding a colleague (staff or volunteer) having abused a child. If the concern is that a line manager has abused a child a Director must be informed.

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, Senior Members of the Multi-Disciplinary Team (MDT) and Senior Clinical Manager On-Call)

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 MDT 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.

A hospice Social Worker (or in their absence, the Hospice Safeguarding Lead, the Deputy Safeguarding Lead or another senior clinician) should be involved in all such MDT discussions.

The Hospice Safeguarding Lead (or in their absence the Deputy Safeguarding Lead or another senior clinician) 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.

<u>Out of hours</u>, in the absence of MDT colleagues required for an MDT discussion and also in the absence of the Safeguarding Lead, the Senior Clinical Manager On-Call will need to take responsibility for making decisions in the light of risk and urgency. The decision will need to address whether the matter can wait until MDT discussion and consultation with the Safeguarding Lead become possible or whether an immediate referral to Children's Social Care is necessary. In making this decision the Senior Clinical Manager On-Call may seek advice from the medical consultant on call. If in any doubt at all the decision should be to refer to Children's Social Care. A social worker and the Safeguarding Lead need to be brought up to date with any safeguarding issues which have arisen and were dealt with out of hours at the earliest opportunity.

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.

A safeguarding referral to Children's Social Care must always be completed and their advice sought before an alleged perpetrator of abuse is approached.

Ultimately the responsibility for decisions whether to make a referral lies with the MDT in consultation with the Hospice Safeguarding Lead (unless out of hours where the responsibility lies with the Senior Clinical Manager On-Call).

8.2.2.2 Recording of Follow Up and Decisions

Any discussions or decisions by the MDT, and 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 parent or care giver and agreement sought for a referral to Children's Social Care unless

- The parent or care giver is the alleged perpetrator

or 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 them that after considering their 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 and Who to Notify

The Hospice Social Workers 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 Children's Social Care 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.

To make a *local* referral you need to contact the county wide SPOA (Single Point of Advice) service on 01323 464222. Referrals can be made verbally initially (especially if significant immediate risk) but must be confirmed by emailing completed referral form to 0-19.SPOA@eastsussex.gov.uk (for referral form see Appendix 2 or mail merge form 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.

Safeguarding alerts to Children's Social Care and/or the police need to be reported to the CQC if the alleged abuse involves any of the hospice services, or if the alleged abuse took place in the hospice. It is the responsibility of the Hospice Safeguarding Lead to make the Registered Manager aware in each instance. Notifications to the CQC need to be submitted by the Registered Manager or a hospice social worker.

In addition, matters may need to be reported to the Charity Commission where the hospice or an individual member of staff is thought to be the cause of risk. This reporting to the Charity Commission will be undertaken by the Registered Manager, the Social Workers or the Safeguarding Lead.

All safeguarding concerns for children, whether alert raised or not, need to be recorded by the Social Workers on the 'Safeguarding Concerns & Alerts Summary' spreadsheet (the 'Safeguarding Log'). In the Social Workers' absence recording is to be undertaken by the Safeguarding Lead or Deputy Safeguarding Lead.

8.4 Alerts Which Do Not Meet the Local Authority's Safeguarding Threshold

It is not unusual for the Local Authority to decide that an alert does not meet the criteria and their threshold for follow-through as an active safeguarding case. The Local Authority will only get involved with the most serious cases. Nevertheless, concerns expressed will remain on the Local Authority's records and add to a fuller picture should further alerts be made to them.

Where alerts are not followed through by the Local Authority, the MDT remains responsible for closely monitoring situations and if appropriate for re-alerting the Local Authority.

8.5 Follow-through for Children Not Under the Care of the MDT

Some children under St Wilfrid's are not cared for by the MDT. This currently includes for example bereaved children under the Seahorse Project. In terms of the above process the concern needs to be raised with the line manager who, unless concerns are very minor, should call an 'ad hoc MDT' by involving the St Wilfrid's Social Worker and other relevant MDT members. All other follow-through as above.

8.6 Safeguarding Concerns Where the Person Thought to be the Cause of Risk is 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 or volunteers 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 from harm. All discussions and decisions must be documented.

Where the internal review concludes that concerns are serious, the alert process as in 8.2 will be followed. The alerts 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 alerts.

