

## TRUST-WIDE NON-CLINICAL POLICY DOCUMENT

# SAFEGUARDING AND PROTECTION OF CHILDREN

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**2018 – Version 7**

**Striving for Perfect Care for  
the People We Serve**

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# SAFEGUARDING AND PROTECTION OF CHILDREN

### Further information about this document:

Document name	<b>Safeguarding and Protection of Children</b>
Document summary	<b>Roles, responsibilities and accountability in relation to safeguarding children Roles, responsibilities and accountability of the Named Nurse, Named Doctor and Nominated Officer for Safeguarding Children High Secure Services Clarity about information sharing The 'Paramountcy Principle'</b>
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To be read in conjunction with	<b>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 HSS24 – Policy and Procedure child contact (High Secure Services) SD23 – Policy and Procedure of Young Carer's Assessment and Planning SA38 – Service Provision to Young People Aged Under 18 MC01 – Over-arching Policy and Procedure of the Mental Capacity Act 2005 Working Together to Safeguard Children 2015</b>
<b>This document can be made available in a range of alternative formats including various languages, large print and braille etc</b>	
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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 adults, including:

- being alert to the possibility of child / adult abuse and neglect through their observation of abuse, or by professional judgement made as a result of information gathered about the child / 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 / 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 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 FREDAs principles of **F**airness, **R**espect, **E**quality **D**ignity, and **A**utonomy.

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## **1. PURPOSE AND RATIONALE**

### **1.1 Purpose**

This document explains:

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

### **1.2 Rationale**

The purpose of this policy is to ensure children are protected from maltreatment and to ensure their overall welfare is promoted in order to prevent impairment of their health and development.

The policy ensures 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.

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

## **2. OUTCOME FOCUSED AIMS AND OBJECTIVES**

2.1 The objectives of the policy are to identify concerns that a child may be suffering or likely to suffer significant harm. Another key objective is to ensure children's needs are promoted in a way that prevents impairment of their health and development. Promoting a child's welfare includes creating opportunities to enable children to have optimum life chances in adulthood and ensuring that children grow up in circumstances consistent with the provision of safe and effective care.

2.2 These Aims and Objectives 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;
- 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 2017;
- 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](http://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. DEFINITIONS – PRINCIPLES**

- 4.1 This policy is based on the expectation that staffs must ensure the welfare of children in the course of their daily work.
- 4.2 Service users must be made 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. (Paramountcy Principle, Children Act 1989).
- 4.4 In circumstances where there are concerns that a child is suffering or likely to suffer harm, this must result in a referral to Children's Social Care. The local authority is obliged to consider initiating enquiries under Section 47 of the Children Act 1989 (Section 47 Enquiries) to find out what is happening to a child or whether action should be taken to protect a child.
- 4.5 In circumstances where a child has been identified as 'in need' a referral should be made to the local authority under the Children Act 1998 section 17. The Children Act 1998 defines a child in need as:

*A child whose vulnerability is such that they are unlikely to reach or maintain a satisfactory level of health or development, or their health and development will be significantly impaired, without the provision of service Or a disabled child*

- 4.6 The Early Help Assessment Framework should be followed to promote multi-disciplinary and multi-agency working at an early stage in order to identify and provide services to Children in Need of additional support before their needs escalate.
- 4.7 Working Together to Safeguard Children 2015 identifies four categories of abuse, these are defined as:

- **Physical Abuse:**

A form of abuse which may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces, illness in a child.

- **Emotional Abuse:**

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

- **Sexual Abuse:**

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

- **Neglect**



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

- provide adequate food, clothing and shelter (including exclusion from home or abandonment)
- protect a child from physical and emotional harm or danger
- ensure adequate supervision (including the use of inadequate care-givers)
- ensure access to appropriate medical care or treatment
- It may also include neglect of, or unresponsiveness to, a child's basic emotional needs

### **Policy Standards**

- 4.8 The following policy standards outline the broad statement of intent, which will be clarified in the relative sections throughout this policy document.
- 4.9 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.
- 4.10 Safeguarding children is monitored and managed through effective supervision and audit of practice.
- 4.11 Safeguarding children concerns can only be assessed by local authority children and families assessment teams (section 4).
- 4.12 The Named Nurse and Named Doctor manage child protection within the Trust.
- 4.13 The document clarifies the policy and procedure for Safeguarding children within the Trust.
- 4.14 All staff must be trained, in child safeguarding/protection awareness commensurate with their role within the Trust.
- 4.15 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**

- 4.16 The Trust should work within the principles of the Children Act 1989, the Children Act 2004, and other relevant legislation.
- 4.17 There are several key elements of this policy that staff must understand and adhere to:
- 4.18 Making a safeguarding referral to the Local Authority – The flowchart in Appendix B explains the process and contact details of appropriate professionals. The flowchart also details the process that should be followed prior to making a referral.
- 4.19 All information exchanged with other agencies must be confirmed in writing within 48 hours.
- 4.20 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. The 'Paramourncy 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 C).

- 4.21 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.
- 4.22 **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.
- 4.23 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.
- 4.24 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).
- 4.25 The contact details for all the relevant staff /agencies can be found within the Trust Intranet Safeguarding Share Point Site.
- 4.26 This policy is supported by a Corporate Escalation Procedure (Appendix C).

## 5. DUTIES

### **Roles, responsibilities and accountabilities of all staff**

- 5.1 Anyone working or involved 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 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 fulfill their duty to assist Social Care in assessments, as well as attending and reporting to child protection conferences when necessary.
- 5.3 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.
- 5.4 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.
- 5.5 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.
- 5.6 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.

- 5.7 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. Also see SA38 – Service Provision to Young People Aged under 18 for further guidance in relation to failed appointments.

<http://www.merseycare.nhs.uk/media/2534/sa38-v4-service-provision-to-under-18s-uploaded-17-nov-15-15-review-oct-2017.pdf>

### **Roles, responsibilities and accountability of the named nurse, names doctor and nominated officer for safeguarding children (HSS)**

- 5.8 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.
- 5.9 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.
- 5.10 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.
- 5.11 They are responsible for conducting the Trust's internal case reviews. They investigate and respond to safeguarding children complaints on behalf of the Trust.
- 5.12 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.
- 5.13 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.
- 5.14 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**

- 5.15 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.

- 5.16 The Executive Director of Nursing and Operations is the Trust Board member with individual responsibility for ensuring that a Policy & Procedure for effective Safeguarding of Children and Young People is in place; that it is implemented effectively; that all staff are aware of and operate within the requirements and that systems are in place for the effective monitoring of the standards contained within the policy.
- 5.17 The Quality Assurance Committee is an established part of the governance structures of the Trust which has the responsibility to ensure that safeguarding of children arrangements are managed appropriately across the organisation. The Committee ensures that the policy framework is appropriate and receives assurances in relation to compliance with the requirements of this policy through the receipt of reports, audit activity and from the review mechanisms established by the Medical Director.
- 5.18 The Safeguarding Strategy Group will support the Executive responsible for Safeguarding in providing assurance to the board or one of its committees on all matters relating to Safeguarding within the trust. In particular the Group will:
- (a) Support the generation of the annual reports to the Board (or delegated committee) in relation to safeguarding both children and adults;
  - (b) Provide minutes and reports to the Quality Assurance Committee
  - (c) Make recommendations to the Board on safeguarding issues;
  - (d) Ensure compliance with safeguarding/protection of children and vulnerable adults, standards for OFSTED, Care Quality Commission, Local Safeguarding Children's Boards, Safeguarding Adults Boards and any other inspectorate;
  - (e) Ensure the production, implementation and review of LSCB and LSAB action plans devised as a result of Serious Case Reviews/Safeguarding Children Reviews and Internal Serious Untoward Incidents when there is a safeguarding dimension.
- 5.19 The Board of Directors 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.

### **The Voice of the Child**

- 5.20 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 behavior 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.
- 5.21 A child-centered 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).
- 5.22 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 favorably than others in being able to access effective services which meet their particular needs.

## **6. PROCESS AND PROCEDURE**

### **CHILDREN IN SPECIFIC CIRCUMSTANCES**

- 6.1 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 be undertaken by children and family social workers. It is not the remit of adult mental health social workers.

