Safeguarding Children Policy

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Summary of Changes			
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SUMMARY POINTS
• The Wentworth Clinic has a duty outlined in legislation to make arrangements to safeguard and promote the welfare of children and young people, and to co-operate with other agencies to protect individual children and young people from harm
• The purpose of this document is to support staff to follow a consistent approach, when there are concerns about the welfare of a child, unborn baby or a presenting adult who is a carer for a child
• A child to be has no legal status; therefore in law the needs of the pregnant woman over-ride that of the child to be.
• To provide clear expectations of staff responsibilities and guidance for mandatory training and supervision

Introduction

The Wentworth Clinic recognises its responsibilities and is committed to safeguarding and promoting the welfare of all Children and Young People (thereafter referred to as a child or children).

This policy is relevant to all staff and because Safeguarding Children is everyone's responsibility.

The Wentworth Clinic complies with its statutory responsibilities as laid out in legislation, which includes the Children Act 1989, the Children Act 2004, Social Work Act 2017 and Working Together to Safeguard Children 2018. The protection of children from harm and promoting their welfare depends on shared responsibility and effective joint working between agencies.

2. Purpose

The purpose of this document is to:

- Provide staff with comprehensive definition and explanation, however, to:
- Support all staff to follow a simple, but consistent approach within the Wentworth Clinic, when there are concerns about the welfare of a child, unborn baby or a presenting adult who is a carer for a child
- To provide clear expectations of staff responsibilities, guidance for mandatory training and for safeguarding supervision

A child to be has no legal status; therefore in law the needs of the pregnant woman over-ride that of the child to be.

3. Definitions

Safeguarding and promoting the welfare of children is defined as:

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

3.1 Definition of a Child

For the purpose of this document, the term 'child' refers to all Children and Young People who have not yet reached their 18th Birthday. If a child has reached 16 years of age, is living independently, is in further education, a member of the armed forces, is in hospital, or in custody or in a youth offenders institute, this does not change their status or entitlement to services or protection under the Children's Act.

3.2 Parental Responsibility

Parental responsibility is a legal concept that consists of the rights, duties, powers, responsibilities and authority that parents have in respect of their children including the right to give consent to medical treatment.

A mother automatically has parental responsibility for her baby from birth and the father usually has parental responsibility if he is either married to the baby's mother or listed on the birth certificate**.**

If the parents of a baby are married when the baby is born, or if they have jointly adopted a baby, both have parental responsibility and both keep parental responsibility if they later divorce.
An unmarried father can get parental responsibility for his baby by either; jointly registering the birth of the baby with the mother, through a parental responsibility agreement with the mother or through a parental responsibility order from a court.

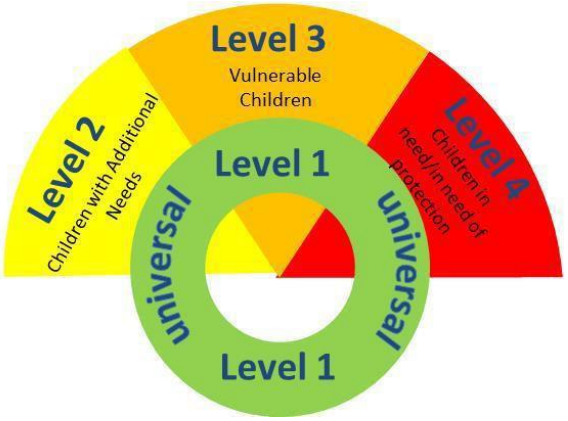
Parental responsibility may be temporary when associated with a residence order, guardianship, emergency protection order or care order.

Same-sex partners will both have parental responsibility if they were civil partners at the time of the treatment, for example donor insemination or fertility treatment.

For same-sex partners who are not civil partners, the 2nd parent can get parental responsibility by either; applying for parental responsibility if a parental agreement was made or becoming a civil partner of the other parent and making a parental responsibility agreement or jointly registering the birth.

