SAFEGUARDING CHILDREN PROCEDURE

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<tr>
<th>Guideline Reference: 1701</th>
<th>Version: 1.2</th>
<th>Status: Adopted</th>
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<tr>
<td>Type: Clinical Procedure</td>
<td>Guideline applies to (Staff Group): All West Suffolk Hospital Employed SCH staff</td>
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As part of transition to the new service contract this Suffolk Community Healthcare (Serco) procedural document has been adopted by West Suffolk NHS Foundation Trust with the following amendments:

- Pg.4 removal of the statement of overarching principles
- Pg.4 1.1 SCH replaced by West Suffolk Hospital and SCH staff prefixed by West Suffolk Hospital employed
- Pg.4 1.3 and throughout the document ‘safeguarding Named Nurse prefixed with SCH Consortia
- Pg.4 1.4 for West Suffolk Hospital employed SCH staff added following SCH Safeguarding Children Policy
- Pg. 8 4.5 or West Suffolk Hospital added following SCH
- Pg. 9 8.4 Record Keeping Policy specified for West Suffolk Hospital employed SCH staff
- Pg. 10 9.4 SCH policy changed to West Suffolk Hospital policy for SCH staff
- Pg.11 9.6 Access to Health and Social Care Records Policy specified for SCH staff employed by West Suffolk Hospital
- Pg. 11 10.2 for West Suffolk Hospital employed SCH staff added following policies and procedures
- Pg. 11 10.3 and inform West Suffolk Hospital added in reference to reporting allegation of abuse
- Pg. 14 15.1 Leadership Team emended to Executive Team
- Pg.13 15.2 Director of Nursing title and accountability amended to correspond to WSH structure.
- Pg.13 15.4 Director of Nursing title amended to correspond to WSH structure
- Pg. 15 16.5 SCH policy amended to specify for West Suffolk Hospital employed SCH staff
- Pg. 16 20 Heading relating to SCH policies amended to specify for West Suffolk Hospital employed SCH staff
- Version amended to reflect the minor changes 1.2

Where the procedural documents refer to Suffolk Community Healthcare (SCH) this is referring to those staff employed by West Suffolk NHS Foundation Trust as part of the Suffolk Community Healthcare Consortium, with West Suffolk NHS Trust and Norfolk Community Health and Care Trust.

Following a settling in period, a programme of review for all SCH procedural documents aligned with West Suffolk NHS Foundation Trust will be reviewed in consultation with subject matter experts and Suffolk Community Healthcare staff.

Date Adopted: 30 September 2015
Review Date: No later than 31 March 2016
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<tr>
<td><strong>Policy Reference:</strong> SCH Serco CP9b</td>
</tr>
<tr>
<td><strong>Type:</strong> Clinical Procedure to be read in conjunction with Safeguarding Children Policy</td>
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<tr>
<td><strong>Policy/ procedure applies to (staff groups):</strong> All staff within SCH Serco</td>
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<tr>
<td><strong>Policy/ procedure Compliance:</strong> This procedure and the accompanying policy must be complied with fully at all times by the appropriate staff. Where it is found that this policy cannot be complied with fully, this must be notified immediately to the owner through the waiver process</td>
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<tr>
<td><strong>Policy owner:</strong> Director of Nursing Therapies and Governance</td>
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<td><strong>Other contact:</strong> Head of Nursing and Professional Practice</td>
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<tr>
<td><strong>Last review date:</strong> New procedure</td>
</tr>
<tr>
<td><strong>Reviewer:</strong> N/A</td>
</tr>
<tr>
<td><strong>Location of electronic master:</strong> SCH Intranet</td>
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**AGREED POLICY REVIEW / RATIFICATION / ADOPTION PATH:**

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<td><strong>Agreed by:</strong> Safeguarding Group</td>
<td><strong>Agreed by:</strong> Clinical Policy and Audit Group</td>
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<tr>
<td><strong>Date:</strong> May 13 (virtual)</td>
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<td><strong>Agreed by:</strong> Clinical Quality and Safety Assurance Group</td>
<td><strong>Noted by:</strong> Leadership Group</td>
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<tr>
<td><strong>Date:</strong> 22/5/13 and 25/11/14</td>
<td><strong>Date:</strong> 18/6/13 and Dec 14</td>
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SAFEGUARDING CHILDREN PROCEDURE

1 Introduction

1.1. Safeguarding is everyone’s responsibility and as such West Suffolk Hospital is committed to safeguarding and promoting the welfare of children and young people. (A child is defined as those up to their 18th birthday) and it is the responsibility of all West Suffolk Hospital employed SCH staff to follow these procedures and the associated policy to safeguard children regardless of which member of the family is the primary client.

1.2. These procedural guidelines provide the knowledge base and guidance on what actions to take when there are concerns, allegations or disclosures of actual harm or risk of harm to a child/ren.

1.3. The SCH Consortia Safeguarding Named Nurse is available for advice, support and assistance for any Safeguarding matter. All Safeguarding policies, information, updates are available on the SCH Intranet.

1.4. This procedure contains a number of appendices and staff should read this procedure in conjunction with the Suffolk Safeguarding Children Board (SSCB) procedures and the SCH Safeguarding Children Policy for West Suffolk Hospital employed SCH staff

2 Definitions/ Recognition/ Indicators of Abuse

2.1. Concerns for a child’s welfare may arise when a member of staff is not entirely satisfied with the clinical, social or emotional picture that is presented or where abuse is suspected.

2.2. The National Institute for Health and Clinical Excellence (NICE) clinical guideline, “When to Suspect Child Maltreatment”, is a valuable resource to help healthcare practitioners who are not specialists in child protection.

2.3. For more detailed indicators of abuse see appendix 3

2.4. The Children Act 1989 (Section 47) introduced the concept of significant harm as a definition of abuse;

- **Harm** means ill treatment or the impairment of health or development, including for example, impairment suffered from seeing or hearing the ill-treatment of another e.g. domestic abuse;

- **Significant** relates to the child’s health and development and the comparison with that which could reasonably be expected of a similar child.

- **Significant harm** relates to four categories of abuse, these are physical, emotional, sexual abuse and neglect.

2.5. **Physical abuse**

- Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, female genital mutilation 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 (appendix 7 gives further guidance)

2.6. **Emotional Abuse**

- Emotional abuse is the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child’s emotional development. It may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that
are beyond the child’s developmental capability, as well as overprotection and limitation of
exploration and learning preventing the child participating in normal social interaction.

- Emotional abuse may involve seeing or hearing the ill treatment of another for example
domestic violence. It may involve 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 ill-treatment of a child, though it may occur alone.

2.7. **Neglect**

- Neglect is the persistent failure to meet a child’s basic physical and/or psychological
needs, likely to result in the serious impairment of the child’s health or development. It
involves the failure to ensure adequate supervision including the use of caretakers, or to
ensure access to appropriate medical care or health appointments and treatment.

- Neglect may occur during pregnancy as a result of maternal substance misuse.

2.8. **Sexual Abuse**

- Sexual abuse involves forcing or enticing a child or young person to take part in sexual
activities, including prostitution, whether or not the child is aware of what is happening.

- The activities may involve physical contact, including penetrative (e.g. rape or buggery or
oral sex) or non-penetrative acts (oral sex).

- They may include non-contact activities, such as involving children in looking at, or in the
production of, pornographic material or watching sexual activities including the use of
internet, webcam, cameras including mobile phones, or encouraging children to behave in
sexually inappropriate ways.

- Sexual abuse should be considered for those children who run away from home. Pregnancy
in a young person or a concealed pregnancy may also raise concerns of sexual
abuse.

2.9. **Sexual Activity and Legal Implications**

- Cases of underage sexual activity that present a cause for concern should be handled
sensitively and staff should seek advice where required. The law and Working Together
(2010) clearly states that;

  ➢ **Under 13 years**
  
  Sexual activity with a child under 13 years is illegal as the child is not legally capable
  of consenting to sexual activity (Sexual Offences Act 2003). SCH staff must report any
  known cases to their line manager, the Safeguarding Named Nurse and referred to
  Children’s Social Care or police.