8.7 Safeguarding Alerts Raised for Hospice Patients or Carers by External Professionals

Where staff become aware that a safeguarding alert has been raised for a child under St Wilfrid's Hospice by external professionals, or where they become aware of any other safeguarding related activities by external professionals in relation to one of our children, this should be recorded on the child's electronic record and the hospice Social Workers should be made aware to ensure joint-up working.

8.8 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
- East Sussex Children Services refer to 'public task' as the legal basis for sharing information for safeguarding purposes (Sussex Child Protection procedures point 2.2.9). GMC guidance supports this:
  "Ask for consent to share information unless there is a compelling reason for not doing so. Information can be shared without consent if it is justified in the public interest or required by

law. Do not delay disclosing information to obtain consent if that might put children or young people at risk of significant harm. Do not ask for consent if you have already decided to disclose information in the public interest."

8.9 Employees Protecting Themselves against Allegations of Abuse

Staff and volunteers need to protect themselves from allegations of abuse as far as possible.

- They are advised not to have unnecessary physical contact with children and young people. There may, however, be occasions when physical contact is unavoidable or positively desirable or necessary, such as providing comfort and reassurance for a distressed child, or physical support when working with a disabled child. Physical contact should only take place with the consent of the child or young person and the purpose of the contact should be clear.
- Staff and volunteers should not spend excessive amounts of time alone with children, away from others. Meetings with individual children should take place as openly as possible. If appropriate, consent from a parent or adult with parental responsibility should be gained. If privacy is needed, whether in a private home or in the hospice, the door should be kept partly open or visibility through a glass door or window ensured.
- It is not good practice to take children on car journeys alone, however short. Where this is unavoidable, it should be with the full knowledge and consent of the parents or carers and the Hospice Safeguarding Lead must be made aware of the purpose and anticipated length of the journey.

8.10 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, in line with the following document:
Intercollegiate Document, Children Safeguarding: Roles and Competencies for Health Care Staff, August 2018.

Training will include face-to-face group training delivered by those with particular expertise in safeguarding (external trainers and/or the St Wilfrid's Safeguarding Lead and social workers). 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 Learning & Development Manager reporting to the Safeguarding Lead.

All cases of safeguarding concerns, whether alert raised or not, are reviewed by the Safeguarding Lead in conjunction with the social workers. In each case learning from practice is identified, as relevant, and followed through as appropriate.

9. Equality and Diversity

In pursuing safeguarding concerns St Wilfrid's will take account of equality and diversity issues. St Wilfrid's will strive to ensure that the manner in which concerns are followed through do not inadvertently discriminate against any groups based on their race, disability, gender, age, sexual orientation, religion and belief.

10. Governance Structure for Children Safeguarding

St Wilfrid's has a designated Safeguarding Lead, currently the Patient and Family Support Director. The Registered Manager will act as a deputy to the Safeguarding Lead in the Lead's absence. The Safeguarding Lead reports to the SMT, Board sub-committees and to the Board of Trustees regarding safeguarding.

The Quality & Safety Group has responsibility for reviewing the hospice safeguarding policies (children and adults) for submission to the Clinical Governance Committee. It also has responsibility for identifying and managing risk in relation to *safe* clinical practice regarding safeguarding.

The Clinical Effectiveness Group has oversight of learning and development in relation to adult safeguarding and takes responsibility for ensuring best *effective, caring* and *responsive* clinical practice regarding safeguarding. It identifies and manages risk in relation to these particular areas.

The Clinical Governance Committee has overall governance oversight of *clinical* safeguarding. This includes regular monitoring and review of risks identified by the Quality & Safety Group and Clinical Effectiveness Group.

11. Policy Monitoring

Adherence to this policy and procedure is monitored through the clinical governance process. An annual report is compiled by the Safeguarding Lead and presented to the governance groups, Safeguarding Steering Group and the Board.

12. Policy Review

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

13. 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
Domestic Abuse Bill 2021
Pan Sussex Child Protection and Safeguarding Procedures https://sussexchildprotection.procedures.org.uk/
Please note - the Pan Sussex Procedures manual should normally be viewed on-line but can be printed, for reference only. The manual will be updated regularly, so staff should avoid retaining printed versions - hard copies are only valid for 72 hours.
Pan Sussex - Bruising/injuries in Children who are Not Independently Mobile (NIM) Guidance (reviewed April 2021) – available via Google search

14. References

GMC – Confidentiality and sharing information - https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/protecting-children-and-young-people/confidentiality-and-sharing-information
HM Government (2018), Working Together to Safeguard Children: A guide to interagency working to safeguard and promote the welfare of children
Stalker K. et al, A study of disabled children and child protection in Scotland – a hidden group? Children and Youth Services Review 56 (2015) 126-134

Equality Impact Assessment Tool

The hospice aims to design and implement services, policies and measures that meet the diverse needs of their service, population and workforce, ensuring that none are placed at a disadvantage in relation to others. The Equality Assessment Tool is designed to help staff consider the needs and assess the impact of the policy in this light. Appropriate adjustments will be made to accommodate individual communication needs.