3.3 Continuum of Levels of Need

The diagram below shows the levels of need (Level 1 Universal supports all children which is why the green ring continues while need increases)



- Level 1 Universal Service. All children will receive Universal Services, including as need increases
- Level 2 Universal Plus Services. Children/families who have additional needs
- Level 3 Partnership Plus Services. Children and families who are vulnerable and need a multi-agency response
- Level 4 Specialist/Statutory Services. Children and families with the highest levels of complex need, including those at risk of significant harm Child Protection and Children in Need

3.4 Early Help

The concept of Early Help is outlined in Working Together to Safeguard Children (2018); 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. Providing Early Help is more effective in promoting the welfare of children than reacting later. This requires all professionals, including those in universal services and those providing services to adults with children, to understand their role in identifying emerging problems and to share information with other professionals to support early identification and assessment.

3.5 Child in Need (CiN)

A child in need is defined under the Children Act 1989 as '*a child who is unlikely to achieve or maintain a satisfactory level of health or development, or their health and development will be significantly impaired, without the provision of services; or a child who is disabled'*. In these cases, assessments by a social worker are carried out under section 17 of the Children Act 1989.

3.6 Child Protection

This refers to the activity that is undertaken to protect specific children who are suffering, or are likely to suffer, significant harm under section 47 of the Children Act 1989 and there may or may not be a child protection plan in place. The Children Act 1989 introduced the concept of 'significant harm', this threshold justifies compulsory intervention into family life in the best interests of children, and gives local authorities a duty to make enquires.

3.7 Looked after Children (LAC) are children in respect of whom a compulsory care orders or other court order has been made under Section 31a of the Children Act 1989. This also refers to children accommodated voluntarily, including under an agreed series of short-term placements, which may be called 'short breaks', 'family link placements' or' respite care' under Section 20 of the Children Act 1989.

3.8 Child Abuse Categories (Children Act 2004)

These definitions are used when determining significant harm and children can be affected by combinations of maltreatment and abuse, which can be impacted on by for example domestic violence and abuse in the household or a cluster of problems faced by the adults.

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. Neglect may occur during pregnancy as a result of maternal substance misuse, maternal mental ill health or learning difficulties/ disabilities or a cluster of such issues. Where there is domestic abuse and violence towards a carer, the needs of the child may be neglected.

Once a child is born, neglect may involve a parent 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.

Neglect may also include neglect of, or unresponsiveness to, a child's basic emotional, social and educational needs.

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

Emotional abuse Emotional abuse is the persistent emotional maltreatment of a child such as to cause severe and persistent effects on the child's emotional development, and may involve:

- Conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person
- Imposing age or developmentally inappropriate expectations on children. These may include:
    - Interactions that are beyond the child's developmental capability
    - Overprotection and limitation of exploration and learning
    - Preventing a child participating in normal social interaction
    - Seeing or hearing the ill-treatment of another e.g. where there is domestic violence and abuse
    - Serious bullying, causing children frequently to feel frightened or in danger
    - Exploiting and corrupting children

Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.

Child Sexual Abuse (CSA)

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 (e.g. rape or oral sex)
- non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing
- non-contact activities, such as involving children in looking at, including online and with mobile phones, or in the production of, pornographic materials, watching sexual activities or 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.

Penetrative sex where one of the partners is under the age of 16 is illegal, although prosecution of similar age, consenting partners is not usual. However, under section 5 of the Sexual Offences Act (2003), the law considers that children under 13 cannot give their consent to any sexual activity therefore any penetration of the mouth, vagina or anus of a person under that age is automatically rape.

In some circumstances, for example a teacher/pupil relationship or other position of trust, it is unlawful

to have sex with someone under the age of 18.

3.9 Child Sexual Exploitation (CSE) and Criminal Exploitation (CE)

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

Criminal Exploitation (CE)
Child criminal exploitation describes any form of exploitation involving children, and occurs when an individual or a group takes advantage of an imbalance of power to coerce, control, manipulate or deceive a vulnerable person into criminal or sexual activity. Victims may be exploited even if the activity appears consensual. Criminal exploitation does not always involve physical contact, it can occur through the use of technology.
County lines is a term describing gangs and organised criminal networks who move drugs across areas, who are likely to exploit children and vulnerable adults into criminal behaviour. County lines is a major issue involving violence, gangs, safeguarding, criminal and sexual exploitation, modern slavery and missing persons, radicalisation and extremism, and requires a multi-agency response.
Some factors that heighten a child's vulnerability to exploitation include a history of neglect or abuse, drug or alcohol misuse, poor mental health, a physical or learning disability, social isolation and being in care. A young person may exhibit some of these signs if they are being exploited:

- Episodes of going missing/being found out of area
- Unexplained money, clothing, mobile phones
- Relationships with controlling individuals or gangs
- Unexplained injuries/suspicion of assault
- Carrying weapons
- Self-harm or significant changes in emotional well-being

3.10 Female Genital Mutilation (FGM)

FGM is a procedure where the female genital organs are injured or changed and there is no medical reason for this. It is frequently a very traumatic and violent act for the victim and can cause harm in many ways. The practice can cause severe pain and there may be immediate and/or long-term health consequences, including mental health problems, difficulties in childbirth, causing danger to the child and mother; and/or death.

Reporting FGM to police and/or social services in the event of risk to a child
If FGM is confirmed in a child under the age of 18, (on examination or if the patient or parent says it has been done), the clinician must refer this as a matter of urgency to the police.

If FGM is suspected (but not confirmed) or the child is at risk (but has not had FGM), the clinician must refer to social services or the police; the urgency of the referral depends on the degree of risk.

Pregnant women

- A member of the clinical team must make an individual risk assessment using an FGM safeguarding risk assessment tool and if the unborn child, or any other child in the family, is considered to be at risk of FGM then reporting to social services or the police must occur
- The clinician should document maternal history of FGM in the personal child health record ('Red Book')
- If the birth results in a baby girl, the clinician must notify the GP and health visitor

3.11 Domestic Abuse

The definition of domestic violence and abuse now includes young people aged 16 and 17 and aims to increase awareness that young people in this age group do experience domestic violence and abuse.

This is defined as 'any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse: Psychological; Physical; Sexual; Financial; Emotional'.

Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape, and regulating their everyday behaviour.

Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim. This definition includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

Where there is domestic violence and abuse, the well-being of the children in the household is paramount and must be promoted. All assessments must consider the need to safeguard the children (including unborn children).

4. Procedures/Document Content

4.1 What to do if you have Concerns (Appendix 1 for pathway)

If you have reasonable cause to suspect that a child or young person is suffering or likely to suffer significant harm or an unborn baby is likely to suffer harm once born, you have a duty to refer to Children's Social Care, under Section 11 of the Children Act 2004.

There will be some urgent situations where a telephone referral to Children's Social Care will be made in the first instance (or to gain advice or inform them of the referral). Children's Social Care has the duty to feedback to referrers within 24 hours regarding the action being taken. If feedback is not received, it is appropriate to make a request to the Children's Social Care requesting this information. The outcome of a referral might be:

- A Strategy Discussion
- Commencement of a child protection enquiry under section 47 of the Children Act 1989.This may involve keeping the child safe by placing them with other family members/ temporary foster carer while the enquiry takes place. An initial child protection conference may be held and the child may be subject to a child protection plan.
- Assessment and provision of services under section 17 of the Children Act 1989 – A Child in Need
- Not at threshold for social care intervention and no action and but referral to Early Help services or Universal Services of health visiting / children centres / school nursing / schools

4.2 Information Sharing

Information sharing is essential for effective safeguarding and promoting the welfare of children and young people. It is a key factor identified in many serious case reviews (SCRs), where poor information sharing has resulted in missed opportunities to take action that keeps children and young people safe.

The General Data Protection Regulation (GDPR) and the Data Protection Act 2018 introduced new elements to the data protection regime, superseding the Data Protection Act 1998. Practitioners must have due regard to the relevant data protection principles which allow them to share personal information. However, the GDPR and Data Protection Act 2018 do not prevent, or limit, the sharing of information for the purposes of keeping children and young people safe.

