

Freedom of Information Act 2000 disclosure log entry

Reference

Gender Specific Trauma Support

Date sent

09/05/2019

Subject

18-19384

Details of enquiry

Please provide information and responses to the following requests:

1. Gender specific and trauma-informed support

- a. The Trust's policy(ies) on ensuring compliance with equality duties with regards to including the specific needs of female patients in the service planning and commissioning process;
- b. The Trust's policy on working with female patients in a gender-specific and/or trauma-informed way;
- c. The Trust's policy on offering a choice of a female primary or allocated nurse or keyworker to female inpatients;
- d. The Trust's policy on offering a choice of a female care coordinator to female patients in the community;
- e. The Trust's policy on offering female patients a choice of being treated in women-only mental health services.

For each question please complete the following:

- Provide a copy of the relevant policy;
- Specify whether this information is available online, and provide a link to the online copy where this is the case;
- Specify how staff and patients are able to access the relevant policy, and any steps taken by the Trust to ensure they are able to access it.

Please respond to each question* with respect to:

- i) Adult Mental Health Services
 - (1) Community;
 - (2) Inpatient services.

- ii) CAMHS**:
 - (1) Community;
 - (2) Inpatient services.

2. Patients histories of abuse: policies

- a. Your policy on routine enquiry about domestic violence and/or sexual abuse for patients in mental health services.
- b. Your policy on training and supporting staff to perform routine enquiry about domestic violence and sexual abuse;
- c. Your policy for providing follow-up support where patients disclose previous or ongoing domestic violence and sexual abuse while in inpatient or community mental health services;

For each question please complete the following:

- Provide a copy of the relevant policy;
- Specify whether this information is available online;
- Specify how staff and patients are able to access the relevant policy, and any steps taken by the Trust to ensure they are able to access it.

Please respond to each question* with respect to:

- i) Adult Mental Health Services
 - (1) Community;
 - (2) Inpatient services.
- ii) CAMHS**:
 - (1) Community;
 - (2) Inpatient services.

3. Patients histories of abuse: practice and recording

For the financial year 2017-18, please provide details of the following. If this information is not collected for the financial year please provide for the latest 12 month period.

- a. Total numbers of patients seen across all services.
- b. Total numbers of patients asked about domestic violence and/or sexual abuse, by gender.
- c. Total numbers of patients flagged as having reported incidents of domestic violence and/or sexual abuse.

Please respond to each question with respect to:

- i) Adult Mental Health Services
 - (1) Community;
 - (2) Inpatient services.
- ii) CAMHS**:
 - (1) Community;
 - (2) Inpatient services.

Response Sent

Please provide information and responses to the following requests:

4. Gender specific and trauma-informed support

- i. **We do not provide gender-specific services and adapt our approach to the individual needs of each client.**

- ii. We do not have gender specific trauma support policies and do not allocate clinicians by gender according to the gender of the patient.
 - iii. In relation to trauma, we treat patients who present with histories of trauma using a traditional psychodynamic approach within our generic psychotherapy service.
 - iv. We have a specialist trauma unit within adult complex needs, which provides a range of interventions including psychodynamic psychotherapy, EMDR, yoga and art therapy.
-
- f. The Trust's policy(ies) on ensuring compliance with equality duties with regards to including the specific needs of female patients in the service planning and commissioning process
[See response under 1. above](#)
 - g. The Trust's policy on working with female patients in a gender-specific and/or trauma-informed way;
[See response under 1. above](#)
 - h. The Trust's policy on offering a choice of a female primary or allocated nurse or keyworker to female inpatients;
[Not applicable: The Trust provides outpatient psychotherapy services via day clinics only, and we do not treat inpatients.](#)

outpatient only
 - i. The Trust's policy on offering a choice of a female care coordinator to female patients in the community;
[See response under 1. above](#)
 - j. The Trust's policy on offering female patients a choice of being treated in women-only mental health services.
[See response under 1. Above, however if a request was made for a female worker, we would take all reasonable steps to ensure that this could be provided.](#)
5. Patients histories of abuse: policies
- d. Your policy on routine enquiry about domestic violence and/or sexual abuse for patients in mental health services.
[We do not have a specific policy relating to routine enquiry regarding these factors:](#)
[CYAF: Our Safeguarding and risk assessments contain specific questions on the risk to a child of being exposed to domestic violence and/or sexual abuse. The completion of these forms is required for all patients. Our Safeguarding policy requires clinical staff to make appropriate enquiries when there are concerns](#)
[Adults Our psychotherapy service provides a therapeutic environment in which the client would feel able to discuss these, if needed.](#)
 - e. Your policy on training and supporting staff to perform routine enquiry about domestic violence and sexual abuse
 - i. [Staff receive training at induction and then safeguarding level 3 training every 3 years](#)
 - ii. [Staff training in understanding trauma and abuse generally forms part of any](#)
 - iii. [psychotherapy training](#)

- f. Your policy for providing follow-up support where patients disclose previous or ongoing domestic violence and sexual abuse while in inpatient or community mental health services;
The Trust provides outpatient psychotherapy services via day clinics only, and we do not offer inpatient services.

Please see our attached safeguarding policy, as we do not have a specific policy regarding this. We would offer support within the framework of the clinical setting we provide, and would, in principle, also liaise with other agencies if indicated.

6. Patients histories of abuse: practice and recording

For the financial year 2017-18, please provide details of the following. If this information is not collected for the financial year please provide for the latest 12 month period.

- d. Total numbers of patients seen across all services.
3221 clients see across all services
- e. Total numbers of patients asked about domestic violence and/or sexual abuse, by gender.
We do not routinely record this information via a callable field within our electronic files and to manually extract this data would involve manual opening, reading, extraction and collation of data which would require resources beyond the scope of the FOI Act 2000, and for this reason we are unable to supply this data.
- f. Total numbers of patients flagged as having reported incidents of domestic violence and/or sexual abuse.
Please refer to our response to the above question, 3b.

Safeguarding of Adults at Risk Policy and Procedure

Version:	3.2
Bodies consulted:	-
Approved by:	EMT
Date Approved:	12.1.16
Lead Manager:	Adult Safeguarding Lead
Responsible Director:	Medical Director
Date issued:	Jan 16
Review date:	Dec 17



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Safeguarding of Adults at Risk Policy and Procedure

1 Introduction

It is the responsibility of every NHS funded organisation and each individual healthcare professional working in the NHS to ensure that the principles and duties of safeguarding adults are holistically, consistently and conscientiously applied, with the well-being of those adults and children at the heart of what we do.

Safeguarding adults from harm is a core duty of the Trust. By the nature of services provided within the Trust, it is likely that staff will have contact with adults who are at risk of safeguarding concerns. This Policy provides guidance for staff to ensure that the principles of safeguarding adults are embedded in all aspects of Trust practice.

Safeguarding Adults is about preventing and responding to concerns of abuse, harm or neglect of adults. Professionals should work together in partnership with people so that they are:

- The aims of Adult Safeguarding are to:
- Stop abuse or neglect wherever possible;
- Prevent harm and reduce the risk of abuse or neglect to adults with care and support needs;
- Safeguard adults in a way that supports them in making choices and having control about how they want to live;
- Promote an approach that concentrates on improving life for the adult concerned;
- Raise public awareness so that communities as a whole, alongside professionals, play their part in preventing, identifying and responding to abuse and neglect;
- Provide information and support in accessible ways to help people understand the different types of abuse, how to stay safe and what to do to raise a concern about the safety or well-being of an adult; and
- Address what has caused the abuse.

This policy and procedure aims to provide a co-ordinated approach to the management of any reported instances or suspicion of abuse against adults at risk while in the care of the Trust staff.

Adult safeguarding responsibilities fall within the six safeguarding principles:

1. Empowerment - People being supported and encouraged to make their own decisions and informed consent.
2. Prevention - It is better to take action before harm occurs.

3. Proportionality - The least intrusive response appropriate to the risk presented.
4. Protection - Support and representation for those in greatest need.
5. Partnership - Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
6. Accountability - Accountability and transparency in safeguarding practice.

All actions taken should fit within these principles.

What is a safeguarding adults concern?

A safeguarding adults concern is any worry about an adult who has or appears to have care and support needs, and may be subject to, or is at risk of abuse and neglect, and unable to protect themselves.

Abuse may be:

- A single act or repeated act
- An act of neglect or a failure to act

A detailed description of the kinds of abuse faced by adults can be found in Appendix B

2 Purpose

The main aim of this policy is:

- To ensure that all staff working within the Trust know and understand their responsibilities in working together to safeguard adults at risk.
- To ensure that all staff are able to identify both an adult at risk and situations where actual or potential harm or abuse to adults at risk may occur.
- To ensure that all staff know how to respond to such concerns and know where to seek appropriate advice or support.
- To ensure that all staff know how to raise an alert regarding a concern in relation to an adult at risk.
- To ensure that staff are aware of how to make a safeguarding adults alert
- all decisions and actions are taken in line with the Mental Capacity Act (2005) and the Care Act (2014)
- In addition the Trust will adhere to guiding principles laid down in: "No Secrets" DoH 2000, the Disability and Discrimination Act 2005 and the Care Act (2014).
- This policy and procedure is intended for use by all Trust staff who have contact with adult patients. This includes adults who are seen as part of work with child patients.

3. Definitions

The following definitions apply in the policy and procedure

Term	Definition
Adult at Risk	An adult aged 18 years or over is a person “who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of themselves or unable to protect themselves against significant harm or exploitation” (No Secrets DH 2000).
Safeguarding	Protecting an adult’s right to live in safety, free from abuse and neglect (Care Act, statutory guidance chapter 14)
Abuse	<p>Abuse is defined as: ‘a violation of an individual’s human and civil rights by any other person or persons ‘Abuse may be physical, psychological, sexual, neglect or acts of omission. It may involve people taking money without permission, or not looking after someone properly.</p> <p>It may include poor care practices, bullying or humiliating, or not allowing contact with friends and family. Abuse often involves criminal acts. Abuse can be a single act or may continue over a long period. It can be unintentional or deliberate, but will result in harm to the victim, either physically, emotionally or in its effect on the person’s wellbeing or development.</p> <p>Categories, patterns and signs of abuse are listed at Appendix B</p>
Indicators of Abuse	The abuse, unnecessary harm or distress can be physical, sexual, psychological, and financial or as the result of neglect (See Appendix B for further details). It may be intentional or unintentional and can be a single act, temporary or occur over a period of time.
Carers	The carer/s may be family members, NHS staff and paid carers and may be adults at risk themselves. (See Appendix B for further details)
Safeguarding Concern	A sign of suspected abuse or neglect that is reported to the local authority or identified by the local authority
Safeguarding Enquiry	The action taken or instigated by the local authority in response to a concern that abuse or neglect may be taking place
Investigator	An investigator is a person within the Trust who has had training to undertake internal investigations of reported cases of suspected abuse.

4 Roles and responsibilities

4.1 Chief Executive

The Chief Executive as accountable officer has overall responsibility for ensuring the implementation of effective safeguarding adults at risk procedures.

4.2 Medical Director

The Medical Director has day to day responsibility for ensuring that the Trust is operating within the procedures set out in this document. He will liaise specifically with the Lead Advisor for Adults at risk. He will provide the professional lead and expertise for the implementation of this procedure.

4.3 Adult Safeguarding Lead

The adult safeguarding lead will be a senior member of staff who has attended specialist training in the safeguarding of adults at risk. The lead will provide advice and training at trust and clinical induction and INSET and at other times as required, including advising the trust on the provision of level 1, 2 and 3 adult safeguarding training. The lead adviser will provide a quarterly update on Adult Safeguarding issues to the Patient Safety and Risk Work Stream Lead.

The lead advisor will act as the professional interface with other agencies, in conjunction with clinical staff, in the ongoing management of any cases where abuse is identified or suspected.

4.4 Care Co-ordinator

The care co-ordinator for any person who is suspected of being at risk of abuse will have the overall responsibility for the management of the individual case and will ensure that appropriate liaison with members of the team, both internal to and external to the trust take place.

4.5 All Clinical Staff

All staff have a duty to report suspected, alleged or actual harm or abuse involving an adult at risk. Staff should be aware of and follow Trust policy and local procedures.

Safeguarding adults at risk involves multi- agency working together to ensure that health and social care is appropriately co-ordinated and individuals are protected from potential or actual harm or abuse. Clinical staff and teams should maintain close and effective links with all relevant statutory and voluntary agencies to collectively ensure that adults at risk are safeguarded.

Clinical staff should ensure that potential or actual safeguarding adults concerns and issues are raised, discussed and recorded within regular clinical supervision and / or team case reviews.

5 What to do if you suspect an adult is at risk

This section outlines the actions to be taken if abuse of adults at risk is suspected or disclosed

5.1 Raising a concern

A concern should be raised with the local authority if a person

- a) Has care and support needs
and
- b) Is experiencing, or is at risk of, abuse or neglect
and
- c) As a result of their care and support needs is unable to protect themselves against the (risk of) abuse or neglect

Clinicians need to establish:

- Current level of risk and what immediate steps are needed to ensure safety.
- The individual's wishes and views about the safeguarding issue including their views regarding sharing information with other agencies i.e. the local authority or the police. Wherever possible safeguarding concerns should be raised with the consent of the patient.
- Whether the patient has mental capacity to make decisions regarding their own protection and to understand the safeguarding process.
- In the event that people lack the capacity to provide consent, action should be taken in line with the Mental Capacity Act 2005. Please refer to the MCA guidance.

