Sarah Agnes Foundation (SAF) Safeguarding children policy.

1.0 Introduction

'*Working Together to Safeguard Children'* (March 2015) states Effective safeguarding arrangements in every local area should be underpinned by two key principles:

1. Safeguarding is everyone's responsibility: for services to be effective each professional and organisation should play their full part; and
2. A child-centred approach: for services to be effective they should be based on a clear understanding of the needs and views of children. (page 8, paragraph 14).
   https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf

As a community organisation, we have established links with the statutory and non-statutory services in Barking and Dagenham. We have listed details of designated safeguarding individuals in each locality as well as the Multi-Agency Safeguarding Hub, and out-of-hours emergency services. We adhere to the guidance provided by the Barking and Dagenham Safeguarding Children's Board Child Protection and Safeguarding document and we are registered for updates with this service.

http://www.bardag-lscb.co.uk Documents/Multi-agency%20thresholds%20document%20final%20version%201.pdf

This manual, together with SAF safeguarding procedures, and the contact list of named safeguarding leads is available to all clinicians in the service (via shared drive and hard copies).

2.0 Purpose

The aim of this policy is to enable SAF to demonstrate how it meets its statutory safeguarding responsibilities, follows guidance and promotes best practice. This policy defines the local arrangements, roles and responsibilities and how the team works together with other agencies to safeguard children.

A child is defined as anyone who has not yet reached their 18th birthday; this extends to the unborn child.

3.0 Duties

Section 11 of the Children Act 2004 places a duty to all clinicians to make arrangements to ensure that, in discharging their functions, they have processes which safeguard and promote the welfare of children.

All SAF staff must adhere to the underlying policies, principles and values

set out in the Barking and Dagenham Child Protection and Safeguarding Procedures:

http://www.bardag-lscb.co.uk Documents/Multi agency%20thresholds%20document%20final%20version%201.pdf
and outlined in '*Working Together to Safeguard Children'* these are:

- aim to ensure that all affected children receive appropriate and timely therapeutic and preventative interventions;
- those professionals who work directly with children should ensure that safeguarding and promoting their welfare forms an integral part of all stages of care they offer;
- those professionals who come into contact with children, parents and carers in the course of their work also need to be aware of their safeguarding responsibilities;
- ensure that all health professionals can recognise risk factors and contribute to reviews, enquiries and child protection plans, as well as planning support for children and providing on-going promotional and preventative support through proactive work.

In addition *Working Together to Safeguard Children* sets out specific responsibilities for adult mental health services:

"Adult mental health services – including those providing general adult and community, forensic, psychotherapy, alcohol and substance misuse and learning disability services – have a responsibility in safeguarding children when they become aware of, or identify, a child at risk of harm. This may be as a result of a service's direct work with those who may be mentally ill, a parent, a parent to be, or a non-related abuser, or in response to a request for the assessment of an adult perceived to represent a potential or actual risk to a child or young person. These staff need to be especially aware of the risk of neglect, emotional abuse and domestic abuse. They should follow the child protection procedures laid down for their services within their area." Thus each SAF member of staff is expected to be aware of local policies and procedures for safeguarding children.

3.1 Responsibilities of the team

It is essential that all SAF staff recognise any concerns or risks relating to safeguarding children and take the appropriate action in response to this concern or risk. They must be familiar with safeguarding guidance and recognition signs of abuse or neglect as outlined in the Barking and Dagenham guidelines:

http://www.bardag-lscb.co.uk Documents/Multi-agency%20thresholds%20document%20final%20version%201.pdf

All SAF staff have a duty to report concerns to Children's Social Care; see **Making a Referral Procedure**.

All clinical staff must be trained to the levels and competencies outlined in "Safeguarding Children and Young People; Roles and Competencies for Health Care Staff". The Intercollegiate Document RCPCH (2014) Knowledge, skills, attitudes and values have been checked against competencies for child psychologists/child psychotherapists outlined on pages 44-45 of this document.
http://www.lscbchairs.org.uk/sitedata/files/Safeguarding_Children_Heal.pdf
These competencies are reviewed annually.

