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Child Safeguarding Policy

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1. PURPOSE

This policy guides Harrogate and District Foundation Trust (HDFT) staff when there are concerns about the safety, welfare and wellbeing of an unborn baby, infant, child or young person under the age of 18.

Safeguarding is everyone's business. The contents of this policy apply to all staff working within HDFT, including agency staff, students and learners, volunteers and all contractual staff.

The HDFT safeguarding children teams can be contacted for support and advice for any aspect of this policy, or any aspect of safeguarding children, on the following numbers in working hours:

HDFT Safeguarding Children Community Single Point of Contact (SPOC): 01423 649880

HDFT Acute Safeguarding Children and Maternity Advice Line: 01423 557539

HDFT On-call paediatrician/Named Doctor Safeguarding Children for Harrogate hospital: via hospital switchboard – 01423 885959

Outside of normal working hours, the relevant local authority Emergency Duty Team can be contacted for advice (see appendix two). In North Yorkshire, this number is 0300 131 2 131

2. BACKGROUND/CONTEXT

The Children Act (2004) and Working Together to Safeguard Children (2023) set out the principles for safeguarding and promoting the welfare of children and young people. They emphasise that the welfare of children is paramount and that safeguarding children and young people and supporting their welfare is a shared responsibility that all members of the community should be involved in. Health professionals and organisations have a key role in safeguarding and promoting the welfare of children.

Working Together to Safeguard Children (2023), defines safeguarding as:

- Protecting children from maltreatment.
- Preventing the impairment of children's mental or physical health or development.
- Ensuring that children are in circumstances consistent with the provision of safe and effective care.
- Promoting the upbringing of children with their birth parents, or otherwise their family network through a kinship care arrangement whenever possible, where this is in the best interests of the children.
- Taking action to enable all children to have the best outcomes in line with the outcomes set out in the Children's Social Care National Framework.

Locally agreed child protection procedures can be accessed through local safeguarding children partnership (LSCP) website. The LSCP should correspond to the child's usual address. Each LSCP (see Appendix 1 – definitions) is committed to learning from local experience and national best practice, and to keep these procedures under constant review and provide additional guidance as appropriate. This policy reflects the principles outlined within these documents and is in accordance with safeguarding children's policies and procedures of the following Safeguarding Children Partnerships: North Yorkshire, Wakefield, Darlington, Durham, Stockton, Middlesbrough, Sunderland, Gateshead and Northumberland.

This policy should be read in conjunction with related national and HDFT policies, procedures and guidance, a full list of which can be found in Section 10 of this policy.

3. DEFINITIONS

See Appendix 1 for a full list of definitions.

Child/Children: Anyone who has not yet reached their 18th birthday. The fact that a child has reached 16 years of age, is living independently or is in further education, is a member of the armed forces, is in hospital or in custody in the secure estate, does not change their status or entitlements to services or protection.

This is important because young people aged 16 and 17 years with safeguarding needs may be accessing adult services in provider organisations.

Whilst unborn children are not included in the legal definition of children, intervention to ensure their future well-being is encompassed within safeguarding children practice, such as pre-birth planning meetings when there are existing concerns around the welfare of the unborn child.

Child Abuse: A form of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Harm can include ill treatment that is not physical as well as the impact of witnessing ill treatment of others. This can be particularly relevant, for example, in relation to the impact on children of all forms of domestic abuse, including where they see, hear, or experience its effects. Children may be abused in a family or in an institutional or extra-familial context by those known to them or, more rarely, by others. Abuse can take place wholly online, or technology may be used to facilitate offline abuse. Children may be abused by an adult or adults, or another child or children (Working Together 2023). Categories of abuse:

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

- **Neglect:** This is defined as the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy, as a result of maternal substance abuse, for example. 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 caregivers)
- 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:** This is a form of abuse which 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.

- **Sexual Abuse:** This 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. It 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 perpetrate sexual abuse, as can other children.

Child in Need: Children shall be taken to be 'in need' under section 17 of the Children Act 1989, for the purposes of Part III of that Act, where:

- they are unlikely to achieve or maintain, or have the opportunity to achieve or maintain, a reasonable standard of health or development;
- their health or development is likely to be significantly impaired, or further impaired, without the provision of services by a local authority under Part III of that Act;
- they are disabled.

Under section 17, local authorities have a general duty to safeguard and promote the welfare of children within their area who are in need and, so far as is consistent with that duty, to promote the upbringing of such children by their families, by providing a range and level of services appropriate to those children's needs

Child Protection: This is a part of safeguarding and promoting the welfare of children and young people. Child Protection refers to that activity which is undertaken to protect specific children who are known to be suffering or at risk of suffering significant harm, as defined by The Children Act (1989), Section 47.

Significant Harm: Significant harm was introduced in The Children Act (1989) as the threshold which justifies compulsory intervention in family life in the best interests of the child. There are no absolute criteria on which to rely when judging what constitutes significant harm. Consideration of the severity of ill-treatment may include the degree and the extent of physical harm, the duration and frequency of abuse and neglect, the extent of premeditation, the presence or degree of threat, coercion, sadism, bizarre or unusual elements including a violent assault, suffocation, or poisoning.

More often significant harm is a compilation of events, both acute and longstanding, which interrupt, change or damage the child's physical and psychological development. In each case it is necessary to consider any maltreatment alongside the family's strengths and supports.

4. Policy Effect

4.1. General Principles of Safeguarding and Promoting the Welfare of Children

The general principles that must be applied are:

- Safeguarding is everyone's business and the welfare of the child is paramount.

- Abused or neglected children may present with signs and symptoms within any setting. Prompt action must always be taken to ensure the immediate safety of a child.
- Professionals should adopt a whole family approach when assessing the needs of a child; i.e. they must see the child in the context of their family and how the needs and strengths of the family interact with each other. If a professional is involved with one child in a family, they must consider the needs and circumstances of all children in that family.
- The voice of the child must be heard. Effective safeguarding systems are those which place the child at the centre of the process. Children should, wherever possible, be seen alone and their views must be captured. Particular consideration must be given to how this is done with children who have communication difficulties.