5.2 Overriding the wishes of the adult at risk

In the majority of cases staff will follow the wishes of the patient regarding the sharing of information with others. However, where there is a potential risk to other adults at risk or to children and young people, the wishes of the individual may be overridden. Where the sharing of information to prevent harm is necessary consent can also be overridden.

5.3 Reporting to the local authority

Report your concern to the local authority without delay using the procedures set out by each borough. These will vary between boroughs.

A safeguarding enquiry (previously known as a safeguarding investigation) will be the responsibility of the local authority, except in situations when it is alleged that the abuse relates to care in the Trust.

5.4 Trust or Social Care Trust Staff Suspected of Abuse

If the suspected abuser is a member of Trust staff then consult the Trust policy on managing allegations against staff.

5.5 Reporting within the Trust

The clinician must inform the case-coordinator and service manager. In all cases the clinician should seek advice and discuss the case with the Medical Director, Lead Advisor or Associate Medical Director (Patient Safety and Risk).

Safeguarding concerns are reported using the adult safeguarding alert form that forms part of the clinical record. A form should be completed before the end of the session during which the disclosure took place or immediately afterwards whether substantiated or not.

5.6 Record keeping

Concerns should be fully documented in the health records by the first person to report the suspected abuse, and at all subsequent stages by those concerned in the investigation.

The care co-ordinator will monitor and record the ongoing care and wellbeing of the patient during any investigation and will ensure that all external professionals involved in the care of the patient are kept informed. The outcome of the safeguarding enquiry should be clearly documented in the patient record.

For guidance on assessing competency please refer to the Trust Consent Policy

5.7 Supporting Staff

The Trust recognises that involvement in any aspect of identification or reporting of suspected abuse of a vulnerable adult can be stressful for staff. It is therefore committed to supporting staff through the process of raising a safeguarding concern. Staff should raise concerns directly with the case co-ordinator, service manager or the named professionals.

Staff are advised at induction that the Trust provides a Staff Advisory Service which can be accessed by any member of staff, where a trained professional will offer one-to-one support.

The Trust has conducted a training needs analysis and details of training arrangements on adults at risk are contained in the Staff Training Procedure.

6 Training

All staff have a responsibility to undertake required Trust and /or aligned local authority safeguarding adults at risk training commensurate with their role.

The Trust has conducted a training needs analysis and details of training arrangements on adults at risk are contained in the Staff Training Procedure.

7 Process for monitoring compliance with this policy

The Trust will monitor compliance with this policy and procedure in the following way:

- The Staff Training and Development Committee will monitor uptake of adult safeguarding training as part of their continual monitoring of mandatory training and will report compliance of this to the Corporate Governance and Risk group of the CQSG. The group will refer training issues to the respective director for action as required;
- The Trust Safeguarding Lead will provide an annual report to the Patient Safety and Clinical Risk Lead of the CQSG who will provide assurance of compliance it to the Board via the CQSG. This report will address any externally imposed changes in relation to safeguarding adults' procedures. In addition they will highlight any issues that have arisen in respect of either safeguarding adults or the delivery and uptake of training in line with the requirements set out in the policy;
- The Lead Advisor will review any incidents relating to Safeguarding and report concerns/ investigations/ lessons learned to the Patient Safety and Clinical Risk Lead;
- The Safeguarding Lead will be responsible for adding any specific safeguarding adult risks to the Operational Risk Register as they arise and this Risk Register will be monitored through the Trust's Risk Management Procedures;
- The Named Professionals will undertake a spot check audit of cases with adult safeguarding concerns to ensure that the records show that all relevant procedures have been followed. If this audit raises concerns the named professional will make recommendations to the Patient Safety and Clinical Risk Lead and an action plan will be developed and followed. Any action plan will be monitored by the Patient Safety Sub group.

8 References

- DOH (2000). No secrets: guidance on developing and implementing multi-agency policies and procedures to protect adults at risk from abuse http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008486

- Department of Health. (2006). Tackling the Health and Mental Health Effects of Domestic and Sexual Violence and Abuse. London: Department of Health. Available at: www.dh.gov.uk
- Department of Health. (2005). Responding to Domestic Abuse: A Handbook for Health Professionals. London: Department of Health.
- Department of Health. (2004). The Government's Response to the Recommendations and Conclusions of the Health Select Committee's Inquiry into Elder Abuse. Available at: www.dh.gov.uk
- Guidance for completing the Safeguarding Adults Collection (SAC) 2015-16, HSCIE, available at http://www.hscic.gov.uk/media/16704/SAC-Guidance/pdf/SAC_guidance_1516_v1.0.pdf
- Social Care Act 2014. Available at: <http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted/data.htm>
- Mental Capacity Act 2005
- Incident Reporting Policy
- Safeguarding Children Policy
- Clinical Risk Assessment Procedure
- Consent Policy and procedure
- Staff training Policy

Appendix A: Equality Impact Assessment

1. Does this policy, function or service development impact on patients, staff, students and/or the public?

YES

2. Is there reason to believe that the policy, function or service development could have an adverse impact on a particular group or groups?

NO

*3. If you answered **YES** in section 5, how have you reached that conclusion? (Please refer to the information you collected e.g., relevant research and reports, local monitoring data, results of consultations exercises, demographic data, professional knowledge and experience)*

4. Based on the initial screening process, now rate the level of impact on equality groups of the policy, function or service development:

Positive impact:

High

(i.e. highly likely to promote, or clearly does promote equality of opportunity)

Date completed Jan 16

Name Rob Senior

Job Title Medical Director

9 Appendix B: What is abuse?

The Care Act statutory guidance (2014) details types of abuse as

- Physical abuse
- Sexual abuse
- Psychological abuse
- Financial or material abuse
- Modern slavery
- Discriminatory abuse
- Organisational abuse
- Neglect and acts of omission
- Domestic abuse
- Self-neglect

The statutory guidance identifies specific types of abuse, but also emphasises that organisations should not limit their view of what constitutes abuse or neglect, as they can take many forms and the circumstances of the individual case should always be considered.

Restraint - Unlawful or inappropriate use of restraint or physical interventions and/or deprivation of liberty is physical abuse. There is a distinction to be drawn between restraint, restriction and deprivation of liberty.

In extreme circumstances unlawful or inappropriate use of restraint may constitute a criminal offence. Someone is using restraint if they use force, or threaten to use force, to make someone do something they are resisting, or where a person's freedom of movement is restricted, whether they are resisting or not.

Restraint covers a wide range of actions. It includes the use of active or passive means to ensure that the person concerned does something, or does not do something they want to do, for example, the use of key pads to prevent people from going where they want from a closed environment.

Sexual exploitation - involves exploitative situations, contexts and relationships where adults at risk (or a third person or persons) receive 'something' (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of them performing, and/or another or others performing on them, sexual activities. An example could be an adult at risk, being provided with an incentive (alcohol, drugs or even a place to sleep and 'friendship') in exchange for providing sexual activity with a person/s. It affects men as well as women. People who are sexually exploited do not always perceive that they are being exploited.

Human trafficking - is actively being used by Serious and Organised Crime Groups to make considerable amounts of money. This problem has a global reach covering a wide number of countries. It is run like a business with the supply of people and services to a customer, all for the purpose of making a profit. Traffickers exploit the social, cultural or financial vulnerability of the

victim and place huge financial and ethical obligations on them. They control almost every aspect of the victim's life, with little regard for the victim's welfare and health.

The Organised Crime Groups will continue to be involved in the trafficking of people, whilst there is still a supply of victims, a demand for the services they provide and a lack of information and intelligence on the groups and their activities.

Hate Crime - The police define Hate Crime as "any incident that is perceived by the victim, or any other person, to be racist, homophobic, transphobic or due to a person's religion, belief, gender identity or disability". It should be noted that this definition is based on the perception of the victim or anyone else and is not reliant on evidence. In addition it includes incidents that do not constitute a criminal offence.

Disability Hate Crime - The Criminal Justice System defines a disability hate crime as any criminal offence, which is perceived, by the victim or any other person, to be motivated by hostility or prejudice based on a person's disability or perceived disability.

The Police monitor five strands of hate crime:

- Disability
- Race
- Religion
- Sexual orientation
- Transgender

Mate Crime - A 'mate crime' as defined by the Safety Net Project is "when vulnerable people are befriended by members of the community who go on to exploit and take advantage of them. It may not be an illegal act but still has a negative effect on the individual." Mate crime is often difficult for police to investigate, due to its sometimes ambiguous nature, but should be reported to the police who will make a decision about whether or not a criminal offence has been committed. Mate Crime is carried out by someone the adult knows and often happens in private. In recent years there have been a number of Serious Case Reviews relating to people with a learning disability who were murdered or seriously harmed by people who purported to be their friend.

Forced marriage - is a term used to describe a marriage in which one or both of the parties are married without their consent or against their will. A forced marriage differs from an arranged marriage, in which both parties consent to the assistance of a third party in identifying a spouse. In a situation where there is concern that an adult is being forced into a marriage they do not or cannot consent to, there will be an overlap between action taken under the forced marriage provisions, and the safeguarding adults process.

The Anti-social Behaviour, Crime and Policing Act 2014 makes it a criminal offence to force someone to marry. In addition, the Forced Marriage (Civil Protection) Act 2007 may be used to obtain a Forced Marriage Protection Order as a civil remedy. Registrars and registry staff need to be supported through relevant training to know the signs of possible forced marriage.

Honour-based violence is a crime, and referring to the police must always be considered. It has or may have been committed when families feel that dishonour has been brought to them. Women are predominantly (but not exclusively) the victims and the violence is often committed with a degree of collusion from family members and/or the community. Many of these victims will contact the police or other organisations. However, many others are so isolated and controlled that they are unable to seek help.

Adult safeguarding concerns that may indicate honour-based violence include domestic violence, concerns about forced marriage, enforced house arrest and missing person's reports. If an adult safeguarding concern is raised, and there is a suspicion that the adult is the victim of honour-based violence, referring to the police must always be considered as they have the necessary expertise to manage the risk.

Female genital mutilation (FGM) involves procedures that intentionally alter or injure female genital organs for non-medical reasons. The procedure has no health benefits for girls and women. The Female Genital Mutilation Act (2004) makes it illegal to practise FGM in the UK or to take girls who are British nationals or permanent residents of the UK abroad for FGM whether or not it is lawful in another country.

Domestic abuse (DA)

Around a quarter of safeguarding adults work relates to domestic abuse, The Home Office (March 2013) defines domestic abuse 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

Self-neglect and hoarding -There is no one operational definition of self-neglect, however the Care Act makes clear it comes within the statutory definition of abuse or neglect, if the individual concerned has care and support needs. The Department of Health, defines it as, "... a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding."(2014)

Radicalisation – Prevent and Channel

PREVENT

The revised Prevent Strategy was announced by the Home Secretary in June 2011. The strategy focuses on identifying and stopping people becoming involved with extremist ideologies including terrorists or supporting terrorism. The strategy contains a number of initiatives that can proactively contribute to

the protection and safeguarding of vulnerable individuals. It has been recognised that healthcare staff may meet and treat people who are vulnerable to such radicalisation and that people with mental health issues or learning disabilities may be more easily drawn into terrorism. We also know that people connected to the health sector have taken part in terrorist acts.

The key challenge for health staff is to ensure that, where there are signs that someone has been or is at risk of being drawn into extremist ideologies, such as terrorism, healthcare workers can interpret those signs correctly and are aware of support that is available and are confident in referring the person for further support.

Radicalisation is a process not an event and there is no single process or pathway to radicalisation. Preventing service users from becoming involved in terrorist activities or from supporting terrorism is no different from safeguarding vulnerable individuals from other forms of exploitation. (DH 2011 Building Partnerships, Staying Safe). This document can be found on the Trust Intranet page.

CHANNEL

Channel is a multi-agency approach to provide support to individuals who are at risk of being drawn into terrorist related activity. The Channel process is a key part of the Prevent Strategy. Channel seeks to safeguard individuals who might be vulnerable to being radicalised, so that they are not at risk of being drawn into terrorist related activity.

The Channel process identifies those most at risk of radicalisation and refers them via the Police or Local Authority for assessment by a multi-agency panel. The panel, chaired by the Local Authority considers how best to safeguard them and support their vulnerability through a support package tailored to the individuals' needs. It is important to note that Channel deals with vulnerable individuals in the pre-criminal space and aims to prevent the individuals from being drawn further into terroristic or criminal acts.

Partnership involvement ensures that those at risk have access to a wide range of support (from mainstream services such as health & education, as well as specialist mentoring or faith guidance and wider diversionary activities). Each support package is monitored closely and reviewed regularly by the multi-agency panel.