4.0 Definitions.

4.1 **Safeguarding**: Safeguarding and promoting the welfare of children is defined for the purpose of statutory guidance under the Children Acts 1989 and 2004 respectively as:

- Protecting children from maltreatment
- Preventing impairment of the child's health or development
- Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care.

And undertaking that role so as to enable those children to have optimum life chances and to enter adulthood successfully.

4.2 **Child in Need:** Under Section 17 of the Children Act 1989, children in need are those whose vulnerability is such that they are unlikely to reach or maintain a satisfactory level of health or development, or their health and development will be significantly impaired, without the provision of services, and those who are disabled. The critical factors to be taken into account in deciding whether a child is in need under the Children Act 1989 are what will happen to a child's health and development without services, and the likely effect the services will have on the child's standard of health and development.

Children with a new or an enduring significant disability are by definition children in need under Section 17, as are children who have been in-patients in hospital for more than 3 months.

4.3 **Child Protection**: Some children are in need of protection because they have suffered or are likely to suffer significant harm. Section 47 of the Children Act 1989 gives the local authority Children and Young Peoples Directorate the duty to make enquiries to decide whether they should take action to safeguard or promote the welfare of a child who is suffering or is likely to suffer significant harm.

It identifies significant harm as the threshold that justifies compulsory

intervention in family life in the best interest of the child. A person may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm.

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

4.5 **Types of Abuse:**

- 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.

- Sexual abuse ~ involves forcing or enticing a child or young person to take part in sexual activities, including prostitution, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative (e.g. rape, buggery or oral sex) or non – penetrative acts. They may involve non-contact activities, such as involving children in looking at, or in the production of, sexual online images, watching sexual activities, or encouraging children to behave in sexually inappropriate ways.

- 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 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);
  - ensure access to appropriate medical care or treatment.
  - This includes neglect of, or unresponsiveness to, a child's basic emotional needs.

- Emotional abuse ~ is the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effect on the child's emotional development. It may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond the child's developmental capability,

as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction. It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying, causing children to be 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.

4.6 Fabricated & Induced Illness – (Factitious Illness)

Concerns may be raised when it is considered that the health or development of a child is likely to be significantly or further impaired by a parent or caregiver who has fabricated or induced illness by the:

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

These are not mutually exclusive.

Alerting features that should prompt you to consider fabricated or induced illness:-

- A child's history, physical or psychological presentation, or findings of assessments, examinations or investigations, leads to a discrepancy with a recognised clinical picture, even if the child has a past or concurrent physical or psychological condition.

Alerting factors that should prompt you to suspect fabricated or induced illness:

- A child's history, physical or psychological presentation, or findings of assessments, examinations or investigations leads to a discrepancy with a recognised clinical picture plus one or more of the following, even if the child has a past or concurrent physical or psychological condition:
- reported symptoms and signs are only observed by, or appear in the presence of, the parent or carer;
- an inexplicably poor response to prescribed medication or other treatment;
- new symptoms are reported as soon as previous symptoms stop
- biologically unlikely history of events;
- despite a definitive clinical opinion being reached, multiple opinions from both primary and secondary care are sought and disputed by the parent or carer and the child continues to be presented for investigation and treatment with a range of signs and symptoms;
- child's normal daily activities (for example, school attendance) are

limited, or they are using aids to daily living (for example, wheelchairs) more than expected from any medical condition that the child has.

(NICE clinical guideline 89, When to suspect child maltreatment, July 2009)

4.7 **Every Child Matters: Change for Children: 'Every Child Matters: Change for Children' Programme** (DfES 2003) stated that all children deserve the opportunity to achieve their full potential. The five outcomes that are key to children and young people's wellbeing are:

- Stay safe
- Be healthy
- Enjoy and achieve
- Make a positive contribution
- Achieve economic wellbeing

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/272064/5860.pdf

4.8 **Mental Health and Safeguarding**

The majority of parents who suffer mental ill-health are able to care for and safeguard their children and/or unborn child. Some parents, however, will be unable to meet the needs and ensure the safety of their children and at the most extreme, parental mental ill-health has been identified as a clear factor in a significant number of child deaths (Falkov,1995). The welfare of the child must be paramount**.**

Working Together to Safeguard Children (HM Gov 2006) Para 2.93 states: "To safeguard children of parents, mental health practitioners should routinely record details of patients' responsibilities in relation to children, and consider the support needs of patients and of their children, in all aspects of their work, using the Care Programme Approach."