- Effective safeguarding relies on a high degree of professional curiosity. To be professionally curious a practitioner will ensure their assessment of a child or children and their family is holistic by trying to understand what is happening around them, rather than making assumptions and taking things at face value. A lack of professional curiosity is a recurring theme in serious case reviews / child safeguarding practice reviews. Where practitioners are eager and willing to engage with children and their families or carers, assessment of risk is much more robust, information is sought from other agencies and shared, and the practitioner has a good understanding of potential barriers.

4.2 What To Do When Abuse is Suspected or Disclosed

NB - The following information can be found in the flowchart in appendix 3

4.2.1 There may be a direct disclosure of abuse, either from the child or from another person, or there may be a suspicion that abuse is occurring. **Please refer to section 4.4.1 if you believe the child is at immediate risk of harm.**

When abuse is disclosed, it is important to:

- Take the disclosure seriously, accept what is being said and explore further with the child, if possible, without asking leading questions. Where this is not practicably possible, professional judgement should be used.
- Establish the level of risk the child is subject to and any immediate action that is required

All marks found on examination should be recorded and any that are unexplained, or where the explanation of how the child got the injury does not match the injury itself, should be reported to the police and to children's social care and investigated. Practitioners from the maternity & 0-19 service should use the body map template on SystmOne or Badgernet, to record any relevant marks or bruises. Acute staff should record on a body map within the acute record and in the red book if available.

In the acute trust, any child protection medical examination, is undertaken either at the request of children's social care or the Police, or when a referral has been or is about to be made by a paediatrician to social care in the context of concerns for the wellbeing of a child. The examination should always be conducted and supervised by a Consultant Paediatrician. This will usually be arranged following a strategy meeting, unless the child has come through a hospital emergency department with an injury. If consent is refused by the parent, carer or child, this must be discussed with children's social care and/or the police to ensure the child's safety. **See Child Protection Medical SOP.**

In all circumstances, all events, conversations and actions taken should be recorded.

4.2.2 When a Child Discloses Sexual Assault or When Sexual Assault is Suspected

Refer to the HDFT Child Sexual Assault Procedure (see appendix 4)

Remember: a child under 13 cannot legally consent to any sexual activity therefore should staff become aware of a child engaging in sexual activity, they should refer to children's social care

Child Sexual Exploitation (CSE – see appendix 1) is a form of sexual abuse

4.2.3. Disclosure of Historical Abuse

Adults may disclose that they were victims of abuse in childhood. When this occurs, staff should try to ascertain if it is the first time they have disclosed this. This includes attempting to establish if the person is still in contact with the perpetrator. Given the possibility that the alleged perpetrator may still pose a risk to children, a referral to social care and/or the police may be required, depending on how much information the person is willing to share. Practitioners should use their professional judgement and seek advice from the HDFT safeguarding children's teams.

Should there be grounds for the sharing of information and the person does not consent to this, advice should be sought from the HDFT safeguarding children's teams.

If a child discloses abuse that occurred earlier in their childhood a safeguarding referral should be made and advice sought from the HDFT safeguarding children's teams.

4.2.4 Domestic Abuse

Adults may disclose that they were victims of abuse in childhood. When this occurs, staff should try to ascertain if it is the first time they have disclosed this. This includes attempting to establish if the person is still in contact with the perpetrator. Given the possibility that the alleged perpetrator may still pose a risk to children, a referral to social care and/or the police may be required, depending on how much information the person is willing to share. Practitioners should use their professional judgement and seek advice from the HDFT safeguarding children's teams.

Should there be grounds for the sharing of information and the person does not consent to this, advice should be sought from the HDFT safeguarding children's teams.

If a child discloses abuse that occurred earlier in their childhood a safeguarding referral should be made and advice sought from the HDFT safeguarding children's teams.

Fabricated Illness (FII)/Perplexing Presentations

Refer to the HDFT FII/Perplexing Presentations Policy

FII is a condition whereby a child, young person (or an adult) suffers harm through the deliberate action of her/his parent or carer and which is attributed by the adult to another cause.

It is a relatively rare but potentially lethal form of abuse and the usual child protection procedures apply. It can lead to physical or emotional harm. The child can be directly harmed, both physically and emotionally (through illness induction and taking on a sick role) and indirectly due to the medical response (where the child suffers unnecessary examinations, investigations, procedures and treatments).

Practitioners in all agencies need to be aware of local Safeguarding Children Partnership procedures for managing FII.

4.3 Safeguarding Referrals

4.3.1. Referral Process

If it is known or suspected that a child is suffering, may be suffering or is likely to suffer significant harm, the person who has this concern has a ***duty*** to refer their concerns immediately to children's social care and/or the police. If there is an imminent risk of harm, the police should be contacted and the duty social worker within children's social care must be contacted at the safest available opportunity, by telephone, to report the concerns. The verbal referral to children's social care must then be followed up in writing within 24 hours by the same staff member via the relevant LSCP processes.

Where there are concerns about the safety, wellbeing or welfare of a child or young person but they are not at imminent risk of harm, or where support services are needed then there is no need to call children's social care and a referral can be made using the relevant local authority's referral form and following local processes.

In all circumstances HDFT safeguarding children's teams must be informed when making a safeguarding referral (Contact emails in Appendix - p27)

Where a staff member has a concern outside of office hours, the relevant local authority's Emergency Duty Team should be contacted. See Appendix 2 for a list of contact details.

Where staff are working on the premises of another agency (e.g. in a school), the relevant person (i.e. the designated teacher for child protection) must be informed of their concerns and the action taken.

4.3.2. Consent

Consent should be established on assessment. If a child is being referred to children's social care for concerns about child protection/significant harm, consent from the parents/carers is not required to make the referral. It is however good practice to inform the child's parents/carers of the intention to refer the child to children's social care, unless there is reason to believe that so doing would increase the risk to the child.

