

# Child Protection Policy and Procedures

<b>Scope</b>	<b>Trust wide</b>
<b>Owner</b>	<b>Safety Management Group</b>
<b>Contact</b>	<b>Sarah Turner, Named Nurse Safe-guarding Children</b>
Version	2.0
Issue date	January 2008
Reviewed	
Next Review date	December 2010

## Search summary:

Most parents and carers are able to care for/safeguard their children. However, In some cases there are concerns for the safety and welfare of children. This guidance should be followed where such concerns exist.

This guidance should be read in conjunction with Ox leas:

Domestic Abuse Policy

Information Sharing Policy

Child Visiting Policy

Admission of Adolescents Policy

Adult Protection procedures

Incident reporting Policy

Whistle Blowing Procedure

Disciplinary Procedure

Safeguarding Children Training Strategy

Mandatory Training Policy

And the London Safeguarding Children Procedures

# ***VERSION CONTROL***

## **Document Location**

Oxleas NHS Trust Foundation Trust Intranet	<i>See under</i> Safe-guarding Adults and Children
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## **Change History**

<b>Vrsn</b>	<b>Owner</b>	<b>Changed by</b>	<b>Change summary</b>	<b>Date</b>
1.0	Child Protection Committee	N/A	First issue of policy	May 2004
2.0	Child Protection Committee	Sarah Turner	Revised to coincide with implementation of the Children Act 2004	Oct 2005
3.0	Safe-guarding Children Committee	Sarah Turner	Revised following publication of London Safe-guarding Children guidance	Jan 2008

## **Responsibility for distribution of this document**

<b>Sarah Turner, Named Nurse Safe-guarding Children</b>
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# OXLEAS NHS Foundation Trust

## Child Protection Policy

### 1. Policy Statement

1.1 The purpose of this document is to assist staff to protect and safeguard children who are at risk of abuse or neglect. (The Children Act 1989 defines a child as being up to the age of 18 years). This guidance must be read in conjunction with the relevant section(s) of **The London Safeguarding Children Procedures 2007**. This is a multi-agency document setting out procedures to be followed in a wide range of situations.

1.2 Protecting children from harm is part of the wider work of safeguarding and promoting the welfare of children (Appendix 1. Key Terms). Oxleas NHS Foundation Trust has a duty under s11 of the Children Act 2004 to ensure that its functions are discharged with the need to safeguard and promote the welfare of children. This means;

- Protecting children from maltreatment (see Appendix 2. Types of Abuse).
- Preventing impairment of children's health or development.
- Ensuring children grow up in circumstances consistent with the provision of safe and effective care.

1.3 The trust will fulfil its commitment to safeguard and promote the welfare of children by:

- Ensuring that there is senior management commitment to the importance of safeguarding and promoting children's welfare.
- Having a clear line of accountability.
- Supporting a culture that enables issues about safeguarding and promoting children's welfare to be addressed, and ensuring that accurate records with regard to decisions and actions are maintained.

### 2. Working in Partnership

2.1 The Trust is a statutory partner of Bexley, Bromley and Greenwich Local Safeguarding Children Boards, and shares in the responsibility for the effective discharge of the LSCB's functions. Oxleas has representation on each of the three LSCBs. The trust's LSCB representatives report to Oxleas Safeguarding Children Committee. The trust will work closely with the LSCBs in their quality assurance, monitoring and safeguarding children arrangements.

2.2 The Trust acknowledges the overriding commitment to the principle of the Paramount Welfare of the Child, and its duties under the Children Act 1989 and 2004 to cooperate with the Local Authority in child protection work. This will include; sharing information and referral using the appropriate inter-agency

referral form; collaborative assessment; production of reports for child protection meetings; and attendance at these by relevant trust professionals.

2.3 Information sharing between agencies may sometimes be inhibited by concerns about; confidentiality; compliance with human rights legislation; Data Protection Act compliance and Caldicott guidelines. It is important to appreciate that The Children Act 1989 permits the disclosure of information necessary to safeguard children. *'What to Do If You're Worried a Child Is Being Abused'* clarifies when and how information should be shared. If an individual is in any doubt a discussion must take place with a senior colleague or the trust Named Professionals for Child Protection/ Safeguarding Children (Appendix 3. Who to Contact). All decisions about the management of confidential information will be informed by the principle that the welfare of the child is paramount.

2.4 Staff will work collaboratively with other agencies involved in safeguarding to ensure that services are provided in a manner which acknowledges and takes account of race, religion, culture, ethnicity, language, gender, sexual orientation, age, health and any disability of the child or family.

### **3. Organisational Arrangements**

3.1 Safeguarding Children/Child Protection activities within the Trust are overseen by the Safeguarding Children Committee which reports to the Safety Management Group. The Chair of the Committee is the Lead Director for Safeguarding Children and has reporting responsibility to the Board.

3.2 Child Protection Service Leads representing each service across the trust are members of the Safeguarding Children Committee. They undertake to disseminate information to staff and act as a link for their staff to the committee.

3.3 The Board of Oxleas NHS Foundation trust will ensure that the Child Protection Policy and Procedures are implemented and that staff members are guided, supported and trained. Training will be delivered in accordance with Oxleas Safeguarding Children Training Strategy. This states that:

All staff working for Oxleas NHS Foundation Trust both NHS and contracted who work with children or come into contact with adults who are parents/carers during the course of their work, will receive safeguarding children training suited to their role within the Trust and keep this up to date by attending refresher training. It is recommended that other groups of staff also attend safeguarding children training. Safe-guarding children training requirements are also described in the Mandatory Training Policy

3.4 The Trusts Named Doctor for Child Protection and Named Nurse for Safeguarding Children will be supported by the trust board to undertake their roles in providing leadership, guidance and support on safeguarding children issues.

3.5 Staff are recruited safely, including obtaining appropriate CRB clearance, and reviewing this at stated intervals. The trusts commitment to safe recruitment will be reflected in a statement in Job Descriptions as appropriate.

3.6 Health Professionals are involved at all stages of child protection work including; early recognition and referral; providing information towards assessment of risk and family support; participation in case conferences etc; contributing to child protection plans; providing therapeutic support; and review processes.

3.7 All professionals should be familiar with guidance on Child Protection/ Safeguarding Children from their own Professional organisations, and should refer to the London Safeguarding Children Procedures.

3.8 It should be noted that no set of procedures or guidelines can be a substitute for good professional practice, nor can it cover every possible eventuality or alter the ultimate responsibility of all staff in direct contact with children and families.

## **4. Monitoring Statement**

4.1 The trust will monitor compliance with this document via the Safeguarding Children Committee which reports to the Safety Management Group. The Committee will oversee; the safeguarding children audit programme; safeguarding children training; incidents which effect children; Serious Case Reviews; and the child protection risk register. Other audits which have implications for safeguarding children will be received by the Safeguarding Children Committee.

4.2 The safeguarding children audit programme will include audits which relate to identified and emergent risks, as well as referrals and safeguarding children advice, support and supervision of staff and cases. The audit programme will be the responsibility of the trusts Named professionals for safeguarding children. Audit will be undertaken annually where appropriate.