Para 2.94 states that: "Close collaboration and liaison between adult mental health services and children's social services are essential in the interests of children. This may require sharing information to safeguard and promote the welfare of children or to protect a child from significant harm."

Where SAF professionals suspect a child and/or unborn child has suffered or is at risk of suffering significant harm as a result of commission or omission on the part of the parent/carer, the referral process must be followed.

A referral to Children's Social Care **must** always be made where there is evidence of any of the following high risk indicators in the adult:-

- psychotic beliefs particularly if focussed on or involving the child e.g. command led hallucinations suggesting harm to the child;
- persistent negative views expressed about a child, including rejection;
- on-going emotional unavailability, unresponsiveness and neglect, including lack of praise and encouragement, lack of comfort and love and lack of age-appropriate stimulation;
- inability to recognise a child's needs and to maintain appropriate parent-child boundaries;
- on-going use of a child to meet a parent's own needs;
- suicide plans which include the child;
- distorted, confusing or misleading communications with a child including involvement of the child in the parent's symptoms or abnormal thinking. For example, delusions targeting the child, incorporation into a parent's obsessional cleaning/contamination rituals, or a child kept at home due to excessive parental anxiety or agoraphobia;
- on-going hostility, irritability and criticism of the child or young person, inconsistent and/or inappropriate expectations of child;
- serious neglect of the child.

The following are other negative indicators that, if present, increase the risk of abuse:

- combination of depression, substance misuse and personality disorders at various points in time are the most frequently reported psychiatric conditions affecting parents who abuse their children;
- mental illness combined with a background of domestic abuse;
- both parents have a mental disorder or a lone parent with limited support has a mental disorder;
- poor compliance with treatment;
- lack of insight into the disorder and its likely impact on the child;
- self harming behaviour and suicide attempts;
- parental learning difficulties and mental illness.

It is also important to consider the nature of the illness:

- Pattern: frequency of episodes, length of episodes. In general, an illness that has longer and more frequent episodes will have a greater impact than illnesses of short duration.
- Severity: the impact of an illness will not be directly related to its severity, e.g. a parent with a short severe illness may be hospitalised and substitute care provided for the child with little impact on parenting.
- Chronicity: a less severe illness that is chronic may lead to substandard care or neglect of the child, if long term medication or the illness itself lead to cognitive and/or personality changes
- Specificity: what are the symptoms of the illness and their likely impact?

The following are positive indicators / protectors that may reduce the risk of significant harm:

- older age of the child at the onset of their parent's illness (less exposure to difficulties and a greater range of potential coping resources);
- the more sociable child who is able to form positive relationships
- a more able child;
- a parent who has discrete episodes of mental illness with a good return of parenting skills and abilities between episodes;
- alternative support from adults with whom the child has positive, trusting relationship;
- success outside of the home e.g. at school or in sport.

Professionals can improve children's chances of avoiding significant harm by strengthening these protectors.

4.9 Substance Misuse and Safeguarding Children.

Substance misuse by parents does not, by itself, necessarily lead to concerns about parenting, child abuse and neglect. However, children are more at risk of harm and neglect if parents misuse drugs or alcohol. These will inevitably be a significant proportion of the families referred to a PIP. The category of neglect now includes the impact on the unborn child as a result of maternal substance abuse.

- It has been estimated that there are between 200,000 and 300,000 children in England and Wales where one or both parents have serious drug problems (Hidden Harm 2003).
- Alcohol Concern (2001) estimate that almost a million children are living with an alcoholic parent.
- Two thirds of children involved in care proceedings have parents with substance misuse problems.

Impact on Children:

- Serious effect on unborn child due to poor nutrition and lifestyle.
- Lack of basic care and poor school attendance.
- Child taking on caring role of siblings or parents.
- Exposure to criminal or other inappropriate behaviour.

Impact on Parent/s:

Can affect ~ a parent's caring skills,
perception and judgement,
attention to basic physical needs,
control of emotion,
attachment to child.