Do not discuss the referral with parents/carers in the following circumstances:

- If you suspect intra-familial sexual abuse or the parent / parents are suspected perpetrators
- If you suspect fabricated or induced illness (FII)
- If you consider that discussing your actions with parents would place the child (or yourself) in danger.

If a child is being referred as a Child in Need or Early Help (i.e. a child who needs additional support, but for whom there are no concerns about abuse or neglect – see Appendix 1) consent must be obtained from the child's parent or someone with parental responsibility, or the child if age 16 or 17 years old. A child/young person can consent to, or refuse assessment if they can demonstrate they have the maturity and understanding to do so (Gillick competency). However, even if they refuse, consent can be gained from a person with PR. From the age of 16, the Mental Capacity Act (MCA) applies and the young person can consent to, or refuse assessment/treatment, unless they have been assessed as lacking capacity to do so, in which case a decision must be made in the person's best interests.

4.4. Police Engagement

4.4.1 999

The police should be contacted on 999 in the following circumstances:

- Where a criminal offence has been committed or is suspected
- Where a child is believed to be in imminent danger of significant harm

While the first concern must be to ensure the safety and wellbeing of the child/children, in situations where a crime may have been committed, it is important that forensic and other evidence is preserved. The police may need to attend the scene and agencies and individuals play an essential part in ensuring that evidence is not contaminated or lost. It is important that assumptions are not made about what evidence to preserve and how to preserve it. The police should be contacted for guidance.

If there is an ongoing police investigation, support for the child should continue however this needs to be in collaboration with the investigating officer and be overseen by the HDFT safeguarding children's teams.

4.4.2 Mandatory Reporting of Female Genital Mutilation (FGM)

When there are concerns about FGM, the HDFT FGM Policy should be followed.

FGM is a criminal offence – it is child abuse and a form of violence against women and girls, and therefore should be treated as such. The FGM Act (2007) states that:

- A person is guilty of an offence if s/he **excises**, **infibulates** or otherwise **mutilates** the whole or any part of a girl's labia majora, labia minora or clitoris.
- It is also an offence for a UK national or permanent UK resident to **aid, abet, counsel or procure** this procedure for another person.

Mandatory reporting is required where there is a disclosure of FGM on a person under the age of 18. This should be done by contacting the police on 101. A referral to children's social care should be made and the HDFT children's safeguarding team should be contacted. FGM in any age group is also reported nationally.

The most significant risk factor for girls and young women is coming from a community where FGM is known to be practised and/or where a mother, sister or other female family member has been subjected to FGM. Practitioners should be aware of this and provide families with advice and information which makes it clear that FGM is illegal.

4.4.3 Forced Marriage

The Antisocial Behaviour, Crime and Policing Act (2014) made it a criminal offence to force someone to marry. If there are concerns that a person under the age of 18 has been forced to marry, a referral should be made to children's social care and the police, and the safeguarding children's team should be contacted. Additional advice can be sought from the Forced Marriage Unit on: 020 7008 0151.

Child marriage is formal or informal union before age 18. It is a violation of a child's human rights and a form of gender based violence that robs children of childhood. Child marriage also disrupts education and drives vulnerability to violence, discrimination and abuse. It is illegal and a criminal offence to exploit vulnerable children by arranging for them to marry, under any circumstances whether or not force is used.

4.4.4 Radicalisation

The Antisocial Behaviour, Crime and Policing Act (2014) made it a criminal offence to force someone to marry. If there are concerns that a person under the age of 18 has been forced to marry, a referral should be made to children's social care and the police, and the safeguarding children's team should be contacted. Additional advice can be sought from the Forced Marriage Unit on: 020 7008 0151.

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4.4.5 MAPPA (Multi-Agency Public Protection Arrangements

MAPPA is in place to ensure the successful management of violent and sexual offenders living in the community in order to protect the public. All MAPPA offenders are assessed to establish the level of risk of harm they pose to the public and risk management plans are then worked out for each offender to manage those risks. These set out the action that needs to be taken to minimise the risk. Should staff become aware of a violent or sexual offender accessing HDFT services, they should contact the safeguarding children's team.

4.5. Following a Safeguarding Referral

4.5.1 Feedback

The referrer should receive feedback on the outcome of the referral after five working days. If feedback is not provided, the practitioner should contact the relevant local authority to obtain an outcome of the referral and update the child's record accordingly.

4.5.2 Attendance at Child Protection Meetings

All health staff that are working with a child or family where child protection processes are initiated may be required to attend Initial Child Protection Conferences (ICPC) and Review Child Protection Conference (RCPC). HDFT's safeguarding children's teams support this process.

4.5.3 Escalations Where Professionals Disagree

Professional challenge is healthy, and it keeps children safe. Staff should be able to respectfully challenge other professionals regarding safeguarding decisions when required and provide supporting evidence for their opinions. If there is a disagreement between professionals on the best course of action to keep a child safe, refer to **HDFT Professional Challenge Escalation Pathway.**

4.6 Information Sharing

It is important that information is shared effectively between agencies to safeguard children. Serious case reviews have highlighted that missed opportunities to record, understand the significance of, and

share information in a timely manner can have severe consequences for the safety and welfare of children. If a professional has concerns about a child's welfare and believes they are suffering, or likely to suffer harm, then they should share the information with children's social care. No professional should assume that another individual or organisation has already shared information that they think may be critical to protecting a child.

Where staff need to share special category personal data (personal data that is sensitive and therefore gives extra protection, e.g. data concerning health), the Data Protection Act (2018) contains "safeguarding of children and individuals at risk" as a processing condition that allows staff to share information. This includes the sharing of information without consent if: it is not possible to gain consent or to gain consent would put the child at risk.

All information should be shared in accordance with the **HDFT Data Protection, Confidentiality and Security Policy.**

4.7 Additional Considerations for Staff Working in the Acute Setting

For all children admitted to an acute ward the admitting practitioner must request details regarding any previous or current safeguarding concerns, (or children's social care involvement), for any family members.

