Blackpool Teaching Hospitals
NHS Foundation Trust

Safeguarding Children Guidance and Procedures (Includes Child Protection Supervision procedures)

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This must be completed and form part of the document appendices each time the document is updated and approved

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Consultation / Acknowledgements with Stakeholders		
Name	**Designation**	**Date Response Received**
	Safeguarding Named Professionals Meeting	
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Angela Mason	Paediatric Advanced Nurse Practitioner	07/11/2019
Lynne Mackinnon	Family Nurse Partnership	04/11/2019
Lorraine Sanderson	Paediatric Ambulatory Care Sister	07/11/2019
Lisa Elliott	Specialist Midwife Substance Misuse/Named Midwife for Safeguarding	08/11/2019
Natasha Watkin-Lewis	Business Manager Safeguarding team	15/11/2019

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1 Introduction / Purpose

The purpose of this policy is to:

- Ensure that all staff are aware of their duties in relation to safeguarding children.
- Ensure staff are aware of what constitutes child abuse and have a recognition of the key indicators.
- Ensure all professionals understand the importance of sharing appropriate information in a timely manner and the need to discuss their concerns with colleagues and other agencies as appropriate.
- Provide guidance on what to do if a staff member has concerns about a child's welfare, who to contact for advice and support and how to make a referral to Children's Services
- Set out the training and supervision requirements for staff.

2 General Principles / Target Audience

The policy applies to all staff working for Blackpool Teaching Hospital NHS Foundation Trust (the Trust) or working under the auspices of the Trust including voluntary and agency staff and those on student placement.

3 Definitions and Abbreviations

ANO	Agency Nominated Officer
BTHNHSFT	Blackpool Teaching Hospital Foundation Trust
CAF	Common Assessment Framework
CAFCAS	Child and Family Court Advisory Service
CAMHS	Children and Adolescent Mental Health Service
CCGs	Clinical commissioning groups
CDOP	Child Death Overview Panel
CIS	Children Integrated Services
CLA	Children Looked After
CORP	Corporate
CSAP	Child Safeguarding assurance Partnership
CSC	children's social care
CSE	Child Sexual Exploitation
CSPR	Child Safeguarding Practice Review
CYPA	Children and Young Persons Act 1969
DDCP	Designated Doctor Child Protection
DNA	Did not Attend
DNCP	Designated Nurse Child Protection
DH	Department of Health
FII	Fabricated and Induced Illness
FNP	Family Nurse Partnership Team
GP	General Practitioner
HV	Health Visitor
IMR	Internal Management Review

LASCA	Lancashire and South Cumbria Agency
LP	Lead Professional
MARAC	Multi-Agency Risk Assessment Conference
MASH	Multi-Agency Safeguarding Hub
NHS	National Health Services
NN	Named Nurse
PPU	Public Protection Unit (Lancashire Constabulary)
PR	Parental Responsibility
PSRF's	Police Safeguarding Referral Form
SCR	Serious Case Review
SIO	Safeguarding Investigation Officer
SN	School Nurse
SUDC	Sudden Unexpected Death of Children

4 Responsibilities (Ownership and Accountability)

Health professionals are in a strong position to identify welfare needs or safeguarding concerns regarding individual children and where appropriate, provide support. This includes understanding strengths & risk factors, communicating effectively with children and families, liaising with other agencies, assessing needs and capacity, responding to those needs and contributing to multi-agency assessments and reviews. Section 11 of the Children Act 2004 places duties on a range of organisations and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children.

Health professionals and organisations have a key role to play in actively promoting the health and well-being of children.

4.1 Chief Executive

The Chief Executive has a statutory responsibility for ensuring that the health contribution to safeguarding and promoting the welfare of children is discharged effectively through the services provided by the Trust.

4.2 Head of Safeguarding responsibilities include:

- Providing a strategic lead for safeguarding across the organisation and the provision of support to enable the corporate and operational responsibilities for safeguarding are met.
- Leading the organisation to understand and embed learning from Child Safeguarding Practice Reviews (CSPR).
- Ensure Trust staff are aware of their responsibilities across the safeguarding agenda and receive appropriate training, supervision and support in carrying out these responsibilities.
- Be accountable for safeguarding standards and advise the Director of Nursing and appropriate Divisional teams on safeguarding concerns

- Working collaboratively with partner organisations to grow business and ensure that the health economy is an equal partner in all safeguarding delivery
- Attending the Blackburn with Darwen, Blackpool and Lancashire Child Safeguarding Assurance Panel (CSAP).

4.3 Named Professionals responsibilities include:

- Providing a vital source of professional advice on safeguarding and child protection matters to health professionals and links with partner agencies. promote good professional practice which safeguards and promotes the welfare of children and their families.
- Providing supervision and support to promote good professional practice which safeguards and promotes the welfare of children and their families.
- Promoting, influencing, developing and delivering the safeguarding training strategy.
- Supporting the Trust in its clinical governance role by ensuring safeguarding issues are part of the governance system.
- Contribute to reviews undertaken by the CSAP including CSPR's.
- Working together with other organisations, in accordance with CSAP guidance, to provide a rapid and coordinated response in the event of sudden and unexpected child death.

4.4 All Managers responsibilities include:

- Ensuring that all staff are made aware of their roles and responsibilities in relation to this policy
- Ensuring that all staff have read the policy and are aware of what actions they need to take
- Ensuring all staff they manage, attend the mandatory safeguarding training and clinical / safeguarding supervision and review this annually through the appraisal process.
- Releasing staff for safeguarding meetings and arrange cover to facilitate attendance.

4.5 Individual responsibilities include:

- All staff should actively safeguard and promote the welfare of children and understand risks of abuse to both children and the unborn child.
- Identify emerging problems and to share information with other professionals to support early identification and assessment. Including the needs of parents who may need extra help.
- Understand the strengths & risk factors to recognise children in need of support and/or safeguarding through accessing appropriate training.

- Contribute to enquiries from other professionals/ agencies about children and their family or carers;
- Assess, plan and respond to the needs of children and their families and understand the capacity of parents/carers to meet their children's needs
- Contribute to child protection conferences, and strategy discussions; playing an active part through the child protection plan and providing a written report.
- Contribute to CSPR's and the learning identified
- Actively seek and participate in child protection supervision.

5 Procedure

5.1 Introduction

Working Together 2018 covers the legislative requirements and expectations on individual services to promote the welfare of children. Working Together is informed by the requirements of the Children Act 1989 & 2004, which provides a comprehensive framework for the care and protection of children.

This document sets out how the Trust will work to safeguard and promote the welfare of children. There is a need for a shared responsibility and effective joint working between agencies and professionals that have different roles and expertise if children are to be protected from harm and their welfare promoted. The Blackburn with Darwen, Blackpool and Lancashire Children's Safeguarding Assurance Partnership (CSAP) is the key statutory mechanism for agreeing locally how relevant organisations will co-operate to safeguard and promote the welfare of children.

No single professional can have a full picture of a child's needs and circumstances; if children and families are to receive appropriate help at the right time, everyone who comes into contact with them has a role to play in identifying concerns, putting children at the centre, sharing information, working together with a child centred approach and taking suitable action.

5.2 Definitions:

A Child: (In this document, as in the Children Act, 1989 and 2004), is anyone who has not yet reached their 18th birthday. The fact that a child has reached 16 years of age, is living independently or is in further education, is a member of the armed forces, is in hospital or in custody in the secure estate for children and young people, does not change his/her status or entitlement to services or protection under the Children Act, 1989.

Safeguarding and promoting the welfare of children is defined (in Working Together 2018) as:

- Protecting children from maltreatment.
- Preventing impairment of children's health or development.

- Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care.

Child Protection is part of safeguarding and promoting welfare and refers to the activity which is undertaken to protect specific children who are suffering or are likely to suffer significant harm.

5.2.1 Definition of types of abuse

Emotional Abuse is the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to a child that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may include not giving the child opportunities to express their views, deliberately silencing them or 'making fun' of what they say or how they communicate. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond a child's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction.

It may involve seeing or hearing the ill-treatment of another as in Domestic Abuse. 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.

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

- provide adequate food, clothing and shelter (including exclusion from home or abandonment);
- protect a child from physical and emotional harm or danger;
- ensure adequate supervision (including the use of inadequate care-givers); or
- ensure access to appropriate medical care or treatment.

It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

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 in non-mobile babies and injuries must be considered as possible subjects of non-accidental injury and referred for immediate paediatric assessment (non-mobile children include very young children or children of any age with motor development delays or physical disabilities that restrict mobility).

Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening.

The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet).Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.

Some other forms of child abuse and child protection concerns with definitions include:

Child sexual exploitation is child abuse and children and young people who become involved face huge risks to their physical, emotional and psychological health and well-being. Sexual exploitation of children and young people under 18 involves exploitative situations, contexts and relationships where young people (or a third person or persons) receive something" (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, attention, gifts, money) as a result of them performing, or others performing on them, sexual act or activities. Child sexual exploitation grooming can occur through the use of technology without the child's immediate recognition; for example being persuaded to post sexual images on the Internet/mobile phones without immediate payment or gain. In all cases, those exploiting the child/young person have power over them by virtue of their age, gender, intellect, physical strength and/or economic or other resources. Violence, coercion and intimidation are common, involvement in exploitative relationships being characterised in the main by the child or young person's limited availability of choice resulting from their social/economic and/or emotional vulnerability.

