

TRUST-WIDE NON-CLINICAL POLICY DOCUMENT

**CORPORATE POLICY AND
PROCEDURE FOR THE
SAFEGUARDING AND
PROTECTION OF CHILDREN**

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Lead Author(s):	Named Nurse for Safeguarding Children

TRUST-WIDE NON-CLINICAL POLICY DOCUMENT

2016 - Version 4

Quality, recovery and
wellbeing at the heart
of everything we do

TRUST-WIDE NON-CLINICAL

CORPORATE POLICY AND PROCEDURE FOR THE SAFEGUARDING AND PROTECTION OF CHILDREN

Further information about this document:

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Author(s) Contact(s) for further information about this document	<p style="text-align: center;">Chantelle Carey - Named Nurse Safeguarding Children (updated Denis Cullen July 2016) Email: Denis.Cullen@merseycare.nhs.uk Telephone: 0151 473 2803</p>
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To be read in conjunction with	<p>IT10 – Policy and Procedure for Confidentiality and Information Sharing</p> <p>SA12 - Policy and Procedure for the Management of Domestic Abuse Policy</p> <p>SD22 – Policy and Procedure for Visits by Children to Mersey Care NHS Foundation Trust Sites</p> <p>HSS24 Policy and Procedure child contact (High Secure Services)</p> <p>SD23 – Policy and procedure of Young Carer's Assessment and Planning</p> <p>SA 38 -Service Provision to Young People Aged Under 18</p> <p>Working Together to Safeguard Children 2015</p>
<p>This document can be made available in a range of alternative formats including various languages, large print and braille etc</p>	
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SUPPORTING STATEMENTS

This document should be read in conjunction with the following statements:

SAFEGUARDING IS EVERYBODY'S BUSINESS

All Mersey Care NHS Foundation Trust employees have a statutory duty to safeguard and promote the welfare of children and vulnerable adults, including:

- being alert to the possibility of child/vulnerable adult abuse and neglect through their observation of abuse, or by professional judgement made as a result of information gathered about the child/vulnerable adult;
- knowing how to deal with a disclosure or allegation of child / adult abuse;
- undertaking training as appropriate for their role and keeping themselves updated;
- being aware of and following the local policies and procedures they need to follow if they have a child/vulnerable adult concern;
- ensuring appropriate advice and support is accessed either from managers, *Safeguarding Ambassadors* or the trust's safeguarding team;
- participating in multi-agency working to safeguard the child or vulnerable adult (if appropriate to your role);
- ensuring contemporaneous records are kept at all times and record keeping is in strict adherence to Mersey Care NHS Foundation Trust policy and procedures and professional guidelines. Roles, responsibilities and accountabilities, will differ depending on the post you hold within the organisation;
- ensuring that all staff and their managers discuss and record any safeguarding issues that arise at each supervision session.

EQUALITY AND HUMAN RIGHTS

Mersey Care NHS Foundation Trust recognises that some sections of society experience prejudice and discrimination. The Equality Act 2010 specifically recognises the *protected characteristics* of age, disability, gender, race, religion or belief, sexual orientation and transgender. The Equality Act also requires regard to socio-economic factors including pregnancy/maternity and marriage/civil partnership.

The trust is committed to equality of opportunity and anti-discriminatory practice both in the provision of services and in our role as a major employer. The trust believes that all people have the right to be treated with dignity and respect and is committed to the elimination of unfair and unlawful discriminatory practices.

Mersey Care NHS Foundation Trust also is aware of its legal duties under the Human Rights Act 1998. Section 6 of the Human Rights Act requires all public authorities to uphold and promote Human Rights in everything they do. It is unlawful for a public authority to perform any act which contravenes the Human Rights Act.

Mersey Care NHS Foundation Trust is committed to carrying out its functions and service delivery in line with a Human Rights based approach and the FREDA principles of **Fairness, Respect, Equality Dignity, and Autonomy.**

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1. PURPOSE AND RATIONALE

PURPOSE

This document explains:

- Why the policy is necessary (rationale)
- To whom it applies and where and when it should be applied (scope)
- The underlying beliefs upon which the policy is based (principles)
- The standards to be achieved (policy)
- How the policy standards will be met through working practices (procedure).

RATIONALE

1.1 The purpose of this policy is to ensure a structured and systematic approach to child protection across the organisation. The Children Act 1989 places a statutory duty on Health Professionals to help Social Services with their enquiries so long as it is compatible with their own statutory duties or other duties and obligations and does not unduly prejudice the discharge of any of their functions. The Department of Health guidance listed below is issued under Section 7 of the 1970 Local Services Act, which means it is secondary legislation and therefore must be complied with unless local circumstances indicate exceptional reasons which could justify a variation.

1.2 It advises further involvement of Health Professionals by collaborating and working together with Social Services. This does not exempt the Health Professional from instigating multi-agency action under their duty of care.

2. SUPPORTING DOCUMENTS

THESE PROCEDURES ARE BASED ON:

- The principles of the Children Act 1989 Section 11 of the Children Act 2004
- The UN Convention on the Rights of the Child
- The Human Rights Act 1998
- The Data Protection Act 1999
- The Adoption and Children Act 2002
- Department of Health guidance on Working Together to Safeguard Children 2015
- The Framework for the Assessment of Children in Need and their Families 2000
- Safeguarding Children Involved in Prostitution 2002
- What to do if you are worried a child is being abused 2003-12-16
- The Laming Report 2003
- When to Suspect Child Maltreatment NICE Guidelines 2009
- Local Safeguarding Children's Board Policies and Procedures (Liverpool, Sefton, Knowsley, Lancashire and Rochdale Local Authorities)

<http://www.seftonlscb.co.uk/professionals/multi-agency-safeguarding-procedures.aspx>

<http://liverpoolscb.proceduresonline.com/index.htm>

<http://knowsleyscb.proceduresonline.com/index.htm>

<http://www.lancshiresafeguarding.org.uk/>

www.rochdale.gov.uk/council...social-care/.../safeguarding

- Handling Cases of Forced Marriage Ministry of Justice 2009
- Safeguarding Children and Young People who may be affected by Gang Activity DCSF 2010
- Safeguarding Children from Abuse Linked to a Belief in Spirit Possession DCSF 2007

3. SCOPE

- 3.1 Every member of staff has an individual responsibility for the protection and safeguarding of children. All levels of management must understand and implement the Trust Safeguarding and Protection of Children Policy and Procedure.
- 3.2 High Secure Services (Ashworth Hospital) have to appoint a “Nominated Officer” for Safeguarding Children under the Directions in the Health Service Circular 1999/160. These Directions apply to the three High Secure Hospitals in England. The Nominated Officers role has developed over the years and they are responsible for safeguarding children and the protection of children in High Secure Services.
- 3.3 Any advice regarding safeguarding children in High Secure Services should be referred to the Nominated Officer for safeguarding children or their deputy in the first instance.
- 3.4 These procedures are for all staff working within Mersey Care NHS Foundation Trust. Staff seconded to Mersey Care NHS Foundation Trust, are expected to follow these procedures.
- 3.5 Any student/trainee employed by Mersey Care NHS Foundation Trust must identify their status when talking about clients to professionals in other agencies.

4. PRINCIPLES

- 4.1 This policy is based on the expectation that staff are able to ensure the welfare of children in the course of their daily work.
- 4.2 Service users are aware of the limitations of and exceptions to confidentiality in relation to child protection.
- 4.3 “When there is a conflict of interests between the needs of the adult and those of a child, the welfare of the child is paramount” (Paramourncy Principle, Children Act 1989).

POLICY STANDARDS

- 4.4 The following policy standards outline the broad statement of intent, which will be clarified in the relative sections throughout this policy document.
- 4.5 Safeguarding children is the business of everyone in Mersey Care NHS Foundation Trust. All staff should be aware of their individual level of responsibility and accountability in relation to safeguarding children.
- 4.6 Safeguarding children is monitored and managed through effective supervision and audit of practice.

- 4.7 Safeguarding children concerns can only be assessed by local authority children and families assessment teams (section 4).
- 4.8 The Named Nurse and Named Doctor manage child protection within the Trust.
- 4.9 The document clarifies the policy and procedure for Safeguarding children within the Trust.
- 4.10 All staff must be trained, in child safeguarding/protection awareness commensurate with their role within the Trust.
- 4.11 All child protection issues are managed within the legal framework; the Local Safeguarding Children Boards' guidelines and Mersey Care NHS Foundation Trust Policy.

CORPORATE PROCEDURE

- 4.12 The Trust should work within the principles of the Children Act 1989, the Children Act 2004, and other relevant legislation.
- 4.13 There are several key elements of this policy that staff must understand and adhere to:
- 4.14 How do I make referrals to another agency? – The flowchart in table 1 explains the process and contact details of appropriate professionals. The flowchart also details the process that should be followed prior to making a referral.
- 4.15 All information exchanged with other agencies must be confirmed in writing within 48 hours.
- 4.16 If there is a difference of opinion between professionals regarding whether a child is at risk of harm the Named Nurse for Safeguarding Children must be informed. and the “Paramountcy principle” would apply. Assessment of risk to children may only be undertaken by a child and family Social Worker. The escalation policy should also be followed in circumstances where difference of opinion occurs (see Appendix D).
- 4.17 The need for any information recorded or reported to be fact not opinion - Trust staff may need to refer an allegation/concern for assessment to determine the facts. This must be clearly stated in the referral – see flow chart.
- 4.18 **NO MEMBER OF TRUST STAFF** should interview a child suspected or known to be at risk of harm as part of the formal child protection processes. This is the role of Social Care. This does not preclude Trust staff from listening and offering support to any child in distress.
- 4.19 If the issue is relating to a child who usually is accommodated outside the area, the concerns need to be referred to the Named Nurse for Safeguarding Children who would liaise with the appropriate Local Authority.
- 4.20 Staff can establish whether the child or family is known to children’s services, or whether a child is subject to a child protection plan, by contacting the relevant Social Services. (Explain who you are, and why you are requesting this information).

- 4.21 The contact details for all the relevant staff /agencies can be found at the end of this policy.
- 4.22 This policy is supported by a Corporate Escalation Procedure (see diagram in Appendix 3).