4.3 The Board will receive an annual safeguarding children report and other reports concerned with safeguarding children as necessary.

## **5. Scope of the Policy**

5.1 This policy and the following procedures apply to all Trust staff, clinical, support and administrative, who have contact with families, carers and children. The guidelines also apply to agency staff and other staff not employed directly by the Trust e.g. volunteers.

## **OXLEAS NHS Foundation Trust**

# Child Protection Procedures

## 6. Introduction to the Procedures

6.1 **Safeguarding Children is Everyone's responsibility. Whatever your role within the trust the welfare of children should be your paramount consideration.** In cases of suspected abuse the duty of care that a health professional owes to a child, will take precedence over any obligation to the parent or other adult.

6.2 The purpose of this guidance is to assist staff to protect children who are at risk of abuse or neglect and to prevent harm to children. The Children Act 1989 defines a child as being anyone up to the age of 18 years. Babies and young children are particularly vulnerable, the welfare of unborn children must also be considered during pregnancy.

6.3 This guidance must be read in conjunction with the relevant section(s) of The London Safeguarding Children Procedures, this is a multi-agency manual setting out procedures to be followed in a wide range of situations. The purpose of this guidance is to take account of local considerations. This guidance is also in accordance with that set out in:

- *What to do if You're Worried a Child is Being Abused*, DFES 2006
- *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*, HM Government 2006

## 7. Responsibilities of All staff

7.1 All staff should:

- Have access to the London Safeguarding Children Procedures, which are available in bases, on the intranet and on the London Safeguarding Children Board website.
- Understand the risk factors for abuse and neglect and recognise children in need of support and or safeguarding/ protection.
- Recognise the needs of parents who may need extra help in bringing up their children, and know where to refer for help.
- Recognise the risks of abuse to an unborn child.
- Understand the risks posed by and the needs of children who harm others.
- Access child protection advice where appropriate.

- Promote a culture of listening to children and seeking their views where appropriate.
- Respond sensitively to the needs of children and their families from a range of racial, cultural, religious or linguistic backgrounds.
- Understand the roles and responsibilities of other departments and agencies in safeguarding children and refer children to them appropriately.
- Contribute to enquiries from other professionals about a child and their family.
- Liaise closely with professionals internally and in other agencies and take the lead professional role in multi-agency networks as appropriate.
- Plan and respond appropriately to the needs of children and their families, particularly those who are vulnerable.
- Contribute to child protection conferences, and other meetings, which safeguard children and contribute to planning support for children at risk of significant harm.
- Help ensure that children who are suffering or at risk of suffering harm through abuse or neglect, and parents under stress, have access to services to support them.
- Contribute to serious case reviews and implementation of recommendations as required.
- Be alert to children who are not attending school/ not on a school roll.
- Always consider the safety and welfare of children including unborn children.
- Inform service users that confidentiality can never be absolute, and that they have a duty to share information in order to safeguard children.
- Be alert to the effects of domestic abuse on children and the effects on families such as increased mobility etc.

7.2 Staff with information about an adult or child which may impact on the welfare or safety of a child, have duty to share that information. **The welfare of the child is the paramount consideration in all cases.** The Children Act 1989 permits the disclosure of information necessary to safeguard children. Consent to share information must ordinarily be sought. However, information, which is shared as part of a child protection enquiry, may go ahead without such permission. If you are in **any doubt**, you must discuss your concerns with a senior colleague or the trust's Named Professionals for Safeguarding Children/Child Protection. (Appendix 3. Who to Contact) This discussion must be recorded in the case notes. If a difference of opinion exists and you remain

concerned it is your responsibility to report those concerns i.e. refer to Children's Social Care. (See Oxleas Information Sharing Policy and the London Safeguarding Children Procedures for further information).

7.3 The threshold for a child protection referral is **reason to suspect** significant harm. Staff **do not** have a responsibility to eliminate other alternative explanations, or conduct an investigation prior to referral for enquiries and specialist assessment. They should be prepared to provide information and co-operate with Children's Social Care/Police in order to assist in the process of a child protection investigation.

7.4 Due regard should be given to issues of race, religion, culture, language, sexual orientation, disability, social background and mental capacities in all areas of safeguarding children work. Failure to act to protect a child from discrimination is likely to undermine other efforts being made to safeguard the child. However, abusive behaviour or acts cannot be justified within the context of cultural/ racial differences etc.

7.5 Where cases which include risk to the safety or welfare of children are discussed in multi professional or other team meetings, a record of that discussion and any decisions/ plans made should be made in the service user's records.

## **8. Role of Adult Focused Staff**

8.1 Statutory guidance as set out in Working Together to Safeguard Children 2006 requires mental health practitioners to **routinely record details of patient's responsibilities in relation to children and consider the needs of patients who are parents and their children in all aspects of their work using the care programme approach**. Practitioners should refer to Royal College of Psychiatrists policy documents: Patients as Parents 2002 and Child Abuse and Neglect the Role of Mental Health Services 2004

8.2 There is a clear expectation that all professionals in mental health settings should, when assessing a parent with a mental disorder consider the impact of this on their parenting capacity. The welfare of children must be considered at all stages of work with service users from assessment through to discharge. Current partners should be included in this assessment.

8.3 Staff in all services should ensure that their assessment includes basic information about all child/ren i.e. the names, age, ethnicity, first language of the child, GP, primary carer and school.

8.4 Children who are cared for by an adult with severe and enduring mental health problems or learning disabilities may be children in need, (Appendix 1. Key Terms and Appendix 4. Parental Factors) within the terms of the Children Act 1989. Services have a responsibility to the following children:

- Unborn children of service users who are pregnant or expectant fathers;

- Children who are the offspring of service users, whether living in the same household or not;
- Children who are in any way related to service users – as grandchildren, nephews, nieces, siblings, etc.;
- Children who live in households shared with, or visited by, service users;
- Any child who may be currently in contact with a perpetrator about whom a service user has disclosed past abuse.

8.5 Adult focused services may play a role in relation to safeguarding and promoting the welfare of children in one or more of the following ways:

- Identifying children who are being or have been abused or neglected;
- Making referrals to Children’s Social Care if a child is in need of support or protection;
- Contributing to child protection investigations and subsequent child protection conferences and reviews;
- Providing information for other agencies and courts where necessary;
- Supporting parents care for their children and keep them safe;
- Advising parents about the impact of their mental illness or substance misuse on their children (including unborn);
- Identifying when the impact of a service user’s mental illness, learning disability, or substance misuse is impairing their child’s health and development and taking action to safeguard the child;
- Contributing to multi-agency assessments of children and their families;

8.6 Adult focused services may be working with an adult whose child is also known to CAHMS so this should be checked.

8.7 When adult focused services and children’s social care services are both involved with a family, ideally joint assessments should be carried out to assess parent support needs and risk of harm to the child, involving other services such as primary care as appropriate.

8.8 Children should be given an opportunity to contribute to assessments as they often have good insight into the patterns and manifestations of their parent’s mental ill-health.