Child criminal exploitation (CCE) and County lines CCE is common in county lines and occurs where an individual or group takes advantage of an imbalance of power to coerce, control, manipulate or deceive a child or young person under the age of 18. The victim may have been criminally exploited even if the activity appears consensual. CCE does not always involve physical contact; it can also occur through the use of technology.
Home Office, (2018) defines county lines as a term used to describe gangs and organised criminal networks involved in exporting illegal drugs into one or more importing areas within the UK, using dedicated mobile phone lines or other form of 'deal line'. They are likely to exploit children and vulnerable adults to move and store the drugs and money and they will often use coercion, intimidation, violence (including sexual violence) and weapons. County lines activity and the associated violence, drug dealing and exploitation has a devastating impact on young people, vulnerable adults and local communities.

Forced Marriage/Female Genital Mutilation is a crime and immediate safeguarding actions must be taken. If a child has had or is at immediate risk of FGM (Serious Crime Act 2015) regulated professionals must contact the police.

Please contact the safeguarding team and/or Police for all such cases.

Please refer to CORP/PROC/073
http://fcsp.xfyldecoast.nhs.uk/trustdocuments/Documents/CORP-PROC-073.docx

Modern Slavery and Child Trafficking is child abuse. It is defined as recruiting, moving, receiving and harbouring children for the purpose of exploitation (HM Government 2011). Child trafficking is a form of modern slavery (HM Government 2014). Many children are trafficked into the UK from overseas, but children can also be trafficked from one part of the UK to the other.

Please refer to CORP/PROC/073
http://fcsp.xfyldecoast.nhs.uk/trustdocuments/Documents/CORP-PROC-073

Children vulnerable to radicalisation: PREVENT strategy is to stop people becoming terrorists or supporting violent extremism by providing practical help to prevent individuals from being drawn into terrorism and ensure they are given appropriate advice and support.

All concerns relating to Prevent must be escalated as a matter of urgency to the Safeguarding Team.

Please refer to CORP/POL/524
http://fcsp.xfyldecoast.nhs.uk/trustdocuments/Documents/CORP-POL-524.docx

6 Legal Requirements

The Children Act 1989 places specific duties on agencies to co-operate in the interests of vulnerable children, in particular sections 17 and 47.

Section 17 places a duty on Local Authority, Education Housing and Health to safeguard and promote the welfare of children who are in need. Section 17 (10) states that **a child shall be taken to be in need** if: -

- He/she is unlikely to achieve or maintain, or have the opportunity of achieving or maintaining a reasonable standard of health or development without the provision of services;

Or

- His/her health or development is likely to be significantly impaired or further impaired, without the provision of such services; or
- He/she is disabled.

Section 47 places a duty on any of the above to help a local authority with its enquiries in cases where there is reasonable cause to suspect that a child is suffering or likely to suffer, significant harm.

The Children Act 1989 introduced the concept of '**significant harm**' as the threshold justifying compulsory intervention in family life in the best interests of children; There are no absolute criteria on which to rely when judging what constitutes significant harm. Decisions about significant harm are complex and should be informed by a careful

assessment of the child's circumstances. When considering the question of whether harm suffered by a child is significant, his health and development shall be compared with that which could reasonably be expected of another child of similar age and understanding.

6.1 Parental Responsibility (PR)

Parental Responsibility (PR) is defined in the Children Act 1989 as "all the rights, duties, powers, responsibilities and authority which by law the parent of a child has in relation to the child and his property". **(APPENDICIES for who has PR?)**

6.2 Confidentiality and Information Sharing

Effective sharing of information between professionals and local agencies is essential for effective identification, assessment and service provision.

Early sharing of information is the key to providing effective early help where there are emerging problems. At the other end of the continuum, sharing information can be essential to put in place effective child protection services. Serious Case Reviews (SCRs) have shown how poor information sharing has contributed to the deaths or serious injuries of children.

Fears about sharing information cannot be allowed to stand in the way of the need to promote the welfare and protect the safety of children.

All practitioners and staff must protect all confidential information concerning patients and clients obtained in the course of professional practice and abide by their professional codes of conduct. Disclosures should only be made with consent, where required by the order of a Court, where justification of disclosure is in the wider public interest or where there is an issue child protection and sharing information is in the best interest of the child "Wider public interest" means the interest of an individual or groups of individuals or society as a whole, and would, for example, cover matters such as serious crime, child abuse, Prevent (terrorism and violent extremism) drug trafficking or other activities, which place others at serious risk.

If in any doubt as to whether information should be shared then advice **must** be sought from the **safeguarding team on 01253-951265**.

Information Sharing: Guidance for practitioners and managers (2008) supports frontline practitioners, working in child or adult services, who have to make decisions about sharing personal information on a case by case basis.

6.3 Child Protection Procedures

What to do if you are concerned that a child may be or has been abused

If there is any suspicion that a child is at risk or may have suffered abuse should be discussed with a senior member of staff or a member of the safeguarding team. If there are immediate concerns for the child's safety inform the police and Children's Social Care (CSC) immediately.

Blackpool CSC - 01253 477299
Lancashire CSC – 0300 1233 6720

Any serious incident involving a child must be reported to the safeguarding team:

Telephone 01253-951265
Email – bfw-tr.safeguardingbth@nhs.net

The Head of Safeguarding or Named Nurse Safeguarding must be informed immediately, within one working day. A member of the safeguarding team will then inform the appropriate managers within the Trust, appropriate agencies and the CCG

The staff member reporting the incident will complete an untoward incident.
Please refer to CORP/POL/524
http://fcsp.xfyldecoast.nhs.uk/trustdocuments/Documents/CORP-POL-524.docx

Safeguarding Children Issues arising during the evening, weekends or bank holiday

If a practitioner identifies a suspected case of child abuse out of office hours or at the weekend / bank holiday, CSC, Emergency Duty Team (EDT) should be contacted. (Please see section 3.6.8.2 for out of hours contact details) or telephone 999 and ask the operator for the Police.

In all circumstances consider that emergency action may be necessary for the protection of children at risk of immediate serious harm.

Lancashire EDT – 0300 123 6722
Blackpool EDT – 01253 477600

6.4 If a child discloses abuse:

- Do not question the child or try to encourage further disclosure.
- Allow the child to use his/her own words even if the child struggles to find the words.
- Do not ask leading questions Make accurate contemporaneous notes documenting as far as possible “verbatim” what is said.
- Tell the child you are listening to them and that they are brave telling you and that they did the right thing in telling you.
- Reassure the child that they have done nothing wrong. Tell the child you will support them but you must tell others in order to do this.
- Never promise confidentiality.
- Be honest and answer child’s questions as far as you are able.
- Refer to children’s social care/integrated services
- If an interpreter is being used then the records must be countersigned by this individual if possible.

6.5 If an adult informs you about suspected abuse of a child:

- Listen and document the information given as far as possible verbatim.
- Check with the informant that the details given are correct.
- Ask them to refer to CSC giving them the contact details or to the Police.
- If the adult is a parent/relative/non-professional explain that they have a responsibility to refer to CSC. Advise them that you will be contacting CSC to confirm that they have made the referral. If they refuse explain that as you are now in receipt of the information you will have to make the referral.

If the informant is another professional, advise them that they have to make a direct referral themselves documenting and follow up the outcome to ensure that the information has been passed on to CSC.

6.6 Anonymous Referrals

Referrals about the welfare of a child made to a health professional by people who wish to remain anonymous must be taken seriously and dealt with by: -

- Encouraging the referrer to make a referral to CSC or to the police giving them the telephone contact details for CSC for the area that the child lives in. Inform them that they can remain anonymous. Inform the referrer that you will be contacting CSC yourself in order to check that they have made the referral.
- Obtaining and recording as much information as possible about the allegation or the concern and checking with the referrer that the information is correct.
- Noting whether the referrer is male / female or a child.
- Contacting a member of the safeguarding team if you are unsure of what action to take.
- Informing the professional with case responsibility (if it is not you) of the action you have taken.
- If you know the identity of the person making the referral to you, record this in your records **even** if you do not disclose this information to social services.
- If when contacting CSC it becomes apparent that the anonymous referrer has not given the details, the health professional has a responsibility to make the referral themselves.

Health professionals **cannot** make anonymous referrals.

7 Making a Section 47 referral to Children's Social Care

A referral requesting an Inquiry under Section 47 of the Children Act would be made in cases where there is reasonable cause to suspect that a child is suffering or likely to suffer, significant harm.

Personal information about children and families is subject to a legal duty of confidentiality and should normally only be discussed with consent. However, when there are safeguarding concerns and you are making a Section 47 referral it is not necessary to gain consent.

Professionals should discuss any concerns with the family and seek agreement to make a referral to Children's Social Care. If seeking agreement/consent may place a child at increased risk of further harm and would not be advisable. Incidences of this may be:

- Suspected fabricated or induced illness
- Female genital mutilation

Where a decision is taken not to seek parental permission before making a referral to Children's Social Care this **must** be documented in the records and include the rationale for this decision and confirmed in the written referral to CSC.

