SAFEGUARDING AND PROMOTING THE WELFARE OF CHILDREN

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EXECUTIVE INTRODUCTION

"The support and protection of children cannot be achieved by a single agency…every service has to play its part. All staff must have placed upon them the clear expectation that their primary responsibility is to the child and his or her family." (Lord Laming, 2003, Para. 17.92 – 17.93). The Countess of Chester Hospital Foundation Trust, hereafter known as CoCH is an acute trust providing services predominantly to Cheshire West and Chester and Flintshire.

CoCH has a statutory duty to safeguard and promote the welfare of children and young people (the Children Act, 2004). This Safeguarding and Promoting the Welfare of Children Policy outlines corporate and individual responsibilities in accordance with legislation, guidance and standards.

Section 11 of the Children Act (2004) places a legal duty on all health organisations to ensure that in discharging their functions, they have regard to the need to safeguard and promote the welfare of children. CoCH's duty under Section 11 is, therefore, wider than child protection. To be effective it requires staff members to acknowledge their individual responsibility for safeguarding and promoting the welfare of children as well as the commitment of Trust management to support them in this.

The Trust will ensure that all staff have access to expert advice, support, safeguarding supervision and training in relation to safeguarding children. It is the responsibility of NHS Trusts to make sure all staff are aware of their role in identifying children in need of protection and know how to act upon their concerns. Safeguarding children and young people is a multiagency activity and is dependent upon partnership working with other statutory and non- statutory agencies. It is essential therefore that this policy is read in conjunction with the Local Safeguarding Children Partnership (SCP) multi agency safeguarding procedures or All Wales Procedures relevant to the individual child and their family.

This policy outlines the roles and responsibilities of all employers and employees of CoCH to safeguard and promote the welfare of children and the actions to be taken where there are concerns for a child's safety or welfare. This policy also applies to the management of concerns about an unborn child.

Hilda Gwilliams
Director of Nursing and Quality, Executive Lead for Safeguarding Children
September 2022

SECTION ONE: DEFINITIONS, CATEGORIES, INTERVENTIONS AND GENERAL PRINCIPLES

The **"What to do if you're worried a Child Is Being Abused"** flowchart is available in all areas of the Trust. For additional and up to date copies these can be found on the safeguarding page on the intranet (appendix 3)

Out of hours

The on-call Consultant Paediatrician is available to discuss any urgent safeguarding concerns and Children's Social Care Emergency Duty Team is also available to discuss/assess/take urgent action to protect a child if it is out of hours. These numbers are available on the **What to do if you're worried a Child Is Being Abused** flowchart (appendix 3)

A "child" is defined as "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, in prison, or in a young offender's institution, does not change his or her status or entitlement to services or protection under the Children Act 1989. This policy also applies to the management of concerns about an unborn child.

"Safeguarding and Promoting the Welfare of Children" is the action we take to promote the welfare of children and protect them from harm – and is everyone's responsibility.

"Working Together to Safeguard Children (DCSF 2018) states: everyone who comes into contact with children and families has a role to play. Safeguarding and promoting the welfare of children is defined as: "Protecting children from maltreatment; preventing impairment of children's health or development; and ensuring that children grow up in circumstances consistent with the provision of safe and effective care; and taking action to enable all children to have the best outcomes"

4 CATEGORIES OF ABUSE

Physical
Sexual
Neglect
Emotional

Indicators of child abuse

It is vital to look at the whole picture to ensure that nothing of concern is missed and to ensure that abuse is not wrongly diagnosed.

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.

- Bruising, especially on the trunk, face and ears
- Bruises on upper arm, shoulders and neck consistent with gripping
- Finger- tip bruising/finger marks
- Burns or scalds especially cigarette burns, or burns caused by lengthy exposure to heat
- Human bite marks
- Fractures especially spiral fractures
- Any serious injury with no explanation or conflicting explanations/inconsistent accounts

Bruising is the commonest presenting feature of physical abuse in children. For specific guidance around the issue of bruising in children See appendix 2 Safeguarding Children Partnership bruising protocol.

Any concerns regarding the nature or mechanism of physical injuries sustained by a child must be discussed without delay with a senior Paediatrician who must take the lead on deciding the next steps and investigations.

All cases of suspected non-Accidental injury (NAI) must be notified to the CoCH Named Doctor for Safeguarding Children and the CoCH Safeguarding and Complex Care Team (see the flowchart for current contact details, appendix 3)

Remember any delay by CoCH staff in the detection of the physical abuse of a child could place the child (and siblings) at ongoing risk of serious or fatal injury.

Emotional

Abuse is the persistent emotional maltreatment of a child such as to cause severe distress 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 capacity, as well as over protection and limitation of exploration and learning, or preventing the child participating in normal social interaction. It may involve seeing or hearing the mistreatment 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.

- Witnessing and or hearing harm to others (domestic abuse can be a cause of significant emotional harm to children)
- Low self - esteem/confidence

- Reduced eye contact
- High anxiety and fear levels
- Constant criticism of a child
- Lack of self - worth
- Only worthy in so much as what they can do for others

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 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 children 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.

- Soreness of genital area, anus or mouth
- Unexplained recurrent urinary tract infections and discharges or abdominal pain
- Sexualised behaviour
- Damage to genitals, anus or mouth
- Sexually transmitted disease
- Unexpected pregnancy

In any case of suspected sexual abuse identified in the hospital the case must be notified immediately to a senior Paediatrician who will then have responsibility for the on-going management. If Children's Social Care request a sexual abuse medical, this is a specialist and sensitive process and is undertaken at the appropriate Sexual Abuse Referral Centre (SARC), the **What to do if you're worried a Child Is being abused"** flowchart (appendix 3) has up to date contact numbers for these services. The senior Paediatrician will liaise with the Police and Children's Social Care regarding this process.

Neglect

This 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 in pregnancy because of maternal substance misuse. 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 and danger, ensure adequate supervision (including the use of inadequate caregivers), or ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, a child's basic emotional needs which could include.

- Constant hunger, tiredness
- Poor personal hygiene, poor state of clothing
- Emaciation, pot belly, short stature, poor skin tone
- Untreated medical problems

- Persistent failure to attend for medical appointments that may be detrimental to the child's health may also be considered as a source of neglect

Neglect is difficult to define, and agencies/individual practitioners can have varied views about what could constitute neglect. Neglect cases evidence that the neglect of the children had continued unrecognized and unchallenged and as a result the children had suffered from significant harm. Neglect remains the most common type of abuse of children.

More information is available via the SCP manual of procedures or on the Safeguarding intranet page.

LEVELS OF INTERVENTION

THE CONTINUUM OF NEED

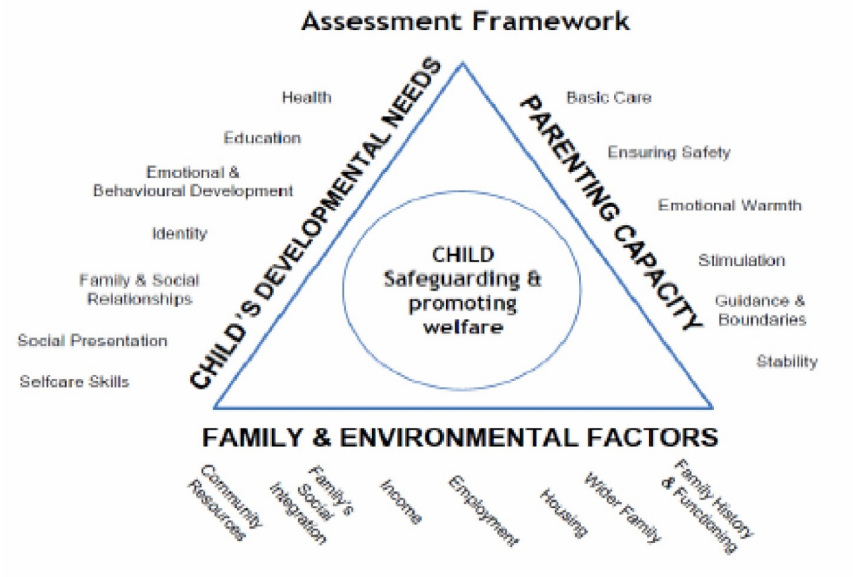
Levels of Intervention

It is widely recognised that providing children with early help services is more effective in promoting the welfare of children than reacting later. 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. Early help can also prevent further problems arising; for example, if it is provided as part of a support plan where a child has returned home to their family from care, or in families where there are emerging parental mental health issues or drug and alcohol misuse. (H M Government 2018). Effective early help relies upon local organisations and agencies working together to:

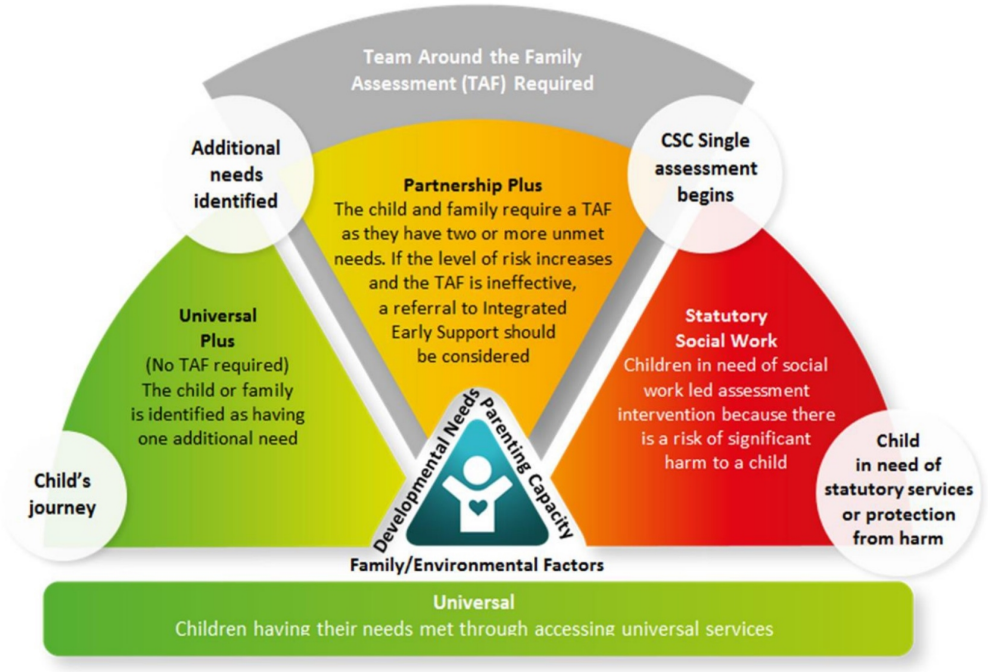
• identify children and families who would benefit from early help
• undertake an assessment of the need for early help
• provide targeted early help services to address the assessed needs of a child and their family which focuses on activity to improve the outcomes for the child Local authorities, under section 10 of the Children Act 2004, have a responsibility to promote inter-agency co-operation to improve the welfare of all children.