8.9 A child who assumes a parenting role to other siblings or acts as a young carer may be in need support services in their own right. Young carers may provide care for a parent and /or siblings. Children undertaking caring are entitled to an assessment of their needs from Children’s Social Care. Children acting as carers may be unable to achieve or maintain a standard of health or development because of their caring responsibilities and may be a Child in

Need, (Appendix 1. Key Terms).

8.10 Care Programme Approach (CPA) assessments and meetings for adults who are parents must include an ongoing perspective on the needs and risk factors for the children concerned. Children's Social Care should be invited to contribute if they are involved with a family or risks and needs have been identified that justify their involvement.

8.11 Staff may be working with an adult who discloses they were abused in childhood. Other children may currently be at risk from the same abuser. Professionals must inform the service user of their professional duty to share information to safeguard children and endeavour to ascertain whether the past abuser is currently in contact with children who could be at risk of harm. (See Appendix 5. Historical Abuse).

8.12 Where there are concerns that a pregnant service user; is at risk of relapse; has a history of difficulty in meeting the needs of previous children; or whose level of difficulty is likely to impact on her ability to meet her child's needs, these should be referred at the earliest opportunity to children's social care so that an assessment and joint planning can occur. Staff should also liaise closely with other involved professionals including Midwives, Health Visitors and G.P.s etc. A joint plan of support and monitoring must be agreed prior to birth, which includes contingency should difficulties arise and review arrangements.

8.13 Where a service user attending an in-patient unit has expressed ideas/thoughts of harming, or has harmed, a child, a joint planning meeting must be held with children's social care prior to discharge from the in-patient unit.

## **9. Child and Adolescent Focused Staff**

9.1 As part of assessment and care planning, CAMHS professionals should identify whether child abuse or neglect or domestic violence are factors in a child's mental health problems and refer the child to Children's Social Care as appropriate. CAMHS professionals must also ensure that the harm is addressed appropriately in the child's treatment and care.

9.2 CAMHS professionals may have a role in partnership with Children's Social Care the initial assessment process in cases where their specific skills and knowledge are helpful.

9.3 Where a child makes a disclosure that indicates that they may have suffered or are at risk of suffering significant harm CAMHS professionals must make a referral to children's Social Care and ensure that other involved staff e.g. Child and Adolescent Psychiatrist are aware of the issues.

9.4 Where staff are unsure about the child's level of competence and the need for the parents to be informed prior to sharing information this should be discussed with senior staff or the trust's Named Professionals for Safeguarding Children/ Child Protection. Contemporaneous records of all discussions should be maintained.

9.5 Where a child/family fails to engage with CAMHS services, the referrer should be asked to follow up the child to reassess the need for additional services and the welfare of the child. Where concerns are known to exist or the child has a child care social worker, information regarding non engagement should be shared with other professionals as appropriate.

**10. What to do if you suspect child abuse/ neglect**

*Assess potential risk to the child promptly*

**DELAY COULD BE HARMFUL**

**Physical Injury/ a crime may have been committed/ emergency protection needed**  
**Dial 999 / Refer to A&E**  
Follow up with a referral to local Children's Social Care

**Concerned about parental capacity to meet child's needs**  
**Possible Neglect, Emotional, Sexual or Physical abuse**  
(Appendix 2. Types of Abuse)

**SEEK ADVICE**

**Always** discuss with Manager/ Supervisor / Senior colleague.  
**and/or**

Named Nurse Safeguarding Children for Oxleas 01322 625029 / 0777 176 7120  
Or Named Doctor for Child protection 0208 836 6436

**and/or**

Consult with local Children and Families Team within Children's Social Care  
(Appendix 3. Who to Contact)

**Document discussion, decisions and action plan**

**STILL CONCERNED**

If not yet done so, inform family of your concern and proposed course of action (unless to do so would put the child or yourself at further risk/ a crime has been committed i.e. sexual abuse)

**TO REFER**

Contact Local Children's Social Care Team (see Appendix 3. Who to Contact)

Follow up telephone referral in writing within 48 hours on an inter-agency referral form. Document discussion, decisions, actions and plans.

Send photocopy/fax of referral to Named Nurse Safeguarding Children, Pinewood.  
Fax: 01322 625 711 for monitoring purposes.

Ensure GP/CAMHS/Adult mental health team etc informed as appropriate.

## 11. What to do in an Emergency

11.1 In the case of physical injury, staff may need to persuade parents/carers to take the child immediately to A&E and if necessary call 999 for an ambulance. If the parent/carer has agreed to take the child to hospital, Staff must contact the duty consultant Paediatrician at the relevant hospital and confirm arrival with the A&E department.

11.2 A telephone referral must be made to Children's Social Care duty team, (see Appendix 3. Who to Contact). The referral must be made to the social care department covering the child's address. Follow this up in writing within 48 hours, on an interagency referral form. A written response should be sent to you within one working day of your referral being received. If you do not receive this response within three working days follow up with the social care team manager.

11.3 In the event of parental refusal or that there are **serious and immediate** concerns for a child then the Police should be contacted 999, (see Appendix 6) for details about Police Protection). The child's local Children's Social care office must be informed as soon as possible.

11.5 Where it is believed that a crime has been committed (i.e. rape, sexual assault etc) and there may be a need to gather forensic evidence staff should contact the Police. The referral to the Police should be followed up with a referral to the child's local Children's Social Care Department.

11.4 All observations, discussions, decisions and actions taken should be recorded contemporaneously in the health record. The time of events should be documented along with the date, signature (where appropriate), printed name, professional role and contact number.

## 12 What to do When Abuse or Neglect are Suspected

12.1 You **must** make a referral to Children's Social Care if there are signs that a child under the age of eighteen or an unborn baby:

- Is experiencing or may have already experienced abuse or neglect
- Is likely to suffer significant harm in the future.

12.2 Staff should discuss their concerns or any proposed action with their Line Manager, senior clinician, or Named Professional for Safeguarding Children/Child Protection and agree a plan of action. If a difference of opinion exists then it remains the responsibility of the individual with concerns to take further action i.e. make a referral to Children's Social Care.

12.3 Where a child, about whom there are concerns for their welfare, is known to have an allocated Child Care Social Worker, referrals should be made to him/her or in their absence their manager or a duty officer. Staff can check whether a child has a child protection plan within a particular authority by contacting the Children's Social Care department for that borough. If the child's does not have a child protection plan it should not be assumed that concerns

are not valid or that other concerns do not exist. Where a child does not have an identified key worker within Social Care referrals should be made to the Duty Social Worker in the borough in which the child lives.

12.4 Where in-patient, day care or rehabilitation services have concerns about an adult's care of a child, they should where appropriate, contact the relevant community adult mental health team for further information and to discuss their concerns. These concerns and the plan of action decided upon should be documented in the records. A referral should be made directly to the relevant Children's Social Care team.

12.5 If staff are concerned that parental mental ill health is affecting the safety, health or development of a child or may pose a potential risk to an unborn child, this should be discussed with the parent/carer at the earliest possible opportunity, and prior to a referral to Children's Social Care unless to do so would put either the child or member of staff at risk. If this is the case advice must be sought from Children's Social Care.