The HDFT safeguarding children's teams should be contacted if there are any concerns and more information is required about the family (this information can also be requested through health visitors or social care). Web V should always be checked for safeguarding updates upon attendance at hospital and prior to discharge.

Where there are known concerns regarding family members who may pose a risk to a child, these people will have no access to the ward, until further discussions with children's social care have been held and safety plans made as appropriate. The ward manager / matron must liaise with the HDFT safeguarding children's teams, children's social care and the HDFT Security Risk Manager to agree a risk management plan for the alleged perpetrator.

All children below age one year with an injury, or any child who is not yet independently mobile, with fractures, bruise, cut, laceration, abrasion burns and scalds, must be discussed with the Consultant Paediatrician or senior paediatric registrar on call, and the content and outcome of this discussion recorded in the patient notes. Parents should be informed that admission to the ward may be necessary and is usually routine. However, admission to the Children's Ward will be at the discretion of the Consultant Paediatrician on call, along with the orthopaedic or other specialist team.

All children with suspected abuse must be seen by a Consultant Paediatrician (or by a paediatric registrar who is supervised by a consultant paediatrician) even if referred to another specialty:

- Always consider that the abuse/neglect may be the cause of critically ill child.
- Establish the identities of accompanying adults and children, as well as any other family and household members. Record full names and relationships in the child's records and share this information with children's social care when making a child protection referral.

Where a child has been receiving inpatient care for 12 weeks or over, the local authority must be informed, due to its duties under Section 85 of the Children Act (1989). When a child is approaching the 12-week mark of being a hospital inpatient, staff from the current inpatient area are required to make a referral to children's social care in the area where the child/children live. The ward manager or nurse in charge must inform the acute safeguarding team. The 12 weeks inpatient stay must take into account admissions to other hospitals.

4.8 Allegations Against Staff/Those Who Work with Children

Where there are concerns about allegations against a person in position of trust, refer to **HDFT Managing Allegations against People in Positions of Trust.**

It is essential, in order to safeguard vulnerable children, that any concerns where the person is a staff member who works with children, or works externally to HDFT with children, whether or not the concerns/allegations relate to current, recent or historical behaviour, are shared promptly with the LADO (Local Authority Designated Officer). The LADO must be contacted where there are indications that a person has/may have:

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

Staff must contact the safeguarding children's team, who will refer to the LADO as required, following local processes.

Should there be an allegation about a person who works with adults with care and support needs, a PiPoT (Person in a Position of Trust) referral may need to be made. For further information, please see the HDFT Safeguarding Adults Policy.

4.9 Was Not Brought

Children who are not brought to their health appointments may be at increased risk of harm. See the **HDFT Procedure for the Management of Circumstances When Parents/Carers Fail to Bring Children/ Young People for Health/Medical Appointments.** Within the Emergency Department (ED) setting if a child leaves the department without being seen then the ED Left without Being Seen Protocol (LWOBS) should be completed. If a child directed to ED by 111 does not attend for review an alert is flagged by ED team to GP the following day.

4.10 Death of a Child in the Hospital Setting/Deceased Children Brought to the Hospital

Deceased children who are brought to the hospital for examination should not be taken to the mortuary until a paediatrician has examined them.

There are different statutory requirements when a child dies, which are based on chapter seven of Working Together to Safeguarding Children (2023), and include the child death review processes. In any death of a child, a Child Death Overview Panel (CDOP) investigation has to be started. In order for this process to start, the following people need to be contacted after the death: the on-call Paediatrician; HDFT children's safeguarding team; the police; and children's social care (the Emergency Duty Team out of hours).

Child Death Review process: The purpose is to collect information about the deaths of all children in the area so the CDOP can:

- Document, analyse and review information in relation to each child that dies in order to confirm the cause of death, determine any contributing factors and to identify learning arising from the

process that may prevent future child deaths.

- Make recommendations to all relevant organisations where actions have been identified which may prevent future deaths or promote the health, safety and wellbeing of children
- Contribute to local, regional and national initiatives to improve learning from CDRs

Refer to HDFT Sudden Death in Childhood (SUDIC) folder and HDFT child death flowcharts.

4.11 Training and Supervision

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- Make recommendations to all relevant organisations where actions have been identified which may prevent future deaths or promote the health, safety and wellbeing of children
- Contribute to local, regional and national initiatives to improve learning from CDRs

Refer to HDFT Sudden Death in Childhood (SUDIC) folder and HDFT child death flowcharts.

4.12 Impact on Individuals with Protected Characteristics

This policy aims to safeguard all children and young people who are in receipt of services (or whose family members or carers are in receipt of services) from the Trust, and who may be at risk of abuse, irrespective of disability, race, religion/belief, nationality, or gender, or sexual orientation.

All Trust staff must respect the alleged victim's (and their family's/carer's) race or ethnicity, religion or belief, gender and sexuality. However, this must not prevent action to safeguard children and young people who are at risk of, or experiencing, abuse.

All reasonable endeavours must be used to establish the child, young person and families'/carers' preferred method of communication, and to communicate in a way they can understand. This will include ensuring access to a professional interpreter service where people have English as a second language (including British Sign Language or Makaton).

5. Roles and Responsibilities

Executive Director of Nursing, Midwifery and AHPs

The Executive Director of Nursing, Midwifery and AHPs has overall responsibility for ensuring that

policies and procedures are in place to protect children accessing HDFT services, including to ensure that HDFT has arrangements in place that reflect the importance of safeguarding and promoting the welfare of children.

Deputy Director of Children, Young People and Safeguarding

The Deputy Director of Children, Young People and Safeguarding receives delegated authority to lead on behalf of the Executive Director of Nursing, Midwifery and AHPs.

Director of Workforce and Organisational Development

The Director of Workforce and Organisational Development is responsible for ensuring that safe recruitment practices are in place. They are also responsible for ensuring disciplinary, whistleblowing and other related policies are in place and that statutory guidance is adhered to with regard to DBS.

Named Doctor Safeguarding Children

Provides support and advice to the acute safeguarding children's team in relation to clinical decisions/ clinical presentation.

