Tower Hamlets GP Care Group

Safeguarding Children Policy

Date Issued	29th March 2017
Date to be reviewed	Three yearly or as required due to legislative change.
Title	TH GPCG Safeguarding Children Policy
Supersedes	All Previous Policies
This policy will impact on	All individuals working in the Tower Hamlets GP Care group in whatever capacity. All subcontracted Providers are therefore expected to comply with this policy.
Financial Implications	No change
Policy Area	Governance
Version No	2
Issued By	Governance and Assurance Board
Author	Caroline MacGregor Adapted from Barts Health safeguarding policy authored by Judith Lewsey and Chris Hahn
Document Reference	
Effective Date	01/04/2017
Review Date	01/11/2017

Approval Record

	Committees / Groups / Individual	Date
Consultation	Clinical Leads for Health Visiting Barts Health Named Nurse for Safeguarding Children Governance and Assurance Board	March 2017
Approved by		30/3/17

Safeguarding Children Policy

Contents

INTRODUCTION

Tower Hamlets GP Care group (THGPCG) is situated in the borough of Tower Hamlets in London. The Local Safeguarding Children Boards (LSCB) adopts the London Child Protection Procedures 2014 (LCPP 2014) therefore the majority of safeguarding processes across the health economy will be common to each health provider within the borough.

The majority of subject specific safeguarding issues and what action should be taken if identified, are included within this policy. Where this may not be the case, reference to national policies or guidance documents are detailed.

If any member of staff is not aware what action to take having read this policy, they should contact the Safeguarding Children Lead or Operational Director, They may also access assistance from the Barts Health Safeguarding Children Professionals based at both the Royal London Hospital and Mile End Hospital.

This Policy should be read in conjunction with the London Child Protection Policy and Procedures 2014 (LCPP 2014)

PURPOSE OF THE POLICY

THGPCG is committed to safeguarding children and young people. It is required to fulfil its statutory Duty under Section 11 of the Children Act 2004 to safeguard and promote the welfare of children.

All staff within the organization may, in the course of their work, come into contact with children and families and have a responsibility to ensure that they know what to do if they encounter child abuse or are concerned that a child or young person is at risk of harm.

THGPCG staff working with children, young people and/or their families/carers, should take reasonable measures to ensure that the risk of harm to children's welfare is minimized and where there are concerns, appropriate actions to address those concerns must be taken, working to this and other relevant policies, procedures and guidelines in full partnership with other agencies.

All staff should note the principles of the Children Act 1989/2004 (HM Government 1989/2004) that states: 'A child's welfare is paramount and each child is unique.'

TO WHOM THE POLICY APPLIES

This policy applies to all staff employed by THGPCG, including permanent employees, those on temporary or honorary contracts, Bank Partners employees, students, sub-contractors and other agency staff.

SCOPE OF THE POLICY

The aim of this policy is to ensure that THGPCG has a workforce who, whether they work directly with children or not, are aware of their responsibility to safeguard and promote the welfare of all children. It must be used in conjunction with other policies, procedures, individual borough pathways and local clinical guidelines.

Barts Health Safeguarding Children Team provides a statutory and supportive role to all staff working within, or contracted by the THGPCG organization. It has a responsibility to provide a comprehensive safeguarding children's service for all health staff involved with the care of children and their families.

This policy outlines the roles and responsibilities of the Safeguarding Children Team in supporting the THGPCG.

It details the safeguarding structures and lines of accountability and provides clear guidance in relation to individual THGPCG staff and health agency responsibilities as reflected in the London Child Protection Procedures 2014 (LCPP 2014)

EQUALITY AND DIVERSITY

Child protection work with families is offered with a clear child focus, based on careful assessment of each individual child's needs. The approach should be sensitive to the different family patterns and lifestyles that take place in a multi-cultural society, and to the various child rearing patterns that are offered in different racial, ethnic and cultural groups. It must however ensure individuals adhere to the law of the country in which we live.

All healthcare staff that work with children and young people and/or adults who have parenting responsibilities have a duty to safeguard and promote their welfare. This responsibility is not limited to those children with whom we have a formal working relationship. It extends to all children with whom we come in contact with through our work regardless of the nature of that contact. Staff also has a duty to act on safeguarding concerns even if they are not in direct contact with the child.

Professionals must be clear that child abuse cannot be condoned for religious or cultural reasons. All children, whatever their religious or cultural background must receive the same care and safeguards with regard to abuse and neglect.

The safeguarding work of staff is offered to all children regardless of any disability. In fact, children with disabilities/complex needs are at higher risk of abuse and therefore staff needs to be aware and alert to this possibility. There is a commitment to a high standard of safeguarding for all children, with a culture of openness and honesty with children and their families.

DEFINITIONS

The Children Act 1989/2004 (HM Government 1989/2004) defines a child as anyone who has not reached their 18th birthday, 19th if disabled and it also includes the unborn child.

The fact that a child has become 16 years of age, is living independently, is married, is in further education, is a member of the armed services, is in hospital or in custody in the secure estate for children and young people, does not change his or her status or entitlement to services or protection under the Children Act 1989/2004.

Safeguarding and promoting the welfare of children is defined as:
protecting children from maltreatment; preventing impairment of children's health or development; ensuring children are growing up in circumstances consistent with the provision of safe and effective care.

Child protection is a part of safeguarding and promoting welfare. It refers to the activity that is undertaken to protect specific children who are suffering, or are likely to suffer, significant harm.

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.

FOUR CATEGORIES OF ABUSE

Physical abuse:

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. Physical abuse also includes Female Genital Mutilation which has prevalence within the borough within residents originating from countries of the cultural behavior.

Emotional abuse:

Emotional abuse is the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may 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 also occur alone.

Emotional abuse also includes radicalization or exploitation by a radical group.

Sexual abuse:

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. Sexual abuse also includes sexual exploitation.

Neglect:

Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance 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.

(HM Working together to safeguard Children 2015)

Where abuse takes place:

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.

Professionals may also abuse children. If you suspect that abuse is being carried out by a member of staff, you must inform your line-manager immediately. If it is your line manager you have concerns regards please escalate to the Operational Director or organizational safeguarding lead. (See Appendix 1) If unsure you may also approach the Safeguarding children professionals who will advise you what to do.

RESPONSIBILITIES

Chief Executive:

The THGPCG Chief Executive has responsibility for ensuring that the health contribution to safeguarding and promoting the welfare of children is discharged effectively across the organization. They are responsible for identifying a board executive lead for safeguarding children, as well as a Named Nurse, Doctor and Midwifes for Safeguarding Children.

Executive Lead:

The THGPCG board executive lead has the overall responsibility for governance, systems and organizational focus on safeguarding and promoting the welfare of children. They are responsible for providing and/or ensuring the availability of appropriate expertise and advice and support to the Local Safeguarding Children Boards.

Designated Doctors and Nurses:

Designated Doctors and Nurses are employed by the CCG and take a strategic and professional lead on all aspects of the health service contribution to safeguarding children across the health economy. They provide advice and supervision to Named Professionals and ensure that THGPCG undertakes its statutory responsibilities within services commissioned by CCG's and Local authorities to safeguard and promote the welfare of children.

Named Professionals for Safeguarding Children:

The Named professionals provided by the Barts Health and from within THGPCG ensure that expert specialist advice, training, and support relating to safeguarding children matters including clinical decisions is provided across all sites to all staff in THGPCG including externally contracted or commissioned staff.

The named professionals include Named Nurses, Named Midwives and Named Doctor
Named professionals provided by Barts Health provide professional safeguarding advice within the organization and provide advice and expertise for fellow professionals. Named professionals support the organization in its clinical governance role, by ensuring that audits on safeguarding are undertaken and that safeguarding issues are part of the THGPCG clinical governance system. They work closely with the board safeguarding children lead to ensure that all services are aware of their responsibilities and that the organization is meeting its statutory requirements as specified in (HM Government Working together to safeguard children 2015)

Director of HR:

The Director of HR is responsible for ensuring that THGPCG has
policies in place to comply with NHS Employers and CQC's safer recruitment requirements. The Director is also responsible for ensuring that HR support the organizations
designated officer to manage allegations against staff.

Directors and Leads of Service:

Leads of services ensure that they and their staff are familiar with the child protection policies as defined by this document; access the appropriate level of safeguarding training and supervision

commensurate to their role; that there are clear supervision arrangements within their service area to ensure that staff receives the support they need to safeguard and promote the welfare of children, young people and their parents/carers.

All Staff:

All staff, regardless of grade or position, has a responsibility to safeguard and promote the welfare of all children. All staff must follow the THGPCG Safeguarding Children Policy and associated guidelines where there are child protection concerns. If staff have concerns about a child's welfare they must not assume someone else will do something about it –it is their responsibility to act. This cannot be delegated tooters. If staff is unsure what action to take, they must contact their Line Manager or Safeguarding Children Team.

ASSESSMENT

Assessing the caring responsibilities of all parents/carers:

Vulnerable children, children in need and children who are in need of protection may be hidden from view if the focus of the health intervention is directed at the parent, carer or guardian. The fact that they are a parent, carer or guardian may not be known at the point of a service being delivered.

In the routine assessment of all adult patients, regardless of their age, direct questions should be asked to ascertain if they are a parent, carer or guardian of a child or young person. The outcome of this routine enquiry should be included in the assessment of their needs including their capacity to parent. If their parenting capacity is compromised by either the presenting health concern or compliance with the expected treatment programme, consideration must be given to the welfare of the children in their care.

The appropriate parts of this policy must be adhered to ensure both the child and parent/carer receives the support they require and information will need to be shared with other health professionals working with the child.

Vulnerable children/definition of a vulnerable child:

There is no exhaustive list that will accurately define those families where child protection or safeguarding concerns may arise. The table below highlights some vulnerability indicators and these must be considered as part of the assessment process. Details are provided to further, LSCB and national guidance where known to be available. More detailed information relating to subject specific safeguarding issues is detailed further down this policy to comply with Department of Health and Care Quality Commission (CQC) requirements. Please note this list is not exhaustive.