Referrals should be made to the Local Authority Children's Social Care for the area where the child is living or is found. Where it is known that Children's Social Care are already actively involved with the child, concerns should be referred directly to the child's social worker or their team manager or, in the absence of both, the Duty Officer.

If staffs have safeguarding concerns that a child is at risk of or is suffering significant harm and the parents/carers do not agree to a referral, staff must still refer.

7.1 Referral and immediate actions

- If a safeguarding medical assessment of the child is necessary CSC will refer to the Paediatrician to arrange for this to be completed.
- At the end of the referral discussion, the referrer and the CSC representative should be clear about who will be taking what action if any.
- Record the discussion and decisions taken, in the child's records and document the name of the person accepting the referral and date and sign the records.
- Confirm your referral in writing within two working days using the appropriate referral form. All relevant information held by the referrer should be included e.g. centile charts, chronology of significant events. In cases of physical abuse a skin map showing the location and nature of the injuries must be included (**Appendix 1**)
- A copy of the referral form and any attached documents must be filed within the individual child's records and / or electronic records.
- All referrals to CSC will be dealt with in accordance with Pan Lancashire Safeguarding Children Procedures. CSC are responsible for making the necessary investigations and taking any immediate action required. It is expected that all health staff and practitioners fully participate with the investigation process as required.
- CSC has a duty to inform the referrer of decisions made regarding the referral and any subsequent action required. However if the referrer has not been informed of the

outcome of the referral within 48 hours, the referrer must contact CSC to determine the outcome of the referral.

- Liaise with other health professionals, including the GP, known to have involvement with the child or family and inform them of the referral.
- Any concerns relating to a response from CSC should be discussed with the safeguarding team.

7.2 Protecting Children in Specific Circumstances

7.2.1 Children Looked After

The term 'Children Looked After' relates to children and young people, aged 0-18 years of age, who are provided with accommodation by the Local Authority. .

Children placed in Care can be placed on a Care Order, an Interim Care Order, Police Protection Order or a voluntary arrangement (The Children Act, 1989 and 2004).

Placements may be:

- Within their own home
- With family or friends
- A registered Foster Carer working for the Local Authority or for an Independent Fostering Agency
- Local Authority residential home
- Independent residential home.
- Semi-independent living

Most children become looked after as a result of abuse and neglect. Although they have many of the same health issues as their peers, the extent of these is often greater because of their past experiences.

Please refer to CORP/PPROC/689
http://fcsp.xfyldecoast.nhs.uk/trustdocuments/Documents/CORP-PROC-689.docx

7.2.2 Private Fostering Arrangements

A private fostering arrangement is essentially one that is made privately (that is to say without the involvement of the local authority) for the care of a child under the age of 16 (under 18, if disabled) by someone other than:

- A parent of the child;
- A person who has parental responsibility for the child;
- A close relative to the child.

And with the intention that it should last for 28 days or more.

Private foster carers may be from the extended family, such as cousin or great aunt. However, a person who is a relative under the Children Act 1989 i.e. Grandparent, brother, sister, uncle or aunt (whether of the full or half blood or by marriage) or step-parent, will not be a private foster carer.

A private foster carer may be a friend of the family, the parent of a friend of the child, or someone previously unknown to the child's family who is willing to privately foster a child. The period for which a child is cared for and accommodated by the foster carer is continuous, but that continuity is not broken by the occasional short break. If a period of care lasts less than 27 days but further periods are planned which total 28 days or more, then the private fostering procedures apply.

Private fostering is the arrangement made by the parent and the private foster carer. Local authorities do not approve or register private foster carers. A proper balance needs to be maintained between the rights of parents to make private arrangements for the care of their children, and other statutory duties towards privately fostered children.

Privately fostered children are a diverse and sometimes vulnerable group. They may include:

- Children sent from abroad to stay with another family, usually to improve their educational opportunities;
- Asylum-seeking and refugee children;
- Children and young people who are staying with friends or other non-relatives;
- Language students living with host families.

Under the Children Act 1989 private foster carers and those with Parental Responsibility are required to notify the local authority of their intention to privately foster or to have a child privately fostered, or where a child is privately fostered in an emergency.

Health professionals should notify the local authority of a private fostering arrangement that comes to their attention, where they are not satisfied that the local authority has been or will be notified of the arrangement. The referral would be as a Child in Need.

For further information please refer to
http://panlancashirescb.proceduresonline.com/chapters/p_private_foster.html

7.2.3 Parental Substance Misuse

A child's growth and development depends on a variety of interacting social and biological factors, which can be broadly grouped into three categories: conception and pregnancy, parenting, and the wider family and environment.

Hidden Harm (ACMD 2011) a report which outlines the way in which problem drug use can impact on the development of children in affected families.

7.2.4 Mental Illness of a Parent or Carer

Mental ill health in a parent or carer does not necessarily have an adverse impact on a child, but it is essential always to assess its implications for any children involved in the family. The parent or carer may neglect their own, or their children's physical, emotional and social needs. The child may take on inappropriate caring responsibilities, which may have an adverse effect on his or her development

Children may not be exposed to or involved with specific symptoms, yet parenting can still be altered. The presence of mental illness can reduce and/or change a parent's responsiveness toward their child. For example, a parent may become less emotionally involved, less interested, less decisive or more irritable with the child. This will affect the quality of the parent-child relationship, parenting capacity and the child's well-being.

Some forms of mental ill health may blunt parent or carers' emotions and feelings or cause them to behave in bizarre or violent ways towards their children or environment. At the extreme a child may be at risk of severe injury, profound neglect, or even death

7.2.5 Fabricated or Induced Illness (FII)

IF THERE IS SUSPICION OF FABRICATED OR INDUCED ILLNESS, YOU MUST NOT INFORM THE FAMILY – contact the safeguiarding team for advice.

FII is an illness that is either fabricated or induced by a parent or someone who is in the position of a parent

Fabricated or Induced Illness can take a number of forms and differing degrees of gravity. Professionals need to be mindful of a spectrum of concerns.

For further information please refer to
https://panlancashirescb.proceduresonline.com/pdfs/fab_ind_ill.pdf

7.2.6 Children being Sexually Exploited

Sexual exploitation of children and young people under 18 involves exploitative situations, contexts and relationships where young people (or a third person or persons) receive something (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, attention, gifts, money) as a result of them performing, or others performing on them, sexual act or activities. Child sexual exploitation grooming can occur through the use of technology without the child's immediate recognition; for example being persuaded to post sexual images on the Internet/mobile phones without immediate payment or gain. In all cases, those exploiting the child/young person have power over them by virtue of their age, gender, intellect, physical strength and/or economic or other resources. Violence, coercion and intimidation are common, involvement in exploitative relationships being characterised in the main by the child or young person's limited availability of choice resulting from their social / economic and/or emotional vulnerability".

Pan Lancashire have a Child Sexual Exploitation Standard Operating Protocol. This document sets out the procedures of Safeguarding and protecting the welfare of children

from Child Sexual Exploitation. It sets out how through our partnerships we assess, challenge and provide an enhanced, effective service to reduce the harm and threats posed to children and young people from Child Sexual Exploitation.

For further information please refer to
http://panlancashirescb.proceduresonline.com/pdfs/ch_sx_exploit_stanard_op_pr.pdf

If CSE indicators are then apparent, CSE screening tool (**Appendix 15**) to be completed and sent with Children's social care referral.

When a child or young person presents staff to consider completing a CSE 'Spotting the signs' pro-forma (**See appendix 16**) Completed forms are to be sent to Safeguarding for monitoring.

The Trust has a dedicated Sexual Exploitation Team:

Blackpool - 01253 477350
Fylde & Wyre – 07825 853394

7.2.7 Underage Sexual Activity

A child under 13 is not legally capable of consenting to sexual activity. Any offence under the Sexual Offences Act 2003 involving a child under 13 is very serious and should be taken to indicate a risk of Significant Harm to the child;

All cases of sexually active under 13 year olds must be reported to Children's Social Care and a Strategy Discussion held.

The child's best interests must be the overriding consideration in making any such decision including in the cases of underage sexual activity.

Any decision whether or not to share information must be properly documented. Decisions in this area need to be made by, or with the advice of, people with suitable competence in child protection work such as Named Professionals or senior managers;

Cases involving under-13s should always be discussed with a Named Professional in the organisation. Under the Sexual Offences Act, penetrative sex with a child under 13 is classed as rape. Where the allegation concerns penetrative sex, or other intimate sexual activity occurs, there would always be reasonable cause to suspect that a child, whether girl or boy, is suffering or is likely to suffer Significant Harm.

Sexual activity with a child under 16 is also an offence. Where it is consensual it may be less serious than if the child were under 13, but may nevertheless have serious consequences for the welfare of the young person. Consideration should be given in every case of sexual activity involving a child aged 13-15 as to whether there should be a discussion with other agencies and whether a referral should be made to Children's Social Care. Within this age range, the younger the child, the stronger the presumption must be that sexual activity will be a matter of concern;

If the decision not to refer a sexually active child aged 13-15 the rationale for this decision must be clearly documented in the child's records.