5. DUTIES

ROLES, RESPONSIBILITIES AND ACCOUNTABILITIES OF ALL MENTAL HEALTH SERVICES STAFF

- 5.1 Anybody working or involved in mental health services in the statutory, voluntary and independent sectors should bear in mind the welfare of children, irrespective of whether they are primarily working with adults or children and young people. They are likely to become aware of a broad range of children's needs in their daily work.
- 5.2 All mental health professionals should be aware of legislation concerning child protection, and informed about their local child protection procedures, the work of the Local Safeguarding Children's Boards, and of their responsibilities for safeguarding children. They may need to fulfil their duty to assist Social Care in assessments, as well as attending and reporting to child protection conferences when necessary.
- 5.3 The Head of Social Care/Safeguarding Lead will ensure that there is a safeguarding Operational Group overseeing the work of safeguarding in practice across the Trust; the Deputy Director of Nursing & Quality holds the delegated responsibility for ensuring the Trust has an appropriate Safeguarding Strategy in place and will chair a Trust Safeguarding Strategy Group. The Board will assure its self of compliance with this policy through the accountability arrangements delegated to the Quality Assurance Committee and via consideration of an annual report.
- 5.4 The mental health perspective is important in respect of many aspects of children's welfare. Local Safeguarding Children Boards should be able to call upon the expertise of adult mental health services, learning disability, forensic and substance misuse services to effectively share information in relation to parental mental health/substance misuse and learning disabilities and how this can impact on parenting capacity.
- 5.5 Mental health services including forensic services have a role to play in assessing the risk posed by adult perpetrators, and in the provision of treatment services for perpetrators. In particular cases, the expertise of substance misuse and learning disability services will also be required.
- 5.6 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 and identify a child at risk of harm. This may be as a result of services' direct work with young people,, a parent, a parent to be, or a non-related abuser, or in response to a request for the assessment for an adult perceived to represent a potential or actual risk to a child or young person.

- 5.7 Close collaboration and liaison between the mental health services and children's welfare services are essential in the interests of children. This will require the sharing of information where this is necessary to safeguard a child from significant harm. Child and adolescent mental health services can help in facilitating communication between mental health services and children's social care, especially when there are concerns about responding appropriately both to the duty of confidentiality and the protection of children. The Named Doctor and the Named Nurse can also provide advice.
- 5.8 Service users who are aged under 18, and who fail to attend arranged visits or outpatient appointments, must be contacted to ensure their safety and wellbeing. If they are receiving a service from social Care their social worker should be contacted.

ROLES, RESPONSIBILITIES AND ACCOUNTABILITY OF THE NAMED NURSE, NAMED DOCTOR AND NOMINATED OFFICER FOR SAFEGUARDING CHILDREN (HSS)

- 5.9 The Named Doctor and Named Nurse will take the professional lead within the Trust on child protection matters. They should have expertise on children's health and development, the nature of child maltreatment and local arrangements for safeguarding children and promoting their welfare.
- 5.10 High Secure Services (Ashworth Hospital) have to appoint a "Nominated Officer" for Safeguarding Children under the Directions in the Health Service Circular 1999/160. These Directions apply to the three High Secure Hospitals in England. The Nominated Officers role has developed over the years and they are responsible for safeguarding children and the protection of children in High Secure Services. Any advice regarding safeguarding children in High Secure Services should be referred to the Nominated Officer for safeguarding children or their deputy in the first instance.
- 5.11 They provide a source of advice and expertise to fellow professionals and other agencies. They have an important role in promoting good professional practice within the Trust in safeguarding children.
- 5.12 They are responsible for conducting the Trust's internal case reviews. They investigate and respond to safeguarding children complaints on behalf of the Trust.
- 5.13 They raise the standard and quality of care to vulnerable children and their families within the Trust by adopting a multi-agency framework. They assist the Trust to understand its safeguarding and protection of children role and responsibilities.
- 5.14 They substantially contribute to the development of Trust and multi-agency policy and procedure practice guidelines. They ensure that appropriate safeguarding and protection of children standards are adhered to.
- 5.15 The Named Nurse reports to the Executive Director of Nursing, who is the Board Executive with responsibility for safeguarding. The Nominated Officer for Safeguarding Children (HSS) reports to the Chief Executive for responsibilities around safeguarding. The Named Doctor reports to the Medical Director.

THE RESPONSIBILITY OF THE ACCOUNTABLE OFFICER

- 5.16 The Chief Executive, as the Accountable Officer, has overall responsibility for ensuring the implementation of an effective safeguarding and protection of children policy and procedure, for the development of corporate governance and for meeting all statutory requirements.
- 5.17 The Executive Director of Nursing has delegated responsibility to ensure that a Policy & Procedure for Safeguarding Children and Young People is in place; that it is implemented effectively and systems are in place for the effective monitoring of the standards contained within the policy.
- 5.18 The Trust Board has ultimate responsibility for ensuring that an effective system for managing any risks associated with safeguarding children exists within the Trust and that all staff working in the Trust are aware of, and operate within the policy. The Board will assure its self of compliance with this policy through the accountability arrangements delegated to the Quality Assurance Committee and via consideration of an annual report prepared by the Head of Social Care and Named Nurse.

6. THE VOICE OF THE CHILD

- 6.1 Children want to be respected, their views to be heard, to have stable relationships with professionals built on trust and for consistent support provided for their individual needs. This should guide the behaviour of professionals. Anyone working with children should see and speak to the child; listen to what they say; take their views seriously; and work with them collaboratively when deciding how to support their needs.
- 6.2 A child-centred approach is supported by: the Children Act 1989 (as amended by section 53 of the Children Act 2004). This Act requires local authorities to give due regard to a child's wishes when determining what services to provide under section 17 of the Children Act 1989, and before making decisions about action to be taken to protect individual children under section 47 of the Children Act 1989. These duties complement requirements relating to the wishes and feelings of children who are, or may be, looked after (section 22 (4) Children Act 1989), including those who are provided with accommodation under section 20 of the Children Act 1989 and children taken into police protection (section 46(3) (d) of that Act).
- 6.3 The Equality Act 2010 puts a responsibility on public authorities to have due regard to the need to eliminate discrimination and promote equality of opportunity. This applies to the process of identification of need and risk faced by the individual child and the process of assessment. No child or group of children must be treated any less favourably than others in being able to access effective services which meet their particular needs.

7. CHILDREN IN SPECIFIC CIRCUMSTANCES

- 7.1 All families may experience difficulties from time to time for a whole host of reasons, which may have an impact on their children. There are circumstances either when sources of stress in families have an impact on a child's health development, and wellbeing, directly or because it affects the capacity for parenting. In these circumstances it is important not to generalize or make assumptions about the impact on the child, but the needs of the child must be properly assessed. This can only undertaken by children and family social workers. It is not the remit of adult mental health social workers.

DOMESTIC ABUSE AND SAFEGUARDING CHILDREN

- 7.2 Domestic abuse describes a continuum of behaviour ranging from verbal abuse, through threats and intimidation, manipulative behaviour, physical and sexual assault, to rape and even homicide.
- 7.3 The Trust has a Management of Domestic Abuse Policy and Procedure (SA12) please refer to this policy for actions to be taken.

FABRICATED OR INDUCED ILLNESS

- 7.4 Safeguarding Children in whom illness is fabricated or induced is a specific category of abuse (DH 2002).
- 7.5 A procedure has been developed and is attached to this policy as Appendix B.

SUDDEN INFANT DEATH SYNDROME (SIDS)

- 7.6 The risk of physical injury to a child sleeping next to an adult occurring as a result of the adult lying over or against the child (overlay) is recognised. The risk is increased if the adult is sedated due to the effects of alcohol and/or prescribed or illicit drugs. Health professionals working with the parents/carers of young children/babies should reinforce the risks from co-sleeping, educating parents/carers about safe sleeping arrangements, particularly those known to misuse substances where such risk to children will be increased.

MENTAL HEALTH OF PARENT OR CARER AND CHILD PROTECTION

- 7.7 “Mental illness in a parent or carer does not necessarily have an adverse impact on a child, but it is essential always to assess its implications for any children involved in the family.”
- 7.8 It has potential for impact in the following ways:
- Parental illness may markedly restrict children’s social and recreational activities
 - Children may have caring responsibilities inappropriate for their years
 - Parents, if depressed, may neglect their own and their children’s physical and emotional needs
 - In some circumstances, some forms of mental illness may blunt parents’ emotions and feelings or cause them to behave towards their children in bizarre or violent ways
 - Post-natal depression can be linked to behavioural and physiological problems in the infants of such mothers
 - Children most at risk of significant harm are those who feature in parent’s delusions and children who become targets of parental aggression or rejection, or who are neglected as a result of parental illness. In all cases where a child features in a patient’s delusional beliefs, or is included in a suicide plan, a referral to children’s services must be made.
 - Unusually, but at an extreme, a child may be at risk of severe injury or even death
 - Remember it is the behaviour and thought processes of the parents/carers rather than the diagnosis that identifies the risk to the child

- Some parents may fabricate or induce illness in their child. If there is concern regarding this, the Fabricated and Induced Illness guidelines should be implemented.
- 7.9 The interests of the child are paramount and initiating child protection procedures is not conditional on obtaining consent.
- 7.10 There may be limitations with confidentiality, when there are concerns about children and in the greater public interest. Professionals should never promise complete confidentiality in these circumstances.
- 7.11 Immediate response to make a child safe from harm may be necessary.
- 7.12 Where there is cause for concern about what is happening, the ability of the parent or caregiver to ensure that the child's needs are being adequately responded to, must be considered.
- 7.13 Advice can be sought from the Trust Specialist Practitioners for Safeguarding, or directly from the Liverpool, Knowsley, Sefton Rochdale or Lancashire Children services duty social worker.
- 7.14 If a child's needs are not being adequately responded to, then a referral to Social Care must be made.
- 7.15 Social Care will gather information about the dimensions of parenting capacity to examine the parent's problems, the impact on the child and the effect of the parent on the child. The advice of a Mental Health Professional will be vital for the assessment of risk to children.
- 7.16 Attendance at Child Protection Conferences is now sought from a wider range of professionals who work with parents, particularly in relation to substance misuse, domestic abuse and learning disability (DOH 2013). It is expected the Mersey Care NHS Foundation Trust staff attend Child Protection Conferences when required. On occasions when this is not possible liaison with the safeguarding team is required and a written report must be submitted to the Conference Chair or the Social Worker.
- 7.17 Children or Young People who are subject to a Child Protection Plan should be clearly identified as such by using the warning flag within the electronic records system.
- 7.18 Children or Young People who are Looked After Children (LAC) should be clearly identified as such by using the warning flag within the electronic records system.