- The risk is greater where the substance misuse is chaotic and out of control and where both parents are misusing.

- Parent's needs may be prioritised above their children's needs and there may be less money available.
- There is a risk of physical harm if drugs and paraphernalia (gear) or alcohol are not kept safely out of a child's reach.
- Children may also be at risk from adults who are visiting the house when parents are not in a position to protect them.

4.9.1 Safeguarding Children Risk Assessment Substance Misuse:

This is to be completed if the service user is a parent; has regular contact with children or lives in a household where there are children (i.e. the partner of someone who has children). It should be done in conjunction with the clinical director and recorded in the file for the family.

Full name of adults either living in the household or visiting regularly (i.e. partners) and a consideration of these factors:-

a) How are the adult's behaviours impacting on the babies and older children? e.g. does this constitute frightening / frightened behaviour?

b) What is the role of alcohol/drugs within the adult relationship; look for unresolved dependency issues?

c) Is there a substance free parent/supportive partner or relative in contact with family?

d) Is there evidence of domestic abuse, physical, economic or verbal?

e) What is the impact of taking substances on adult's health/behaviour/mood?

f) Is there an accompanying psychiatric disorder?

g) Are there financial difficulties that impact care of the children?

h) Are adults driving whilst under the influence of alcohol/drugs?

i) Are there indications that older children are taking on caring/excessive household responsibilities?

j) Is the children's safety considered?

k) Do adults place their own needs before the needs of children?

l) Are other substance misusers sharing or regularly visiting the accommodation?

m) Do the children witness the taking of drugs?

n) Is the premises used to sell drugs?

o) Are the children left alone whilst adults are procuring drugs/alcohol or are they being taken to places where they could be at risk?

p) Could other aspects constitute a risk? e.g. exposure to criminal activity, conflict between dealers.

Safe storage: If alcohol/ drugs/ injecting equipment is kept in the house, are they stored securely? Have drug users been advised about the risk to children of the consumption of methadone etc.?

Liaison with other professionals: share relevant information with family Health Visitor, School Nurse, Substance abuse service, Social Worker, etc.

Are the children at risk of significant harm? Consider seeking further advice or refer to Children's Social Care immediately

Action taken: Include date and time of discussion and response.

4.10 Female genital mutilation (FGM)

Female genital mutilation (FGM) is illegal in the UK. It's also illegal to take a British national or permanent resident abroad for FGM or to help someone trying to do this.

The maximum sentence for carrying out FGM or helping it to take place is 14 years in prison.

Definition: FGM is any procedure that's designed to alter or injure a girl's (or woman's) genital organs for non-medical reasons.

It's sometimes known as 'female circumcision' or 'female genital cutting'. It's mostly carried out on young girls.

FGM procedures can cause:

- severe bleeding
- infections
- problems with giving birth later in life - including the death of the baby

Any suspicion of FGM must be referred to Children's Social Care **Making a Referral Procedure** Girls are at particular risk of FGM during school summer

holidays as this is the time when families may take their children abroad for the procedure.

Any medical provision for a pregnant woman who has herself been the subject of female genital mutilation provides the opportunity for recognition of risk and preventative work with parents.

A child may be considered to be at risk if it is known that older girls in the family have been subject to the procedure. Prepubescent girls of 7 to 10 are the main subjects, though the practice has been reported amongst babies.

Possible indicators are similar to other forms of abuse, especially **Sexual Abuse**, including:

- Bleeding, discharge, urinary infections;
- Reluctance to receive medical attention or to participate in sporting activities;
- Prolonged absence from school, with noticeable behaviour change on return and long periods away from classes or other normal activities;
- Some children find it difficult to sit still in class and look uncomfortable or may complain of pain between their legs;
- Mentioning something somebody did to them that they are not allowed to talk about.

Children's Social Care must inform the Police Child Protection Team (CPT) at the earliest opportunity and convene a **Strategy Meeting** within two working days if:

- There is suspicion that a girl or young woman, under the age of eighteen, is at risk of undergoing this procedure;
- It is believed that a girl or young woman is at risk of being sent abroad for that purpose; or
- There are indications that a girl or young woman has suffered mutilation or circumcision.