For advice on any issues related to either Prevent or Channel, including raising a concern relating to a service user or a colleague, please contact the Trust PREVENT Lead or Adults at Risk Lead. (See Safeguarding section on intranet for contact details)

Safeguarding Children Procedure

Version:	4.6
Bodies consulted:	Clinical Governance Manager
Approved by:	PASC
Date Approved:	21.1.16
Lead Manager:	Child Safeguarding Lead
Responsible Director:	Medical Director
Date issued:	Nov 17
Review date:	Oct 19



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1 Introduction

The Tavistock and Portman NHS Foundation Trust (the Trust) is committed to promoting the safeguarding of children and young people and protecting them from the risks of harm as required by section 11(2) (a) Children Act 2004: safeguarding children is everyone's responsibility. The Trust's approach to safeguarding and child protection has been developed in line with the Pan-London Child Protection Procedures (2015), Working Together to Safeguard Children 2015 When to Suspect Child Maltreatment, 2009, (which superseded "What to Do If You Are Worried a Child is Being Abused, 2006"), The Protection of Children In England: A progress Report 2009, and the Government's Response a Year On, 2010.

2 Scope

- 2.1 These procedures are intended to be used for all staff at the Trust. They are supplementary to local, regional and national procedures.
- 2.2 Copies of the aforementioned documents are available from the Named Doctor or the Named Professional in the Trust.
- 2.3 These procedures apply to all children and young people (0-17), the unborn, of any nationality, whether they are being treated via the National Health Service or privately.
- 2.4 In addition, those clinicians assessing and treating adults have a duty to be competent regarding child development, family functioning and parental capacity and crucially have the same duty of care to safeguard and protect children.
- 2.5 Throughout this document, a **child** means those children aged between 1- 12 years. A young person relates to 13 – 17 year olds.

3 Roles and Responsibilities

- 3.1 **Chief Executive**
 - 3.1.1 The Chief Executive is the Accountable Officer who has overall responsibility for ensuring the implementation of effective Safeguarding Procedures.
- 3.2 **Named Doctor/Named Professional**
 - 3.2.1 The Named Doctor and Named Professional will take the professional lead within the Trust for safeguarding and child protection matters. They should have expertise on children's health and development, the nature of child abuse, local arrangements for safeguarding children and promoting their welfare.

- 3.2.2 They provide a source of advice and expertise to fellow professionals, support the interface with other agencies and play an important role in promoting good professional practice in safeguarding children.
- 3.2.3 They are also responsible for overseeing the effective conduct of the Trust's internal case reviews and will ensure investigation and response to child protection complaints on behalf of the Trust.
- 3.2.4 They review the Trust's policy and procedures, practices and multi-agency working. They ensure that appropriate child protection standards are kept.
- 3.2.5 The accountabilities of the Named Doctor and Named Professional will be clearly identified in their job descriptions along with their responsibilities in relation to this policy and procedure.

3.3 **Director of Human Resources**

3.3.1 The Director of Human Resources is responsible for:

- Ensuring the Trust's Recruitment and Retention Policies comply with relevant legislation and guidance relating to the employment staff working with children and other vulnerable people and includes ensuring enhanced Disclosure and barring checks are expedited regarding all staff, honorary workers and volunteers.
- Ensuring that the Trust's induction programme and mandatory training programmes include safeguarding and child protection training as defined by the training needs analysis (refer to the Staff Training Policy).

3.4 **Case Co-coordinator (formerly known as the Case Consultant)**

3.4.1 The Case Co-coordinator has responsibility for individual cases, as set out in detail within this policy and procedure.

3.4.2 Where a serious incident has occurred staff will **also** follow the requirements set out in the Trust's Serious Incident Policy.

3.5 **Directors, Associate Clinical Directors, Line Managers, Team managers and Heads of Discipline**

Directors, associate clinical directors, line managers, team managers and heads of discipline are responsible for:

- Promoting working practices that ensure the welfare of the unborn, children and young people.
- Ensure all staff attend all relevant training in respect of safeguarding and child protection: induction, mandatory and INSET training as required by the Trust
- Ensure staff who are affected in any way by child protection issues receive the appropriate help and support they require, either by referral to the Named Professionals, the Staff and Student Advisory Service or by direct referral to Occupational Health
- Ensure recruitment practice is mindful of Safer Recruitment protocols and all recruiting staff have undertaken Safer Recruitment training.

3.6 **All Staff**

All staff are required to work to promote children's rights as detailed in the Article of the United Nations Convention on the Rights of the Child 1989. This is in line with the

requirements of the Human Rights Act 1998. All Trust staff (employed, honorary or volunteers) have a duty to safeguard and promote the welfare of children (section 5, Children Act 2004). To meet their responsibilities, all individual staff must ensure:

- They attend training provided by the Trust in respect of safeguarding and child protection;
- They are aware of how to obtain help and advice in relation to child protection matters;
- They follow the London Child Protection Procedures, 2017 when there are child protection concerns;
- They understand the sharing of personal information about children and families held by them should not be disclosed without the consent of the data subject. However, the law permits disclosure of confidential; information necessary to safeguarding children and young people, i.e. protecting children and young people will override the child's, young person or parents/carers' right to confidentiality. Staff should take advice from the Named Professionals in complex cases and ensure that any confidential information shared is undertaken in the child's or young person's best interests;
- They seek advice initially from the Case Co-coordinator, their Line Manager or the Named Professionals in all complex cases and understand that child protection issues should never be managed by a single professional;
- All staff are encouraged to consider the construct of Think Family i.e. both adult and children clinicians must consider the implications of presenting symptoms or pathology and its impact on children and any other vulnerable persons;
- They report any allegation or concern of child protection regarding a member of staff to the Named Professionals;
- All staff are encouraged to consider the construct of Think Family i.e. both adult and children clinicians must consider the implications of presenting symptoms or pathology and its impact on children and any other vulnerable persons.

4 Procedures for dealing with suspected abuse

Recognition of Abuse

4.1.1 To assist staff a summary set of guidelines on recognising abuse is shown at **Appendix B**. This should only act as a guide to staff as child abuse/maltreatment can manifest in a way that may not at first be understood as abuse. Staff are reminded to remain vigilant and be open to evidence of safeguarding and child protection either through their direct care of the child or through learning of possible safeguarding and child protection concerns from others e.g. parent/carers and other professionals.

4.2 Opportunities and Obstacles in Identifying Safeguarding Issue

4.2.1 Safeguarding and child protection cases may arise in the following ways:

- Planned referral for psychosocial assessment where possible abuse is suspected
- Concerns which arise during the course of an assessment and/or treatment

4.1.2 Any physical, emotional and sexual abuse disclosed by a child or young person to member of staff/ trainee/clinical associate/ honorary or volunteer worker should be

immediately reported to the Case Co-ordinator. An urgent internal discussion should take place and a referral should be made to the Children's Services in the area the child currently lives.

- 4.2.3 However, if the Case Co-ordinator is not available the Team Leader or another Case Co-ordinator from the same clinical team should provide cover for the case.
- 4.2.4 If a member of staff/ trainee/ clinical associate/ honorary or volunteer worker observes signs indicative of possible abuse, they should ask the child and parent/carer. If the explanation given is not plausible and consistent and raises concern as to possible abuse, the staff member/trainee/clinical associate/honorary member of staff/volunteer should indicate a need to discuss this further with colleagues, and inform the Case Co-ordinator immediately.
- 4.2.5 If a child appears to be suffering from neglect, the staff member/trainee/clinical associate/honorary member/volunteer should gain relevant information from the Parent/carer/child and discuss with the Case Co-ordinator. The parent/carer should be informed if a referral to Children's Services is made unless it would not be in the child or young person's best interests for such a disclosure to be made.
- 4.2.6 If a child or young person appears to be suffering from emotional abuse, which may cause significant harm, the Case Co-ordinator must be informed.
- 4.2.7 In all cases where the Case Co-ordinator considers that a child or young person is likely to be at risk of further abuse and/or silencing these concerns must not be discussed with the parents/carers before contacting Children's Services.
- 4.2.8 Thereafter, Children's Services might instigate either a section 17 (Child in Need Assessment) or a section 47 (Child Protection investigation) under the statutory instruments of the Children Act 1989.
- 4.2.9 In cases where there is some doubt about whether to refer to Children's Services contacting the appropriate MASH Team Manager to discuss concerns may assist in progressing matters.
- 4.2.10 In all circumstances where a referral to Children's Services is being considered clinicians must inform the case coordinator/team leader/or other senior clinician and advise either the Named Doctor or the Named Professional.

4.3 Informing the Named Professionals for Safeguarding Children

- 4.3.1 The Trust's Named Doctor or Named Professional must be notified of all cases of suspected and known child abuse.

4.4 Understanding the Obstacles to Recognising Child Maltreatment

There are obstacles among healthcare professionals in recognising child maltreatment and accepting that child maltreatment commonly occurs. Some of these obstacles relate to the healthcare practitioners' professional and personal experiences (including maltreatment) or lack of training. Other obstacles include the following:

1. concern about missing a treatable disorder	7. uncertainty about when to mention suspicion, what to say to parent(s) or carer(s) and what to write in the clinical file
2. healthcare professionals are used to working with parents and carers in the care of children and fear losing the positive relationship with a family already under their care	8. losing control over the child protection process and doubts about its benefits
3. discomfort of disbelieving, thinking ill of, suspecting or wrongly blaming a parent or carer	9. child protection processes can be stressful for professionals and time-consuming
4. divided duties to adult and child /patients and breaching confidentiality	10. personal safety
5. understanding the background and reasons why the maltreatment might have occurred, especially when there is no perceived intention to harm the child	11. fear of complaints, litigation and dealings with professional bodies
6. difficulty in saying that a presentation is unclear and there is uncertainty about whether the presentation really indicates significant harm	12. fear of seeking support from colleagues

(See *When to Suspect Child Maltreatment*, July 2009, page 16)

Recording Information

- 4.4.1 Detailed contemporaneous records (within 24 hours, must be kept by all involved and must clearly differentiate between fact, reported information and opinion. (Keeping fact and opinion in separate pages or paragraphs in records is advised).
- 4.4.2 The reasons for any decisions made must be recorded clearly, including the decision(s) and reason(s) why the child was or was not referred to Children's Services.
- 4.4.3 Recording on CareNotes must be undertaken in a timely manner as well as being mindful regarding who may have access to the records.
- 4.4.4 See the Trust's Healthcare Records procedure for guidance regarding standards for record-keeping.

5 Sharing Information

51 The importance of sharing information with other agencies is fundamental.

5.1.1 Sharing Information effectively enables:

- (i) improved communication between professionals;
- (ii) a better understanding of what should be shared, with whom and under what circumstances, and the dangers of not doing so;
- (iii) building confidence and trust with partners and families;
- (iv) better knowledge of other agencies services;
- (v) less duplication for service users.

5.2 Confidential Information

5.2.1 Confidential information is personal identifiable information not normally in the public domain or readily available from another source, has a degree of sensitivity and value; all staff have a duty to maintain confidentiality.

5.3 Common Law Duty of Confidence

5.3.1 A breach of confidentiality is when a person shares information with another in circumstances where it is reasonable to expect that the information will be kept confidential. However, all professionals have a duty to disclose information where failure to do so would result in a child or children or others suffering from neglect or physical, sexual, exploitation or emotional abuse.

5.4 Public Interest and Proportionality (PIP)

5.4.1 The public interest 'test' can be used to make judgments regarding managing confidential information and when consent to share information has been refused. If any of the following apply, it is 'a public interest matter':

- (i) to protect children and other people from harm;
- (ii) to promote the welfare of children;
- (iii) to prevent crime and disorder;
- (iv) alternatively, non-disclosure may also be, in some circumstances, in the public interest.

5.4.2 Clinicians may also consult the Trust's Caldecott Guardian.

5.5 The Law

5.1.1 The law does not prevent individual sharing of information with other practitioners to assist a child if:

- (i) those likely to be affected consent;
- (ii) the public interest in safeguarding the child's welfare overrides the need to keep the information confidential;

- (iii) disclosure is required under a Court Order or other legal obligation.

5.6 Communicating with Children, Young People and Parents

- 5.6.1 Sharing information should be a considered response, which should seek to be inclusive regarding the views and feelings of children, young people and their parents/carers.
- 5.6.2 Young people aged 16 or 17, or a child or young person under 16 who has the capacity to understand and make their own decisions, may give, or refuse consent to sharing information.
- 5.6.3 Children aged 12 or over may generally be expected to have sufficient understanding. Younger children may also have sufficient understanding. When assessing a child's understanding you should explain the issues to the child in a way that is suitable for their age, language and likely understanding.
- 5.6.4 The following criteria should be considered in assessing whether a particular child on a particular occasion has sufficient understanding to consent, or refuse consent, to sharing of information about them:
 - Can the child understand the question being asked of them?
 - Does the child have a reasonable understanding of:
 - What information might be shared?
 - The main reason or reasons for sharing the information?
 - The implications of sharing that information, and of not sharing it?
 - Can the child:
 - Appreciate and consider the alternative courses of action open to them?
 - Weigh up one aspect of the situation against another?
 - Express a clear personal view on the matter, as distinct from repeating what someone else thinks they should do?
 - Be reasonably consistent in their view on the matter, or are they constantly changing their mind?
- 5.6.5 In most cases, where a child cannot consent or where a clinician has assessed that they are not competent to consent, a person with parental responsibility should be asked to consent on behalf of the child or young person.
- 5.6.6 Where parental consent is required, the consent of one parent is sufficient. In situations where family members are in conflict, clinicians should discuss with the Named Professionals to decide whose consent should be sought. If the parents are separated, the consent of the resident parent would usually be sought. If a child is judged to be competent to give consent, then their consent or refusal to consent is the one to consider even if a parent disagrees.
- 5.6.7 In cases where there is conflict between the wishes of the parent and the

child, particularly if the child is older, clinicians should make a decision aimed at securing the best outcome for the child/young person. Acting in the best interests of the child, may require overriding refusal to consent by the child, young person and their parents or carers. The ability to override, if required, refusal to consent should always be exercised when there are child protection concerns.