Vulnerable Indicators:

- Animal Abuse
- London Child Protection Procedures and Practice Guidance (2014) (LCPP 2014)
- Bullying
- London Child Protection Procedures and Practice Guidance (2014) (LCPP 2014)
- Children in hospital for more than 3 months
- Working Together to Safeguard Children: A guide to inter-agency working to safeguard
- and promote the welfare of children (2015)
- Child Looked After
- Promoting the Health and Welfare of Looked-After Children – Statutory Guidance (2015)
- Child subject to a Child Protection Plan and Child subject to a Child in Need Plan
- Working Together to Safeguard Children: A guide to inter-agency working to safeguard and
- promote the welfare of children (2015)
- Concealed Pregnancy
- Domestic Abuse
- All local and national Policies, procedures and statutory guidance.
- Fabricated or Induced Illness
- Safeguarding Children in Whom Illness is Fabricated or Induced (2008)
- And Fabricated or Induced Illness by Carers: A Practical Guide for Pediatricians (2009)
- Faltering Growth (without any known organic cause)

- Female Genital Mutilation
- Female genital mutilation: resource pack (HM Govt. 2017)
- FGM Multi-Agency Practice Guidelines (HM Govt. 2017)
- FGM toolkit : Resolution 2016
- Forced Marriage
- London Child Protection Procedures and Practice Guidance (2014)
- Multi Agency Practitioner Guidance (2014)
- Frequent attendances to the Emergency Department
- Gang Activity / Youth Violence
- Safeguarding children affected by gang activity and or youth violence LCPP (2010)
- Homelessness
- Shelter (2010)
- Learning Disability
- Safeguarding Disabled Children (DCSF 2009)
- London Child Protection Procedures and Practice Guidance (2014)
- Missing from Care, Home or School
- Identifying Children who are Missing education Gov.uk (2016)
- Guidance on children who runaway or are missing from home Gov.uk (2014)
- Sexual Abuse /Exploitation
- Sexual Offences Act (2003)
- Child Sexual Exploitation. Gov.uk (2017)
- The London Child Sexual Exploitation Operating Protocol 2nd Ed. LCPP (March 2015)
- Spirit Possession
- Safeguarding Children from Abuse Linked to a Belief in Spirit Possession, DfE (2007)
- Substance Misuse
- London Child Protection Procedures and Practice Guidance (2014) LCPP (2014)
- Teenage parents
- Trafficking
- Safeguarding children who may have been trafficked: Practice Guidance DfE (2011)
- Care of unaccompanied children Gov.uk (2015)
- Unborn Children
- Young Carers
- The Young Carers (Needs Assessments) Regulations. Gov.uk 2015

The following cases must be discussed with a member of the Safeguarding Children Team:

- Children were fabricated or induced illness is confirmed or suspected
- Injuries in children without adequate explanation
- Cases involving children with concerns that are likely to result in civil or criminal proceedings
- Those where despite single or multi-agency support, the child is continuing to suffer significant harm and where there is inter-agency conflict on how the case should be progressed.
- All unexpected child deaths
- Cases where sexual abuse is perpetrated by a child
- Sexual activity in under 13yr olds
- Domestic abuse cases where the victim or perpetrator is under the age of 16.
- Cases where a member of staff (THGPCG or external organization) is alleged to have harmed a child.

EARLY HELP

National reviews on health, poverty, child protection and early year's education have all emphasized the importance of coordinated early help or early intervention for children and families to give children and young people the best possible start in life.

If a child is identified as having additional unmet needs and a child protection threshold is not met an Early Help assessment (which is based upon the principles of the Common Assessment Framework - CAF) should be undertaken to clearly identify the needs of the child and actions required and advice should be sought from the Early Help Hub.

Tel: 020 7364 5744.
Email: earlyhelp@towerhamlets.gov.uk

CHILDREN SUBJECT TO STATUTORY REQUIREMENTS

Children in Need

A child is defined as being 'in need' if:

- He is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him of services by a local authority.
- That their health or development is likely to be significantly impaired or further impaired, without the provision for them of such services.
- They are disabled.

Children Act 1989 (Sect. 17) (HM Government 1989)

Children in Need of Protection

A child is defined as being in need of protection if:

- 'There is reasonable cause to suspect that a child is suffering, or is likely to suffer significant harm'

Children Act 1989 (Sect. 47) (HM Government 1989)

The definition of significant harm was amended under the Child Adoption Act 2002 (Sect.120) to include: 'impairment suffered from seeing or hearing the ill-treatment of another'.
(HM Government 2002)

MAKING A REFERRAL TO CHILDREN'S SOCIAL CARE

If a child is considered to be a 'child in need' or a 'child at risk of significant harm' as defined by Children Act 1989, a referral must be made to Children's Social Care.

Child in Need Referrals (Sect.17)

Parental consent or the consent of the child (if Gillick competent) is required for Child In Need referrals. Tower Hamlets: All Child In Need referrals must be made to Children's Social Care on a completed Common Assessment Framework or Early Help Assessment. The Common Assessment Framework or Early Help Assessment must additionally detail why Child In Need services are being requested.

Child Protection Referrals (Sect.47)

Where there are clear allegations, evidence, or strong suspicion of abuse, there must be NO DELAY in making the referral. Where the child is an inpatient the referral must be completed by the end of the shift.

Tower Hamlets Community: Children supported by community services in Tower Hamlets must be made to the IPST/MASH using the Tower Hamlets Inter-Agency Referral Form.

If the referral is urgent then a telephone referral must be made prior to the referral being sent.

Tel: 0207 364 5601/ 5606 /3859 /2972,
Fax: 0207 364 2655.
Outside of office hours (17.00 - 09.00, weekends and bank Holidays): Tel: 0207 364 4079.

Any child protection referral must not interfere with or delay the management of the child's immediate or on-going health needs.

All referrals must be clearly documented in the child's electronic medical record along with a copy of the referral form. The interagency referral form is available for down load on the LSCB website and attached as Appendix 2

If you have reason to believe that a child is in imminent danger of harm the police should be called using the **999** emergency services number.

Following up referrals made to Children's Social Care:

Children's Social Care should provide the referrer with initial decisions within 24 hours.

If the referrer has not received an acknowledgement of the referral within three working days, they should contact the relevant social work team to clarify what action is being taken. Depending on the nature of the referral, a decision may be expected more quickly than this and therefore may need to be followed up within this timescale.

Should a child be discharged from a hospital or urgent care setting following a referral, urgent communication must take place by the service area with the Health Visitor /School Nurse and GP to follow up the outcome of the referral.

Children in Hospital for More than Three Months

Any child who will be in hospital for more than three months must be referred, under Section 85 of the Children Act 1989 to the borough's Children's Social Care Team.

The referral should be made as soon as it is anticipated that the child will be in hospital long term. This will enable social work colleagues to plan for the assessment and make any arrangements necessary to ensure the safeguarding and promotion of the child's welfare in advance of discharge from the hospital. Community health staff may be required to attend a discharge planning meeting.

Any child subject to a Section 85 assessment must not be discharged from the hospital without prior consultation with the social worker.

Child Protection Medicals

A Child Protection Medical is undertaken in some cases when children are referred to Children's Social Care or the Police with concerns relating to any form of abuse or neglect and a specialist medical opinion is required to:

- Identify unmet medical or developmental needs.
- Identify a management plan.
- Analyze known medical or developmental concerns and interventions in the context of abuse and neglect and advise on their significance.
- Examine and assess to provide evidence for statutory, civil or criminal proceedings as required.

A Child Protection medical M may also be requested by health professionals where a child protection concern may arise solely from the medical presentation in a case where a second opinion may be needed before making a referral as child protection.

Requests for child protection medicals must be directed to:

Mon–Fri 9am-5pm: Wellington Way Health Centre Tel: 0208 980 3510
Outside of these hours the request must be directed to the on-call Pediatric Registrar via The Royal London Hospital via switchboard.

All child protection medicals undertaken must be recorded on the child's electronic medical record. And a copy of all child protection medical reports must be forwarded to the Designated Doctor for Safeguarding Children in Tower Hamlets or the borough in which the child lives- if not resident in the local Tower Hamlets borough.

RESPONSE TO A MEMBER OF THE PUBLIC EXPRESSING CONCERN ABOUT A CHILD

If a member of the public contacts a member of staff with information regarding the possible abuse of a child, the member of staff must act on this information. This could be in the following ways:

- Provide the caller with the contact details for Children's Social Care in the borough in which the child resides so they can self-report their concerns.

  Tel: 0207 364 5601/ 5606 /3859 /2972
  Fax: 0207 364 2655
  Outside of office hours (17.00 - 09.00, weekends and bank Holidays): Tel: 0207 364 4079

- It should be explained to them that they can share this information anonymously.

- If the caller does not want to self-report, the member of staff must make a 3rd party referral to Children's Social Care.

If you have reason to believe that a child is in imminent danger of harm the police should be called using the 999 emergency services number.

If the child / young person are known to the service, information regarding the incident must be Recorded within the health record. Notify the health visitor/ school nurse and GP that this referral has taken place so they can follow up the outcome of the referral.

If the allegation relates to a member of staff or a volunteer, please refer to the previous guidance regarding allegations against staff.

PARENTAL RESPONSIBILITY AND CONSENT TO TREATMENT

Consent may be given either by the person with parental responsibility for the child or, where the child has capacity to give consent, by the child. Generally, a parent makes the decision for their child.

However, where the child has sufficient maturity and understanding of the proposed procedure (often referred to as meeting the Frazer guidelines or being 'Gillick competent'), then the child is legally able to consent to treatment (but may not be able to refuse treatment).

In the event of a conflict between a health professional and a child/parent/carer, parent and a child or two adults with parental responsibility, healthcare professionals should discuss the case with their Legal Team.