4.11 Domestic Abuse

Definition: Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality. (Home Office 2004).

It should be acknowledged that men also experience domestic abuse, Some reports show that 1/3rd of the victims of DA are men (National Centre for Domestic Violence 2012). Women are more likely to experience repeat incidents of abuse, be frightened or be injured after an attack, and as they often the lead carers at home, abuse against them affects their children (DOH 2005).

1 in 4 women will experience domestic abuse in their adult lives (Council of Europe, 2002) and 2 women will be killed each week by a current or former partner (Home Office 1999) Domestic violence often starts or escalates during pregnancy ~ and the first few weeks following birth may also be a high risk period. Domestic violence is strongly associated with death during pregnancy, foetal death, miscarriage and depression. For the child, it is associated with future difficulties with emotional regulation.

There is a strong link between domestic violence and child protection.

- Physical assaults to pregnant women cause risk to both the foetus and mother.
- Older children may suffer physical blows during episodes of violence
- In the majority of cases of domestic violence the child is also a victim of violence.
- Children will be greatly distressed by witnessing physical and emotional abuse.
- There may be a negative impact on ability to look after children by adults suffering physical and psychological abuse.
- Children may be drawn into the violence or emotional abuse or may be pressurised into concealing the abuse
- Children's exposure to parental conflict, even where violence is not present, can lead to serious anxiety and distress.
- Adults invariably under-estimate the amount of times a child has witnessed violence (see below).
- The risks increase when violence is combined with drink or drug misuse.

Where professionals are aware of domestic abuse, and there are children living in the house, this must be discussed with the clinical director and a referral should always be made to Social Care.

An amendment of the Adoption and Children Act 2002 extended the legal definition of harm to include the impairment suffered from seeing or hearing the ill treatment of another. This is significant, as in a study of incidents involving domestic abuse, 90% of children were in the same room or next door (Hughes 1992).

- Nearly 75% of children on the Child Protection Register live in households where domestic violence occurs (DoH 2002a).
- 62% of children who witness domestic violence are likely to be physically abused by the same perpetrator (Hester and Pearson, 1998).

- 76% of children who were ordered by the courts to have contact with a violent parent, were said to have been further abused as a result of contact being set up. (Radford, Sayer & AMICA, 1999).

It is important to consider the long-term effects of witnessing domestic violence. A study of 64 children aged 7-12 years who had witnessed domestic violence towards their mother during the previous year, showed traumatic symptoms e.g. unwanted remembering of traumatic events and hyper-vigilance in 52% of cases. Longer term, children who had witnessed domestic violence had significantly worse psychosocial outcomes, similar to those of physically abused children (Kitzmann et al, 2003). Those children who have been both physically abused as well as witnessing the violence tend to show the highest levels of behavioural and emotional disturbance (Sternberg et al. 1993; O'Keefe, 1994).

4.11.1 Recognised Risk Factors:

- **History.**
  Previous domestic assault is the simplest, most robust risk marker of subsequent domestic assault. 35% of households have a second incident within five weeks of the first. The question about past abuse must always be asked.

- **Escalation.**
  Minor violence is a predictor of escalation to major violence.

- **Separation.**
  Victims are at greatest risk of homicide at the point of separation or after leaving a violent partner.
  50% of female spousal homicides are committed post separation
  75% of calls to police for assistance are made post-separation.

4.11.2 The Role of Health / PIP Professionals:

Evidence shows that parents may find it difficult to raise the subject of domestic abuse themselves and that direct questions get more positive results than vague queries. PIP clinicians should be prepared to take a proactive approach.

- Never ask about domestic abuse when someone else is present. Find a way of seeing the parent alone.
- Ensure privacy and no interruptions. Consider that s/he might want to talk to someone else i.e. different gender, race.
- Be patient and understand that the parent may also have time pressures.
- Aim to have a supportive conversation and avoid pushing the parent into revealing domestic abuse
- Never accept culture as an excuse for domestic abuse.

- Are children involved? Consider the link between domestic abuse and child abuse.