Head of Safeguarding

Ensures HDFT fulfils its statutory duties in relation to adult and children safeguarding and will provide advice to the Named Nurses/Named Professionals to fulfill the responsibilities of this policy.

Named Nurse Safeguarding Children/Named Midwife

Ensures HDFT fulfills its statutory responsibilities to safeguard children by:

- Providing safeguarding support and advice to staff.
- Developing and delivering robust safeguarding training packages in line with best practice.
- Ensuring supervision to promote safe and effective professional practice for all relevant staff in line with the HDFT supervision policy.
- Contribute to the work of the relevant LSCP and ensure robust communication between the LSCP and HDFT

Specialist Nurse Child Protection

Provides support and advice to staff in relation to safeguarding children. They will support and monitor safeguarding referrals made by HDFT staff. They will support staff who have raised safeguarding concerns where necessary.

Safeguarding Link Workers/Champions

Represent their department, ward or team at safeguarding children's link worker/champions meetings. They act as a resource in their area in relation to safeguarding children and promote the agenda and profile of safeguarding children.

Line Managers/Heads of Service

Line managers/Heads of Service must

- Ensure that staff are aware of this policy and associated guidance and know how to respond appropriately to safeguarding concerns/disclosures of abuse. They will support staff who have raised safeguarding concerns where necessary.
- Ensure staff are compliant with mandatory safeguarding children training in accordance with their role, including checking the safeguarding training passports and confirming they have met the learning requirements.
- Ensure staff are aware of who to contact in HDFT for specialist safeguarding advice.
- Ensure staff are compliant with mandatory supervision in accordance with their role.

All Staff:

All staff must work in line with the local safeguarding multiagency policies and procedures. It is the responsibility of all staff to:

- Identify children who are being, or have been, abused or neglected.
- Identify where there may be an impact on children due to parental/carer mental illness or substance misuse.
- Listen to the voice of children.
- Refer concerns to the relevant local authority's children social care teams.
- Contribute to, including by providing information to, multi-agency assessments, including Section 47 child protection conferences and reviews.
- Attend mandatory safeguarding children's training and supervision in accordance with their role.
- Know how to contact safeguarding teams in HDFT and to seek advice.

6. Equality Analysis

This policy adheres to the Equality and Diversity Strategy by reflecting its beliefs and aims in order to ensure that the Trust's workforce implements this policy in a non-discriminatory and appropriate way in its delivery of healthcare. It has undergone stage 1 Equality Impact Assessment screening. This policy does not require a full stage 2 Equality Impact Assessment.

7. Consultation, Review and Communication

This policy will be reviewed every three years, or earlier, in response to policy/practice/legislation change.

This policy will be communicated via relevant governance groups; training, the HDFT intranet and the safeguarding newsletter

8. Standards/Key Performance Indicators

The following KPIs will evidence if this policy has been implemented effectively:

- Safeguarding concerns being appropriately identified and referred.
- Section 11 audits will evidence that staff are appropriately trained in safeguarding children in line with the intercollegiate document.
- Section 11 audits will evidence that staff have robust safeguarding children supervision.
- No recurrence of practice issues identified through Safeguarding Adult Review's / Child Safeguarding Practice Review's / Learning Lessons / Non-statutory learning.

9. Monitoring Compliance and Effectiveness

Policy element to be monitored	Standards and Performance indicators	Process for monitoring	Individual or group responsible for monitoring	Frequency or monitoring	Responsible individual or group for development of action plan	Responsible group for review of assurance reports and oversight of action plan
Adherence to the policies and procedures	*Children at risk of harm are identified and protected. Safeguarding referrals are completed when concerns are identified No recurrence of practice issues identified through lessons learnt*	Audit of Child protection referrals. Themes from SPOC. Deep dive audits (non-acute)	Safeguarding Children team	Ongoing	Head of Safeguarding Named Nurses Child Protection	HDFT Safeguarding Governance Forum
Staff to attend mandatory safeguarding children training and supervision	*Safeguarding concerns should be raised via the correct process 100% of the time*	Training Monitored by Learning and Development	Safeguarding Children team	Ongoing	Head of Safeguarding Named Nurses Child Protection	HDFT Safeguarding Governance Forum

10. References/Associated Documentation

National Guidance

- Children Act 1989
- Working Together to Safeguard Children 2023
- Information Sharing Advice for Practitioners 2018
- The Human Rights Act 1998
- Children and Social Work Act 2017
- Promoting the health and well-being of looked-after children 2015
- Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (2019)
- Equality Act 2010.
- NICE Guidance (2017) Child Maltreatment: When to Suspect Maltreatment in Under 18s

HDFT Guidance:

- Domestic Abuse Policy

- Managing Allegations against People in Positions of Trust
- Procedure to Follow when a Child Discloses Sexual Assault
- The Management of Injuries in Non-Independently Mobile Children
- Perplexing Presentation and Induced Illness Policy
- Procedure for the Management of Circumstances where Parents and/or Carers Fail to Bring Children/Young People for Health/Medical Appointments
- Mental Capacity Act Policy
- DoLS Policy
- Female Genital Mutilation (FGM) Policy
- Missing Children and Family Procedure
- Escalating Concerns Where Professionals Disagree Flowchart
- Safeguarding Adults Policy
- Disciplinary Policy
- Whistleblowing Policy
- Professional Challenge Escalation Policy
- Child Protection Medical SOP
- SUDIC Folder

11. Consultation Summary

Those listed opposite have been consulted and any comments/actions incorporated as appropriate. The author must ensure that relevant individuals/groups have been involved in consultation as required prior to this document being submitted for approval.	**List Groups and/or Individuals Consulted**
	Safeguarding SMT
	Named Nurses Child Protection 0-19
	Named Nurse Child Protection Acute
	Deputy Director of Nursing for Children, Young People and Safeguarding
	Equality, Diversity & Inclusion Manager
	Head of Safeguarding
	Associate Directors of Nursing
	General Managers
	Strategic Lead - AHPs
	Named Doctor – Safeguarding Children
	Designated Doctor – Safeguarding Children
	Named Midwife

12. Appendices

Appendix 1 - Definitions

Child Trafficking

Trafficking is where children are tricked, forced or coerced to leave their homes and are moved or transported (within a country, town or city, a different part of a town or city they live in, or across borders whether by force or not), and then exploited, forced to work or sold.