For further information please refer to
http://panlancashirescb.proceduresonline.com/chapters/p_sexually_active_yp.html?zoom_highlight=sexually+active

7.2.8 Abuse of Children with Disabilities

Children with disabilities are likely to have poorer outcomes across a range of indicators including low educational attainment, poorer access to health services, poorer health outcomes and more difficult transitions to adulthood. They are more likely to suffer family break up and are significantly over-represented in the populations of looked after children and young offenders.

Research evidence suggests that children with disabilities are at increased risk of abuse and neglect, and that the presence of multiple disabilities appears to increase the risk of both abuse and neglect, yet they are underrepresented in safeguarding systems. Children with disabilities can be abused and neglected in ways that other children cannot and the early indicators suggestive of abuse and neglect can be more complicated than for children with disabilities.

The reasons why children with disabilities are more vulnerable to abuse are summarised below:

- Many children with disabilities are at an increased likelihood of being socially isolated with fewer outside contacts than children without disabilities;
- Their dependency on parents and carers for practical assistance in daily living including intimate personal care increases their risk of exposure to abusive behaviour;
- They have an impaired capacity to resist or avoid abuse;
- They may have speech, language and communication needs which may make it difficult to tell others what is happening;
- They often do not have access to someone they can trust to disclose that they have been abused;
- They are especially vulnerable to bullying and intimidation;
- Looked after children with disabilities are not only vulnerable to the same factors that exist for all children living away from home but are particularly susceptible to possible abuse because of their additional dependency on residential and hospital staff for day to day physical needs.
- Where there are safeguarding concerns about a children with disabilities, there is a need for greater awareness of the possible indicators of abuse and/or neglect as the situation is often more complex. It is crucial that the disability is not allowed to mask or deter the need for an appropriate investigation of child protection concerns.

The following are some indicators of possible abuse or neglect:

- A bruise in a site that might not be of concern on an ambulant child, such the shin, might be a concern on non-mobile child;
- Not getting enough help with feeding leading to malnourishment;
- Poor toileting arrangements;
- Lack of stimulation;
- Unjustified and/or excessive use of restraint;
- Rough handling, extreme behaviour modification e.g. deprivation of liquid, medication, food or clothing, over feeding/over medication;
- Unwillingness to try to learn a child's means of communication;
- Ill-fitting equipment e.g. callipers, sleep boards, inappropriate splinting, misappropriation of a child's finances;
- Invasive procedures which are unnecessary or are carried out against the child's will.

For further information please refer to http://panlancashirescb.proceduresonline.com/pdfs/BwD_sg_dis_child.pdf?zoom_highlight=disabled#search="disabled"

7.2.9 Children who Self Harm

Children who self-harm mainly do so because they have no other way of coping with problems and emotional distress in their lives. This can be to do with factors ranging from bullying to family breakdown. But self-harm is not a good way of dealing with such problems. It provides only temporary relief and does not deal with the underlying issues

"Self-harm might be described as the term used to describe the coping strategy that some people use to deal with stresses in their life:

It involves a person hurting themselves physically;

- Self-harm often takes the form of a person cutting, burning or banging themselves;
- According to the young people who participated, self-harm is often about "surviving", "coping", "taking control", "release of pressure", "distraction from other stuff - places/people", "complex emotions".

Self-harm describes a wide range of things that people do to themselves in a deliberate and usually hidden way. In the vast majority of cases self-harm remains a secretive behaviour that can go on for a long time without being discovered.

The term self-harm is often used as an all-encompassing term referring to suicidal ideation and attempted suicide.

Some young people who self-harm may say that they want to die and a proportion of them may genuinely want to. Nevertheless, self-harm and suicide differ in terms of the intent

behind the behaviour - self-harm is motivated by the desire to endure and survive. Understandably, many people assume that when a person injures themselves they are making a suicide attempt. But "self-injury is not the same thing as a suicide attempt, despite these differences, self-harm is associated with an increased risk of suicide, since both actions are based in distress.

7.2.10 Prevent

Aims to reduce the number of young people becoming or supporting violent extremists, it is one of the most challenging parts of the counter terrorism strategy.

Young people in particular may be vulnerable to a range of risks as they pass through adolescence. They may be exposed to new influences and potentially risky behaviour e.g. drugs and alcohol misuse, influence from peers, influence from older people or via the internet and they may begin to explore ideas and issues around their identity.

Of course many young people will experience some of these issues and not develop an interest in any extremist views but it does make them more vulnerable to being radicalized into a belief system that is extreme i.e. animal rights extremism, left wing or right wing extremism or militant Islamism.

- Staff must be aware and VIGILANT and may contact the Safeguarding Team for advice and support.
- If staff suspect any such incidents they must discuss with their line manager and make arrangements to report their suspicions accordingly:
- In an emergency 999
- National Anti-Terrorist Hotline - 0800 789 321
- Crime stoppers – 0800 555 111
- Lancashire Prevent HG team – 01772 413366 /412604 41296

For further information please refer to
http://fcsp.xfyldecoast.nhs.uk/trustdocuments/Documents/CORP-POL-524.docx

8 Making a Section 17 Child In Need Referral to Children's Social Care

Section 17 states that a child shall be taken to be in need if: -

- He/she 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/her of services by a local authority under this section.
- His/her health or development is likely to be significantly impaired, or further impaired, without the provision or such services, or
- He/she is disabled.

As soon as you have concerns that a child is presenting as a child in need requiring a statutory assessment a referral should be made for a Section 17 Inquiry.

9 Pre Birth Assessment of Need

Research and experience indicate that very young babies are extremely vulnerable and that work carried out in the antenatal period to assess risk and to plan intervention will help to minimise harm. A number of local serious case reviews have been critical of agencies' work in the pre-birth stages, with one commenting about the lack of recognition on the part of some key workers and decision makers whose failure to recognise that significant harm was already being caused to the unborn child.

Antenatal assessment is a valuable opportunity to develop a proactive multi-agency approach to families where there is an identified risk of harm.

Lancashire and Blackpool Safeguarding Children Boards have developed a Multi-agency Pre-birth Protocol to ensure that a clear system is in place to develop robust plans which address the need for early support and services and identify any risks to unborn children. For further information re pre-birth protocol follow link below

Please refer to
http://panlancashirescb.proceduresonline.com/pdfs/multi-agency_prebirth_protocol.pdf?zoom_highlight=pre+birth#search="pre birth"

CORP/PROT/311 http://fcsp.xfyldecoast.nhs.uk/trustdocuments/Documents/CORP-PROT-311.docx

10 Child Protection Meetings

10.1 Strategy Discussions

If there is reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm there should be a strategy discussion involving local authority CSC, the police, health, education and other agencies associated with the family. This might take the form of a multi-agency face to face meeting or a skype meeting. A strategy discussion can take place following a referral or at any other time, including during the assessment process.

CSC should convene a strategy discussion to determine the child's welfare.

The discussion should be used to:

- share available information;
- agree the conduct and timing of any criminal investigation; and
- Decide whether enquiries under section 47 of the Children Act 1989 should be undertaken.

10.2 Initial and Review Case Conferences

- Staff must attend all conferences and reviews where ever possible, if staff are unable to attend due to annual leave or sickness a representative from the Trust.
- A report should be completed for conferences and the content of the report should be shared with the child's parents/ carer prior to the conference.
- All reports must be dated and signed by the practitioner writing them.

Practitioners attending meetings within the safeguarding and protecting children's agenda should fully participate in the multi-agency discussions which include constructively challenging decisions that the professional does not consider to be in the best interest of the child.

10.3 Attendance at Child Protection Case Conferences

The health professional **must** attend every child protection case conference to which they are invited except in circumstances when they are no longer involved with the child in which case they must contact the current health professional promptly and they would be expected to attend.

The only exceptions will be sickness or holiday, in such cases a deputy must be nominated by the practitioners' line manager to attend on their behalf. If a health professional cannot attend a case conference due to their workload it is their team and manager's responsibility to find cover to enable them to attend the case conference. For newly qualified staff attending a conference for the first time, or in complex cases a request for support at the conference can be made to their supervisor/line manager or safeguarding team

In certain circumstances there may be more than one health professional representing a service area, for example, school nursing, in these circumstances it may be acceptable for one professional to represent a colleague from the same discipline where that member of staff has limited involvement with the family or is unable to attend.

A written report **must** be submitted. The health professional should only give information for which they have ownership (i.e. from their own organisation).

10.4 Report Writing

The purpose of a written report is to act as an aide memoir and to ensure that health information is shared and is part of the overall child protection plan. Only information that is relevant to assist in the safeguarding of child/children must be disclosed.

A copy must be kept within the record of all children who are subject of the report.

Review case conference reports do not need the same depth of background information as the report for an Initial Case Conference. A factual account of events since the initial child protection conference is adequate. This should be presented using the pro-forma (**Appendix 2a and 3**).

10.5 Core Group Meetings

When a child or children are subject to a child protection plan, a decision will be made at the child protection case conference to identify appropriate members of the core group.

The first core group should meet within 10 working days from the initial child protection conference if the child is the subject of a child protection plan;

Health staff who are members of the core group must attend the core group meetings. If for some reason they are unable to attend a deputy should attend. If more than one health professional in involved with the family there can be a negation between the health professionals as to who is the most suitable health representative to represent other areas of health. Whilst at the meeting ensure that there is clarity about the agreed actions and who is carrying them out and within what time scales. Ensure that actions agreed at the core group are documented in the records.