### **DOMESTIC ABUSE AND SAFEGUARDING CHILDREN**

- 6.2 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.
- 6.3 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**

- 6.4 Safeguarding Children in whom illness is fabricated or induced is a specific category of abuse (DH 2002).
- 6.5 Concerns may be raised by staff, who may suspect that the health or development of a child has been, or is likely to be significantly affected, by a parent or carer who may have fabricated or induced illness in their child in order to gain attention.
- 6.6 Staff may observe unusual behaviour or unexplained incidents which alert them to the possibility of FII. They should explore the presenting information to identify where it is on the continuum from parental concern, over anxiety, through to suspected significant harm.
- 6.7 Health professionals would usually discuss any concerns about a child with the parent or carer and seek their consent to make a referral to Children's Services. However, in these circumstances it is imperative that the health professional does not discuss their concerns with the parents/carers as it may place the child at increased risk of significant harm.
- 6.8 Staff should not make a referral to Children's Services without seeking advice from the Safeguarding Children Service.
- 6.9 Staff should contact the safeguarding children's 'On Call' duty line who will advise them as to the appropriate course of action. If the concerns raised by the practitioner suggest the possibility of FII then the Safeguarding Children's Specialist Nurse will contact the Named Nurse Safeguarding Children who will ensure that a referral to the Designated Doctor / Consultant Community Paediatrician is made to assess the information. This will trigger the Pan Merseyside FII health protocol.
- 6.10 The Pan-Merseyside Health protocol for the management of suspected FII cases can be accessed by employees via the Safeguarding Children Service, as required.
- 6.11 For additional information relating to signs and symptoms of FII and the internal process once a FII is suspected see appendix D

### **BRUISING IN NON-MOBILE INFANTS**

- 6.12 Bruising is the commonest presenting feature of physical abuse in children. Recent serious case reviews have indicated that clinical staff have sometimes underestimated or ignored the highly predictive value for child abuse, of the presence of bruising in children who are not independently mobile (those not yet crawling, cruising or walking independently).
- 6.13 NICE guidance *When to Suspect Child Maltreatment (2017)* states that bruising in any child not independently mobile should prompt suspicion of maltreatment.
- 6.14 If any staff member has cause for concern due to a bruise being evident in a non-mobile infant, this must be immediately reported to the relevant local authority as per this policy.

### **SUDDEN UNEXPECTED DEATH IN CHILDHOOD**

- 6.15 The Merseyside Joint Agency Sudden Unexpected Death in Childhood (SUDiC) protocol should be used for the death of any child aged from 0 to 18 years.
- 6.16 In the unfortunate event that an infant, child or young person dies, multi-agency policy must be followed by staff. Statutory guidance in *Working Together to Safeguard Children (2015)* requires all deaths within a LSCB area to be reviewed by the local Child Death Overview Panel.
- 6.17 There are two inter-related processes for reviewing child deaths:
- 6.18 To provide a rapid response by a group of key professionals who come together for the purpose of enquiring into and evaluating each unexpected death of a child.
- 6.19 To facilitate the overview of all child deaths in the LSCB area undertaken by a panel.
- 6.20 The SUDiC protocol enables the rapid response element to be commenced immediately following notification of all unexpected deaths.
- 6.21 This protocol detail exactly what should be done by each individual and will offer guidance and support for practitioners during the initial period following the death. A copy of this protocols is available via the Safeguarding Share Point intranet site.
- 6.22 Health professionals who have been working with the family will be invited to attend a Strategy Meeting convened under these protocols. Occasionally they may also be contacted earlier as part of the strategy discussion to provide information.
- 6.23 Staff will be required to provide a verbal report at the strategy meeting detailing their involvement with the family. It is essential that any member of staff invited to attend a strategy meeting notifies the Safeguarding Children “on call” service immediately with the details. One of the Named Nurse will also attend the Strategy Meeting.
- 6.24 As a health organisation Mersey Care is required to secure all health records when a sudden or unexpected death occurs, this may be an urgent request depending on the nature of the death and any known safeguarding issues. The LSCB in both Liverpool and Sefton have a subgroup which reviews the available information to decide whether the case meets the threshold for a Serious Case Review.
- 6.25 It is essential that you contact the safeguarding children’s team if you are notified of any child deaths on your caseload, irrespective of any known or suspected safeguarding issues.
- 6.26 If there is any current involvement with Children’s Social Care, the social worker must be notified by the child’s health professional as soon as possible after receiving notification.
- 6.27 For the process to follow and Mersey Care responsibilities relating to a death of a child or young person, see appendix E.

6.28 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**

6.29 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.

6.30 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.

6.31 The interests of the child are paramount and initiating child protection procedures is not conditional on obtaining consent.

6.32 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.

6.33 Immediate response to make a child safe from harm may be necessary.

6.34 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.

6.35 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.

6.36 If a child's needs are not being adequately responded to, then a referral to Social Care must be made.

6.37 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.

## **ATTENDANCE AT CHILD PROTECTION CONFERENCE AND USE OF FLAGGING SYSTEM**

- 6.38 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.
- 6.39 For practitioners who maybe inexperienced in managing child protection cases, a discussion with one of the safeguarding children's specialist nurse prior to attending a case conference is essential.
- 6.40 Prior to attendance the caseload holding practitioner will be required to complete a pre-conference health report to support decision making. A copy of this report must be sent to the safeguarding children's team a minimum of 2 working days prior to the conference.
- 6.41 The pre-conference report must be completed using the relevant model of assessment dependent on the Local Authority area. For Liverpool Local Authority, the chosen model is strength based approach, within Sefton Metropolitan Borough Council the model is Signs of Safety. Sefton LSCB have a pre-conference template that staff should access and complete for the Pre-Conference report. Both formats require information relating to:
- What they are worried about? (past harm, future danger, complicating factors)
  - What is working well for the child and their parents/family/carers(existing strengths and existing safety)
  - What needs to happen?
  - NNSC contact Liverpool QAU with regards to pna for Strengths based model?
- 6.42 The content of the report should clearly distinguish between fact and professional opinion, ambiguous language and abbreviations should not be used. The report should include information with regards to the child's health and development, parenting capacity, current and historical significant information.
- 6.43 If support is required whilst developing a pre-conference report the safeguarding children's specialist nurses can provide support, guidance and advice with regards to the preparation of the report.
- 6.44 Both signs of safety and strength based approach templates are available electronically for staff via the intranet on SIRS. This template must be utilised for all multi agency reviews and child protection core groups.
- 6.45 Prior to attendance at the child protection conference, the caseload holding practitioner must liaise with the allocated social worker to identify how many copies of the report will be required. One copy will be maintained by the Independent Reviewing Officer following the meeting. All other copies must be numbered to ensure the practitioner can ensure all copies are returned following the end of the conference.
- 6.46 If the practitioner is unable to attend the child protection conference it is their responsibility in conjunction with their Line Manager (Team Leader) to identify a deputy to attend on their behalf. This could be a colleague who is already attending the meeting. A report will be prepared by the practitioner and shared with their colleague.
- 6.47 If the practitioner is unable to attend the completed report must be forwarded to the social worker / Independent Reviewing Officer two working days prior to the conference date.
- 6.48 Following the initial child protection conference, the practitioner will be required to attend the associated 'core' groups and any subsequent child protection conference meetings. Prior to each conference meeting a new pre-conference report will be required containing relevant information following the process above.



- 6.49 All staff must prioritise attendance when invited to a child protection conference to support the multi-agency process.
- 6.50 The Safeguarding Children's Specialist Nurse is not required to attend Initial Child Protection Case Conferences with practitioner's except under the following circumstances:
- The staff member is newly qualified / inexperienced in Safeguarding matters.
  - The practitioner requests support from the Safeguarding team due to the complexity of the case to be discussed at the Conference. Following a discussion of the case a decision will be made whether a member of the safeguarding team need to attend the conference with the practitioner.
- 6.51 The safeguarding children's specialist nurse is also available to support newly qualified / inexperienced staff at review Case Conferences, or support experienced staff as requested or if the case is identified as being particularly difficult.
- 6.52 If professionals disagree with the multi-agency outcome of the conference, he/she has a responsibility to declare his/her disagreement and reasons in order that it will be recorded appropriately. The professional must then inform the safeguarding children's team of the disagreement with the outcome. This should be recorded within the child / young person's child health record / EMIS.
- 6.53 If the outcome is for the child/young person to be placed on a child protection plan, membership of the on-going core group will be decided at the time of the initial conference.
- 6.54 If more than one service is involved with a family who are subject to child protection plan, it will be the responsibility of the core group member to share appropriate information in a timely manner with other colleagues across the trust.
- 6.55 All staff who attends a child protection case conference must record the following information within the child health record / EMIS:
- Post Conference Report
  - Date, time and venue of the conference
  - A brief summary of the reason the child protection conference was convened
  - The decision of the conference (category of abuse)
  - Content /recommendations of the plan
  - Outcome and action plan
  - Copy to SCSN
- 6.56 The practitioner is to complete and forward the GP notification template to enable sharing of information. The GP surgery will then place a 'flag' on the GP EMIS system.
- 6.57 A copy of the child protection conference minutes are to be filed/scanned into all siblings' records to ensure a full family picture is maintained.
- 6.58 Caseload holding practitioners are required to undertake a review of all children subject to a child protection plan. For Health Visitors, this will consist of a monthly home visit. This is a minimum requirement and any difficulty with meeting this requirement must be reported to the safeguarding children's team and the allocated social worker.
- 6.59 School nurse contact will be determined by the needs of the child or family. School aged children should be reviewed a minimum of once between the initial child protection conference and the review conference/ core group (usually 3 monthly).