In situations where there is a concern regarding the capacity or understanding of a 16 or 17 year old, the HM Government Guidance 2005 applies; therefore an assessment of mental capacity must be undertaken by an appropriate professional. (Mental Capacity Act 2005)

PRIVATE FOSTERING

A private fostering arrangement is defined as:

'an arrangement between families/households, without the involvement of a local authority, for the care of a child under the age of 16 (under 18 if disabled) by someone other than a parent or close relative (close relatives are parents, step-parents, siblings, aunts/uncles and grandparents) for 28 days or more ***(Private Fostering Legislation Guidance 2005)***

This could be an arrangement by mutual agreement between parents and the carers or a situation where a child has left home against their parent's wishes and is living with a friend and the friend's family.

The period for which the child is cared for and accommodated by the private foster carer should be continuous, but that continuity is not broken by the occasional short break.

Privately fostered children are a diverse and sometimes vulnerable group and will include:

- Children sent from abroad to stay with another family, usually to improve their educational opportunities;
- Asylum seeking and refugee children;
- Teenagers who, having broken ties with their parents, are staying in short term arrangements with friends or other non-relatives;
- Children of prisoners placed with distant relatives;
- Language students living with host families;

Private foster carers and those with parental responsibility are required to notify Children's Social Care of their intention to privately foster, to have a child privately fostered or where a child has been privately fostered in an emergency.

It is likely that Children's Social Care will have been notified of most private fostering arrangements however THGPCG staff should refer any children who are identified as being privately fostered to social care in case this has not been reported by the parent or foster carer.

CARE OF ADOLESCENTS

An adolescent is defined as anyone between the ages of 11- 17 years of age (HM Government Working together 2015)

Children and young people under the age of 16 should not be admitted to adult wards unless in exceptional circumstances. If there are no adolescent facilities available and if this is the child's and family's own preference, subject to an assessment of clinical need and the child's physical and emotional development, it may be considered.

A young person over the age of 16 may be admitted to a pediatric ward where this is judged appropriate to his or her physical and emotional development.

A consultant pediatrician or pediatric specialist will supervise the management of all children admitted to a pediatric ward. A consultant pediatrician must always be available for support of care of 16 and 17 year olds. THGPCG staff should challenge if a child moving from their care to hospital care is not looked after in this way.

If a young person under 18 is admitted to an adult ward, the assessment must give consideration to the additional needs that a young person may have and services they may require, for example:

- Education and emotional support (CAMHS/CFCS)
- Support from a Registered Children's Nurse
- An assessment of any risks posed by other patients or visitors.
- Arrangements in relation to open and flexible visiting times.

CHILDREN ATTENDING SERVICES WHO ARE SUBJECT TO A CHILD PROTECTION PLAN

Tower Hamlets, children presenting at a nonscheduled care setting must be checked to see if they are subject to a child protection plan within that Borough.

If children attend from other boroughs, staff will not be able to automatically check whether or not the child is subject to a child protection plan however this information must be sought from the child or their parent / carer during the initial assessment process. It can also be established from borough Children's Social Care teams if concerns arise.

If a child is found to have a child protection plan and their attendance is not deemed to be linked to any child protection issues then the Social Worker should be notified by telephone or email.

Within Emergency Departments (ED's), any concerns, as well as children subject to child protection plans, must additionally be logged onto the psychosocial spreadsheet for review at the psychosocial meeting. This does not detract from the individual responsibility for services to notify the appropriate social worker services.

The fact that a child is not subject to a child protection plan should not diminish any concerns held and the assessment processes and guidance within this policy should be adhered to.

NON ATTENDANCE AT HEALTH APPOINTMENTS

When any child fails to attend health appointments, it is the responsibility of the health professionals involved with the family to reassess the health needs of that particular child. It is not acceptable to discharge such a child from the service for non-attendance without a reassessment and liaison with the original referrer and if known any lead professional.

If the child / young person are subject to a child protection plan, the social worker must be informed immediately.

Failure to attend appointments and the reason for non-attendance (if known) must be documented in the medical record and if relevant, the personal child health record.

When children fail to attend hospital or other medical or specialist appointments that if left untreated or unmonitored could lead to the impairment of a child's normal growth and development, a referral to Children's Social Care should be considered identifying the likely impact on the child.

The practitioner from that service should also undertake the following: contact with the parent/carer to make sure they fully understand that the non- attendance could be perceived as a sign of neglect.

The reason for not attending should be documented within the child's clinical record. Inform the child's GP and Lead Professional. Best practice would also additionally be to notify the child's Health Visitor

The clinician must not discharge from the service without checking with the referrer the social situation. (When to Suspect Child Maltreatment in under 18's -NICE 2009 reviewed 2014)

NO ACCESS VISITS

If there is no reply or no access during a previously planned visit i.e. an appointment has been made with the parent/carer, a no reply/no access visit card should be left stating the date and time of the visit and the date and the time of the next proposed visit and a contact number to enable the client to make contact. All no access visits should be recorded and if there is an allocated social worker they should be informed.
If it is later established that the child is not currently living at the address and their whereabouts are unknown, the safeguarding children team should be contacted for further advice. Staff working in Tower Hamlets should follow the Unseen Child Policy Flowchart appendix 1.

CHILDREN LEFT HOME ALONE

If a baby or child is found at home alone, they are locked in the house and or the practitioner is unable to gain entry and there is immediate concern for the child's safety, the Police should be called (999).

If the practitioner is able to speak with the child from outside of the property and there are no immediate safety concerns, establish the child's understanding of the whereabouts of the parent/responsible person and the arrangements made. If the parent can be located, reunite parent and child and advise the parent/carer of the dangers of leaving children alone; if the parent or responsible person seems likely to return shortly, wait outside the property ensuring the child remains safe. If at any time of waiting the children cannot be seen to assess the risk then call the police (999)

If a baby or child is found in the care of an adult incapacitated through illness or substance misuse, the practitioner should ensure the child is left with a responsible and safe adult. If no responsible safe adult is able to be identified then the Police should be contacted.

All incidents involving children left home alone or found in the care of an adult incapacitated through illness or substance misuse should be referred to Children's Social Care as the child is at risk of significant harm.

If a child is identified as being home alone because a sibling is in the walk in centre or attending out of hours, or where it is identified during a telephone conversation, call 999 and refer the child to Children's Social Care.

The on call named Nurse for safeguarding children should be contacted if further advice is needed.

CHILDREN / FAMILIES REFUSING SUPPORT

If children are subject to a child in need/child protection plan and support, or where applicable home visits are refused; the social worker must be informed by the end of the working day.

If the child is vulnerable and does not have an allocated social worker, the case must be discussed with the Safeguarding Children Team as consideration needs to be given as to whether a child protection referral needs to be made.

CHILDREN NOT IN THE EDUCATION SYSTEM

It is a legal requirement that all children of school age receive an education. If any child of school age is found not to be in the education system, the Borough's Pupil Services must be notified using Whipps Cross: Staff must inform the Safeguarding Children Team who will contact the Missing from Education Team.

If the child/young person lives in any other Borough, that Borough's Pupil Services and the community safeguarding children team must be notified

Further information can be found in: Safeguarding Children Missing from School (LCPP 2005)

CHILDREN NOT REGISTERED WITH A G.P.

All children have the right to access healthcare at the point of need, an effective way to ensure this is through GP registration. If there are no legal reasons prohibiting this, the health professional should signpost the family to their local CCG:

Tower Hamlets: 020 3688 2500

This information must additional be shared with the child's Health Visitor and if applicable the School Nurse who will follow up with the parent or guardian to ensure that the child is registered.

If there is language or other difficulties in accessing or communicating with the GP surgery, assistance should be offered to the parent or guardian to facilitate registration.

Where parents or guardians fail to ensure the GP registration of their children or children in their care over a prolonged period, staff should give consideration as to whether this constitutes a safeguarding issue taking into account other factors known in the context of the child's health.

CHILDREN NEW TO THE BOROUGH

Staff must be alert to children/young people who may have recently moved into the borough, e.g. transfer in from another borough or moved here from abroad. This may become apparent when staff discover the child is not registered with a GP, does not attend school or become aware that the child has had a number of different addresses.

The full details of the child outlined above must be obtained and documented in the child's medical record.

Consideration must be given to families who do not speak English as a first language and may need communication support to help them understand health services being provided/referrals being made. This is particularly important for people who are not accustomed to health service provision and as a consequence may not know how to avail themselves of the different services or may have fears about engaging with the services. A health advocacy service is available.

CHILDREN MISSING FROM CARE OR HOME

Staff must inform the Police (999) and Children's Social Care if they become aware that a child / young person have run away from home or a Local Authority Care Home.

Further guidance can be found in: Safeguarding Children Missing from Care or Home (LCPP 2006)

INFORMATION SHARING

A key factor in many serious case reviews has been a failure to share and understand the significance of the information shared and to take appropriate action in relation to the concerns disclosed or observed.

All staff must recognize that sharing information is vital for early intervention to ensure that children are protected from abuse and neglect.

Staffs need to be aware of when, why and how information should be shared so that they can do so confidently and appropriately as part of their day to day practice.

The member of staff should consider and discuss with the child and/or parent confidentiality, consent and information sharing at the outset including the duty to share information where there are concerns about a child's welfare. Should a concern or allegation take place these must be discussed again and if a referral to children's social care is to made, the child and/or parent/carer must be informed unless to do so would place the child at increased risk of significant harm.

Professionals must use their judgement but should also be aware that failure to pass on information that might prevent a tragedy could expose them to criticism in the same way as an unjustified allegation.

The safeguarding of children is paramount and must override any duty of confidence.

The law will not prevent you from sharing information with others if:

- Consent has been obtained.
- The public interest in safeguarding the child's welfare overrides the need to maintain confidentiality.
- Information is being shared to inform a Sect.47 assessment being undertaken by Children's Social Care. The Children Act 1989 places an obligation on health professionals to share information when an assessment is being undertaken.
- Disclosure is required under a court order or other legal obligation.