St Wilfrid's Hospice

Policy and Procedure Title: Child Protection and Safeguarding Date Completed: December 2020

Assessment Tool Completed By: Name: Andrea Dechamps Job Title: Director of Patient & Family Support

		Yes/No	Comments
1.	**Does the document/guidance affect one group less or more favourably than another on the basis of:**		
	Race	No	
	Ethnic origins (including gypsies and travellers)	No	
	Nationality	No	
	Gender (including gender reassignment)	No	
	Culture	No	
	Religion or belief	No	
	Sexual orientation	No	
	Age	No	
	Disability - learning disabilities, physical disability, sensory impairment and mental health problems	Yes	
2.	**Is there any evidence that some groups are affected differently?**	Yes	Strong evidence that disabled children are more likely to be abused than their non-disabled peers (Stalker et al 2015).
3.	**If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?**		
4.	**Is the impact of the document/guidance likely to be negative?**	No	
5.	**If so, can the impact be avoided?**	N/A	
6.	**What alternative is there to achieving the document/guidance without the impact?**	N/A	
7.	**Can we reduce the impact by taking different action?**		We can reduce impact by focus on above through awareness raising / training

If you have identified a potential discriminatory impact of this procedural document, please refer it to the Head of People, together with any suggestions as to the action required to avoid/reduce this impact.

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.

Disclosures of smacking or hitting, whether physical marks have been left or not, need to be considered under safeguarding. Clarity with regards to the number of incidents and severity (physical marks or not) will help to consider the way forward.

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.

Please note latest guidance regarding bruising / injuries in children who are not independently mobile (NIM). Bruising is the commonest presenting feature of physical abuse in children. Recent serious case reviews have indicated the highly predictive value, for child abuse, of the presence of bruising in children who are not independently mobile. Of course, there may be an innocent explanation for bruising. For more detail see the guidance (Bruising/Injuries in Children who are Not Independently Mobile (NIM) Guidance (reviewed April 2021).

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 (including cyber bullying) causing children frequently to feel frightened or in danger, or the exploitation or corruption of children.

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

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.

Domestic Abuse. In addition to the four broad categories above the 2021 Domestic Abuse Bill recognises for the first time children not only as witnesses of domestic abuse but also potential victims. This relates to children wo see or hear, or experience the effect of domestic abuse and are related or personally connected to the person being abused or the alleged perpetrator.

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 may 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 see Pan Sussex Child Protection and Safeguarding Procedures
https://sussexchildprotection.procedures.org.uk/

Appendix 2

Single Point of Advice referral

NHS Sussex Partnership NHS Foundation Trust

East Sussex County Council eastsussex.gov.uk

To make a referral you need to contact the countywide SPOA service 01323 464222 or 0-19.SPOA@eastsussex.gov.uk /
You should have discussed with your agency Safeguarding lead with reference to the East Sussex Continuum of Need prior to sending the SOR in with an assessment of where on the CON the concerns sit at. The referral should be discussed in this way first, unless there is a significant immediate risk of harm in which case SPOA should be contacted by telephone.

For more information on the Continuum of Need please go to https://czone.eastsussex.gov.uk/Continuum

- If handwritten, please complete in BLOCK CAPITALS
- If you run out of space please attach a separate sheet

To: (if applicable)		Today's date:	

Please attach any relevant additional information e.g. Chronology, Early Help Plan, CAF (information from attached documents does not have to be repeated on this form)
Please tell us what documents you have attached:

1. Child / young person you are concerned about			
Full name		Gender	
Date of Birth		Educational setting	
Address		Family Phone number	

2. All other children & young people you are aware of in the household				
Full name	Date of birth	Gender	Relationship to above	Educational setting