  ➢ **Age 13 - 15**
  
  Sexual activity with a child under 16 is an offence. Where it is consensual it may be
  less serious than if the child were under 13 but may nevertheless have serious
  consequences for the welfare of the young person. Staff should seek advice when
  they are concerned.

  ➢ **Age 16 - 17**
  
  It is an offence for a person to have a sexual relationship with a 16-17 year old if that
  person holds a position of trust or authority in relation to them e.g. teacher, doctor,
  nurse. Staff must report any known cases to their line manager, the SCH
  Safeguarding Named Nurse and be referred to Children’s Social Care or the police.

- Additional information and guidance on working with those sexually active under 16 year
olds is available on the Suffolk Safeguarding Children Board (SSCB) website
2.10. **Vulnerable to Radicalisation**

a) Being influenced or radicalised by extremism leading to adverse effects on the individual, family members, the local community and/ or the potential creation of unacceptable risk to public protection.

b) The 2011 Prevent Strategy aims to stop people from becoming terrorists; often referred to as being radicalised or supporting terrorism. The Department of Health and the Home Office have developed guidance for health care organisations, to enable them to implement Prevent locally, called “Building Partnerships, Staying Safe.”

2.11. **Suffolk Safeguarding Children Board**

An inter-agency forum which meets every 3 months and promotes the protection of children from abuse. It is responsible for developing, implementing, monitoring and evaluating procedures and practice models which encourage the prevention, detection and reporting of child abuse in all its forms. See: [http://suffolksafeguardingchildrenboard.onesuffolk.net/](http://suffolksafeguardingchildrenboard.onesuffolk.net/)

2.12. **Customer First**

Social Care Services have a lead role in assisting and supporting the most vulnerable people in our community. Customer First is the specialist call centre which is the initial point of contact for social services in Suffolk.

They have the trained staff who receive all the referrals about children and pass the information to the Multi Agency Safeguarding Hub (MASH) who will assess the information and using the SSCB thresholds make a decision about the level of intervention that the child may need.

2.13. There are certain risk factors and situations that may place children at particular risk of suffering significant harm. The presence of one or more of these factors does not automatically imply that abuse will result, but may increase the likelihood.

2.14. Staff should be aware of the risk factors for children living with a parent or carer with mental illness, substance misuse, or domestic abuse.

2.15. For a full description of parental risk factors in child abuse see appendix 2.

3 **Identification of Abuse**

3.1. Abuse may be suspected or known of due to

a) A disclosure from the child experiencing the abuse

b) Information from a third party, such a relative, friend, carer, another employee or another agency

c) Indicators of abuse have been observed:

d) Staff must be aware and receptive to signs of harm, neglect and abuse and must:

i) Look beyond first impressions

ii) Help children express what is happening to them

iii) Recognise patterns of concern

3.2. Once abuse is suspected, the identifier has a duty to report it therefore cannot keep this information a “secret”

3.3. Staff must treat the information as confidential and share in accordance with this policy on a “need to know” basis. There is a formal duty of care to report abuse. It is best practice to make it clear to anyone who shares information about abuse to themselves, or to another person, that the information given will have to be passed on in accordance with policies and procedures for protecting children.
3.4. There are exceptions to this i.e. when informing the family may be considered to place the child at risk or the parents/ carers lack the mental capacity to give informed consent.

4 Procedure for where there are concerns that a child(ren) has suffered or is likely to suffer Significant Harm

4.1. If staff are concerned that a child or unborn baby has suffered or is likely to suffer significant harm then a referral to the relevant Children's Social Care Department must be made via Customer First using the Multi-Agency Referral form. This can be found on the SSCB website at

http://www.suffolkscb.org.uk/procedures/referring-concerns-to-social-care/:

4.2. The completed form must be sent via secure email to Customer First.

Customer.First@suffolk.gcsx.gov.uk

4.3. A printed copy should be retained and a copy sent to the Safeguarding Named Nurse. If the referral is urgent or you need urgent advice you can telephone Customer First directly on 0808 800 4005, this is a 24 hour service.

4.4. It is best practice that, wherever possible, the patient should be informed of the concerns and consent to the referral process. However, consent is not necessary if:

a) The referral is made in order to protect an individual and related to level of risk
b) The patient does not have the capacity to consent
c) The alleged perpetrator is in a “position of trust” i.e. a police officer, social worker, nurse, doctor, teacher, carer etc
d) A fabricated or induced illness is suspected
e) Notifying the patient or family/carer could put the vulnerable person at an increased risk
f) The patient's life is in danger or they are likely to suffer serious harm.

N.B. If there are concerns whether consent should be obtained then advice should be sought form the named nurse safeguarding children or via the professional consultation line 03456061499

If a child discloses that they are being abused it is essential to remain calm; accept what is said without comment or judgement.

4.5. Document details of any physical signs, draw diagram using body map if possible, and record information from the patient/ other person regarding how/ when the injury occurred etc. Photographic evidence is very useful but it is essential to obtain consent.

4.6. When there has been a serious injury or death, staff are responsible for considering the welfare of other children in the household and reporting those concerns to their line manager, Safeguarding Named Nurse and/ or Children’s Social Care accordingly. All actions taken must be clearly recorded.

4.7. Where a child or parent discloses information to staff the staff member should record a clear and exact account of what was observed or said to them: In reference to child disclosures staff should.

• Listen to the child rather than directly questioning further.
• Never stop a child who is freely recalling significant events.
• Write what was said verbatim, as well as time, setting and personnel present
4.8. Staff should seek agreement from the family for a referral to Children’s Social Care unless this may;
   • Place a child at increased risk of significant harm e.g. by the behavioural response from parent/carer
   • Place the staff member at risk;
   • Lead to the risk of loss of evidential material.

4.9. Such permission is not required if it is determined that any criteria in the bullet points above is present. Reasons for not seeking permission should be recorded in case notes and within the referral.

4.10. Staff should not rely on a parent to pass on information about family difficulties to other professionals.

4.11. Referrals to Children’s Social Care should be made at the earliest opportunity and within one day and can be made by telephone but must be followed up in writing within 24 hours using the relevant multi agency referral form (MARF). A copy should be sent to the Safeguarding Named Nurse and the child’s GP where relevant.

4.12. Whenever a referral is made staff should make clear exactly what the risks are or category of abuse. As much information as possible relating to the concern is required in order for Children’s Social Care to make informed decisions regarding action to be taken. This includes a Common Assessment Framework Assessment if used, relevant past medical/social history, staff involvement with family members, previous referrals, and views on parenting capacity. All decisions and actions taken must be recorded in the relevant child/adult/family records.

4.13. Children’s Social Care must acknowledge referrals within 1 working day of receipt of the written referral. Where no acknowledgement is received within 3 working days, the referrer must contact Children’s Social Care again.

4.14. Where Children’s Social Care decides to take no action, the referrer should anticipate feedback about that decision and its rationale. Where there is a disagreement or concern regarding actions taken following a child protection referral then the SSCB escalation Policy should be followed.

4.15. Where there is a difference of opinion between SCH or West Suffolk Hospital senior professionals regarding a risk to a child, the SCH Consortia Safeguarding Named Nurse should be consulted.

4.16. If a referral needs to be made outside normal working hours then the Customer First or Police should be contacted (appendix 6 for key staff contact details). Staff should contact their line manager and record all discussions information and actions taken in the child/adults record.

4.17. Reports of suspected child abuse by a third party must be taken seriously and staff have a duty to advise the reporter to contact Children’s Social Care directly. Staff cannot keep information confidential and have a responsibility to contact Social Care to ensure the concerns have been reported. All information and actions taken must be recorded in the child/adults records as appropriate.