All children on a child protection plan, a child in need plan or a child who is causing professional concern should have the appropriate 'Alert' initiated on the electronic EMIS system or identified clearly within the child's paper records.

For more information please refer to

Blackpool Threshold Document

http://panlancashirescb.proceduresonline.com/pdfs/blackpool_thresholds_intervent.pdf

Lancashire Continuum of Need and Threshold Guidance

http://www.lancashiresafeguarding.org.uk/resources/assessment-and-referral.aspx

10.6 Record Keeping in Safeguarding Children

Record keeping is an integral part of a health professional's professional practice and as such, it should inform all aspects of the care process Accurate record keeping is fundamental to providing high quality patient care through effective communication with patients and health professionals within the multidisciplinary team.

Effective record keeping provides an essential underpinning to good child protection practice. Please refer to CORP/PROC/567 for additional information.

10.7 Chronology of Significant Events

A chronology of significant events form must be completed for all children and young people. For those practitioners using paper records please use **Appendix 7, 7a, 7b** for electronic records please use the electronic chronology.

A chronology provides a sequential story of significant events in a family's history whilst interweaving information about emotional and/or relationship difficulties. It contributes to

an emerging picture, based on fact and interactions of a case – current information is understood in the context of previous information, informing professional assessment.

As such it provides a skeleton of key incidents and events that inform the assessment of children and young people who are considered at risk of significant harm and are the subject of child protection plans.

A significant event is an incident that impacts on the child's safety and welfare, circumstances or home environment. This will inevitably involve a professional decision and / or judgment based upon the child and family's individual circumstances.

A chronology of significant events can provide a useful tool in identifying neglect and Fabricated or Induced Illness (FII)

When families are giving professional cause for concern this must be clearly documented in the child's paper and or electronic records.) An alert must be recorded on EMIS and or in the records.

11 Multi-Agency Safeguarding Hub (MASH)

The MASH concept is the co-locating of safeguarding agencies and their data into a secure assessment, research and decision making unit that is inclusive of all notifications relating to safeguarding child and adult welfare in a Local Authority area. The co-location of agencies builds trust and confidence and speeds up the process of information sharing and decision-making. The added value of MASH is that it provides for a fuller, more informative intelligence product with a risk assessment supported by a clearly recorded rational for operational use at the earliest stage.

11.1 Police Safeguarding Referral Form (PSRF's)

On receipt of information from a PSRF the professional should review any other information that they hold on the child/family, this may include discussions with other health professionals i.e. School Nurses / Health Visitors and make a professional decision on the next step to take this could include:

- Making contact by phone to the victim
- Arranging a home visit with the victim
- Seeing the child in school

If following review of the information held on the child/family the professional decides not to make contact with the child/family the rationale for this decision must be clearly documented in the records.

In line with Information Sharing Guidance, PSRF's should never be printed off. Information that is proportionate and relevant, should be documented in the records, bearing in mind that the information recorded should be accurate, timely and anonymised if deemed necessary.

The PSRF should then be deleted from the system.

All PSRF's must be recorded on the Chronology of Significant Events.

12 Early Help

All children have the right to live and grow up in a safe environment in which they are protected from harm, nurtured to build their resilience to any adversity that they may face and supported to achieve their aspirations. Some children will need additional help and protection to achieve this and this document provides the multi-agency framework by which all practitioners who work alongside children and families provide the right support, at the right time and in the right place.

Central to this approach is the provision of effective early help, rather than reacting later when more harm has been caused. Early help is everyone's responsibility and typically best provided or co-ordinated by the organisations already working with the child and their family. Support delivered by practitioners with established positive relationships will always have greater chance of engaging children and families and maximising positive outcomes. Practitioners should make use of conversations within and outside their own organisation to ensure that their assessment is accurate and clearly reflects the voice of the child and family. Any subsequent action plan should be co-produced, with the child and family at the heart of discussions, to ensure the best chance of success.

Refer to Local Authority/CSAP for Early Help process and services available.

13 Resolving Inter-agency Disagreements

It is inevitable that there will be occasions when another professional or agencies views differ, this could be linked to thresholds, case management decisions or disagreements over actions taken.

Blackpool Teaching Hospitals NHS Trust expect professionals to do all they can to resolve differences with Partner agencies and there is a pan-Lancashire procedure that can support this.

Please refer to
http://panlancashirescb.proceduresonline.com/chapters/p_resolving_prof_disagree.html?zoom_highlight=resolving

14 Health Services refused

Health staff need to be mindful that there can be many reasons for a parent / carer to refuse a professional access and it is widely recognised that such disengagement from services can be a safeguarding concern. One significant reason is to prevent the discovery of a child who is being neglected or ill-treated.

It is up to those with parental responsibility to act on the child's behalf and to ensure that they are recipients of these services. In circumstances where children are denied these services by their parents/carers health professionals must consider what effects this may have on the child or children.

Consideration to:

- Individual circumstances and likely implications of failure to uptake services.
- Level of understanding of parent carer 9Learning disability/ language barrier).
- Method of communication (change of address/ phone number)

14.1 Next Steps (where there are no safeguarding concerns)

Where the parent/carer continues to decline or refuse services they must be asked to put this in writing. Following a discussion with their line manager,

- A letter will be sent to the parent/carer
- A copy must be attached to the notes of all children affected.
- If the letter is returned a copy of this must also be filed in the records of all of the children concerned.
- A stamped addressed envelope should be included for them to return the letter to the line manager.

If, following assessment, the health professional's opinion is that the child's development or welfare will be significantly impaired without the provision of services, then a referral outlining the concerns and the possible health implications of declining health interventions must be made to CSC.

The General Practitioner (GP) must be informed in all circumstances.

14.2 Where there are known child protection / safeguarding concerns and / or the child is subject to a Child Protection Plan

In these circumstances the health professional must:

- Notify the social worker (if social care is involved) of the difficulties experienced in engaging the family / carers of the children.
- Explain to the social worker the possible implications of this for the child / children concerned.
- Notify the pupil welfare service if the child / children are poor school attendees or persistently missing from school, out of school or home educated as above.
- Notify the GP and health colleagues as indicated.
- Discuss with a member of the safeguarding team.

14.3 Further Action

Health staff should continue to monitor whether the family are registered with a named GP in the area. Discussion must take place regarding whether or not these services could be provided in a different way.

14.4 Missed / was not brought to appointment

It is not unusual for a child to miss the occasional routine health appointment and although this can have implications for access for other children, it is not likely to have a serious adverse impact on the child. However, in some cases missing appointments either once or on several occasions may have an adverse impact on a child's health and development.

Please refer to
http://fcsharepoint/trustdocuments/Documents/CHILD-POL-003.docx

15 Child Deaths

A death of a child or young person is obviously one of the most tragic events that a family or practitioner will have to experience. It is essential that all deaths are rigorously reviewed so that lessons can be learnt for future practice. A child death review (CDR) is a process which systematically reviews the death of children. The majority of deaths in England arise from medical causes. Information that a child has died can come into the trust via different methods, f staff are informed that a child has died they must contact the safeguarding team, who will cascade the information to:

- Child Death Overview Panel
- Head of Safeguarding
- Designated Nurse
- Child Health
- Health Visitors/ School Nurses
- Team Leaders / Line Manager
- Any other professional that are known to be involved with the family.

When practitioners become aware of a child death any paper records should be sealed within an envelope, then signed and dated and the records held within the caseload unless otherwise directed by the Safeguarding team. For electronic records the case load holder at the time of the child death should email the system administration team and they will archive the record.

An unexpected death is defined as the death of an infant or child (less than 18 years old) which was not anticipated as a significant possibility for example, 24 hours before the death; or where there was a similarly unexpected collapse or incident leading to or precipitating the events which lead to the death.

15.1 Child Death Overview Panel

The Child Death Review partners are responsible for ensuring that a review of each death of a child normally resident in Pan-Lancashire is undertaken by a Child Death Overview Panel (CDOP). The Panel will have a fixed core membership drawn from organisations represented on the CSAP with flexibility to co-opt other relevant professionals to discuss

certain types of death as and when appropriate. CDOPs responsible for reviewing deaths from larger populations are better able to identify significant recurrent contributory factors.

Professionals should provide the coroner with all the evidence the coroner requires to.

15.2 Responsibilities of Child Death Overview Panels include:

- reviewing all child deaths up to the age of 18, excluding those babies who are stillborn and planned terminations of pregnancy carried out within the law;
- collecting and collating information on each child and seeking relevant information from professionals and, where appropriate, family members;
- discussing each child's case, and providing relevant information or any specific actions related to individual families to those professionals who are involved directly with the family so that they, in turn, can convey this information in a sensitive manner to the family;
- determining whether the death was deemed preventable, that is, those deaths in which modifiable factors may have contributed to the death and decide what, if any, actions could be taken to prevent future such deaths;
- making recommendations to relevant bodies promptly so that action can be taken to prevent future such deaths where possible;
- identifying patterns or trends in local data and reporting these;
- where a suspicion arises that neglect or abuse may have been a factor in the child's death, referring a case back to the CSAP Chair for consideration of whether an CSPR is required;
- agreeing local procedures for responding to unexpected deaths of children; and cooperating with regional and national initiatives - for example, with the National Clinical Outcome Review Programme - to identify lessons on the prevention of child deaths.