2a. Ethnicity of children & young people in the household			
White	Mixed	Asian/Asian British	Black/Black British
◉ British	○ White & Black	○ Indian	○ Carribean
○ Irish	○ White & Black African	○ Pakistani	○ African
○ Gypsy Roma	○ White & Asian	○ Bangladeshi	
○ Irish traveller	○ Arab	○ Chinese	
○ Other*	○ Other*		
Other ethnic group (please state):		○ Prefer not to state	

3. Parents/carers or adults you are aware of in the household			
Full name	Gender	Relationship	Parental responsibility? Y/N

3a. Any other significant adults, children or young people who live elsewhere			
Full name	Gender	Relationship	Parental responsibility? Y/N

Has the parent/carer been offered any parenting support groups?	☐ Yes	☐ No
Has the parent/carer attended any parenting support groups?	☐ Yes	☐ No

Referral checklist – CAMHS referrals only - please indicate presenting problems.

Anxiety	☐ Obsessive symptoms	☐ Fears & Phobias	☐ Social anxiety	☐ Somatic complaints
	☐ Separation issues	☐ Anxious generally	☐ Panics	
Mood	☐ Depression/low mood	☐ Self-harm	☐ Loss of appetite	☐ Extremes of mood
	☐ Suicidal thinking	☐ Withdrawn	☐ Sleep disruption	
Experiences	☐ Hallucinations	☐ Hearing voices	☐ Bizarre ideas	☐ Delusions
Eating	☐ Preoccupation with food	☐ BMI less than 18	☐ Sudden weight change	
	☐ Excessive use of exercise	☐ Dispupted eating pattern (bingeing/restricting)		
Relationships	☐ Family relationship difficulties		☐ Peer relationship difficulties	
	☐ Easily distracted	☐ Impulsive	☐ Difficulty sitting still or concentrating	
Drug/alcohol	☐ Drug or alcohol misue - child or parental			
Safeguarding	☐ Emotional abuse	☐ Neglect	☐ Domestic abuse	
	☐ Physical/sexual abuse	☐ Prevent concerns		
	☐ Child sexual exploitation concerns			
Risk to others	☐ Sexually harmful behaviour		☐ Other risk	
Physical health	☐ Adjustment to health issues			
School	☐ Not attending school			
Trauma	☐ Distressed by a traumatic event			
Identity	☐ Gender issues			

4. Why are you worried about this child / family? What is your risk assessment for them? Please include a chronology if not already attached

5. Do you know what has already been tried to support this family and the outcome of that support? (include attachments as appropriate)

6. What help do you think Early Help, Social Care or CAMHs can give in this case?

7. What is the young person's view of the difficulties?	What are the parent/carers views of the difficulties?

8. Who in the family is aware of this referral? Have the family given consent?
Please note: it is possible that this referral and its contents will be discussed within the SPOA team and also within MASH if the referral is passed through to that service. MASH is a multi-agency team and consists of staff from Children's Social Care, Police and other key early help services, information will be shared in order to work out the

best way to respond to the concerns. We use the principles of information sharing as set out within Working Together 2015.

9. Please list any organisations or services you think are working with any members of the family i.e. education, health

10. Referrer information: Please tell us about you			
Name		Role	
Service		Contact details	
Signature			

11. GP information: for CAMHS referrals only			
Name:		Contact details:	
Practice:			

Appendix 3

Children Safeguarding Process

Practitioner observes incident or receives disclosure / has concerns (policy 8.2.1.2)

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Practitioner to make a record of incident / disclosure / concern in Crosscare (policy 8.2.1.4)

Make a record of the incident / disclosure / concerns using the headings below. Record in Crosscare counselling window / escalation plan (if using counselling window to record contact) or under consultations. Use the following headings.

- Incident / disclosure / concern – quote what was said and / or record what you observed. Focus on being factual, not speculative. Focus on exact detail (e.g. exact number of incidents disclosed, severity)
- Background – summarise relevant background information
- Plan– this should include your plan to inform your manager. It may also include plan for immediate actions to ensure a child's safety.

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Practitioner to inform manager or senior staff member without delay (policy 8.2.1.3)

'Without delay' - what does this mean? Consider urgency and level of risk. As a rule of thumb, inform the relevant person about issues within 24 hours (preferably within the same working day) unless high urgency/high risk and immediate follow-through required.

The preference is for you to inform your line manager. However, if this is not possible speak to one of the social workers, the Safeguarding Lead, or another senior member of staff.