5.6.8 Trust clinicians should always record whether consent has or has not been sought, whether consent has been given or refused and should confirm these processes in writing to eligible children and young people and their parents.

5.6.9 The need to renew consent should be reviewed and the person who gave consent should be kept informed of circumstances in which the data is shared, wherever this is appropriate.

5.1 Sharing Information Checklist

- 5.1.1
- 1) Is there a legitimate reason to share information?
 - 2) Is there a necessity to identify the individual?
 - 3) If the information is confidential, has consent been obtained?
 - 4) If consent to share information is refused, do the circumstances meet the 'public interest test'.

6 Referral to children's Services

Informing Children's Services should be undertaken by the Case Coordinator, or allocated clinician.

Where the case is already known to Children's Services, the Case Co-coordinator or allocated clinician will need to speak to the allocated social worker or their line manager.

Where the case is not known to Children's Services, the Case Co-coordinator or allocated clinician will refer to the local Multi-Agency Safeguarding Hub (MASH).

Referrals using email should be undertaken using secure email. Clinicians should always seek confirmation of receipt of any referral not exceeding 2 days. For urgent referrals, follow up should be immediately undertaken.

6.1 Information Checklist when making a Referral to Children's Services

- 6.1.1
- 1) Full Names, D.O.Bs and gender of children and adults living in the Household
 - 2) Address of Family Home, GP and School(s)
 - 3) Identity of Adult with PR (parental responsibility)
 - 4) Ethnicity, First Language and Religion
 - 5) Salient Events in Family History
 - 6) Cause for Concern
 - 7) Any Special Needs of Child or Parent
 - 8) Child's Current Whereabouts
 - 9) Details of the Alleged Perpetrator and Relationship to the Child
 - 10) Other Agencies currently, or in the Past, involved with the Family
 - 11) Parental Agreement to the Referral obtained or not

6.2 **Tasks Usually Undertaken by Children's Services**

6.2.1 Children's Services will:

- Check whether there is already salient information about the child within the local authority and request checks for information with the Police. And ensure that the wishes and feelings of the child are known under the Children Act 1989 as amended by section 53 Children Act 2004;
- Consult with other agencies that have direct knowledge of the child and family;
- Decide whether a meeting is necessary and if so whether it should be a Strategy Meeting or Professionals' Meeting;
- Convene a Strategy Meeting with local agencies, (in urgent situations the Children's Services Team Manager will hold strategy discussions by telephone);
- Plan who and when investigations/assessments will be done. This will include considering the part played by professionals in the local authority where the child is residing and any other authority involved;; if the child is subject to a Care Order and work in conjunction with the police to achieve a best interview (ABE), if required; if it is clear there no child protection concerns, Children's Services will record on the file the decision not to proceed and consider any other actions, which may be required to safeguard the child's needs and welfare.
- Alternatively, the Strategy Meeting/Discussion may decide to commence a child protection investigation. Under section 47, Children Act 1989.

6.3 **Tasks for Trust Professionals**

6.3.1 Trust clinicians need to be prepared to give information to the Police and Children's Services Department.

6.3.2 Attend Strategy Meetings and Conferences as necessary. This is not just important because we may be the referrers but staff may have a major contribution in considering the issues concerning the child, e.g. development, mental health state, emotional vulnerability, functioning of the family and parental capacity.

6.3.3 Prepare reports for Child Protection Initial and Review Conferences.

6.3.4 Requests or Court Directions for court reports should always be discussed with Case Co-coordinators and Team Leaders.

6.3.5. If it is clear there is no child protection concern, there must be a record on the patient's CareNotes record as to why the decision to proceed no further has been made.

6.3.6 To assist and participate in any Serious Case Review or Child Death Review processes conducted under the auspices of a Local Safeguarding Children Board.

6.4 **Out of Hours Advice**

6.4.1 If a concern arises after office hours (after 5 pm. or at the weekends) consideration must be given as to whether the local Children's Services Out of Hours or Emergency Team should be informed at once rather than waiting until the next working day.

6.4.2 Camden Out of Hours or Emergency Team can be reached by phoning the local authority and asking for the Out of Hours or Emergency Team. (0207 278 4444). If you are dealing with a non-Camden child, you must contact the local authority where the child ordinarily lives.

6.4.3 If there are any difficulties in getting through, particularly in cases of emergency, the Police Child Protection Team should be contacted. For Camden the telephone numbers are: 0207 388 6953 or 0207 725 4547.

6.5 Allegations Made Against Staff, Students, Honorary Workers and Trainees

- 6.5.1 If an allegation is made against a member of staff this must be taken as seriously as any other allegation and treated in the same way.
- 6.5.2 Staff who hear or witness abuse caused by a staff member/ trainee/ clinical associate/ honorary or volunteer worker should record their concerns and report the matter immediately to the Team Leader, who must notify their Service Line Managers and Associate Director, who should advise either the Named Doctor or the Named Professional for Safeguarding Children.
- 6.5.3 If the allegation is against the Case Co-ordinator, the Associate Director should be informed.
- 6.5.4 The staff member against whom the allegation is made should be informed of this by the Associate Director and Team Leader.
- 6.5.6 The Trust's designated senior officer (DSO), Dr Dinesh Sinha should not investigate the matter or interview the member of staff, child or potential witnesses. The primary task of the DSO is to ensure there are written records, which are dated and signed by the person reporting the allegation and any potential witnesses.
- 6.5.7 Before any referral to the Local Authority Designated Officer (LADO) now referred to as the Designated Officer (DO) is made one of the following criteria must be met, this should not be deterred by the staff member's resignation:
- (i) behaviour that has harmed a child or may have harmed a child;
 - (ii) possibly committed a criminal offence against or related to a child;
 - (iii) behaved towards a child or children in a way that indicates they are unsuitable to work with children.
- 6.5.8 The relevant Clinical Director and the Named Professionals should be notified, if any of the above criteria are met.
- 6.5.9 Where there is not sufficient substance in an allegation to warrant a child protection investigation, there should be an internal inquiry to consider whether the behaviour of the professional or member of staff should be addressed by further training/supervision or disciplinary proceedings.
- 6.5.10 Either the Case Co-ordinator, Team Leader, Service Line Manager or Associate Director will meet with the parents/carers with or without the young person as appropriate, to inform them of the proceedings.
- 6.5.11 Staff should also be aware of the Trust's Whistle-Blowing procedure, which can be found in the suite of policy documents on the Trust's Intranet.
- 6.5.12 In addition staff can access an independent charity (Public Concern at Work) whose lawyers can provide free confidential advice about how to raise a concern about malpractice at work: www.pcaw.co.uk.

6.6 Investigation by Local Authority Social Service Department and Police Child Protection Team

6.6.1 The statutory responsibility for investigating any suspected child abuse lies with two agencies **Local Authority Children's Services and the Police Child Protection**. Children's Services has a duty to investigate where there is any cause for concern that a child or young person may have been abused and the Police have a responsibility to investigate criminal acts.

6.6.2 Investigations are carried out under section 47, the Children Act 1989 in partnership with the parents/carers so long as such investigations do not prejudice the welfare of the child.

6.6.3 The following are the guidelines for their investigations:

- The scope of the enquiry, including siblings and other children at possible risk of harm;
- The need for any paediatric or specialist assessment;
- How to meet the best interest of the child/ren or young person in the enquiry, taking into account any additional needs such as arising from disability or a need for an interpreter and speech and language difficulties;
- How the child's wishes and feelings will be ascertained so that they can be taken into account;
- When, how and who will undertake interviews with the children and if an ABE interview will be required;
- Any further action if consent for an interview or medical assessment is refused;
- The needs of other children and young people in contact with the alleged abuser/s including all children and young people within the household;
- Who other than the family should be interviewed, by whom, when and for what purpose;
- Agree what other actions may be needed to protect the child or provide interim services and support, including securing the safe discharge of a child in hospital, what information may be shared, with whom and when taking in account the possibility of information sharing placing a child at risk of significant harm or jeopardising police investigations;
- Any implications for disciplinary action;
- Any legal action required;
- The need for further strategy meetings/discussions;
- Timescales, agency and individual responsibility for agreed actions, including the timing of police investigations and relevant methods of evidence gathering.

6.6.4 In special circumstances for instance where the child or young person's mental state is of concern, the child or young person has severe disabilities or particular learning difficulties, or the child is very young, professionals from specialist child mental health services (CAMHS) may be asked to consult or undertake these interviews.

6.6.5 The investigation establishes the facts and assesses the level of risk to the Child or young person and any other under 18 year olds or vulnerable persons in the same household.

- 6.6.6 Throughout the investigation all professionals should keep an open mind about the concerns.
- 6.6.7 The number of investigations/examinations of the child or young person's should be kept to the minimum necessary to clarify the child or young person's situation.
- 6.6.8 Parents/carers and other key family members are consulted and informed at all stages of the investigation unless it is clearly in the interests of the child that there should be some delay in doing so. This consultation /information giving must extend to all those with parental responsibility in so far as is possible.
- 6.6.9 Issues of gender, race, culture, religion, language, and disability must be taken into account.
- 6.6.10 Appropriate interpreters should be used where English is not the language used by the family or where the child/young person or parent has specific communication needs. Note: Children and young people have the right under the Criminal Justice Act: Memorandum of Good Practice 1992 to be interviewed in their first language.
- 6.6.11 If the investigation is a part of an assessment in the course of court proceedings, leave of the Court must be sought in advance for any examinations.
- 6.6.12 Detailed contemporaneous records must be kept by all involved and must clearly differentiate between fact, reported information and opinion.
- 6.6.13 Professionals are advised to keep fact and opinion in separate pages in records.

6.7 Child Protection Conferences

- 6.7.1 Child Protection Conferences are convened under the procedures of the relevant local authority. The Initial Child Protection Conference decides whether the child or young person is at risk of abuse whether a child protection plan is required and, if so, the membership of the child protection core group.
- 6.7.2 Thereafter, the Review Child Protection Conference should review the progress of the Child Protection Core Group focused upon the child or young person's safety; the child or young person's needs, the capacity of the parents/carers and their ability to meet the child or young person's needs; parental/carer understanding of professionals' concerns and their ability to change.
- 6.7.3 Parents/carers and other family members are invited to attend Initial and Review Child Protection Conferences unless there are valid reasons for excluding them.
- 6.7.4 It is **essential** that key Trust staff attend these Conferences.
- 6.7.5 Trust staff must be alert to a child being subject to a Child Protection Plan for

more than two years and/or having a history of child protection plans and discuss these matters with the Case Co-ordinator or the Named Doctor or Named Professional.

6.8 Role of Trust Staff during Initial and Review Conferences

Following an Initial or Review Child Protection Conference, the Trust may continue to have a significant role with the child or young person and his/her family as part of the Child Protection Plan. Apart from continuing any existing treatment, this may include any of the following:

- Contributing to the comprehensive assessment of the child, young person and family or adult
- Carrying out further specified investigation
- Providing therapeutic treatment
- Providing reports for Court (subject to the Directions of the Court)
- Attending Court (subject to the Directions of the Court)
- Be available for consultation, by phone if need be, to discuss interviewing the child or young person to assist police and social work colleagues.

6.8.2 Legal advice and support in the preparation of Court Reports and the giving of evidence can be obtained from the legal team of the relevant Local Authority.

6.8.3 In addition, staff have access to the Trust's solicitors via the Director of Corporate Governance and Facilities.

6.9 Management When There is a Threat of Violence

6.9.1 The Case Co-ordinator and Team managers should be informed whenever there is considered to be a risk of violence either to a child or young person or to any other person so that appropriate arrangements for security e.g. alerting Trust support staff. In the exceptional circumstances, where it is thought that there is an extremely high risk of violence, it may be appropriate to inform and request a police presence prior to appointments. However, this should be discussed with the Associate Clinical Director and Director prior to any appointment being offered.

6.10 Supporting Staff Involved in Child Protection

6.10.1 The Trust recognises that involvement in any aspect of child protection can be stressful for staff. It is therefore committed to offering help and support for any staff member who have concerns. Staff are advised at Trust Induction events of the Staff and Student Advisory Service which can be accessed by any member of staff, where a trained professional will offer one-to-one support. In addition, staff should raise concerns directly with the Case Co-ordinator or Team Leader or the Named Professionals.

6.11 Supervision

‘Supervision can be described as the working relationship between professionals whereby supervisees are supported to offer an account of their work, reflect on it, receive feedback and guidance where appropriate. The purpose of supervision is to enable workers to make sense of their work, to gain in ethical competency, confidence and creativity to give the best possible service to their clients.’ (Inskipp and Proctor, 1993)

6.11.1 All staff who have children identified as being in need, or are LAC or subject to child protection concerns, and where there are child protection plans, staff should receive specific safeguarding supervision from either the Case Co-coordinator or the Team Manager, or a staff member with designated safeguarding supervision responsibilities. All child protection plans are to be subject to at least a quarterly safeguarding supervision session.