- 6.60 If a school aged child has no identified health needs which need to be addressed it is expected that School Nurses will liaise with appropriate school staff on a regular basis to gather information and encourage children to utilise the drop in service available within school. The safeguarding children's specialist nurse will be able to provide advice and support if required.
- 6.61 As a member of a Core Group the Practitioner should attend all future Core Group meetings (this is essential for effective working with the family. In the circumstances that the practitioner is unable to attend, up to date information should be shared with the allocated Social Worker or alternatively a deputy (colleague) may attend the core group with a report on behalf of the professional. The deputy should feedback any relevant information and the outcome of the core group.
- 6.62 The caseload holder must attend all Review child protection conferences (the first review conference should be held 3 months after the initial conference and then 6 monthly thereafter whilst the child's name remains subject to a Child Protection Plan).
- 6.63 In the event that the child/ young person is not made subject to a Child Protection Plan but concerns remain, practitioners should attend subsequent Child in Need or EHAT meetings. The outline of any Child in Need plan should be discussed and agreed by members of the Child in Need meeting.
- 6.64 If the caseload holder believes the Child Protection Plan is not effective or if new information comes to light, they should inform the Social Worker and the safeguarding children's team without delay in order to escalate concerns as appropriate and implement the relevant LSCB escalation policy if required
- 6.65 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.
- 6.66 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.
- 6.67 Practitioners should also be able to identify parents they are working with whose child/children are subject to Child Protection arrangements/ Looked after Child arrangements by using the warning flag within the electronic records system.

**LSCB Link to procedures:**

[http://liverpoolscb.proceduresonline.com/chapters/p\\_ment\\_ill.html](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://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**

- 6.68 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.
- 6.69 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.

- 6.70 Social Care has 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.
- 6.71 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.
- 6.72 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**

- 6.73 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.
- 6.74 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.
- 6.75 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 / CRIMINAL EXPLOITATION**

- 6.76 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.
- 6.77 Children at risk of suffering violence within the community. This may involve both the perpetrators and victims of violent activity.
- 6.78 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
- 6.79 Warning flags on Electronic systems should be used to identify children who are at risk of gun and gang crime and exploitation.

Link to LSCB Procedures:

[http://liverpoolscb.proceduresonline.com/chapters/p\\_gangs.html](http://liverpoolscb.proceduresonline.com/chapters/p_gangs.html)

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

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

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

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

## **FORCED MARRIAGE AND HONOUR BASED VIOLENCE**

- 6.80 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).
- 6.81 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.
- 6.82 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://liverpoolscb.proceduresonline.com/pdfs/force_marriage.pdf)  
<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/>

## **ABUSE LINKED TO SPIRIT POSSESSION**

- 6.83 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).
- 6.84 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**

- 6.85 Children who are /at risk of being sexually abused or sexually exploited should be treated as victims of abuse and their needs require careful assessment.
- 6.86 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.
- 6.87 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.

6.88 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. .

6.89 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:

6.90 Children at risk of exploitation should be clearly identified by using the warning flags within electronic records.

[http://liverpoolscb.proceduresonline.com/chapters/p\\_safeg\\_sex\\_exp.html](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/>

6.91 Further guidance can also be obtained via:

[www.education.gov.uk/publications/eOrderingDownload/00689-2009BKT-EN.pdf](http://www.education.gov.uk/publications/eOrderingDownload/00689-2009BKT-EN.pdf)

[http://liverpoolscb.proceduresonline.com/chapters/p\\_ch\\_abuse\\_net.html](http://liverpoolscb.proceduresonline.com/chapters/p_ch_abuse_net.html)

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

6.92 Guidance for working with sexually active young people under the age of 18 years can be accessed in Appendix 5.

6.93 If a child under 13 years of age discloses they have had any aspect of a sexual relationship or are seeking support from sexual health services this must result in an immediate referral to the relevant Local Authority.

6.94

## **SAFEGUARDING CHILDREN WHO MAY HAVE BEEN TRAFFICKED**

6.95 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.

6.96 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.

6.97 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.

6.98 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:

6.99 “Trafficking of persons” shall mean the recruitment, transportation, transfer, harbouring or receipt of person, by means of the threat of or use of:

- 6.100 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.
- 6.101 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.
- 6.102 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.
- 6.103 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
- 6.104 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.
- 6.105 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.
- 6.106 The Trafficking Toolkit ([www.crimereduction.gov.uk/toolkits/](http://www.crimereduction.gov.uk/toolkits/)) provides useful guidance on dealing with trafficking.
- 6.107 Mersey Care has a responsibility to notify the Government of cases of Modern Slavery through the National Referral Mechanism (NRM) reporting system.
- 6.108 Further information may be obtained via the following websites:
- [http://liverpoolscb.proceduresonline.com/chapters/p\\_ch\\_trafficked.html](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.lancshiresafeguarding.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](http://www.education.gov.uk/publications/eOrderingDownload/DFE-00084-2011.pdf)

## **TRAVELLING FAMILIES**

- 6.109 The Local Authority has a duty to protect the children of travellers who are at risk of significant harm. Staff must refer any concerns about a child from a travelling family to Children's

Services in the same way as every other child. The focus must be on the needs of the child and not on the needs of the parents.

- 6.110 Children in travelling families do not always attend school and may not be known to the School Health Service or to Primary Care. Staff must always make contact with the Specialist Health Visitor for travelling families to make sure that appropriate health checks are made where possible.

### **ASYLUM SEEKING FAMILIES / UNACCOMPANIED ASYLUM SEEKING CHILDREN (UASC)**

- 6.111 The Local Authority has a duty to protect children of refugees, asylum seekers and migrant workers, who are at risk of significant harm.
- 6.112 All staff must refer any concerns about any children of an asylum seeker, refugee or migrant worker to Services in the same way as every other child in Liverpool or Sefton.
- 6.113 It is important to give as much information as possible to assist Children's Services identify the status of the child and family. The focus should be on the needs of the child and not the needs of the parents
- 6.114 These children do not always attend school and may not be known to the School Health Services or to Primary Care Services. Staff must always make contact with the relevant School Nurse Team Leader, if the child is of school age, to ensure that appropriate health checks are made where possible.
- 6.115 Good quality interpreting services are essential when dealing with families whose first language is not English. Mersey Care has provision for approved interpreting services which must always be used.
- 6.116 A UASC is an asylum-seeking child under the age of 18 who is not living with their parent, relative or guardian in the UK. In most cases UASC will be referred to local authorities by the UK Border Agency (UKBA) shortly after they arrive in the United Kingdom.
- 6.117 Local authorities should adopt the same approach to assessing the needs of a UASC as they use to assess other children in need in their area. The child will not have a parent, relative or other suitable adult carer in the United Kingdom, and is likely to have to be accommodated under section 20 of the Children Act.
- 6.118 There are some children and young people whose age may be in dispute and may be undergoing the age assessment process which will determine whether or not they receive support from the Local Authority.
- 6.119 Further advice in relation to refugees and asylum seekers can be sought from the Specialist Health Visitors/Asylum Seekers Refugees and Migrant Workers. For current contact details please contact the safeguarding children's team.

### **UNACCOMPANIED CHILDREN ATTENDING A WALK IN CENTRE /TREATMENT CENTRE**

- 6.120 Unaccompanied children may attend walk in centres for a variety of reasons which may mean that they are particularly vulnerable
- they may not wish to see their own GP
  - they do not wish for their parent / carer to know about their attendance
  - the parent/carer may have been instrumental in the reason for the attendance e.g. an alleged assault or incidence of abuse.
- 6.121 All unaccompanied children / young people should be made aware of the Walk in Centre statement of confidentiality and the limitations to confidentiality.

6.122 Children and young people may disclose information which may be a cause for concern to employees or Independent Contractors such as:

- incidents of abuse
- they are being sexually exploited
- they are involved in criminal activity or a lifestyle which may cause concern

6.123 Employees or Independent Contractors may have to deal with children and young people about whom there are concerns that they may be a victim of sexual exploitation. A child involved in prostitution should always be treated as a victim of abuse.

6.124 Please refer to the Consent to Treatment Policy which gives specific advice for staff on this issue.

### **CHILDREN, YOUNG PERSONS AND THE MENTAL CAPACITY ACT AND DEPRIVATION OF LIBERTY SAFEGUARDS**

6.125 Please refer to MC01 – Over –arching Policy and Procedure of the Mental Capacity Act 2005 for further guidance. This guidance has been updated following court ruling: Birmingham City Council v D (2016) EWCOP 8, (2016) MHLO 5.