LSCB Link to procedures:

http://liverpoolscb.proceduresonline.com/chapters/p_ment_ill.html

<http://www.seftonlscb.co.uk/worried-about-a-child.aspx>

<http://www.lancshiresafeguarding.org.uk/>

www.rochdale.gov.uk/council...social-care/.../safeguarding

<http://knowsleyscb.proceduresonline.com/>

SHARING OF INFORMATION ABOUT CIRCUMSTANCES OF FAMILY STRESS – DOMESTIC ABUSE, MENTAL HEALTH OF A PARENT, DRUG AND ALCOHOL MISUSE

- 7.19 Research and experience have shown repeatedly that to keep children safe from harm requires professionals and others to share information about:
- A child's health and development and exposure to possible harm
 - Parents who may need help and may not be able to care for a child adequately and safely
 - Those who pose a risk of harm to children.
- 7.20 There are a number of references in Department of Health documents, guidance on the legal framework and professional guidance papers, which will assist professionals in deciding what and if information should be shared.
- 7.21 Social Care have a statutory duty to make enquiries and they need the help from other agencies to do this effectively. When approaching Health Professionals for information, consent for disclosure of information would normally be sought. Social workers should be clear about the nature and the purpose of the request, whether the consent of the subject of the information requested has been obtained, or whether in the view of Social Services, such consent seeking would itself place a Child at Risk of Significant Harm. A written consent form may be held by Social Services, a copy of which should be provided to Health Professionals if available.
- 7.22 Guidance in those documents referred to above make it clear that in certain circumstances, disclosure is necessary in the interests of others. Adults who pose a risk of harm to a child and children, who may be the subject of abuse, are included in circumstances where information can be released, without the consent of the patient or client.
- 7.23 It is mandatory to share information with the Health Visitor if a service user has care of a child under 5 (as per the Trust Policy and Procedure for the Care Programme Approach, SD21). In the case of school age children, the School Health Practitioner should be informed. The service users consent should be sought regarding this, however where Safeguarding concerns exist consent is not required.

GP REGISTRATION

- 7.24 Families often move into an area and do not immediately register with a local GP or school; this may be for a variety of reasons and not necessarily mean that they are avoiding contact with professionals. However, it must be acknowledged that sometimes children and families become "invisible" to services and therefore any risk may be increased.
- 7.25 If a member of staff becomes aware of a child living within the area who is not currently registered with a GP or school, they should make contact with the Named Nurse for Safeguarding Children who will alert the appropriate Community Health Service.
- 7.26 If there are any concerns identified which would require a referral to Children's Services, this should be made following the same process for any other referral.

GUN AND GANG CRIME

- 7.27 Young people at serious risk of harm from community based violence such as gang, group and knife crime are likely to have significant needs. The safeguarding process needs to respond effectively to the needs of the individual.
- 7.28 Children at risk of suffering violence within the community. This may involve both the perpetrators and victims of violent activity.
- 7.29 In incidences where service users who are either young people or are parents/carers are known to be involved in gun and gang related crime, advice should be sought from Social Care, the Police and the Named Nurse for Safeguarding Children should be informed.

Link to LSCB Procedures:

http://liverpoolscb.proceduresonline.com/chapters/p_gangs.html

<http://www.seftonlscb.co.uk/worried-about-a-child.aspx>

<http://www.lancashiresafeguarding.org.uk/>

<http://knowsleyscb.proceduresonline.com/>

<http://www.rochdale.gov.uk/children-and-childcare/Pages/child-protection.aspx>

FORCED MARRIAGE AND HONOUR BASED VIOLENCE

- 7.30 Forced marriage and honour based violence affects victims from many communities. The majority of cases reported to date in the UK involve South Asian families, but there have been cases involving families from across Europe, East Asia, the Middle East and Africa. Some forced marriages take place in the UK with no overseas element, while others involve a partner coming from overseas or a British national being sent abroad (DOH 2010).
- 7.31 If there are concerns that a young service user, (male or female) or a child of a service user, is at risk from forced marriage or honour based violence, a referral to Social Care is required. Do not inform the victim's family of the disclosure as this will greatly increase the risk.
- 7.32 The Named Nurse for Safeguarding Children should also be contacted who will alert The Forced Marriage Unit.

Link to LSCB procedures:

http://liverpoolscb.proceduresonline.com/pdfs/force_marriage.pdf

<http://www.seftonlscb.co.uk/media/6863/Mersey-FM-HBV-protocol-final-April-2014.pdf>

<http://www.lancashiresafeguarding.org.uk/>

<http://www.rochdale.gov.uk/children-and-childcare/Pages/child-protection.aspx>

<http://knowsleyscb.proceduresonline.com/>

ABUSE LINKED TO SPIRIT POSSESSION

- 7.33 There are a number of common factors which put a child at risk of harm, including rationalising misfortune by attributing it to spiritual forces and when a carer views a child as being 'different', attributes this difference to the child being 'possessed' or involved in 'witchcraft', and attempts to exorcise him or her. A child could be viewed as 'different' for a variety of reasons such as: disobedience; independence; bedwetting; nightmares; illness; or disability. The attempt to 'exorcise' may involve

severe beating, burning, starvation, cutting or stabbing, and/or isolation, and usually occurs in the household where the child lives (DOH 2010).

- 7.34 When concerns exist regarding a belief in spirit possession, Safeguarding Children principles including: sharing information across agencies; being child focused at all times; and keeping an open mind when talking to parents and carers should be applied. The Named Nurse for Safeguarding Children should be alerted and appropriate referrals to Children's Social Care should be undertaken.

CHILD SEXUAL EXPLOITATION

- 7.35 Children involved in prostitution and other forms of commercial sexual exploitation should be treated primarily as victims of abuse and their needs require careful assessment.
- 7.36 Children who are being sexually exploited are highly likely to be in need of welfare services and may need protection under The Children Act 1989. Even when the child/young person appears to believe that they are making their own decision about whether to be involved in prostitution, it is highly likely that they are being manipulated or coerced into such behaviour.
- 7.37 Gaining the child's trust is vital if he or she is to be helped to be safe and well and provided with the opportunity and strategies to exit from prostitution. However, it is not acceptable practice for Professionals to withhold information from Children's Services about children and young people involved in prostitution on the grounds of confidentiality.
- 7.38 If a member of MCT staff has concerns about a child/young person who they think may be being abused, or is at risk of being abused through CSE, they must discuss those concerns with the Named Nurse for Safeguarding Children who as the Single Point of Contact for the Trust. . CSE 1 form should also be completed by practitioner and sent along with a referral to Children's Social Care (see Appendix E).
- 7.39 Child Sexual Exploitation is a high priority issue for Liverpool, Knowsley, Sefton, Lancashire and Rochdale LSCB's. There is information available via each LSCB website which can be accessed via the following:

http://liverpoolscb.proceduresonline.com/chapters/p_safeg_sex_exp.html

<http://www.seftonlscb.co.uk/media/6863/Mersey-FM-HBV-protocol-final-April-2014.pdf>

<http://www.lancshiresafeguarding.org.uk/>

<http://www.rochdale.gov.uk/children-and-childcare/Pages/child-protection.aspx>

<http://knowsleyscb.proceduresonline.com/>

- 7.40 Further guidance can also be obtained via:

www.education.gov.uk/publications/eOrderingDownload/00689-2009BKT-EN.pdf

http://liverpoolscb.proceduresonline.com/chapters/p_ch_abuse_net.html

<http://www.seftonlscb.co.uk/child-sexual-exploitation.aspx>

SAFEGUARDING CHILDREN WHO MAY HAVE BEEN TRAFFICKED

- 7.41 The organised crime of child trafficking into the UK has become an issue of considerable concern to all professionals with responsibility for the care and protection of children.
- 7.42 Any form of trafficking children is an abuse. Children are coerced, deceived or forced into the control of others who seek to profit from their exploitation and suffering. Some cases involve UK-born children being trafficked within the UK.
- 7.43 It is essential that professionals working across social care, education, health, immigration and law enforcement develop an awareness of this activity and an ability to identify trafficked children.
- 7.44 The definition of trafficking contained in the „Palermo Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children“ (ratified by the UK in 2006) is as follows:
- 7.45 “Trafficking of persons” shall mean the recruitment, transportation, transfer, harbouring or receipt of person, by means of the threat of or use of:
- 7.46 Force; or other forms of coercion; abduction; fraud; deception; the abuse of power; or of a position of vulnerability; or the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation.
- 7.47 Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs.
- 7.48 Most children are trafficked for financial gain; this can include payment from or to the child's parents. In most cases, the trafficker also receives payment from those wanting to exploit the child once in the UK. Trafficking is carried out by organised gangs and individual adults or agents.
- 7.49 Trafficked children may be used for:
- Sexual exploitation
 - Domestic servitude
 - Sweatshop, restaurant and other catering work
 - Credit card fraud
 - Begging or pick pocketing or other forms of petty criminal activity
 - Agricultural labour, including tending plants in illegal cannabis farms
 - Benefit fraud
 - Drug mules, drug dealing or decoys for adult drug traffickers
 - Illegal inter-country adoptions
 - If any member of staff suspects that a child or young person maybe a victim of trafficking or that a property is being used to house victims of trafficking they must contact the Named Nurse for Safeguarding Children immediately. The Named Nurse is the Trust Single Point of Contact (SPOC) for child trafficking.
- 7.50 A referral to Children's Services will need to be made and a strategy meeting will be convened to safeguard the child or young person effectively.

7.51 The Trafficking Toolkit (www.crimereduction.gov.uk/toolkits/) provides useful guidance on dealing with trafficking.

7.52 Further information may be obtained via the following websites:

http://liverpoolscb.proceduresonline.com/chapters/p_ch_trafficked.html
<http://www.seftonlscb.co.uk/media/6863/Mersey-FM-HBV-protocol-final-April-2014.pdf>
<http://www.lancashiresafeguarding.org.uk/>
<http://knowsleyscb.proceduresonline.com/>
<http://www.rochdale.gov.uk/children-and-childcare/Pages/child-protection.aspx>
www.education.gov.uk/publications/eOrderingDownload/DFE-00084-2011.pdf

FEMALE GENITAL MUTILATION (FGM)

7.53 Female Genital Mutilation is a collective term for procedures which involve the removal of all or part of the external female genitalia for cultural or other non-therapeutic purposes. It is medically unnecessary, extremely painful and has significant health consequences for women/girls who experience it. FGM is typically performed on girls between the ages of 4 – 13 years but is also performed on new born babies and young women before marriage or pregnancy. Within the United Kingdom, FGM in any of its forms has been classed as a criminal offence since the Prohibition of Female Circumcision Act was passed in 1985. In 2003, The Female Genital Mutilation Act superseded this and it became, for the first time, an offence for UK nationals or permanent residents to carry out FGM abroad, or to aid, abet, counsel or procure the carrying out of FGM abroad, even in countries where the practice is still legal.

7.54 Mersey Care NHS Foundation Trust Health Professionals should be alert to the possibility of FGM amongst communities known to perform it. Professionals should be aware of and work with the strengths and support systems available within families and communities. However, the Mersey care Safeguarding Children Procedures should be followed in circumstances where FGM is suspected or known to have either taken place or be likely to take place. Although illegal in the majority of countries worldwide, the World Health Organisation estimates that approximately 3 million girls a year are at risk from this procedure in Africa alone. In addition, 100-140 million girls and women worldwide are currently living with the consequences of FGM.