12.6 If staff find or suspect that a child (under 16 or 18 if disabled) is living in a **private fostering** arrangement i.e. living with a carer who is someone other than a parent, grandparent or sibling of the child or the parent (for more than 28 days) then a referral must be made to the child's local Children's Social Care department so that an assessment of the placement can be made. It is the foster carer's responsibility to notify this arrangement themselves. However, if you suspect that they have not or will not do this then it becomes the practitioner's responsibility to do so.

12.7 If it becomes apparent that a child of school age is **not attending school**, this information must be passed to the child's social worker (if applicable) or the local Education Welfare department.

12.8 If staff are made aware of an individual who is known or suspected to have caused significant harm to children, living in a household which includes children or having contact with children, Children's Social Care must be informed immediately.

12.9 If staff become aware of **domestic abuse** in a household which includes children they should refer to Oxleas Domestic Abuse Policy and Procedures for guidance, remembering that domestic abuse is a source of emotional harm for children and is closely associated with other forms of abuse and neglect. Any risks from Domestic Abuse are increased by the presence of additional factors such as mental health problems, substance misuse or learning disability, (Appendix 4. Parental Factors).

12.10 Staff must ensure that where a service user's (adult or child) first language is not English a gender appropriate interpreter is used. If an interpreter is not used in this situation then reasons for not doing so must be recorded in the notes.

12.11 Where abuse is alleged by the child, the response should be limited to listening carefully to what the child has to say, so as to clarify the concern, offer reassurance about how s/he will be kept safe and what action will be taken. The child must not be pressed for information, led or cross-examined or given

false assurances of absolute confidentiality, as this could prejudice police investigations, especially in cases of sexual abuse.

12.12 If the child can understand the significance and consequences of making a referral to LA children's social care, they should be asked their view. However, it should be explained to the child that whilst their view will be taken into account, the professional has a responsibility to take whatever action is required to ensure the child's safety and the safety of other children.

12.13 Where a service user discloses that they have in the past, or are currently suffering abuse their consultant must be informed of the disclosure and action to be taken. All information must be recorded contemporaneously in the notes.

12.14 When working with families/or individuals who care for children, who are uncooperative staff should refer to the London Safeguarding Children Procedures section 10 for guidance.

12.14 An informal consultation if required can be made with the Children's Social Care Duty Social Worker (see Appendix 3. Who to Contact). However, an urgent referral must not be delayed by the need for consultation. If you wish to make a referral this must be clearly stated.

12.15 Staff should not delay having a consultation or making a referral due to concerns being identified "out of hours". Arrangements are in place for Children's Social Care staff to be available at all times in each Local Authority. Information should be shared with the welfare of the child as the paramount consideration rather than in line with conventional office hours, (Appendix 3. Who to Contact).

12.16 All observations, inter-professional discussions, decisions and actions taken should be recorded contemporaneously. The time of events should be documented along with the date, signature & printed name (where appropriate), professional role and contact number.

## **13. To Make a Referral**

13.1 To make a referral of a child protection concern, telephone the Children's Social Care department (see Appendix 3. Who to Contact) covering the child's address.

13.2 If the child is known to have an allocated social worker, the referral should be made to them, or in their absence to the social worker's manager or a duty children's social worker. In all other circumstances referrals should be made to the duty officer.

13.3 Where available the following information should be provided with the referral. However, absence of information must not delay referral.

- Full names, dates of birth and gender of child/ren
- Family address
- Identity of those with parental responsibility, (see Appendix 7).

- Parental Responsibility) or individuals caring for the child.
- Names and dates of birth of all household members
- Ethnicity, first language and religion of children and parents/carers
- Any need for an interpreter, signer or other communication aid
- Any special needs of children/ parent or carer.
- Any significant/important recent or historical events/incidents in a child or family's life
- Cause for concern including details of any allegations, their sources, timing and location
- Child's current location and emotional and physical condition
- Referrer's relationship and knowledge of child and parents/carers
- Known previous involvement of other agencies or professionals
- Information regarding parental knowledge of, and agreement to, the referral

13.4 **Out of hours** contact Children's Social Care Duty Team (see Appendix 3. Who to Contact) or the Police.

13.5 The referral must be followed up in writing on an inter agency referral form within two working days, (Bexley, Bromely and Greenwich forms are available on the intranet). Send a photocopy of the referral to the Named Nurse for Safeguarding Children, Pinewood House for monitoring purposes. Ensure that you keep a copy in the records.

13.6 The referrer should keep formal contemporaneous records of; all discussions with the child/ parent/ managers etc; decisions taken; information shared and with whom; copies of referrals. Times of events should be recorded.

13.7 The Children's Social Care department must acknowledge your referral in writing within one working day. If this acknowledgment is not received within three working days the referrer should contact the social care department again.

13.8 Junior and less experienced staff will be supported by their line manager or senior personnel, as appropriate during the process of referral.

## 14. Sharing information

14.1 Staff have a duty to ensure that children are safeguarded from harm . This means that the interests of the child are paramount and must be considered before the interests of the parent/ guardian. Service users should be made aware of this so that they understand that **confidentiality can never be absolute.**

14.2 The principle of "need to know" should be applied when sharing information. If information is requested by social care as part of a section 47 (child protection) enquiry, clinicians have a duty under the Children Act 1989 to pass on information with or without the service users consent. If information is requested as part of a section 17 (child in need) enquiry, then information should only be shared with consent. It is likely in this instance that the person

seeking information will have the service users consent to do so. However, it is important that when requests for information are received staff clarify why the information is being requested. (See Oxleas information sharing policy and the London Safeguarding Children procedures).

#### 14.3 Key principles in information sharing

- Openly and honestly explain what, how and why information will be shared
- Always consider child's safety and welfare – this must be the overriding consideration
- Seek consent – this should be respected unless there is sufficient need to override
- Seek advice when in doubt
- Ensure that information is accurate, necessary, shared with appropriate people and stored safely
- Record the reasons for the decision – to share or not share information

HM Government '*Every Child Matters Information Sharing: practitioners guide 2006*

14.4 Where practicable, concerns should be discussed with the parent and agreement sought for a referral to Children's Social Care unless seeking agreement is likely to place the child at risk of significant harm through delay or the parent's actions or reactions. Seek advice if unsure.

14.5 Where a professional decides not to seek parental permission before making a referral to Children's Social Care, the decision must be recorded in the notes with reasons, and confirmed in the referral.

14.6 A child protection referral from a professional cannot be treated as anonymous, so the parent will ultimately become aware of the identity of the referrer. Where the parent refuses to give permission for the referral, unless it would cause undue delay, further advice should be sought from a senior manager or Named Professional for Safeguarding children/Child Protection.

## **15. If You Feel Your Referral is Not Being Responded To Appropriately**

15.1 Where Children's Social Care consider that the referral does not meet the eligibility criteria for their assessment (see Appendix 8. Threshold for Assessment by Social Care Table), but you remain seriously concerned about the welfare of the child you should seek to resolve the issue through discussion and/or a meeting within a week or a timescale that protects the child.

15.2 If professionals are unable to resolve differences within the timescale, their disagreement must be addressed by more experienced / senior staff.