15.3 Rapid response to unexpected deaths

A Rapid Response will be initiated for any child death which is in line with the Working Together 2018 definition of an unexpected death (the death of an infant or child (less than 18 years old) which was not anticipated as a significant possibility for example, 24 hours before the death; or where there was a similarly unexpected collapse or incident leading to or precipitating the events which lead to the death).

The Rapid Response process is a co-ordinated inter-agency approach designed to obtain the best information possible to understand how the child has died. In conjunction with local services it will involve the early gathering of information, multi-agency sharing of information and discussion, review of the body, home/ scene visit (as appropriate), post mortem examination, support to parents and the follow-up multi agency meeting. The Rapid Response will be led by the Safeguarding Investigation Officer (SIO) and/or Sudden Unexpected Death of Children (SUDC) Nurse, working closely with CSC. The Rapid Response process will vary in each child death, dependent on the case.

If staff are made aware of a child death from another source they must inform the safeguarding team as soon as possible.

15.4 The role of the SUDC Specialist Nurses

The Trust will coordinate the internal response to child deaths and inform the SUDC nurse.

http://panlancashirescb.proceduresonline.com/chapters/p_sudden_death.html

15.5 Notification & Report Form

Following every child death the Child Death Overview Panel will require a notification form to be completed electronically on the Pan-Lancashire database..

Once the appropriate staff (who have been involved with the child) have been identified (both acute & community) a member of the safeguarding team will provide contact details to a member of CDOP. Practitioners will be sent a password from the CDOP team to complete the form on line.

The completed forms are submitted electronically and will inform the discussion at the CDOP meetings.

16 Child Safeguarding Practice Reviews (CSPR)

The purpose of CSPR's are to identify at a local and national level, improvements to be made to safeguard and promote the wellbeing of children going forward. Carrying out a

review should also seek to prevent or reduce reoccurrence of similar incidents.

These processes should be transparent, with findings of reviews shared publicly. The findings and learning are important locally. Nationally this information is significant as it can identify system issues and influence policy and practice change.

17 Other Factors to Consider

17.1 Children not registered within Education

If professionals find children who are missing from education they must inform the appropriate missing from school departments.

For Children within Blackpool Footprint	**For Children within North Lancashire Footprint**
Contact the 'School Admissions co-ordinator 01253 - 476446 **Or the** Pupil Welfare Officer: 01253 – 476569	Contact the Missing from School Advisor 01772 531383Office Number : 01772 531383 Complete Notification of a Child Young Person Missing from Education Form **(Appendix 6)**

- Give the child's main carer details of schools in their area of residence
- If there are safeguarding concerns and the family lives within the North Lancashire Footprint the family will be allocated to the school nurse nearest to where the child lives.
- Within the Blackpool Footprint the family will be allocated to the School Nurse responsible for Education Diversity

17.2 Missing children and families

If a member of staff loses contact with a family about whom they have no concerns, they should take reasonable steps to try and locate them.

Where a family goes missing and there are child protection / welfare concerns, then the named nurse for safeguarding and the allocated family social worker / key worker must be informed. The named nurse safeguarding children will cascade this information locally to the appropriate professional groups in the form of an 'Alert'. I.e. if client is pregnant local maternity services will be informed.

Where the child / children have a child protection plan, the Head of Safeguarding and the Key Worker must be informed. The Local Authority who will then arrange for appropriate alerts to be issued nationally.

17.2.1 Community staff

When a child is missing, the EMIS record must remain open until the family are located. During which time the following must be contacted to make reasonable attempts to locate the child:

- Child health department / Lancashire and South Cumbria Agency (LASCA)
- GP, put alert on GP system to inform health professional if they attend the surgery or their records are requested from (LASCA)
- School/Nursery
- Other professionals involved, for example, social workers, hospital.

All attempts to locate the family must be recorded on the electronic template.

17.2.2 Missing family Alerts

Issues that may give professionals concerns;

- Incomplete information
- No Parent Held Record (Red Book)
- Can't remember name of GP/GP Practice
- Can't remember names of school/nursery child attended
- Gaps in previous addresses

Any health professional, who knows the whereabouts of a missing child or family, should inform the safeguarding team immediately.

17.3 Action to be taken if child is not registered with a General Practitioner (GP):

- If the child resides in Blackpool refer to the Homeless HV team and a home visit can be allocated.
- Give the child's main parent/carer, information and contact numbers for local GPs in area of residence.
- If family cannot register with a local practice, advise them of the address and contact number for Lancashire and South Cumbria Agency who will allocate the family to a General Practitioner:

  Lancashire and South Cumbria Agency,
  3 Caxton Road,
  Preston, PR2 9ZZ
  Tel: 01772 221 375

- When a member of staff has advised a parent/carer to register a child with a GP and given the above information, it is that staff member's responsibility to liaise with the Health Visitor / School Nurse (depending on the age of the child). This will ensure follow up by the Health Visitor or School Nurse.
- Parents/ carers must be informed that in the event of a child requiring medical treatment prior to the allocation of the GP, the child can be treated at any GP Surgery as a temporary resident or at any NHS or GP Led Walk-in-Centre. Alternatively emergency treatment is available at the Accident and Emergency Department at Blackpool Teaching Hospital or the Royal Lancaster Infirmary.
- When a family have chosen not to register with the General Practitioner and there is no health professional involved, contact must be made with Line Managers/Team Leaders who will allocate the family a health professional. If there are safeguarding issues highlighted within this family the Safeguarding Team should also be notified.

17.4 No Access Visits

No access visits require a course of action to be decided and then acted upon and some have serious implications and require urgent action. If you are in doubt always act in the best interest of the child.

17.5 Not At Home

If the Health Professional is satisfied that the house is being lived in and the objective to see the child/children is not achieved, routine action could include:

- Visiting at a different time;
- Phone call or letter (consideration should be given to this letter being sent Recorded Delivery) to arrange an appointment;

- Check with the General Practitioner for change of address;
- Visit a relatives address;
- Contacting the Child Health Department and ask them to attempt to trace the child on National Tracking;
- If the child is known to other agencies, check with your Multi-Agency colleagues to determine if they have an alternative address.

If these measures fail and result in no response the following action should be taken:

- If there are no safeguarding/welfare concerns this should be discussed with your team leader/line manager as appropriate and an action plan agreed which should then be documented in the child's records;
- If there are Safeguarding welfare concerns these should be discussed with your multi-agency colleagues and the safeguarding team to decide on an appropriate cause of action which should be then documented in the child's records;

17.6 No admittance to the family home

The health professional suspects the house is occupied at the time of the visit by the family but the door is not answered.

If the child/children's names are not subject to a Child Protection Plan and there have been no previous concerns, the incident should be discussed with your Team Leader / Line Manager, and an action plan agreed and documented. Advice can be sought from the safeguarding team.

The child / children are subject of a Child Protection Plan, the Key Social Worker should be informed and the multi-agency Core Group of professionals should be made aware. Discuss with the safeguarding team and document action plans formulated.

17.7 Admission to the home – no access to child/children

The health professional is admitted to the home and after reasoned discussion is refused access to the child / children.

If the child / children have a child protection plan their key worker must be informed at once along with the named nurse for safeguarding children.

If the child / children are not subject to a Child Protection Plan and there have been no previous concerns, the incident should be discussed with your Team Leader/Line Manger, and an action plan agreed which should be documented. The Safeguarding Team must be informed.

Arrangements for an alternative intervention can then be made.

Be wary of excuses for you not to see the child / children. A recurring theme in child abuse inquires is:

- carers avoiding or refusing to allow practitioners to have sight of the child
- the extent to which carers will seek to deceive involved professionals.

17.8 No access to adults – child/children unattended

There is no legal age at which children can be left unattended at home. Where a health professional finds children unattended and has concerns for their safety, action must be taken for the child's/children's immediate protection. The police must be notified immediately for their intervention and investigation. A referral should be made to Children's Social Care. Document all actions taken and by whom.

17.9 Vacant Caseload

All children with a child protection plan or around whom there are safeguarding concerns must have a named health professional allocated by their line manager. Where the existing caseload holder is unable to be at work for a period of time their manager must ensure that cover is provided which is sufficient in ensuring that safeguarding monitoring and responsibilities are carried out.

17.10 Family request for a change of professional

Each case must be considered individually. If alternative arrangements can be made within the practice this should be the first course of action. If there is not an alternative and there are safeguarding concerns regarding the child or the child has a child protection plan there must be a joint discussion between the named nurse safeguarding children and the line manager and an agreed plan of action formulated.

If the parents / carers are prepared to put their reasons in writing this should be encouraged.

Health professionals should be aware that frequent requests of this nature may be an indication of an underlying problem or agenda.

18 Community Records

18.1 Receiving Child Protection Records from elsewhere

The caseload holder is responsible for the transfer of records. They can delegate this task to a member of their team providing that team member is aware of Trust policy and guidelines in respect of records and is able to carry out the task.

Some records are received by the safeguarding team and an email is sent to the new caseload holder informing them of same.