7.55 Whilst the current incidence of the practice actually performed in this country is unknown, Liverpool is one of the cities within the UK that FGM is considered to be an endemic practice. It is thought that whilst some female children undergo FGM in the UK, despite it being illegal, there is also a likelihood that children are taken back to their country of origin in order to perform FGM.

7.56 Factors which may alert Mersey Care NHS Foundation Trust staff to FGM:

- Midwives, Health Visitors and GP's may become aware that a woman who has undergone FGM herself already has female children or gives birth to a female child.
- Other siblings are known to have undergone FGM
- Family belongs to a cultural group which is known to practice FGM
- An allegation or disclosure of proposed or actual FGM is received by Mersey Care NHS Foundation Trust staff
- Suspicions are raised about a child being prepared for FGM e.g. preparations for a long holiday where the other family members are not

intending to go or a disclosure by a child that a “special procedure” is taking going to take place.

- Children whose behaviour alters on return from a trip abroad, prolonged periods of absence from school or normal activities, bladder or menstrual problem, difficulty/ pain in walking and sitting.

RESPONSE BY MERSEY CARE NHS FOUNDATION TRUST STAFF TO FGM

7.57 It must be remembered that families from cultures that practice FGM do not regard this practice as abusive. Therefore, it is imperative that extreme sensitivity is exercised by the Mersey Care NHS Foundation Trust Health Professional, when addressing this issue, to include appropriate terminology, use of an appropriate interpreter (i.e. an approved independent interpreter) and the support of a member of the Liverpool FGM Steering Group (accessible via the safeguarding children On Call service - 0151 285 4660).

7.58 If it is thought that a female child could be at imminent risk of FGM or has possibly recently undergone FGM, Mersey Care NHS Foundation Trust staff must contact the Named Nurse for Safeguarding Children immediately and make a referral to Children’s Social Care. FGM assessment form to be completed and sent to Safeguarding Team (see Appendix F attached).

7.59 It is essential that there is no delay in making a referral to Children’s Social Care immediately particularly for services which operate outside of normal working hours:

http://liverpoolscb.proceduresonline.com/chapters/p_safeg_sex_exp.html

<http://www.seftonlscb.co.uk/worried-about-a-child.aspx>

<http://www.seftonlscb.co.uk/media/6863/Mersey-FM-HBV-protocol-final-April-2014.pdf>

<http://www.lancashiresafeguarding.org.uk/>

<http://www.rochdale.gov.uk/children-and-childcare/Pages/child->

E SAFETY

7.60 Whilst the internet and the digital world such as social media should be embraced, it also poses a danger to children and young people, who may be exposed to pornography, cyber bullying, sexting etc. If Mersey Care NHS Foundation Trust staff are concerned that a child or young person is at risk, concerns should be discussed with Safeguarding Ambassadors, Safeguarding Practitioner or the Named Nurse for Safeguarding Children and appropriate referrals to Children’s Services should be made. Whilst appropriate systems are in place to prevent access of certain materials from Trust computers, any concerns re staff misusing equipment in such a way should be reported immediately.

7.61 Link to LSCB procedures:

http://liverpoolscb.proceduresonline.com/chapters/p_ch_abuse_net.html

<http://www.seftonlscb.co.uk/policy-guidance.aspx>

www.rochdale.gov.uk/council...social-care/.../safeguarding

<http://www.lancashiresafeguarding.org.uk/>

<http://knowsleyscb.proceduresonline.com/>

CHILDREN WITH A DISABILITY

7.62 Disabled children are more vulnerable to abuse because they may:

- Have fewer outside contacts than other children;
- Receive intimate personal care, so increasing the risk of exposure to abusive behaviour;
- Have an impaired capacity to resist abuse;
- Have communication difficulties that make it harder to tell others of their concerns;
- Be more vulnerable to bullying, intimidation and abuse by both adults and peers.

7.63 Looked after disabled children are not only vulnerable to the same factors that exist for all children living away from home but are particularly susceptible to possible abuse because of their additional dependency on residential and hospital staff for day to day physical needs.

7.64 Where there are concerns about the welfare of a disabled child, these should be acted on in exactly the same way as with a non-disabled child. The same thresholds for action must apply. Where there are safeguarding concerns about a disabled child, there is a need for greater awareness of the possible indicators of abuse and/or neglect as the situation is often more complex. It is crucial that the disability is not allowed to mask or deter the need for an appropriate investigation of child protection concerns:

<http://www.seftonlscb.co.uk/worried-about-a-child.aspx>
www.rochdale.gov.uk/council...social-care/.../safeguarding
<http://www.lancashiresafeguarding.org.uk/>
<http://knowsleyscb.proceduresonline.com/>
http://liverpoolscb.proceduresonline.com/chapters/p_ch_abuse_net.html

DISCLOSURE OF INFORMATION ABOUT SEX OFFENDERS

7.65 The Home Office has produced guidance for dealing with the exchange of information about those persons convicted of, or cautioned for sexual offences and those considered a risk to children and others.

7.66 A Sex Offenders Register exists for offenders convicted of a sexual offence.

7.67 The Police and Probation Services are required to undertake a risk assessment in these circumstances.

7.68 There are local inter-agency risk assessment protocols in place, which should be followed.

7.69 For further advice and guidance, contact the relevant Named Nurse, Nominated Officer for Safeguarding Children (HSS) or safeguarding units.

REQUEST FOR INFORMATION ABOUT PATIENTS OR CLIENTS – SHARING INFORMATION AND CONSENT

7.70 Professionals can only work together to safeguard children if there is an exchange of relevant information between them. This has been recognised by the courts. Any disclosure of personal information to others must always however have regard to both common and statute law.

- 7.71 Normally personal information can only be shared with third parties (including other agencies) with the consent of the subject of that information. Wherever possible, consent should be obtained before sharing personal information with third parties.
- 7.72 In some circumstances, consent may not be possible or desirable but the safety and welfare of the child dictate that the information should be shared. "Routinely professionals should explain to patients at the outset the parameters of confidentiality i.e. the duty are not absolute and there may be occasions when information has to be disclosed. If the patient does not consent, as a matter of public duty or under one of the exceptions listed in Schedule 3 of the Data Protection Act 1998 such as in furtherance of duties under the Children Act 1989.
- 7.73 The law recognises that disclosure of confidential information may need to occur in the absence of consent.
- 7.74 We have a duty to co-operate with Social Services when they are undertaking Section 47 enquiries. However, for Trust staff you are advised not to disclose any other information to any court appointed officer without seeking advice first from the Named Nurse for Safeguarding Children.
- 7.75 Record the details of the circumstances in the patient's records and the rationale for any decisions taken.
- 7.76 Notices or posters about the Trust's confidentiality statement should be widely displayed in the waiting areas.
- 7.77 Information leaflets should be widely available for parents/carers and competent children and young people detailing the limitations of confidentiality.
- 7.78 Seek advice in circumstances when there is a disagreement between a competent young person and their parent from the safeguarding or Child Protection Unit.

CHILDREN MISSING FROM EDUCATION

- 7.79 Where staff identify a child or young person is not attending school referrals to appropriate Local Authority should be made.

YOUNG PEOPLE MISSING FROM SERVICE

- 7.80 There is a DNA procedure in place for these circumstances which is outlined within the policy on Service Provision for 16-18 year olds. This procedure should be applied to all young people within our service irrespective of age:

<http://www.merseycare.nhs.uk/media/2534/sa38-v3-service-provision-to-under-18s-uploaded-17-nov-15-review-oct-2017.pdf>

8. ESCALATION PROCEDURE (SEE TABLE 1 IN APPENDIX 3)

- 8.1 If you disagree with how your referred concerns have been progressed refer to the appropriate local authority Safeguarding Children service for further advice. There is an 'Escalation' procedure in place that they can guide you through.
- 8.2 Disagreements in how cases are progressed or managed between Mersey Care NHS Foundation Trust staff and Social Care should be escalated internally to the

Named Nurse for Safeguarding Children who will manage the conflict appropriately. See Appendix 3 for escalation flow chart.

9. PROCESS AND PROCEDURE

ALLEGATIONS OF ABUSE AGAINST CHILDREN BY MERSEY CARE NHS FOUNDATION TRUST PROFESSIONALS (OR PAID CARE GIVERS)

9.1 The Safeguarding Children Lead and/ Human Resources Department must be informed.

9.2 There are circumstances when Health Professionals will become suspicious / aware of allegations of, or disclosure of, abuse by a professional. This must be reported to the Named Nurse for Safeguarding Children who will inform the Local Authority Designated Officer (LADO) will be involved in the oversight of individual cases, providing advice and guidance to employers and liaising within a multi-agency context to establish suitability of an individual to work with children.

These allegations should be taken seriously and the allegations management procedures (and/or adult protection procedure if appropriate) should be followed. Social Services should always be notified.

9.3 This abuse may involve:

- A patient or client
- A child in the professional's family
- Any domestic abuse in a Health Professionals household where there are children.

9.4 The Named Nurse for Safeguarding Children should be informed in such circumstances when the allegation concerns abuse of a child.

9.5 The Named Nurse and/or Doctor/Nominated Officer for Safeguarding Children (HSS) Social Services and are invited to attend strategy/network meetings as appropriate.

9.6 There will be four possible strands to dealing with an allegation against Health Professionals:

- Safeguarding children enquiries
- Local Authority Designated Officer (LADO) investigation
- Police investigation into a possible offence
- Disciplinary procedures: where it appears that the allegation may amount to misconduct or gross professional misconduct on the part of staff.

SPECIFIC REQUESTS FOR INFORMATION

Police

9.7 Contact with Police Officers from the Family Crime Investigation Units, or from any other departments may occur in a number of different ways. They may telephone or make arrangements by appointment to meet with Health Professionals. They may be seeking information for a variety of reasons – investigating a child protection matter, criminal offence, and domestic abuse allegations. Occasionally staff need to be interviewed as witnesses to certain events. There is an

expectation that health services will co-operate with the police. The consequences of inter-agency co-operation are that there has to be an exchange of information.

- 9.8 However, do not give any information at all to a police officer without first talking to Named Nurse for Safeguarding Children or Nominated Officer for Safeguarding Children (HSS) or a Trust Director who is responsible for making the decision whether or not to share information with the police, in the best interests of the child. Take the details of the information needed, the reason for the request and the details of the police officer including rank, department and contact telephone number. Advise the police officer that you need to receive a section 29 form from them detailing the request before information can be shared. Contact the named Nurse for Safeguarding Children to discuss the request.
- 9.9 In certain circumstances, police officers are working to very tight time constraints and may appear very insistent that you give them information immediately and quote all sorts of legislation and powers that they have. In those circumstances ask them to contact you again in an hour which will give you time to seek urgent advice.