15.3 The professionals involved in this conflict resolution process must contemporaneously record each intra- and inter-agency discussion they have,

approve and date the record and place a copy in the records together with records of any other communications and information.

15.4 Professionals in all agencies have a responsibility to act without delay to safeguard the child, (e.g. by calling for a case to be allocated or for a strategy meeting / discussion, for a core group meeting or for a child protection conference or review conference).

15.5 If following this process the differences persist the Named Nurse for Safeguarding Children may refer the matter to the Local Safeguarding Children Board for resolution.

## **16. Continuing care**

16.1 Staff may be approached by Children's Social Care and asked to provide information about a child or family. Staff may also be asked to undertake specific types of assessments as part of an initial or core assessment, or to contribute to ongoing therapeutic work with a child or parent and to review that work.

16.2 Professionals are required to attend Child Protection Initial and Review Case Conferences; Child Protection Pre-Birth Conferences; Professionals Meetings; Strategy Meetings and Core Group Meetings

16.3 Professionals must provide reports to child protection case conferences. Reports should contain principally fact and direct observation. Only opinion which is evidenced by fact should be included. Any information provided by a third party should be recorded as such. It is a priority for psychiatrists, psychologists, CPN's, mental health workers and all other professionals to attend strategy meetings, child protection conferences and core groups, (see Appendix 9).

16.4 Some situations may not reach the threshold for Children's Social Care intervention. All situations should continue to be monitored by the professional/case worker and considered in supervision, (Appendix 10. Supervision, Support and Monitoring). If required the Named Nurse for Safeguarding Children will assist/advise in this process. Details of risk assessment, plan of action and timescales for review should be documented and countersigned by the manager. It may be appropriate to complete a CAF in these cases, (see Appendix 11) Common Assessment Framework).

16.5 Continued consideration should be given to ongoing joint assessment visits with Child Care Social Workers and Health Visitors etc.

16.6 Professionals with ongoing responsibilities for the child or adult carer must ensure they liaise regularly and share up to date information especially around key developments in the child's welfare, the adult's mental health and court proceedings (as applicable) with key agencies. There is an expectation that other agencies will do the same.

16.7 CPA meetings and pre-discharge planning meetings must include routine

consideration of the needs of children of the patient. Local Children's Social Care teams must be informed prior to their discharge if a service user will have significant contact with a child who has a Child Protection Plan, is 'Looked After' or is receiving services as a Child in Need.

16.8 A service user who may pose a risk to children should be referred to the local MAPPA committee, (Multi Agency Public Protection Arrangements). The assessment and management of risks posed by the individual will be established and monitored by the panel.

16.9 Staff working with families where harm is known or suspected must keep full contemporaneous records of interactions including details of physical and emotional findings and information reported by individuals. Staff must adhere to record keeping guidelines and ensure that the time and dates that interactions and incidents occurred are recorded.

16.10 When working with families/or individuals who care for children, who are uncooperative staff should refer to the London Safeguarding Children Procedures section 10 for guidance.

## **17. Closure/transfer of cases**

17.1 Information concerning change of worker or closure of the case must be communicated in writing to the relevant Child Care team if the case is open to them.

17.2 The transfer of responsibility for a case where there are concerns for a child must be preceded by a discussion between the relevant managers.

17.3 The transfer of responsibility for a case where there are concerns about a child to a different authority/Trust must be recorded on the case files and confirmed in writing to the new authority. This correspondence must highlight relevant concerns. Where the child has a Child Protection Plan, is "Looked After", is subject to legal orders, or is a Child in Need the named Social Worker /Children's Social Care team must be informed.

## **18. Incident Reporting**

18.1 In certain circumstances safeguarding issues will reach the criteria for Oxleas incident reporting procedures. These circumstances will include:

- Incidents of serious child abuse/neglect or the death of a child where the case is referred to the Local Safeguarding Children Board for consideration of instigation of a Serious Case Review under Section 8 of Working Together to Safeguard Children 2006.
- Allegations made against staff that they have: behaved in a way that has harmed a child, or may have harmed a child; committed a criminal offence against or related to a child; behaved toward a child or children in a way that indicates that s/he is unsuitable to work with children or other vulnerable groups (Appendix 12. Allegations Against Staff).

- Visit by a child to a service user terminated
- Child placed at risk during a visit to a service user.
- Child in contact with an individual who poses a risk to children whilst under the trusts care/ on trust premises.
- Failure to share information causing a child to be/continue to be at risk of harm.

## **Appendix 1**

### **Key Terms**

#### **Safeguarding and Promoting the Welfare of Children**

Includes:

- protecting children from Maltreatment;
- preventing impairment of children's health or development; and
- ensuring that children are growing up in circumstances consistent with the provision of safe and effective care;

And undertaking that role so as to enable those children to have optimum life chances and to enter adulthood successfully.

## **Significant harm**

Some children are in need because they are suffering or are likely to suffer significant harm. Under the Children Act 1989 significant harm is the threshold that justifies compulsory intervention in family life in the best interests of children, and gives the local authority a duty to make enquiries to decide whether they should take action to safeguard or promote the welfare of a child who is suffering, or likely to suffer significant harm.

Staff working in NHS Foundation Trusts **must** make a referral to social services if there are signs that a child under the age of eighteen years or an unborn baby:

- Is experiencing or may already have experienced abuse or neglect.
- Is likely to suffer significant harm in the future

## **Child in Need**

Children who are defined as being in need under section 17 of the Children Act 1989, are those whose vulnerability is such that they are unlikely to reach or maintain a satisfactory level of health or development, or their health and development will be significantly impaired, without the provision of services, this includes children who are disabled (section 17(10) Children Act 1989).

Staff who suspect that a child may be “in need” should consider using a CAF, (see Appendix 13).

## **Abuse and Neglect**

Child abuse and neglect is a generic term encompassing all ill treatment of children including serious physical and sexual assault as well as cases where the standard of care does not adequately support the child’s health or development. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting, by those known to them, or, more rarely, by a stranger. They may be abused by an adult or adults or another child or children.

## **Appendix 2**

### **Types of Abuse**

Abuse is defined as:

“Child abuse consists of anything which individuals, institutions or processes do, or fail to do, which directly or indirectly harms children, or damages their prospects of a safe and healthy development into adulthood”

Childhood Matters – report of the national Commission of Enquiry into the prevention of child abuse 1996

Abuse is divided into four categories:

- **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 feigns the symptoms of, or deliberately induces illness in a child

- **Emotional Abuse**

Emotional abuse is the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond the child's developmental capacity, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction. **It may also involve seeing or hearing the ill-treatment of another (e.g. domestic abuse).** It may involve serious bullying causing children frequently to feel frightened, or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.

- **Sexual Abuse**

Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, including prostitution, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative (e.g. rape, buggery or oral sex) or non-penetrative acts. They may include non-contact activities, such as involving children in looking at, or in the production of, pornographic material or watching sexual activities, or encouraging children to behave in sexually inappropriate ways.

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

For further information as to what constitutes abuse and specific information on particular forms of abuse staff should refer to the London Safeguarding Children Procedures.