Under these circumstances, staffs have a responsibility to share appropriate and proportionate information about a child or young person with other professionals /agencies in accordance with Safeguarding Practitioners: Information Sharing Advice (Working together to Safeguard children 2015).

If at any time you are unsure as to whether or not information can be shared, further advice must be sought from your; Service manager, the Director of Governance, the Caldecott Guardian or the Safeguarding Children Team. See chart appendix 1 for contact details.

All decisions taken as to whether to share/not share information must be documented in the child's clinical record.

Further Information can be found in The Code, Professional standards of practice and behavior for nurses and midwives (NMC 2013) and GMC Guidelines Good Medical Practice (GMC 2013).

DISAGREEMENT OVER THE HANDLING OF REPORTED CONCERNS

Disagreements over the handling of reported concerns may occur when Children's Social Care and or other agencies conclude that no action is required but the referrer believes that protective action is needed.

If you are concerned or unhappy about the decisions made you should:

- Initially discuss the matter with the social worker (and police officer where involved) who is
- managing the case and attempt to resolve the difference of opinion.
- Make enquiries of other health professionals/organizations to ensure there are no other
- concerns about the family.
- Keep written records of all contacts with other agencies, including telephone calls.
- Put your concerns in writing if the difference of opinion has not been resolved either to the
- team manager of the Social Services Team or Police Family Unit and copy it to your
- Named Nurse / Doctor for Safeguarding Children and Service manager.
- The Named professional can support with the writing of this letter if required and can give advice regarding the concerns you hold.
- If there are still concerns about the child's safety or management of the concern. If appropriate, the
- Named Professional will escalate the case in line with the Tower Hamlets joint Escalation Policy which can be found on the London Safeguarding Children Board website.
- Health professionals can request a child protection conference even if the social worker has not
- done so and has no plans to do so. This would normally be undertaken by the Safeguarding Children
- Team on the professional's behalf.

DISAGREEMENT WITHIN HEALTH

In cases where there is a difference of opinion between health professionals over the handling of a case where there are safeguarding concerns, a health professionals meeting should be convened. All the health professionals involved with the child or family should attend to share information and discuss the concerns. Consideration should be given to whether a member of the Barts Health Safeguarding Children Team or THGPCG Service managers should additionally attend to give an opinion.

If they are unable to resolve this they will escalate the issue to the Designated Doctor or Nurse for Safeguarding Children.

If the issue remains un-resolved following the input of either the Named or Designated professionals; the case must be raised with the Executive Safeguarding Lead (see appendix 1) for direction on how to proceed.

Where the differences are between health professionals in different health organizations, the above process should be applied and must include the Named and Designated safeguarding professionals of the respective health organization.

ACCESS TO ADVICE AND SUPPORT FOR STAFF

All staff has 24hr telephone access to a safeguarding professional who can be contacted to discuss individual cases:

Monday–Friday 9-5: advice can be sought from a member of the Safeguarding Children Team on:

- **Acute Services: Tel: 0203 594 6003**
- **Community Services: Tel: 0208 223 8879**

Outside of office hours, the on-call Named Nurse for Safeguarding Children can be contacted Via The Royal London Hospital switchboard on **Tel: 0207 377 7000**

Safeguarding concerns identified in a child under the age of 1 must additionally be discussed with the on-call Pediatric Registrar (via switchboard) who will discuss the case with the Consultant where necessary.

Any actions required following a telephone contact must be documented in the child's medical record by the professional seeking the advice.

CHILD PROTECTION AND INTERAGENCY MEETINGS

Health professionals have a duty to cooperate in child protection meetings (Children Act 2004). Professionals who hold a caseload i.e. Midwives, Health Visitors, Family Partnership Nurses and School Nurses are expected to attend all child protection meetings and must prioritize the attendance within their workload.

If staffs are unable to attend a child protection meeting they should ascertain if a colleague can attend on their behalf. If no health professional is able to attend, then it is the responsibility of the professional to contact their line manager for further advice.

If the line manager is unable to facilitate attendance from within the service, they should contact the Director of the service who if unable to arrange attendance cover will notify both social care and the Barts Health Safeguarding children team.

If at any time during a child protection meeting, a practitioner does not agree with the decisions being made, they should ensure that their view is minuted. Following the meeting the case should also be discussed with their line manager who may also suggest the Safeguarding Children team is notified.

Newly qualified staff and staff who are returning to practice must be accompanied to child protection meetings by their manager or mentor until they feel confident to attend alone and have completed their suite of Safeguarding children competencies (.Appendix 3)

Minutes of all child protection meetings

Staff should take notes to inform their record keeping entries, which cannot be identified by personal identifiable information, during any child protection meetings they attend. The following must be recorded in the child/young person's medical record same day or within 24 hours.

- The main points of the meeting
- Any change in the child's status
- Any decisions or updated action plan

Minutes of meetings should on receipt be recorded as received in the child/young person's health record and scanned into the electronic record as an attachment.

Inaccuracies should be drawn to the attention of the chair of the meeting as a matter of urgency and the subsequent minutes should be checked to ensure that they contain any required amendments. If minutes contain inaccurate information that is not corrected it will be assumed that they were accurate.

PROFESSIONAL MEETINGS

Team Around The Child (TAC) Meeting

A TAC meeting is a multi-agency meeting convened by the lead professional, tasked with supporting a child/young person and where appropriate the parents/carers to identify unmet needs and produce a timely and well-coordinated package of support/interventions.
The child/young person or their parents/carers must be informed of the meeting and given the opportunity to attend unless deemed by doing so would place a child or adult at further risk of harm.

Child Protection Conference (Initial)

A child protection conference is a multi-agency meeting led by Children's Social Care to receive and review information and consider whether the threshold has been met to make a child the

subject of a child protection plan.

Professionals who hold a caseload as described previously are expected to attend all child protection conferences and must prioritize these within their workload.

All services involved in the care of a child/young person should always complete a report in advance of the case conference on the following pro forma:

- Tower Hamlets: LBTH Universal Children's Report Pro forma (Appendix 4)
- All reports must be typed; the report should be forwarded to the Child Protection Coordinator chairing the conference five days before the conference is to be held by secure nhs.net account to secure gscx.account.
- In extreme circumstances of being unable to submit the report electronically, 10 copies (enough to allow for one for each attendee) of the report may be transported to the meeting via a secure metal briefcase. The briefcase and contents must not leave the sight and care of the individual professional during transporting. A taxi will be provided by the organization to avoid use of public transport. The Service lead must be notified if this is to take place as sensitive information is being transported in the public arena and a Datix incident report will need to be completed.
- The contents of any reports must be shared with the parents or carers prior to the conference and if applicable with the child. If doing so puts the child at further risk, then the reasons for not sharing should be documented within the child's health record. This should also be communicated to the chair of the case conference.
- Staff attending will be expected to contribute to the discussion and decision-making process of the conference.
- The Safeguarding Children Team can provide assistance with report writing and will support attendance where necessary.
- If a child has been seen for a child protection medical or the child is under the care of a Peadiatrician, the Pediatrician or a deputy have responsibility to attend and provide a report.

Case Conference (Pre-Birth)

A pre-birth case conference is held when an assessment under Section 47 of the Children Act 1989 gives rise to concerns that an unborn child may be likely to suffer significant harm.

The conference has the same status, and proceeds in the same way, as an initial child protection conference and therefore practitioners involved in the care of the unborn child must comply with the requirements.

Case Conference (Review)

The first review is after three months and thereafter six monthly with the exception of pre- birth case conferences where the first review is after one month and thereafter six monthly. At this meeting the child protection plan is reviewed, information assessed and decisions concerning the child's welfare is made.

The respective report pro forma must be updated in advance of the review conference reflecting your work with the child and or family that has taken place since the initial conference as well as any updated assessments. The updated report must be forwarded to the Child Protection Coordinator chairing the conference five days before the conference is to be held. Via secure nhs.net emails to gscx secure email. The need to transport paper copies in exceptional circumstances is addressed previously.

Where more than one THGPCG professional is involved in the care of the child/young person or family it is acceptable for only one of them to attend the review conference however individual reports must still be submitted and the Child Protection Coordinator informed that this is to be the case. The representative attending must be briefed by colleagues prior to the conference and complete all children's records following the conference as well as feeding back to the individual practitioners.

Core Group Meeting

The Core Group should meet within ten days of any case conference and the members will be jointly responsible for formulating, implementing and refined the child protection plan as required to reflect the recommendations made at the case conference.

Where more than one THGPCG professional is involved in the care of the child/young person or family, the health professional with the most direct contact with the child or family should take the lead health role in close liaison with the other professionals involved.

The THGPCG representative on the core group is responsible for attending every meeting. If they are unable to attend they should in the first instance seek to identify another health professional involved in the care of the child/young person to attend on their behalf. If no other professionals can be identified to attend then they should escalate this to their line manager,

If core groups are cancelled on a regular basis or are held when the health professional is not available, this will affect the functioning of the group and defeats the object of the child having a multi-agency child protection plan. This should be raised with the relevant Child Protection Coordinator in writing.

Child in Care Review Meeting

Children who are under the care of the Local Authority will have either a six or twelve monthly review of their case which looks holistically at the child's needs and which will be chaired by an Independent Reviewing Officer.

All staff may have direct contact with children who are looked after (LAC) by the Local Authority. If they are invited to a Statutory Review; they should attend, but if unable to, should provide a health report. If requested, reports for Looked After Child reviews should be completed on the pro forma sent by the Independent Reviewing Officer along with the invitation.

Further information regarding the LAC process can be found in Promoting the Health and Welfare of Looked-After Children – Statutory Guidance (DFE 2015)

Child In Need Meetings

A Child in Need Meeting will be held if there are no substantiated concerns that the child may be suffering, or at risk of suffering, significant harm however Local Authority intervention is required.