Solicitors in Child Care Proceedings – Requests from Local Authority for Statements of Evidence for Court

- 9.10 A request should be received in writing from the relevant legal department of the Local Authority.
- 9.11 Discuss the request with line manager /Named Nurse for Safeguarding Children.
- 9.12 Always have the statement checked by a Safeguarding Ambassador, Line Manager or Named Nurse for Safeguarding Children before sending the report.

14-18 YEAR OLD YOUNG PEOPLE SECTION SHOULD BE READ IN CONJUNCTION WITH THE TRUST POLICY FOR THE PROVISION OF CARE FOR UNDER 18'S.

<http://www.mersecare.nhs.uk/media/2534/sa38-v3-service-provision-to-under-18s-uploaded-17-nov-15-review-oct-2017.pdf>

- 9.13 Mersey Care NHS Foundation Trust Professionals should be able to recognise when information given by a young person even a 14-18 year old suggests that either s/he is a "child in need" or is likely to suffer significant harm.
- 9.14 In relation to significant harm this can encompass a situation where a child is out of parental/carer control.
- 9.15 Under the Children Act 1989, Health Professionals have a duty to safeguard and promote the welfare of the child.
- 9.16 The legal duty of confidentiality and consent is the same for children and young people as adults. The concept of Fraser Competence is specifically relevant to this group.
- 9.17 The Health Professional has to balance whether by indicating to a patient/client in advance that disclosure will take place or whether after disclosure is made information has to be relayed on and the patient may avoid seeking assistance in the future. Potentially this could compromise the patient's well being and cause worse problems than already exist and from which the Health Professional is trying to protect the individual.

- 9.18 Young people who may be being sexually exploited or substance misuse will cause a difficulty for the Health Professional in what to do with that information, particularly when you are asked to keep the information confidential. There may even be some circumstances in which a young person discloses such an unsuitable lifestyle that Health Professionals will have to consider whether instant action needs to be taken e.g. by way of an Emergency Protection Order.
- 9.19 Notwithstanding the previous point above, information given about the young person's lifestyle, which could cause him or her to be in need or at risk of significant harm, needs to be disclosed.
- 9.20 Most people under the age of 18 will have an interest in sex and sexual relationships. When a professional working with a young person under the age of 16 becomes aware that the young person is engaged in sexual activity, clear procedures should be in place to assist accurate assessment of the likelihood of suffering Significant Harm in order to protect the welfare of the child or young person. As a minimum the professional should take advice from the Named Nurse for Safeguarding Children.
- 9.21 After considering all the factors in each specific case and if the decision is made to refer to Social Services or in an emergency situation to the police, unless a particularly serious situation exists, the young person should be advised as to the intentions of the Health Professional and the nature of the information to be shared.
- 9.22 Always seek expert advice (if necessary) if possible before making a decision.
- 9.23 Very detailed supporting documentation should be kept which includes any discussion on consent, confidentiality, discussion about parental involvement and the nature of what is to be disclosed and what is not to be disclosed.
- 9.24 Staff have a duty to meet the legal responsibilities, which includes the legal and ethical issues on real or potential conflict between the interests of the child and the parents.
- Seek advice if there is a disagreement between a competent young person and their parent.

FRASER COMPETENCE

- 9.25 This term has been used since the House of Lord's ruling in the case of Victoria Gillick v West Norfolk and Wisbech Health Authority and the Department of Health and Social Security in 1985.
- 9.26 It is used to decide whether or not a child is competent to give consent to treatment. As part of Lord Fraser's judgement he issues guidelines, which specifically refer to contraception, but the principles also apply to other treatment, including abortion. They apply to Health Professionals in England and Wales.

COMMON ASSESSMENT FRAMEWORK (CAF) AND EARLY HELP ASSESSMENT TOOL (EHAT)

- 9.27 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.

9.28 Effective early help relies upon local agencies working together to:

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

9.29 As an adult facing service, Mersey Care NHS Foundation Trust staff are required to work within the Early Help framework by making appropriate Pre CAF (Knowsley/Sefton) and Early Help Assessment Tool (Liverpool) referrals to the appropriate Local Authority.

PREVENT

9.30 Prevent is the Government counter terrorism strategy which aims to reduce the risks the UK faces from terrorism. This strategy aims to stop people becoming involved in or supporting terrorist activity.

9.31 Link to Trust Prevent implementation policy SD43:

<http://www.merseycare.nhs.uk/media/2901/sd43-v3-prevent-uploaded-1-jul-16-review-may-2017.pdf>

10. CONSULTATION

10.1 The Named Nurse for Safeguarding Children developed this policy in consultation with the Safeguarding Strategy Group, Safeguarding Operational Group and the designated Nurse for Safeguarding Children.

11. TRAINING AND SUPPORT

Safeguarding Training is mandatory for all trust staff at the appropriate level, which is clearly identified in the Safeguarding Children and Adults training Strategy. Level 1 is mandatory at induction and three yearly for all staff. Level 2 and 3 are mandatory within 3 months of commencing work with the Trust for all staff who work directly with service users and their families.

12. SPECIALIST LEARNING DISABILITY DIVISION

There is a separate policy attached that outlines the policy for Child Contact within the specialist Learning Disability Division.

13. MONITORING

13.1 The Safeguarding Team have developed an auditing cycle to monitor the compliance with advice given to staff to ensure that the policy is followed. The outcome of quarterly audits will be presented to the Safeguarding Strategy group by Specialist Practitioners for Safeguarding/Named Nurse for Safeguarding Children.

13.2 The safeguarding policy will be a standing agenda item at Safeguarding Strategy meetings.

APPENDIX A: SAFEGUARDING CONTACTS SPECIALIST LEARNING DISABILITY DIVISION

CHILD VISITING/CHILD CONTACT PROCEDURE

1. **Guiding Principles**
2. **Pre-admission procedures**
3. **Requests**
4. **When contact has been authorised**
5. **When contact has not been authorised**
6. **Contact during Section 17 leave**
7. **Recording and Monitoring**
8. **Appeals**
9. **Review**

1. **Guiding Principles**

1.1 Specialist Learning Disability Division is committed to the five principles that underpin the Mental Health Code of Practice (2015) and considers these when making any decisions in relation to care, support or treatment under the act. These five guiding principles are:

- Least restrictive option and maximising independence
- Empowerment and involvement
- Respect and dignity
- Purpose and effectiveness
- Efficiency and equity.

1.2 Article 8 of the European Convention on Human Rights (1998) protects family life and Specialist Learning Disability Division recognises and promotes the importance of maintaining or renewing these links. Family contact including child visits are seen as an important part of the care that we provide and therefore this is encouraged and made as comfortable and easy as possible for both the patient and their family.

- 1.3 For the purposes of this policy, a child is stated to be a person under the age of 18 as stated in the Children's Act (1989). Similarly, for the purpose of this policy anyone who is receiving treatment and care at Specialist Learning Disability Division or being assessed for it shall be referred to as 'patient'.
- 1.4 Specialist Learning Disability Division has the belief that children and young people have their own independent rights which need to be a significant consideration in decision making. The principal that "**the welfare of the child is paramount**" (Children Act, 1989) must override all other considerations and this is reinforced within the Code of Practice. With this in mind, the Local Authority may be asked to assess whether it is the best interest of a child to visit the patient or have this contact as part of Section 17 leave.
- 1.5 Children visiting the main site will not be able to visit patients on the wards but they will be provided with access to our family rooms. These child-friendly environments are separated from the wards in order to safeguard against exposure to potentially distressing experiences that could occur within the hospital environment. The location for visits made to periphery houses will be discussed on an individual basis by the MDT. Children must not be left unattended and must always be supervised by the person who has parental responsibility, even whilst being observed by a member of Specialist Learning Disability Division staff.
- 1.6 Safeguarding children and protecting them from harm is everyone's responsibility. Everyone who comes into contact with children and families has a role to play' (Working Together to Safeguard Children, 2015). Therefore, no single discipline will have complete responsibility for this contact; however the social work team will take the lead role relating to this procedure. When child contact takes place, supervising staff must ensure the safety of the individuals present and it must be agreed by the patient's clinical team prior to it taking place. Furthermore, all documentation must be completed and stored in Carenotes.
- 1.7 The social work team must be invited to all initial MDT discussions concerning child contact.

2. Pre-admission procedures for Patients to have contact with children at Specialist Learning Disability Division

- 2.1 During the assessment process to determine a patient's suitability for admission, the social work team will attempt to gain information regarding whether the person being assessed has parental responsibility. This information will be included within the social work 'Pre-Admission Report'.
- 2.2 If admission to Specialist Learning Disability Division is appropriate, attempts will be made to ascertain if there may be requests for children to visit or have contact as part of Section 17 leave and whether there are any child protection concerns.

3. Requests made by Patients or Others Who Have Parental Responsibility for Children to Visit Patients at Specialist Learning Disability Division (Specialist Learning Disability Division)

- 3.1 When a request is made by a patient or a parent for children to visit a patient at Specialist Learning Disability Division, a clinical note will be recorded on Carenotes and a referral sent to the social work team via Carenotes. The patient's NHS number must be quoted within this referral so that it can be used as the unique identifier. This will avoid any confusion.
- 3.2 The social work team will complete Section A of the Child Contact Risk Assessment Form embedded within Carenotes (Appendix 1). This will be undertaken by liaising with the patient's ward team and by gathering information from Carenotes. A check will be made to consider any recent incidents the patient may have been involved in and the Safeguarding team will be contacted to enquire about any open referrals.
- 3.3 The social work team will then speak to the person who has parental responsibility for the child/ children in order to gain consent.
- 3.4 At this stage, the person with parental responsibility will be asked if they are currently working with children's services and will be made aware that we will speak with the local authority. Additionally, they must be advised that if we have any concerns we will contact Children's Social Care in order for a Best Interest's Assessment to take place. This is considered to be Best Practice in line with the Department of Health's framework for the assessment of children in need and their families (2000).
- 3.5 If this consent is given, a form will be sent as part of the Child Visiting Pack (Appendix 2) in order to gain written permission. This consent form must be returned at the earliest possible opportunity to the social work team. If a Best Interest's Assessment is required, a referral cannot be made until we have received this consent form.
- 3.6 With this information the social work team will begin Section B of the Child Contact Risk Assessment Form embedded within Carenotes (Appendix 1). The patient's social worker will be contacted so that their viewpoint can be included within the assessment.
- 3.7 The social work team will liaise with the local authority where the child resides in order to see if they are known to services or are currently open to them. Lancashire LSCB guidance highlights the importance of contacting the child's social worker when applicable. If the family are working with children's services, the child's social worker will be communicated with throughout this process as per Lancashire LSCB guidance; this will be done by the social work team.
- 3.8 If the child or children are under the care of the Local Authority or involved in care proceedings under the Children's Act (1989), the social work team will request a best interest's assessment from the Local Authority.