'Informing' means having a conversation.

For **bereavement volunteers** working off site – attempt to ring the Counselling Services Lead on 01323 434257. If there is no reply, then leave detailed message and in parallel contact the Counselling Services Lead by email with details of Crosscare number and safeguarding in the subject line. Classify email as high importance and copy in Andrea.Dechamps@stwhospice.org.uk; Michael.Geary@stwhospice.org.uk; Sophie.Bishop@stwhospice.org.uk One of the above will get back to you.

Out of hours (also for bereavement volunteers) - assess whether the matter can wait until the next working day morning. Consider urgency and level of risk. If matter cannot wait, then inform the senior clinician on-call. For on-call purposes they are available on **07748 963 729**. If in doubt, always inform the senior clinician on call.

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Practitioner to make a second record in Crosscare regarding actions taken (policy 8.2.1.4)

Record in Crosscare under Review/Update - Miscellaneous Information.

A brief recording to confirm that you informed a manager (who) will usually suffice. The manager will take responsibility from hereon to record discussions and plans.

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Manager / senior clinician receiving alert to record conversation with practitioner on Crosscare

Record in Crosscare under Review/Update - Miscellaneous Information:-

- record having been alerted to incident/concern/disclosure by practitioner
- record any immediate plan for follow through discussed with practitioner
- record your plan for convening MDT discussion (see next point)

Manager / senior clinician having received alert to convene MDT discussion (policy 8.2.2.1)

MDT discussion regarding alert to be attended by 'appropriate members' of the MDT. As a rule of thumb, a minimum of 3 MDT members to attend. A hospice Social Worker (or in their absence, the Hospice Safeguarding Lead, the Deputy Safeguarding Lead or another senior clinician) should always be involved. It may be appropriate to involve the practitioner who raised concern. For MDT discussion out of hours see policy 8.2.2.1 para 5.

Discussion needs to focus on decision for most appropriate follow-through, from 'no action at this point but keep under review' to alert to Children Services.

A referral to Children Services *must* be made if a child under 18 or an unborn baby is suffering, has suffered or is likely to suffer 'significant harm' (actual or suspected). If in doubt a referral must always be completed.

A safeguarding referral to Children's Social Care must always be completed and their advice sought before an alleged perpetrator of abuse is approached.

As part of the decision to refer the issue of parental consent to the referral needs to be considered and decided – see policy 8.3.2

Manager / senior clinician having received alert to record MDT discussion and outcome on Crosscare

Record in Crosscare under Review/Update - Miscellaneous Information.

The following need to be recorded: -

- who attended MDT discussion
- decision taken by the MDT and rationale for decision
- plans for follow through
- decision regarding parental consent (in particular if decision not to seek consent and reasons for this)

Manager / senior clinician having received alert to ensure that Safeguarding Lead is consulted regarding safeguarding decisions taken by the MDT, before action is taken (policy 8.2.2.1)

This will usually be a separate and subsequent step to the MDT discussion above. Occasionally the Safeguarding Lead may have already participated in the MDT discussion. In that case no separate discussion is necessary.

If the Safeguarding Lead is not available then the Deputy Safeguarding Lead or another senior clinician will take their place. For consultation with safeguarding lead out of hours see policy 8.2.2.1 para 5.

Safeguarding Lead to record consultation regarding safeguarding decisions taken by the MDT

If the Safeguarding Lead is not available then the Deputy Safeguarding Lead or another senior clinician will take their place.

Referral to Children Services to be made if agreed as the right course of action by MDT and Safeguarding Lead (policy 8.3.)

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

Who will make the referral can be decided on a case by case basis – see policy 8.3.3

Parents and caregivers should usually be consulted regarding a referral (but see important exceptions - policy 8.3.2)

Consider whether other bodies need to be notified such as police, CQC, Charity Commission – see policy 8.3.3

In parallel to the above process, **social worker** involved in the MDT discussion to update Safeguarding Log with concern after initial MDT discussion and continue to update log as relevant.

Social worker to remain involved with case in an advisory capacity until safeguarding concern no longer relevant. Social worker to continue to take responsibility for updating of log. Safeguarding Lead to initiate review of case and reflection for any learning, together with social worker and where appropriate Counselling Services Lead, once safeguarding concern closed.

If the social worker is not available then the Safeguarding Lead or Deputy Safeguarding Lead will undertake the recording on the Safeguarding Log.