To effectively share information:

- All practitioners should be confident of the processing conditions, which allow them to store, and share the information that they need to carry out their safeguarding role. Information which is relevant to safeguarding will often be data which is considered 'special category personal data' meaning it is sensitive and personal
- Where practitioners need to share special category personal data, they should be aware that the Data Protection Act 2018 includes 'safeguarding of children and individuals at risk' as a condition that allows practitioners to share information without consent
- Information can be shared legally without consent if a practitioner is unable to, or cannot be reasonably expected to gain consent from the individual; or if to gain consent could place a child at risk
- Relevant personal information can be shared lawfully if it is to keep a child or individual at risk safe from neglect or physical, emotional or mental harm, or if it is protecting their physical, mental, or emotional well-being

4.3 Confidentiality and information sharing

If information sharing is to take place with the consent of the individuals involved, providing they are clearly informed about the purpose of the sharing, there should be no breach of confidentiality or breach of the Human Rights Act 1998. If the information is confidential, and the consent of the information subject is not gained, then practitioners need to decide whether there are grounds to share the information without consent. This can be because it is overwhelmingly in the information subject's interests for this information to be disclosed. It is also possible that a public interest would justify disclosure of the information (or that sharing is required by a court order, other legal obligation or statutory exemption).

In the context of safeguarding a child or young person, where the child's welfare is paramount, it is possible that the common law duty of confidence can be over overcome. Practitioners must consider this on a case-by-case basis. As is the case for all information processing, initial thought needs to be given as to whether the objective can be achieved by limiting the amount of information shared and if all of the personal information needs to be shared to achieve the objective.

4.4 Consent and Children

Clinicians must involve children and young people as much as possible in discussions about their care, even if they are not able to make decisions on their own. A young person's ability to make decisions depends more on their ability to understand and weigh up options, rather than on their age. When assessing a young person's capacity to make decisions, clinicians should bear in mind that a young person under 16 may have capacity to make decisions, depending on their maturity and ability to understand what is involved. At 16 a young person can be presumed to have capacity to make most decisions about their treatment and care (Mental Capacity Act 2005).

Confidentiality statement for children

You have the right to confidentiality, which means anything you say should not be passed on to anyone else. However, in exceptional circumstances, to protect you or someone else from serious harm the practitioner has a duty to share the information. You would normally be told about any decisions made to share your information

A useful guidance making decisions 0-18 years (GMC 2013), gives guidance on involving children and young people in decisions, assessing capacity and best interests, and what to do if they refuse treatment. It also explains the different legal requirements across the UK for decision-making involving children and young people.

4.5 Chaperones

Whilst it is accepted that a child (under the age of 16) must be seen in the presence of a parent/carers/appropriate adult it is recognised that in some circumstances it may be necessary to see a child without a parent /carer present. This maybe in the case of a safeguarding concern or in an emergency.

The child and their parents/carer must receive an appropriate explanation of the procedure in order to obtain their informed consent to examination

The child being prepared for transition to adult services maybe seen without their parents/carers, but must be examined in the presence of a chaperone.

4.6 Voice of the Child

Children generally want to:

- be respected
- have their views heard
- have stable relationships with clinicians built on trust
- have consistent support provided for their individual needs. This should guide the behaviour of clinicians

This involves:

- Listening to the child's wishes and feelings -using observations alongside what the child says about their situation now as well as plans and hopes for the future
- Providing children with honest and accurate information about the current situation, as seen by clinicians, and future possible actions and interventions

- Involving the child in key decision-making processes
- Providing appropriate information to the child about his or her right to protection and assistance
- Inviting children to make recommendations about the services and assistance they need and/or are available to them
- Ensuring children have access to independent advice and support (for example, through advocates or children's rights officers) to be able to express their views and influence decision-making
- Considering with them issues arising in relation to identity, diversity, culture, faith, sexual orientation, language, disability, low confidence and trust.

4.7 Bruising, Burns and Injuries in Non Mobile Children

Bruising in a baby who has no independent mobility is very uncommon and may be an indicator of a serious medical condition or physical abuse; infant deaths from non-accidental injuries often have a history of minor injuries prior to hospital admission. The pattern, number and distribution of accidental bruising in non-abused children are different to that in those who have been abused. Accidental bruises are more commonly found over bony prominences and on the front of the body but rarely on the back, buttocks, abdomen, upper limbs or soft-tissue areas such as cheeks, around the eyes, ears, palms or soles of the feet.