When incoming records contain child protection/safeguarding information and the sender has not contacted the professional that they have sent the records to the following action must be taken by the health professional receiving the records.

- The sender should be contacted without delay by the receiving professional and clarify family details and concerns.
- Inform child health of the transfer in of records.

When families transfer in from another area Health Visitors/ School Nurses must read the child's records and date and sign that they have done so on the chronology of significant events form. Make note of outstanding actions or any identified health needs in the records. Any abbreviations in the records that are not clear must be clarified by contacting the previous health professional.

Please refer to CHILD/GUID/020
http://fcsp.xfyldecoast.nhs.uk/trustdocuments/Documents/CHILD-GUID-020.docx

18.2 Transfer Out of Child Protection Records

Where there is a child who has a child protection plan or child protection concerns who moves to another area, the health professional responsible for the care management will: -

- Ensure the records are collated in chronological date order and a transfer out letter (**Appendix 10**) completed.
- Inform other health professionals and social workers involved of the family's change of circumstances (**Appendix 11**)
- Where there are pre-school children and school-age children arrangements must be made for the records to be collected and sent out together.
- Where information is recorded electronically, the electronic record **MUST** be printed out and included in the child's paper record prior to the records being transferred out.
- If the child only has electronic records this can be emailed via secure email.

Prior to sending items of mail staff must: -

- Contact the recipient to confirm the correct postal and/or email address. This will be the safeguarding team in the receiving area. Their details can be obtained from safeguarding team.
- Ensure all contents relate to the same child.
- The notes, when gathered together should be placed in a Grey Tuff envelope with transfer out letter (**Appendix 10**) and a recorded delivery receipt letter (**Appendix10a**)
- Each envelope should not exceed 2.5 kg (the weight of a ream of A4 paper).
- A label clearly identifying the sender should be placed on the rear of the envelope.
- A label clearly identifying the notes to be sent 'Recorded Delivery' should be placed on the front of the envelope in the top left-hand corner.
- A large label clearly identifying the recipient address should be put on the front of the envelope marked 'Private and confidential – to be opened by addressee only'.

- The child health department must be informed of the change of details
- The address of the team sending out the records should be inserted into (Appendix 10 and a copy of Appendix 10a) should be retained within the team and married up with the acknowledgement of safe receipt of the records when this is returned from the new area.

Please refer to CHILD/GUID/020
http://fcsp.xfyldecoast.nhs.uk/trustdocuments/Documents/CHILD-GUID-020.docx

All child protection records that contain current or historic child protection information must be sent by recorded delivery.

18.3 For all records of families with children who have transferred into the area:

- A contact must be made with the family within **five** working days to arrange a home visit. If the staff member cannot contact the family, they must visit the family home the following week. Where a child transfers in with child protection or health concerns, the visit must take place within **three** working days.
- A routine contact should be undertaken within **one** month for school children by the school nurse, who should liaise with the school initially within **five** working days or if during a holiday period, as soon as school reopens.

18.4 Transfer of child protection records between professionals within the Trust

When a family moves, the existing staff member should contact the new staff member and inform them of the transfer.

Contact must be made with the new professional to discuss the reasons for concern, action taken and current level of involvement with the family. The transfer form of a child with a strictly confidential file (**Appendix 10**) must be completed. Records should be sent in a self-seal polythene mailing envelope or bag which is tear-resistant via the internal post system. If the child has paper and electronic records the electronic records must be printed and put with the paper records. If the child has electronic only records these can either be printed or sent electronically via secure email.

Where the Children's Integrated Services Department is involved, the staff member who is transferring the records must notify the Key Worker (Social Worker) in writing of the name of the new staff member, their base and contact number (**Appendix 11**). All other professionals involved with the child must be informed of the change of details.

18.5 Records for Children on a CP Plan but no longer in Mainstream School

When a child has reached the age of 16 and is no longer in mainstream school discussions must be had with the safeguarding team to decide who is best placed to continue with the statutory process.

19 Adoption Records

The subject of medical records and adoption always raises a number of practical issues and ethical tensions. The fundamental purpose of records is to transmit information from one professional to another in order to promote the care and well-being of the patient. Separate, fragmented or duplicated records are not only unhelpful but can also be positively dangerous in some circumstances.

It is essential that all the child's notes be maintained together. This means that in the event of an adoptive parent or appropriate professional needing to know more about a child's medical history, the records can be accessed.

Currently the practice is of open adoption, where children go into placement with life-story books and the potential adopters have often met the birth parents and talked extensively to professionals and other family members. It is therefore appropriate that past medical history is available on a need-to-know basis.

Whoever is notified of the official adoption creates a new record on the system with the child's new identity details. They inform other involved services of the adoption (by checking active referrals and consultation history) and all involved parties ensure they create a referral on the new record and record any relevant information needed going forward ensuring there is no reference to the child pre adoption identity details. Each service closes the referral in the old record and informs the System Administration Team of the adoption so the pre adoption record can be archived.

19.1 Records for children who are leaving the area to be adopted

These records should be the health professional in the receiving area.

19.2 Records for children who move into the area following a placement with prospective adopters

- The staff member should request the pre adoption records through the child health department or directly from the previous area if they have the details of the previous health visitor or school nurse.

If a child is placed with the prospective adopters prior to finalisation of the adoption, the child's name must not be changed until the final adoption order is granted. The records must be maintained under the child's original name.

- Electronic records must be closed, and the Health Visitor/School Nurse must take of the referral to themselves they will then not be able to access the old records unless they are refer the child to themselves.
- A new set of records commenced in adoptive child's new name and new NHS number, the containing pertinent health information such as vaccinations and immunisation status; development etc.

20 Requests for Statements/ Records/attendance at court

All requests for statements/reports in relation to safeguarding children and Children Act Proceedings must be directed to the safeguarding team.

When the safeguarding team receive a request for a statement they will contact the practitioner required to write the statement (this is usually the caseload holder) to discuss the content of the statement and timescales.

20.1 Writing a Court Statement

- The statement is usually written by the health professional involved with the child/children and family.
- If the professional is not available then it is the responsibility of the Team Leader / Line Manager to allocate another professional to complete the statement,
- The Pro-Forma **Appendix 9** must be used to complete the statement. This allows for the statement to be prepared electronically. This completed pro forma must be e-mailed to the safeguarding team to allow for alterations, suggestions and formatting prior to signing and submission to the applicant
- Statements must be clear, concise, factual, honest, accurate, chronological, always dated and signed.

In the case of a child whose injuries have been found by the practitioner, included in the statement must be a concise account of how, when and where the injuries occurred and the nature of the injuries. .A Skin Map can be included (**Appendix 1**)

The statement will be forwarded to the applicant via the safeguarding team. Legal advice will be sought on a needs led basis. The statement is highly confidential; information contained within it should not be divulged to other members of staff unless they are involved in the case. Your statement will be seen by a number of people including parents and opposing parties who may use it in legal evidence.

20.2 Attendance at court

If staff receive a request to attend court they must contact the safeguarding team and their line manager with the details of the court case. The safeguarding team will liaise with the solicitors to confirm the availability of staff to attend court on the dates requested. A witness summons (Subpoena) is required for all court attendances.

No staff member must attend court unprepared and must consult the safeguarding team prior to court attendance. Team Leader/Line Managers or other experienced practitioners will accompany the staff member to court, except in complex cases where a member of the safeguarding team will accompany the staff member, this is at the discretion of the safeguarding team.

20.3 Police access to health records

Where a child has died or there has been a serious injury to a child to police may require the child's community/hospital records. The process below must be followed

- The police will complete a DP1 form signed by an inspector level or above
- The safeguarding team will contact the practitioner with responsibility for the child if paper records are required.
- DP1 form to be sent to the Data Access Team

Records may be required out of office hours (9-5), a request from the police for the release of records during this time should be directed to the manager on Call.

20.4 Request for Police statement

The request for a police statement usually comes via the safeguarding team – if it comes directly to a staff member please direct the police to contact a member of the safeguarding team who will co-ordinate this.

- If a statement is taken by interview, staff will be supported by a member of the safeguarding Team.
- Staff should not give a verbal statement before discussing with a member of the safeguarding team.

21 Child Protection Supervision

Effective safeguarding supervision is mandatory and should help to ensure that practice is soundly based and consistent with the Trust Safeguarding Policies whatever model of supervision is used..

Supervision provides the framework for examining cases from different perspectives. When functioning properly, supervision will facilitate good quality, innovative and reflective practice in a safe environment. This will subsequently lead to better outcomes for the children and families. It is about the "how" of child protection practice-discussing cases of actual or suspected child abuse, discussing cases at varying levels of concern from high risk cases to the very early potential indicators in order to ensure safe practice and better outcomes for children and their families.

21.1 Child Protection Supervisors

There is an expectation that all Safeguarding Supervisors within the acute and community settings will be required to;

- Have at least two years' experience of working with children and families.

- Have a working knowledge of the child protection and safeguarding agenda be conversant with the Pan Lancashire CSAP Procedures and Internal Child Protection Safeguarding Procedures.
- Have attended relevant child protection supervision training courses.

If there are circumstances where the supervisor is not adhering to the supervision agreement, they will be invited to discuss the situation with their line manager.