In many cases providing a child and their family with early help support will prevent a referral into the local authority. Early help support usually relies on the completion of a TAF/CAF or early help assessment. These continuum's demonstrate examples of how levels of need & levels of intervention can be viewed. These can be different depending upon the local authority in which you work. It may be difficult with individual cases to decide where on the continuum the child's needs are, similarly, the concept of "significant harm" can be difficult to confirm / assess, therefore if staff have any doubts, then they should seek advice from the CoCH safeguarding team. In some cases there will be concerns that a child may be at risk from significant harm and not just require early help services. This will always require a referral into the local authority's children's social care department.

The diagram below is the assessment framework which support practitioner's in making a comprehensive assessment of a child.



The Diagram below is the Cheshire West and Chester Continuum of Need



In Cheshire West & Chester the levels of need and levels of interventions are clarified using this model: The model is discussed further in Group 3 safeguarding children training and in individual case supervision. A child /family that have 2 or more unmet needs could have an assessment where the outcome would be support via the **Team around the Family (TAF)** with a Lead Professional from one of the agencies involved with the family).

Safeguarding and Promoting the Welfare of Children

Concerns that a child is suffering from or could be at risk of suffering from significant harm will require a referral to CHILDREN'S SOCIAL CARE for a statutory single assessment or a pre-birth risk assessment

Following a statutory assessment by children's social care there are two categories under which Local Authority Children's Social Care will assess risk and respond to the needs of a child.

A **Child in Need** "a child shall be taken to be in need if he is unlikely to achieve or maintain, or to have the opportunity of achieving or, maintaining, a reasonable standard of health or development without the provision for him of services by the Local Authority" (Children Act 1989 Section 17)

A **Child in Need of Protection** "a child who is suffering, or is likely to suffer significant harm, this can be a result of a deliberate act/acts or as a result of a failure to provide proper care" (Children Act 1989 Section 47)

A Child in Care

The term *Looked after Children (Children in Care)* has a specific legal meaning based on the Children Act (1989). A child is looked after by a local authority if he or she has been provided with accommodation for a continuous period of more than 24 hours, in the circumstances set out in Sections 20 and 21 of the Children Act (1989) or is placed in the care of a local authority by virtue of an order made under part IV of the Act. These children are a vulnerable group of children having already experienced adverse and / or traumatic events which has resulted in them being in the care of the local authority.

Children subject to a Child Protection Plan or Looked After Children

Staff **must** check the alerts system whenever in contact with a child to check if the child is already subject to child protection planning. This is particularly important if a child has **not been brought** to a scheduled OPD appointment. In unplanned care settings, the CP-IS alert on EPR+ should alert as positive if a child is subject to a child protection plan or who is Looked after (in care) by the Local Authority. If a child is CP-IS positive and attends an unplanned care setting, a referral regarding their attendance is required via the Think Family Safeguarding and Complex Care referral form to the Safeguarding team.

ESSENTIAL PRACTICE FOR ALL STAFF

1. All Children who attend the CoCH must have a safeguarding children checklist completed **see Appendix 5**.

2. The EPR+ alert system along with CP-IS status (for unplanned care) must be accessed to check if there is any Safeguarding Children concerns in place for the child.

3. All children should be spoken to (where appropriate) and their own wishes and feelings should be sought by staff. **There must be evidence in the child's CoCH records that staff have sought the wishes and feelings of children to whom they have given care.**

4. When a child suspected to have been abused is admitted to the hospital, the consultant paediatrician on-call should be informed as soon as possible. CoCH Paediatricians **do not** complete sexual abuse medicals and therefore the on-call paediatrician will direct the referrer to the relevant Sexual Abuse Referral Centre.

5. In all cases of physical injury/bruising, a body chart **must** be commenced at the onset. This should clearly identify all injuries on the child and all entries should be signed, dated and timed. It is extremely important that an accurate record of all bruising and marks on the child is made, including the need to record any bruising that emerges after / during admission. **The SCP bruising protocol must be adhered to (Appendix 2), copies are available in the key clinical areas**

6. All records must be factual, consistent and accurate (clearly reflect the situation and actions taken) and should be written at the time or as soon as possible after the event (within 24 hours). Avoid abbreviations, jargon, meaningless phrases or offensive statements.

7. All discussions about the child should be recorded in the hospital notes, including telephone conversations. The records should be readable on photocopies and written using black ink. They should be dated, timed accurately and signed with name legibly printed alongside your signature for the first entry. Any correction should be done by striking through errors with one line - initial, time and date. The original entry should still be read clearly. Do not amend using white correction fluid, scribbling out or writing over the original. Electronic records must also be kept up to date.

8. If a junior doctor is taking notes on a ward round describing a consultant's findings and opinion it is essential that the Consultant ensures that what is recorded in the notes is an accurate reflection of his/her findings.

9. During ward rounds, when assessing a child with suspected abuse, the doctor conducting the ward round must ensure that all available information (check electronic records and alert systems), past and present is reviewed before future management decisions are made. This includes checking the computerised patient care notes kept by nursing staff, any completed body charts and (where appropriate) checking on information from other hospitals to which the child has previously been in contact. Paediatricians can seek support/supervision from the Named Dr for Safeguarding Children or the Trust Safeguarding team. Early discussion with the CoCH Safeguarding team as part of the information collation will also help to identify if there have been any previous concerns re the adults in the home, eg substance misuse, domestic abuse of mental health issues etc.

10. If Children's Social Care and the Police convene a strategy meeting, attendance to this by the relevant paediatrician and CoCH staff **must be given priority** and the outcome of this must be accurately recorded in the child's records so that subsequent members of staff fully understand the case and the on-going plans. A strategy meeting should always be convened within 24 hours of the decision to hold one. In more complex cases a series of strategy meetings may be necessary. The CoCH Safeguarding team need to be made aware of the strategy meeting.

11. In all cases referred to Children's Social Care by CoCH staff, the responsibility does not stop at the point of referral, the Trust has a duty to follow up the referral to ensure the response to the referral is appropriate in terms of meeting the needs of/ or the protection of the child. Any concerns must be escalated to the CoCH safeguarding team, who will escalate the concerns as appropriate. No child can be discharged from the hospital unless there is a clear plan in place.

12. If CoCH staff are required to attend a child protection conference, they must seek supervision from the CoCH safeguarding team to compile a report for conference. This report must be shared with the parents prior to conference and a copy must be submitted to the child protection case conference chair at least 2 working days before conference.

13. In all cases where there are concerns for an unborn baby advice must be sought from the CoCH safeguarding team with regards to submitting a referral to children's social care to request a pre-birth risk assessment. In all cases where a child (including an unborn child) is subject to a Child Protection Plan and CoCH community staff are involved in the on-going care of the child, that member of staff will in accordance with the SCP procedures be a member of the Core Group. The Core Group will meet regularly to ensure that the recommendations from the Child Protection Plan

are being achieved. The staff member must take/submit a written report for each core group meeting to the named social worker for the child and should always receive a copy of the core group minutes which should be kept in the child's hospital records.

14. When a child is born at the CoCH and Children's Social Care are involved in most cases there will need to be a "Multi-agency Discharge Planning Meeting" prior to discharge, the CoCH safeguarding team need to be aware of these cases.

15. If a child subject to a Child Protection Plan or who is open as a Child In Need to Children's Social Care, no longer requires community care from CoCH (e.g. discharge from maternity care services in the postnatal period), the CoCH staff member must inform the named Social Worker in writing for the child to ensure they are aware that CoCH staff will no longer be visiting the child/family. This action must be recorded in the hospital records.

16. Each case will be different with a specific plan of action upon discharge of the child from the hospital. It is the responsibility of all staff involved to ensure that at each point they follow the plan that is in place to ensure the child's needs are met and that the child is afforded the highest possible protection when discharged from the CoCH care

17. We have a duty to ensure that all paperwork related to concerns about a child are filed in the child's hospital records for future reference

For more information on the standards we must adhere to at all times please see the **SCP Practice Standards for Child Protection and Children in Care and Children in Need** via the SCP manual of procedures **(CoCH intranet Safeguarding Children Web Page)**

SECTION TWO: DUTIES, ROLES AND RESPONSIBILITIES

Appendix 1 shows the current organisational chart for safeguarding children. In addition, the following responsibilities of key staff are outlined below.

Chief Executive

As the accountable officer, the Chief Executive must ensure that responsibility for Safeguarding Children is delegated to an appropriate executive lead, as outlined in the executive portfolios.

Director of Nursing

As nominated executive lead, the Director of Nursing must ensure that there are robust systems and processes in place regarding Safeguarding Children and attend and contribute to the work of constituent SCPs at a strategic level.

Associate Director of Nursing (Safeguarding and Complex Care)

The Associate Director of nursing is responsible for supporting the Director of Nursing in the strategic contribution of CoCH to the work of the SCP and is responsible for the CoCH safeguarding service as well as line managing the Named Nurse for Safeguarding Children. The Associate Director will chair the Safeguarding Steering Group.

Associate Directors and Divisional Medical Directors

Associate Directors and Divisional Medical Directors are responsible for:

- Ensuring staff can access safeguarding children's procedures, policies and guidance.

- Ensuring staff are aware of their responsibilities under this policy, and that it is fully implemented within their area of responsibility.
- Ensuring that staff work effectively with professionals from other agencies and organisations.
- Ensuring operational implementation of this policy into practice and taking appropriate action should any breach of this policy take place.
- Ensuring that service plans / specifications / contracts include reference to the standards expected for safeguarding children.
- Ensuring that recruitment and selection process guidance is followed during recruitment of staff.
- Ensuring staff attend safeguarding children training in accordance with the CoCH training programme and at the appropriate level according to their responsibilities to safeguard and promote the welfare of children.
- Ensuring that safeguarding children training is discussed with staff during annual Performance Development Reviews and included in individual staff development plans.
- Ensuring staff are released from their work area to attend single and inter-agency safeguarding children training according to staff roles and responsibilities.