These meetings are usually held to either support families prevent a child becoming the subject of a child protection plan or where a child no longer requires a child protection plan but Local Authority intervention is still required.
Reports for Child in Need Meeting should be completed on the Borough's respective Universal Children's Report.

Strategy Meetings

Strategy meetings are usually held within 72 hours of an incident or allegation of abuse and their purpose is to share information and to plan an investigation.

These meetings will always involve Children's Social Care and the Police but may require attendance from another involved agency that has information to share, which will further inform the investigation.

The Safeguarding Children Team on each site must be informed of all strategy meetings and will attend where possible.

Practitioners attending from THGPCG should be sufficiently senior and able to contribute to the discussion of available information and to make decisions on behalf of the organization.

If the child is a hospital patient (in/out patient) or receiving services from the Child Development Team, the medical consultant responsible for the child's health care (or an appropriate deputy) Will attend as should a qualified member of the nursing team if the child is an inpatient.

Where a medical examination may be necessary or has taken place a senior doctor from those providing services should also be involved.

A pediatric Radiologist will be invited to all strategy meetings held in respect of children who have presented with a potential non-accidental fracture.

Legal Planning Meetings

A Legal Planning Meeting will be held in complex cases where the Local Authority is considering legal options, e.g. care orders. Health professionals are not usually invited to these meeting however may be if a health opinion needs to be sought. Any request to attend these meetings should be discussed with your line manager.

Family Group Conference

Family group conferences are used as a vehicle to engage the wider family in support within cases where there is a risk of legal proceedings being initiated. Health professionals are not usually invited to attend.

TRANSFER OF A CHILD WITH KNOWN CHILD PROTECTION CONCERNS TO ANOTHER HOSPITAL

In advance of any transfer, the medical and nursing teams must ensure telephone liaison occurs with receiving staff regarding the child protection concerns. Details of this communication must be documented in the child's health record.
The medical transfer letter must include details of the child protection concern.
The senior nurse must ensure that the Named Nurse for Safeguarding Children is informed of the transfer and child protection concerns on the day of transfer or first thing on the next working day.

SAFEGUARDING SUPERVISION

Supervision is: "A process in which one worker is given responsibility to work with another worker(s) in order to meet certain organizational, professional and personal objectives. These objectives are competent, accountable performance, continuing professional development and personal support". (Morrison 1993, adapted from Harris, 1987)

All THGPCG staff must have access to safeguarding children supervision as per Royal College of Pediatric and Child Health: Intercollegiate Document (RCPCH 2014) and in keeping with THGPCG safeguarding supervision policy.

For THGPCG 0-5 year's caseload holders see the Policy for THGPCG Health Visiting Supervision.

SAFEGUARDING CHILDREN TRAINING

One of the key elements of safeguarding and promoting children and young people's welfare is that all staff in all agencies and services have a clear understanding of their individual and their agencies roles and responsibilities and are able to undertake these in an effective manner as within Working Together to Safeguard Children (2015)

.
Safeguarding children training is mandatory for all staff. Staff groups will require different competencies in order to fulfil their role, depending on their degree of contact with children and young people and their level of responsibility as detailed in Safeguarding children and young people: roles and competencies for healthcare staff: Intercollegiate Document (RCPCH 2014).

RECORD KEEPING

When recording concerns relating to a child in paper or electronic records, the standards outlined in the NMC Record Keeping Guidance for Nurses and Midwives 2012 and other professional guidance should be followed.

It is important to differentiate between information that has been passed on to you or that which others have told you, and to record the source of information that you have received. It is important to distinguish between fact, hearsay and assumption. Opinions can be recorded, but your records should indicate clearly that it is an opinion, also record your reason for reaching that opinion.

Records may be viewed (including the Personal Child Health Record) and may be produced in court and used in the making of statements. As professionals you should be using the relevant professional guidelines and organizational policy for record keeping.

Discussions held about children and families should be recorded in the records, this includes telephone discussions. Remember to record the time of the discussion and the name of the

person spoken to as well as the content of the discussion. Entries should be clearly signed and dated.

Within Tower Hamlets Community Health Service, an up to date genogram and chronology of significant events pro forma must be completed for all vulnerable children and kept within the child's electronic health record. Each entry within the chronology of significant events should contain a brief record of the incident which where relevant will lead professionals to the full information in the body of the records.

Basic Data Collection

The following basic data must be obtained at the first contact for any child who attends at any service (acute or community), or is admitted to hospital:

- Full name (ask if child is known by any other first name or surname), gender, date of birth, ethnicity and language spoken.
- General Practitioner details.
- Details of school for school age child. Reason for non-attendance at school should be recorded, e.g. new to area; excluded from school.
- Details of who accompanies child to hospital and their relationship to children
- Details of primary carers (if different from above), including their full names and dates of birth and clarify who has parental responsibility for the child (important for consent purposes).
- Details of siblings or other children living in the household.
- Details of a Lead Professional, including Social Worker where relevant.

TRANSFER OF RECORDS AND CARE

If a child subject to concern or a Child Protection or Child in Need plan moves within the locality of Tower Hamlets the Health Visitor and GP should undertake a verbal handover to the receiving practitioner within 5 working days and ensure a summary handover is recorded within the child or young person's records. The template for this to be completed by Health Visitors is available on the EMIS Community Unit.

For children who are transferring out of area the same process must be applied within five working days of request of the records or notification of the transfer. Health visiting records must additionally be forwarded to the Children's safeguarding team for quality assurance prior to transfer and the transfer checklist completed. Please see process and checklist appendix 6

KEEPING PROFESSIONALS SAFE

Despite sensitive approaches by professionals, some families may respond with hostility and sometimes this can lead to threats of violence and actual violence. It is therefore important to try and understand the reasons for the hostility and the actual level of risk involved (LCPP 2014).

Aggression towards outside agencies blocks access and can shield abusive families from scrutiny. If this occurs, it is critical both for the professional's personal safety and that of the child that risks are accurately assessed and managed.

Threatening behaviour can include deliberate use of silence; using written threats; bombarding professionals with e-mails and phone calls; using intimidating or derogatory language; racist attitudes and remarks; homophobic attitudes and comments; using domineering body language; using dogs or other animals as a threat – sometimes veiled; swearing; shouting; throwing things and physical violence.

Staffs have a responsibility to plan for their own safety, just as THGPCG has the responsibility for trying to ensure their safety.

Where there are threats or actual violence towards staff, the atmosphere of violence suggests greater risk of violence towards children and this must be considered within the child's assessment.

All threats or episodes of violence to staff must immediately be communicated to all professionals known to be working with the child / family by telephone and then confirmed in writing within 24 hours. This includes when a parent/carer/family makes a threat of violence to you towards another professional/agency.

Following this, (within Tower Hamlets) a TAC meeting must be convened so that a multiagency risk assessment can be undertaken. This meeting must also formulate an action plan detailing future contact with the family and this plan must be fully recorded in the child's clinical record within all THGPCG services working with the child/family.

Threats of violence made at meetings by parents/families towards an absent professional should be accurately recorded along with an action plan, which clearly states which professional present will take responsibility for immediately notifying the colleague who has been threatened.

Where contact with the child/family is deemed of too great a risk, a child protection referral must be made to Children's Social Care and the respective Safeguarding Children Team and Head of Service must be informed.

A strategy discussion should be held to formulate an action plan which must be fully recorded in the child's health care record.

Any threats towards the professional's life both inside and outside of work should immediately be reported to Police and Head of Service. If the threat is received outside of office hours the duty on call director should also be informed.

Any threats or incidents of physical/verbal abuse towards staff must be reported via Datix Incident reporting and to the service manager to enable an appropriate and proportionate response.

NEAR FATALITIES IN CHILDREN

Children who survive a near-fatality may recover completely but some children may remain disabled as a consequence. I n the event of any near-fatality in a child, consideration must be given to possible child maltreatment. History taking may, for example, identify concerns about the level of parental supervision leading up to the event. Such consideration must take place as soon as is practicable given the emergency nature of the presentation.

In the absence of a suitable explanation for the near-fatality, that is, an explanation that is implausible, inadequate or inconsistent then child maltreatment must be suspected and a referral made to the police and children's social care.

When the child is admitted to a hospital setting, the handover between Walk in centre, Out of hours, ED and ward staff must include details of presentation and referrals made to Children's Social Care and the police. This information then becomes incorporated into the plan for the child.

IN THE EVENT OF A CHILD DEATH

Since April 2008 all deaths of children with the exception of still births are reviewed by the Child Death Overview Panel (CDOP). The purpose is to review the deaths of all children who reside in the borough and identify themes and trends and to determine whether there were modifiable or non-modifiable factors that resulted in the child's death. The CDOP is a sub-committee of the LSCB and is accountable to the Chair of the LSCB.

In the event of a child death, a Form a (notification of child death) must be completed and sent to the Single Point of Contact (SPOC) in the borough in which the child dies. See Appendix 5

SERIOUS CASE REVIEWS (SCR)

Local Safeguarding Children Boards (LSCB) cam consider the undertaking of a serious case review (SCR) when abuse or neglect of a child is known or suspected and either, the child has died or the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child (Working together to safeguard Children 2015).

"Seriously harmed" in the context of the above includes, but is not limited to, cases where the child has sustained, as a result of abuse or neglect, any or all of the following:

- A potentially life-threatening injury;
- Serious and/or likely long-term impairment of physical or mental health or physical, intellectual, emotional, social or behavioral development.

Even if one of the above criteria is not met, an SCR should **always** be undertaken when a child dies in custody, in police custody, on remand or following sentencing, in a Young Offender Institution, in a secure training centre or secure children's home. The same applies where a child dies who was detained under the Mental Health Act 1983 or where a child aged 16 or 17 was the subject of a deprivation of liberty order under the Mental Capacity Act 2005

The prime purpose of a SCR is for agencies and individuals to learn lessons to improve the way in which they work both individually and collectively to safeguard and promote the welfare of children. When conducting an SCR, the Safeguarding Children Team will ask that records to date are secured immediately. All health professionals will have access to continue to document any ongoing work or contacts with the family.