### **FEMALE GENITAL MUTILATION (FGM)**

6.126 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.

6.127 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.

6.128 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.

6.129 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**

- 6.130 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).
- 6.131 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 (this is available via staff safeguarding Share Point Intranet Site).
- 6.132 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://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.lancshiresafeguarding.org.uk/>  
<http://www.rochdale.gov.uk/children-and-childcare/Pages/child->

## **E SAFETY**

- 6.133 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.
- 6.134 Link to LSCB procedures:

[http://liverpoolscb.proceduresonline.com/chapters/p\\_ch\\_abuse\\_net.html](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.rochdale.gov.uk/council...social-care/.../safeguarding)

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

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

## **CHILDREN WITH A DISABILITY**

6.135 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.

6.136 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.

6.137 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.rochdale.gov.uk/council...social-care/.../safeguarding)  
<http://www.lancshiresafeguarding.org.uk/>  
<http://knowsleyscb.proceduresonline.com/>  
[http://liverpoolsch.proceduresonline.com/chapters/p\\_ch\\_abuse\\_net.html](http://liverpoolsch.proceduresonline.com/chapters/p_ch_abuse_net.html)

#### **ADULTS WHO POSE A RISK TO CHILDREN (PREVIOUSLY SCHEDULE ONE OFFENDERS)**

6.138 The term 'adults who pose a risk to children' replaces the term schedule 1 offender. This term has commonly been used for anyone convicted of an offence against a child listed in schedule one of the Children and Young Person's Act 1933.

6.139 Children's Services are required to undertake an assessment of risk to any child/children if an "adult who poses a risk to children" is known to be living in a household with children and will usually convene a Child Protection Case Conference.

6.140 Any employee who becomes aware that an adult who poses a risk to a child/young person is:

- Living in a home with children, even on a temporary basis  
**Or**
- Will be visiting a member of the family or any other child on a hospital ward  
**Or**
- Is employed by Mersey Care

They must contact the Named Nurse for Safeguarding Children for immediate advice to discuss the referral into social care. It is essential that the case is not discussed with any other staff or colleagues.

#### **DISCLOSURE OF INFORMATION ABOUT ADULTS WHO POSE A RISK TO CHILDREN**

6.141 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.

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

- 6.143 The Police and Probation Services are required to undertake a risk assessment in these circumstances.
- 6.144 There are local inter-agency risk assessment protocols in place, which should be followed.
- 6.145 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**

- 6.146 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.
- 6.147 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.
- 6.148 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.
- 6.149 The law recognises that disclosure of confidential information may need to occur in the absence of consent.
- 6.150 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.
- 6.151 Record the details of the circumstances in the patient’s records and the rationale for any decisions taken.
- 6.152 Notices or posters about the Trust’s confidentiality statement should be widely displayed in the waiting areas.
- 6.153 Information leaflets should be widely available for parents/carers and competent children and young people detailing the limitations of confidentiality.
- 6.154 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**

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

#### **NON ENGAGEMENT OF FAMILIES**

- 6.156 Families may not engage with health services for a number of reasons and these factors need to be considered in terms of:
- No Access - Child not seen
  - Denied access visit

- Failure to obtain a response when calling to the home
  - Failed appointments
  - Refusal of universal services
  - Child electively home educated
  - Families /children who have, or are believed to have moved out of the UK
- 6.157 If a child/ young person is subject to a child protection plan, looked after children or child in need plan, the plan will normally identify where, when and how often a child should be seen. If a family are thought to have gone missing or cannot be located where they are supposed to be living it is essential that the social worker is informed immediately.
- 6.158 It is also good practice to inform the allocated social worker for any child subject to a child protection plan who has had two consecutive failed home visits, irrespective of the reason given for no access.

## **YOUNG PEOPLE MISSING FROM SERVICE**

- 6.159 There is a procedure in place for when children and young people fail to attend appointments these circumstances which is outlined within the policy SA38 Service Provision to Young People Aged 18 and under. 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>

A child or young person will be considered missing in the following situations:

- There is an unauthorised absence
  - They are missing from home with cause for concern
  - They are missing from 'Care'
  - They are missing from home whilst a 'child in care'
- 6.160 These children and young people will be considered to be 'at risk of significant harm' under the Children Act 1989 and as such Health Professionals have duties and obligations to act.
- 6.161 In such circumstances employees do not need consent to share information with other Agencies/Professionals although consent should always be sought wherever possible.
- 6.162 Further guidance on the response that can be expected by Children's Social Care when children are subject to a child protection plan, can be found in the LSCB Safeguarding Children Inter agency Procedures.
- [http://liverpoolscb.proceduresonline.com/pdfs/stat\\_guide\\_missing.pdf](http://liverpoolscb.proceduresonline.com/pdfs/stat_guide_missing.pdf)
- <http://www.seftonlscb.co.uk/media/9523/Section-8-Missing-Procedure-Final-Sept-15.pdf>
- 6.163 Each child / situation must be assessed on the individual circumstances and vulnerability and you must undertake a preliminary assessment of risk.
- 6.164 This Procedure should be read alongside Statutory guidance on children who run away or go missing from home or care 2014  
<https://www.gov.uk/government/publications/children-whorun-away-or-go-missing-from-home-or-care>
- 6.165 Trust health practitioner's should bear in mind when working with children and families, and where there are outstanding child protection concerns (including where there are concerns about an unborn child who may be at future risk of significant harm), that a series of missed appointments or abortive visits may indicate that the family have suddenly and unexpectedly moved out of the area.

- 6.166 Such cases must be discussed with an Safeguarding Children's Specialists Nurse(SCSN) and consideration given to informing both Children's Social Care and the Police immediately.
- 6.167 When a child subject to a Child Protection Plan/Looked after Children Plan is thought to be missing but still in the area, the health practitioner must take all reasonable attempts to trace the child/family.
- 6.168 Children's Services and the Police may send out a missing alert through their respective systems.
- 6.169 Management of 'Missing'/ Untraceable health records
- 6.170 If a caseload holding professional is aware a child/young person is 'missing' and whereabouts are unknown the Managing Record Standard Operational Procedure (SOP) for untraceable children must be followed.
- 6.171 **TRANSFER OF SAFEGUARDING RELATED RECORDS**
- Internal Transfer**
- 6.172 If a child / young person's health record requires internal transfer within Mersey Care due to a change in GP or School the caseload holder must ensure the clinical record reflects all known concerns prior to transfer. This includes historical concerns if the child/ young person are not currently open to safeguarding procedures. (This will include child protection plan, child in need and looked after children/children in care status).
- 6.173 A written summary of all known safeguarding concerns must be completed by the caseload holding practitioner prior to transfer. If there are current/active concerns a verbal hand over to the receiving practitioner must occur prior to the transfer of the child health record.
- 6.174 The receiving practitioner must notify the safeguarding children's team if they are in receipt of a new child/young person on their caseload who is open to safeguarding procedures. This is to ensure the case receives safeguarding supervision in a timely manner
- 6.175 If there is a delay by the employee to transfer the child health record within the timescales identified within the Trust Records Management Policy, the safeguarding children's team must be contacted to agree a suitable plan of action which must be recorded within the clinical record.
- 6.176 It is anticipated that any delay in transfer will be due to exceptional circumstances and not a matter of routine practice.
- 6.177 The safeguarding service administration team should be advised by employees that records have been internally transferred (CPP/ CIN/ LAC) between practitioners. (A copy of the 'transfer of records' document should be sent to the team.)

**External Transfer**

- 6.178 The transfer process should be initiated as soon as a member of staff becomes aware of a change in GP or school which requires a transfer of records to another health organisation. This must not be delayed whilst awaiting the receiving NHS organisations formal 'request for records'
- 6.179 The health records must be delivered to the safeguarding service administration team within 3 working days of the caseload holding practitioner becoming aware of the changes which necessitate a transfer of health records. This may be following receipt of a request for records from another health organisation or information received from the GP or school indicating that the child has left the Liverpool or Sefton area.