Patterns of bruising suggestive of physical child abuse include:

- Bruising or injuries in children who are not independently mobile
- Bruising or injuries in babies
- Bruises that are away from bony prominences
- Bruises to the face, back, abdomen, arms, buttocks, ears or hands
- Multiple or clustered bruising
- Imprinting and petechial
- Symmetrical bruising

A bruise must never be interpreted in isolation and must always be assessed in the context of medical and social history, developmental stage and explanation given. A full clinical examination and relevant investigations must be undertaken by a suitably qualified Paediatrician.

While professional judgement and responsibility have to be exercised at all times, professionals should refer all children with bruising or injuries who are not independently mobile to Children's Social Care.

4.8 Disabled Children and Children with a Learning Disability

Disabled children are recognised as the most vulnerable group in respect of safeguarding their well-being, and any child with a disability is by definition a 'child in need'. Disabled children may be especially vulnerable to abuse for a number of reasons:

- Many disabled children are at an increased likelihood of being socially isolated with fewer outside contacts than non-disabled children
- Their dependency on parents and carers for practical assistance in daily living, including intimate personal care, increases their risk of exposure to abusive behaviour
- They have an impaired capacity to resist or avoid abuse
- They may have speech, language and communication needs which may make it difficult to tell others what is happening
- They often do not have access to someone they can trust to disclose that they have been abused

Safeguards for disabled children are essentially the same as for non-disabled children. Particular attention should be paid to promoting a high level of awareness of the risks of harm and high standards

of practice, and strengthening the capacity of children and families to help themselves. Measures should include:

- Making it common practice to help disabled children make their wishes and feelings known in respect of their care and treatment
- Ensuring that disabled children receive appropriate personal, health, and social education (including sex education)
- Making sure that all disabled children know how to raise concerns, and giving them access to a range of adults with whom they can communicate. Those disabled children with communication impairments should have available to them at all times a means of being heard
- An explicit commitment to, and understanding of disabled children's safety
- Welfare among providers of services used by disabled children
- Close contact with families, and a culture of openness

Where a disabled child has communication impairments or learning disabilities, special attention should be paid to communication needs, and to ascertain the child's perception of events, and their wishes and feelings.

Where there are concerns about the welfare of a disabled child, they should be acted upon in accordance with the referral pathway (Appendix 1) and in the same way as with any other child.

Young people with learning disabilities are vulnerable to criminal and sexual exploitation due to factors that include overprotection, social isolation and society refusing to view them as sexual beings. A lack of awareness of the sexual exploitation of young people with learning disabilities among professionals also contributes to their vulnerability.

4.9 Children who Self-Harm

Self-harm is defined as an act with a non-fatal outcome in which an individual deliberately did one or more of the following:

- Initiated behaviour (e.g. self-cutting, jumping from a height) which they intended to cause self-harm
- Ingested a substance in excess of the prescribed or generally recommended therapeutic dose
- Ingested a recreational or illicit drug that was an act the person regarded as self-harm
- Ingested a non-ingestible substance or object.

Self-cutting and overdose are the commonest methods. Self-harm is a common precursor to suicide and children and young people who deliberately self-harm may kill themselves by accident or intentionally.

4.10 Management Fabricated or Induced illness

Fabricated or Induced Illness by carers can cause significant harm to children and involves a well child being presented by a carer as ill or disabled, or an ill or disabled child being presented with a more significant problem than he or she has in reality, and suffering harm as a consequence. In severe cases, some of the behaviours by a carer that may result in harm include:

- Deliberately inducing symptoms by administering medication or other substances (this includes non-accidental poisoning), or by intentional suffocation
- Interfering with treatments by over-dosing, not administering medication, or interfering with medical equipment such as infusion lines
- Claiming the child has symptoms which are unverifiable unless observed directly, such as pain, frequent passing of urine, vomiting, or fits, resulting in unnecessary investigations and treatments
- Exaggerating symptoms, again resulting in unnecessary investigations and treatments

- Falsifying test results and observation charts
- Obtaining specialist treatments or equipment for children which are not required
- Alleging unfounded psychological illness in a child

Whether the carer is deliberately fabricating a child's illness, genuinely believes the child to be ill or is unduly anxious, the harm caused to the child can be significant and may include:

- Frequent and invasive medical investigations
- Unnecessary treatments
- Missed education and social isolation
- Limitation in daily life and the adoption of a sick role or lifestyle as a disabled person
- Characterisation as being disabled, through the receipt of disability benefits or special educational provision
- The child becoming anxious or confused about their state of health and abilities.