Named Safeguarding Professionals

The Named Nurse & Doctor for Safeguarding Children and the Named Midwife has responsibility for:

- Promoting excellent professional practice within CoCH providing advice and expertise for fellow professionals.
- Supporting CoCH in its governance role, by ensuring safeguarding children audits are undertaken.
- Ensuring the provision of safeguarding children clinical supervision and advice is available.
- Ensuring a safeguarding child training strategy is in place and is delivered to provide access to safeguarding children training, in line with national legislation and guidance. • Ensuring the Safeguarding Children Policy is in place and maintained.
- Coordinating CoCHs response and representing CoCH at Child Practice Reviews and multiagency reviews ensuring the resulting action plans are actioned within the Trust.
- Participating in the various SCP Sub-groups
- Responsible for chairing and organising the relevant Safeguarding Subgroup (appendix 4 Terms of Reference).

Nurse Specialists for Safeguarding Children

The Nurse Specialists for Safeguarding Children are responsible for:

- Identifying additional safeguarding children training needs through the safeguarding children clinical supervision process and in conjunction with the Named Nurse for Safeguarding Children and Named Midwife advice on how these needs can be met.
- Providing advice and support to all staff on safeguarding children issues and for providing safeguarding supervision.
- Delivery of safeguarding training
- Delivery of safeguarding children audit programme

Human Resource Department

The Human Resources department are responsible for:

- Ensuring safeguarding children's responsibilities that are relevant to the job role are reflected in all job descriptions.
- Ensuring the Recruitment and Selection Process Guidance for Managers is informed by safe recruitment practice, including National Health Service Litigation Authority recruitment and selection standards.
- Ensuring newly appointed staff attend corporate induction.
- Supporting the Associate Director of Nursing in the 'managing safeguarding children's allegations against staff' process.

CoCH Education

The CoCH Education Department are responsible for:

- Publicising single agency safeguarding children training opportunities for staff. • Monitoring the safeguarding children training attendance for level 1, 2 and 3 sessions provided or facilitated by the Safeguarding Children Team.
- Informing Managers of staff within their service who did not attend for any booked safeguarding children training session.
- Generating reports on attendance at level 1, 2 and 3 sessions arranged through the department as requested

All Staff

Staff are responsible for:

- Attending mandatory safeguarding children training dependent on the staff member's responsibility for safeguarding and promoting the welfare of children, as identified in the Learning and Development Training Needs Analysis.
- Knowing who to contact if they need to discuss or report concerns about a child's safety or welfare (appendix 2).
- Knowing how to access and to be familiar with this safeguarding policy and SCP Procedures (appendix 3).
- Contributing when requested to do so, to the multi-agency meetings established to safeguard and protect children e.g. child protection conference and making available relevant information about the child and family, including a written report for child protection conferences.
- Discussing with their line manager when they are aware of circumstances, difficulties or problems in their working life which may adversely affect their working relationships and ability to safeguard children. This should be discussed with their line manager so that appropriate support can be provided.
- Further details of specific staff roles in both adult and children services are detailed in Working Together (HM Government, 2015). Staff should refer to this and be familiar to their specific responsibilities. 12.7
- All staff have a responsibility to report risks and incidents via the Trust Datix incident reporting system. **Staff must ensure that they check the EPR+ alert system** and in unplanned care the CP-IS system when first in contact with a patient. The alerts highlight

that there are safeguarding concerns associated with the child and staff have a duty to respond accordingly.

All Trust employees must comply with this policy, specific points for some staff groups are highlighted below.

Additional Roles Specific to Key Staff

The role of adult nursing staff

The safety and health of a child are intertwined aspects of their holistic well- being and are impacted upon by the way they are living their life, and their role and daily lived experience within their own family environment. Even though many health professionals work primarily with adults, their duty to safeguard children over-rides any responsibilities to adult health service users. When caring for adults whose situation may impinge on the ability to care safely and effectively for children, for example concerns about substance misuse, mental health issues, or domestic abuse, staff must "think family" and remember that children of any age are depending on their parents to be able to care for them safely and effectively. The What to Do Flowchart (appendix 3) must be followed where safeguarding issues relating to parents who have children under 18 are identified. The CoCH Safeguarding team can support staff with making decisions where necessary.

In all cases relating to parents with mental health issues, safeguarding concerns will be apparent when the parents/carers express delusional beliefs involving their child or if they may harm their child as part of a suicide plan.

The role of the Paediatrician /Paediatric staff

For the role of the paediatricians in the management of suspected child abuse (requiring a child protection medical) see **Appendix 6,** Child Protection Medical Examination Pathway. Copies of the safeguarding children pro-forma for this purpose are available within the **Safeguarding Children boxes in the key clinical areas. In any such case the safety and whereabouts of any siblings must be confirmed as a matter of priority.**

The role of Accident & Emergency staff

The Safeguarding children checklist (**Appendix 5**) must be completed on every child (up to the age of 16 years) attending the ED. ED staff must be vigilant when attending to children and young people. Adult attendance to the ED may also give rise to concerns about children that the adult is responsible for, most commonly because of adult self- harm, mental health, substance abuse and domestic abuse. ED staff must continue to be vigilant re adult attendance and refer any children about whom there are concerns about immediate risk of significant harm, to Children's Social Care and notify the safeguarding children team who will follow the referral up with Children's Social Care. Similarly, if ED staff have concerns (but these do not require an immediate response to protect the child), a notification to the safeguarding children team should be left in the safeguarding children box, this will be collected and actioned by the safeguarding children team.

If an ED staff member suspects a child may have been subjected to a Non-Accidental Injury (NAI) or the mechanism of injury is unexplained/ inconsistent, they must discuss the case with a senior paediatrician immediately. If concerns remain, the child **must be admitted to the children's unit** for further assessment and investigation. In these circumstances, the senior paediatrician should lead

on taking the decision to refer the child to Children's Social care (if this has not already taken place in the ED). The senior paediatrician/ senior nursing staff on the children's unit have the on-going responsibility for liaising with Children's Social Care and the police regarding the next steps. **In all cases of suspected NAI, the whereabouts and safety of any siblings must be considered as a matter of urgency**. The child must not be discharged from the hospital without clear instruction from Children's Social Care **(following a Strategy meeting)** in conjunction with the police and agreed by the Consultant Paediatrician leading on the case. All actions must be clearly documented. Children who are being abused and neglected are dependent on others (**like NHS staff**) to recognise the abuse. If the above processes are not followed and the child is discharged, the child **could be put at risk of further serious or fatal injury**.

The Role of Maternity Services

Any safeguarding concerns in relation to an unborn baby, that may mean the new baby may not be cared for safely and effectively must be discussed with the safeguarding team at the earliest opportunity. This discussion will focus on the needs/risks in conjunction with the Continuum of Need model. If concerns about an unborn baby are referred to Children's Social Care , the safeguarding children pro-forma must record that a Multi-Agency Referral to Children's Social Care has been made and a "Pre-Birth Risk Assessment" (PBRA) has been requested. In all cases, a formal referral to the Health Visitor for antenatal assessment must be made and this action must be recorded. Consideration must also be given to the need to refer to the appropriate children's centre staff and this should always take place where domestic abuse has been identified as a cause for concern.

A copy of the (PBRA) policy can be accessed via the SCP manual of procedures. **In all cases where a pre-birth assessment is to be completed the community midwife must ensure she is working closely with the allocated social worker. Regular safeguarding children clinical supervision with the CoCH safeguarding team must also take place.**

Important points:

If a woman was initially considering not continuing with her pregnancy, the midwife must take this into account in the assessment of the level of on-going support the woman and her family will need.

If a pregnant woman about whom there are safeguarding children concerns transfers her care from the COCH to another hospital, the COCH safeguarding team must ensure that the safeguarding children team at the receiving hospital are informed.

When the baby is born there must be robust on-going liaison between the maternity services staff, the CoCH safeguarding team and Children's Social care until the woman and her baby are transferred (discharged) from hospital to community care. In most cases a multi- agency Discharge Planning Meeting (DPM) will be required. When discharge from maternity services takes place, the allocated social worker must be informed by the community midwife and this action must be recorded. The social worker needs to know that there will be no more visits by maternity services. If there are concerns about the on-going plans for the management of the case the community midwife must liaise with the CoCH safeguarding team who will escalate the case within Children's Social Care if necessary.

The age of consent for sexual intercourse is 16 yrs. Pregnancy in a young person below 16 years will need careful consideration for any suggestion of non-consensual sexual activity or child sexual exploitation. **Pregnancy in a child under 13 years must always be viewed as a significant safeguarding issue and MUST always be discussed with the CoCH safeguarding team and Children's Social Care.**

In the case of a new-born if Children's Social Care and Legal Teams have concluded that mum and baby should be separated at birth (rare cases only where the mother is deemed to pose an immediate risk of significant harm to her newborn and legal advice has been sought), the CoCH Safeguarding team will ensure there is robust liaison between the Children's Social Care Legal Services and the CoCH Legal services. This is in recognition that the Trust must abide by our statutory responsibilities to always act in the best interests of the child, the separation of parent and child within the hospital environment must not take place unless it is absolutely necessary, and the Trust must be able to justify this action if challenged legally**.**

SECTION THREE: REFERRALS- WHAT TO DO

Referral to Children's Social Care

If a child lives in Cheshire West and Chester (CWAC) and is made subject to a Child Protection Plan (CPP) then CoCH is notified, and an alert is placed on the child's hospital record alert. If a member of staff has concerns about a child, they are in contact with who is subject to a CPP staff can contact the CoCH for further advice or the 'What to do flow chart' can be followed (appendix 3). A CPP alert means that the child has been assessed as *being at risk of significant harm.* If staff have concerns about a child and there is no CPP alert in place, then they can contact Children's Social Care in the area in which the child lives to see if the child is/has been known to them for any reason. A detailed discussion with them should ensue about the concerns the staff member has about the child and the telephone conversation should end with the practitioner knowing exactly what the next action needs to be. The name of the Social Worker spoken to, and the date and time of the conversation **must be recorded each time a conversation with Children's Social Care takes place.** If the outcome is that a formal referral is required, then this phone call will be treated as a **telephone referral**.

All **telephone referrals** to children's social care **must be** followed up in writing within **48 hours and a copy must be filed in the child's hospital records, the adult records if the referral is for the child of an adult patient and the hospital obstetric notes in the case of an unborn baby** (In ED cases a the copy of the referral will normally be sent with the child's records if admitted to the children's Unit, or if left with the ED safeguarding children notification for the CoCH safeguarding children team to collect, the team will take responsibility for ensuring the copy if filed within the child's records where appropriate.

If the outcome of the initial telephone call concluded that a referral to Children's Social Care is not needed this must be recorded. If the staff member does not agree with any action taken (or not taken as the case may be) they must seek further advice via the CoCH Safeguarding team/Named Dr Safeguarding Children or a Consultant Paediatrician in accordance with the individual case.