4.18. Cross Boundary referrals; if a child lives outside Suffolk then the referral will need to be made to the relevant Local Authority where the child resides.

5 Assessment Framework and Assessment Framework Triangle

5.1. The Framework for the Assessment of Children in Need and their Families (DoH 2000) is a useful tool for staff to refer to when assessing children and families and completing reports for Case Conferences (see appendix 2) or partnership meetings. The Framework contains three principle domains including;
• Child’s development needs
• Parenting capacity to respond appropriately to those needs
• Wider family and emotional factors

6 Multi-agency Referral Form and Common Assessment Framework
6.1. Referrals to children’s social care must be made using the Multi-agency Referral Form (MARF); this form is used to make a referral or to confirm in writing a referral made by telephone. This has been designed to ensure that Children’s Services have enough information about the child or young person and the concerns which have prompted the referral to be able to carry out an Initial Consideration to determine whether or not an Initial Assessment should be undertaken. See http://www.suffolk.gov.uk/care-and-support/children-young-people-and-families/common-assessment-framework-caf/common-assessment-forms

6.2. Most referrals, though not all, will be supported by a completed Common Assessment (CAF). This may be generated by the Social Care team to give additional info following a MARF.

6.3. The Common Assessment Framework (CAF) is a national assessment framework which can be used to identify the unmet additional needs of children and young people. CAF enables professionals to work with families to explore all aspects of a child or young person’s life with a view to enabling early intervention where appropriate.

6.4. The CAF process is dependent on the child, young person and family giving informed consent for assessment information to be shared with relevant professionals. If a family refuse to work with CAF and there are no safeguarding concerns, you should continue to engage with the family and work towards building stronger relationships wherever possible


6.6. For clear guidelines on information sharing go to www.dcsf.gov.uk/informationsharing and NHS Safer Tools

7 Child Safeguarding Thresholds
7.1. Definitions and decisions around what constitutes abuse are not always clear or easy; “Meeting the Needs of Children and Families in Suffolk: Social Care and Common Assessment Framework: Thresholds Document 2013 ” is available to support practitioners to make appropriate recommendations and response to child safeguarding concerns http://www.suffolkscb.org.uk/procedures/referring-concerns-to-social-care/

7.2. All staff, either paid or volunteers, have the duty to report safeguarding concerns to their line manager or the SCH Consortia Safeguarding Named Nurse and if there are any doubts this should be discussed with them before making a referral.

8 Record Keeping
8.1. The findings from a number of Serious Case Reviews have identified poor record keeping as a significant concern. The consequence of poor record keeping can result in confusion for professionals and may directly place a child or young person at risk.

8.2. All recordings regarding a child or adult constitute a legal document and can be used in court proceedings; therefore it is important to include all relevant information for all household members regardless of who the primary client is.

8.3. All records and assessments of parents and children must consistently record the racial, linguistic and religious identity and needs of the child and family
8.4. Staff should follow the Record Keeping Policy for West Suffolk Hospital employed SCH staff. All discussions, decisions, actions and rational for why no action is deemed necessary must be recorded contemporaneously with a date, name and signature. All recordings should be based on fact or professional opinion and kept in the patient’s records.

8.5. At each new contact with a child or parent, the basic information about the child/ren should be checked and updated where applicable.

8.6. The records of clients who have children subject to a Child Protection Plan (formerly Child Protection Register) should indicate this.

8.7. Recording of relevant adult information by Community Health staff

Community Health staff should use the relevant electronic/paper record to record information regarding parents/carers and significant others including:

a) Relevant adult’s records
b) All appropriate medical information/reports.
c) Relevant social details and background, place of residence, relationship to child.

8.8. Where available, relevant child/adult paper records and electronic systems should indicate or use an alert flag, that a child has a Child Protection Plan and include the category of abuse or neglect the child has suffered and the decisions in the plan relating to the member of staff’s role.

8.9. Relevant information from the child protection plan, Child in Need Plan/Partnership meeting relating to the parents/carers or significant others should be recorded in the adult records.

8.10. When a Child Protection Plan has been discontinued an entry in the Child Record/relevant adult record must indicate this.

8.11. It is important that all records, including the parent/carers adult records are kept together and if appropriate transferred together.

8.12. If part of the record has to be separated there must be an entry in the electronic/paper record stating where the retained record can be located.

9 Confidentiality/ Information sharing

9.1. All SCH staff have a duty to assist Social Care with Section 47 enquiries when a child is believed to be at risk of significant harm.

9.2. If a member of staff is approached via telephone for information on a child by a Social Worker or other professional, the member of staff must identify whom they are speaking to and if they do not recognise the caller phone back.

9.3. Record details of caller and time and the action taken in the relevant child record and if parents/guardian have given consent to share information or if this is being shared without consent due to the nature of the safeguarding concerns.

9.4. Safe sharing of information principles must be applied including:

- Ensuring emails are sent via secure NHS accounts to secure gcsx.gov accounts
  Child/family details should not be emailed to any other agency outside of health unless a secure system is used in accordance with West Suffolk Hospital policy for SCH staff policy.
- Posted information should be in an unmarked enveloped and marked private and confidential and include a compliment slip from sender

9.5. If any other person, including parents/carers, request information about a child, parent or third party staff should contact their line manager or the SCH Consortia Safeguarding Named Nurse for advice.
9.6. Health records will not normally be released to persons outside the Health Service except on Court Orders. However, there is a process for this and this is described in the Access to Health and Social Care Records Policy for SCH staff employed by West Suffolk Hospital.

10 Whistle-blowing

10.1. Where concerns are raised about a vulnerable adult due to malpractice or misconduct in the workplace or due to the direct actions of an employee, those concerns should in most circumstances be raised following the WSH Whistle-blowing and/or the WSH Capability Policy. This provides staff with the greatest degree of protection and the organisation with a system and process to address the concerns.

10.2. Advice can also be sought from the SCH Consortia Safeguarding Named Nurse and from the Human Resources Department. This will ensure that concerns are managed in accordance with policies and procedures for West Suffolk Hospital employed SCH staff. If the concern is of a serious nature it will be managed by the SCH Consortia Safeguarding Named Nurse and HR Department or other designated investigator, this may also involve other external agencies as appropriate.

10.3. SCH must report any allegation of abuse that happens on its premises to the CQC via the NPSA and inform West Suffolk Hospital. The organisation must also inform NHS Suffolk/ local CCG as part of the Serious Incident reporting process.

11 Hiding Abuse/Denial

11.1. For many reasons people may not be able to tell you directly about the abuse they are experiencing:

- Perpetrators are often close family members or family friends
- Perpetrators may make threats about what may happen if the victim tells other people
- Perpetrators often blame victims for the abuse e.g. “You make me do it” “You deserve it”.
- The child may have disclosed in the past and found that they were ignored or not taken seriously
- They may be frightened that any intervention will only make matters worse and place them at greater risk
- They may be embarrassed or ashamed
- They may feel that they are to blame because they have been unable to protect themselves
- They may not trust people who are “official”, from a different culture or gender
- They may not be aware that what is happening to them is abusive and wrong.

12 Domestic Abuse

12.1. Domestic abuse is defined as: “any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality”.

(Home Office cited in Department of Health 2006)

12.2. Domestic abuse can be:

- Physical
- Sexual
- Psychological
12.3. The extent of the problem:

a) 2 women are killed every week by a current or former partner
b) 6% of men say that they have been a victim of domestic abuse
c) 16% of women in England and Wales say that they have been physically assaulted by a partner at some point
d) 25% abuse occurs in 1 in 4 homes
e) 30% of domestic abuse cases start during pregnancy
f) 35% of households that experience a first assault will experience a second within five weeks
g) 52% of child protection cases involve domestic violence 54% of rapes in the UK are committed by a woman’s current or former partner
h) 70% of children living in refuges in the UK have been abused by their fathers
i) 75% of cases of domestic violence result in physical injury or mental health consequences to women
j) 90% cases of domestic abuse occur when the children are in the same or next room

12.4. If the concerns arise because an adult is or is suspected as being a victim of domestic abuse and there is a child/children in the family or a pregnancy, a referral must be made to safeguard the child(ren), even if they claim the child/children do not hear or witness the abuse. (Department of Health 2006)

12.5. A referral form (MARF) to Children’s Social Care must be completed and faxed to the Children’s Safeguarding Team via Customer First. Again, copies must be taken. One must be kept in the patient’s records and one each must be sent to the SCH Named Nurse Safeguarding Children.