Where appropriate, it is important to give the child with suspected fabricated or induced Illness, an opportunity to describe what has happened.

4.11 Honour Based Violence

Honour based violence is a violent crime or incident which may have been committed to protect or defend the honour of a family or community. It is often linked to family members or acquaintances who mistakenly believe someone has brought shame to their family or community by doing something that is not in keeping with the traditional beliefs of their culture.

4.12 Responding to Disclosure what to do if a child talks about or discloses abuse (see Appendix 1 for pathway)

Clinicians should:

- Make the child aware of the confidentiality statement for children (see below)
- Recognise possible signs of maltreatment
- Receive the information from the child
- Listen carefully asking only 'open' questions
- Respond to the child
- Let them know what you are going to do next
- Report the disclosure as soon as possible to your manager or named professional (follow the pathway)
- Refer to Children's Social Care without delay
- Record the disclosure accurately and on the same day

Confidentiality statement for children

You have the right to confidentiality, which means anything you say should not be passed on to anyone else. However, in exceptional circumstances, to protect you or someone else from serious harm the practitioner has a duty to share the information. You would normally be told about any decisions made to share your information

4.13 Safe recruitment of staff

All staff, volunteers and contracted staff must receive the appropriate level of checks following the requirements laid out in the Safeguarding Vulnerable Groups Act 2006 and the Protection of Freedoms Act 2012. The implementation of the Protection of Freedoms Act 2012 has led to the establishment of the Disclosure and Barring Service (DBS).

4.14 Allegations against staff

Local Authorities have an assigned Local Authority Designated Officer (LADO) who receives reports and allegations and provides advice and guidance to multi-agency partners.

All allegations of abuse of children by those who work with children must be taken seriously. This includes an allegation or concern that a person who works with children:

- has behaved in a way that has harmed a child
- may have harmed a child
- may possibly committed a criminal offence against or related to a child

If the concerns arise about the person's behaviour to her/his own children, the police and/or the LADO must consider informing the employer in order to assess whether there may be implications for children with whom the person has contact at work.

Any concerns or behaviour witnessed by clinic staff, must be reported.

4.15 Escalating concerns (Appendix 1)

Any member of staff with a concern should in the first instance speak to Professor Ilankovan, or Mrs Ilankovan, or contact the appropriate official listed.

5.0 Roles and Responsibilities

The Children Act 1989, Section 11 of the Children Act 2004, Social Work Act 2017 and Statutory guidance Working Together 2018 places a duty to make arrangements for ensuring that the functions and services provided on their behalf are discharged with regard to the need to safeguard and promote the welfare of children and young people.

5.1 Professor Ilankovan is responsible for ensuring that the clinic safeguarding systems and processes are in place and that there is a clear policy

5.2 All Staff must:

- Follow the guidance and procedures set out in this policy
- Be trained to the appropriate level of safeguarding children aligned to their role
- Ensure that significant safeguarding incidents are brought to the attention of the Director of Nursing as the Executive Lead for Safeguarding Children

6. Safeguarding Children Mandatory Training

All staff that are exposed to children and young people have a responsibility to safeguard and promote their welfare and should know what to do if they have concerns about safeguarding issues, including child protection. This responsibility also applies to staff working primarily with adults who have dependent children that may be at risk because of their parent/carer's health or behaviour. To fulfil these responsibilities, there is a duty to ensure that all staff have access to appropriate safeguarding training, learning opportunities, and support to facilitate their understanding of the clinical aspects of child welfare and information sharing.

Different staff groups require different levels of competence depending on their role and degree of contact with children, young people and families, the nature of their work, and their level of responsibility.