Staff should also refer to the London Safeguarding children Procedures for information on vulnerability factors and child in specific circumstances.

## Appendix 3

### Who to Contact

#### Bromley Children's Social Care

Bromley East (Orpington)	01689 836900	Fax: 01689 876774
Bromley West (Penge)	020 8659 2131	Fax: 020 8778 3849

Out of hours	020 8464 4848
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Police Child Protection Team	020 8284 5882
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#### Greenwich Children's Social Care

Initial Response and Assessment Service 020 8921 3172

Out of hours 020 8854 8888  
CAPE 020 8316 4774  
Police Child Protection Team 020 8284 9344

### **Bexley Children's Social Care**

For consultation – Safeguarding Children Unit 020 8303 7777 x6302  
To refer- East Bexley 020 8303 7777 ext 2612/2613  
West Bexley 020 8310 0566

Out of hours 020 8303 7777  
Police Child Protection Team 020 8284 9363

### **Lewisham Children's Social Care**

Duty service 020 8314 6106  
020 8314 6660  
020 8314 3786  
020 8314 6331

### **Kent Children's Social Care**

Dartford 01322 277 744  
Swanley 01322 611 000  
Gravesend 01474 328 664

### **Oxleas - For advice**

Named Nurse Safeguarding Children 01322 625029 mob: 07771 767102  
Named Doctor Child Protection 020 8836 6418

## **Appendix 4.**

### **Parental Factors**

#### **Domestic Abuse**

Children may suffer both directly and indirectly if they live in a household where there is domestic abuse. Domestic abuse is likely to have a damaging effect on the health and development of children. Staff working with families where domestic abuse is present should refer to Oxleas Domestic Abuse Policy and Procedures.

In 2004 the Governments definition of domestic violence was extended to include acts perpetrated by extended family members as well as intimate partners. Consequently, acts such as forced marriage and other so called honor

crimes, which can include abduction and homicide, can now come under the definition of domestic violence. Many of these acts are committed against children. See London Safeguarding Children Procedures.

## **Mental Illness in a Parent or Carer**

Parental mental illness does not necessarily have an adverse impact on a child's developmental needs, but it is essential to always assess its implications for each child in the family. Many children whose parents have mental ill health may be seen as children with additional needs requiring professional support, and in these circumstances the need for a common assessment should be considered, (Appendix 11. Common Assessment Framework).

Where a parent has enduring and / or severe mental ill-health, children in the household are more likely to be at risk of, or experiencing, significant harm. This could be through physical, sexual or emotional abuse, and / or neglect.

A child at risk of significant harm or whose well-being is affected, could be a child:

- Who features within parental delusions;
- Who is involved in his / her parent's obsessional compulsive behaviours;
- Who becomes a target for parental aggression or rejection;
- Who has caring responsibilities inappropriate to his / her age.
- Who may witness disturbing behaviour arising from the mental illness (e.g. self-harm, suicide, uninhibited behaviour, violence, homicide);
- Who is neglected physically and / or emotionally by an unwell parent;
- Who does not live with the unwell parent, but has contact (e.g. formal unsupervised contact sessions or the parent sees the child in visits to the home or on overnight stays);

Or s/he could be an unborn child of a pregnant woman with any previous major mental disorder, including disorders of schizophrenic, any affective or schizo-affective type; also, severe personality disorders involving known risk of harm to self and / or others.

The following factors may impact upon parenting capacity and increase concerns that a child may have suffered or is at risk of suffering significant harm:

- History of mental health problems with an impact on the sufferer's functioning;

- Unmanaged mental health problems with an impact on the sufferer's functioning;
- Maladaptive coping strategies;
- Misuse of drugs, alcohol, or medication;
- Severe eating disorders;
- Self-harming and suicidal behaviour;
- Lack of insight into illness and impact on child, or insight not applied;
- Non-compliance with treatment;
- Poor engagement with services;
- Previous or current compulsory admissions to mental health hospital;
- Disorder deemed long term 'untreatable', or untreatable within time scales compatible with child's best interests;
- Mental health problems combined with domestic abuse and / or relationship difficulties;
- Mental health problems combined with isolation and / or poor support networks;
- Mental health problems combined with criminal offending (forensic);
- Non-identification of the illness by professionals (e.g. untreated post-natal depression can lead to significant attachment problems);
- Previous referrals to Children's Social Care for other children.

See Royal College of Psychiatrists documents:

- Patients as Parents 2002
- Child Abuse and Neglect: the role of mental health services 2004

### **Parental Drug and Alcohol Misuse.**

Maternal substance misuse in pregnancy can have serious effects on the health and development of the child before and after birth. Pregnant women (and their partners) must be encouraged to seek early antenatal care and treatment to minimise the risks to themselves and their unborn child.

Newborn babies may experience withdrawal symptoms, which may interfere with the parent / child bonding process. Babies may also experience a lack of basic health care, poor stimulation and be at risk of accidental injury.

The risk to child/ren may arise from:

- Substance misuse affecting their parent/s' practical caring skills: perceptions, attention to basic physical needs and supervision which may place the child in danger (e.g. getting out of the home unsupervised);
- Substance misuse may also affect control of emotion, judgement and quality of attachment to, or separation from, the child;
- Parents experiencing mental states or behaviour that put children at risk of injury, psychological distress (e.g. absence of consistent emotional and physical availability), inappropriate sexual and / or aggressive behaviour, or neglect (e.g. no stability and routine, lack of medical treatment or irregular school attendance);
- Children are particularly vulnerable when parents are withdrawing from drugs;
- The risk is also greater where there is evidence of mental ill health, domestic violence and when both parents are misusing substances;
- There being reduced money available to the household to meet basic needs (e.g. inadequate food, heat and clothing, problems with paying rent [that may lead to household instability and mobility of the family from one temporary home to another]);
- Exposing children to unsuitable friends, customers or dealers;
- Normalising substance use and offending behaviour, including children being introduced to using substances themselves;
- Unsafe storage of injecting equipment, drugs and alcohol (e.g. methadone stored in a fridge or in an infant feeding bottle). Where a child has been exposed to contaminated needles and syringes;
- Children having caring responsibilities inappropriate to their years placed upon them;
- Parents becoming involved in criminal activities, and children at possible risk of separation (e.g. parents receiving custodial sentences);
- Children experiencing loss and bereavement associated with parental ill health and death, parents attending inpatient hospital treatment and rehab programmes;
- Children being socially isolated (e.g. impact on friendships), and at risk of increased social exclusion (e.g. living in a drug using community);
- Children may be in danger if they are a passenger in a car whilst a drug / alcohol misusing carer is driving.

## **Parental Learning Disability**

Parental learning disabilities do not necessarily have an adverse impact on a child's developmental needs, but it is essential to always assess the implications for each child in the family. Learning disabled parents may need support to develop the understanding, resources, skills and experience to meet the needs of their children. Such support is particularly necessary where the parent/s experience the additional stressors of:

- Social exclusion;
- Having a disabled child;
- Experiencing domestic violence;
- Having poor mental health;
- Having substance misuse problems;

In most cases it is these additional stressors, when combined with a parent's learning disability, that are most likely to lead to concerns about the care their child/ren may receive. If a parent with learning difficulties appears to have difficulty meeting their child/ren's needs, a referral should be made to Children's Social Care, who have a responsibility to assess the child's needs and offer supportive and protective services as appropriate.