The relevant Governance Group and Borough LSCB quality Assurance Subgroup will be responsible for progressing and monitoring any serious case review action plans. Further information on the SCR process is available in Chapter 4 of Working Together to Safeguard children 2015

ALLEGATIONS AGAINST STAFF OR VOLUNTEERS

Allegations of abuse might arise from a child, an adult, a parent, and members of the public or staff members. Investigation and consideration should be given to cases if the allegation indicates the staff member has:

- Behaved in a way that has harmed a child, or may have harmed a child.
- Possibly committed a criminal offence against or related to a child.
- Behaved towards a child or children in a way that indicates/they are unsuitable to work with children in connection with their employment (either organizational or other employment) or voluntary activity, or where concerns arise about the person's behavior with regard to his/her own children.

If a staff member is alleged to have abused a child it is important to ensure that any actions taken protect the rights of both the child and the staff member. In such a case, the THGPCG Managing Allegations of Child Abuse Or Abuse Against Adults At Risk, Made Against Staff (2016) must be adhered to in line with Chapter 2 of (HM Government Working Together to Safeguard Children 2015).

If the Child/Children of a member of staff has been deemed by the Local Authority to be at risk of significant harm and the subject of a child protection plan and their parent / carer is known to be employed within any agency or organization, a discussion must take place with organizations Safeguarding lead, Service manager, and Director of Human Resources as detailed in Policy: This meeting should also be inclusive of the Locality Designated Nurse or Doctor for Safeguarding Children.

Following this discussion, a decision will be taken whether the Local Authority Designated Officer (LADO) additionally needs to be informed.

REQUESTS FOR STATEMENTS FROM THGPCG STAFF

Staff may be required to provide statements in a number of different circumstances. Requests may come from Solicitor's, Guardian Ad Litem, Court Welfare Officers or the Police. If you receive a request to provide a legal witness statement you should always inform your line manager.

Staffs who are approached for a statement should not disclose any information regarding the child or family over the telephone. Details of the request, namely, who the legal representative is acting on behalf of, and in what capacity, should be sought and passed to the line manager. All requests must be received in writing.

The THGPCG Legal Team, Information Governance Manager and the Safeguarding Children Teams are available to provide advice and support through the process. You will be supported through the process and will be provided a suitably experienced and senior person within the organization to accompany you for giving of any statement, or to brief and accompany you, should you be called to court to give evidence regarding you statement.

GOVERNANCE

Failure to follow safeguarding children processes must be recorded on a Datix Incident Form.

All safeguarding related Datix must be investigated and managed by a relevant line manager in accordance with the Adverse Incident Policy (2017). The Designated Nurse for Safeguarding Children will have oversight nature of the Datix and investigation.

The Barts Health Safeguarding Children Team is also available for managers and staff to discuss investigations and recommendations.

Compliance with the Safeguarding Children Policy will be assessed by regular audit. The Safeguarding Children Team is responsible for supporting THGPCG to develop the THGPCG Safeguarding Children Audit.

THGPCG will Schedule and identify appropriate staff to lead on these and develop and progress action plans to address issues which arise.

PERSON WHO POSES A RISK TO CHILDREN

Should it become known that a person who poses risk to children is receiving treatment in any department /service then a full risk assessment must be undertaken with immediate effect to mitigate and ensure the safety of any children in the vicinity or also accessing the service.

Advice can be sought from the senior managers (appendix 1) and Bart's health Safeguarding Children's team/Designated Nurse/Designated Doctor.

This process must be undertaken sensitively to avoid alarm to others and enable the person posing risk to receive their required treatment whilst ensuring the safety of all children and young people.

SAFER RECRUITMENT

THGPCG undertakes its recruitment procedures and practices in accordance with current employment legislation and guidance as detailed within relevant HR policies.

All staff directly employed or contracted by BHT should conduct themselves in an appropriate manner and adhere to their own professional codes of conduct.

Further information regarding safer recruitment and Criminal Records Bureau (CRB) checks is available in the relevant HR recruitment policy. All staff are required to have an Enhanced Disclosure and Barring Scrutiny check prior to employment and this is monitored and action undertaken to ensure re-newal every three years. Additionally staff must sign annually as part of the P D & R Appraisal process with their manager that they have not received any convictions or cautions within the last year.

SUBJECT SPECIFIC TOPICS

DISABLED CHILDREN

Disabled children are more likely to be abused than non-disabled children and they are especially at risk of harm when they are living away from home. They may be particularly vulnerable to coercion due to physical dependency or because a learning disability or communication difficulty means that it is not easy for them to communicate their wishes to another person.

The above will increase the risk that any sexual relationship they may have may not be consensual.

In assessing whether a relationship presents a risk of harm to a disabled child or young person, professionals need to consider the indicators listed in Sect. 288 and additionally in Safeguarding Disabled Children; Practice Guidance (DCSF 2009)

DOMESTIC ABUSE

Domestic Violence is defined as: Any incident or pattern of incidents of controlling, coercive or threatening behavior, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse:

- psychological
- physical
- sexual
- financial
- emotional

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

Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."

This definition, which is not a legal definition, includes so called 'honor' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group. (Home Office 2013)

The issue of children living with domestic abuse is now recognized as a matter for concern in its own right by both government and key children's services agencies. The Adoption and Children Act 2002 s.120 amended The Children Act 1989 definition of significant harm in Sect. 31 of the 1989 Act (care and supervision orders), to include: "impairment suffered from seeing or hearing the ill-treatment of another".

It is important that all staff is aware of the potential impact of domestic abuse on an unborn baby or child living within such circumstances. Relevant staff should be adequately trained and supported to enable them to ask about abuse in a way that makes it easier for people to disclose. Staff in some services will additionally be trained to ask routinely as part of good clinical practice,

even when there are no indicators of such abuse.

Further guidance can be found in the THGPCG Policy: Domestic Abuse Policy and Procedures (2016) Completion of a Dash risk assessment tool will help to determine the level of risk and actions to be taken and if a referral to the Local Multi Agency Risk Assessment Conference is indicated. Please see Appendix 7 for tools.

FABRICATED OR INDUCED ILLNESS

The term 'fabricated or Induced Illness' encompasses many different situations in which children are presented as 'sick' but where illness has arisen as a result of a parent/carers actions in inducing an illness or by fabricating an illness by telling a story of symptoms which lead health professionals to believe the child has an illness.

These include five key forms of parent/carer behaviour:

- Pretence of illness (e.g. feigning symptoms)
- Fabrication of illness or medical history
- Inducement of illness
- Exaggeration of genuine illness
- Enforced invalidism

Any concerns or suspicions regarding Fabricated illness must be discussed with the Named Doctor for Safeguarding Children. These concerns MUST NOT be discussed with the family at this stage. Further guidance is available in: Safeguarding Children in Whom Illness is Fabricated or Induced (DCSF 2008) and Fabricated or Induced Illness by Carers: A Practical Guide for Pediatricians (RCPCH 2009)

FEMALE GENITAL MUTILATION

Female Genital Mutilation (FGM) comprises all procedures that involve partial or total removal of the external female genitalia, or injury to the female genital organs for non-medical reasons (World Health Organization 2012).

.

FGM is everyone's concern. It is important to remember that girls and women who have had FGM are often reluctant to seek help and support and they may not associate their symptoms with the practice. You may be the first person they have spoken to about their experiences. Sensitivity, empathy and an awareness of FGM are essential. Women live with the consequences every day of their lives.

This definition, which is not a legal definition, includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group. (Home Office 2013)

The issue of children living with domestic abuse is now recognized as a matter for concern in its own right by both government and key children's services agencies. The Adoption and Children Act 2002 s.120 amended The Children Act 1989 definition of significant harm in Sect. 31 of the 1989 Act (care and supervision orders), to include: "impairment suffered from seeing or hearing the ill-treatment of another".

It is an offence for any person (regardless of their nationality or residence status) to:

- perform FGM in England and Wales (section 1 of the act)
- assist a girl to carry out FGM on herself in England and Wales (section 2 of the act)
- assist (from England or Wales) a non-UK person to carry out FGM outside the UK on a UK national or UK resident (section 3 of the act)
- To takea firl out of the country for the purpose of FGM

If the mutilation takes place in England or Wales, the nationality or residence status of the victim is irrelevant.

If an offence under sections 1, 2 or 3 of the act is committed against a girl under the age of 16, each person who is responsible for the girl at the time the FGM occurred could be guilty of an offence under Section 3A of the act.

Maternity Services , and other practitioners in contact with families GP's must routinely ask all pregnant women at booking whether they have been cut as a child.

Any Family or cultural history of FGM must be risked assessed as to the implication of the risk and attitudes impacting on the ability of parents to keep girls within the family safe. The Department of Health Resource Tool kit (2016) must be applied and if risk is deemed to be present, then both a referral to the Police and too social care must be initiated. The courts have legal power to issue a prohibition order to protect the girl. Appendix 8

SEXUALLY ACTIVE CHILDREN

Underage sexual activity which presents cause for concern is likely to raise difficult issues and should be handled particularly sensitively.

A sexual relationship can present a risk of significant harm to a child if one of the intimate partners is coercive or abusive. The abuse can include physical, sexual abuse and emotional abuse.

Assessment of Risk

- Sexual abuse and the exploitation of children involve an imbalance of power. The assessment should seek to identify possible power imbalances within the relationship.
- These can result from differences in size, age, material wealth and / or psychological, social and physical development.
- In addition, gender, sexuality, race and levels of sexual knowledge can be used to exert power.