Safeguarding Children is mandatory and all staff need to complete the training every 3 years appropriate to their role:

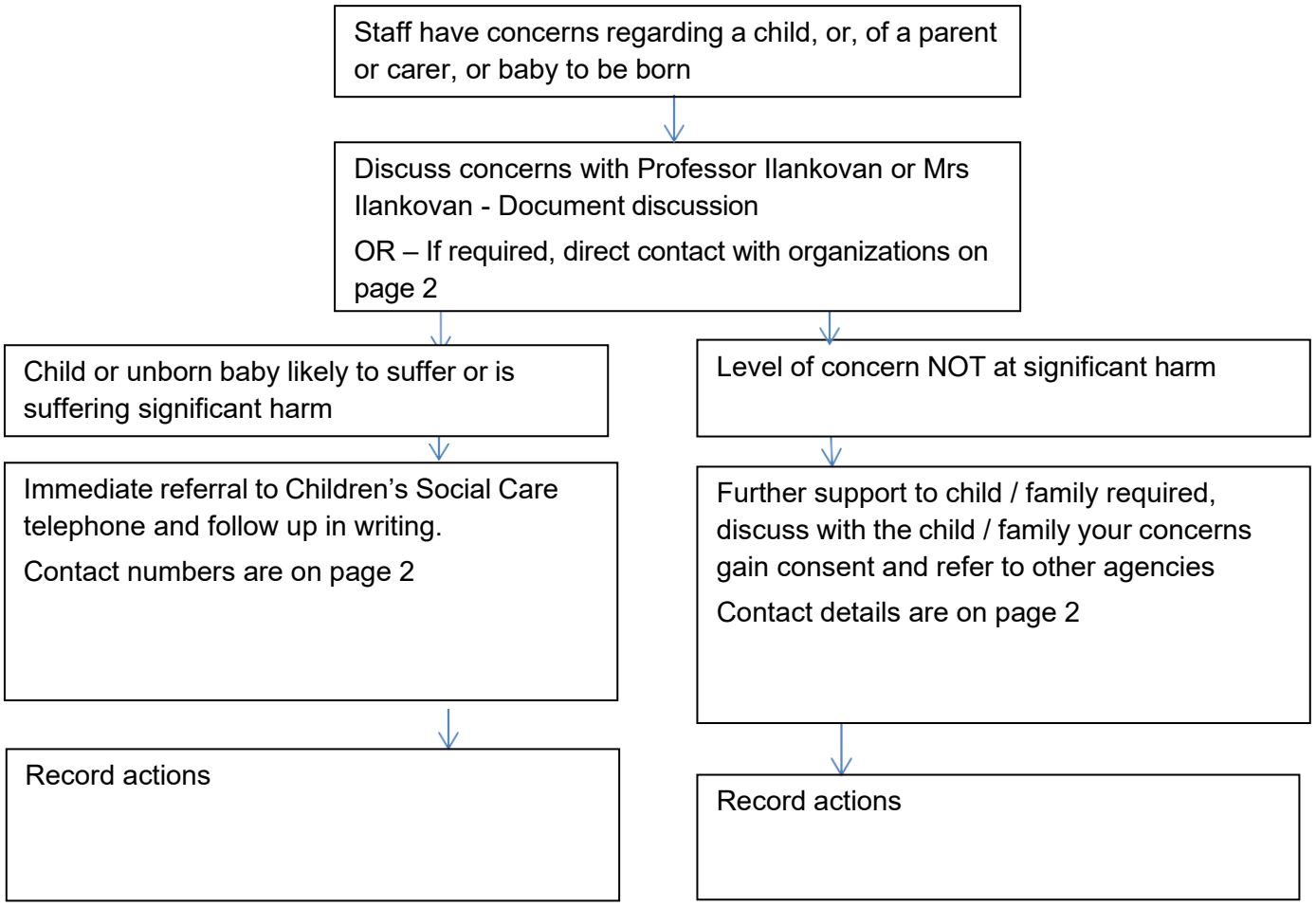
- **Level 1**: All staff including non-clinical managers and staff working in health care settings
- **Level 2**: Minimum level required for non-clinical and clinical staff who have some degree of contact with children and young people and/or parents/carers
- **Level 3**: Clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns
- **Level 4**: Named professionals specialist training

7. Review

This policy will be reviewed 2 yearly or earlier in response to National Statutory guidance or Pan Dorset multi-agency procedural changes.