- 3.9 Similarly, when concerns are raised the social work team will liaise with the local authority where the child resides in order to complete a Best Interest's Assessment. Concerns may arise due to the nature of the patient's offence or recent behaviour.
- 3.10 The MDT will meet in order to discuss the Risk Assessment form embedded within Carenotes (Appendix 1) and complete section C. This discussion will focus upon the proposed contact and a final decision will be made regarding whether it can go ahead, the social work team must be invited to the MDT meeting. If contact is authorised, the contact management plan will be included within Section C. Procedures will then follow those to allow contact or not to allow contact. This decision will be recorded on Carenotes by the social work team.
- 3.11 If the patient needs or asks for any preparatory work prior to this contact, it will be completed at this point by the social work team.

4. The Procedure to follow if the Contact has been Authorised

- 4.1 Following the MDT discussion, if possible, the patient will be invited into the meeting to discuss the outcome. At this stage the Contact Management Plan will be discussed with the patient (Section C of the Child Contact Risk Assessment Form, Appendix 1). The social work team will advise the person with parental responsibility and the child's social worker if applicable, that the contact has been authorised and of the associated Contact Management Plan (section C).
- 4.2 Children will not be allowed to visit patients unless their names are included in the appropriate section of the patients Carenotes record alongside the name of the accompanying adult.

5. The Procedure to follow if the Contact has Not been Authorised

- 5.1 How this decision will be given to the patient will be determined by the MDT. If appropriate, the patient will be invited into the MDT to discuss the outcome and the review date. The review date will be determined on an individual basis.
- 5.2 If it is inappropriate to invite the patient into the MDT, ward staff will communicate this information to the patient on the same day of the meeting. The review date should be communicated alongside the rationale for the decision. This information will be communicated by the social work team by letter to the person(s) with parental responsibility and to the child's social worker.

6. Patients Contact with Children during Section 17 Mental Health Act 1983 (Amended 2007) Leave of Absence (Procedure Number)

- 6.1 All aspects of planning and management of leave of absence must be undertaken giving full regard to the welfare of children.

- 6.2 Requests for contact with children during leave of absence will be processed in the **SAME** way as requests for children to visit patients at Specialist Learning Disability Division.
- 6.3 Patients may not have contact with specified children on Leave of Absence which have not been approved through this procedure.
- 6.4 When a Leave of Absence has been granted and approval gained for any contact with named children, a Home Risk Assessment (Procedure 4.6 v.5.2) must be undertaken. This can be completed by ward staff and the patient's external social worker/ Specialist Learning Disability Division social worker.
- 6.5 The Contact Management Plan needs to be discussed with the patient prior to leave taking place. Similarly, supervising staff must familiarise themselves with this prior to leave taking place.

7. Recording and Monitoring Child Contact

- 7.1 All child contact should be booked with 5 days' notice; this is for on and off site contact. Onsite child visits must be booked via the social work team and must use the patient's NHS number as the primary identifier.
- 7.2 Following on from any child contact either at Specialist Learning Disability Division or during a patient's leave of absence, the Recording Child Contact Form (Appendix 3) must be completed. This should be recorded in the appropriate section of Carenotes.
- 7.3 If any concerns are raised regarding a patient's contact with children, this contact should be suspended and urgently reviewed by the MDT. If this is during a leave of absence, the supervising staff must liaise with the ward to determine whether or not the contact should continue.
- 7.4 All Child Contact must be discussed in ward round. Furthermore, a review should take place by the MDT including social work at least every six months. If a patient has not had any contact with the named child in over six months the approval procedure will need to be started again.
- 7.5 A list of children who are approved to visit/ have contact with patients on Section 17 leave will be maintained by the Social Work Team. This will be updated weekly and sent electronically to ward managers, deputy managers and reception staff. The rooms will be booked by the social work administrator; this can be arranged by emailing the social work email address and must include the patient's NHS number as the primary identifier.

8. Appeals

- 8.1 When the MDT decides not to authorise child contact, if the patient and/or the person with parental responsibility disagree with this decision they have the right to appeal.

- 8.2 Appeals will be reviewed by the senior management team at Specialist Learning Disability Division. This appeal panel will consist of two members of the senior management team who were not involved in the original decision. They will review the decision and inform the patient's clinical team and the person making the appeal.
- 8.3 If the Local Authority decides that contact is not in the child's best interests, those making the appeal will be advised of the Local Authority's complaints procedures.

9. Review of Policy

This policy will be reviewed on an annual basis in conjunction with Lancashire CCG in order to conform to the latest guidance.

References

Children's Act 1989. Retrieved from

<http://www.legislation.gov.uk/ukpga/1989/41/contents>

Children's Act 2004. Retrieved from

<http://www.legislation.gov.uk/ukpga/2004/31/contents>

Department of Health 2013. 'Guidance on the High Security Psychiatric Services (Arrangements for Visits by Children)'. Retrieved from

<https://www.gov.uk/government/publications/high-security-psychiatric-services-directions>

Department of Health 2015 'Working together to safeguard children'. Retrieved from

<https://www.gov.uk/government/publications/working-together-to-safeguard-children--2>

Human Rights Act 1998. Retrieved from

<http://www.legislation.gov.uk/ukpga/1998/42/contents>

Lancashire Safeguarding Children Board, 'Visiting of Psychiatric Patients by Children'. Retrieved from

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

Mental Health Act 1983 Code of Practice 1999: Guidance on the visiting of psychiatric patients by children. Retrieved from

http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4012153.pdf

Mental Health Act 1983: Code of Practice 2015. Retrieved from

<https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983>

List of Supporting Documents:

IT10 – Policy and Procedure for Confidentiality and Information Sharing

SA12 - Policy and Procedure for the Management of Domestic Abuse Policy

SD22 – Policy and Procedure for Visits by Children to Mersey Care NHS

Foundation Trust Sites

SD23 – Policy and procedure of Young Carer's Assessment and Planning

SA 38 - Service Provision to Young People Aged Under 18

HSS24 - Policy and Procedure Child Contact (High Secure Services)

Working Together to Safeguard Children 2015

Trust Safeguarding Children and Adults Training Strategy 2015/16

APPENDIX B: SAFEGUARDING CONTACTS

Mersey Care NHS Foundation Trust Safeguarding Office:
0151 471 2380 (Trust Headquarters) & 0151 250 5203 (Broadoak Unit)
All referral forms are available on the Mersey Care NHS Foundation Trust
Safeguarding Share Point pages

Chantelle Carey
Named Nurse for Safeguarding Children
0151 250 5203
Mobile: 07810055533
chantelle.carey@merseycare.nhs.uk

Leigh Tindsley
Named Professional Safeguarding Adults Lead
0151 250 5203
Mobile: 07810655692
Leigh.tindsley@merseycare.nhs.uk

Cath Taylor
Safeguarding Lead Specialist - Learning Disability Division
Room F67 Medical Block, Mitton Road,
Whalley, Clitheroe, BB7 9PE
Internal: 3281
External: 01254 821281
Email: cath.taylor@merseycare.nhs.uk

Sarah Asher
Specialist Safeguarding Practitioner - Learning Disability Division
Room F67 Medical Block, Mitton Road,
Whalley, Clitheroe, BB7 9PE
Internal: 3281
External: 01254 821281
Sarah.asher@merseycare.nhs.uk

Crispin Evans
Specialist Safeguarding Practitioner
0151 471 2380
Mobile 07773978253
Crispin.evans@merseycare.nhs.uk

Lindsay Devine
Specialist Safeguarding and PREVENT Practitioner
0151 250 5203
Mobile: 07795971766
Lindsey.devine@merseycare.nhs.uk

Dr Sakib Shamas-UD-DIN
Named Doctor Safeguarding Children Mersey Care NHS Foundation Trust
sakib.shamas-UD-Din@merseycare.nhs.uk

Robert McLean, Head of Forensic Social Care/Nominated Officer for Safeguarding Children – Secure Division,
Mersey Care NHS Foundation Trust, High Secure Services, Ashworth Hospital
0151 473 2808 (office hours)
robert.mclean@merseycare.nhs.uk

Liverpool Children's Services
Careline 0151 233 2700

Sefton Social Services
Out of hours Team 0151 920 8234
Customer Service referral 0151 634 3737