- 6.180 The caseload holding practitioner must inform the safeguarding children specialist nurse of the imminent transfer of records. If there is a Child Protection Case Conference or Looked after Child / Child in Need review scheduled in the new area the timescale for transfer must be more urgent.
- 6.181 The caseload holding professional must summarise their current involvement and any outstanding issues which need to be addressed urgently, and record details of the following in the EMIS Child Health records:
- New address
  - New GP
  - New School
  - Name and contact number for the receiving health professional
  - Name of the health organisation in which the new health professional works
  - Destination of where records are being transferred to.
- 6.182 Prior to transfer of records the caseload holding professional must contact the receiving health professional by telephone and provide a verbal handover of the issues in the case, historical, present information and health concerns which may require referral in the new area. This conversation must be recorded in the Child Health Record/EMIS prior to being printed.
- 6.183 The name, telephone number and address of the receiving Named Nurse in the new organisation must be obtained during the telephone call to the receiving health professional. This is required by the Safeguarding Children Service to enable the transfer of the records direct to the receiving organisations safeguarding children's service.
- 6.184 A "Transfer of records" form must be completed by the caseload holding professional and secured to the child health record. All available information should be recorded on this form. Prior to transfer it is the responsibility of the clerical staff within the locality/service to check the new patient address via the National Summary Care Record.
- 6.185 The caseload holding professional must notify the Child Health Information Service of the transfer to enable the child health system to be updated. A copy of the "Transfer of records" form can be used for this purpose.
- 6.186 The caseload holding professional must also inform the clerical staff who provides support to their clinic, to enable transfer details from the caseload to be recorded and an audit trail to be maintained. The details must include the date the records were placed in the internal post collection to the safeguarding service or the name of the person who delivered them by hand directly to the safeguarding children office. It is not sufficient to record "transferred via safeguarding".
- 6.187 The Safeguarding Service will review all records prior to transfer out of Mersey Care to quality assure the transfer process. Any records which have not met the required standards will be returned to the caseload holding professional to complete. The Safeguarding Service will make direct contact via email indicating which aspect of the process is incomplete, giving a timescale for return to the Safeguarding Service to prevent any further delay.
- 6.188 All health records which require external transfer via the safeguarding service will be sent to the new health organisation by recorded delivery within 3 working days of receipt into the safeguarding children office.
- 6.189 Transfer of all other records must be undertaken via the Child Health Information Service.

### **Green Bag Transfer**

- 6.190 When caseload holding practitioners are required to send records into the safeguarding service either for external transfer or audit purposes the green bag system is to be utilised. Using the green bag system immediately identifies that the records contained within the green pouch contain a safeguarding element.
- 6.191 When placing records within the green bag, normal Mersey Care transfer or records policy must be followed. Individual records are to be placed within an envelope and sealed. The name of the receiving practitioner / service is to be clearly recorded on the front of the envelope, with the sealed envelope then to be placed within the green bag.
- 6.192 The green bag will then be transferred via the Mersey Care internal post delivery system direct to the safeguarding children's team and the green bag is able to accommodate a number of sets of records.
- 6.193 The destination address must be accessible through the clear window of the green bag, and the bag left in the agreed location for the collection of the internal mail. (It is essential that this location is secure and not accessible by the general public). Green bags must not be addressed to an external organisation.

### **Transfer of Safeguarding records into Mersey Care**

- 6.194 If a caseload holding practitioner receives notification from an external organisation that a child/young person with an active safeguarding concern is transferring into Mersey care, the caseload holder is to direct the external organisation to transfer the records direct to the safeguarding service.
- 6.195 If records are received via any other route e.g. the Child Health Information Service or directly to the child health service, the Safeguarding Service must be notified immediately.
- 6.196 On receipt of the case record, the safeguarding service will process the record to confirm the home address, GP and/or school is within the catchment area of Mersey Care. The record will then be date stamped to indicate receipt into the organisation.
- 6.197 If there is insufficient information to determine who the new caseload holder will be (e.g. no address, GP or school) the Named Nurse Safeguarding Children will liaise with the external organisation for additional information.
- 6.198 The safeguarding service administration team will complete Section 1 of the revised Child Health Notification System form and attach it to the health records for each child/young person. The caseload holding professional will be responsible for completing Section 2 and returning the information to the Child Health Information Service
- 6.199 If the child/family have not yet registered with a local GP the case may need to be allocated for a home visit by a practitioner in the clinic base closest to the family home.
- 6.200 All relevant details will be recorded on the electronic 'transfer in' log to include current and historical information. The records will then be placed in a green bag for transfer to the relevant practitioner.
- 6.201 On receipt of the record, the caseload holding professional is to complete the child health notification system form and inform the child information service to enable the IT system to be updated. The form is to be returned within 3 working days.
- 6.202 The receiving caseload holder is to inform the safeguarding children's specialist nurse of the receipt of a new case to ensure inclusion in the supervision process.
- 6.203 If the transfer involves a child subject to a child protection plan there may be a slight delay in arranging a transfer case conference in the new area and in such circumstances the caseload

holder may wish to discuss the case, either in person or by phone, with the safeguarding children's specialist nurse to ensure that an appropriate plan of care is in place.

## **ESCALATION PROCEDURE (SEE APPENDIX C)**

- 6.204 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.
- 6.205 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.

### **Allegations of abuse against children by Mersey Care NHS Foundation Trust professionals (or paid care givers)**

- 6.206 The Safeguarding Children Lead and/ Human Resources Department must be informed.
- 6.207 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 Designated Officer for the Local Authority (previously known as (LADO) who 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.
- 6.208 This abuse may involve:
- A patient of client;
  - A child in the professional's family;
  - Any domestic abuse in a Health Professionals household where there are children.
- 6.209 The Named Nurse for Safeguarding Children should be informed in such circumstances when the allegation concerns abuse of a child.
- 6.210 The Named Nurse and/or Doctor/Nominated Officer for Safeguarding Children (HSS) Social Services and are invited to attend strategy/network meetings as appropriate.
- 6.211 There will be four possible strands to dealing with an allegation against Health Professionals:
- Safeguarding children enquiries;
  - Designated Officer for the Local Authority investigation;
  - Police investigation into a possible offence;
  - Disciplinary to misconduct or gross professional misconduct on the part of staff.

## **SPECIFIC REQUESTS FOR INFORMATION**

### **Police**

- 6.212 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.

- 6.213 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.
- 6.214 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 or statements of evidence for court**

- 6.215 A request should be received in writing from the relevant legal department of the Local Authority.
- 6.216 Discuss the request with line manager /Named Nurse for Safeguarding Children.
- 6.217 Always have the statement checked by a Safeguarding Ambassador, Line Manager or Named Nurse for Safeguarding Children before sending the report.
- 6.218 Mersey Care NHS Foundation Trust Professionals should be able to recognise when information given by a Child suggests that either s/he is a “child in need” or is likely to suffer significant harm.
- 6.219 In relation to significant harm this can encompass a situation where a child is out of parental/carer control.
- 6.220 Under the Children Act 1989, Health Professionals have a duty to safeguard and promote the welfare of the child.
- 6.221 The legal duty of confidentiality and consent is the same for children and young people as adults. The concept of ‘Gillick Competence’ is specifically relevant to this group.
- 6.222 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.
- 6.223 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.
- 6.224 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.

- 6.225 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.
- 6.226 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.
- 6.227 Always seek expert advice (if necessary) if possible before making a decision.
- 6.228 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.
- 6.229 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.
- 6.230 Seek advice if there is a disagreement between a competent young person and their parent

### **COURT PROCEEDINGS**

- 6.231 If a request is received for a court report or a redaction of patient records for court proceeding, this request must follow organisational process for providing this information.
- 6.232 A formal request should always be received from the Local Authority legal department, usually via the secure NHS. Net email account for the Named Nurses. A copy of the Court Order must also be obtained to satisfy Mersey Care Information Governance requirements.
- 6.233 Occasionally it may be received directly by the health professional and in such circumstances the health professional must contact the safeguarding children's team immediately to inform them of the receipt. No action must be taken by any professional until the Safeguarding Service is aware of the request and have verified its authenticity.
- 6.234 The procedure followed by the safeguarding children's team on receipt of a formal request can be seen in appendix 8.

### **PRIVATE PROCEEDINGS**

- 6.235 Information is not normally provided for private law proceedings, unless it is deemed to be in the best interest of the child. If a decision is made to share information it must only be shared with the express written consent of the parent/carer with parental responsibility with an accompanying Court Order.
- 6.236 If employees receive a request either verbally or in writing for information they must discuss this request with the Safeguarding Children Service before giving any information.
- 6.237 It is sometimes the case that a court order has been made without appropriate authority i.e. where someone who is not party to the case has been ordered to produce a report. In addition, some letters which are accompanied by a court order incorrectly interpret the court order and therefore request reports from named individuals or by certain dates which the court itself has not specified.

- 6.238 If a court order is received which directs that reports are prepared or information is disclosed, the court order should be given to the Information Governance Manager for immediate consideration.

### **CAFCASS / COURT APPOINTED OFFICERS**

- 6.239 There is a specific form, provided by CAFCASS, which may be used to provide relevant information to CAFCASS /Court Appointed Officers only when written consent is received from the parent/carer with parental responsibility. In these circumstances information may be shared in the best interests of the child following consultation with the Named Nurse if required.
- 6.240 Information must only be shared about the child in question and not extended family members or siblings.