4.11.3 If a parent discloses Domestic Abuse:

- Focus on the parent's immediate safety and that of the children.
- Give her/him information and refer to relevant agencies;
- Make it easy for the parent to talk about her/his experiences;
- Support and reassure her/him;
- Be non-judgemental and
- Look after yourself (DOH, 2005).

4.12 Child Sexual Exploitation

Definition: *"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, gifts, money) as a result of performing, and/or others performing on them, sexual activities. Child sexual exploitation can occur through use of technology without the child's immediate recognition, for example the persuasion to post sexual images on the internet/mobile phones with no 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 relationship 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."*

Sexual exploitation is used to describe a broader range of abusive situations than children involved in prostitution. This enables greater awareness and understanding of the issue and lower thresholds for intervention. Where 'children involved in prostitution' is the basis for a protocol, the threshold for intervention is going to be much higher. A wider definition protects children and young people at risk of being sexually exploited, not just those in entrenched exploitative relationships.

The majority of sexually exploited children are hidden from public view. They are unlikely to be loitering or soliciting on the streets. Research and practice has helped to move the understanding away from a narrow view of seeing sexual exploitation as a young person standing on a street corner selling sex.

There is also often a presumption that children are sexually exploited by people they do not know. However evidence shows that this is often not the case and children are often sexually exploited by people with whom they feel they have a relationship, e.g. a boyfriend/girlfriend.

5.0 Policy

5.1. Roles and Responsibilities: Chapter 2 of 'Working Together to Safeguard Children' (DOH, 2006) sets out the roles and responsibilities of all organisations with regard to safeguarding children.
The ultimate responsibility for safeguarding children arrangements lies with the clinical director for SAF.

5.2 Management Responsibilities: The clinical director / manager / trustee board for the SAF team will ensure that:

- all staff have access to and know how to seek specialist safeguarding children advice;
- all staff have a DBS check, to the appropriate level, as part of the recruitment process, this includes bank staff, agency staff, students and volunteers;
- the service they manage has an identified senior practitioner/manager/trustee who will act as Allegations Manager;
- all staff have undertaken child protection training at the right level for their role, and they have updates at the appropriate time interval
- all staff have access to the local Child Protection Procedures;
- there is a regular audit of child protection practice, to include audit of child protection record keeping;
- staff are supported to participate in individual management reviews and serious case reviews.

5.3 Individual Responsibilities of staff:-

- All staff should actively safeguard and promote the welfare of babies and children.
- Concerns that babies and/or children are at risk of, or suffering from, child abuse or neglect should always be immediately shared with the clinical director, and if he or she is unavailable, a senior member of staff. Reasons for the concern and actions taken must be documented in the clinical notes and briefly on the chronology of risk sheet.
- Help and advice in most areas can be sought from the Named Nurse or Doctor, the Link Person for the SSU, Safeguarding Children Service or Emergency Duty Team (out of hours). All staff should have access to relevant telephone numbers.
- If a decision is made that the threshold for child protection has not been reached consideration should be given to requesting the completion of a Common Assessment Framework (CAF) or Early Help Family Assessment Form if one has not already been completed. Professionals working with adults in the family should contact for example, the child's Health Visitor, Children Centre or school.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/272064/5860.pdf

5.3.1 Report writing guidelines for a Child Protection Conference:

- The purpose of a Child Protection Conference Report is to communicate specific information to the conference members to facilitate informed decision making regarding whether the child/children should have a Child Protection Plan.
- Start your report with a brief history of your involvement with the family and compliance with planned appointments and treatment. Continue using the information available to you in your professional capacity working with the family. Finally summarise the strengths in the family and your concerns regarding the health and wellbeing of the children and the functioning of the family. At this point do not make any recommendations about whether the children should have a Child Protection Plan.

Sign and date your report, check it with the clinical director and take sufficient copies to the conference.

5.4 Did not Attend (DNA).

- Many serious case reviews/ Homicide reviews, both nationally and at a local level have featured DNAs as a precursor to serious child abuse and child death.
- Professionals should be child focussed and consider children and young people even when the DNA relates to the parents/carers, particularly when poor mental health or problematic substance misuse is a feature.
- **All** DNAs including cancelled appointments should be recorded in the clinical records and on the Chronology of Risk sheet to establish any emerging patterns. Regular DNA should always be discussed with the clinical director.
- DNAs should form part of an on-going assessment on whether there are safeguarding concerns. If the child has a Child Protection Plan, **all** DNAs should be reported to their social worker as soon as possible. If the named social worker is unavailable the information should be given to the team leader or duty team.