If "out of hours" advice/information in relation to concerns about a child is needed, the Emergency Duty Team (EDT) of the Local Authority Children's Social Care for the area in which the child lives

and/or the on call Consultant Paediatrician should be contacted. All contact details can be found on the 'what to do flow chart'.

During out of hours, **unless the child is deemed to be at risk of immediate harm**, staff should normally wait until normal hours (9-5 Mon-Fri) when the case can be discussed with the CoCH safeguarding team and/or Children's Social Care. However out of hours the 'What to do if you are concerned about a child should be followed and a referral should be made to the CoCH safeguarding team via the EPR+ referral form to detail the concerns and actions taken.

CWAC written referrals are made by completing a web base Multi- Agency Referral Form (MARF). Via CoCH Safeguarding Children web page

Flintshire written referrals are paper based and the forms are accessed via the CoCH Safeguarding children web page, the form can be completed electronically, saved and then emailed to **childprotectionreferral@flintshire.gov.uk**

For other Local Authority areas advice should be sought during the initial telephone conversation about the identified concerns about how to make the written referral.

Outcome of referral to Children's Social Care

It is the duty of the referrer to Children's Social Care to follow up the referral. In the case of a referral made in the ED when the child is not admitted, a referral made to the CoCH safeguarding team will trigger the follow up. In all other areas where the child is an inpatient, receiving a community care package or is an unborn child then the referrer should have confirmation from Children's Social Care of the outcome and planned action following the referral within 24 hours (**or sooner depending on the urgency of the situation**). The outcome of the referral if verbal must be documented, if written must be filed in the child's hospital notes or in an antenatal case in the mother's obstetric notes. In the case where immediate protection of a child may be needed, Children's Social Care and the Police will usually arrange a strategy meeting. The relevant paediatrician and CoCH staff must attend this meeting.

A *Single Assessment* by Children's Social Care is a statutory assessment. The timescale for completion of the Single Assessment is a maximum of 45 working days. At the beginning of the assessment, the social worker should be clear about the timescale for its completion with the child/ parents and professionals involved. In the case of an unborn child, it is a "Pre-Birth Risk Assessment" that takes place.

When a referral is made to the CoCH Safeguarding Team the actions taken by them will include:

- Ensure the correct actions have been and will continue to be taken.
- A record of all CoCH safeguarding notifications, copies of referrals to Children's Social Care and actions taken is kept.
- All notifications to the CoCH safeguarding team and actions taken by staff are shared with the Paediatric Liaison Nurse daily. This ensures that the relevant Health Visitor or School Health Advisor is updated regarding the actions taken by the CoCH to address the needs/reduce risk, (this includes updating teams outside of CWAC if the child is from another area).

SECTION FOUR: KEY SAFEGUARDING ISSUES

Equality and Diversity

All staff will have respect for diversity and sensitivity to race, culture, religion, gender, sexuality and disability, whilst also recognising that every child regardless of ethnicity or familial cultural beliefs will be afforded the same protection from abuse as all children.

Abuse and neglect occur in all cultures. Anxiety about being accused of racist practice **must not** prevent the necessary action to protect a child. All children whatever their religious background or culture, must receive the same care and safeguards. Whilst it is important that CoCH staff are sensitive to differing family patterns and lifestyles and to child rearing patterns that differ across racial, ethnic, and cultural groups, all children have a right to grow up safe from harm and should be clear that any behaviour that may constitute child abuse cannot be condoned for religious or cultural reasons.

Transition from child to adult services

This group of children may be particularly vulnerable. The COCH Safeguarding and Complex Care Team work closely across children and adult services to share information about individual cases where appropriate. The Safeguarding and Complex Care team may be contacted by partner agencies for example when a young adult with a learning disability will be attending the hospital for a medical intervention. In addition, the Safeguarding and Complex Care Team receive a daily report regarding children aged 16-17 being nursed on adult wards and this supports the 'Think Family' agenda ensuring the needs of these children are met within adult services if required. Appendix 7 shows the standards of care expected of children who are admitted to adult clinical areas.

Children who are not brought to appointments (was not brought)

It should be routine practice for a copy of the Trusts WNB letter to be sent to the

- GP
- Referrer (if not the GP)
- Health Visitor (preschool aged child)
- School Health advisor (school aged child)

The potential impact of any child not being brought to their appointment needs to be considered. The relevant Consultant or Lead Clinician will take responsibility for deciding if the case needs to be discussed with the CoCH Safeguarding and Complex Care team. Staff must be familiar with checking the EPR+ alert system to check if a child is already subject to a Child Protection Plan or has identified vulnerabilities. The Trusts Was Not Brought Policy should be followed.

Children Inpatient at the CoCH

Children and young people should be cared for at home wherever possible, when it is necessary for children to be admitted to and cared for in the CoCH, the highest standards of privacy, dignity and care should be provided in a safe, healthy, child friendly and age developmentally appropriate environment.

All children in the care of the CoCH will:

- Have the safeguarding children check list see **Appendix 5** completed as part of the admission process and the EPR+ alert system will be checked to identify if there are any alerts in place that would make a child vulnerable.
- If a child is admitted who is already subject to a Child Protection Plan or who is a child in care, the named social worker will be informed of the admission. If the child has any other level of Children's Social Care involvement, consideration will be given, after discussion with the child/ parent/carer, of the need to update the Social Worker.

The complaint's procedures will be clear and effective and made available to all children in a format that they understand, the complaints procedures will address informal as well as formal complaints made by children.

Age criteria for admission to the children's unit

Where possible, children less than 16 years of age should not be cared for on an adult ward. Nursing advice may be sought from the Paediatric Matron and medical advice from the on-call Paediatricians who may be contacted by bleep through the switchboard, to discuss a child who may require to be admitted to the children's unit past their 16th Birthday. Where there may be on-going safeguarding children's issues advice should be sought from the Safeguarding and Complex Care team.

Criteria for Admission to Children's Unit

- Children and Young People (0-16 years)
- Children with long term conditions warranting continuing Paediatric involvement. i.e. Cystic Fibrosis or Congenital Cardiac Abnormalities. A young person presenting to ED in Diabetic Ketoacidosis (DKA) up to the age of 17.
- Children with complex needs who remain under the care of the Paediatricians past their 16th birthday.
- Children with Complex or Palliative Care needs who are not expected to survive very long after their 16th birthday i.e. Children with Cancer in the terminal stages of their disease.
- A Young person who is specifically requesting admission to a children's ward and it is deemed that psychologically it is in their best interest to admit them to this area.

Criteria for Admission to Adult Areas

In some cases, it may be in the young person's (<16 years) best interest to be admitted to an adult Ward. Again, should this be the decision, liaison between the areas should take place as above.

- A young person admitted for termination of pregnancy.
- A violent young person under the influence of drugs or alcohol or with behavioural/mental health issues who may require security or police presence, which would not be appropriate or safe for the other children within the children's wards.
- Young people before their 16th birthday who are considered competent and mature enough to request admission to an adult ward.
- Refer also to Jubilee Centre Guidelines for Special Day Case Surgery.

Any deviation from the normal criteria for admission should be discussed with Nursing and Medical staff involved before a decision is made. Justifiable objections only will be accepted. We will act only in the best interest of the child or young person, as their care, safety and emotional wellbeing

is paramount. ***Advice can also be sort from the Paediatric Matron on telephone*** I&S ***children's unit*** I&S ***or the Safeguarding and Complex Care team on*** I&S

Appendix 7 shows the standards of care expected of children who are admitted to adult clinical areas. This can also be found on the safeguarding page of the intranet.

The supervision of parental/carer contact with children in the hospital environment

It is not the role of Trust staff to provide supervised contact between parents and children. In rare cases CoCH staff may have to take initial, short term, responsibility for a child until Childrens Social Care and / or the Police confirm the on-going plan re contact. During this initial period staff must be diligent with their observation and documentation of fact, as this may become evidence for an on-going case.

Children's Social Care must confirm as soon as possible if unsupervised contact is to be allowed. **If Children's Social Care state that only supervised contact can take place, then they have responsibility to provide a supervisor for any contact**. Children's Social Care must also ensure that the parents are aware that they are to be supervised and the reasons for this. A rota should be provided to the ward for the duration of the child's stay, a copy should also be given to the parents to ensure they are aware of the times they can visit. Should there be any difficulties with maintaining this rota or if Children's Social Care staff have not attended at the appointed time to supervise, then the parents will be asked to leave the ward (the above will also apply to a new-born baby where parental contact must be supervised).

Children in hospital (for greater than 12 weeks)

Section 85 of the Children Act (1989) requires the Trust to make a referral to Children's Social Care when a child has been in hospital for 12 weeks or more. This is so that the Children's Social Care can assess the child's needs and decide whether any services are required. If this situation arises, it must be presented in a manner that does not alarm the parents/carers. This action is a statutory duty for the hospital and is not undertaken because there are any concerns of a safeguarding children nature. A referral must also be made to the CoCH safeguarding team for any children in hospital for more than 12 weeks.

Safe Discharge of Children from CoCH

If a referral is being made to Children's Social Care for a child who is an inpatient by someone other than the Consultant Paediatrician**, the Lead Consultant for the child must be informed.** Only a consultant can discharge a child/adolescent about who there have been safeguarding children concerns. Discharge can only take place if the Consultant caring for the child at the time agrees with Children's Social Care and the Police. A discharge planning meeting will be required in many cases.

The plan for the child's future care, including follow-up arrangements must be recorded prior to discharge, the discharge arrangements must be discussed with Children's Social Care who will need to ensure that the home environment is safe and that a plan is in place for safeguarding the child when back at home, it is important to check, prior to discharge, that arrangements have been made for GP registration of any child not registered with a GP on admission. Where the child is not registered with a GP, it is the CoCH responsibility to advise the family to identify a GP via the NHS Choices website https://www.nhs.uk/using-the-nhs/nhs-services/gps/how-to-register-with-a-gp-practice/ document this action on the child's EPR+

After discharge, the hospital notes must be sent to the responsible Consultant for a discharge summary, and to check that all appropriate action on the child had been recorded and followed.

Where it is discovered, a child is not receiving any form of education a referral should be made to the Safeguarding and Complex Care Team. The discharge of any child or young person who has been admitted to the Children Unit because of self-harming behavior must involve coordinated planning with community services, to include the Child and Adolescent Mental Health Services (CAMHS). Where it appears that the child or young person may be at risk of significant harm if discharged, consideration must be given to the need to refer the child to Children's Social Care and a safeguarding referral is required to the CoCH Safeguarding Team.