In order to determine whether a relationship presents a risk of harm to a child, the following indicators should be considered:

- Whether the child is competent to understand, and consent to, the sexual activity they are involved in (children under 13 are not legally capable of consenting to sexual activity);
- What the children in the relationship's living circumstances are, whether they are attending school, whether they or their siblings are receiving services from Children's Social Care or another social care agency etc
- The nature of the relationship between those involved, particularly if there are age or

power imbalances;

- Whether overt aggression, coercion or bribery was or is involved, including misuse of alcohol or other substances as a disinhibitor;
- Whether the child's own behaviour (e.g. through misuse of alcohol or other substances) places them in a position where they are unable to make an informed choice about the activity;
- Any attempts to secure secrecy by the sexual partner beyond what would be considered usual in a teenage relationship;
- Whether methods used to secure a child's compliance, trust and / or secrecy by the sexual partners are consistent with grooming for sexual exploitation. Grooming is likely to involve efforts by a sexual predator (usually older than the child) to befriend a child by indulging or coercing them with gifts / treats (i.e. money or drugs), developing a trusting relationship with the child's family, developing a relationship with the child through the internet etc. in order to abuse the child;
- Whether the sexual partner is known by one of the agencies as having, or previously having had, other concerning relationships with children (which presupposes that checks will be made with the police);
- Whether the child denies, minimizes or accepts the concerns held by professionals.

The age of the child or young person is a contributory factor in the course of action which must be taken:

Children under 13 years

A child under 13 is not legally capable of consenting to sexual activity and therefore under the, penetrative sex with a child under 13 years old is classed as rape (HM Sexual offences ACT 2003).

In all cases where a member of Trust staff identifies or is concerned that a child under the age of 13 is or may be involved with penetrative sex or other intimate sexual activity, there would always be reasonable cause to suspect that the child, whether girl or boy, is suffering, or is likely to suffer, significant harm.

All cases must therefore be discussed with the Safeguarding Children Team and there is a presumption that the case will be referred to Children's Social Care so that a strategy discussion can be held to discuss appropriate next steps.

Only the Named Nurse for Safeguarding Children can approve a decision not to share information with Children's Social Care in cases involving under 13's.

Children 13 to 16 years

Sexual activity with a child under 16 is also an offence. Where it is consensual it may be less serious than if the child were under 13, but may nevertheless have serious consequences for the child's welfare.

In every case of sexual activity involving a child aged 13 to 15, an assessment of risk must be undertaken considering the indicators detailed above.

Following this assessment, if it is determined that the child / young person is at risk of significant harm, a referral must be made to Children's Social Care.

16 and 17 year olds

Sexual activity involving a 16 or 17 year old, though unlikely to involve an offence, may still involve harm or the risk of harm.

It is an offence for a person to have a sexual relationship with a 16 or 17 year old if they hold a position of trust or authority in relation to them. Examples include teachers, health professionals.

In all cases involving 16 and 17 year olds, consideration should be given as to whether they are at risk of or experiencing sexual exploitation.

Sexual Exploitation

Sexual exploitation of children and young people under 18 involves exploitative situations, contexts and relationships where the young people (or third person/s) 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.

Child sexual exploitation can occur through the use of technology without the child's immediate recognition; for example being persuaded to post sexual images on the internet/mobile phones without immediate payment or gain.

Violence, coercion and intimidation are common. Involvement in exploitative relationships is characterized by the child's or young person's limited availability of choice resulting from their social, economic or emotional vulnerability. The London Child Sexual Exploitation Operating Protocol 2nd Ed (Metropolitan Police 2015).

A common feature of CSE is that the child or young person does not recognize the coercive nature of the relationship and does not see themselves as a victim of exploitation.
Vulnerability factors to sexual exploitation

There are many different vulnerable factors and signs of vulnerability:

- Evidence of sexually transmitted infections,
- Inappropriate sexualized behaviour or pregnancy.
- Absent from school or repeatedly running away.
- Evidence of truancy from school,
- Periods of being missing from care or from home.
- Familial sexual abuse,
- Physical abuse,
- Emotional abuse, neglect, as well as risk of forced marriage or honour-based violence;
- Domestic violence.
- Substance misuse.
- Parental mental health concerns.
- Parental criminality.
- Experience of homelessness
- Living in a care home or temporary accommodation.
- Learning difficulties or poor mental health.
- Problems relating to sexual orientation.
- Thoughts of, or attempted, suicide or self-harming;
- Unexplained injuries or changes in physical appearance

- Gangs, older age groups and involvement in crime: Involvement in crime; direct involvement with gang members or living in a gang-afflicted community; involvement with older individuals or lacking friends from the same age group; contact with other individuals who are sexually exploited
- Use of technology and sexual bullying: Evidence of 'sexting', sexualized communication on-line or problematic use of the internet and social networking sites.
- Alcohol and drug misuse: Problematic substance use.
- Receipt of unexplained gifts or money: Unexplained finances, including phone credit, clothes and money.
- Distrust of authority figures: Resistance to communicating with parents, carers, teachers, social services, health, police and others

Risk Assessment Framework

There are 3 categories of sexual exploitation:

Category 1 (At Risk): a vulnerable child who is at risk of being targeted and groomed for sexual exploitation

Category 2 (Medium Risk): a child who is targeted for opportunistic abuse through the exchange of sex for drugs, accommodation (overnight stays) and goods, etc. The likelihood of coercion and control is significant

Category 3 (High Risk): a child, whose sexual exploitation is habitual, often self-defined and was Coercion / control are implicit.

The full risk assessment framework can be found in Appendices 1 and 2 of the Safeguarding Children Abused Through Sexual Exploitation (LCPP 2006c)

The framework needs to be used flexibly to take account of each child's individuality, the uniqueness of his / her circumstances and the changes that may occur for him / her over time.

All Trust staff should be alert to the possibility that a child they are in contact with may be being sexually exploited.

Practitioners may already have concerns about the child e.g. that s/he is missing school, frequently missing from home, misusing substances, is depressed or self-harming etc.

In all cases where a child / young person is identified to be at risk of sexual exploitation, the case must be discussed with the Safeguarding Children Team as a referral will need to be made to Children's Social Care, The child / young person may also need to be referred to their Boroughs Multi Agency Sexual Exploitation Group (MASE) which will be supported by the Named safeguarding professional see Appendix 9

Children who perpetrate sexual abuse

In all cases where sexual abuse is perpetrated by a child / young person, the case must be referred to children's social care and the case discussed with the Safeguarding Children Team.

CHILDREN/YOUNG PEOPLE AT RISK OF RADICALISATION

Trust staff may in the course of their work, meet and treat people who may be vulnerable to being drawn into terrorism. Being drawn into terrorism includes not just violent extremism but also non-violent extremism, which can create an atmosphere conducive to terrorism and can popularize views which terrorists exploit.

If you have concerns that that a child or young person may be susceptible to radicalization and or violent extremism, a referral must be made to Children's Social Care. There is no "Channel panel" (the usual pathway for cases to be considered) in Tower hamlets but all cases are considered as part of the Social inclusion multi agency panel alongside the police.

If your concerns relate to an adult patient or member of staff, consideration must be given to whether any children are at risk due to the behaviour of the adult either because they live in the family home or will come into contact with adult during the course of their work. If so, the child will additionally need to be referred to Children's Social Care.

If you believe a child, young person, adult patient or member of staff is engaging in terrorist activity, the Police will also need to be informed.

Further information can be found in: Prevent Duty Guidance (Protecting children from the threat of radicalization Gov.uk 2015)

APPENDIX

Appendix 1 Nominated Leads Roles within the TH GP CG

Tower Hamlets GP Care group	Nominated leads
Information Governance Lead	Director of Quality & Assurance Ruth Walters Email: ruth.walters@nhs.net Tel: 07776287807
Caldicott Guardian	Chair Dr. Phillip Bennett-Richards Email: pbr@nhs.net Tel: 07803-988072
Senior Information Risk Owner	Director of Quality & Assurance Ruth Walters Email: ruth.walters@nhs.net Tel: 07776287807
Accountable Emergency Officer	Chief Operating Officer Tracy Cannell Email: tracy.cannell@nhs.net Tel: 07894219017
Safeguarding Lead	Chair Dr. Phillip Bennett-Richards Email: pbr@nhs.net Tel: 07803-988072
Child Sexual Abuse and Exploitation Lead	Director of Health Visiting Carrie MacGregor Email: carrie.macgregor@nhs.net Tel: 07800997309
Mental Capacity and Deprivation of Liberty Lead	Deputy Chair/Clinical Lead Dr. Nicola Hagdrup Email: nicola.hagdrup@nhs.net Tel: 07799-414447
Prevent Lead	Director of Health Visiting Carrie MacGregor Email: carrie.macgregor@nhs.net Tel: 07800997309
Freedom To Speak Up Guardian (Whistle blowing)	Deputy Chair/Clinical Lead Dr. Nicola Hagdrup Email: nicola.hagdrup@nhs.net Tel: 07799-414447

Appendix 2 Interagency referral form to Children's Social Care

Community Inter-agency Referral Form

This form needs to be forwarded to the Integrated Pathways Support Team (IPST)

Tel: 0207 364 5601/ 5606 /3859 /2972
Fax: 0207 364 2656 / 2655
Email: MASH@towerhamlets.gcsx.gov.uk
Please also email a copy to the safeguarding children team:
BHNT.CHSBartsHealthSafeguardingChildrenTeam@nhs.net

Please note that this form needs to be emailed from an nhs.net email address

This form is to be used by all agencies referring child/children to London Borough of Tower Hamlets CSC for assessment as a child in need, including in need of protection.

All urgent referrals should be initiated by phone/fax and with completion of as much of this form as possible or an updated CAF or a Signs of Safety Mapping tool. If information is incomplete, a MASH worker will work through the form to ensure the information is accurate and good quality. If you are a service provider in Tower Hamlets, as part of the Family Wellbeing Model, you may be asked to provide a CAF as well as this form. You should get feedback within 24 hours on this referral and we will proactively work with you and other services to ensure a service is provided to the child, even if it does not meet the thresholds for a statutory response as outlined in the Family Wellbeing Model.