Where a parent has enduring and / or severe learning disabilities, children in the household are more likely to be at risk of, or experiencing abuse or neglect.

The following factors may contribute to a child having suffered or being at risk of suffering significant harm:

- Children of parents with learning disabilities are at increased risk from inherited learning disability and more vulnerable to psychiatric disorders and behavioural problems, including alcohol / substance misuse and self-harming behaviour;
- Children having caring responsibilities inappropriate to their years placed upon them, including looking after siblings;
- Neglect leading to impaired growth and development, physical ill health or problems in terms of being out of parental control;
- Mothers with learning disabilities may be targets for men who wish to gain access to children for the purpose of sexually abusing them.

## **Appendix 5**

### **Historical Allegations of Abuse**

It is not unusual for people to disclose experiences of physical, sexual and / or emotional abuse and / or neglect which constitute significant harm.

Staff should ensure that service users are aware of the limits to confidentiality. Confidentiality can never be absolute

Organisational responses to allegations by an adult of abuse experienced as a child, or of a child relating to abuse suffered in the past, must be of as high a standard as a response to current abuse because:

- There is a significant likelihood that a person who abused a child/ren in the past will have continued and may still be doing so;
- Criminal prosecution may be possible if sufficient evidence can be carefully collated.

Wherever historical abuse enquiries relate to alleged abuse within institutions such as children's homes or residential / boarding schools, professionals should follow the processes for in the London Safeguarding Children Procedures.

When an adult discloses childhood abuse, the professional receiving the information should record the discussion in detail. If possible, the professional should establish if the adult has any knowledge of the alleged abuser's recent or current whereabouts and contact with children.

In view of the potential continuing risk the alleged abuser may pose to children, the professional should make a referral to Children's Social Care.

The adult who has disclosed should be reassured that the police are able and willing to progress an investigation even for those adults who are vulnerable as a result of mental ill health or learning difficulties, and that, even without their direct involvement, all reasonable efforts will be made to investigate the alleged abuse.

Where an adult alleges abuse in childhood in a different local authority area, the information should be shared with agencies in the area where the abuse is alleged to have taken place.

## **Appendix 6**

### **Police Protection**

Under the Children Act 1989, police officers have the power to remove or detain a child, including the power to prevent removal from a certain place, e.g. a hospital, without a court order, where the officer has reasonable cause to believe that a child would otherwise be likely to suffer significant harm. Police officers also have a general power under the Police and Criminal Evidence Act 1984, to enter premises without a warrant, for the purposes of saving life and limb.

No child may be kept in Police Protection for more than 72 hours.

The officer taking the child into police protection must inform the local authority of his actions and the circumstances and they will investigate these. The child should also be given an age appropriate explanation and the parents and anyone else with parental responsibility for that child should be informed.

Taking a child into Police Protection does not give the police parental responsibility for the child and contact with the parents (and anyone else with

parental responsibility) should be allowed, unless there are extenuating circumstances.

<b>Police 999 or Bromley</b>	<b>020 8313 1212</b>
<b>Bexley</b>	<b>020 8284 9354</b>
<b>Greenwich</b>	<b>020 8284 9354</b>

## **Appendix 7**

### **Parental Responsibility**

The term parental responsibility is intended to reflect the everyday reality of being a parent and emphasise the responsibility of all those who are placed in that position. Aspects of parental responsibility can include the following:

- Consent to medical treatment
- Decisions regarding education
- Decisions as to the name of the child
- Appointment of a guardian for a child
- Consent or not to marriage (for a child between the ages of 16-18)
- Applying for passports
- Administering the child's property
- Allowing the child to be interviewed

The mother of a child automatically has parental responsibility. The father will have parental responsibility if:

- He was married to the mother at the time of the child's birth, or they marry subsequently, from the date of the marriage.

- His name is registered on the birth certificate and he was present at the time of registration (since 1<sup>st</sup> December 2003)
- He entered into a parental responsibility agreement with the mother
- He obtained a court order for parental responsibility
- He obtained a residence order for the child

Other persons can apply for parental responsibility by means of a residence order or parental responsibility agreement. The local authority can acquire parental responsibility if granted a care order, for the duration of the order.

The only means by which parental responsibility is distinguished are by: the child reaching the age of majority (18 years); the death of the child; or if a freeing or adoption order is made.

## Appendix 8

### Threshold for Assessment by Children's Social Care

Section 47 / core assessment	Initial assessment
Any allegation of abuse or neglect or any suspicious injury in a pre- or non mobile child.	Allegation of physical assault with no visible or only minor injury (other than to a pre-or non mobile child).
Allegations or suspicions about a serious injury / sexual abuse to a child.	Any injury / incident triggering concern (e.g. a series of apparently accidental injuries or a minor non-accidental incident).
Two or more minor injuries in pre-mobile or non verbal babies or young children (including disabled children).	Any incident / injury triggering concern (e.g. a series of apparently accidental injuries or a minor non-accidental incident).
Inconsistent explanations or an admission about a clear non-	

accidental injury.	
Repeated allegations or reasonable suspicions of non-accidental injury.	Repeatedly expressed minor concerns from one or more sources.
A child being traumatised, injured or neglected as a result of domestic violence.	Domestic violence.
Repeated allegations involving serious verbal threats and/or emotional abuse.	Allegation concerning serious verbal threats to children.  Allegations of emotional abuse including that caused by minor domestic violence.
Allegations / reasonable suspicions of serious neglect.	Allegations of periodic neglect including insufficient supervision; poor hygiene, clothing or nutrition; failure to seek / attend treatment or appointments; age; young carers undertaking intimate personal care.
Medical referral of non-organic failure to thrive in under fives.	
Direct allegation of sexual abuse made by child or abuser's confession to such abuse.	Suspicions of sexual abuse (e.g. sexualised behaviour, medical concerns or referral by concerned relative, neighbour, carer).
Any allegation suggesting connections between sexually abused children in different families or more than one abuser.	
An individual (adult or child) posing a risk to children.	
Any suspicious injury or allegation involving a child subject of a current child protection plan or looked after by a local authority.	
No available parent and child vulnerable to significant harm (e.g. an abandoned baby).	No available parent, child in need of accommodation and no specific risk if this need is met.
Suspicion that child has suffered or is at risk of significant harm due to fabricated or induced illness.	

Child/ren subject of parental delusions.	
A child at risk of sexual exploitation or trafficking.	
Registered sex offender or convicted violent offender subject to MAPPA moving into a household with under 18 year olds.	
Pregnancy in a child aged under 13.	
A child at risk of FGM, honour based violence or forced marriage.	