Safe Discharge from Maternity Services

Where there are safeguarding concerns no baby will be discharged from the hospital until a safe discharge plan has been agreed with Children's Social Care. All details of the child protection plan / looked after plan will be documented in the electronic safeguarding children pro-forma and the relevant community midwife if not already aware, will be fully updated regarding the concerns and involvement of Children's Social Care.

It may at times be necessary to keep a baby in hospital (a place of safety) whilst Children's Social Care finalise the details of plans and attain an Interim Care Order (ICO). In some cases, it will be necessary for Children's Social Care to seek an Emergency Protection Order (EPO) or for a Police Protection Order (PPO) to be sought. Where mothers take the decision to leave the hospital before the relevant care order is in place, the baby will remain on the postnatal ward as a place of safety. In some cases when care proceedings are to be initiated post -delivery a police incident number will be sought /provided by Children's Social Care. The incident number would only be used if the police must be contacted because of an attempt to remove the baby from the hospital by the parents. The plan in the maternity services safeguarding children pro-forma must be followed, the social worker for the child must be informed of discharge and these actions must be documented. In most cases a Discharge Planning Meeting (DPM) will be held before mum and baby go home. The DPM should be attended by a midwife from the postnatal ward and the community midwife. Midwives should be able to provide information regarding observations of parenting whilst the mother and baby have been an inpatient. The ward should facilitate a private room for the DPM to take place in and suitable IT equipment if the meeting is taking place remotely.

Child Mental Health/Substance Misuse

CoCH staff must consider that abuse, neglect and exploitation can manifest in presentations whereby children and young people may present with a history of mental health issues, self-harm (including eating disorders), or threats of self-harm, and substance misuse as these behaviours may be indicative of a serious mental or emotional disturbance as a result of the child's distress. For all children under the age of 16 the Cheshire Self harm pathway MUST be followed. As well as following the clinical processes in relation to the presenting complaint, any additional safeguarding children issues must be notified to the CoCH Safeguarding team using the established notification process. This includes consideration of the need to refer to local substance misuse services.

Sexually Active Children

A child **under the age of 13** is not legally capable of consenting to sex (it is statutory rape) or any other type of sexual touching; Sexual activity in older children (i.e., from 13 to 18 years) needs to be considered in relation to both *the giving, and the getting of consent*, with the promotion of mutual negotiation as the norm being an important aspect of preventative activity (NSPCC, 2018). In cases of children aged 13 years or under who are sexually active these **must** be discussed with the CoCH safeguarding children team.

Sexual activity with a child under 16 is an offence. Staff have a responsibility to undertake an assessment of young people aged 13 to 15 years who are engaged in sexual activity following Fraser competencies guidelines (NSPCC, 2018), to determine the risk of sexual and other forms of exploitation or coercion including trafficking. This assessment will inform the decision-making process relating to the appropriateness of a referral to Children's Social Care and the Police. Risk assessment is a complex process and practitioners are encouraged to discuss concerns with a member of the Safeguarding Children Team whenever they are unsure about the appropriate course of action.

Those children aged 16 and 17 years may be viewed by health professionals and others as being of 'the age of consent' in terms of the Sexual Offences Act (2003), but this age group are particularly vulnerable to Child Exploitation being missed precisely because of the legalities of sexual consent in this age group (NSPCC, 2018).

It is an offence for a person to have a sexual relationship with a 16- or 17-year-old if they hold a position of trust or authority in relation to them.

Where sexual activity with a 16- or 17-year-old does not result in an offence being committed, it may still result in harm, or the likelihood of harm being suffered.

Non-consensual sex is rape whatever the age of the victim. If the victim is incapacitated through drink or drugs, or the victim or his or her family has been subject to violence or the threat of it, they cannot be considered to have given true consent and therefore offences may have been committed. No individual, whatever their age, can give consent in a situation where there is intoxication, duress, violence, power imbalances and/or vulnerabilities through age differences, learning difficulties or mental health issues. A child under 18 years of age cannot consent to their own abuse through exploitation (NSPCC, 2018). Any concerns must be discussed with the CoCH safeguarding team.

On occasion, staff maybe informed of an allegation of childhood historical sexual abuse. It needs to be acknowledged that it is very difficult for anyone to inform another person that they have been abused. However, it is important to establish if there are any current risks by who and to whom. Service users should be encouraged and supported to report the details of any historic abuse to the police. In all circumstance the CocH safeguarding team should be informed as they would need to consider whether further action in the best interest of others safety needs to happen without the consent of the service user. These cases can be complex, and it is important that advice and support is sought especially if it concerns a person in a position of trust.

Service users may need time to consider whether to report for various reasons, staff can revisit this at appropriate periods during therapy / interventions. Details of external agencies that specialise in

supporting people who are victims of historical sexual abuse such as the Cheshire Rape and Sexual Abuse Support Centre (RASASC) should be given. All decisions should be documented especially if the service user does not give any details of the alleged perpetrator as this may result in no referrals being made at that point in time.

Contextual Safeguarding and Child Exploitation

Children and young people may be vulnerable to neglect and abuse or exploitation from others outside of their family. These threats can take a variety of different forms, including: sexual, physical and emotional abuse; neglect; exploitation by criminal gangs and organised crime groups; trafficking; online abuse; sexual exploitation and the influences of extremism leading to radicalisation.

Contextual Safeguarding

Contextual Safeguarding is an approach to understanding, and responding to, young people's experiences of significant harm beyond their families. It recognises that the different relationships that young people form in their neighbourhoods, schools and online can feature violence and abuse. Parents and carers have little influence over these contexts, and young people's experiences of extra-familial abuse can undermine parent-child relationships. We need to develop new ways of working with young people who are at risk or are being exploited within the community. This can involve being exploited by adults or peers. Young people involved in contextual safeguarding can be both victims and perpetrators but should never be responsible for their own exploitation. For this reason we need to be able to respond to them through a child welfare model rather than through the criminal justice system

This may include:

- Child Sexual Exploitation (CSE)
- Online exploitation including sexting
- Criminal Exploitation
- Modern Day Slavery/child trafficking/unaccompanied asylum-seeking children
- Female Genital Mutilation
- Forced Marriage and Honour Killing
- Bullying

Child Sexual Exploitation

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. (DfE 2017).

Child Criminal Exploitation

Child Criminal Exploitation occurs where an individual or group takes advantage of a person under the age of 18 and may coerce, manipulate or deceive a child or young person under that age into any 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 and/or (c) Through violence or the threat of violence. The victim may be exploited even if the activity appears consensual (i.e. moving

drugs or the proceeds of drugs from one place to another). Child Criminal Exploitation does not always involve physical contact; it can also occur through the use of technology. (Home Office 2018)

County Lines

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

In all cases where staff have concerns regarding a young person who may be suspected of being at risk of exploitation the young person must be discussed with the CoCH safeguarding team. If a child discloses, they may be at risk of child exploitation a risk assessment tool which staff should be aware of and where appropriate should be used with the young person. These can be found on the Safeguarding and Complex Care intranet page.

In all cases where CoCH staff are concerned that a child could be at risk from CE**, a CE risk screening tool should be completed, this is available on the SCP website and can also be accessed on the safeguarding intranet page. This tool is a list of questions that can be completed with or without the child being present.** Contact the CoCH safeguarding team for further guidance.

Harmful Sexual Behaviour Amongst Children and Young people

"One or more children engaging in sexual discussions or acts that are inappropriate for their age or stage of development. These can range from using sexually explicit words and phrases to full penetrative sex with other children or adults.' (NSPCC 2016).

The CoCH Safeguarding Team must be contacted if a child or young person displays sexualised behaviour that is not appropriate for their age or developmental stage. Possible signs include using sexualised language such as adult slang to talk about sex sexualised behaviour such as sexting or sharing and sending sexual images using mobile or online technology, viewing pornography that is inappropriate for age and developmental status.

Honour Based Violence and Abuse

"A crime that is or has been justified or explained (or mitigated) by the perpetrator of that crime on the ground that it was committed as a consequence of the need to defend or protect the honour of the family (European Parliamentary Assembly 2003)."

Honour Violence is an increasingly alarming issue. Young people under the age of 18yrs have been victims. This is a cultural and not religious issue and must be taken seriously. If a child (anyone under the 18) discloses or appears to be under the threat of honour violence, they are potentially at risk of serious and fatal harm even from their parents and close family members. This is a safeguarding children issue and must be discussed with Children Social Care and the Police urgently. Staff must remember that the risk is likely to be posed by close family members including parents.

For further advice concerning forced marriage issues contact **KARMA NIRVANA on Tel: 01 I&S I&S** (the staff here are experts in these issues). **The forced marriage unit can also be contacted on 0207 008 0151 or emergency duty officer on 0207 008 1500** (the staff here are experts in these issues). A referral must be made to The CoCH safeguarding team for these cases.

Modern Slavery and Human Trafficking

Human trafficking and modern slavery involve men, women or children being brought into a situation of exploitation through the use of violence, deception or coercion and forced to work against their will. People can be trafficked for many different forms of exploitation such as forced prostitution, forced labour, forced begging, and forced criminality, domestic servitude, forced marriage, forced organ removal.

It is important to note that when children are trafficked, no violence, deception or coercion needs to be involved: simply bringing them into exploitative conditions constitutes trafficking.

Modern slavery, including child trafficking, is child abuse. If a staff member encounters a child who may have been exploited or trafficked, they must contact the CoCH Safeguarding team for further advice as Children's Social Care and the Police should be notified.

All children, irrespective of their immigration status, are entitled to safeguarding and protection under UK law. When there is reason to believe a victim of trafficking or modern slavery could be a child, the individual must be given the benefit of the doubt and treated as a child until an assessment is carried out.
Further information can also be found following the links below:

https://www.gov.uk/government/publications/identifying-and-supporting-victims-of-human-trafficking-guidance-for-health-staff

Victims may show signs of physical or psychological abuse, look malnourished, unkempt, withdrawn

- May seem under control of others, not travel alone, rarely interact or appear unfamiliar with the neighbourhood
- May be living in dirty cramped conditions
- May have no identification documents, few personal possessions, wear the same clothes everyday
- May have to be dropped of or picked up for work on a regular basis either very early or late at night
- May appear frightened or hesitant to talk, avoid eye contact

You must contact the safeguarding and complex care team if you have any concerns

Children at risk of Radicalisation (PREVENT)

The Prevent Strategy (Home Office, 2011) defines the term 'radicalisation' as "the process by which a person comes to support terrorism and forms of extremism, leading to terrorism".

Prevent is aimed at front line staff and is designed to help make staff aware of their role in preventing vulnerable people being exploited for terrorist purposes.