Children are trafficked for:

- Sexual and/or Criminal Exploitation
- Forced Marriage
- Forced Labour (factories, agriculture)
- Domestic Slavery (cooking, cleaning, childcare)
- Undertaking crimes, like theft, working on cannabis farms or moving and selling drugs.

Trafficked children experience many types of abuse and neglect. Traffickers use physical, sexual and emotional abuse as a form of control. Children and are also likely to be physically and emotionally neglected and may be sexually abused.

Child protection conference:

A Child Protection Conference is called when concerns exist that children are suffering or may be at risk of suffering significant harm. At the conference information will be shared about the family history, the child's health, development and functioning and the children and their parent/carer's capacity to ensure the child's safety and promote their well-being. Those present will consider the evidence and form a view if the child has or is likely to suffer significant harm, then an inter-agency Child Protection Plan or Safety Plan will be written together about what everyone is going to do and when and how they are going to do it so that the children can be kept safe.

Working Together to Safeguard Children (2023) provides statutory guidance on how conferences should be conducted and who should attend, as well as noting that all involved practitioners should: 'work together to safeguard the child from harm in the future, taking timely, effective action according to the plan agreed.'

Child Safeguarding Practice Reviews:

Under Working Together 2023, when a child dies or is seriously harmed* in circumstances where abuse or neglect are known or suspected (i.e., is a serious child safeguarding case), Local Safeguarding Children Partnerships are required to consider whether a Child Safeguarding Practice Review (CSPR) is appropriate and to consider the involvement of organisations and professionals with the child and family.

In order to do this, a rapid review must be carried out within 15 days of the notification of the serious child safeguarding case to the National Child Safeguarding Practice Review Panel.

The purpose of each review is to:

- Identify improvements that can be made to safeguard and promote the welfare of children.
- Understand whether there are systemic issues, and whether and how policy and practice need to change.
- Seek to prevent or reduce the risk of recurrence of similar incidents.

Child Safeguarding Practice Reviews are learning exercises and not investigations to find out who is to blame for things going wrong, with the overall purpose being that of improving practice.

Child Sexual Exploitation (CSE): Child sexual exploitation is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology which includes internet and social media platforms.

Concerns: Concerns refer to any suspicion, allegation, or other apprehension relating to the safety or wellbeing of a child or young person who may be experiencing or at risk of abuse. Individuals do not need proof in order to make a referral under safeguarding children's procedures.

Contextual Safeguarding: As well as threats to the welfare of children from within their families, children may be vulnerable to abuse or exploitation from outside their families. These extra-familial threats might arise at school and other educational establishments, from within peer groups, or more widely from within the wider community and/or online.

These threats can take a variety of different forms and children can be vulnerable to multiple threats, including exploitation by criminal gangs and organised crime groups such as county lines; trafficking, online abuse; sexual exploitation and the influences of extremism leading to radicalisation. Extremist groups make use of the internet to radicalise and recruit and to promote extremist materials. Any potential harmful effects to individuals identified as vulnerable to extremist ideologies or being drawn into terrorism should also be considered.

County Lines: The term county lines refer to urban gangs supplying drugs to suburban areas, as well as market and coastal towns, by using dedicated mobile phone lines or "deal lines". Gangs use children and vulnerable people to move drugs and money to these areas. Once caught up in county lines, exploited individuals are at risk of extreme physical and/or sexual violence, gang recriminations and trafficking (Gov.uk, 2018).

DBS: Employers can check the criminal record of someone applying for a role. This is known as getting a Disclosure and Barring Service check

Domestic Homicide Review: A Domestic Homicide Review (DHR) is a comprehensive review of the circumstances in which the death of a person aged 16 or over, has or appears to have resulted from domestic abuse. DHR's are part of the Domestic Violence, Crime and Victims Act 2004 and became law in April 2011. They do not replace, but are in addition to, the inquest or any other form of inquiry into the homicide. Information within DHR's is anonymised to protect the family and friends of the victim. All the information shared between agencies to undertake the review remains confidential until the Home Office has reviewed and approved it for publication.

Early Help: Providing early help is more effective in promoting the welfare of children than reacting later. Early help means providing support as soon as a problem emerges, at any point in a child's life, from the foundation years through to the teenage years. Early help can also prevent further problems arising; for example, if it is provided as part of a support plan where a child has returned home to their family from care, or in families where there are emerging parental mental health issues or drug and alcohol misuse

Honour Based Abuse: Honour-based abuse is a crime or incident committed to protect or defend the 'honour' of a family or community.

If a person's family or community think they have shamed or embarrassed them by behaving in a certain way, they may be punished for breaking their 'honour' code. There isn't one specific crime of honour-based abuse. It can involve a range of crimes and behaviours, such as: certain way, they may punish you for breaking their 'honour' code.

People who carry out honour-based abuse are often close family members but also extended family or community members.

Forced marriage, domestic abuse and sexual violence are often connected to and are types of honour-based violence. A child may be in the centre of the family and exposed to emotional harm.

Local Safeguarding Partnerships (LSCP): The Local Safeguarding Children Partnership (LSCP) is the key statutory mechanism for agreeing how the relevant agencies in each local area will co-operate to safeguard and promote the welfare of children in that locality, and for ensuring the effectiveness of what they do. The Children Act 2004 requires each local authority to establish a Safeguarding Partnership.

Working Together to Safeguard Children, Multi-Agency Safeguarding Arrangements sets out in detail the arrangements for the work of each Local Safeguarding Children Partnership.

Local safeguarding meetings are held where partners come together across children, adult and community safety services to identify the safeguarding need of areas and look to address this need through partnership working.