21.2 Supervisees

Are required to: -

- Attend a supervision session at least every three months.
- Take responsibility for arranging supervision with their supervisor.
- Come to the session with identified practice issues for discussion.
- Be prepared to reflect, think through and explore options that will promote the best interests of the child and the family..
- Accept responsibility for own performance and be clear and honest in seeking assistance.
- Maintain confidentiality and update outcome of supervision session in the records for audit purposes.

21.3 The Supervision Arrangements

21.3.1 Individual Peer "One to One" Supervision

Must be accessed by:

- All practitioners within universal services who have a clinical responsibility for children (caseload holders) – these include health visitors, school nurses, health mentors, Family Nurse Partnership Nurses and Child and Adolescent Mental Health Service (CAMHS) workers.
- All specialist Midwives

Supervision must take place three monthly (dependant on model used) as a minimum.

21.3.2 Group Supervision

- This type of supervision will be accessed by health professionals who are not case holders but who have involvement with children on a day to day basis e.g. nursery nurses specialist school nursing team; Paediatric and Neonatal outreach nurses, and Community staff Nurses

- Any member of staff having group supervision may also have individual supervision sessions on a needs led basis as arranged with their supervisor or the safeguarding team.

21.3.3 Case by case ad hoc supervision

Staff working on paediatric wards and in Accident and Emergency Department can request case by case supervision from the safeguarding tea/safeguarding children supervisor in their area if applicable, around specific cases.

21.4 Recording the Supervision Session

There is a requirement for the supervision session to be recorded in order to protect both child and their family and the health professional. Safeguarding supervision must ensure that the focus of the work is on the child and that the child's needs are always paramount. There needs to be evidence that the voice of the child is considered and recorded as part of the child protection supervisory process. The record is also available as a benchmark and is an aid to the audit of the quality of the supervision process. The supervision record must be stored in the records. It is an organisational document which can be accessed should it be necessary for such circumstances as auditing, grievance, discipline and internal and external inquiries.

During the session the following must be completed

- The Individual Supervision Record Form **(Appendix 18**).
- The Safeguarding Children Supervision Discussion Form (**Appendix 19**).
- The Supervision Attendance Record Form (**Appendix 20**).
- Group Supervision Record Form (**Appendix 21**). (and If an individual family or child is discussed within the group a Safeguarding Children Supervision Form (**Appendix 19)**)

21.5 Content of Supervision Sessions

Possible cases to bring into supervision are those that have been identified as having a child protection, child in need or are causing concerns that require additional professional intervention. .

21.6 Unplanned or "ad-hoc" Supervision

There are occasions when it is necessary for a supervisee to resolve immediate issues that are causing concern for example in relation to a particular case that cannot wait for formal supervision. It is however important that informal discussions are brought into the formal supervision process and recorded. During unplanned or "ad-hoc" supervision, supervisors and supervisees need to be explicit about the purpose and objectives of the discussion to avoid any potential for misunderstanding or ambiguity.

When unplanned or ad-hoc supervision takes place The record of ad-hoc / unplanned supervision discussion form (**Appendix 24**) must be completed by the supervisor and then copied and forwarded to the supervisee for inclusion in the supervision diary.

21.7 Supervision for Family Nurse Partnership Team

As stated in FNP Safeguarding – children, young people and adults, FNP National Unit, August 2017

- The Named Nurse for safeguarding role within FNP:
- A three way meeting involving the family nurse, supervisor and named nurse takes place at least 3 monthly to discuss safeguarding cases' and the named nurse should provide clinical supervision for the supervisor's clinical work on, at least, a monthly basis .
- Arrangements are in place to ensure that when the supervisor is not available, family nurses can contact the named nurse / safeguarding team for advice, guidance and support. The expectation is that the supervisor has up to date knowledge about cases and can discuss this with the family nurse during the next supervision session.
- There should be a transparent flow of information between the FNP team and the named nurse / safeguarding team.

Named Nurse for Safeguarding will also provide supervision as required on an ad hoc basis.

21.8 Supervision for the Safeguarding Team

The Safeguarding team will have 3 monthly group supervision facilitated by the Safeguarding team utilising the tietze model of supervision.

22 Safeguarding Children Training

All staff are required to have mandatory safeguarding training which ranges from level 1 -5 dependant on role.

Level	Role
Level 1	All staff working in healthcare services
Level 2	Non-clinical and clinical staff who, in their role, have contact with children & or parents/ carers
Level 3	All clinical staff working with children & or their parents/ carers
Level 4	Specialist roles named professionals for safeguarding children
Level 5	Specialist roles designate professionals for safeguarding children

Please refer to https://www.rcn.org.uk/-/media/royal-college-of-nursing/documents/publications/2019/january/007-366.pdf

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Appendix 1: Body Map

Appendix 2: Individual Agency Report for Initial / Review Child Protection Conference

Appendix 2a: Final Core Group Report For Review Child Protection Conference

Appendix 4: Letter to Parents

Appendix 5: Proforma for the letter to parent /carer

Appendix 6: Notification of a Child or Young Person Missing from Education

Appendix 7: Chronology Of Significant Events

Appendix 8: Confidential – Blackpool Assessment of Need Form

Appendix 8b: Confidential –Lancashire Continuum of Need Form

Appendix 9: Court Statements

Appendix 10: Transfer Out of Children

Appendix 11: Change of Health Professional

Appendix 12: Pre- Adoption Child Records

Appendix 13: Fabricated or Induced Illness Template

Appendix 14: Chain of Custody of specimens

Appendix 15: CSE Screening Tool

Appendix 17: Child Protection Clinical Supervision Agreement / Contract

Appendix 18: Individual Supervision Record Form

Appendix 19: Safeguarding Children Individual Discussion Form

Appendix 20: Supervision Attendance Record

Appendix 21: Group Supervision Record Form

Appendix 22: Supervision Review Form

Appendix 24: Record of Ad Hoc / Unplanned Supervision

Appendix 26: Equality Impact Assessment Form

Department	Safeguarding	**Service or Policy**	Corporate	**Date Completed:**	07/11/2019

GROUPS TO BE CONSIDERED

Deprived communities, homeless, substance misusers, people who have a disability, learning disability, older people, children and families, young people, Lesbian Gay Bi-sexual or Transgender, minority ethnic communities, Gypsy/Roma/Travellers, women/men, parents, carers, staff, wider community, offenders.

EQUALITY PROTECTED CHARACTERISTICS TO BE CONSIDERED

Age, gender, disability, race, sexual orientation, gender identity (or reassignment), religion and belief, carers, Human Rights and social economic / deprivation.

QUESTION	RESPONSE		IMPACT	
	Issue	Action	Positive	Negative
What is the service, leaflet or policy development? What are its aims, who are the target audience?	This document is to ensure that all members of staff have clear guidance on the processes to be followed. The target audience is all staff and volunteers across the organisation	For staff to be aware of their legal responsibility's in relation to safeguarding children	Yes	
Does the service, leaflet or policy/ development impact on community safety • Crime • Community cohesion	yes	Helps to protect children from abuse	Yes	
Is there any evidence that groups who should benefit do not? i.e. equal opportunity monitoring of service users and/or staff. If none/insufficient local or national data available consider what information you need.	No			
Does the service, leaflet or development/ policy have a negative impact on any geographical or sub group of the population?	No			
How does the service, leaflet or policy/ development promote equality and diversity?	Ensures a cohesive approach across the organisation in relation to safeguarding	All policies and procedures Include an EA to identify any positive or negative impacts		
Does the service, leaflet or policy/ development explicitly include a commitment to equality and diversity and meeting needs? How does it demonstrate its impact?	The policy includes EA which provides the opportunity to highlight any potential for a negative/adverse impact			
Does the Organisation or service workforce reflect the local population? Do we employ people from disadvantaged groups				
Will the service, leaflet or policy/ development i. Improve economic social conditions in deprived areas ii. Use brown field sites iii. Improve public spaces including creation of green spaces?	N/A			
Does the service, leaflet or policy/ development promote equity of lifelong learning?	N/A			
Does the service, leaflet or policy/ development encourage healthy lifestyles and reduce risks to health?	Policy helps reduce the harm to children from abuse			
Does the service, leaflet or policy/ development impact on transport? What are the implications of this?	N/A			
Does the service, leaflet or policy/development impact on housing, housing needs, homelessness, or a person's ability to remain at home?	Yes	To protect a child it may be removed from their home		
Are there any groups for whom this policy/ service/leaflet would have an impact? Is it an adverse/negative impact? Does it or could it (or is the perception that it could exclude disadvantaged or marginalised groups?	N/A			
Does the policy/development promote access to services and facilities for any group in particular?	No			

Appendix 26: Equality Impact Assessment Form

Does the service, leaflet or policy/development impact on the environment • During development • At implementation?	N/A			

ACTION:			
Please identify if you are now required to carry out a Full Equality Analysis		**No**	**(Please delete as appropriate)**
Name of Author: **Signature of Author:**	**Lisa Farrell**	**Date Signed:**	**07/11/2019**
Name of Lead Person: **Signature of Lead Person:**		**Date Signed:**	
Name of Manager: **Signature of Manager**	Hazel Gregory	**Date Signed:**	