The Counter Terrorism and Security Act (2015) places a duty on a range of organisations to have due regard to the need to prevent people of all ages being drawn into terrorism.
If a staff member has concerns that a child may have been radicalised or is at risk of radicalisation, staff must contact the CoCH Safeguarding team where a Prevent referral can be advised and made

to the channel panel meeting. CoCH staff attend and present appropriate information to Channel Panel. The safeguarding team attend Channel Panel. It is therefore vitally important that all cases are therefore discussed with the safeguarding team.

Appendix 8 outlines the Prevent pathway that trust staff are required to follow.

The Prevent referral process can be described in three stages: notice, check and share.

- **Notice**: staff must be aware of an individual's vulnerability to radicalisation, changes in behaviour, ideology and other forms of extremism.
- **Check** out your concerns with the individual where possible, and where safe, with your line manager, colleagues and multi-disciplinary clinical meetings.
- **Checking out your concerns** with the CoCH Safeguarding Team will help to ensure a proportionate response to the concerns.
- **Share** your concerns with partner agencies, and as far as possible be open and honest with the individual about the duty to share your concerns.
- Further information regarding the PREVENT Strategy and guidance can be found via the following link:

https://www.gov.uk/government/publications/prevent-duty-guidance

Children Living with Domestic Abuse

Domestic abuse can be a source of significant harm to children in the following way:

- Emotional harm through witnessing or hearing the abuse of another.
- Risk of physical harm if they intervene to protect a parent / carer or if a parent/carer is assaulted whilst holding the child.
- Children could be neglected due to impaired parenting capacity of the parent/carer due to domestic abuse issues.

Domestic abuse can include physical assault, sexual abuse, psychological abuse and financial exploitation. Anyone in society can suffer from this type of abuse, regardless of their age, gender sexual orientation, financial position, culture or beliefs. The abuse may be from someone they are currently in a relationship with or have previously had a relationship with. This includes abuse from family members (family members are defined as mother, father son, daughter, brother, sister and grandparents whether directly related, in-laws or stepfamily) as well as opposite and same sex partners. Whatever form the abuse takes, it is rarely a one-off incident. It usually forms a pattern of coercive and controlling behaviour with which the abuser seeks power over the victim. Controlling or coercive behaviour in an intimate or family relationship is an offence (Section 76. Serious Crime Act 2015).

CoCH staff are in a unique position in that they may be the only professional involved with a victim or child who is in a domestic abuse situation. During the care / treatment episode they should ensure they see the person at least once on their own for the individual to be asked about abuse and given the opportunity to discuss and/or to make a disclosure. Questions relating to abuse should never be asked in the presence of a potential perpetrator or in front of children aged 2 years plus.

A Domestic Abuse Stalking and harassment Risk Indicator Checklist (RIC) will need to be completed to assess if the incident meets the requirements to be referred to Multi Agency Risk Assessment

Conference (MARAC). The RIC can be accessed through CoCH intranet Safeguarding pages and there is a domestic abuse flow chart on the front page. All clinical staff should be familiar with the RIC and have it readily available for its use especially when working in community settings.

Incidents of domestic abuse should be reported the same day to the Safeguarding and Complex Care Team. The team has an Independent Domestic Violence Advocate who can support the victim and further assess and support their needs.

Where there are children involved, consideration should be given as to whether the incident also warrants a social care referral as the two processes should run concurrently if required. Further support can be provided by the safeguarding team.

See also CoCH Domestic Abuse Policy

Fabricated or Induced Illness / Perplexing Presentation

These cases are complex and difficult to identify, and individual suspected cases typically require immense consideration and discussion before they are to be regarded in child protection terms. There are 3 main ways of fabricating or inducing illness in a child

- Fabrication of signs and symptoms, this may include fabrication of past medical history
- Fabrication of signs and symptoms and falsification of hospital charts and records, and specimens of bodily fluids, this may also include falsification of letters and documents
- Induction of illness by a variety of means

The characteristics of fabricated or induced illness are a lack of the usual corroboration of findings with symptoms or signs, or – in circumstances of proven organic illness – lack of the usual response to proven effective treatments. An in-depth assessment of the child's development and developmental history, medical evaluation and an assessment of the child and family will be required to make sense of the underlying reasons for the signs and symptoms.

When a possible explanation for the symptoms suffered by a child is that it appears to be a perplexing presentation or that it may have been fabricated or induced by a parent or carer and therefore the child's health or development is or is likely to be impaired, the case MUST be discussed with the Named Doctor for Safeguarding or the CoCH safeguarding team.

Parents should not initially be informed of any discussions held. Decisions about what the parents will be told, by whom and when must be made in agreement with the agencies involved

The CoCH Named doctor for Safeguarding Children and the CoCH Safeguarding Children Team must be notified of all suspected cases.

Current guidance can be found on the link in appendix 9.

Children and E-Safety

CoCH recognises that electronic communications - via mobile phones, internet resources such as social networking sites, and email - play a very significant role in the lives of children and young

people. Their use, however, is not always safe; electronic media can be involved in the victimisation and abuse of children.

Practitioners should remain vigilant to the risks associated with E-safety and children and discuss any concerns that they feel puts the child at risk with either their manager or a member of the safeguarding team

Disabled children

Disabled children are 3 times more likely to be abused because they may

- have fewer outside contacts than other children?
- receive intimate personal care from a number of carers
- have impaired capacity to resist or avoid abuse
- have communication difficulties, and the child may be inhibited about complaining for fear of losing services and support
- be more vulnerable to "bullying" and "intimidation" from their peers.

All staff working with disabled children must be mindful of the potential increased risk of abuse they face. All staff working with children 16 and over must ensure that where the child lacks capacity to make decisions, the management of this will be governed via the Mental Health Capacity Act.

Children at Risk of or who have suffered from Female Genital Mutilation (FGM)

Female Genital Mutilation (FGM) is defined by the World Health Organisation as: 'all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons. FGM is sometimes also known as female genital cutting or female circumcision.

The FGM mandatory reporting duty is a legal duty provided for in the FGM Act, 2003 (as amended by the Serious Crime Act, 2015) which requires all regulated healthcare professionals to report FGM in a girl under 18, either through disclosure by the victim or relative and/or are visually confirmed. This is no different from any other obligation on healthcare professionals to report abuse against children.

Appendix 10 includes the FGM reporting duty flowchart and further information regarding FGM.
FGM comprises of all procedures involving the partial or total removal of the female external genitalia or other injury to the female genital organs for non-medical reasons. There are four types of FGM, ranging from a symbolic prick to the vagina to the extensive removal and narrowing of the vagina opening. In the UK all forms of FGM are prevalent. All health professionals must remain vigilant to this potential issue, if direct female adult members have been subject to these procedures the risk of children associated to them is significantly increased.

If a child is suspected to be at risk or has undergone FGM, professionals are required to discuss the case with the Safeguarding Children team immediately or follow the 'what to do if you're worried a child is being abused' (appendix 3). Further information on FGM can be found on the following

webpage: www.gov.uk/government/publications/multi-agency-statutory-guidance-on-female-genital-mutilation

If CoCH staff have any reason to suspect that a child may be at risk of FGM, (midwives or Obstetricians) has been practiced on a woman to whom they are delivering care, they should be aware that this could increase the risks to any other girls in the family. Similarly paediatric staff may become aware that a child they are having contact with may be at risk or the child may disclose that they are being prepared for "special procedure". The parents in most cases believe that this act is in their daughters' best interests and do not intend this to be an act of abuse, however the Local Authority Children's Social Care is likely to treat a case of suspected imminent FGM as a child protection matter and may seek Emergency Protection Measures. **If CoCH staff have any concerns about a child they have contact with, they must discuss with the CoCH Safeguarding Children Team/ Consultant Paediatrician and / or Children's Social Care.**

Forced Marriage

Forced marriage is a marriage conducted without the valid consent of one or both parties. The UK Government regard forced marriage as an abuse of human rights and a form of domestic abuse and, where it affects children and young people, child abuse (HM Government, 2014).

Forcing a child into marriage is a safeguarding children issue. Therefore, if any child or young person under the age of 18 years attending CoCH services discloses concerns that this is going to happen to them, urgent advice should be sought from Children's Social Care. The child should be spoken to ALONE, and staff should NOT attempt to mediate with the parents / carers / siblings as this may increase the risks of threats to the child.

Each organisation has a named professional for Forced Marriage issues, for CoCH this is the Named Nurse for Safeguarding. If a professional is concerned about a forced marriage issue, then they should contact the Safeguarding Team or if urgent Children's Social care.

Further information can be sought from the Foreign and Commonwealth Office website, accessed via the following link: https://www.cps.gov.uk/legal-guidance/honour-based-violence-and-forced-marriage

Young Carers

A young carer is a young person under the age of eighteen who has a responsibility for caring on a regular basis for a relative (or very occasionally a friend) who has an illness or disability. This can be primary or secondary caring and leads to a variety of losses for the young person.
All professionals in contact with young carers should consider if they need support services.
The extent and effect of their caring responsibilities may satisfy the criteria for Children in Need or Early Help Services (particularly where a child is unlikely to achieve or maintain a reasonable standard of health or development because of their caring responsibilities).

Unless there is reason to believe that it would put the child at risk, young carers should be told if there is a need to make a referral, in order that their trust in a worker is retained. If possible, the young carers consent should be sought through a discussion of why the referral must be made and the possible outcomes.

Private Fostering

This is where a child under the age of 16yrs (18yrs if disabled) is fostered under a private fostering arrangement (without the involvement of the Local Authority Children's Social Care), by someone other than a parent or close family relative for more than 28 days or more in the carers own home. Privately fostered children are a diverse, potentially vulnerable group, e.g. they may be in this situation because of parental ill health or distress, they may stay with friends because they have fallen out with their parents and may not be accessing education, or they may be children from overseas whose parents do not reside in this country. CoCH staff have a duty to inform the Local Authority Children's Social Care if they become aware of a private fostering arrangement and are not satisfied that the local authority is/or will otherwise be made aware. Seek advice from the CoCH safeguarding Children team and/or Children's Social Care if in doubt. The Local Authority has a statutory duty to satisfy itself that the private fostering arrangement is in the child's best interests.

SECTION FIVE: SUPPORTING STAFF AND VOICING CONCERNS

Escalation and Resolution

What is an escalation/ professional disagreement? If you feel that a practitioner or an agency is not acting in the best interests of the child, young person, or family, you have a responsibility to respectfully challenge the practitioner or agency and escalate your concerns.