5.5 Adult Disclosure of Abuse: Remember, if an adult discloses that they are a survivor of childhood abuse you should consider if their abuser remains a risk to other children, and if so make an appropriate referral. The adult survivor may wish to do so as well but may need support to do so. Working with this adult will probably require you to access robust supervision with a clinician who understands issues of abuse and its consequences.
Historical abuse should be reported to the police if not already recorded. There will be a local telephone number.

It is the joint responsibility of both Managers and individual Clinicians to ensure they have adequate Child Protection Training.

6.0 Statutory Safeguarding Responsibilities

6.1 Allegations management: If a member of staff has a concern about another member of staff or a volunteer where they have:

- behaved inappropriately in a way that has harmed or may have harmed a child or
- 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 is unsuitable to work with children,

then they must consult with the clinical director. Any allegations made against a member of staff must be reported to the Local Authority Designated Officer and SAF will cooperate fully with any subsequent investigation or recommendations made. Staff can be confident that allegations will be dealt with fairly and in line with national guidance. For more information see the local child protection / safeguarding children website.

6.2 DBS Scheme.

The core purpose of the DBS scheme is to prevent unsuitable people from working or volunteering with children and vulnerable adults. Employers retain their responsibilities for ensuring safe recruitment and employment practices.
The Safeguarding Vulnerable Groups Act 2006 sets out the scope of the scheme for England, Wales & NI.

It will cover those who work or volunteer in '**Regulated Activities**' who will need to be registered on the scheme. A 'Regulated Activity' is one of:

- A **specified Nature** e.g. teaching, training, care, supervision, advice, treatment or transport for children or vulnerable adults, **or**
- In a **Specified Place** e.g. in schools, children's homes, hospitals, juvenile detention facilities, adult care homes.
- All Regulated Activity must be "**frequently, intensively and/or overnight"** i.e. once a month, 3 or more occasions in a period of 30 days and/or overnight between 2 and 6am.

All people working or volunteering in specified places and meeting the frequency criteria must be DBS registered. No distinction is made between paid and voluntary work. A regulated activity also covers Fostering and Defined office Holders e.g. Directors of Children's trusts, Trustees of Children's Charities and School Governors.

Further information can be found on the governmental disclosure and barring service web site: https://www.gov.uk/government/organisations/disclosure-and-barring-service

6.3 **Multi- agency Working:** the SAF service must demonstrate that it works effectively with its local partner agencies.

6.4 **Information Sharing:-** SAF must ensure that there are robust mechanisms in place for sharing information with partner agencies in order that:

- information on vulnerable children and young people is passed efficiently between agencies and
- each baby, child or young person receives a service that meets their needs.

Health / SAF professionals have a key role to play in actively promoting the health and wellbeing of children. This includes non-clinical staff and all volunteers and trustees. There is a growing recognition of the importance of the mental health and substance misuse issues of parents and how they might impact on children. Lessons learned nationally from Serious Case Reviews highlights the importance of interagency working in the field of safeguarding.

Close collaboration and liaison between the services provided by each SAF and the local Children's Social Care service are essential. This may require the sharing of information to safeguard and promote the welfare of babies and children or protect a child from significant harm.

For advice if you are unsure about what information to share with whom speak with the clinical director.

- **Remember that the Data protection Act is <u>not</u> a barrier to sharing information** but provides a framework to ensure that personal information about living persons is shared appropriately.

- **Be open and honest** with the person (and/or their family where approriate) from the outset and why, what, how and with whom information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so.

- **Seek advice** if you are in any doubt, without disclosing the identity of the person where possible. If the clincal director is unavailable there will be a named safeguarding professional within the local health or social work provision who can be conatcted.

- **Share with consent where appropriate** and, where possible, respect the wishes of those who do not consent to share confidential information. You may still share information without consent if, in your judgement, that lack of consent can be overridden in the public interest or in the interests of the baby or child . You will need to base your judgement on the facts of the case.