12.6. Under the ‘Domestic Crime and Victims Act 2004’ charges can now be brought against a perpetrator without an abused person’s permission.

12.7. For indicators and effects of Domestic Abuse please see appendix 2.

13 Vulnerability, complex factors & additional needs

13.1. Staff working with children or adults must consider the support needs required to maintain the welfare of any children they come in contact with in all aspects of their work.

13.2. When working in either adult or child settings, staff should be aware that a number of Vulnerability Factors will affect children’s welfare such as; Social Exclusion, Bullying, Missing Children/Families, Forced Marriages, Migrant Children, Disabled Children, and those at risk of violent extremism or radicalisation etc. Additional information on these areas are available via the SSCB website.

13.3. Significant harm and additional vulnerability factors can apply to young people, from community based violence such as gang, group and knife crime. In these circumstances staff need to ensure that the safeguarding process responds effectively to involve both the perpetrators and victims of violent activity.

13.4. Exposure to, or involvement with, groups or individuals who condone violence as a means to a political end is a particular risk for some children. Children and young people can be drawn into violence themselves or they can be exposed to messages through direct contact with members or, increasingly, through the internet. This can put a young person at risk of being drawn in to criminal activity and has the potential to cause significant harm. The government’s ‘PREVENT’
strategy is to support individuals who are vulnerable to recruitment or have already been recruited by violent extremists. Staff concerned that a child or family may be affected by violent extremism must consult their line manager.

13.5. Staff should be aware of the risks of children and young people being at risk of abuse and being exposed to inappropriate material via use of information communication technology (ICT). This includes the distribution of indecent photographs of children, Internet chat room/web cams with a view to grooming children. Children themselves can also engage in text bullying and use of mobile cameras to capture violent assaults of other children for circulation.

14  Consent

14.1. It is best practice that, wherever possible, the child/family should be informed of the concerns and consent to the referral process. However, consent is not necessary if:

a) The referral is made in order to protect an individual and related to level of risk
b) The child/family do not have the capacity to consent
c) The alleged perpetrator is in a “position of trust” i.e. a police officer, social worker, nurse, doctor, teacher, carer etc.
d) A fabricated or induced illness is suspected
e) Notifying the child or family/carer could put the vulnerable person at an increased risk
f) The child’s life is in danger or they are likely to suffer serious harm.
g) If an individual is considered is considered “Vulnerable to Radicalisation/Extremism”
   i) It is generally best practice not to inform the alleged perpetrator/s that a referral has been made. However, there may be situations where it may be necessary.
   ii) Do not share any information with the perpetrator without discussion with your line manager or the SCH Consortia Safeguarding Lead
   iii) Obtaining patient consent for the purpose of a referral of a “Person Vulnerable to Radicalisation/Extremism” can in itself prejudice the purpose of the reporting process and on-going multiagency procedures.
   iv) For this reason any concerns related to; a member of staff, a member of the public, a patient, carer or relative; staff are advised to seek advice from the Safeguarding Lead before taking any action. In these cases, do not raise any suspicions or concerns with the individual or family.

15  Summary of Roles and Responsibilities for West Suffolk Hospital employed SCH staff

15.1. Chief Executive/Executive Team
Has overall accountability and responsibility for ensuring SCH meets its statutory and legal requirements and adheres to guidance issued by the DoH and the Suffolk Safeguarding Children Board (SSCB)

15.2. Director of Nursing & Quality
Accountable to the Chief Executive and has delegated responsibility for safeguarding children and for the ratification of this policy.

15.3. SCH Consortia Safeguarding Named Nurse

15.4. Accountable to the Director of Nursing of WSH and has consortia-wide responsibility for ensuring staff are aware of their roles and responsibilities in relation to Safeguarding Children. Their role is:
• To be responsible for advising and support the organisation and workforce in providing services that Safeguard Children consistent with national, regional and local legislation, policies and best practice.

• To advise and support the organisation and workforce in providing services that Safeguard Children consistent with national, regional and local legislation, policies and best practice.

• To ensure that the organisation and workforce discharge their safeguarding responsibilities under Section 11 of the Children Act 2004.

• The safeguarding responsibilities of the post-holder extend across the whole organisation including clinical and nonclinical staff.

• The post-holder represents the organisation on Safeguarding Children and Adult matters across all other statutory and non statutory agencies.

• The post-holder is the point of contact in the organisation for all safeguarding matters from statutory and non statutory agencies both within and out of Counties.

• To support the dependent service to CDS.

15.5. Local Area Managers/ Clinical Team Leaders/ Modern Matrons

• Have a responsibility to ensure their staff receive the training required for Safeguarding within SCH. They are responsible for ensuring that they are familiar with this policy and for implementing it into practice in association with their staff.

• Staff members who do not comply with the relevant mandatory training requirement, must be managed appropriately by their line manager who is responsible for monitoring staff compliance with training using the annual appraisal system.

15.6. Staff working with, or coming into direct contact with, children

It is the responsibility of all individuals to ensure that any concerns about the welfare or safety of children are properly recorded and that any evidence is retained or preserved. In the event the concerns relate to SCH refer to the SCH Capability and / or Whistle blowing policy. All staff, volunteers and care providers share a responsibility to:

• Maintain a working knowledge of this policy and its contents and comply with the policy and procedures set out within it.

• Attend mandatory training as specified in the mandatory training matrix.

• To raise their concerns and seek advice if they are unsure of any part of the process from their line manager or the Safeguarding Named Nurse.

• Remind and challenge colleagues about their role and responsibilities in safeguarding vulnerable adults.

• Record using the assessment template on SystmOne that a safeguarding issue has been identified and that an onward referral to Customer First has been made.

15.7. Human Resources Department

• Has the responsibility and accountability to ensure safe and secure recruitment systems and processes are in place and meet national and local requirements, to ensure recruitment practices are safe and reduce the risk of abusive behaviour and practice.

• They must also work in collaboration with the SCH Consortia Safeguarding Vulnerable Adult Lead in the management of allegations of abuse by staff members and to ensure the rights of ‘whistle blowers’ and alleged perpetrators are respected.

15.8. SCH Consortia Workforce Development Team

Have responsibility and accountability to ensure that information and training is available to staff to meet identified requirements in the following:-
• Safeguarding (adults and children)
• Equality and Diversity
• Conflict Resolution
• Mental Capacity Act,
• Deprivation of Liberties Act (DOLs)
• Independent Mental Capacity Advocacy Service (IMCA)
• Prevent

15.9. **SCH Safeguarding Group**

Responsible for:

• Overseeing, implementing and monitoring all requirements placed on Suffolk Community Healthcare for safeguarding children, adults and older people.

• Ensuring safeguarding with all directly managed and directly commissioned services is a priority, identifying risks and taking measures to ensure these are eliminated, managed and mitigated wherever possible. (this will include oversight of CDS

• Ensuring SCH has policies, practices and processes in place that meets SCH’s statutory responsibility to promote the welfare of children under Section 11 of the Children’s Act 2004 and the protection of vulnerable adults and are reflective of Care Quality Commission regulations

• Providing assurance to the Leadership Group via Clinical Quality and Safety Assurance Group (CQSAG) on SCH compliance with legislation and local and national standards on safeguarding.