Mental Capacity Act (MCA): The MCA applies to all persons over the age of 16 who are assessed to lack capacity to consent or withhold consent to treatment or care. However, under the MCA there are occasions when anyone lacking capacity should, or may require an Independent Mental Capacity Advocate, where treatment or residence decisions have a significant impact on an individual's life and rights.

Modern Slavery: Modern slavery encompasses slavery, servitude, forced and compulsory labour and human trafficking. Traffickers and slave drivers coerce, deceive and force individuals against their will into a life of abuse, servitude and inhumane treatment (Gov.uk, 2014).

The National Referral Mechanism (NRM) is a framework for identifying and referring potential victims of modern slavery and ensuring they receive the appropriate support.

Victims may not be aware that they are being trafficked or exploited, and may have consented to elements of their exploitation, or accepted their situation. If you think that modern slavery has taken place, the case should be referred to the NRM so that the Single Competent Authority (SCA) can fully consider the case. You do not need to be certain that someone is a victim. Contact the safeguarding children team who will support with the referral.

Parent refers to the person with legal Parental Responsibility for the child. Parental responsibility continues until the child reaches 18 years of age.

Parental Responsibility (PR): This is the legal rights, duties, powers, responsibilities and authority a parent has for a child and their property. A person who has PR for a child has the right to make decisions about their care and upbringing until the young person has Gillick competence and can consent to their own treatment. Important decisions in the child's life, e.g. whether or not a child receives medical treatment, **(This must be agreed with someone who has PR).** The following people automatically have PR:

- The birth mother
- The father, if married to mother at the time the child was born
- The father, if not married to the mother but he is registered on the child's birth certificate, if the birth was registered after 2003
- Any civil partners of the mother registered as the child's legal parent on the birth certificate

A local authority can gain PR by getting an order from the Court.

Private Fostering: This is when a child under the age of 16 years (or under 18 years, if disabled) is cared for by someone who is neither their parent nor a close relative (i.e. step-parent, grand-parent, brother, sister, blood uncle or aunt). This is via a private arrangement made between the carer and the child's parent. It is classed as a private fostering arrangement if it lasts for 28 days or more.

Many private fostering arrangements remain unknown to the local authority and this is a cause for concern as privately fostered children and young people, without the safeguards provided by law, are a particularly vulnerable group.

It is an offence not to tell the local authority about a private fostering arrangement. There are many reasons why children and young people are privately fostered. Such examples include parental ill health, children or young people who are sent to this country for education or health care by birth parents from overseas, children or young people who are living with a friend due to parents working unsociable hours etc. Therefore, if staff become aware of any private fostering arrangement, they should notify the local authority.

Seriously harmed in the context of the above includes, but is not limited to, cases where the child has sustained, as a result of abuse or neglect, any or all of the following:

- A potentially life-threatening injury
- Serious and/or likely long-term impairment of physical or mental health or physical, intellectual, emotional, social or behavioural development

This definition is not exhaustive and even if a child recovers, this does not mean that serious harm cannot have occurred. The Local Safeguarding Children Partnerships will ensure that any decision making is informed by available research and evidence.

Appendix 2 - Contact Numbers for Local Authority Children's Social Care

Wakefield	0345 8503503
North Yorkshire	03001312131
Middlesbrough	01642 726004
Stockton	01429 284284
Darlington	01325 406252
Durham	03000 267979
Gateshead	0191 4332653
Sunderland	0191 5617007
Northumberland	01670 536400
Leeds	0113 3760336 out of hours 0113 5350600
Bradford	01274 435600
York	01904 551900 out of hours 03001310131

NB: Please remember to copy the relevant Safeguarding Children's Team into emails/referrals to social care

Acute staff:

hdft.acutesafeguardingchildrenteam@nhs.net

Community staff:

Northumberland: hdft.scnorthumberland@nhs.net

Durham: hdft.scdurham@nhs.net

Gateshead hdft.scgateshead@nhs.net

Sunderland: hdft.scsunderland@nhs.net

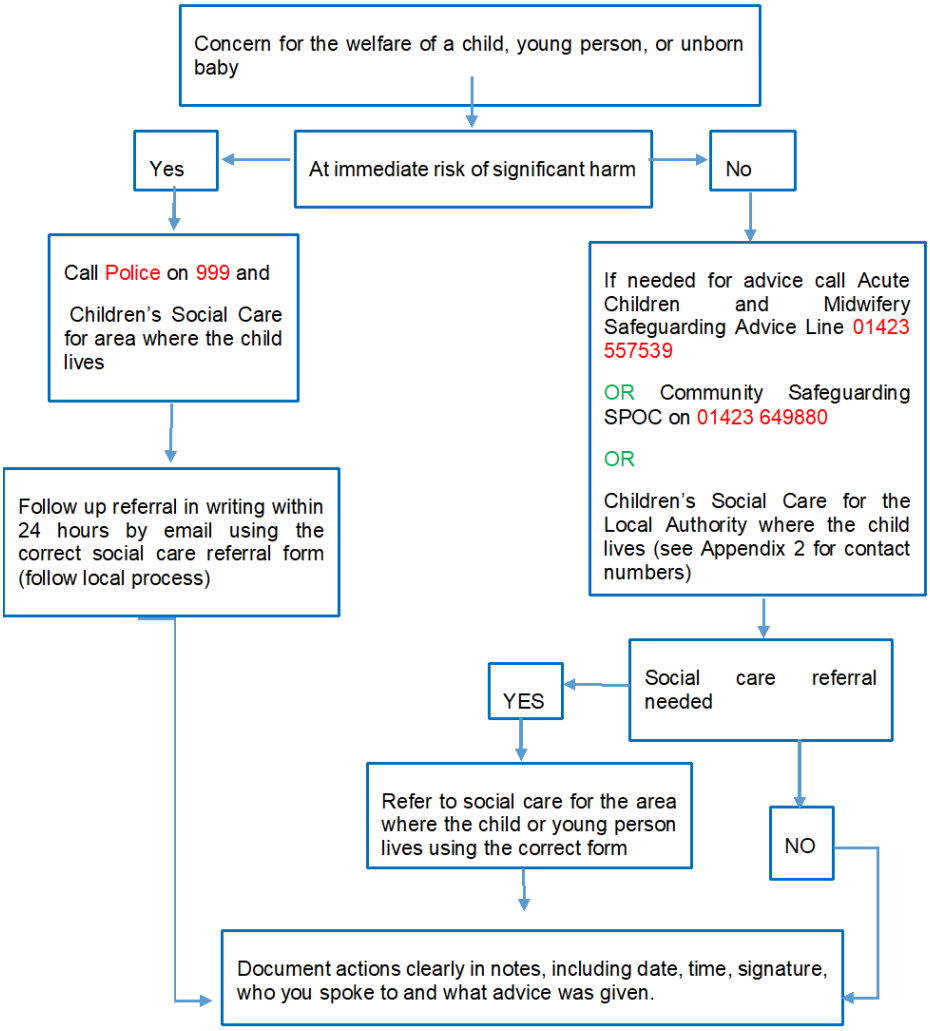
Stockton: hdft.stockton-safeguarding@nhs.net