### **PRESS / MEDIA INTEREST**

- 6.241 If a member of staff believes that any event will potentially attract media interest relating to a safeguarding children's incident they must inform the Named Nurse immediately. The Named Nurse will liaise with the relevant Local Authority to ensure accuracy of the information and then notify the Communication Department and if appropriate the Director of Nursing.

### **GILLICK COMPETENCE**

- 6.242 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.
- 6.243 It is used to decide whether or not a child is competent to give consent to treatment. As part of Lord Fraser's judgment 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.

### **EARLY HELP ASSESSMENT FRAMEWORK AND PRE EARLY HELP ASSESSMENT TOOL (PRE- EHAT)**

- 6.244 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.
- 6.245 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.
- 6.246 As an adult facing service, Mersey Care NHS Foundation Trust staffs are required to work within the Early Help framework by making appropriate referrals to the Early Help Teams from each Local Authority.

## **PREVENT**

6.247 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.

6.248 Link to Trust Prevent implementation policy SD43

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

## **7. CONSULTATION**

7.1 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.

## **8. TRAINING AND SUPPORT**

8.1 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 and refreshed 3 yearly. This is for all Trust staff who work directly with service users and their families.

## **9. MONITORING**

9.1 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 and Safeguarding Children Specialists Nurse.

9.2 The Safeguarding Policy will be a standing agenda item at Safeguarding Strategy meetings

## 10 Equality and Human Rights Analysis

<b>Title: SD13 Safeguarding and Protection of Children and Young People</b>
<b>Area covered: Trust Wide (apart from Ashworth which has its own Policy)</b>

<p><b>What are the intended outcomes of this work?</b>  This is a review the policy has already been subject to an equality and human rights assessment. No new equality issues have been identified.  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).</p>
<p><b>Who will be affected?</b> <i>e.g. staff, patients, service users etc</i></p>

<b>Evidence</b>
<p><b>What evidence have you considered?</b>  <b>Procedures</b> The following documents were used in the formation of the policy :</p> <ul style="list-style-type: none"> <li>• Children Act 1989, Children Act 2004</li> <li>• Working Together to Safeguard Children (DoH 2015)</li> <li>• UN Convention on the Rights of the Child</li> <li>• Human Rights Act 1998</li> <li>• The Framework for the Assessment of Children in Need and their Families (DH 2000)</li> <li>• Mental Health and Social Exclusion Report 2004 - Action 16 ‘Improving opportunities and outcomes for parents with mental health needs’ and their children</li> <li>• Care Programme Approach (CPA) Briefing: Parents with mental health problems and their children April 2008 CPA Briefing.</li> <li>• Social Care Institute for Excellence (SCIE) Think child, think parent, think family guide and national evaluation 2012  <a href="http://www.scie.org.uk/children/parentalmentalhealthandchildwelfare/">http://www.scie.org.uk/children/parentalmentalhealthandchildwelfare/</a> Here.</li> </ul>
<b>Race</b> No Issues identified
<b>Age</b> 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.
<b>Gender reassignment (including transgender)</b> No issues identified
<b>Sexual orientation</b>

<b>No issues identified</b>
<b>Religion or belief</b> <b>No issues identified</b>
<b>Pregnancy and maternity</b> <b>No issues identified</b>
<b>Carers</b> <b>No issues identified</b>
<b>Other identified groups</b> <b>No issues identified</b>
<b>Cross Cutting</b> <i>implications to more than 1 protected characteristic</i>

<b>Human Rights</b>	<b>Is there an impact?</b> <b>No issues identified.</b> <b>How this right could be protected?</b>
<b>Right to life (Article 2)</b>	<b>Human Rights based approach supported.</b> <b>This policy ensures that children are protected at all times</b>
<b>Right of freedom from inhuman and degrading treatment (Article 3)</b>	<b>Human Rights based approach supported. It ensures that children are the priority and respects their rights to dignity and respect.</b>
<b>Right to liberty (Article 5)</b>	<b>No issues identified</b>
<b>Right to a fair trial (Article 6)</b>	<b>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.</b>
<b>Right to private and family life (Article 8)</b>	<b>Human Rights Based Approach Supported.</b> <b>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).</b>
<b>Right of freedom of religion or belief (Article 9)</b>	<b>No issues identified</b>
<b>Right to freedom of expression</b> <b>Note: this does not include insulting language such as racism (Article 10)</b>	<b>No issues identified</b>
<b>Right freedom from discrimination (Article 14)</b>	<b>No issues identified</b>

Engagement and Involvement
<b>The following staff/groups were consulted with in the delivery of this policy document</b>
<b>The Trust Named Doctor for Safeguarding Children</b>
<b>The Safeguarding Strategy Group</b>
<b>Trust wide Women and Think Family Group</b>

<b>Summary of Analysis</b>
<b>Eliminate discrimination, harassment and victimisation</b> 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).
<b>Advance equality of opportunity</b> N/A
<b>Promote good relations between groups</b> N/A

<b>What is the overall impact?</b> Supports the human rights of children and supports the right to family life
---

<b>Addressing the impact on equalities</b> No negative impact identified.
--

<b>Action planning for improvement</b> <b>See below action plan</b>
Detail in the action plan below the challenges and opportunities you have identified. <i>Include here any or all of the following, based on your assessment</i> <ul style="list-style-type: none"> <li>• <i>Plans already under way or in development to address the <b>challenges and priorities</b> identified.</i></li> <li>• <i>Arrangements for continued engagement of stakeholders.</i></li> <li>• <i>Arrangements for continued monitoring and evaluating the policy for its impact on different groups as the policy is implemented (or pilot activity progresses)</i></li> <li>• <i>Arrangements for embedding findings of the assessment within the wider system, OGDs, other agencies, local service providers and regulatory bodies</i></li> <li>• <i>Arrangements for publishing the assessment and ensuring relevant colleagues are informed of the results</i></li> <li>• <i>Arrangements for making information accessible to staff, patients, service users and the public</i></li> <li>• <i>Arrangements to make sure the assessment contributes to reviews of DH strategic equality objectives.</i></li> </ul>

**Name of persons who carried out this assessment:**  
**George Sullivan (Equality and Human Rights Advisor Secure Division)**  
**Chantelle Carey Named Nurse Safeguarding Children**

**Date assessment completed:**  
**May 2018**

**Name of responsible Director/Lead Trust Officer**  
**Executive Director of Nursing and Operations**

**Date assessment was signed: May 2018**



11.

## Action plan template

This part of the template is to help you develop your action plan. You might want to change the categories in the first column to reflect the actions needed for your policy.

Category	Actions	Target date	Person responsible and their area of responsibility
<b>Monitoring, evaluating and reviewing</b>	<b>This impact assessment will be subject to a review should the policy change or be updated.</b>		
<b>Transparency (including publication)</b>	<b>The policy should be placed on the Trust website. The policy shall not be placed on the website without the equality and human rights analysis.</b>	<b>May 2018</b>	<b>Policy Group</b>
<b>Increasing accessibility</b>	<b>Policy to be placed on Trust website once reviewed and ratified.</b>	<b>May 2018</b>	<b>Policy Group</b>

12.

## **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 care notes.

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 care notes and a referral sent to the social work team via care notes. 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 care notes (Appendix 1). This will be undertaken by liaising with the patient's ward team and by gathering information from care notes. 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 care notes (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 care notes (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 care notes 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 care notes 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 Care notes.

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](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](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