Safeguarding supervision can be provided either on a one to one basis or via team based discussion. Safeguarding supervision needs to be recorded onto patient notes using the relevant CareNotes form.

6.11.2 The supervising clinician must ensure the case file is up to date; the allocated clinician attends relevant meetings and conferences and where there is dissent regarding any multi-agency decision-making this is accurately recorded on the case file. Any concerns regarding the management of a safeguarding or child protection matter should be escalated via the Named Doctor or Named Professional.

6.11.3 The supervising clinician needs to ensure all children in need and child protection conferences are provided with an up to date Trust report.

6.11.4 Finally, it is the supervisor's responsibility to ensure supervision and any relevant decision-making therein is recorded on the case file.

6.12 Assessing Cases

6.12.1 Staff are required to complete appropriate Clinical Assessments Forms, including the Safeguarding and Risk Assessment Form. The aforementioned form must also be refreshed regarding any change of circumstances.

6.12.2 Staff must ask appropriate questions if there are any concerns highlighted through the referral process or matters that might arise during the assessment process regarding the following:

(a) domestic abuse and violence, which includes stalking and harassment, harming pets, financial or emotional control as well physical abuse and threatening, controlling or intimidating behaviours. Clinicians should also note victims of domestic violence according to research may take at least five years to disclose;

(b) Parental ill-health and if this is the primary concern rather than the presenting IP;

(c) The above also includes drug and alcohol abuse;

(d) staff must clarify the relationship between referred children and young people to establish whether under 16 year olds are living with adults who are neither their parents nor close relatives. Where is known or suspected that a child or young person is being privately fostered, the allocated clinician must inform the Case Co-coordinator, Team Manager and the Named Professionals. All children and young people under the age of 16 years in the aforementioned circumstances must be referred to Children's Services;

(e) children and young people who are vulnerable to sexual exploitation who may be LAC; or children and young people with a history of running away; whose parents

and carers are concerned about them and their associates; or children and young people who have relationships with older people; or who report being given gifts without an adequate explanation and or children and young people who are using drugs and alcohol. Trust staff should note the Rotherham Inquiry Report and the Goddard Inquiry;

- (f) there is also a focus on intra-familial sexual abuse by the Children's Commissioner and the Government has recognized this as a national priority;

A new mandatory duty is being introduced (October 2015) through the Serious Crime Act 2015 to report cases of FGM. The move follows a public consultation which sought views from a wide range of professionals, community groups, survivors and law enforcement on how a mandatory reporting duty could work and who it should apply to. The mandatory duty will:

- Apply in cases of 'known' FGM – i.e. instances which are disclosed by the victim and/or are visually* confirmed.
- Be limited to girls under 18**
- Apply to all regulated healthcare and social care professionals, and teachers
- Require reports to be made to the police within one month of initial disclosure/identification – depending on the circumstances of the case, this will not necessarily trigger automatic arrests; the police will then work with the relevant agencies to ensure an appropriate safeguarding response is put in place which places the interests of the child 'front and centre'
- Failure to comply will be subject to internal and external governance and the Government is emphasizing the use of disciplinary measures.

Please inform, without delay, the Named Doctor, Dr Caroline McKenna and the Named Professional, Sonia Appleby, regarding any cases of known or confirmed FGM irrespective of age; email: Safeguarding@tavi-port.nhs.uk. Ensure your email address is tavi-port etc. to be compliant with the current email procedure. If you are in doubt ring: 020 8 938 2906 or 020 8 938 2434 or 020 8938 2623.

Please also note the following:

*Trust clinicians are not expected nor should they ever visually confirm FGM

** Mandatory reporting is restricted to those under the age of 18 years.

PREVENT

(f) Trust Staff must be alert and vigilant regarding any suspicions or disclosure of radicalisation. From 1st July 2015, there is a statutory duty to refer all concerns or disclosures to the Local Authority Prevent Lead. Staff should undertake a referral by informing the PREVENT Lead, Irene Henderson and the Named Professionals;

(g) The Lampard Report has required reassurance from all NHS sites to ensure all visitors and service users are managed appropriately and take careful note that no-one because of their perceived celebrity or VIP status has unwarranted access to Trust property or service users.

6.13 Managing Press Involvement

- 6.13.1 If there is a possibility of the Press seeking information regarding a case where the Child Protection process is actually or potentially progressing then it is essential that legal advice is sought from the relevant Local Authority where the child resides. In these circumstances, staff should consult with the Case Coordinator or Team Leader and the Named Professionals.

7 Implementation of Policy and Training Requirements

- 7.1 This policy will be made available to staff via the Trust intranet and the content of the policy will be communicated through induction training and mandatory training sessions for all staff.
- 7.2 The Named Professionals will ensure that all child protection training programmes are reviewed and updated annually and in line with current legislation to provide practitioners with skills appropriate to their needs. The Trust will access Camden Safeguarding Children Board Training Programmes which provides Level 3 multi-agency training for practitioners who are directly working with children and families.
- 7.3 The Trust has determined via a training needs analysis process the following arrangement for staff training based on the Intercollegiate Safeguarding Children and Young People : Roles and Competences for Healthcare Staff- Sept 2014 and has set out the following mandatory training requirements for staff

Category	Intercollegiate group description	Trust group description	Frequency
Level 1	<i>'All non-clinical staff working in health care settings'</i>	All staff	2 yearly as part of mandatory INSET training (training delivered by Safeguarding Lead)
Level 2	Level 2: All non-clinical and clinical staff who have any contact with children, young people and/or parents/carers	For Level 3	Once and then 3 yearly refresher (training delivered by Safeguarding Lead)
Level 3	<i>'All 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 concerns'</i>	All clinical staff in C&F and Portman services, and clinical staff in the Adolescent service services that work with children (e.g. GIDS, LCDS)	Once and then three yearly refresher (training delivered by Safeguarding Lead or received by attending Camden Safeguarding Board multidisciplinary training course)

7.4 Review of Training as Part of Annual Performance Review

Managers undertaking individual performance reviews of staff must include reference to mandatory safeguarding children training according to the appropriate level for their role and ensure that the individual's Professional Development Plan incorporate appropriate training requirements and arrangements are made for staff to access relevant training.

7.5 Transfer of Previous Training

Staff who have previously worked in health and social services and are employed in a clinical role where an advanced safeguarding child training is required must complete Trust-wide and local induction training. However, if in a previous role a member of staff has completed an advanced updating session within the previous twelve months then they will be exempt from further training for the first year of employment subject to documentary proof of training.

8 Process for monitoring compliance with this Procedure

- 8.1 The Trust will monitor compliance with this policy and procedures in the following way:
- the Staff Training and Development Committee will monitor uptake of child protection training as part of their continual monitoring of mandatory training and report compliance of this to the Corporate Governance and Risk group of the CQSG. The group will refer training issues to the Management Committee if necessary;
 - the Named Doctor for Safeguarding will provide an annual report to the Patient Safety and Clinical Risk group of the CQSG who will provide assurance of compliance it to the Board via the CQSG. This report will address any externally imposed changes in relation to safeguarding children procedures. In addition they will highlight any issues that have arisen in respect of either safeguarding children or the delivery and uptake of training in line with the requirements set out in the policy;
 - the Named Professional for Safeguarding Children will review any incidents relating to Safeguarding and report concerns/ investigations/ lessons learned to the Patient Safety and Clinical Risk Lead;
 - the Named Doctor will be responsible for adding any specific safeguarding children risks to the Operational Risk Register as they arise and this Risk Register will be monitored through the Trust's Risk Management Procedures;
 - The Named Professionals will undertake a spot check audit of cases with CP concerns to ensure that the records show that all relevant procedures have been followed. If this audit raises concerns the named professional will make recommendations to the Patient Safety and Clinical Risk Lead and an action plan will be developed and followed. Any action plan will be monitored by the Patient Safety Sub Group;
 - should the Trust be directly or indirectly involved in a section 8 enquiry under the Children Act 1989 this will immediately be flagged as a risk on the register and the Board will be informed both of the process and the outcome.

9 References

Pan-London Child Protection Procedures, 2017

Working Together to Safeguard Children 2018

Safeguarding Children Abused through Domestic Violence, 2006

Safeguarding Children from Abuse Linked to Belief in Spirit Possession, May 2007

Safeguarding Children in whom Illness is Fabricated or Induced, March 2008

Safeguarding Children and Young People from Sexual Exploitation, June 2009

When to Suspect Child Maltreatment CG89, 2009

The Protection of Children in England: A Progress Report, 2009

10 Associated documents¹

Incident Reporting Procedure

Serious Incident Reporting Procedure

Recruitment Procedure

Staff Training and Development Policy

Information Governance Policy

Data Protection Procedure

Media Handling Procedure

¹ For the current version of Trust procedures, please refer to the intranet.

Extract from *Working together to Safeguard Children, 2010* - role of CAMHS and Adult Services in Safeguarding Children

Child and Adolescent Mental Health Services (CAMHS)

- 2.98 Standard 9 of the NSF is devoted to the 'Mental Health and Psychological Wellbeing of Children and Young People'. The importance of effective partnership working is emphasised, and this is especially applicable to children and young people who have mental health problems as a result of abuse and/or neglect. Some forms of emotional distress may, however, fall short of being an identifiable mental health issue. It is also important that the more general need to promote emotional Well-being among children and young people is not neglected as an essential component of safeguarding.
- 2.99 In the course of their work, child and adolescent mental health professionals will therefore want to identify as part of assessment and care planning whether child abuse or neglect, or domestic violence, are factors in a child's mental health problems, and ensure that this is addressed appropriately in their treatment and care. If they think a child is currently affected, they should follow local child protection procedures. Consultation, supervision and training resources should be available and accessible in each service (see Chapter 4).
- 2.100 Child and adolescent mental health professionals have a role in the initial assessment process in circumstances where their specific skills and knowledge are helpful. In addition, assessment and treatment services may need to be provided to young people with mental health problems or with other emotional difficulties who offend. The assessment of children with significant learning difficulties, a disability or sensory and communication difficulties may require the expertise of a specialist learning disability service or CAMHS.
- 2.101 CAMHS also have a role in the provision of a range of psychiatric and psychological assessment and treatment services for children and families. Services that may be provided, in liaison with local authority children's social care services, include the provision of reports for court, and direct work with children, parents and families. Services may be provided either within general or specialist multidisciplinary teams, depending on the severity and complexity of the problem. In addition, consultation and training may be offered to services in the community – including, for example, social care schools, primary healthcare professions and nurseries.

Adult Mental Health Services

- 2.102 Adult mental health services – including those providing general adult and community, forensic, psychotherapy, alcohol and substance misuse and learning disability services – have a responsibility in safeguarding children when they become aware of, or identify, a child suffering or likely to suffer significant harm. This may be as a result of a service's direct work with those who may be mentally ill, a parent, a parent-to-be, or a non-related abuser, or in response to a request for the assessment of an adult perceived to represent a potential or actual risk to a child or young person. Adult mental health staff need to be especially aware of the risk of neglect, emotional abuse and domestic abuse to children. Staff should be able to consider the needs of any child in the family of their patient or client and to refer to other services or support

for the family as necessary and appropriate, in line with local child protection procedures. Consultation, supervision and training resources should be available and accessible in each service.

- 2.103 In order to safeguard children of patients, mental health practitioners should routinely record details of patients' responsibilities in relation to children, and consider the support needs of patients who are parents and of their children, in all aspects of their work, using the Care Programme Approach. Mental health practitioners should refer to Royal College of Psychiatrists policy documents, including *Patients as Parents*⁴⁵ and *Child Abuse and Neglect: the Role of Mental Health Services*⁴⁶ and SCIE Guide 30⁴⁷.
- 2.104 Close collaboration and liaison between adult mental health services and children's social care services are essential in the interests of children. It is similarly important that adult mental health liaise with other health providers, such as health visitors and general practitioners. This may require sharing information to safeguard and promote the welfare of children or to protect a child from significant harm. The expertise of substance misuse services and learning disability services may also be required. The assessment of parents with significant learning difficulties, a disability, or sensory and communication difficulties, may require the expertise of a specialist psychiatrist or clinical psychologist from a learning disability service or adult mental health service.
- 2.105 From April 2010, under section 131A of the Mental Health Act 1983, there is a duty on hospital managers to ensure that if a child or young person under the age of 18 is admitted to hospital for mental health treatment, the environment in the hospital is suitable having regard to their age. Managers of adult services must consult with a person who can provide appropriate advice on CAMHS who would need to be involved in decisions about accommodation, care and facilities for education in hospital.

11 Appendix B: Recognition of Abuse: Guidelines for Staff

What is Abuse and Neglect?

- 1.32 Abuse and neglect are forms of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting, by those known to them or, more rarely, by a stranger for example, via the internet. They may be abused by an adult or adults, or another child or children.

Physical abuse

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

Emotional abuse

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

Sexual abuse

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

Neglect

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

- provide adequate food, clothing and shelter (including exclusion from home or abandonment);
- protect a child from physical and emotional harm or danger;
- ensure adequate supervision (including the use of inadequate care givers);

Or

- Ensure access to appropriate medical care or treatment.