15.10. **SCH Clinical Quality and Safety Assurance Group (CQSAG)**

Responsible for ratifying this policy, and for receiving reports on safeguarding issues from the Safeguarding Named Nurse.

16 **Training and Education**

16.1. The policy and its contents will be incorporated into the Safeguarding Children training sessions. Training is delivered on the as part of Induction for all new staff and to existing clinical staff who have direct contact with adults (people over the age of 18) as part of their role and to non-clinical staff if they work directly with patients. The SCH mandatory training matrix details those staff for whom this training is MANDATORY. These members of staff need to attend face to face training or complete the eLearning as a minimum, every three years.

16.2. These sessions are available to book via the Workforce Development Department. Other stand-alone sessions for Safeguarding Children can be arranged for individual teams, groups or as part of other study days directly with the SCH Consortia Named Nurse Safeguarding Children.

16.3. All staff will be expected to attend Level One Safeguarding Children training as minimum but certain staff may need to attend Level 2 or 3 training. For information relating to required competency levels and training matrix see appendix 13.

16.4. All attendance will be recorded by the SCH Consortia Workforce Development on their database.

16.5. Line managers and staff members will be responsible for ensuring they attend the required training and this will be monitored at department level through annual appraisal systems and...
training workbooks. Non attendance at training sessions will be followed up in accordance with Policy for West Suffolk Hospital employed SCH staff

16.6. Health WRAP (Workshop to Raise Awareness of Prevent) training will be delivered to staff identified as high risk services; these may include:
   a) Community Inpatient Unit staff
   b) Specialist Services
   c) District Nurses
   d) Therapists
   e) Health Care support Workers
   f) Children’s Services; (SEPT)
   g) Workforce/ HR staff

17. Review Period for this Procedure
17.1. 2 yearly with policy

18. Communication of this Procedure
18.1. Via Local Area Managers and Clinical Team Leaders

19. Compliance Monitoring and Audit
19.1. Compliance with Safeguarding training within SCH will be monitored by the SCH Consortia Workforce Development Team
19.2. The monitoring of compliance with this policy will be an evaluation by the SCH Safeguarding Lead who will complete annual Audits on the following:
   • Referrals initiated by the organisation.
   • Appropriateness of referrals
   • Number of staff who have attended training
   • Feedback from external partner agencies on the effectiveness of the safeguarding processes within the hospital.
19.3. The purpose of these audits is to ensure that the SCH Safeguarding Policy is being adhered to. Any Action Plans that arise will be implemented in a timely and appropriate manner. This will be reviewed on an ongoing basis by the SCH Safeguarding Named Nurse.

20. Cross Reference to Other Policies and Procedures for West Suffolk Hospital employed SCH staff
20.1. Safeguarding Adults Policy and Procedure
20.2. SEPT Safeguarding Adults Policy and Procedure
20.3. CDS Safeguarding Adults Policy and Procedure
20.4. Consent Policy
20.5. Record Keeping Policy
20.6. Access to Health and Social care Records Policy
20.7. Forced Marriage and Honour-based Violence Policy (adopted)
20.8. Mental Capacity Act and Deprivation of Liberty Policy
20.9. Capability Policy
20.10. Whistle-blowing Policy
20.11. Violence and Aggression Policy
20.12. Incident Reporting Policy
20.13. Managing allegations against staff policy
20.14. Prevent policy

21 Supporting Documents/ Legislation

21.1. This document will support the organisation’s compliance with its legal obligations as set out in:

- The Human Rights Act 1998
- Mental Capacity Act, 2005
- The requirements of Care Quality Commission Suffolk Adult Safeguarding Board,
- DH Responding to domestic abuse 2006
- DH The Role of Health Service Managers & their Boards 2011

22 References

- Suffolk Safeguarding Children Board guidance: http://suffolksafeguardingchildrenboard.onesuffolk.net/procedures
Appendix 1: Risk Factors for Child Abuse

Mental Illness

- The majority of parents who suffer significant mental ill health are able to care for and safeguard their children and/or unborn child but it is essential always to assess the implications for any children involved in the family.
- A study of 100 case reviews of child deaths where abuse and neglect had been a factor in the death, showed clear evidence of parental mental illness in one third of cases. (Falkov, A (1996) A Study of Working Together’ Part 8 reports.).
- Children most at risk of significant harm are those who feature within parental delusions and children who become targets for parental aggression or rejection, or who are neglected as a result of parental mental illness.
- The National Patient Safety Agency report 2009 “Preventing harm to children from parents with mental health needs” (NPSA/2009/RRR003) emphasises the responsibility staff have in considering the risks to children whose parents or carers express delusional beliefs involving their child and/or might harm their child as part of a suicide plan.
- The following parental risk factors may justify a referral to Children’s Social Care for an assessment of the child’s needs:
  - Previous history of parental mental health especially if severe and / or enduring condition;
  - Predisposition to, or severe post natal illness;
  - Delusional thinking involving the child;
  - Self-harming behaviour and suicide attempts (including attempts that involve the child);
  - Altered states of consciousness e.g. splitting / dissociation, misuse of drugs, alcohol, medication
  - Obsessive compulsive behaviours involving the child;
  - Non-compliance with treatment, reluctance or difficulty in engaging with necessary services, lack of insight into illness or impact on child;
  - Disorder designated ‘untreatable’ either totally or within time scales compatible with the child’s best interests;
  - Mental illness combined with domestic violence and/or relationship difficulties;
  - Unsupported and/or isolated mentally ill parents;
- Parental inability to anticipate needs of the child. Care Programme Approach or Professionals meetings about parents who have mental health difficulties, must include consideration of any needs or risk factors for the children concerned.
- Consultant psychiatrists should be involved in clinical decision making for patients who may pose a risk to children as above. This includes discharge planning and arrangements for home leave.
- Where an adult, who is also a parent / carer, is deemed to be a danger to self or others a referral must be made to Children’s Social Care. Children’s Social Worker and Community Health Services e.g. Health Visitor, midwife must be invited to any relevant planning meetings and contribute toward a risk assessment if required.
Drug and Alcohol Misuse

- As with mental illness in a parent, it is important not to generalise, or make assumptions about the impact on a child of parental drug and alcohol misuse. However it is important to note the report by the Advisory Council on the Misuse of Drugs (ACMD) Hidden Harm—responding to the needs of children of problem drug users estimated that there are between 200,000-300,000 children of problem drug users in England and Wales, i.e. 2-3% of all children under 16 years.
- Parental problem drug use can and does cause serious harm to children at every age from conception to adulthood. Parental Misuse of drugs (prescribed and illegal) and/or alcohol is strongly associated with significant harm to children.
- A referral to Children’s Social Care must always be made when:
  - Combined with domestic abuse and mental illness;
  - The substance misuse of a parent or carer is chaotic or out of control;
  - Drugs and paraphernalia (e.g. needles) are not kept safely out of reach of children;
  - Children are passengers in a car whilst a drug or alcohol misusing carer is driving.