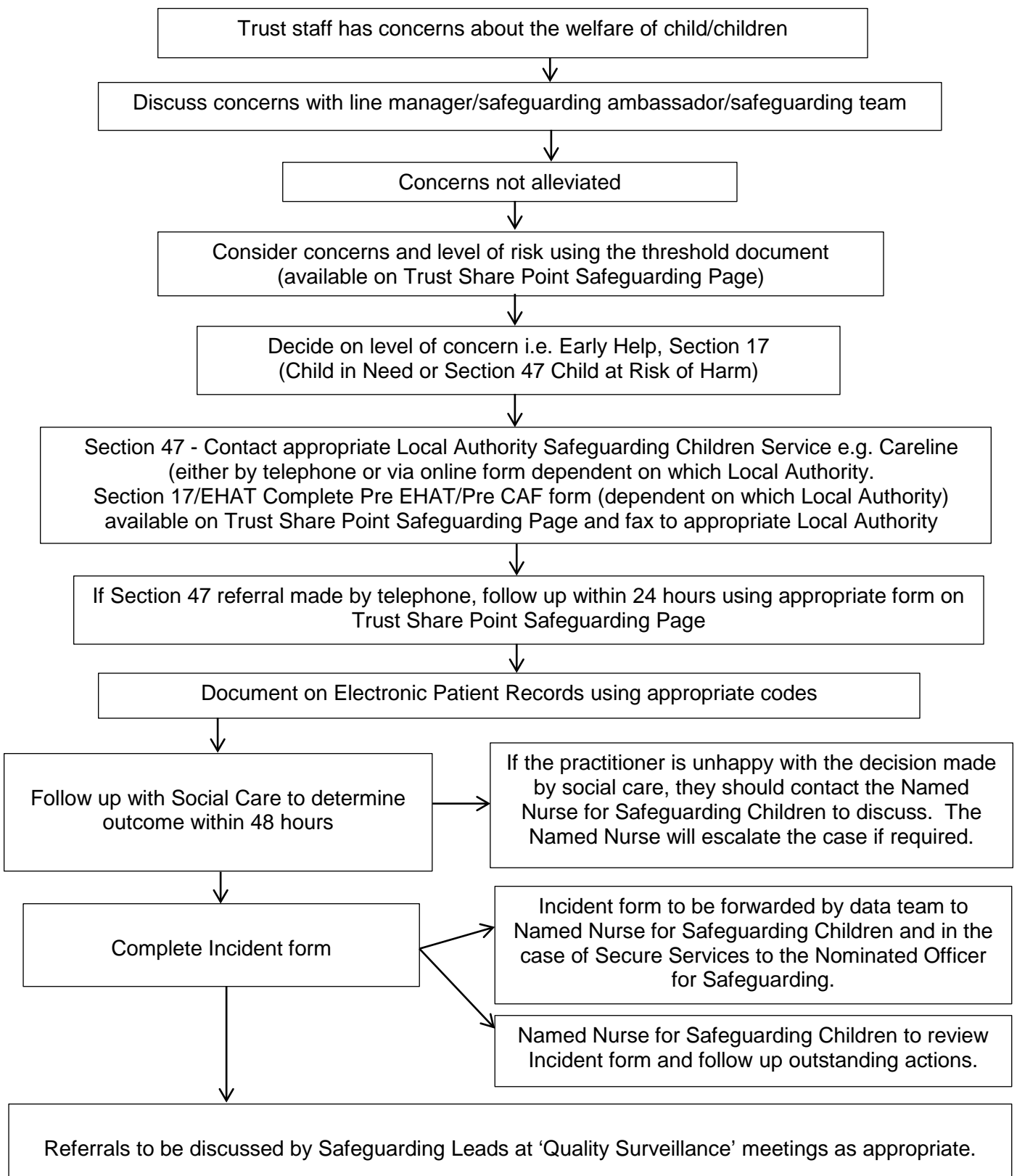
**SA 38** - Service Provision to Young People Aged Under 18

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

Working Together to Safeguard Children 2015

Trust Safeguarding Children and Adults Training Strategy 2015/2016

## APPENDIX B: SAFEGUARDING CHILDREN REFERRAL AND ESCALATION PROCESS







## **APPENDIX D: FABRICATED or INDUCED ILLNESS (FII)**

Concerns may be raised by staff, who may suspect that the health or development of a child has been, or is likely to be significantly affected, by a parent or carer who may have fabricated or induced illness in their child in order to gain attention.

These concerns may arise when:

- Signs and symptoms reported may not be adequately explained by any medical condition from which the child is thought to be suffering.
- Physical examination and medical results do not explain reports signs and symptoms.
- There is a poor response to prescribed medication or treatment, new symptoms are reported on resolution of previous symptoms, or the reported symptoms are not seen to occur in the absence of the parent or carer e.g. a child who is reported to have “fits” which are not observed by anybody other than the parent/carer.
- There are a significant number of presentations to health professionals with a range of symptoms over a period of time, which is felt to be excessive.
- The child’s normal activities are being curtailed beyond what is reasonable to expect from any reported medical condition which the child is thought to suffer.

There are three main ways of fabricating or inducing illness in a child:

- Fabrication of signs and symptoms or past medical history
- Falsification of hospital charts and records, letters and documents
- Induction of illness by a variety of different means

A meeting will be arranged to coordinate all of the available health information in respect of the child, this will usually be arranged by the Designated Doctor /Consultant Community Paediatrician who will be responsible for liaising with the Named Doctor for Mersey Care and family GP. A detailed chronology should be developed which incorporates the relevant information from the health records, GP and any hospital attendances.

Records for any other siblings should also be assessed, including deceased siblings if the records can be obtained, to establish whether there is also a possibility of FII in respect of those children.

It will be the decision of this “health” meeting whether the concerns support the possibility of fabricated or induced illness, and if so, a referral will be made to Children’s Services. If there is a difference of professional opinion by any member of the “health” meeting about whether the concerns support the possibility of fabricated or induced illness which would result in a referral not being made this must be discussed with the Designated Professionals without delay.

The referral will be made following a discussion with the Safeguarding Children Unit who will arrange a strategy meeting with the relevant professionals including Children’s Services, Police, Health and Education if the child is attending school.

Staff must attend the strategy meeting if invited and must always be accompanied by an Named Nurse/SCSN. The Designated professionals should always be informed in these circumstances.

There are a number of possible outcomes to the strategy meeting:

- A child protection investigation under s47 of the Children Act 1989
- Police investigation into possible offences
- Disciplinary procedures against a member of staff who is responsible for the fabrication or induction of illness where allegations amount to misconduct or gross professional misconduct.

Record Keeping issues for staff in suspected cases of FII:

If a request is received for access to a child/young person's records that contain information relating to FII, this information must be fully redacted prior to release. For further information and support with this please contact the Named Nurse for Safeguarding Children.

## **APPENDIX E: PROCESS TO BE FOLLOWED BY ALL STAFF FOLLOWING THE DEATH OF A BABY OR CHILD:**

The identification of a child death may come to the attention of the Safeguarding Children Service from a number of sources which could include an A&E department, midwifery unit, Paediatric Liaison Service, Designated/Named Nurse/Doctor, Police, Children's Services, Health Visitor, School Nurse, or via the Risk Manager /Senior Manager on call.

On receipt of information relating to a child death by any member of the Safeguarding Children Service, the information must be shared with the Named Nurse on duty who is responsible for escalation to the relevant professionals as per the agreed flowchart for child deaths which is at the end of this Chapter.

All child deaths are notified to the Safeguarding Children service for the CCG's via the Designated Nurses as per the Key Performance Indicators (2013/14)

### **Responsibilities of Health Visitor/School Nurse teams**

The death of a child in any circumstances is devastating for the family and staff have an important role to play in liaising with relevant professionals to minimise the trauma of receiving health appointment for the deceased child.

Unless the HV/SN has already been informed via Children's Liaison that specific services such as GP and acute trust appointment services have already been informed they should include them as it is better to inform somebody twice than risk the parent/carer being sent an appointment for their deceased child.

The HV/SN should review the health records to identify any other services involved with the child / family and ensure that they are notified of the death. Examples of services which may need to be informed by the HV / SN are: Child Health Department; General Practitioner; School; therapy services; Midwifery; community dental services; acute trusts e.g. Alder Hey and Ormskirk DGH for out-patient appointments.

The HV/SN should ensure that the HV/SN for any siblings is also notified of the death so that appropriate support can be offered to the parent/carer and any surviving siblings as required.

The HV/SN will ensure appropriate bereavement support and follow up to the family is offered and record all contacts, discussions and visits within the copy of the child's health records.

As part of the Merseyside Child Death Overview Panel (CDOP) process staff will be required to complete the child death "B form" which is submitted to the CDOP coordinator via Sentinel, an online database used for all child deaths.

The Team Leaders within Children's services have been trained and have a username and password to access the system. It is the responsibility of the Team Leader to support the HV/SN in completing the Sentinel request within 15 working days of notification from the Named Nurse.

Once the Sentinel form has been completed the health record for the deceased child should be sent into the safeguarding children's team marked for the attention of the Named Nurses via the internal post system. If the records have already been secured following the death,

arrangements can be made to access Sentinel and this will be facilitated by the Named Nurses.

Mersey Care provides a Care of the Next Infant (CONI) scheme for parents who have lost a child previously and there are several specially trained Health Visitors who act as CONI coordinators for the organisation. A referral should be made for any woman who becomes pregnant again after the death of a baby to offer support in subsequent pregnancies.

## **APPENDIX F: COURT REPORTS / REDACTION OF RECORDS**

### **1. Process for Safeguarding Children Service**

1.1 Named Nurse (on duty) will access NHS.net account and save the cover letter with the Court Order (Public Law Proceedings) and the relevant Safeguarding Children Specialist Nurse, Caseload holder and Team Leader will be emailed to advise that a request has been received from Court (in relation to a specific child/ren subject of the Court Order. Court Order may stipulate that a Court Report or Records (redacted) or both are required for court by a specific submission date.