It may also include neglect of, or unresponsiveness to, a child's basic emotional needs (Working Together to Safeguard Children, 2010)

Other Forms of Abuse

- **On-Line Abuse**

Any type of abuse that happens on the web whether through social networks, playing on-line games or using mobile phones

- **Child Sexual Exploitation (See Appendix C)**

Children exploited for money, power and/or status

- **FGM**

The partial or total removal of external female genitalia for non-medical reasons

- **Bullying and Cyberbullying**

Can happen in school, home or on-line

- **Domestic Abuse**

Witnessing domestic abuse is child abuse

- **Child Trafficking**

Children are recruited, moved or transported exploited, forced to work or sold

- **Grooming**

Can be groomed on-line or in the real world, by a stranger or by someone they know, for example, a family member, friend or professional

- **Abuse linked to spiritual or religious beliefs**

- **Radicalisation**

Radicalisation is defined in the Prevent Strategy as "the process by which a person comes to support terrorism and forms of extremism leading to terrorism"

- **Harmful Sexual Behaviour**

Children and young people who develop harmful sexual behaviours causing harm to themselves or others

- **Fabricated or Induced Illness**

Fabricated or induced illness (FI) is a rare form of child abuse. It occurs when a parent or carer, usually the child's biological mother, exaggerates or deliberately causes symptoms of illness in the child.

Significant Harm

There are no absolute criteria on which to rely when judging what constitutes significant harm. Consideration of the severity of ill-treatment may include the degree and the extent of physical harm, the duration and frequency of abuse and neglect, the extent of premeditation, and the presence or degree of threat, coercion, sadism and bizarre or unusual elements. Each of these elements has been associated with more severe effects on the child, and/or relatively greater difficulty in helping the child overcome the adverse impact of the maltreatment. Sometimes, a single traumatic event may constitute significant harm, for example, a violent assault, suffocation or poisoning. More often, significant harm is a compilation of significant events, both acute and long-standing, which interrupt, change or damage the child's physical and psychological development. Some children live in family and social circumstances where their health and development are neglected. For them, it is the corrosiveness of long-term emotional, physical or sexual abuse that causes impairment to the extent of constituting significant harm.

In each case, it is necessary to consider any maltreatment alongside the child's own assessment of his or her safety and welfare, the family's strengths and supports, as well as an assessment of the likelihood and capacity for change and improvements in parenting and the care of children and young people.

Under section 31(9) of the Children Act 1989 as amended by the Adoption and Children Act 2002:

- '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;
- 'development' means physical, intellectual, emotional, social or behavioural development; 'health' means physical or mental health; and 'ill treatment' includes sexual abuse and forms of ill-treatment which are not physical.

Under section 31(10) of the Act:

Where the question of whether harm suffered by a child is significant turns on the child's health and development, his health or development shall be compared with that which could reasonably be expected of a similar child.

To understand and identify significant harm, it is necessary to consider:

- the nature of harm, in terms of maltreatment or failure to provide adequate care;
- the impact on the child's health and development;
- the child's development within the context of their family and wider environment;
- any special needs, such as a medical condition, communication impairment or disability, that may affect the child's development and care within the family;
- the capacity of parents to meet adequately the child's needs; and
- the wider and environmental family context.

1.30 The child's reactions, his or her perceptions, and wishes and feelings should be ascertained and the local authority should give them due consideration, so far as is reasonably practicable and consistent with the child's welfare and having regard to the child's age and understanding.

12 Appendix C: Child Sexual Exploitation

1 Introduction

The Rotherham Inquiry Report (2013) underscored by Operation Yewtree (2012) and the findings of the Office of children's commissioner, 'IF Only someone Had Listened': Inquiry into child Sexual Exploitation in Gangs and Groups, (2013) has brought into sharp focus the significant vulnerability of children and young people: the absence of consistent professional best practice; references to collusive professional behaviours and as quoted by David Cameron, the 'industrial scale' of child sexual exploitation within England and Wales.

2 Definition

The Government is currently refining a number of definitions to ensure a homogenized approach:

'Child sexual exploitation is a form of child abuse. It occurs where anyone under the age of 18 is persuaded, coerced or forced into sexual activity in exchange for , amongst other things, money, drugs/alcohol, gifts, affection or status. Consent is irrelevant, even where a child may believe they are voluntarily engaging in sexual activity with the person who's is exploiting them. Child sexual exploitation does not always involve physical contact and may occur online.'

3 Child Sexual Exploitation and Consent

The fact that young people are engaged in what they view as consensual sexual activity does not mean that they are not being exploited:

- Victims of sexual exploitation may be coerced into sexual activity with the perpetrators or they may feel unable to say no.
- Some young people may not recognise they are being sexually exploited, instead believing they are behaving as they wish.
- 16 and 17 year olds are often viewed as being more in control of their own choices and so less vulnerable to exploitations.
- Sexual activity between young people of the same age is often perceived as being consensual, but exploitation may still be occurring.

Source: NSPCC

<https://www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/learning/child-sexual-exploitation>

4 Child Sexual Exploitation and Being in Care

4.1 Victims of sexual exploitation often display challenging, offering or risk taking behaviour. Negative attitudes from professionals who view these children as 'troublemakers' can prevent them from getting the protection they need. However risk taking behaviour is a key indicator of abuse.

4.2 When dealing with trouble children, practitioners need to see young people as vulnerable children in need of protection rather than focusing on their challenging behaviour.

4.3 Victims of exploitation who engage in offending behaviour should not be criminalised, but instead need protection and support.

4.4 Perseverance is required to engage with young people. They may not realise they are being exploited, have had negative experiences with professionals in the past, or be scared of the consequences of talking about their abuse.

5 The Warning Signs

5.1 Practitioners must be aware of the warning signs of potential sexual exploitation and grooming. Victims of sexual exploitation often display challenging or offending behaviour, but risk-taking behaviour is a key indicator of abuse.

5.2 Warning signs of potential exploitation include; underage sexual activity; sexual health concerns; teenage pregnancy; getting involved in crime; concerning relationships, placement; truancy, exclusion and disengagement from school.

5.3 The majority of victims in case reviews involving child sexual exploitation are girls. Groups particularly at risk include; children in local authority care, foster care or residential care; and young people who have had difficult early life experiences, including childhood abuse and domestic violence.

6 Comprehensive Assessments

6.1 An early and comprehensive assessment should be carried out. Without a comprehensive assessment, practice becomes task focussed so that individual incidents are addressed, for example sexual health concerns, but the bigger picture of child sexual exploitation is missed.

Source: NSPCC

<https://www.nspcc.org.uk/preventing-abuse/child-protection-system/england/serious-case-reviews/>

7 Under 18s and Balancing Rights versus the Need to Protect

7.1 16 and 17 year olds are often viewed as being more in control of their own choices and so less vulnerable to exploitation.

7.2 Practitioners need to balance their young person's right to make their own decisions and assess their own risk, with the need to protect these young person from exploitation. Even when a young person is unaware or doesn't accept that they are at risk, or when risks to the young person's safety arise from their own behaviour and the decisions they make, professional still need to intervene to prevent exploitation.

7.3 Consensual sex between teens of the same age might still be exploitation.

8. Assessing Child Sexual Exploitation

8.1 If there are concerns or suspicions of child sexual exploitation, seek advice from your immediate supervisor, team manager or the Children Safeguarding Leads: Dr Rob Senior and/or Sonia Appleby.

8.2 Complete the Multi-Agency CSE Risk assessment Form CAF. See as follows:

http://www.cscbnew.co.uk/downloads/Child_Sexual_Exploitation/CSE%20Risk%20Assessment%20Tool%20-%20CAF.pdf

9.3 Record on the Trust's electronic patient record and complete the Trust's Safeguarding Assessment Form.

9. Making a Referral

9.1 Whenever a professional is considering making a CSE referral on behalf of the young person, they should discuss this with the designated officer in their agency (the Named Safeguarding Children Professionals: Dr Rob Senior and Sonia Appleby) first to decide if a referral would be an appropriate response.

9.2 If professionals need further advice on the relevance of indicators or whether to make a referral about a young person, social workers in the MASH team can provide guidance on a "no names" basis.

9.3 All CSE referrals should be made using an e-CAF referral and should include all information the referrer has relating to the young person, their associates and possible perpetrators and any information on possible locations. The CSE risk assessment should also be passed to the MASH as part of the referral.

9.4 All CSE referrals should be passed to the MASH team in the first instance. This is to ensure that all information about the young person, their associates and possible perpetrators can be shared within the MASH leading to a full picture of the level of involvement in CSE and risks to the young person being obtained in a timely manner.

Source: Camden Safeguard Child Board Multi-Agency Guidance

<http://www.cscb-new.co.uk/wp>

[content/uploads/2015/09/Multi_Agency_Guidance_On_Child_Sexual_Exploitation_2015.pdf](http://www.cscb-new.co.uk/wp-content/uploads/2015/09/Multi_Agency_Guidance_On_Child_Sexual_Exploitation_2015.pdf)

10. Getting Consent

10.1 The young person should be informed that a referral is being considered and their views on this sought. However, it is likely that the young person will be resistant to a referral being made and may not give consent. Professionals will need to persevere and it may take time for the young person to agree to a referral for help being made. (See the Referral Pathway below).

10.2 Parents should also be made aware of concerns unless the young person strongly objects to this; however, parents must be involved if the young person:

- is under 13 years age;
- is aged between 13 and 15 but is thought not to be competent to make an informed decision about referral;
- is 16 or 17 years but is thought to lack the mental capacity to make an informed decision about referral.

Where the young person is assessed as being at level 2 or 3 and may be at risk of significant harm, a referral can be made to FSSW without consent being given, although consent should be sought. Professionals can seek advice on this from the MASH social worker.

A referral must be made with or without consent if the young person is under 13 years and the police must also be notified as it is likely that a criminal offence may have taken place.

Source: Camden Safeguard Child Board Multi-Agency Guidance

http://www.cscb-new.co.uk/wp-content/uploads/2015/09/Multi_Agency_Guidance_On_Child_Sexual_Exploitation_2015.pdf

11. Managing Perpetrators

11.1 Take disclosures seriously

11.2 Young people are unlikely to disclose sexual exploitation due to: fear of or loyalty to perpetrators, lack of knowledge or acceptance that they are being exploited, lack of trust and fear of authorities. Too often, even when young people do disclose abuse, no actions are taken by agencies against perpetrators or to support young people and the abuse continues.

11.3 Disclosure from young people of underage sexual activity or sexual exploitation needs to be taken seriously and dealt with as a crime. Actions taken following disclosure should not depend on the victim's willingness to act as a witness in a criminal trial.

11.4 Perpetrators need to be identified quickly and a case built against them by the police. They need to be prosecuted so that victims can feel safe, have trust in the authorities and feel confident that agencies can protect them.

11.5 Work with the multi-agency workforce to reduce future exploitation, victim profiles should be compiled and collated. This information can be used to identify local 'hotspot' locations or methods that are used to target potential victims.

Source: NSPCC

<https://www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/learning/child-sexual-exploitation>

12. Referral Pathway

Matrix of risk, indicators and responses to CSE

Level	Description	Indicators	Intervention/Response	Agencies
CSE RAG rating Green	Young people who are vulnerable to CSE.	<ul style="list-style-type: none"> • Truancing or excluded from school • Occasionally missing from home or placement • Difficult or distrustful relationships with parents and other adults • Lack of parental supervision or living in hostel accommodation • Seen in CSE "hotspot" areas • Early gang involvement • Experimental use of substances 	Early intervention and preventative services to divert the young person from CSE, address the issues that make them vulnerable to CSE and build their resilience.	Integrated Youth services School mentors Sexual health and relationships outreach workers Barnardos Miss U workers FWD
CSE RAG rating Amber	Young people who are being targeted or groomed for CSE	<ul style="list-style-type: none"> • Unexplained gifts , money or new mobile phone • Seen in CSE "hotspot" areas • Older boyfriend • Associates with young people thought to be involved in CSE • Speaks of attending parties with possible adult perpetrators • Established gang involvement • Regular use of substances • Frequently missing from home or placement • Sexual risk taking behaviour • Evidence of on-line grooming • Weakening links with family and friends • Involved in sexual activity in exchange for money/drugs/alcohol/accommodation • Secretive when using mobile phone or internet • Increase in level of personal grooming and appearance, new clothes etc 	Targeted support, including referral for a Child in Need service from FSSW and a CSE plan designed to disrupt the grooming process and prevent the young person from becoming further involved in CSE. Information sharing with the Community warden patrols in "hotspot" areas to disrupt targeting and grooming.	FSSW Police The Children's Society YOS FWD Young People's advocate Young Person's Independent Domestic and Sexual Violence Advisor Camden Safety Net
CSE RAG rating Red	Young people who are or are strongly suspected of being sexually exploited.	<ul style="list-style-type: none"> • Presence of STIs or pregnancy • Movements restricted or controlled through mobile phone • Seen in CSE "hotspot" areas • Known or suspected to associate with known CSE perpetrators • Problem use of substances • Serious emotional or behavioural issues, poor mental health and self-harming • Missing for long periods of time, possibly trafficked • Estrangement from family and friends • Used to recruit others into CSE • Decrease in level of personal grooming and appearance 	Statutory intervention under child protection or CSE procedures to protect the young person from harm and provide support to enable them to exit from the exploitation. Criminal investigation and prosecution of perpetrators.	FSSW Police CAIT The Children's Society FWD MALT/CAMHS Safer London Foundation Camden Safety Net Solace

13 Camden Safeguarding Children Board RAG (Red, Amber and Green) Rating

13.1 CSE Green Rag Rating

13.1.1 These are young people who are vulnerable to CSE because of their circumstances, for example being out of school provision, being looked after in a residential home or frequently running away. These circumstances make it easier for grooming to take place. The purpose of interventions is to help the young person address the issues that make them vulnerable and build resilience to exploitation.