Knowsley Social Services
0151 443 3792/98
Out of hours 07659590081

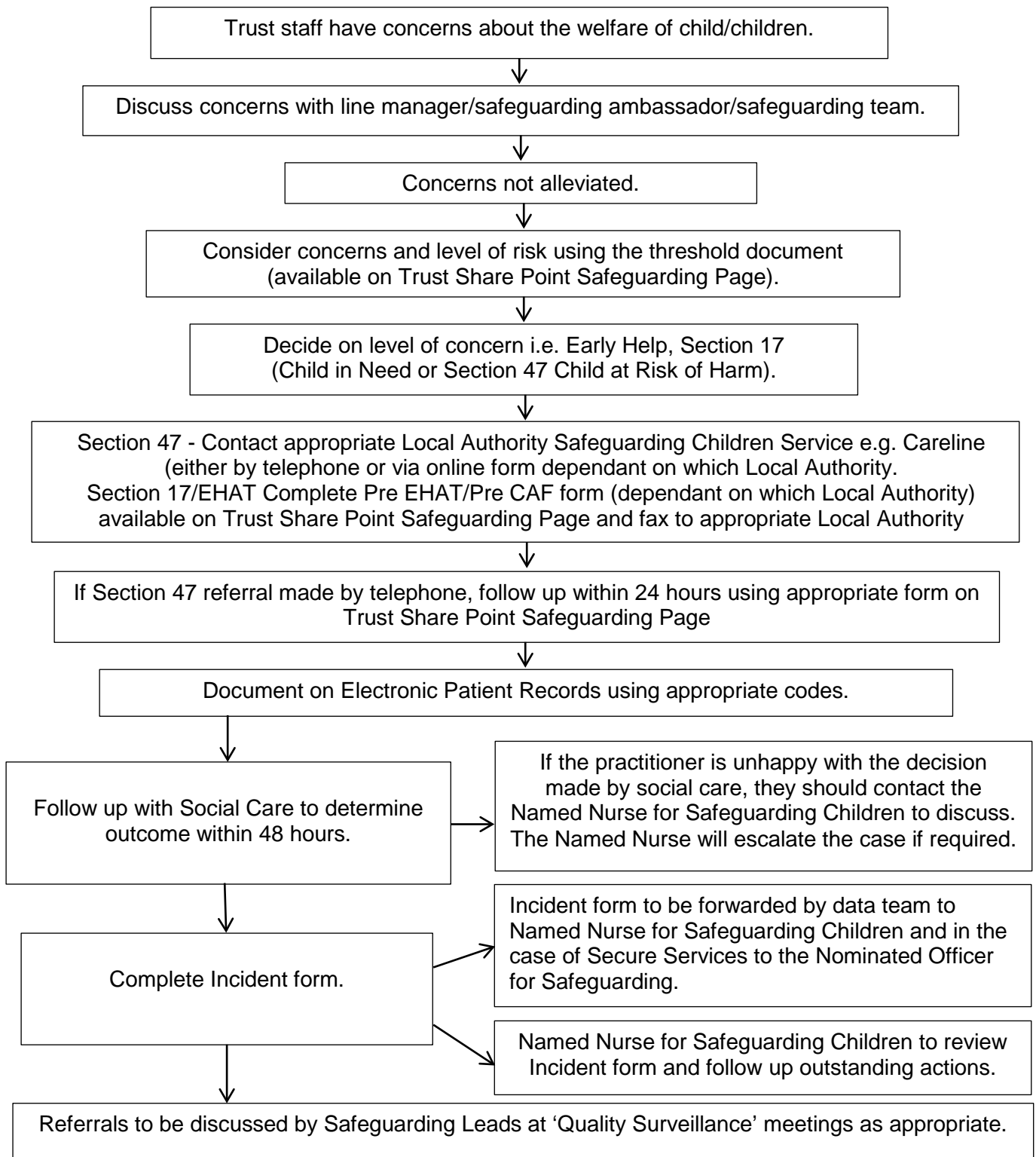
Lancashire County Council Social Care
Care Connect - 0300 123 6720 (8am - 8pm)
Out-of-hours: 0300 123 6722 (8pm - 8am).

Lancashire Constabulary – Via 101

Rochdale Council Social Care Tel: **0300 303 8875** (Emergency Duty Team out of hours; including bank holidays)
<http://www.rochdale.gov.uk/children-and-childcare/pages/child-protection.aspx>

Family Support Units (Merseyside Police)
South Liverpool 0151 777 5181
North Liverpool 0151 777 4611
Sefton 0151 777 3181
Knowsley 0151 777 6388

APPENDIX C: SAFEGUARDING CHILDREN REFERRAL AND ESCALATION PROCESS



APPENDIX D: RESOLUTION OF PROFESSIONAL DISAGREEMENTS IN WORK RELATING TO SAFEGUARDING CHILDREN, YOUNG

Resolution of Professional Disagreements in Work Relating to Safeguarding Children, Young

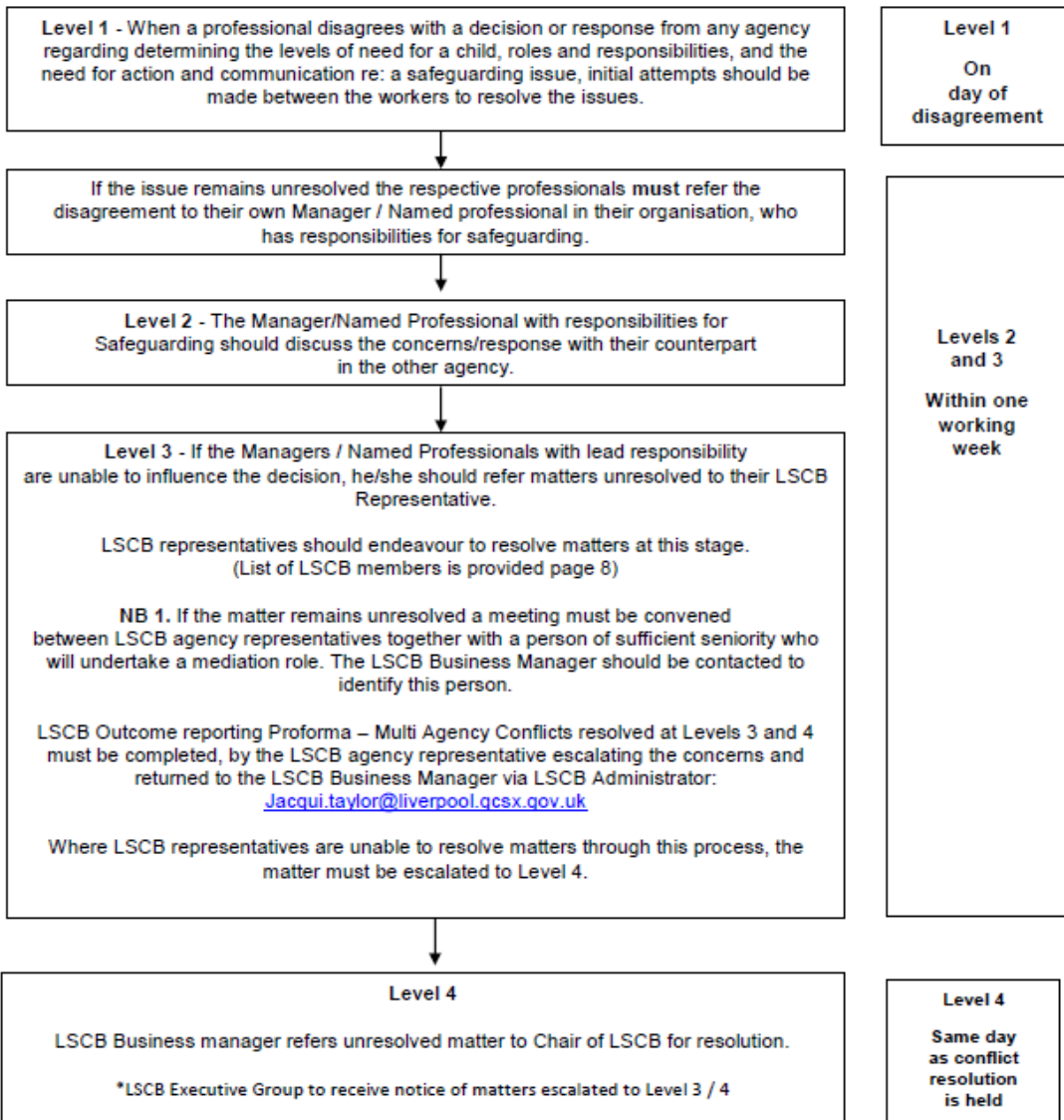
WHEN ANY PROFESSIONAL CONSIDERS A CHILD IS AT IMMEDIATE RISK OF SIGNIFICANT HARM THEN THE INDIVIDUAL MUST ENSURE THEIR CONCERNS ARE ESCALATED ON THE SAME WORKING DAY USING ESTABLISHED CHILD PROTECTION PROCEDURES.

Please Note: At all stages actions / decisions must be shared in a timely manner with relevant personnel who are directly involved with the service user(s).

Where matters are escalated to Levels 3 or 4 this **must be** recorded on the service users file using the pro forma: Recording Inter - Agency conflict and resolution on a Service Users File.

People

Escalation Levels



APPENDIX E: CHILD SEXUAL EXPLOITATION FORM

CSE1

REFERRERS DETAILS				
Name		Date of referral.....		
Agency Name		Job Title.....		
Agency type: Health / Children's Services / Education / Youth Services / Police / Probation / Voluntary services Other – please state.....				
Email address.....		Telephone No.....		
CHILD DETAILS				
Forename(s).....		(M/F)		
Surname / family name(s).....		D.O.B.....		
Ethnicity.....	Religion.....	Nationality.....		
Address.....		Postcode.....		
Is this Address: Home / Other family member address / Foster care / Residential Care / Semi independent Hostel / Secure unit / Other – please state				
Home tel no.		Mob / other contact no.....		
GP name.....		Surgery.....		
School				
CHILDRENS SOCIAL CARE INVOLVEMENT				
Not known to CSC	EHAT / CAF	Child in Need	Child Protection Plan	LAC / Leaving Care
Is this child placed here from another local authority? YES /NO				
If yes – state which.....				

PARENT/CARER/GUARDIAN'S DETAILS	Parental Responsibility?	Yes / No
Forename(s)..... (M/F)		
Surname / family name(s)..... D.O.B.....		
Ethnicity..... Religion..... Nationality.....		
Home address.....Postcode.....		
Home tel no. Mob / other contact no.....		
Occupation.....		
PARENT/CARER/GUARDIAN'S DETAILS	Parental Responsibility?	Yes / No
Forename(s)..... (M/F)		
Surname / family name(s)..... D.O.B.....		
Ethnicity..... Religion..... Nationality.....		
Home address.....Postcode.....		
Home tel no. Mob / other contact no.....		
Occupation.....		
SIBLINGS		
Relationship to young person		
Forename(s)..... (M/F)		
Surname / family name(s)..... D.O.B.....		
Home address.....Postcode.....		
Home tel no. Mob / other contact no.....		
Relationship to young person		
Forename(s)..... (M/F)		
Surname / family name(s)..... D.O.B.....		
Home address.....Postcode.....		
Home tel no. Mob / other contact no.....		

SUSPECTED PERPETRATOR DETAILS

Forename(s)..... (M/F)

Surname / family name(s)..... D.O.B.....

Home address.....Postcode.....

Home tel no. Mob / other contact no.....

Has suspect previously breached a court order or police bail? **Y / N** If **Y** provide details below
.....
...

Child suspects only (under 18 years)

School / occupation.....