A. CHILD/ YOUNG PERSON

Family Name					**Forename/s**			
Childs NHS No					**Mothers NHS No if unborn child**			
DOB/EDD		M		F		***Ethnicity code**		Religion
Child's first language					**Is an interpreter or signer required?**			
Address								
Postcode					**Tel.**			
Current address if different from above								
Postcode					**Tel.:**			

**ONS Ethnicity Codes: White British 1a; White Irish 1b; White other 1c;White & Black Caribbean 2a;White & Black African 2b; White & Asian 2c; Other Mixed 2d;Indian 3a;Pakistani 3b;Bangladeshi 3c; Other Asian 3d; Caribbean 4a;African 4b;Other Black 4c; Chinese 5a;Other ethnic group 5b*

B. CHILD/YOUNG PERSON'S PRINCIPAL CARERS

FULL NAME	DOB If known	Relationship to child	Ethnicity code	Parental responsibility
First language of carers: Is an interpreter or signer required: Y / N				

C. OTHER HOUSEHOLD MEMBERS

FULL NAME	DOB If known	Relationship to child/ young person	Ethnicity code	Tick if also referred

D. OTHER SIGNIFICANT PEOPLE IN THE CHILD/YOUNG PERSON'S LIFE, INCLUDING OTHER FAMILY MEMBERS

FULL NAME	Relationship to child/young person	Address	Tel No

Referrals will be shared with the family and should not be made without their knowledge/agreement unless this would jeopardize the child/young person's safety		
	Y / N	**If no, state reason**
The child/young person knows about the referral		
The parent/carer knows about the referral **The parent/carer has given consent to the referral.**		

F. INFORMATION ON STATUTORY STATUS

	Y/ N	**Please give details of name of child/young person, dates, category (if known)**
Any child in family is/has been on the disability register?		
Any child in family is/has been on the child protection register (CPR)?		
Any child or other family member has been looked after by a local authority?		

G. KEY AGENCIES INVOLVED

Insert name of professional if involved		**Tel**	**Insert Name of professional if involved**		Tel
H.V.			**G.P.**		
Nursery			**EWO**		
School			**Police**		
YOT			**Dentist**		
Community mental health			**Community Pediatrician**		
School Nurse			**Midwife**		
Hospital Consultant			**Other**		

H. INFORMATION SUPPORTING THIS REFERRAL

The purpose of this section is to assist the inter-agency assessment. Where you have no information about a particular area, please write N/K (not known). Please record strengths as well as areas of need or risk so that resources can be directed appropriately.

REASON FOR REFERRAL/REQUEST FOR SERVICES

What are your concerns? (If an allegation of possible physical abuse, please give specific details of any injury including dates and explanations given)

Scale how safe you think the child is:

With 0 being I am certain the abuse will happen again if something isn't done immediately and 10 being the case needs action but I don't think the child is in immediate danger, what rating would you give?

Comments on Score: Please tell us how you reached this score.

What existing safety is there for the child(ren) – are there safe people around the child?

What are you most worried will happen to the child(ren) if the situation doesn't change?

What convinced you to take action now and contact us?
Have you done anything to address this problem (apart from making this referral)? For example has your agency used a CAF or a TAC to focus professional efforts on addressing the concerns? Has the Social Inclusion Panel been consulted for support?
What do you see as the cause of the problem?
What do you expect to happen as a result of this notification?

I. DETAILS OF REFERRER AND SOCIAL WORKER TAKING REFERRAL

Name of worker completing this referral (please print)			
Agency			
Address			
Ward/Consultant			
Telephone number			
Signature		**Date**	

Name of social worker taking referral			
Team		**Date**	
Social work context scale (for social worker to complete): ***On a scale of 0 to 10 with 0 being this is the worst case that the agency has ever worked with and 10 indicates that this is a case the agency would take no further action with, where***			

would you rate yourself?

Appendix 3 Safeguarding Competencies

Competency: Safeguarding Children To participate in the support of children, young people and their families who are vulnerable and in need of support and/or protection in order to improve outcomes and reduce health inequalities.	**Self Assess**	**Mentor Assess**	**Comments/ Evidence**
1. Recognizes potential indicators of child maltreatment: physical abuse (including FGM and FII), emotional abuse, sexual abuse (including sexual exploitation) and neglect.			
2. Understands the potential/actual impact of a parent/carers physical and mental health and/or social issues on the wellbeing and development of a child or young person.			
3. a. Understands the increased vulnerability of Looked after Children and the potential impact on their health and development b. Ensures that the assessment of the parenting capacity of carers (family members, foster carers, legal guardians, new adoptive parents etc.) is completed.			
4. Understands of the importance of children's rights in the safeguarding/child protection context and demonstrates a basic knowledge of relevant legislation such as the Children Act 1989 and 2004 and the Sexual Offences Act 2003.			
5. Demonstrates an understanding of organizational, borough and national policies and frameworks related to safeguarding practice, including the following: • GP Care Group Safeguarding Children, Safeguarding Children Training and Safeguarding Children Supervision Policies Working Together to Safeguard Children 2015 • Pan London Child Protection Procedures 2015 • Tower Hamlets Family Wellbeing Model 2016 • Signs of Safety • Transfer of records for vulnerable children pathway • Record of concern pathway • Unseen child protocol			
6. Is able to accurately complete the following safeguarding / child protection assessments: • GP Care Group 0-19 child and family assessment • The Tower Hamlets Common Assessment Framework (CAF) assessment and CAF review form			
7. Maintains records accurately and contemporaneously, and is able to evidence sound rationale when undertaking clinical assessments and developing plans.			
8. Is able to: • Interpret information gathered within assessments in order to ascertain the level of risk • identify the appropriate intervention/support required • clearly document an on-going health visiting plan.			
9. Is able to accurately complete the following referral forms: • Tower Hamlets Inter-agency referral form			

• Tower Hamlets MASE referral form			
10. Demonstrates knowledge and understanding of information sharing in relation to safeguarding practice. Recognizes when information needs to be shared, who with and is able to do so in a timely and safe manner.			
11. Understands the role of the local safeguarding children team (including LAC team) and Children's Social Care Teams and knows how to contact them.			
12. Demonstrates attendance at relevant training sessions, in accordance with organizational policies, and is able to reflect on how this will influence practice and interventions with vulnerable families.			
13. Is able to evidence reflective discussions in relation to safeguarding / CP cases.			
14. Is able to effectively participate in child protection meetings and provide appropriate reports using the LBTH report proforma.			

Competency: Domestic Abuse To participate in the support of victims of domestic abuse and their children in order to improve outcomes and reduce health inequalities.			
1. Is skilled in asking about domestic abuse as part of assessments (including its nature and extent) and able to identify indicators of abuse.			
2. Is able to respond appropriately to a disclosure of domestic abuse, signposting victims/perpetrators and their families to the appropriate level of support including undertaking safety planning.			
3. Is able to accurately complete relevant domestic abuse related risk assessments, and referral tools including: • DV1 form • DASH risk assessment tool • MARAC referral form and associated consent forms.			

Appendix 4 Universal Children's Meeting Report Template

Universal Childrens Report Format and G

Appendix 5 Form A Child Death Notification

Form-A-Notification-of-Child-Death--Tow

Appendix 6 Transfer of Records

Transfer of records checklist V 3 (Marc

Transfer of records flowchart 2 (March

Appendix 7 Domestic Abuse DASH and MARAC referral tools

TH-DASH.doc

Tower-Hamlets-MARAC-referral-form.doc

Tower-Hamlets-MARAC-victim-consent-form

Tower-Hamlets-MARAC-info-sharing-withou

Appendix 8 Female Genital Mutilation Risk Assessment tool

DoH FGM Risk assessments - word version

Appendix 9 Multi agency Sexual Exploitation Professional Group referral

MASE Referral Form.docx

References

Department for Children Schools and Families (2008) Safeguarding Children in Whom Illness is Fabricated or Induced Crown The Stationery Office.

Department for Children Schools and Families (2009) Safeguarding Disabled Children: Practice Guidance Crown The Stationery Office.

Department for Education (2015) Safeguarding Practitioners: Information Sharing Advice Crown The Stationery Office.

Department for Education (2015b) Promoting the Health and Welfare of Looked-After Children – Statutory Guidance (2015) Crown The Stationery Office

Department for Education and Skills (2005) National Minimum Standards for Private Fostering Crown The Stationery Office.

Department of Health (2015) Female Genital Mutilation Risk and Safeguarding: Guidance for professionals Crown The Stationery Office government (2015)

GMC (2013) Good Medical Practice General Medical Council

HM Government (1989) Children Act Crown Copyright

HM Government (2002) Adoption and Children Act Crown Copyright

HM Government (2003) Sexual Offences Act Crown Copyright

HM Government (2004) Children Act Crown Copyright

HM Government (2005) Mental Capacity Act Crown Copyright

HM Government (2015) Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children Crown Copyright

HM Government (2015) Prevent Duty Guidance: for England and Wales Crown Copyright

Home Office (2014a) Female genital mutilation: resource pack Crown Copyright

Home Office (2014) FGM Multi-Agency Practice Guidelines Crown Copyright

London Child Protection Committee (2005) Safeguarding Children Missing from School

London Child Protection Committee (2006a) Safeguarding Children Missing from Care or Home

London Child Protection Committee (2006b) Safeguarding Sexually Active Children

London Child Protection Committee (2006c) Safeguarding Sexually Exploitation Children (2006)

London Child Protection Committee (2014) London Child Protection Procedures and Practice Guidance http://www.londoncp.co.uk/Metropolitan Police (2105) The London Child Sexual

Exploitation Operating Protocol 2nd Ed
NICE (2014) When to Suspect Child Maltreatment National Institute of Health and Social Care

NMC (2015) The Code, Professional standards of practice and behaviour for nurses and midwives Nursing and Midwifery Council

RCPCH (2009) Fabricated or Induced Illness by Carers: A Practical Guide for Pediatricians Royal College of Pediatrics and Child Health

RCPCH (2014) Safeguarding children and young people: roles and competencies for healthcare staff: the Intercollegiate Document