When would you escalate? When working with practitioners from other agencies there may at times be differences in opinions or concerns about professional practice in relation to a child, young person or family.

If you feel that a practitioner or an agency is not acting in the best interests of the child, young person or family, you have a responsibility to respectfully challenge the practitioner or agency, and escalate that concern if resolution is not achieved.

(SCP Resolution Pathway and Escalation Policy 2016) If at any point a member of CoCH staff feels that their concerns about a child are not being acted upon appropriately they must discuss this with the safeguarding team who will take responsibility for ensuring the case is appropriately managed within the CoCH. If the safeguarding team are concerned that concerns about a child are not being managed appropriately by a partner agency and or Children's Social Care the SCP Resolution Pathway / Escalation Pathway will be implemented (appendix 11)

The Trust will support staff as part of its commitment in the implementation of this policy; the range of support available can be reviewed in the Supporting Staff Policy. Safeguarding children's issues may be stressful for staff who need to empathise with victims and carers, confront abuse issues, resolve conflict and establish support and protection. It is important that the impact on staff is recognised and that they have appropriate opportunities for support through management or clinical supervision. If necessary, it should be possible to offer access to confidential independent counselling. This can be accessed via the Occupational Health Department.

Speak Out Safely (Raising Concerns about Patient Care) and Whistle Blowing Policy

It is the responsibility of all members of staff, medical, clinical or non- clinical, to ensure that high standards of care, treatment and services are provided at all times for patients and that all patients are **safely** in our care. From time to time, staff may have concerns about the care or treatment given to any patient(s), including **children and young people**, and may wish to discuss these with managers. All concerns raised by staff about patient care will be dealt with seriously, promptly, and be subject to a thorough and impartial investigation where necessary. Managers have a particular responsibility to protect patients, and to handle concerns about their care in a way that will encourage the voicing of genuine misgivings, while at the same time protecting staff against unfounded allegations. No recriminations will follow reports which are made in good faith about low standards of care or possible abuses. All staff must comply with the Trust Values and put patients at the heart of everything they do

Information sharing for Safeguarding Children

The purpose of this section is to assist practitioners in understanding when, why, and how, they should share information and should be read in conjunction with H M Government (2018) information sharing guidance that can be accessed via the following link:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/721581/Information_sharing_advice_practitioners_safeguarding_services.pdf

Effective sharing of information between practitioners and local organisations and agencies is essential for early identification of need, assessment, and service provision to keep children safe. Child Safeguarding Practice Reviews (CSPRs) 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.

Practitioners should be alert to sharing important information about any adults with whom that child has contact, which may impact the child's safety or welfare. 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.

Practitioners should not assume that someone else will pass on information that they think may be critical to keeping a child safe. If a practitioner has concerns about a child's welfare and considers that they may be a child in need or that the child has suffered or is likely to suffer significant harm, then they should share the information with relevant agencies.

Practitioners should aim to gain consent to share information but should be mindful of situations where to do so would place a child at increased risk of harm. Information may be shared **without** consent if a practitioner has reason to believe that there is good reason to do so. When decisions are made to withhold information, the rationale for this must be clearly documented. Such circumstances include:

- To prevent significant harm arising to children including through the prevention, detection and prosecution of serious crime likely to cause significant harm to a child or young person.
- If there is a justifiable cause to believe a health, social care, other professional or member of the public is at risk.

- If it would alert the perpetrator for example in cases of sexual abuse or fabricated and induced illness.

Practitioners must have due regard to the relevant data protection principles which allow them to share personal information, as provided for in the Data Protection Act 2018 and the General Data Protection Regulation (GDPR). To share information effectively all practitioners should be confident of the processing conditions under the Data Protection Act 2018 and the GDPR which allow them to store and share information for safeguarding purposes, including information, which is sensitive and personal, and should be treated as 'special category personal data'.

Practitioners who need to share special category personal data, should be aware that the Data Protection Act 2018 contains 'safeguarding of children and individuals at risk' as a processing condition that allows practitioners to share information. This includes allowing practitioners to share information without consent, if it is not possible to gain consent, it cannot be reasonably expected that a practitioner gains consent, or if to gain consent would place a child at risk.

Staff must ensure that the reasons for decisions to share, or not share information are fully recorded in records.

Decisions' regarding the sharing of information requires a professional and informed judgment. Therefore, if an individual is in doubt, this should be discussed with a member of the CoCH Safeguarding team, their line manager or CoCH's Caldicot Guardian.

If after discharge, information comes to light about any patient /client that might impact on the safety of any child, then that information should be shared with any relevant professional as well as the GP involved in the care of the parent or child.

Practitioners should be proactive in sharing information as early as possible to help identify, assess, and respond to risks or concerns about the safety and welfare of children, whether this is when problems are first emerging, or where a child is already known to local authority children's social care (e.g., they are being supported as a child in need or have a child protection plan).

Appendix 13 provides further information regarding this area.

Requests for Interviews and statements

Requests for interviews or statements should be discussed with the Trust Named Professionals. Interviews and statements involving non-medical staff are to be conducted in the presence of the Named Trust Staff or Trust Legal Representative. Medical staff should inform the responsible Consultant before giving interviews and the Trust Named Doctor for Safeguarding Children could be present if desired. Interviews should be arranged by appointment and ad hoc requests will only be granted if adequate Trust representation can be provided. **Any requests for copies of Trust documents must be processed through the Executive / Trust Legal Department**. Any Subpoena's to appear in court, should be notified to the Trust Named Professionals for Safeguarding Children and the Trust Legal Department.

Notification of Safeguarding Children to the Executive Management Team

The Associate Director for Nursing (Safeguarding) and supported by the Trust Named Staff for Safeguarding Children will provide a comprehensive annual report to the Trust Safeguarding

Strategy Board. Feedback of relevant issues from the Local Safeguarding Children Partnership will be circulated through the Executive Lead for Safeguarding Children.

Safeguarding Children Clinical Supervision

All staff involved in Safeguarding children/child protection cases will receive formal supervision from members of the Trust Safeguarding Children Team. The safeguarding team will receive supervision from the Designated or Named Professionals. This may be a combination of (as/when required)) and formal supervision meetings. All supervision will be recorded. Please see the CoCH Safeguarding Children Clinical Supervision policy (2018) available in the Document Library.

COCH Safeguarding Children Training Programme

See Appendix 12

Managing Safeguarding Children Allegations against Staff

The framework for managing allegations against people in the Trust is set out in Working Together to Safeguard Children (2018). The framework applies to all staff who work with children and young people to ensure appropriate actions are taken to manage allegations, regardless of whether they are made in connection to duties within CoCH or if they fall outside of this such as in their private life. An allegation may relate to a person who works with children who has:

- behaved in a way that has harmed, or may have harmed, a child
- possibly committed a criminal offence against, or related to, a child
- behaved in a way that indicates s/he is unsuitable to work with children

It is essential that any allegation of abuse made against a person is dealt with consistently, fairly, quickly and in a way that provides effective protection for the child and at the same time supports the person who is the subject of the allegation. All safeguarding allegations or concerns about a member of staff or volunteer should be discussed timely with the Associate Director for Safeguarding or the Named Nurse for Safeguarding Children. A referral to these personnel should not be delayed in order to gather information and a failure to report an allegation or concern in accordance with procedures is a potential disciplinary matter.

It is the role of the Associate Director for Safeguarding (or an appropriate deputy) in conjunction with the Human Resources Manager and the line manager of the person who the allegation is against to:

- Ensure that a child who has been harmed or who is at risk of harm has been reported in accordance with statutory safeguarding procedures. The Associate Director of Nursing for Safeguarding (or an appropriate deputy) will refer to the Local Authority Designated Officer (LADO). The LADO is responsible for the management and oversight of individual cases and must be informed of all allegations or concerns relating to staff or volunteers that fit the criteria above.
- Work in conjunction with the Human Resources Manager allocated to the case where investigation and/or potential disciplinary action is required, in accordance with the Trust disciplinary policy and procedure.
- Attend Strategy Meetings where required (or via a nominated representative).
- Ensure that risk assessments are undertaken where and when required.
- Oversee the gathering of any additional information which may have a bearing on the allegation, for instance previous concerns
- Co-ordinate the provision of reports and information as required.

- Ensures relevant support mechanisms are in place for employees against whom an allegation of abuse has been made, for example counselling & occupational health. In line with Human Resources policies
- Liaise with the Communication and Engagement team in the event/risk to manage potential media interest
- Establish whether there are any lessons to be learned arising from the allegation that may have wider implications for safeguarding procedures for all agencies concerned.

Child Safeguarding Practice Reviews (CSPR)

A decision whether to conduct a **Child Safeguarding Practice Review**, in Wales this process is referred to as a Child Protection Review (CPR) will be taken by local Safeguarding Partners where a child has been seriously or fatally injured and abuse or neglect was suspected, and where there are concerns about how the agencies involved with the child/family were working together. On receipt of a formal notification of a CPSR, the Executive Lead for safeguarding children will be informed. Once the final CSPR report is finalised by the Safeguarding Children Partnership a further meeting will take place with the CoCH Executive Lead to discuss and agree the action plan. The actions will be implemented as soon as possible CoCH Standard Operational Procedure (SOP). The completed action plan will be received by the Quality, Safety and Patient Experience Committee (QUSPEC). The Trust Board will be kept up to date regarding all on-going cases via the quarterly meetings of the CoCH Safeguarding Strategy Board

SECTON SIX: SUDDEN UNEXPECTED DEATHS IN INFANCY (SUDIC) AND CHILDREN

Definition

The sudden and unexpected death (unexpected in the 24 hrs prior to the death) of a child under the age of 24 months irrespective of the place of death

- At home or in the community
- In the hospital emergency department or ward

A SUDIC should be managed in accordance with the SUDIC guidelines please see the Cheshire West and Chester Local Safeguarding Children Board Manual of procedures (available on the **(CoCH intranet).** Please note the coroner will have jurisdiction over the death and adherence to the protocol will be under public scrutiny at any inquest.

Child Death Overview Panel (CDOP)

The overall purpose of the child death review process is to understand why children die and put in place interventions to protect other children and try to prevent future deaths. More details can be found in the Trust Child Death Overview Policy.

SECTION SEVEN: MONITORING OF THIS POLICY

All polices will be monitored via incidents reported on the Trust risk management system and reviewed at the appropriate incident review group. Compliance with this policy and the Trust safeguarding children training programme will be reviewed via the Trust Safeguarding children audit plan.

Any results from incident reviews or audits will be used to review the current policy.

The annual safeguarding children report will be presented to the CoCH Safeguarding Strategy Board and the Trust Quality Committee.