Domestic Abuse

- Domestic abuse refers to threatening behaviour, violence or abuse including, psychological, physical, sexual, financial or emotional. It also includes Female Genital Mutilation and Honour Based Violence.
- Where there is evidence of domestic abuse, the implications for any children in the household must be considered and referral to Children’s Social Care must be made where staff are aware of;
  - A child’s direct involvement with a domestic abuse incident or injury;
  - A woman is pregnant. Pregnant women frequently experience punches and kicks directed at the abdomen, risking injury to both mother and fetus;
  - Any child injured during episodes of violence or is witnessing the physical and emotional suffering of a parent.
Appendix 2: Assessment Framework Triangle

For guidance on completion please see “Framework for Assessment of Children in Need and Their Families” (Dept of Health, Dept of Education and Employment, Home Office; 2000) at:

Appendix 3: Indicators of abuse

Indicators of Physical Abuse
Unexplained bruising: some types of bruising are particularly characteristic of nonaccidental injury:
Hand slap marks
Marks made by an implement
Pinch/ grab/ grip marks
Black eyes
Bruising (faint or severe): there may be a pattern to the bruising eg when/ where it occurs

Other Physical Indicators:
- Child flinches at physical contact
- Reluctance to undress or uncover part of the body
- A history of unexplained falls or minor injuries
- Prolonged interval between the onset of the injury or illness and subsequent presentation for medical care and attention
- Evidence of improper use of medication by parents/ carers e.g. excessive or repeat prescriptions, under-use of medication
- The general level of care is insufficient or deteriorating eg spectacles, dentures, hearing aid not in evidence; person is unwashed, unkempt or inappropriately dressed, clothing is dirty or soiled
- Unexplained ulcers or pressure sores
- Evidence of malnutrition
- Enforced social isolation

Other Types of Injury
- Burns inside the mouth, inside arms or on genitals
- Bite marks
- Cigarette burns
- Any injury, bleeding or soreness in the genital or rectal area which could also be an indicator of sexual abuse
- A bizarre or vague explanation is offered to explain an injury to a vulnerable adult

Indicators of Sexual Abuse
- Uncharacteristic sexually explicit/seductive behaviour which may include promiscuity or use of sexually explicit language
- Urinary tract infections, vaginal infections or sexually transmitted diseases (STDs) that are not otherwise explained
- Continual open masturbation or aggressive sexual activity with peers
- Self-mutilation
- Difficulty in walking/sitting with no apparent explanation
- Torn, stained or bloody underclothes
- Bleeding, bruising, torn tissue or injury to the rectal and vaginal area
**Indicators of Psychological/Emotional Abuse**

The person who is neglected or abused may display uncharacteristic behaviour that may signal distress. The behavioural signs and symptoms may range from slight to severe. Onset may be sudden or gradual. One or several signs and symptoms may be displayed:

- Referred to in a disrespectful manner
- Humiliated in front of others
- Denied access to social activities
- Denied access to services
- Denied time alone with other people
- Appears scared, anxious or withdrawn
- The child appears to be frightened, fearful or has both low self esteem and feelings of self worth
- The child may be subdued in the presence of particular individuals.
- The child displays acting out, aggressive, destructive, irritable behaviour at less powerful people, animals or objects
- Attempt to achieve a sense of control over their feelings through self-harm, refusing to eat, deliberate soiling, behaving in a way that elicits a predictable response
- Sleep disturbances that cannot be explained
- Eating problems. Changes in appetite. Unusual weight gain/loss. Sudden withdrawal or absenteeism from activities or services

**Indicators of Domestic Abuse**

**Effects on women (physical)**

- General poor health
- Bruising
- Recurrent sexually transmitted infections
- Broken bones
- Burns or stab wounds
- Tiredness
- Poor nutrition
- Chronic pain
- Gynaecological problems/ miscarriage
- Premature birth
- Babies stillborn/ low birth-weight/ injury or neonatal death
- Self harming behaviour
- Death/ maternal death

**Effects on women (psychological)**

- Fear
• Increasing likelihood of misusing drugs, alcohol or prescribed anti-depressants
• Depression/poor mental health
• Wanting to commit or actually committing suicide
• Sleep disturbances
• Post-traumatic stress disorder
• Anger
• Guilt
• Loss of self-confidence/ low self worth
• Feelings of dependency
• Loss of hope
• Feelings of isolation
• Panic or anxiety
• Eating disorders

Effects on children (physical)
• Bruising/ broken bones
• Burns or stab wounds
• Neurological complications
• Tiredness and sleep disturbance
• General poor health
• Stress-related illness (asthma, bronchitis or skin conditions)
• Enuresis or encopresis
• Running away leading to potential homelessness
• Eating difficulties
• Damage following self-harm
• Teenage pregnancy
• Gynaecological problems
• Self-harm
• Damage to the unborn child in pregnancy
• Death

Effects on children (psychological)
• Fear, panic, guilt and anxiety
• Depression/poor mental health
• Introversion or withdrawal
• Thoughts of suicide or running away
• Post-traumatic stress disorder
• Anger, aggressive behaviour and delinquency
• Substance misuse
• Loss of self-confidence
• Assumes a parental role
• Hyperactivity
• Tension
• Low self-esteem
• Sexual problems or sexual precocity
• Eating disorders
• Difficulty in making and sustaining friendship
• Truancy and other difficulties at school.
• Suicide

**NB If a victim of domestic abuse has a child or children (even if they claim the child/children do not hear or witness the abuse) a referral MUST be made to Children and Young People’s services using the ‘Framework for Assessment’ Form.**

*Dept of Health: 2006*

**Indicators of Vulnerability to Radicalisation**

- There is no obvious profile of a person who is likely to be involved in terrorist-related activity, or a single indicator of when a person might move to support extremism. Radicalisers often use persuasive rationale or narrative and are usually charismatic individuals who attract vulnerable people to their cause.

- The following factors may make individuals susceptible to exploitation. None are conclusive in isolation and therefore should only be considered in conjunction with the particular circumstances and other signs of radicalisation.

  - Identity crisis; adolescents/vulnerable adults who are exploring issues of identity can feel both distant from their family/parents and cultural and religious heritage, and uncomfortable with their place in society. Radicalises can exploit this by providing a sense of purpose or feelings of belonging. Where this occurs, it can often manifest itself in a change in a person’s behaviour, their circle of friends, and the way in which they interact with others and spend their time.

  - Personal crisis; this may, for example, include significant tensions within the family that produce a sense of isolation of the vulnerable individual from the traditional certainties of family life.

  - Personal circumstances; The experience of migration, local tensions or events affecting families in countries of origin may contribute to alienation from UK values and a decision to cause harm or to symbols of the community or state.

  - Unemployment or under-employment; individuals may perceive their aspirations for career and lifestyle to be underminded by limited achievements or employment prospects. This can translate to a generalised rejection of civic life and adoption of violence as a symbolic act.
Criminality; in some cases a vulnerable individual may have been involved in a group that engages in criminal activity or, on occasion, a group that has links to organised crime and be further drawn to engagement in terrorist-related activity.

- Similarly to the above, the following have also been found to contribute to vulnerable people joining certain groups supporting terrorist-related activity:
  - Ideology and politics;
  - Provocation and anger (grievance). This includes a misconception and/or rejection of UK foreign policy; perception that government policy is discriminatory;
  - Need for protection;
  - Seeking excitement and action;
  - Fascination with violence, weapons and uniform;
  - Youth rebellion;
  - Seeking family and parent substitutes;
  - Seeking friends and community;
  - Seeking status and identity.
Appendix 5: Consortium Governance Framework Structure
Appendix 6: Suffolk County Council Safeguarding Children Structure and Contact Numbers

Flowchart for Referral

Concerns
Suspicion/allegation of abuse by: child disclosure, observation, report by another person, anonymous communication

RECORD Sign and Date

Consult
Your organisation or group should have a policy for child protection. If appropriate, speak with the person nominated to be the child protection advisor/coordinator. All can speak informally with Children and Young People’s Services

IMPORTANT: Any consultation should not delay a referral

RECORD Sign and Date

Action
DO NOT INVESTIGATE
Refer to Children and Young People’s Services and/or Police. You or your ‘co-ordinator’ should make the referral. Parents and carers should be advised that you are doing this unless this might put the child at risk or cause any delay in referring

RECORD Sign and Date

Confirm
DO NOT INVESTIGATE
Verbal referrals must be followed by a written referral within 24 hours

RECORD Sign and Date

Commitment
You may be required to provide other information, as required

RECORD Sign and Date

REMEMBER
DO NOT DELAY - CHILDREN’S SERVICES AND POLICE ARE ALWAYS AVAILABLE
Flowchart for Referral

ARE YOU CONCERNED ABOUT A CHILD?