Middlesbrough: hdft.0-19.middlesbroughsafeguarding@nhs.net

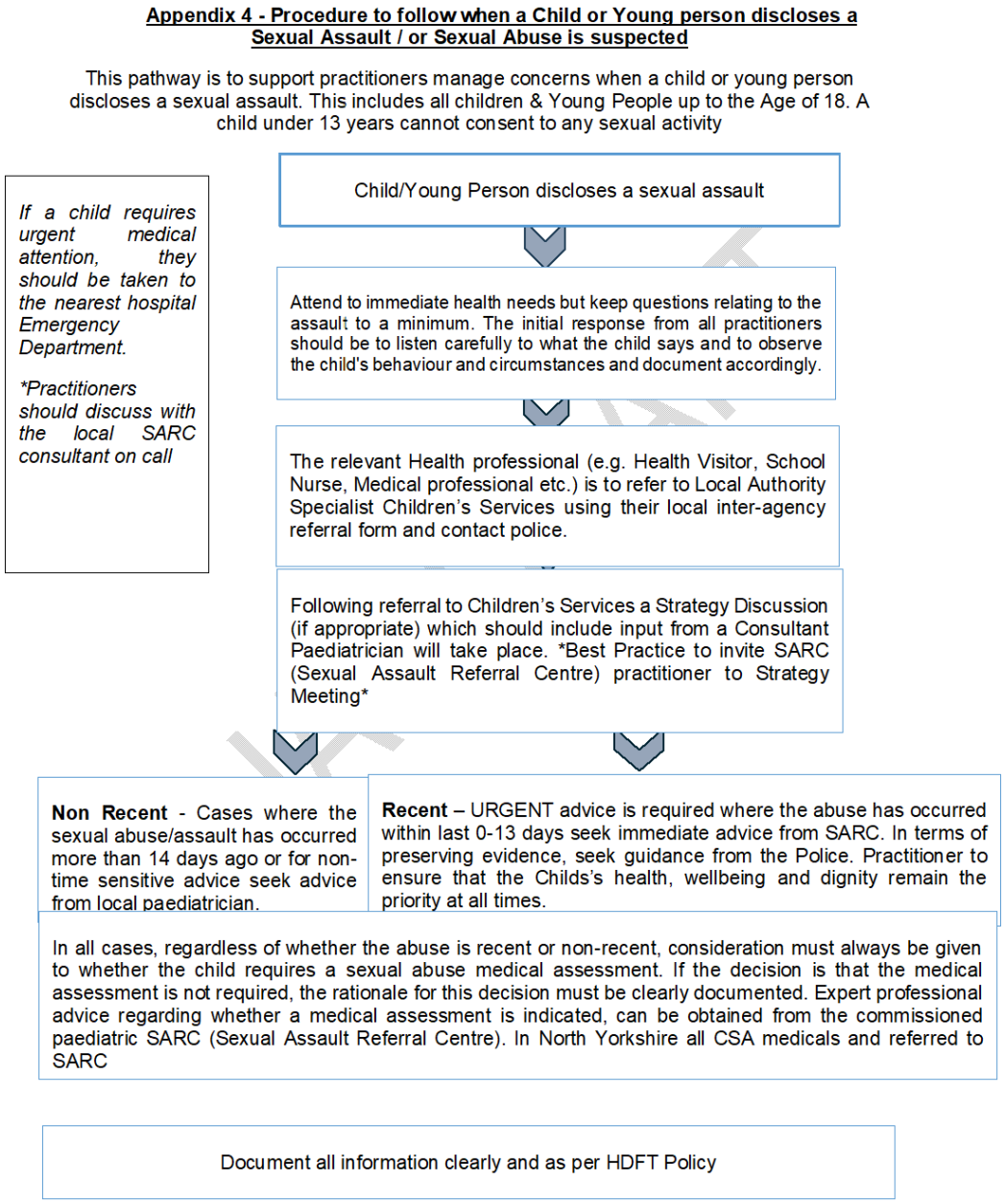
Wakefield: hdft.safeguardingwakefield@nhs.net

Darlington: hdft.0-19Darlington@nhs.net

Appendix 3 - Flowchart of Actions to Take When You Have a Concern



Appendix 4 - Procedure to Follow When a Child/ Young Person Discloses Sexual Assault or Sexual Abuse is Suspected



Approval Signatures

Step Description	Approver	Date
Senior Management Team	SMT Senior Management Team [RH]	23 Jan, 2025
QGMG	QGMG Quality Governance Man Group [PC]	27 Dec, 2024
Policy Governance Team Review	Policy Governance Team Review PGTR [PC]	25 Nov, 2024
Safeguarding Governance Forum	Frances Aldington: Global Learner	21 Nov, 2024
Policy Governance Team Review	PGT Policy Governance Team [KK]	20 Nov, 2024
Policy Owner	Frances Aldington: Global Learner	19 Nov, 2024