REFERENCES

Adoption & Children Act DOH (2002)
A Call to End Violence against Women and Girls HM Government Action Plan (2013)
All Babies Count: Prevention & Protection for Vulnerable Babies (NSPCC 2011)
All Wales Child Protection Procedures (WAG) (2008)
Cheshire West and Chester Local Safeguarding Children Board
Child Protection – a toolkit for Doctors (BMA May 2009)
Children Act DOH (1989)
Children Act DOH (2004) Section 10 Every Child Matters, S11 Duty to Cooperate
Children and Family Act 2014
Children and Social Care Act 2017
Counter Terrorism and Security Act 2015
DOH Sexual Offences Act (2003)
Domestic Violence, Crime & Victims Act 2004
Fraser Guidelines Victoria Gillick v West Norfolk and Wisbech Area Health Authority, House of Lords (1985)
Female Genital Mutilation Risk and Safeguarding: Guidance for Professionals DoH (2015)
Female Genital Mutilation Act: HMG (2003)
Hill Dickinson (2007) November Healthcare Update
"How safe are our children" NSPCC (2013)
Human Rights Act (1998)
Keeping Children Safe (Government response to the Victoria Climbie enquiry) DOH (2003)
NICE: Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively (2014)
NICE: Pregnancy & Complex Social Factors CG110 (2010)
NICE: Antenatal Care for the Healthy Pregnant Woman CG62 (DA) (2003)
NICE: Antenatal & Postnatal Mental Health CG45 (2007)
NICE: *When to suspect child maltreatment (2014)*
NICE: Harmful sexual behaviour among children and young people NG 55 (2016)
Modern Slavery Act 2015
Safeguarding Disabled Children-Practice Guidance DCSF (2009)
Safeguarding Children, A review of arrangements in the NHS for safeguarding children, Care Quality Commission (2009)
Safeguarding Children: Roles and Competences for Health Care Staff, Intercollegiate Document, (2014)
SCR "Child A" Haringey SCP March 2009 (Published 2010 DFE)
Standards for radiological investigations of suspected non-accidental injury, RCR, RCPCH (2008)
Safeguarding C&YP from sexual exploitation HMG (2009)

Tackling FGM in the UK Intercollegiate recommendations for identifying, recording and reporting (2013)

The National Assembly for Wales (2002) Carlisle review

The Protection of Children in England: A progress report; the Lord Laming, (2009) 58 recommendations, Laming also urged Health Secretary Alan Johnson to address the ***"wariness" of healthcare staff to get involved in child protection work***

Working Together to Safeguard Children (HMG 2018)

Associated Documents:

CoCH Domestic Abuse Policy

COCH Missing Child Policy

CoCH Paediatric WNB Policy

Child Death Overview Panel procedures

Safeguarding Children Clinical Supervision Policy

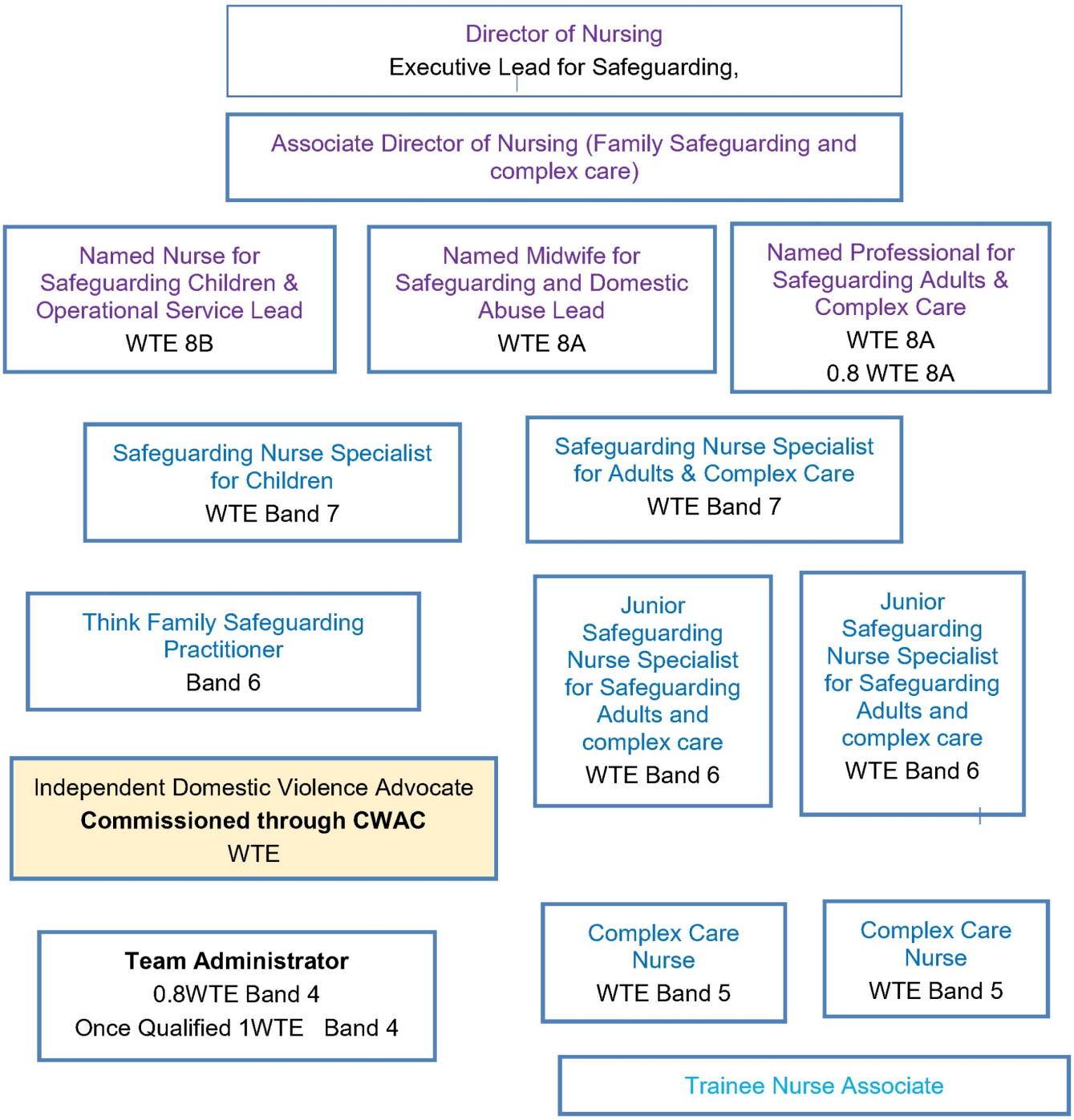
CoCH SCR SOP – no copy on SharePoint for this

Relevant HR Policies

GLOSSARY

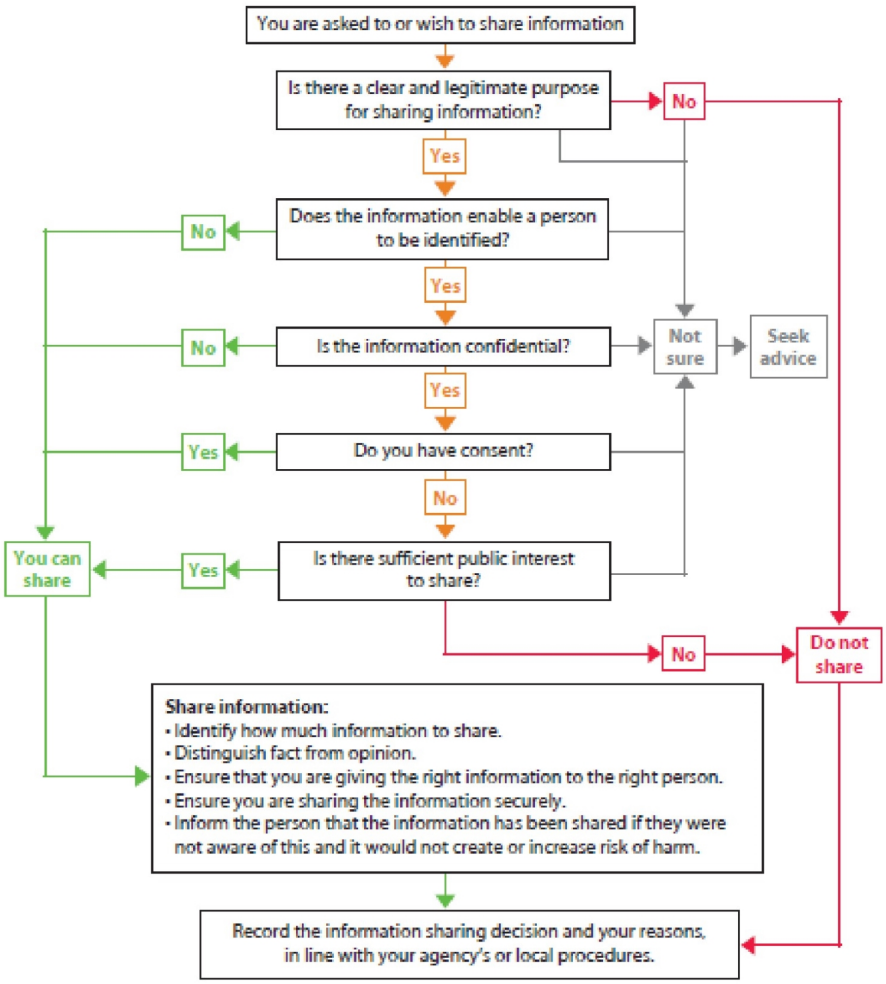
CCE	Child Criminal Exploitation
CSC	Children's Social Care
CoCH	Countess of Chester Hospital
CP-IS	Child Protection Information System (England only)
CSE	Child Sexual Exploitation
CWAC	Cheshire West and Chester Local Authority
ED	Emergency Department
EDT	Emergency Duty Team
IDVA	Independent Domestic Violence Advocate
MARF	Multi agency Referral Form
WNB	Was Not Brought
PBRA	Pre-Birth Risk assessment
SCP	Safeguarding Children Partnership

APPENDIX 1: CURRENT SAFEGUARDING AND COMPLEX CARE ORGANISATIONAL CHART



HM Government

Flowchart of key questions for information sharing



If there are concerns that a child may be at risk of significant harm or an adult may be at risk of serious harm, then follow the relevant procedures without delay.

Seek advice if you are not sure what to do at any stage and ensure that the outcome of the discussion is recorded.

Local contacts

Extract from HM Government *Information Sharing: Guidance for practitioners and managers.*
Copies can be obtained from **www.ecm.gov.uk/informationsharing**