## Appendix 9

### Preparation for Attendance at Child Protection Case Conference

1. Staff who are unfamiliar with what to expect at a case conference should seek guidance from their manager, senior colleague or Named Nurse for Safeguarding Children.
2. It is a priority for relevant staff to attend child protection case conferences even if contact has been minimal. Professionals will be expected to give a view on whether the child should have a Child Protection Plan based on information presented to the conference from all agencies.
3. Staff invited to attend a conference should prepare a typed report. A copy of this must be kept in the record of the service user.
4. Reports should contain principally fact and direct observation. Keep opinion to a minimum and only opinion, which can be evidenced by fact. Any information provided by a third party must be recorded as such.
5. Your report to conference should include where known:-

- Your contact with child/family. Length of time known, reasons for involvement, frequency of contact with the service
  - Brief information about child (if known), e.g. Health and development, Communication skills, Social skills, Interaction with staff, children and with own family.
  - Information regarding other members of the child's family - parents/carers/extended family/siblings
  - The impact/possible impact of parental mental illness etc on parenting capacity
  - Comments, if any, re the incident/situation leading to the conference
  - Any historical information regarding the family and child, of relevance
  - Name, designation, date.
6. If time allows a copy should be sent to the Chair prior to the conference. If not, take sufficient copies for members of the conference.
  7. Take appropriate and relevant records to all conferences.
  8. Inform parents/carers /child (where appropriate) that you will be attending the conference and discuss with them what you will need to share at the conference/ the contents of your report. Parents or carers will normally be invited to attend child protection conferences and meetings. The child may also attend, appropriate to their age and understanding (at the chair's discretion).
  9. Record the outcome of the conference in detail in the child or family members' records.
  10. All case conference reports must be uploaded into the child's and parent's records as appropriate, or be placed in the paper record with a reference to their whereabouts in RIO.
  11. Staff should be given the opportunity to debrief after a case conference.
  12. If unable to attend staff should brief a colleague to attend in their place.

## Appendix 10

### Supervision, Support and Monitoring

1. It is important that there is clarity of understanding about roles and expectations and accountability at all levels. To this end, regular audits of case files should be undertaken by Line Managers/ Senior Managers. Both case worker and their supervisor and manager are responsible for their caseloads.
2. Child protection cases must be regularly discussed in supervision, and any decisions and the reasons for them should be recorded and signed by both supervisor and supervisee. All cases where there are child protection concerns must have a documented plan of action devised between the case worker and line manager which is monitored through supervision and includes a timescale for review.
3. On some occasions (e.g. enquiries about complex abuse or allegations against colleagues) the provision of additional individual or group staff support should be considered.
4. Supervision policy and practice must maximise staff safety and remain alert to the possibility that some staff may be anxious about personal safety and yet reluctant to acknowledge their concern.
5. It is expected that the line manager will be the first person to review a case where concerns are expressed by another professional about its

handling.

6. No professional should have a case involving a vulnerable child allocated to them unless they have the necessary expertise and training to manage the case.
7. Senior Social Care Managers should inspect, at least every 3 months, a random selection of case files and supervision notes.
8. Managers, Supervisors and Team Leaders must ensure that they are trained to an appropriate level to undertake their role with relation to supporting staff who have safeguarding children concerns. Managers and team leaders are also responsible for ensuring that their staff attend appropriate levels of safeguarding children training. (See Oxleas Safeguarding Children Training Strategy).
9. Where cases which include risk to the safety or welfare of children are discussed in multi professional or other team meetings, a record of that discussion and any decisions/ plans made should be made in the service user's records.

## Appendix 11

### Common Assessment Framework CAF

The Common Assessment Framework (CAF) is part of the change for Children agenda. This sets out the five priority outcomes:

- Be healthy
- Stay safe
- Enjoy and achieve
- Make a positive contribution
- Economic wellbeing

Staff will initiate a CAF when they consider that a child may need the provision of additional services in order to achieve these outcomes. The CAF is a multi-agency assessment. Before completing the CAF staff should contact the Children's information Services in the local borough to check if a CAF already exists. The pre-assessment checklist can assist staff in deciding whether to undertake a CAF.

If you consider that a CAF would be useful seek the agreement of the child and/or their parent/carer. The CAF can only be completed with consent.

Complete the CAF with the child and or the parent/ carer using the CAF documentation. This covers three domains;

- Development
- Parents and carers

- Family and environment

If unsure about the suitability of completing a CAF discuss with senior staff/  
Named professionals for Safeguarding Children/Child Protection.

Further information on CAF is available at:  
[www.everychildmatters.gov.uk/deliveringservices/caf/](http://www.everychildmatters.gov.uk/deliveringservices/caf/)

### Allegations against staff

All suspicions and allegations of abuse by staff must be treated with the utmost seriousness.

If an allegation is made against a member of staff that they have:

- 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 toward a child or children in such a way that indicates that s/he is unsuitable to work with children.

A clear record of the information should be made including where possible the words used by the person making the allegation. The record should include the time, date, place of the incident. The matter should be immediately reported to the senior manager.

The senior manager should obtain the written record of the allegation and approve and date this. The manager will record any other information i.e. names of any witnesses etc and any discussions had on the matter.

The Manager will notify;

- The Service Manager
- The Senior Officer within HR for dealing with such Allegations
- The HR senior officer **must** inform the LADO (Local Authority Designated Officer), who will advise, ensure that London Procedures are followed, resolve inter-agency issues and liaise with the Local Safeguarding Children Board, (LSCB).
- The Director of Services Mental Health Directorate
- The Trust's Named Professionals for Safeguarding Children/Child Protection

The matter must also be reported through Oxleas incident reporting procedures.

Investigations into allegations against staff may involve three strands: the child protection investigation, the disciplinary procedure and criminal enquiries. A planning meeting, held as soon as possible after the allegation has been made will ensure all aspects are addressed.

The accused member of staff should be treated fairly and honestly and helped to understand the concerns expressed and processes involved; be kept informed of the progress and outcome of any investigation and the implications for any disciplinary or related process and; if suspended, be kept up to date about events in the workplace.

If a member of staff has concerns about; malpractice; illegal acts or omissions of colleagues, the Whistle blowing Procedure should be used to protect children.

The Manager, in conjunction with HR, will follow the disciplinary procedure with regard to suspension of the member of staff involved, in order to protect the child and the staff member.

Consideration must be given to support mechanisms for staff during a period of suspension e.g. Occupational Health, updates on the investigation etc. If the member of staff is a member of a union or a professional association they should be advised to contact that body at the outset.

The fact that a person tenders his/her resignation, or ceases to provide their services must not prevent an allegation being followed up.

See the following for further information:

London Safeguarding Children Procedures

Oxleas NHS Foundation Trust Whistle blowing Policy

Oxleas NHS Foundation Trust Disciplinary Procedure

Working Together to Safeguard Children (2006)

## References

Children Act (1989) HM Government  
Children Act (2004) HM Government  
London Safeguarding Children Procedures (2006) LSCB  
London Procedure for Children Abused Through Sexual Exploitation (2005)  
LSCB  
London Procedure for Safeguarding Sexually Active Children and Young People  
(2005) LCPC  
NSF for Children, Young People and Maternity Services (2004) DOH  
Responding to Domestic Abuse a Handbook for Health Professionals (2005)  
DOH  
What to do if you're Worried a Child is Being Abused (2006) DFES  
Working Together to Safeguard Children (2006) HM Government