TELEPHONE AND REFER!

A general principle for referral is outlined in the flowchart overleaf.

Telephone Numbers:

Children's Services:
Customer First freephone No: 0808 800 4005
Emergency Duty Service
Week days: 5.20pm to 8.45am
Weekends: 4.25pm Friday to 8.45am Monday 0808 800 4005

Suffolk Police:
Main Switchboard No: 01473 613500

IN AN EMERGENCY DIAL 999

Suffolk's Guidance and Procedures for safeguarding children are available
@ www.suffolkscb.org.uk

Produced by Suffolk Safeguarding Children Board
For further copies please telephone 01473 264733
March 2012 edition
Appendix 7: What to do if you are worried about the welfare of a child (working hours)

If you have concerns about the welfare of a child
Someone makes a disclosure of abuse to you
You witness abuse

- Raise your concerns with your line manager

- Raise your concerns directly with the Safeguarding Named Nurse

Complete the multi-agency referral form (available at: http://suffolksafeguardingchildrenboard.onesuffolk.net/procedures/referring-concerns-to-social-care)

- Print out a copy for the patient records.
- Alternatively, make a verbal referral directly to Customer First (0808 800 4005)

- Document discussions and actions in the patient records and sign and date.
- Inform the Safeguarding Named Nurse

Customer First will direct the referral to the appropriate agency for investigation.

The Safeguarding Named Nurse will work with that agency to achieve resolution of the concerns and will maintain a record of all referrals and resulting actions.

The Safeguarding Named Nurse will be the main point of contact for support, advice and guidance throughout the process.
Appendix 8: What to do if you are worried about the welfare of a child (out of hours)

- If you have concerns about the welfare of a child
- Someone makes a disclosure of abuse to you
- You witness abuse

Assess the level of risk.
Can your concern wait until normal hours without having a detrimental effect?

Yes
Contact your line manager to discuss the next working day or call the Safeguarding Named Nurse during office hours, Mon-Fri.
If you still have concerns, or have been advised to, complete the online referral form http://suffolsafeguardingchildrenboard.onesuffolk.net/procedures/referring-concerns-to-social-care
Print out a copy for the patient records.
Document your discussion and actions in the patient records and sign and date.
Inform the Safeguarding Named Nurse the next working day

No
Are you happy to make a direct referral?

Yes
Telephone the referral to the duty social worker on 0808 800 4005.
Document actions in the patient records and inform the Named Nurse during normal working hours.

No, I need advice

Does the concern involve a member of staff?

Yes
Inform the Senior Manager on call (via Vodafone pager tel no: 07659 550254) who will decide the next steps.
Inform the Safeguarding Named Nurse during normal working hours.

No
Contact the duty social worker on 0808 800 4005 for advice.
Inform the Safeguarding Named Nurse during normal working hours.
Appendix 9: Mental Capacity Act (2005)

The Mental Capacity Act came into force in England and Wales in April 2007. Having ‘mental capacity’ means that a person is able to make their own decisions.

**Questions that must be considered when assessing capacity**

Does the person have the ability to:

- Understand information given to them?
- Retain that information long enough to be able to make the decision?
- Weigh up the information available to make the decision?
- Communicate their decision by any means? i.e. by talking, using sign language or simple muscle movements such as eye blinking or hand squeezing.

The Mental Capacity Act has the following four key principles which emphasise the fundamental concepts and core values of the Mental Capacity Act. These are:

1. **Every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise.** It cannot be assumed that someone cannot make a decision for themselves solely on the basis that they have a particular medical condition or disability.

2. **People must be supported as much as possible to make a decision before concluding that they cannot do so.** Every effort should be made to encourage and support the person to make the decision for themselves. If a lack of capacity is established, it is still important that the person is involved as far as possible in making decisions.

3. **People have the right to make what others might regard an unwise or eccentric decision.** Everyone has their own values, beliefs and preferences which may not be the same as those of other people. A person must not be assessed as lacking capacity for that reason alone.

4. **Anything done for or on behalf of a person who lacks mental capacity must be done in their best interests.**

5. **Anything done for, or on behalf of, people without capacity should be the least restrictive of their basic rights and freedoms.** This means that whenever anything is done to or for a person who lacks capacity it is imperative to choose the option that is in their best interests and consider whether it could be done in a way which impinges less on their human rights and freedom of action.

When conducting an assessment of capacity the professional involved must always start from the assumption that the person has capacity until assessed otherwise.

A person may lack mental capacity to make a particular decision at a particular time but this does not mean that the person lacks all capacity to make any decisions. Lack of capacity may not be permanent and therefore assessments of capacity should be time and decision specific. A “Code of Practice” explains how the Mental Capacity Act works on a day-to-day basis. All professionals have ‘a legal duty to have abide by this code. New criminal offences of ‘Ill-treatment or wilful neglect of people’ were introduced in the MCA in April 2007. (National Care Association 2007)

If a person lacks mental capacity and a decision has to be made about a long term move or about serious medical treatment and they do not have anyone able to support and represent them then the IMCA service can requested to support and represent that persons rights. For further information on IMCA service contact the SCH Safeguarding Named Nurse, Social Care Services or the patient’s GP.
Appendix 10: Multi-Agency Risk Assessment Committee (MARAC)

The Aims of MARAC

- To share information to increase safety, health and well-being of victims - adults and their children
- To determine whether the perpetrator poses a significant risk to any particular individual or to the general community
- To construct jointly and implement a risk management plan that provides professional support to all those at risk and that reduces the risk of harm
- To reduce repeat victimisation
- To improve support for staff involved in high risk domestic violence cases.

Referral to MARAC

- A referral can be made into MARAC by any professional. Cases are usually presented to the MARAC meeting by the representative of the referring agency. West Suffolk Hospital has three members: the Adult Safeguarding Lead, Named Nurse Safeguarding Children and Named Safeguarding Midwife.

The MARAC Meeting

- Meetings are held on a monthly basis; however an interim emergency meeting may be called. Prior to the commencement of the meeting, all attendees sign a confidentiality agreement. There are key professionals who attend every meeting which include representatives from:-
  - Suffolk Constabulary, who chair the meeting
  - Probation
  - Health
  - Children’s Safeguarding Service
  - Adult Safeguarding Service
  - Women’s Aid
  - Housing
  - Education
  - Independent Domestic Violence Advisor (IDVA)
  - Victim Support
  - UK Border Agency
  - Alcohol Abuse Services (NORCAS)
  - Children & Family Court Advisory Support Service (CAFCASS)
  - Domestic Abuse Support Service (Leeway)
  - Victim Care Centre (VCC)
  - Health Outreach Project (HOP)
  - Street Drinking Liaison Team

Neither the victim nor the perpetrator nor the Crown Prosecution Service attend the meeting.

Additional information about MARAC is available on the ‘Adult Safeguarding Website’: [Adult Safeguarding Board (Suffolk)](http://www.caada.org.uk) the CAADA (Coordinated Action Against Domestic Abuse) website: [http://www.caada.org.uk](http://www.caada.org.uk)
Appendix 11: Suffolk Safeguarding Children Board Referral Thresholds

### Appendix 12: Safeguarding Children Competency Levels and Training Matrix

<table>
<thead>
<tr>
<th>Level</th>
<th>Competency/ target group</th>
<th>Example Target Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>Staff in infrequent contact with children, young people and/ or parents/ carers who may become aware of possible</td>
<td>Admin and reception staff</td>
</tr>
</tbody>
</table>
| Level 2 | Staff in regular contact or have a period of intense but regular contact with children, young people and/ or parents/ carers including all health clinical staff who may be in a position to identify concerns about maltreatment including those that may arise from the use of the CAF | Community Hospital staff  
Community Nursing and Therapy teams  
Specialist Nurses                                                                                       |
| Level 3 | Staff who work predominantly with children, young people and / or their parents/ carers and who could potentially contribute to assessing, planning, intervening and reviewing the needs of a child and parenting capacity when there are safeguarding concerns | ?? Dermatology and Neurology nurse specialists                                         |

For full details on levels of competency, training and full matrix please see:

**Title of Document:** Children’s Safeguarding Procedure

**Description:** The Suffolk Adult Safeguarding Board (ASB) is a multi-agency partnership that promotes the development of adult safeguarding work throughout the county. The member organisations have committed themselves to implementing this policy, the good practice principles, and the adult safeguarding procedures.