Appendix 1

What to do if you have Concerns and Referral Pathway



Children's Social Services have a duty to feedback to referrers within 24 hours regarding the action being taken. If this is not received then it is appropriate to make a request to Children's Social Services re: outcome of referral.

BCP Council Contact Details:

If you're worried about the wellbeing of a child, want to report abuse or aren't sure what to do please get in touch.

Children's First Response Hub

The Children's Service First Response Hub provides the public and professionals with advice, information and support for children who are vulnerable and at risk.

Children's First Response Hub can help if you:

- are worried about a child or young person who is at risk of (or is being) hurt or abused
- know of a child or young person who may be vulnerable without additional help and support
- want to know more about services to support children, young people and their families
- need support to agree an Early Help offer.

If you're concerned, but not sure a child is at risk

Discuss the circumstances with us or with someone else who works with children, such as a teacher or health visitor. All professionals who work with children have a responsibility to safeguard them and will know how to help.

Contact Children's First Response Hub

If you're a member of the public please telephone or e-mail the team.

- 01202 123 334
- childrensfirstresponse@bcpcouncil.gov.uk

First Response Hub opening hours:

- Monday to Thursday, 8:30am to 5:15pm
- Friday, 8.30am to 4.45pm

Urgent help out of hours

The out of hours service offer emergency support for any child who is in crisis, needs urgent help or is at serious risk of significant harm.

- 0300 123 9895

In an emergency, or if you believe a child is at immediate danger or risk of harm, call the police on 999.

Dorset Council Contact Details:

If you're worried about the safety or wellbeing of a child or young person who lives in Dorset contact our Children's Advice and Duty Service (ChAD):

Children's Advice and Duty Service (ChAD)

- Name: Single point of contact for safeguarding concerns
  Tel: 01305 228866

Children's Advice and Duty Service (ChAD) for professionals

- Name: Single point of contact for professionals for safeguarding concerns
  Tel: 01305228558

Appendix 2

Safeguarding Children Guidance Notes

These notes are complementary to the Pan Dorset Interagency Child Protection Procedures and social care threshold documents and relate to persons under 18 who are protected by the Children Act 1989/2004, other legislation and Working Together to Safeguard Children 2018. In all cases ask yourself "How can I be sure that it is safe to send this child home"? The possible indicators for risk of harm cannot be taken in isolation from the family as a whole. Every risk assessment should be child centred. Where there is a conflict between the needs of the child and the needs of the parent/carer, the decisions should be made in the child's best interests.

Orange Risk Criteria for HV/SN Liaison (Early Help)	Red Risk Criteria Referral to Social Care + HV/SN & GP (In need/In need of protection)
Mobile child <1 with head injury	Non mobile child – any injury including oral/nasal bleeding, burn, fracture or bruising (Think disability)
Mobile child <5 with burn or scald	Significant injury or life threatening event
All accidental /potential ingestion's of medicines or other substances	Unusual mechanism or inconsistent history
Dog Bite >2	Dog bite < 2
Home safety/ accident prevention	Unreasonable delay in presenting
<18 drug or alcohol misuse (refer to young alcohol service)	Disclosed/alleged/Potential NAI/abuse or significant neglect
All Assaults/bullying/anger management	Self harm/mental heath/ deliberate overdose/ reckless behaviour. (Complete sSERAF) Admit < 16 and refer to CAMHS
Teenage pregnancy (complete sSeraf)(+midwife)	Child sexual exploitation (CSE) risk/ sexual activity/ Pregnancy in under 13`s – complete sSERAF
Concerns about parenting/caring eg:– "low level neglect", significant obesity, underweight, poor dentition, parent/child interaction	Any FGM < 18 (refer child if FGM identified in mother)
< 16 Attending on own	Carers under 18
Unimmunised/incompletely immunised	
	Domestic abuse/ forced marriage /honour based violence
	Parent or carer with alcohol/drug misuse/ mental health/ DSH/OD
	Unborn baby with risk of harm factors in parents (+midwife)
	Child has a social worker/ Looked after Child (LAC) / Child on CP plan
Other:	

No specific risk of harm identified – Routine discharge