Please state whether the following are applicable to this young person...	Yes	No	Don't know
Absent from school			
Attending school with young people who are sexually exploited			
Change in physical appearance			
Drug or alcohol misuse			
Evidence of sexual bullying and/or vulnerability through the internet and/or social networking sites			
Estranged from their family			
Friends with young people who are sexually exploited			
Gang association either through relatives, peers or intimate relationships (in cases of gang-associated CSE only)			
History of abuse			
Homeless			
Involvement in offending			
Lacking friends from the same age group			
Learning disabilities			
Living in a chaotic or dysfunctional household (including parental substance use, domestic violence, parental mental health issues, parental criminality)			
Living in a gang neighbourhood			
Living in hostel, bed and breakfast accommodation or a foyer			
Living in residential care			
Low self-esteem or self-confidence			
Missing from home or care			
Not in education, employment or training			
Physical injuries			
Poor mental health			
Receipt of gifts from unknown sources			
Recent bereavement or loss			

Recruiting others into exploitative situations			
Repeat sexually-transmitted infections, pregnancy and terminations			
Self-harm			
Thoughts of or attempts at suicide			
Unsure about their sexual orientation or unable to disclose sexual orientation to their families			
Young carer			
If you are not ticking any of the above CSE indicators, please consider if a CSE specific referral needs to be made			

CIRCUMSTANCES OF INCIDENT / ANY OTHER INFO

Type of CSE you think this may be or may be heading towards – Please select the one you consider to be most relevant to this situation

Boyfriend Model	
Online	
Organised/ networked sexual exploitation or trafficking	
Party Model	
Peer to Peer	
Group / Gang exploitation	
Other – Please state	

ASSOCIATES OF CHILD / RELEVANT PARTIES
ASSOCIATES OF SUSPECTED PERPETRATOR / RELEVANT PARTIES
IF MISSING WHO WERE THEY FOUND WITH AND WHERE?
LOCATIONS OF CONCERN WHERE YOU BELIEVE CSE IS AN ISSUE
VEHICLES THAT COULD BE LINKED TO CSE AND TO THE CHILD /YOUNG PERSON
TELEPHONE NUMBERS LINKED TO THE CHILD / YOUNG PERSON
TELEPHONE NUMBERS LINKED TO THE SUSPECTED PERPETRATOR

Are Parents/ carers aware of these concerns?	YES / NO
Does the child have awareness of these concerns?	YES / NO
Does the young person consent to you sharing this information?	YES / NO

**PLEASE SEND THIS FORM VIA SOCIAL CARE FRONT DOOR TO THE MACSE
(Multi Agency CSE) MEETING**

It is the responsibility of the referring agency to determine whether the referred child's parents are informed that their child will be discussed at the MACSE meeting.

Clearly best practise would always be to inform / consult with parents regarding their children, but this may be detrimental in some cases. It may not always be in the child's best interests to inform parents and each case should be considered individually.

APPENDIX F: FGM ASSESSMENT FORM

FGM Assessment Form

Section C - FGM Details		
FGM Type (Please enter option number from list on the right hand side)	<input type="text"/>	1 - FGM type 1 2 - FGM Type 2 3 - FGM Type 3 4 - History of FGM type 3 5 - FGM Type 3 – Reinfibulation Identified 6 - FGM Type 4 7 - FGM Type Unknown 8 - Deinfibulation Undertaken to facilitate delivery 9 - Deinfibulation Undertaken
FGM Type 4 Qualifier (Please enter option number from list on the right hand side)	<input type="text"/>	1 - FGM Type 4 Pricking 2 - FGM Type 4 Piercing 3 - FGM Type 4 Scraping 4 - FGM Type 4 Incising 5 - FGM Type 4 Cauterisation
Age Range when FGM was undertaken (Please enter option number from list on the right hand side)	<input type="text"/>	1 - Less than 1 year old 2 – Between 1 and 4 years old 3 – Between 5 and 9 years old 4 – Between 10 and 14 years old 5 – Between 15 and 17 years old 6 – Over 18 7 – Would not say
Country where FGM undertaken		

Section D - Actions Taken			
Safeguarding Team Informed	<DD-MM-YYYY>	Patient Given DoH leaflet	Yes / No (Please delete the answers that do not apply)
School Nurse Informed	<DD-MM-YYYY>	Objection Information Given to Patient	<DD-MM-YYYY>
GP Informed	<DD-MM-YYYY>	Patient Informed of Dataset	<DD-MM-YYYY>
Police Informed	<DD-MM-YYYY>	Patient Objected to Dataset	<DD-MM-YYYY>

Signature of Staff Completing Form	Date

FGM Assessment Form

Section A - Patient details			
Name			
Date of Birth			
Hospital Number			
GP <small>(Please enter option number from list on the right hand side)</small>	<input style="width: 80%; height: 30px;" type="text"/>		1 - Registered – See ePEX 2 - Not Registered – Eligible 3 - Not Registered – Recently Entered Country 4 - Not Registered – Unknown, Unable To Confirm
	Enter if known		If Unknown – Please enter option number from list on the right hand side
Country of Birth			1 - Patient Not Asked 2 - Patient Asked But Not Answered 3 - Not Specified
Country of Origin			
Region of Country of Origin			

Section B - FGM Data Set															
Staff Name		ePEX Staff Code													
Staff Base		Contact Number													
Contact Date	<DD-MM-YYYY>														
Site of Treatment															
Interpreter Required during episode of care?	Yes / No <small>(Please delete the answers that do not apply)</small>														
Name of Referring Organisation															
Referring Organisation Type <small>(Please enter option number from list on the right hand side)</small>	<input style="width: 80%; height: 30px;" type="text"/>		<table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">01 – GP Practice</td> <td style="width: 50%;">07 – Police</td> </tr> <tr> <td>02 – NHS Organisation</td> <td>08 – Justice Service</td> </tr> <tr> <td>03 – Self Referral</td> <td>09 – Immigration Centre</td> </tr> <tr> <td>04 – School</td> <td>10 – Religious Organisation</td> </tr> <tr> <td>05 – Voluntary Sector</td> <td>11 – Other</td> </tr> <tr> <td>06 – Local Authority</td> <td>XX – Not Stated</td> </tr> </table>	01 – GP Practice	07 – Police	02 – NHS Organisation	08 – Justice Service	03 – Self Referral	09 – Immigration Centre	04 – School	10 – Religious Organisation	05 – Voluntary Sector	11 – Other	06 – Local Authority	XX – Not Stated
01 – GP Practice	07 – Police														
02 – NHS Organisation	08 – Justice Service														
03 – Self Referral	09 – Immigration Centre														
04 – School	10 – Religious Organisation														
05 – Voluntary Sector	11 – Other														
06 – Local Authority	XX – Not Stated														
Pregnancy Status Indicator	Yes / No / Unknown / Not Stated <small>(Please delete the answers that do not apply)</small>														
FGM Identification	Self Report / On Examination / Other Clinician / Other <small>(Please delete the answers that do not apply)</small>														
If 'Other Clinician' or 'Other' selected above, please specify here															
FGM Family History Indicator	Yes / No / Unknown / Not Stated <small>(Please delete the answers that do not apply)</small>														
Number of Daughters U18	<small>(Please enter NIL if no daughters – do not leave blank)</small>														
Has the patient been advised on health Implications of FGM?	Yes / No / Unknown-Not Specified <small>(Please delete the answers that do not apply)</small>														
Has Patient Any Sisters U18?	Yes / No <small>(Please delete the answers that do not apply)</small>														
Has the patient been advised on the illegalities of FGM?	Yes / No / Unknown - Not Specified <small>(Please delete the answers that do not apply)</small>														

Equality and Human Rights Analysis

Title: SD 13 Safeguarding and Protection of Children and Young People

Area covered: Trust Wide (apart from Ashworth which has its own Policy)

What are the intended outcomes of this work?

The purpose of this policy is to ensure a structured and systematic approach to safeguarding children the organisation. Complying with our statutory duty to safeguard and promote the welfare of children.

This policy is based on the belief that Trust staff in the course of their daily work are able to ensure the welfare and protection of children and young people.

Service users are aware of issues of safeguarding and protection of children and young people.

“When there is a conflict of interests between the needs of the adult and those of a child, the child’s welfare is paramount” (Paramount Principle, Children Act 1989).

Who will be affected?

Evidence

What evidence have you considered?

The following documents were used in the formation of the policy :

- [Children Act 1989](#), [Children Act 2004](#)
- [Working Together to Safeguard Children \(DoH 2015\)](#)
- [UN Convention on the Rights of the Child](#)
- [Human Rights Act 1998](#)
- The Framework for the Assessment of Children in Need and their Families ([DH 2000](#))

- [Mental Health and Social Exclusion Report 2004 - Action 16 'Improving opportunities and outcomes for parents with mental health needs' and their children](#)
- Care Programme Approach (CPA) Briefing: Parents with mental health problems and their children April 2008 [CPA Briefing](#).
- Social Care Institute for Excellence (SCIE) Think child, think parent, think family guide and national evaluation 2012 <http://www.scie.org.uk/children/parentalmentalhealthandchildwelfare/> [Here](#).
- Liverpool, Sefton, Knowsley, Lancashire and Rochdale LSCB Procedures for Safeguarding Children and Young People.

Disability including learning disability
No issues identified

Sex
No issues identified

Race
No issues identified

Age

Supports the human rights of children and supports the right to family life. Children have the right to make their views known in relation to safeguarding. This will be subject to considerations about child safety and also consent issues.

Gender reassignment (including transgender)
No issues identified

Sexual orientation
No issues identified

Religion or belief
No issues identified

Pregnancy and maternity
No issues identified

Carers
No issues identified

Cross Cutting

Other identified groups No issues identified

Human Rights	Is there an impact? How this right could be protected?
This section must not be left blank. If the Article is not engaged then this must be stated.	
Right to life (Article 2)	Human Rights based approach supported. This policy ensures that children are protected at all times
Right of freedom from inhuman and degrading treatment (Article 3)	Human Rights based approach supported. It ensures that children are the priority and respects their rights to dignity and respect.
Right to liberty (Article 5)	No issues identified.
Right to a fair trial (Article 6)	Decision-making in respect of patient contact with children will be based on assessment of each individual case, with the welfare of the child as paramount and the principal consideration.
Right to private and family life (Article 8)	Human Rights Based Approach Supported. Supports the human rights of children and supports the right to family life. The policy also promotes a human rights based approach and supports article 8 of the human rights right 1998(The right to family life). The current policy supports family life for patients (and family).
Right of freedom of religion or belief (Article 9)	No issues identified.
Right to freedom of expression Note: this does not include insulting language such as	No issues identified.

racism (Article 10)	
Right freedom from discrimination (Article 14)	No issues identified.

Engagement and involvement

The following staff / groups were consulted with in the development of this policy document:

The Trust Named Doctor for Safeguarding Children.

The Safeguarding Strategy Group

Trustwide Women and Think Family Group

Summary of Analysis

Eliminate discrimination, harassment and victimisation

This policy seeks to put in place safeguarding measures with the aim of protecting children.

The policy also promotes a human rights based approach and supports article 8 of the human rights right 1998 (The right to family life).

Advance equality of opportunity

N/A

Promote good relations between groups

N/A

What is the overall impact?

Supports the human rights of children and supports the right to family life.

Addressing the impact on equalities

No negative impact identified.

Action planning for improvement

See below in action plan

For the record

Name of persons who carried out this assessment:

**Chantelle Carey (Named Nurse for Safeguarding Children)
Denis Cullen (Safeguarding Operational Lead/Head of Social care)**

Date assessment completed:

13. November. 2016

**Name of responsible Director/Lead Trust Officer
Executive Director Of Nursing**

Date assessment was signed: November 2016