**Part 1: Assessment of Impact**

**a) How will the policy meet the needs of different communities and groups?**

<table>
<thead>
<tr>
<th>Category</th>
<th>Impact Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>It is not considered that the age will have any impact on the application of this policy although this organisation recognises that some age-groups may hold more entrenched and long standing beliefs than others.</td>
</tr>
<tr>
<td>Disability</td>
<td>It is not considered that this will have any impact on the application of this policy.</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>It is possible that this policy could impact on some families as these behaviours may be influenced by race, ethnicity and nationality and it may challenge some assumptions.</td>
</tr>
<tr>
<td>Gender (including transgender)</td>
<td>This policy is gender neutral and should meet the needs of all such groups.</td>
</tr>
<tr>
<td>Religion or Belief</td>
<td>It is possible that this policy will impact on some families as these behaviours may be influenced by race, belief and faith and it may challenge some assumptions.</td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td>It is considered that this policy should apply equally to all patients whatever their sexual orientation.</td>
</tr>
<tr>
<td>Socio-economic disadvantage</td>
<td>The focus of any review should always be on the individuals concerned regardless of socio-economic group. It should not impact to cause any socio-economic disadvantage.</td>
</tr>
<tr>
<td>People living in rural areas</td>
<td>This policy should be applied equally regardless of place of residence and should not impact on people living in rural areas.</td>
</tr>
<tr>
<td>Other</td>
<td>This organisation recognises that some members of society generally have difficulty accessing health and social care services such as people who are homeless, prisoners or street workers. Whilst it is recognised that safeguarding issues maybe more prevalent in certain cultural and religious groups the guidance for staff is applicable regardless of this. It is expected, therefore that the policy will be applied equally regardless of these factors.</td>
</tr>
</tbody>
</table>

**b) Positive Impact: Reducing Inequalities: How is the Policy likely to have a significant positive impact on equality by reducing inequalities that already exist? Explain how it will meet our duty to:**

<table>
<thead>
<tr>
<th>Category</th>
<th>Impact Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Promote equal opportunities</td>
<td>This policy will ensure that all adults at risk of neglect and abuse have equal right to protection from the professionals and organisations involved in their care.</td>
</tr>
<tr>
<td>Promote good community relations</td>
<td>As with other policies and guidelines within the organisation, this one aims to ensure that SCH provides quality services to the community of Suffolk ensuring that the whole community has access to a safe health and social care environment. Fostering good relations with partner organisations will be enhance by the application of this policy.</td>
</tr>
<tr>
<td>Get rid of discrimination</td>
<td>If staff continue to work within this policy and within professional guidelines and protocols this should avoid discrimination at any level.</td>
</tr>
<tr>
<td>Promote positive attitudes towards, encourage participation in and enable more favourable treatment of, disabled people</td>
<td>This policy applies to all patients equally irrespective of any disability and staff will make all reasonable adjustments to accommodate any disability.</td>
</tr>
<tr>
<td>Promote and protect human rights</td>
<td>SCH recognises that certain individuals are by definition vulnerable and this policy is designed to ensure their human rights are not affected in any way.</td>
</tr>
</tbody>
</table>
c) Negative Impact – Potential Discrimination: Could the Policy have a significant impact on equality in relation to each of the following groups or characteristics?

- **Age**: It is anticipated that age will not have a negative impact on this policy although some age-groups are more vulnerable than others.
- **Disability**: It is possible that this policy could impact negatively in regard to physical and mental disability as it may challenge the care that has been prescribed.
- **Ethnicity**: It is possible that this policy could impact negatively on some families as views and behaviours are influenced by race, ethnicity and nationality and it may challenge some assumptions.
- **Gender (including transgender)**: This policy will be applied equally regardless of gender.
- **Religion or Belief**: It is possible that this policy will impact negatively on some families’ views and behaviours are influenced by religion, belief and faith and it may challenge some assumptions.
- **Sexual Orientation**: This policy will apply equally regardless of sexual orientation and not impact negatively as a result.
- **Socio-economic groups**: The focus of any review should always be individuals concerned, regardless of socio-economic group. The policy should not impact to cause any socio-economic disadvantage.
- **People living in rural areas**: This policy should be applied equally regardless of place of residence and should not impact on people living in rural areas although it is recognised they may have more difficulty accessing certain services.

**Other**: This organisation recognises that some members of society generally have difficulty accessing health and social care services such as people who are homeless, prisoners or street workers. Whilst it is recognised that safeguarding issues maybe more prevalent in certain cultural and religious groups the guidance for staff is applicable regardless of this. It is expected, therefore that the policy will be applied equally regardless of these factors and there will not be a negative impact.

### Part 2: Evidence

**What is the evidence for your answers above?**

- **Age**: It is the intention and aim of this policy that, in consultation with statutory and non-statutory bodies, reflects current best practice and fulfils current statutory obligations under law.
- **Disability**: It is the intention and aim of this policy that it will reflect best evidence based practice and aim not discriminate based on a physical or mental disability.
- **Ethnicity**: It is the intention and aim of this policy that it shall be applied equally according to best practice and legal obligations and not discriminate unfairly based on ethnicity. However, there is evidence that there will be variations in views and behaviours which may impact on the equal application of this policy based on ethnicity.
- **Gender (including transgender)**: It is the intention and aim of this policy that it shall be applied equally according to best practice and not discriminate unfairly based on gender.
- **Religion or Belief**: It is the intention and aim of this policy that it shall be applied equally according to best practice and not discriminate unfairly based on religion or belief. However, there is evidence that there will be variations in views and behaviours based on religion, belief and faith which may impact on the equal application of this policy.
- **Sexual Orientation**: It is the intention and aim of this policy that it shall be applied equally according to best practice and not discriminate unfairly based on sexual orientation.
- **Socio-economic groups**: It is the intention and aim of this policy that it shall be applied equally according to best practice and not discriminate unfairly based on socio-economic status. However, there is evidence that there will be variations in views and behaviours based on socio-economic status which may impact on the equal application of this policy.
- **People living in rural areas**: It is the intention and aim of this policy that it shall be applied equally according to best practice and not discriminate unfairly based on location.

**Other**: This organisation recognises that some members of society generally have difficulty accessing health, social care and other support services such as people who are homeless, prisoners or street workers. As a result there may be further cultural, ethnic and religious variations as a result of this which may affect the equality of impact of the policy.

### Part 3: Conclusion

**B – A negative impact is possible:**

The policy has the clear potential to have a positive impact by on the safety and protection of vulnerable children. However, whilst every effort will be made to reduce any negative impact, this organisation recognises that there are a number of internal and external influences on which affect the views of individuals and groups which may impact on the equality of impact of this policy on various groups in society.

### Part 4: Next Steps

**Action Plan:**

To review the operation of the policy as per SCH protocol to ensure there are no changes in its impact.
<table>
<thead>
<tr>
<th>Part 5: For the Record</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name and Title of people who carried out the EIA: Sarah Miller, Practice and Service Development Nurse</td>
</tr>
<tr>
<td>Name of Director who signed EIA: Pamela Chappell</td>
</tr>
<tr>
<td>Date EIA completed: 7/11/14</td>
</tr>
<tr>
<td>Signature of Director: Pamela Chappell</td>
</tr>
<tr>
<td>Date EIA signed: 2511/14</td>
</tr>
</tbody>
</table>