1.2 In the event that the relevant Safeguarding Children Specialist Nurse (SCSN) is unable to deal with the request due to annual leave, sick leave and so forth it will be allocated to another SCSN.

1.3 If the timescale for completion is not achievable due to the lateness of the request being received via NHS.net account Named Nurse will liaise with the solicitor directly and negotiate an extension for the request.

1.4 NNSC will email practitioner, Team Leader and relevant SCSN to inform them that there has been a request from Court for Court Report/ Records or both. The record will be requested to be forwarded to Safeguarding Service as soon as possible via the Green Bag.

1.5 All requests for information by Court Order will be inputted into the Sefton or Liverpool Court Report and Redaction of Records spreadsheet on the L Drive by the NNSC.

1.6 In the event that the Child Health Records contain information from other areas, the Named Nurse will make contact with the relevant organisation indicating that a Court Order has been received and agree the next steps. The other organisation may wish to prepare their own report or redact their own records and if so they should be returned by recorded delivery to facilitate this. Named Nurse must liaise with the solicitor to inform them of these circumstances. A formal request can be made to the other organisation by the Solicitor

1.7 If the health professional who holds caseload responsibility has had limited personal contact with the family due to a recent change in GP or school then an agreement must be made as to which professional is most appropriate to provide a report.

1.8 If the previous professional is still employed by Mersey Care they should provide the report themselves. If this is not the case then the current caseload holder should write the report and indicate that it has been written from a review of the health records. This role maybe fulfilled by the Safeguarding Children Specialist Nurse and/or Practitioner.

### **2. If a copy of health records is requested**

2.1 Upon receipt of the records the SCSN will ensure that a photocopy of the complete record is made by the Safeguarding Administration team to enable redaction of all third party information which is not pertinent to the case. All EMIS records should be printed in the entirety. This is required to comply with Mersey Care information governance requirements.

2.2 It is the responsibility of the SCSN to provide the redacted version along with the original file to another SCSN/ NNSC for a 2nd check allowing sufficient time for this to be completed and records released to Court on behalf of Mersey Care.

2.3 The SCSN must complete the appropriate information governance documentation indicating what type of information has been redacted and the reason why. The Child Health

Records are released by the Safeguarding Service and the SCSN will forward the documentation to the Information Governance Department to be retained on file.

2.4 In the rare occurrence that the Court Order specifically dictates a “un redacted version” guidance must be sought from the Named Nurse if any of the information is highly sensitive and a discussion will be held with the Information Governance Manager to agree next steps.

### **3. If a Court Report is requested**

3.1 NNSC will email the practitioner, Team Leader and SCSN to inform them that a Court Order has been received for a child/ren and the records are required by the Safeguarding Service, SCSN will assist all professionals in the preparation of a report or prepare the Court Report themselves.

3.2 Once the SCSN has completed an initial draft Court Report; a 2nd SCSN/NNSC will proof read the Court Report and make amendments if required. Advice may be sought from the Named Nurse if required. The report must always be checked by the Safeguarding Children Specialist Nurse who will submit it to the Local Authority Legal Department on behalf of Mersey Care. A good report will help to keep staff out of court.

3.3 Compilation of Court Reports for court must be within the timescale set down by the Court to avoid un-necessary delay which may disadvantage the child in question.

3.4 Staff must prioritise this aspect of their work and seek support from the relevant SCSN and Line Manager as appropriate.

### **4. If Court attendance is requested**

4.1 Once a request has been received from the Local Authority Solicitor, the SCSN will contact the HV/SN to ascertain their availability for court on the specified dates. The SCSN will notify the Named Nurse and relevant Service Manager that staff may be required to attend court.

4.2 The SCSN will contact the relevant Legal Department to agree a date for HV/SN to attend court. It is wise to avoid the first date scheduled for the hearing as witnesses are often not called due to administrative and procedural issues which may need to be addressed by the Court.

4.3 The SCSN must accompany the HV/SN to court to offer support and guidance as staff often find this experience very stressful. If necessary they should arrange a briefing with the HV/SN prior to court to familiarise them with court procedure and agree a meeting place and time. This will provide an opportunity to go through the report and ensure that the HV/SN is familiar with the content as it may have been some time since the report was submitted.

4.4 In criminal cases or those which attract media attention staff may need to be directed to the Witness Service to offer additional support. Staff will only have access to their police statement/ Court Report once in attendance for Court. SCSN will support the practitioner throughout the Court process

4.5 Following the court attendance staff should be given the opportunity to de- brief with the SCSN and if necessary can be directed to the staff counselling service.

## **APPENDIX G: SPECIFIC GUIDANCE FOR WORKING WITH SEXUALLY ACTIVE YOUNG PEOPLE UNDER THE AGE OF 18 YEARS**

### **1.1 If a client discloses information that gives you cause for concern, consider:**

- whether the young person is a Child in Need or a child at risk of significant harm
- The responsibilities and duties of employees under the Children Act 1989 & 2004.

### **1.2 Discuss with the client (child/young person):**

- The limitations of confidentiality and the possible need to share information with colleagues or partner agencies in some circumstances.
- Why you have concerns for his/her welfare or the welfare of others.
- Establish a reliable way of contacting the client to be able to follow up any concerns.
- Inform them if a decision has been made to disclose information
- Seek views, wishes and feeling of the child/young person

### **1.3 Discuss any concerns with the 'On call' Safeguarding Children Specialist Nurse (SCSN) on 0151 285 4660 before any further action is taken. This is especially important if the young person is under 16 years and essential if the young person is under 13 years.**

What actions you take will depend on a clinical assessment of the situation which could be broadly classified using the following indicators:

- Past abuse/event
- Current abuse/events
- At risk of immediate significant harm
- Abuse or danger to others in the community
- Perpetrator of abuse to others
- Risk of Child Sexual Exploitation

### **1.4 If a decision were made to refer on to other Agencies i.e. (MASH), Rainbow Suite, or the Police, this would normally be completed with the advice, support and guidance of the relevant on-call SCSN**

If a referral is made out of hours; the SCSN must be informed the next working day, the printed referral is scanned and attached to the EMIS Child Health Records. This will be accessed by the SCSN and any further advice will be provided. The referral will be datixed by the Practitioner.

If a referral is made without a prior telephone consultation with a SCSN due to the urgency of the situation. (The same process will be completed as in the above bullet point)

### **2.1 Children under 13 years old accessing sexual health services:**

- Any disclosure of a child under the age of 13 relating to any form of sexual contact needs to be immediately reported to children's social care and the police. This is statutory rape and needs to be investigated fully by statutory agencies.

### **3.1 13-18 year old children / young people:**



- In cases where the health professional has cause for concern they must always seek advice from the Safeguarding Service before taking any action. This is particularly important where the health professional has concerns about the young person's competence.
- Health Professionals must be able to recognise when information given by a young person even a 16-18 year old, suggests that either s/he is a "child in need" or a child at risk of significant harm.
- The employee must be aware that sharing of information following a disclosure of abuse may result in reluctance on behalf of a young person to seek further advice in the future.
- There may be circumstances when an employee is asked to keep certain information confidential i.e. a young person engaging in prostitution or risk taking behavior.
- It is important to be honest with the young people from the beginning to ensure that they are aware that some information cannot be kept confidential if it places themselves, or another, at risk of significant harm.
- In some circumstances the young person may give a false name or address in an attempt to avoid future contact. This is particularly likely if the young person suspects that information may be shared against their wishes.
- If in doubt about whether to share information without the consent of the young person, seek advice and support from the on-call SCSN before making a decision.
- employees must keep detailed records which must include all discussions about the following issues:
  - seeking consent
  - confidentiality
  - discussions about parental involvement
  - What may need to be disclosed and what is to remain confidential.
- There may be actual or potential conflict between the views and interests of the young person and their parent/carer. Employees must always seek advice from the Safeguarding Service if there is difference of opinion between a competent young person and their parent/carer.

### 3. **Gillick Competence**

3.1 This term has been used since the House of Lord's ruling in the case of Victoria Gillick v West Norfolk and Wansbeck Health Authority and the Department of Health and Social Security in 1985.

3.2 A child under 16 years old is Gillick competent if they are able to make an informed decision. Please refer to Consent to Treatment policy for further information.

### 4. **Fraser Guidelines**

A young person is competent to consent to contraceptive advice or treatment if:

- The young person can understand the advice, is capable of retaining the information, using it to make an informed decision and can understand the consequences of not following the advice given.
- The Health professional cannot persuade the young person to inform his or her parents or allow the Health professional to inform the parents that s/he is seeking contraceptive advice
- The young person is very likely to begin or continue having intercourse with or without contraceptive treatment
- Unless he or she receives contraceptive advice or treatment, the young person's physical or mental health or both are likely to suffer
- The young person's best interests require the Health professional to give contraceptive advice, treatment or both without parental consent.