- **Consider safety and well-being:** Base your information sharing decisions on considerations of the safety and well-being of the person and others who may be affected by their actions.

- **Necessary, proportionate, relevant, accurate, timely and secure:** Ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those people who need to have it, is accurate and up-to-date, is shared in a timely fashion, and is shared securely. Unless encrypted, emails are not secure communication.

- **Keep a record** of your decision and the reason for it – whether it is to share information or not. If, after discussuon with the clinical director, the decision is to share, then record what has been shared, with whom and for what purpose.

  Information Sharing: Guidance for practitioners and managers. (HM Gov, 2008) *www.teachernet.gov.uk/publications*

6.5 The Learning and Improvement Framework and Reviews

Working Together to Safeguard Children, 2015, states:
'*Professionals and organisations protecting children need to reflect on the quality of their services and learn from their own practice and that of others. Good practice should be shared so that there is a growing understanding of what works well. Conversely, when things go wrong there needs to be a rigorous, objective analysis of what happened and why, so that important lessons can be learnt and services improved to reduce the risk of future harm to children'*
SAF promote a culture of multi-agency collaboration and will work together with all in Barking and Dagenham to support all statutory and non-statutory reviews and to promote the way organisations are working together to safeguard and protect the welfare of children.

6.6 The following principles should be applied by LSCBs and their partner organisations to all reviews:
• there should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the welfare of children, identifying opportunities to draw on what works and promote good practice;
• the approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined;

• reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed;
• professionals must be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;
• families, including surviving children, should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. This is important for ensuring that the child is at the centre of the process;
• final reports of SCRs must be published, including the LSCB's response to the review findings, in order to achieve transparency. The impact of SCRs and other reviews on improving services to children and families and on reducing the incidence of deaths or serious harm to children must also be described in LSCB annual reports and will inform inspections; and
• improvement must be sustained through regular monitoring and follow up so that the findings from these reviews make a real impact on improving outcomes for children.

SCRs and other case reviews should be conducted in a way which:
• recognises the complex circumstances in which professionals work together to safeguard children;
• seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
• seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
• is transparent about the way data is collected and analysed; and
• makes use of relevant research and case evidence to inform the findings. (Learning and Improvement Framework B&H LSCB FINAL VERSION 170913 – 3)

6.7 Child Death Reviews

Working Together to Safeguard Children (2015) requires that all unexpected deaths (defined as those not expected within the last 24hours) are reviewed. This process, which is to identify any local or wider public health or safety concerns arising from a death, or from a pattern of deaths, will take place regardless of any decision to carry out a Serious Case Review and will inform this process.

There are two interrelated processes for reviewing child deaths:

- A rapid response by a group of key professionals who come together for the purpose of enquiring into and evaluating each unexpected death of a child.
- An overview of all child deaths (under 18 years old) undertaken by a panel.

An unexpected death is defined as the death of a child that was not anticipated as a significant possibility 24 hours before the death or where

there was a similarly unexpected collapse leading to or precipitating the events that lead to the death.

6.8 Serious Case Reviews: - A Serious Case Review (SCR) is undertaken when:

- a child dies or is seriously injured, and abuse or neglect are known or suspected to be a factor in the death or injury;
- a child sustains a potentially life threatening injury or serious and permanent impairment of health and development through abuse or neglect; or
- a child has been subjected to particularly serious sexual assault;
- a parent has been murdered and a homicide review is being initiated;
- a child has been killed by a parent with a mental illness; or
- the case gives rise to concerns about interagency working to protect children from harm.

The purpose of the SCR is:

- To establish whether there are lessons to be learned about the way in which local professionals and organisations work together to safeguard and promote the welfare of children.
- To identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a result; and
- as a consequence, to improve inter-agency working and better safeguard and promote the welfare of children
  (Working Together to Safeguard Children, 2015.)

At the end of each Serious Case Review, a SCR Final Report is agreed by the LSCB and published. The updated procedures and guidance as well as published reports are made available via the Brighton and Hove LSCB website: http://www.brightonandhovelscb.org.uk/serious-case-reviews-2/

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