13.2 CSE Amber Rating

13.2.1 These are young people who are being targeted or groomed for CSE. They will be in contact with perpetrators or those who are recruiting for the perpetrators or may have begun a relationship with an older partner.

13.2.2 They could be receiving gifts or attending parties with perpetrators and may be in contact with perpetrators via mobile phones. They may be being given drugs and alcohol by perpetrators to disinhibit and disorientate them which will make them more vulnerable.

13.2.3 This group will require targeted intervention and services in order to build resilience, address their needs and disrupt the grooming process or reduce the level of dependence on perpetrators. It is important that robust action is taken at this level as this is the main opportunity that agencies will have to protect the young person and divert them away from CSE.

13.3 CSE Red Rating

13.3.1 These are young people who are very likely being sexually exploited and have become deeply enmeshed in the exploitation so that it is difficult for them to exit. Intervention at this level will be aimed at helping the young person exit the exploitation and make a recovery and may also involve criminal investigation and action by the police against the perpetrator.

13.3.2 This group may be difficult to engage as their movements may be restricted and they may fear involvement by statutory agencies due to possible reprisals by perpetrators. It may be easier for this group to engage with voluntary sector organisations instead.

14. 'Say Something if You See Something'

14.1 Hackney Children's Social Care has circulated the link below: a short YouTube film written by young people for young people:

<https://www.youtube.com/watch?v=CyHOw7Faf6I>

15 Managing Child Sexual Exploitation Cases

15.1 As with all child protection concerns, do not seek to manage such cases in isolation: child protection concerns and risks must be managed within the context of a multiagency response.

15.2 Ensure all relevant work is recorded on the patient's electronic case file, including all supervision records pertaining to the case.

15.3 If you require additional support, please access the employee assistance scheme, which is a confidential service.

13 Appendix D: Body Maps Procedure

GUIDANCE FOR USING BODY MAPS

This guidance is predicated on the presumption that only doctors within this Trust will perform examinations, and these are restricted to chest*, back* and blood pressure* procedures. This guidance does not obstruct any clinician from taking reasonable action to save life or prevent injury. All doctors undertaking examinations must be mindful of the Trust's Chaperone, Mobile and Lone Working Procedures.

In brief, children should always be accompanied by a responsible adult or member of staff during any examination* no matter how brief. For Gillick competent children and young people, clinicians should gain their consent (verbal or written) if they choose to be examined without a responsible adult or staff member. Vulnerable adults should also be accompanied by a responsible or trusted adult or staff member. Mobiles or any other devices should not be used in any circumstances to record any patient, body images.

Clinicians are further advised to refer to the Trust's Lone Working Policy and should not conduct any form of physical examination* unless they are working on Trust sites.

Within this Trust any form of physical examination of a patient, who has been injured, needs to be undertaken by a doctor **and with the prior knowledge and approval** of senior medical staff namely, the Medical Director, Dr. Rob Senior and the Deputy Medical Director, Dr. Caroline McKenna. In the absence of such approval, the patient should be referred to their GP or A&E as appropriate. All other staff should only note any visible or reported marks, including burns, or injuries on a body map and record, date and sign details on the patient's file.

In circumstances, as a result of observed or reported injuries, please undertake the following:

- Listen to the patient's narrative;
- Reassure your patient without making unrealistic promises particularly regarding confidentiality;
- Establish the facts without asking leading questions;
- Do not subject the patient to repeat any allegations to other members of staff;
- Ensure the patient is safe, and refer to your team manager and the Safeguarding Team. Furthermore, in circumstances where the patient might be at risk of future harm, the patient must be referred to either children or adult social care in their area of residence.
- In circumstances, where the injured person is under 18, referral to Children's Social Care is unequivocal in all cases of Non-Accidental Injury, (NAI). However, in adult cases there will need to be a clear determination as to whether the adult is at risk due to additional vulnerability. The Trust Advisor for Adults at Risk should be consulted prior to any referral.

- If the injuries are alleged to be the result of domestic violence, refer to specialist agencies. In addition, where there are children and young people exposed to domestic violence, referrals should be concurrently made to Children's Social Care and Domestic Violence Specialist Services;
- If your patient needs immediate, specialist medical care, refer to A&E;
- Record events as soon as possible, i.e. on the same day. Record the date, time, place, those present, observed non-verbal behaviour, and the exact words used by the child, young person or adult;
- Complete a body map to indicate the position of any noticeable or reported injuries. (See attached).
- In situations where an injury has prompted an examination undertaken by a doctor or when an injury is observed, the clinician, worker or practitioner must complete a Trust Incident Form;
- Thereafter, if there are any concerns regarding the adequacy of follow-up regarding any patient with a known injury, the clinician, practitioner or worker must escalate their concerns and report to the Safeguarding Team: Named Doctor, Dr. Caroline McKenna; Named Professional for Safeguarding Children, Sonia Appleby and the Trust Advisor for Adults at Risk, Janna Kay

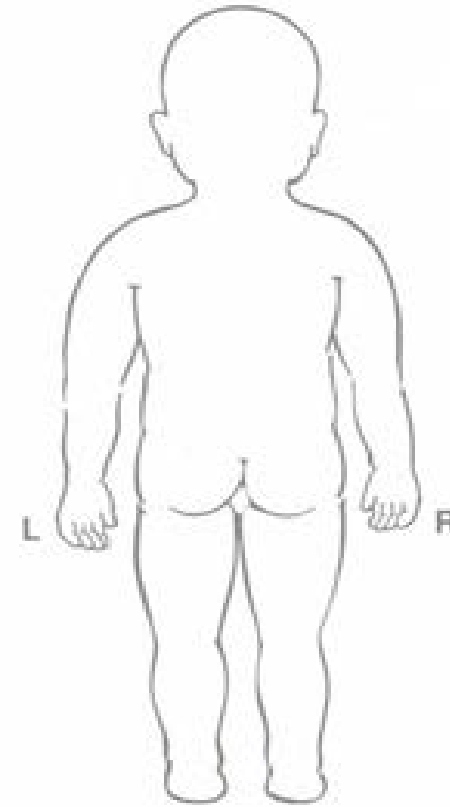
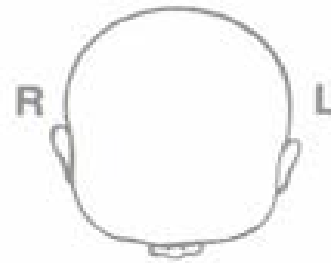
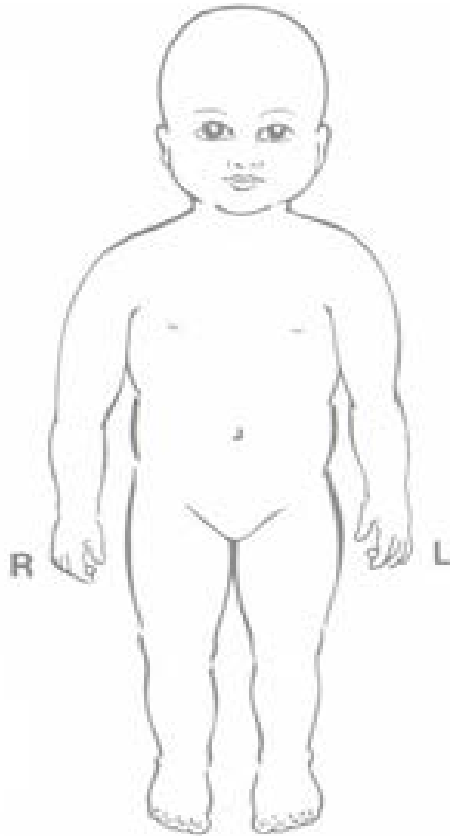
Body Maps Infant

Child's Name:

Date:

Examination findings

(Number Injuries Sequentially, Indicate Dimensions)

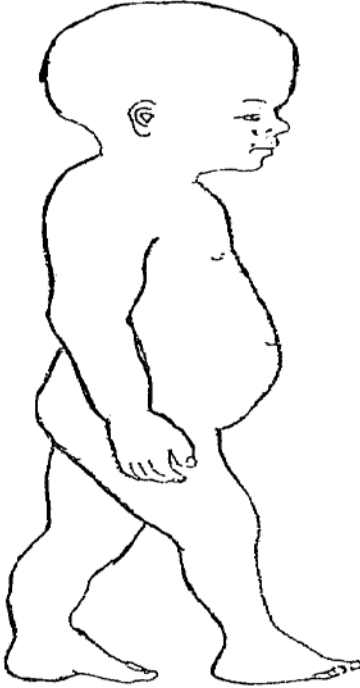


Child's Name:

Date:

Examination findings

(Number Injuries Sequentially, Indicate Dimensions)



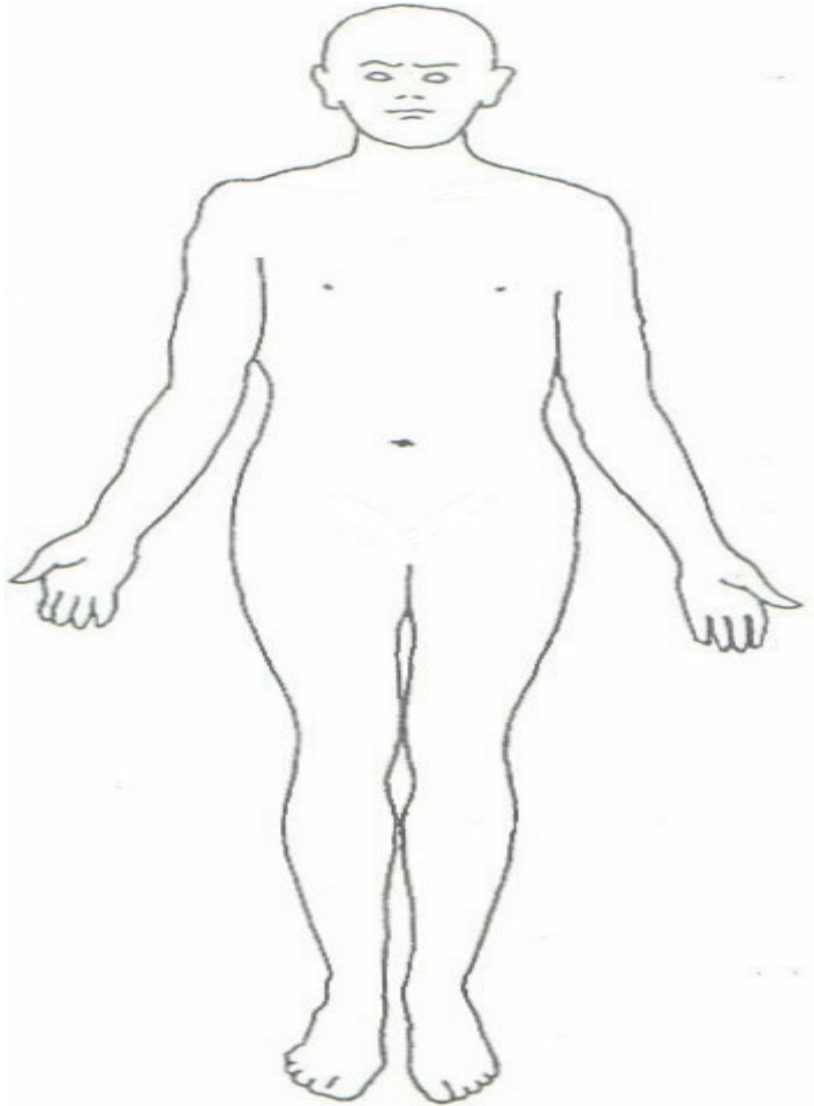
Body Maps (Older Child)

Examination Findings

(Number Injuries Sequentially, Indicate Dimensions

Child's Name:

Date:

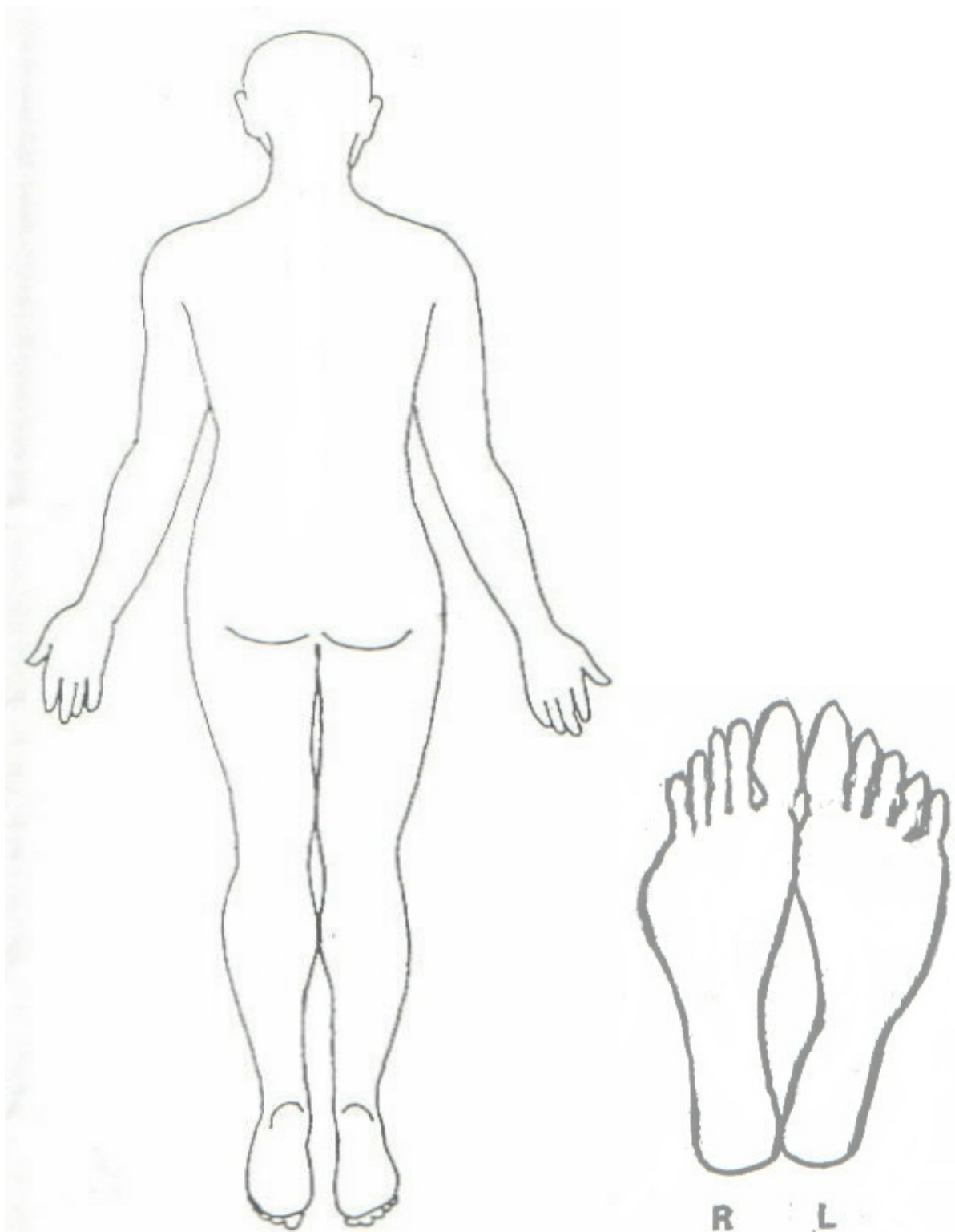


Examination Findings

(Number Injuries Sequentially, Indicate Dimensions)

Child's Name:

Date:

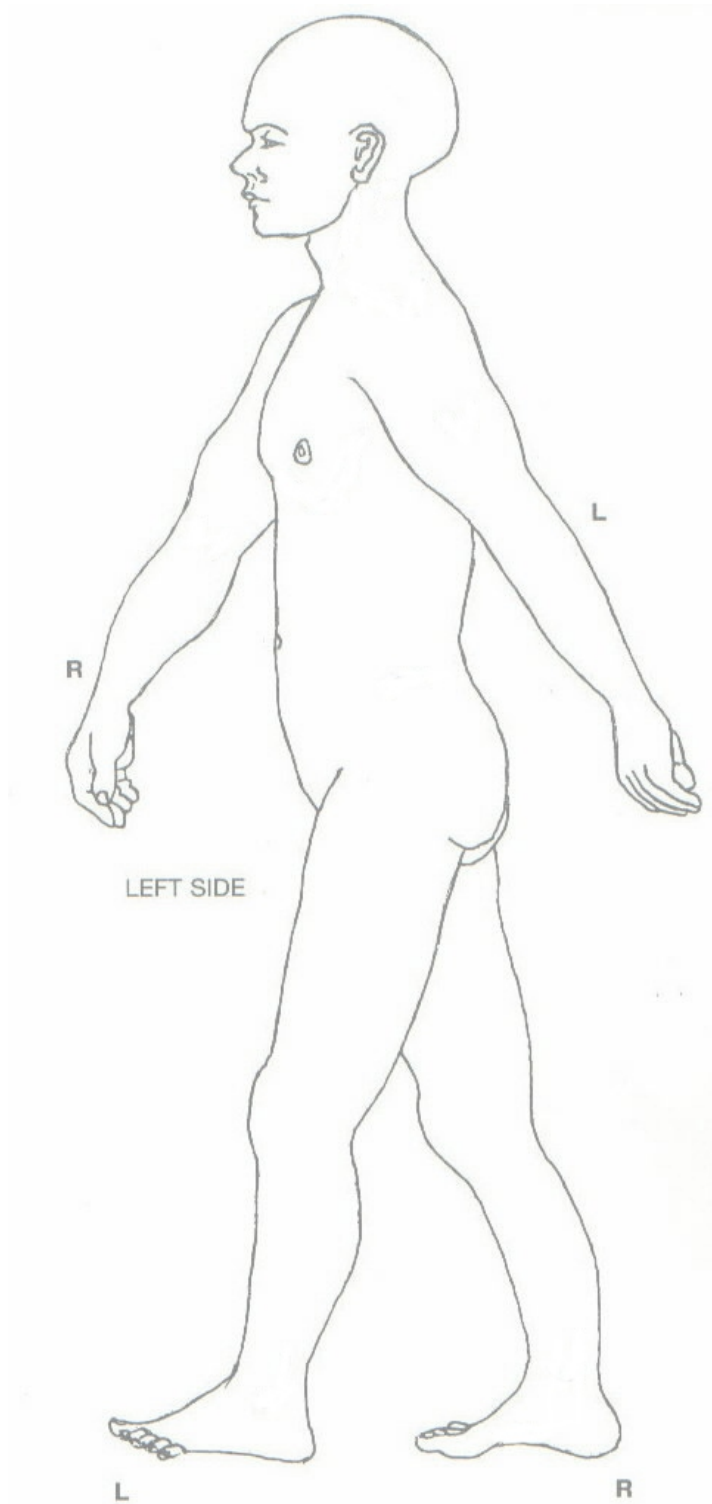


Examination Findings

(Number Injuries Sequentially, Indicate Dimensions

Child's Name:

Date:

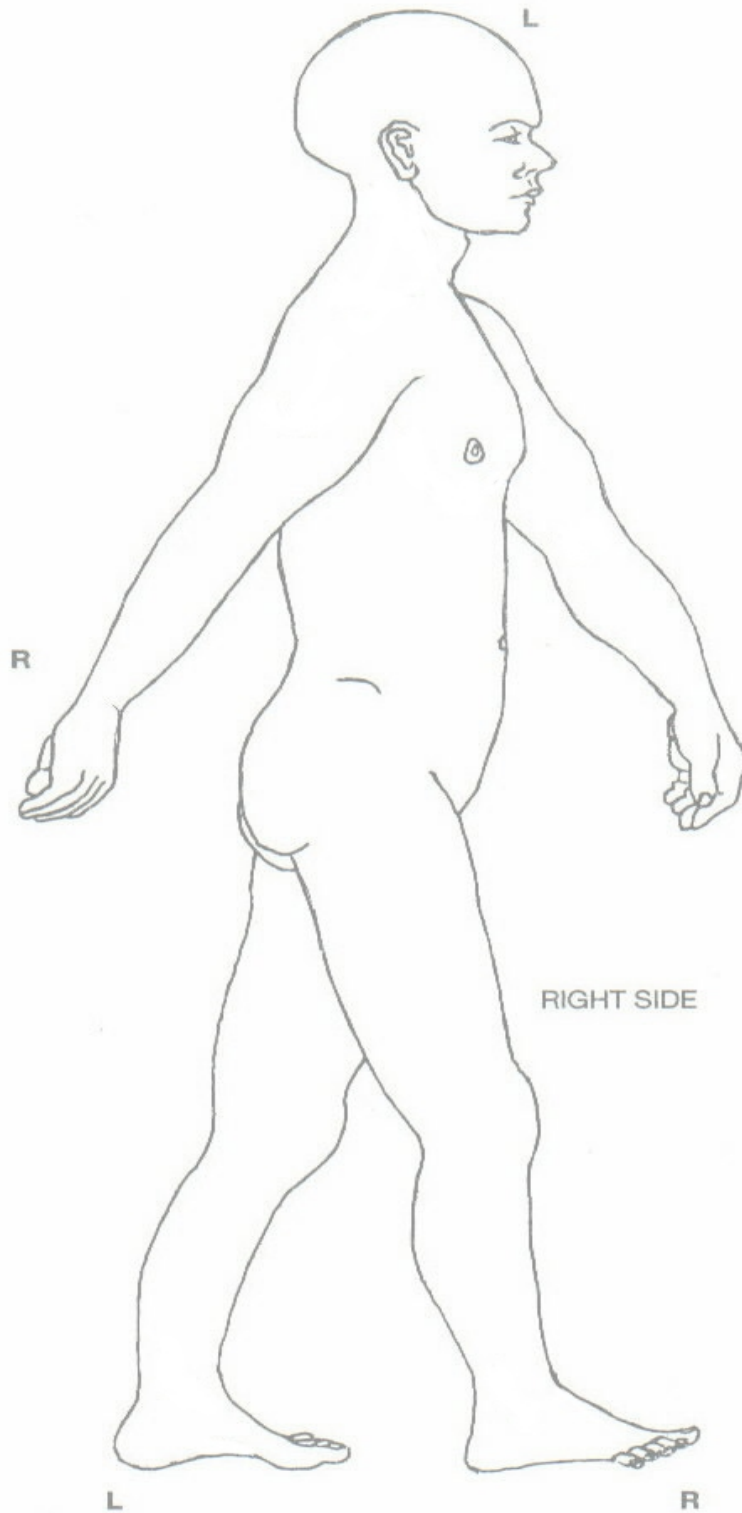


Examination Findings

(Number Injuries Sequentially, Indicate Dimensions

Child's Name:

Date:



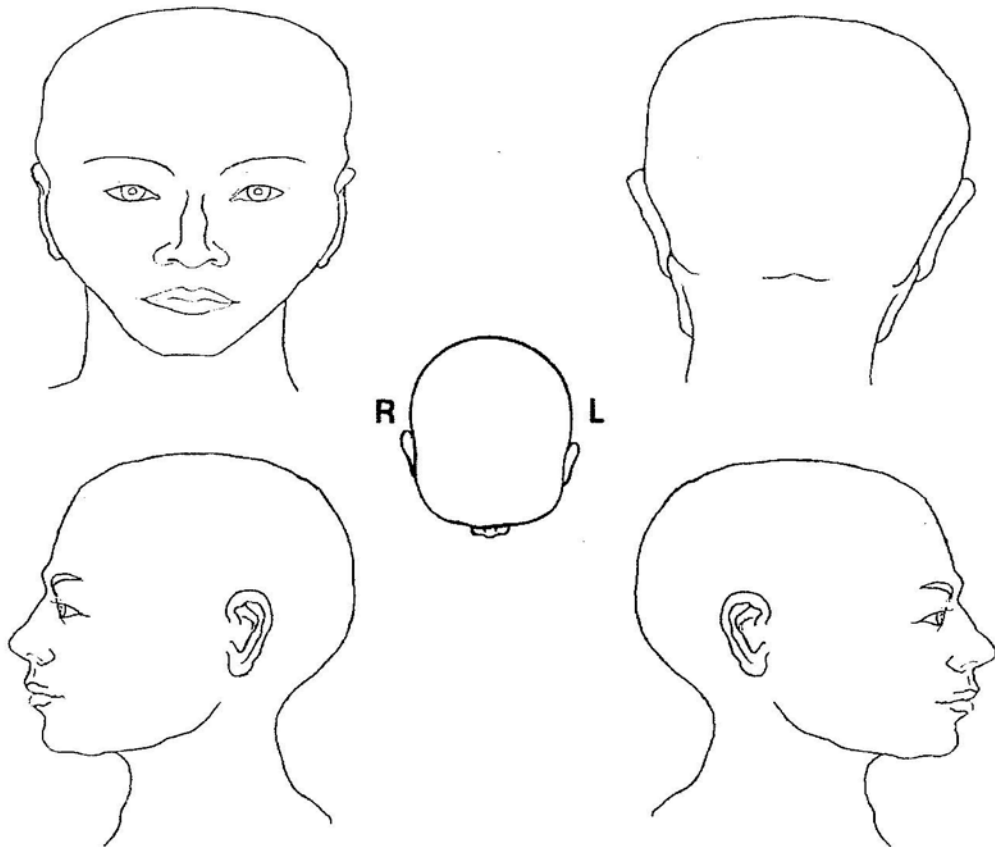
Body Maps Face

Examination Findings

(Number Injuries Sequentially, Indicate Dimensions)

Child's Name:

Date:



Body Maps Hands

Examination Findings

(Number Injuries Sequentially, Indicate Dimensions)

Child's Name:

Date:

