SAFEGUARDING CHILDREN POLICY, PRINCIPLES AND PROCEDURES

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# Document History

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## Plan for Dissemination of Policy

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1. Introduction

South London and Maudsley NHS Foundation Trust has a statutory duty under Section 11 of the Children Act 2004, to protect children from harm as part of the wider work of safeguarding and promoting the welfare of children.

Safeguarding children - the action we take to promote the welfare of children and protect them from harm - is everyone’s responsibility. Everyone who comes into contact with children and families has a role to play.

This means:

- Protecting children from maltreatment
- Preventing impairment of children’s health or development
- Ensuring that children grow up in circumstances consistent with the provision of safe and effective care
- Taking action to enable all children to have the best outcomes.
- Due regard should be given to issues of race, religion, culture, language, gender, sexual orientation and disability in all child protection work.
- The Trust will fulfil its commitment to safeguard and promote the welfare of children by:
  - Ensuring there is senior management commitment.
  - Having clear lines of accountability and structures.
  - Supporting a culture that enables safeguarding issues and promotion of children’s welfare to be addressed, and ensuring that accurate records with regard to actions and decisions are made.
  - Ensuring all staff are appropriately trained in safeguarding children.

This policy incorporates the Statutory Government guidance in Working Together to Safeguard Children 2015.

SLaM has adopted the London Child Protection Procedures 2013 and supplementary procedures, and this policy should be read in conjunction with these. They set out procedures to follow in a wide range of situations.

2. Policy

2.1. Legislation

The Children Act 1989 introduced the concept of significant harm as the threshold that justifies compulsory intervention in family life in order to safeguard children. The local authority has a duty to investigate where it has reason to suspect that a child is suffering or likely to suffer significant harm.

The Children Act 2004 requires each local authority, health and partner agencies to make arrangements to promote cooperation between the authorities, each of the authority’s relevant partners. The arrangements are made with a view to improving the wellbeing of children in the authority’s area – which includes protection from harm or neglect alongside other outcomes (section 10).

The Children Act 2004 (section 11) places duties on a range of organisations and individuals to ensure their functions, and any services that they contract out to others,
are discharged with regard to the need to safeguard and promote the welfare of children.

The Equality Act 2010 puts a responsibility on public authorities to have due regard to the need to eliminate discrimination and promote equality of opportunity. This applies to the process of identification of need and risk faced by the individual child and the process of assessment. No child or group of children must be treated any less favourably than others in being able to access effective services which meet their particular needs.

The United Nations Convention on the Rights of the Child (UNCRC). This is an international agreement that protects the rights of children and provides a child-centred framework for the development of services to children. The UK Government ratified the UNCRC in 1991 and, by doing so, recognises children’s rights to expression and receiving information.

2.2. Definitions

Working Together to Safeguard Children 2015, defines the following categories of abuse.

Abuse

A form of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting by those known to them or, more rarely, by others (e.g. via the internet). They may be abused by an adult or adults, or another child or children.

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 a child 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 a 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, although it may occur alone.

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)
Ensure access to appropriate medical care or treatment

It may also include neglect of, or unresponsiveness to, a child’s basic emotional needs.

**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.

**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.

**Carer**

Someone who provides practical and emotional support to someone with a mental health problem. They may or may not live with the person cared for. They could be a child who does not live with the person they support and help.

**Young carers**

Children and young persons under 18 who provide or intend to provide care assistance or support to another family member. They carry out on a regular basis, significant or substantial caring tasks and assume a level of responsibility, which would usually be associated with an adult. The person receiving care is often a parent but can be a sibling, grandparent or other relative who is disabled, has some chronic illness, mental health problem or other condition connected with a need for care support or supervision.

**Child**

Defined in the Children Act 1989 as anyone under the age of 18 years. Young children, including babies, may be particularly vulnerable and in need of protection. Child protection concerns for the unborn may need to be considered during pregnancy. The fact that a child has reached 16 years of age, is living independently or is in further education, is a member of the armed forces, is in hospital or in custody in the secure estate, does not change his/her status or entitlements to services or protection.

**Child in need**

Children who are defined as being in need under section 17 of the 1989 Children Act 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.
Child Protection/Significant Harm

A child who is at risk of significant harm as a result of maltreatment, abuse or neglect. Decisions about significant harm should be informed by careful assessment of the child’s circumstances and discussions between Local Authority Children’s Social Care and the child and family.

Child Protection is part of safeguarding and promoting welfare. This refers to the activity that is undertaken to protect specific children who are suffering, or are likely to suffer, significant harm. A child may be defined as at risk of significant harm under one or more of the categories of abuse described above.

Local Authority Children’s Social Care (LACSC).

Local Authority Children’s Social Care (also known as Children and Families Departments, Children’s Social Services). The department of local government responsible for the protection and welfare of children in their area.

Early Help

As described in ‘Working Together’, all local agencies should have in place effective ways to identify emerging problems and potential unmet needs for individual children and families. This requires all professionals, including those in universal services and those providing services to adults with children, to understand their role in identifying emerging problems and to share information with other professionals to support early identification and assessment. Providing early help is more effective in promoting the welfare of children than reacting later. Early help means providing support as soon as a problem emerges, at any point in a child’s life, from the foundation years through to the teenage years.

Multi Agency Safeguarding Hubs

A ‘MASH’ allocates a whole range of agencies, including police, local authority children’s social care, education, probation and health staff, to share information and spot emerging problems early, potentially saving lives.

http://www.londonscb.gov.uk/mash/

2.3. Purpose, Development and Scope of the Policy

- To help staff protect and safeguard children at risk of abuse or neglect. For the purpose of this policy the unborn child must also be considered.
- To help staff recognise that safeguarding children is everyone’s responsibility.
- To advise on what to do if staff members have concerns about children and explain what should happen when concerns are shared.
- To clarify roles and responsibilities of staff.
- To describe structures and responsibilities of the organisation.
2.3.1 Policy development

This review follows the development of revised guidance of Local Safeguarding Children Boards, Working Together To Safeguard Children (HM Government 2015)

The Children Act 1989 and Children Act 2004 remain the key statutes in regard to the protection of children.

2.3.2 Consultation

The following consultation has been carried out for version: 4 2014

- Members of the Trust Safeguarding Children Committee
- Chairs of Trust borough safeguarding children committees
- Trust Director of Human Resources
- Safeguarding children quality assurance managers for Lambeth, Southwark, Lewisham, Croydon and Bromley
- CCG designated safeguarding children lead professionals in Lambeth, Southwark, Lewisham, Croydon, Bromley and Kent

2.3.3 Communication with stakeholders - working in partnership

The Trust is a statutory partner of Lambeth, Lewisham, Southwark and Croydon Safeguarding Children Boards (LSCBs), and shares responsibility for safeguarding children. It has a special relationship with the Bromley SCB who cover the areas of the Bethlem Royal Hospital and Kent and Medway SCBs and other LSCBs where SLaM provides services.

The Trust will work closely with the LSCBs in their quality assurance, monitoring and safeguarding children arrangements.

The Trust's LSCB representatives report to the Trust safeguarding children committee via Trust borough safeguarding committees.

2.4 Duties within the Organisation

2.4.1 Organisational arrangements

The Trust Safeguarding Children Committee reports to the Trust board via the Quality sub Committee and the CAG clinical governance committees.

2.4.2 Trust Board

Responsible for supporting the role of the lead board member Director of Social Care and named nurse and doctor in governance of safeguarding children issues and receiving and considering annual reports.

2.4.3 The Trust Safeguarding Children Committee

This meets quarterly and assures the Trust board that effective structures are in place to implement and imbed the safeguarding children policies and procedures across the
Trust and achieve regulatory compliance with external and internal standards and audits as they apply to safeguarding children. It reports to the Quality subcommittee of the Trust board. Membership comprises the Trust named nurse and doctor, Director of Social Care, CAMHS safeguarding children nurses and medical leads and service leads. The chair is the Director of Nursing and has responsibility for reporting to the Trust board. Service Safeguarding leads are responsible for disseminating information to staff and act as a link to the committee for staff.

2.4.4 Trust borough and specialist directorate safeguarding children committees

Borough safeguarding committees are coterminous with local safeguarding children boards (LSCB) and responsible for local SLaM arrangements to contribute to effective joint working to safeguard children within the borough. Membership should comprise of representatives from all local Trust services including CAMHS, adult, older adult and specialist services which includes addictions, perinatal and learning disability. They are chaired by the local Safeguarding Children leads, a senior borough manager or director. The Trust borough committee is responsible for annual section11 reports to the LSCB and ensuring participation with LSCB and Trust safeguarding children committee work. They are responsible for liaison with and provision of data to the local CCG.

2.4.5 Chairs of CAG clinical governance committees and Serious Incident panels

Responsible for ensuring action plans are developed and implementation of recommendations from single and multi-agency serious case reviews involving children, timely reporting on progress and making these available for reporting to local safeguarding children boards [LSCBs] and CAG SI Panels.

Terms of Reference for structured investigations should consider safeguarding Children as an aspect of the investigation where relevant even when a child is not the main subject of the investigation.

2.5 Roles and Responsibilities

2.5.1 Trust board executive member for safeguarding children

Has overall responsibility delegated from the chief executive for ensuring that effective systems and processes are in place to address the safeguarding children agenda and chairs the Trust safeguarding children committee.

2.5.2 Trust Director of Social Care

The Director of Social Care is responsible for the supervision and management of the Named Nurse and Doctor and has strategic responsibility for the implementation of the Trust safeguarding strategy, the quality assurance framework, s.11 compliance and reporting systems are in place for to work in partnership with local safeguarding children boards. [LSCB]

2.5.3 Trust Named Nurse and Trust Named Doctor

The Trust Named Nurse Safeguarding Children and Named Doctor – Safeguarding Children report to the Director of Social Care and the Trust executive member for safeguarding children. They are responsible for the co-ordination, management, development, and implementation and monitoring of the safeguarding children strategy on behalf of the Trust board. The role of the named professionals includes liaising with partner agencies and ensuring that the Trust systems for safeguarding children including education and training, risk and assurance frameworks, annual board report are in place and responsive to relevant guidance.
The Executive Director, Director of Social Care and the named professionals are responsible for ensuring appropriate representation on the Local Safeguarding Children Boards and relevant LSCB subgroups and for ensuring attendance at Clinical Commissioning Group Safeguarding Committees and to be in regular communication with the Designated leads in the CCG.

http://www.londonscb.gov.uk/procedures/london_child_protection_procedures_chapters.html

2.5.4 Safeguarding lead roles, CAMHS lead consultants, AMH specialist roles

The Trust has a structure of Lead roles for safeguarding across each Borough/CAG service. They report to the Trust Safeguarding Committee and Named Nurse or Doctor. Their function is to implement policy, monitor child protection performance data, provide advice and support within each Borough and to provide appropriate training in safeguarding. They liaise with local partner agencies and attend relevant local safeguarding board or CCG safeguarding committees.

2.5.5 CAG responsibility

Each CAG within AMH has identified a senior manager/clinical to take a safeguarding role to ensure CAG compliance with policy, training and good practice.

2.5.6 Chairs of SLaM borough safeguarding children committees

Chairs of these committees are responsible for ensuring that meetings occur and involve all SLaM services provided within the borough and work to achieve statutory guidance.

2.5.7 The Director of Human Resources

Responsible for ensuring safer recruitment standards are maintained:

- Ensuring systems are in place for conducting criminal records (DBS) checks for all Trust staff with access to patients and relatives in the normal course of their duties.
- Ensuring systems are in place for meeting the requirements of DBS disclosures in the NHS (NHS Employers 2004).
- Ensuring systems are in place for meeting requirements of the Disclosure and Barring Service and appropriate reviews.
- Ensuring systems are in place to meet appropriate safeguarding standards in job descriptions.
- [https://www.gov.uk/government/organisations/disclosure-and-barring-service/about#what-we-do](https://www.gov.uk/government/organisations/disclosure-and-barring-service/about#what-we-do)

3. Principles

3.1. Responsibilities and duties

3.1.1 CAG leads, clinical directors and senior managers

Operational managers and directors are responsible for making arrangements to
safeguard and promote the welfare of children within their sphere of responsibility (Section 11 Children Act 2004) and ensuring that where contracted services are used that these services also have appropriate procedures in place for safeguarding children.

Operational managers and directors are responsible for ensuring implementation of recommendations arising from serious case reviews and incidents involving safeguarding children.

Ensure that no person is given access to service users, including researchers and locums, without evidence of Trust engagement procedures and honorary contract issued by SLaM HR or DBS checks, disclosure to professional training body for health professionals.

Managers and supervisors of clinical staff must ensure that staffs receive supervision and training in relation to safeguarding children. All service directors must ensure that the Trust Supervision Policy (2014) is followed and supervision will include case identification and review of safeguarding concerns access to the, who to contact for advice and mandatory training compliance

Managers are responsible for ensuring:
Staff are aware of Trust safeguarding children policies, other relevant policies and procedures, and are performance managed on their compliance with these and that staff have the appropriate level of DBS clearance and HR maintain a record

3.1.2 All SLaM staff, irrespective of discipline or role

All staff whether permanent, temporary or contracted have a duty to ensure that children are protected from harm and comply with the principles laid down in the legislation (described above)

This includes recognising and reporting concerns and to always follow up oral communication in writing to ensure the message is clear. All clinical staff must ensure all relevant clinical documentation is completed and reviewed in order to ensure the ongoing safeguarding of children.

For all staff, the welfare of the child is paramount. This implies that when there is actual, or potential, conflict between the needs of a child and adult (for example, an adult client of SLaM) the child’s needs must be prioritised.

All SLaM employees have a duty to undertake relevant mandatory safeguarding training.

3.1.3 All clinical staff – additional responsibilities

Must be aware of local procedures for reporting concerns about a particular child and refer to local authority children’s social care (LA CSC) if there are signs that a child or unborn baby is experiencing or may already have experienced abuse or neglect or is likely to suffer significant harm in the future.

Must be able to recognise whether a child is in need of additional services (because they are unlikely to achieve or maintain a satisfactory level of health or development, or their health and development will be significantly impaired, without the provision of services; or a child who is disabled) and make a decision about referral to LA CSC or early help services. This might include children whose parents are in hospital, prison and for asylum seeking children. Children and young people in receipt of CAMHS services, or
who have been admitted to hospital, should be considered children in need and might require additional services

Referrals to partner agencies should be coordinated so that the child and family experience a coherent process and a single plan of action.

Establish whether any service user is a parent/carer by completion of the Child Need and Risk Screen, and consider:

- The needs of parents/carers who may require additional support or extra help in caring for their children, and know where to refer for help.

- The impact their condition and symptoms may have on their own or other children, and whether this merits referral to LA CSC. This includes risk of physical, emotional harm or neglect.

- Consider the needs of children caring for their own or other children. Identify young carers and provide information to them about their right to request an assessment of their own needs as a ‘child in need’ and as a carer. Staff who identify that a child may be ‘in need’ should consider using the common assessment framework.

- Consider these issues at all stages throughout the episode of care and documentation and risk assessments should be regularly reviewed. There should be clear written evidence of consideration of the safeguarding needs of children. For example, GP discharge letters and ward summaries must address any actions taken or concerns expressed regarding the needs of children.

- Child protection is an essential component of CPA and Patients Journey processes through the Child Need and Risk form, risk assessments, risk history and Events and correspondence. See also SLaM child visiting policy.

Staff must ensure that they seek information from relevant services about a patient’s history. This needs to include information from other agencies such as children’s social care and other health agencies especially if they have moved or recently transferred into the area. If possible seek information from abroad if your risk assessment gives rise to concerns about family circumstances or children at risk.

All staff must working with current service users must contribute to multi-agency assessments, child protection investigations and subsequent child protection conferences (Appendix) and reviews. Disclosure of information on closed cases should be discussed with the safeguarding children lead for the CAG or Borough as there may be data protection issues to be considered.

3.1.4 Responsibilities for staff working in all adult services, including MHOA and addictions: Think Family

Paragraphs below referring to parents include all adults, carers and siblings with responsibility for the care of children.

Parents with mental health problems and their children are a group with complex needs. Not all parents and children will need the support of health and social care services but those that do can find it difficult to get support that is acceptable, accessible and
effective for the whole family. ‘Think child, Think parent, Think family’ is guidance developed by the Social Care Institute for Excellence (SCIE) which identifies what needs to change and makes recommendations to improve service planning and delivery, and ultimately to improve outcomes for families.

Parents with mental health problems need support and recognition of their responsibilities as parents. Their children’s needs must also be addressed. Different services use very different language to describe the processes they follow for assessing need and delivering support. However, essentially they all operate basic care pathway that involves making and receiving referrals, screening clients, assessing need, putting together a care plan and reviewing existing care plans.

**Principles**

- Providing parents with information about services to support them in their parenting role, information about how to support their children and how to access those services. This should be part of a recovery and well-being plan
- Identification of Children who they are and if there are any on-going needs by completing the Child in Need Risk Screen and updating this assessment at point of change within the family or transition and at any reviews.
- Taking full account of service users’ role and needs as parents or carers by ensuring family information is gathered upon in assessment and in the development of care plans, to include the assessment record and subsequent delivery and review planning
- Improving liaison and multi-agency working with services for children and families in the borough. This will include CAMHS, social services, GPs, children’s centres, schools, voluntary sector organisations and other targeted services
- Creating environments within in-patient Adult Mental Health services that are safe and welcoming for children. Community services should facilitate home visits where appropriate
- Involving children with a safe space to be heard ensuring their wishes and feelings are heard directly. Engaging with children’s knowledge and expertise validates their position in family life and acknowledges the responsibilities they might be taking
- Recognise the impact on children whose parents have mental health problems and enable them to understand issues and receive support
- Ensure that young carers are offered appropriate carers assessments
- Supporting service users through pre-conception advice, pregnancy, childbirth and the post natal period
- Taking into account cultural background and linking with local Black and Minority Ethnic services
- Acknowledging the impact of other social, health and economic factors that may impinge on effectively parenting.
- Staff may be working with an adult whose child is also known to CAMHS. This should be checked with the consent of the parent to support co-ordination of services.


### 3.1.5 Perinatal services

Particular attention needs to be paid to the needs of parents and their children who are in receipt of perinatal services in both the pre and post-birth period. Services must
ensure that they have comprehensive multi-agency risk plans; that coordination and information sharing between all agencies is established as early as possible and that appropriate and comprehensive pre-birth assessment is completed in conjunction with children’s social care where appropriate.

Peri-natal services should ensure that they have appropriate policies and local protocols in place which reflect the specific needs of this client group.

3.1.6 CAMHS clinical staff

CAMHS staff must have comprehensive multi-agency risk plans; that coordination and information sharing between all agencies is established as early as possible and that appropriate and comprehensive pre-birth assessment is completed in conjunction with children’s social care where appropriate.

Peri-natal services should ensure that they have appropriate policies and local protocols in place which reflect the specific needs of this client group.

3.1.6 CAMHS clinical staff

CAMHS staffs need to understand the impact of abuse and neglect on child development and emotional well-being.

CAMHS staff must be able to identify the signs of abuse in children, including the signs of physical, emotional, sexual abuse and neglect. Staff must understand the effects on children of domestic violence, parental mental illness and substance misuse.

CAMHS staff need to be aware of children who are at risk of abuse or exploitation in the following ways: for example, bullying, child on child abuse, sexual violence against girls involved with gangs and other gang related violence, children who have been trafficked, children at risk of radicalisation and involvement in terrorist activity, children at risk of sexual exploitation or those at risk of grooming via social media and children at risk of female genital mutilation (FGM).

Complete the CAMHS risk assessments and to regularly update to identify risk and potential need to involve other agencies

If CAMHS staff are working with a young person who, themselves is pregnant or a parent, to pay particular attention to the safeguarding needs of both the young person and their child and to complete the child need and risk screen

Safeguarding children must be at the centre of the care and treatment provided to all CAMHS service users and as such must be documented accordingly and referrals made to partner agencies in a timely and appropriate way.

3.1.7 CAMHS in-patient units

CAMHS units must have operational policies, staff induction and patient and family information leaflets which reflect the need to safeguard children throughout their stay on the unit. Search policies, visiting policies and social media management policies must reflect the wider safeguarding needs of children. Educational safeguarding policies must be shared with the units and protocols agreed for the management of patient information and risk between the two sites.

Staff must ensure there is no unsupervised contact between external facilities contractors and children in CAMHS in patient units

All staff on CAMHS units, including bank or agency staff must have up to date DBS checks and receive safeguarding training as part of their induction to the unit.
4. Procedures

4.1 Recognising abuse and neglect

Many features may lead you to be worried about the welfare of a child and the following list is not exhaustive. Their presence is not proof that abuse has occurred but must be regarded as an indicator of the possibility of harm. The context of the situation and information from others will help you decide how to proceed, including whether or not to refer to local authority children’s social care services (LA CSC). If in doubt, discuss in your team with your supervisor/team manager, contact your borough/CAG child protection lead and or LA CSC.

4.1.2 Observations about a child

- General appearance suggestive of neglect – unkempt, dirty, not dressed for the weather.
- Concerns about a child’s general appearance or behaviour, including inappropriate sexualized behaviour or remarks, excessive masturbation, recurring acts of severe aggression, appeasing behaviour towards others.
- Child appears frightened of the parent, frozen watchfulness
- Acts in a way that is inappropriate to their age and development
- Developmental delay, failure to grow, loss of weight, or excessive weight gain
- Child thrives away from home environment.
- Unexplained concerns about health and development with no medical cause, listless, apathetic, unresponsive
- Inappropriate explanation for injuries, unexplained and or repeated injuries
- Genital pain or itching, injuries to genital area, bruising to buttocks, abdomen and thighs
- Pregnancy or sexually transmitted disease in a child
- Indiscriminate choice of sexual partners, large age differences.
- Self-harm, mutilation, suicide attempts
- Frequently absent from school or frequent moves to different schools, home tutoring where there are concerns about whether this is being delivered.
- Low esteem or confidence, withdrawn, loner, difficulty relating to others
- Concerns about child’s use of alcohol or drugs
- Child with intoxicated or violent parents or carers
- Disclosure by a child that they have been hit, harmed, treated differently, they are worried about a friend, involved in inappropriate relationships, going abroad for an ‘operation’, or any other concerning disclosure.

4.1.3 Observations about a parent

- Frequently complains about the child, makes negative derogatory remarks about them, speaks about them differently from siblings, scapegoating in the family
- Concerns about unborn child in women with severe mental illness or addiction.
- A chance trigger remark by the parent about the child e.g. inappropriate sexual remarks.
• Mental illness and/or substance misuse that leads to potentially harmful changes in parenting capacity.
• Involving or incorporating child or unborn baby in symptoms / delusions.
• Attributing special powers or negative attributions to a child or unborn baby.

4.1.4 Observations about the relationship between child and parent / carer

• Abnormal or indiscriminate attachment between child and parent or failure to attach.
• Concerns about the relationship e.g. persistent negative comments, undue criticism Flinching in their presence.

4.1.5 Observations about engagement of the child or family with services

• The parent may persistently avoid help or treatment when the child is ill or delay seeking medical attention
• Persistently seeking treatment where this is found not to be clinically necessary
• Broader difficulties of engaging adult clients, which lead to significant reduction in services that manage risk to children/parents
• Parents/carers actively and/or repeatedly preventing you from observing the child

4.1.6 Other

• Information from a third party that concerns you
• Problems in the carer’s home, including domestic violence, severe intra-familial discord.
• Concerns about an unborn child where a pregnant mother has been unable to care for previous children or babies
• Forced marriage.
• Child leaving the country for an ‘operation’. This may be for female genital mutilation.
• Forced marriage
• Concerns about Fabricated or induced illness including:
  • Deliberately inducing symptoms in children
  • interfering with treatment
  • claiming the child has symptoms or exaggerating symptoms, that are unverifiable unless observed directly
  • Obtaining specialist treatment or equipment for children who do not require them or alleging psychological illness in a child.

For a fuller discussion of factors frequently found in a case of abuse or neglect see section 4.3 of the London Child Protection Procedures.
4.2. Referral Process

4.2.1 Actions to be taken when you are concerned about a child

Any concerns about the wellbeing of a child should be discussed with a senior colleague and/or the clinical team. A referral (depending on your level of concerns) should be made to LA CSC. For help and support with this process you can also contact the Borough leads. Referrals to services about a child where there may be concerns typically fall in to four categories and pathways:

- No further action, which may include information to signpost to other agencies.
- Early help - referrals for intervention and prevention services within the Common Assessment Framework and Early Help services range of provision.
- Child in Need services - assessment to be undertaken by Children’s Social Care (Section 17 CA 1989).
- Child Protection services – assessment and child protection enquiries to be undertaken by Children’s Social Care (Section 47 CA 1989) with active involvement of other agencies such as the police.

Local arrangements vary for receiving referrals across Local Authorities and each will have their own threshold document.

4.2.2 Referral for Early Help

Many children and their families might require extra support at different stages in their lives. All children have a variety of universal needs and will have support from health visitors, schools and primary care. Early help means providing support as soon as a problem emerges, at any point in a child’s life, from the foundation years through to the teenage years.

Effective early help relies upon local agencies working together to:

- Identify children and families who would benefit from early help
- Undertake an assessment of the need for early help; and provide targeted early help services to address the assessed needs of a child and their family which focuses on activity to significantly improve the outcomes for the child.

How to refer to Early Help

Most local authorities require a CAF (Common Assessment Framework) to be completed with the cooperation and involvement of the family, parent/carer and/or child and all will require you to discuss this referral with the parent and obtain their consent to refer. You might be asked to be part of a Team around the Child /Family meeting or to take the role as lead professional for the Early Help plan. For more detailed guidance on services available and how to refer, contact the relevant local authority for where the child lives or access information online via the local authority family information service.

CAF forms for partner local authorities are available on the SLaM intranet. All CAF
assessments should be based on common principles, which are set out in the framework for assessment of children in need or the ‘assessment triangle’ [http://www.londoncp.co.uk/consultation/appendix_4.html](http://www.londoncp.co.uk/consultation/appendix_4.html) This provides a systematic approach which considers the impact on the child and assesses their needs. The three domains are:

1. The child’s developmental needs, including whether they are suffering or likely to suffer significant harm.
2. The parents’ or carers’ capacity to respond to those needs.
3. The impact and influence on the child of wider family, community and environmental circumstances.

4.2.3 Referral when a child might require a statutory assessment under the Children Act (Child in Need services or Child Protection services).

**Child in Need**

Referral for these services is likely to be on a CAF and will still require the consent of the parent/carer. Concern that a child will not reach or maintain a satisfactory level of health or development, or their health and development will be significantly impaired, without the provision of services.

Assessments for some children - including young carers, children whose parents have significant mental health or substance misuse problems, children with special educational needs (who may require statements of SEN or Education, Health and Care Plans), unborn children where there are concerns, asylum seeking children, children in hospital, disabled children, children with specific communication needs, children considered at risk of gang activity, children who are in the youth justice system - will require particular care. Where a child has other assessments it is important that these are coordinated so that the child does not become lost between the different agencies involved and their different procedures.

If the referral for a Child in Need assessment is accepted by LA CSC they should inform you within one working day of the decision to complete an assessment which should be completed in a timely manner involving family and appropriate professionals. Following the assessment, a conclusion should be reached by the local authority either to close the case, offer Early Help services or convene a Child in Need meeting to which you should be invited. You will be expected to attend and to contribute to any Child in Need plan.

Attendance at a Child in Need meeting must be documented on ePJS and any plan recorded. If there are minutes of the meetings these must be filed in correspondence.

4.2.4 Children in need of protection

**In case of risk of significant harm and/or abuse.**

If possible, discuss the case with a senior colleague, clinical team, line manager, supervisor or a Trust Safeguarding Children lead or the Named Nurse or Doctor. Ensure you keep written records of these discussions. It should be possible to discuss initial worries with LA CSC duty teams.

If after discussion, harm or risk of harm is considered, you must inform the appropriate
LA CSC by telephone. The appropriate office will usually be the borough in which the child currently resides. Follow up in writing within 48 hours using the appropriate LA CSC referral form or letter providing full details of the child and family and current concerns. LA CSC should acknowledge referrals within one working day of receipt. If this does not occur within three working days, the referrer should contact LA CSC to confirm receipt.

If there is a difference of opinion with a senior professional regarding whether a child is at risk of significant harm and or abuse, attempts should be made to resolve this through further discussion. If this difference cannot be resolved the Trust named safeguarding children doctor or nurse should be consulted. However, if professional remains concerned about a child, (at the very least) they should have a discussion with a senior professional within LA CSC to clarify the outcome.

Staff must keep full contemporaneous records of what is said by all parties, including the child; details of physical and emotional findings and record of dates and times of entries. Information recorded or reported should be fact not opinion.
LA CSC has a duty to investigate the suspicion of abuse or risk of abuse. This will usually involve a multi-disciplinary approach and sharing of information across agencies. They will consider:

- Whether the child is safe
- Who should see the child
- Which family member or trusted adult should be present
- Who should communicate with the parent

If a child is known or suspected to have been abused, or to be at risk of significant harm, immediate and appropriate plans must be made to protect the child.

4.2.5 Where abuse is alleged by a child

The response should be limited to listening carefully to what the child has to say to, clarify the concerns, offer re-assurance 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 assurance of absolute confidentiality as this could prejudice police investigations, especially in case of sexual abuse.

If the child can understand the significance and consequences of making a referral to LA CSC, they should be asked their view. It should be explained that while their view will be taken into account, the professional has responsibility to take whatever action is required to ensure safety of the child and other children.

4.2.6 What to do in an emergency

If a child discloses serious significant harm (such as a sexual assault) where the child is considered to be at immediate risk then there needs to be an immediate referral to CSC and consideration should be given to reporting to the police (via 999 if necessary) if it appears that a crime has been committed. Senior managers should be informed in order to support this process.

4.2.7 Urgent medical attention
If the child is suffering from a serious injury, the professional must seek medical attention immediately from accident and emergency services and must inform LA children's social care, and the duty consultant paediatrician at the hospital.

Where abuse is alleged, suspected or confirmed in a child admitted to hospital, the child must not be discharged until:

LA children's social care local to the hospital and the child's home address (may be two different LA children's social care) are notified by telephone that there are child protection concerns;

A strategy meeting / discussion has been held, if appropriate, which should then include relevant hospital and other agency professionals.

4.2.8 Parental consultation

Where practicable, concerns should be discussed with the parent and agreement sought for a referral to LA 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; For example in circumstances where there are concerns or suspicions that a serious crime such as sexual abuse or induced illness has taken place.

Where a professional decides not to seek parental permission before making a referral to LA children's social care, the decision must be recorded on ePJS with reasons and confirmed in the referral to LA children's social care.

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 manager or the designated safeguarding children professional and the outcome fully recorded.

If, having taken full account of the parents' wishes it is still considered that there is a need for referral:

The parent's withholding of permission must form part of the verbal and written referral to LA children's social care and the parent should be contacted to inform them that, after considering their wishes, a referral has been made.

4.2.9 For an out of hours incident

The LA CSC emergency duty service should be notified.

4.2.10 Children in hospital

Where abuse is alleged, suspected or confirmed children admitted to hospital, a child protection referral should be made on a completed relevant local referral form or letter providing full details of the child and family and current concerns

They must not be discharged from hospital without a documented plan for the future care of the child. The plan must include follow up arrangements.
Children should not be discharged from hospital without an identified GP and health visitor (if appropriate), both of whom must be informed of discharge plans. This also applies to babies admitted with their mothers to perinatal in-patient services.

4.2.11 Considerations for immediate action in alleged Child Sexual Abuse (CSA)

In cases of suspected sexual abuse the case should always be discussed with a senior colleague, before considering any further physical or verbal examinations. Examinations following child sexual abuse suspicions will normally be co-ordinated and arranged by the local LA CSC, and conducted by a professional who has appropriate training and has been approved by the designated/named doctor.

In all CSA suspicions or allegations, LA CSC should be informed. They will take responsibility for arranging a planning/strategy meeting if appropriate. This may be held without the knowledge or involvement of the parents/carers, as it is important not to alert an alleged perpetrator at this stage.

The planning meeting ensures that both the police and LA CSC undertake a coordinated investigation.

4.2.12 Police involvement

The police can be contacted where there is a violent/abusive incident at the hospital, or if a child is being removed by person(s) without parental responsibility (PR) or removed by a person with PR and this is likely to cause significant harm. In addition, health staff can contact the police when there are no out of hours duty social workers available and there is a dangerous situation at the hospital requiring the intervention of the police. In most circumstances, a health professional would not inform the police prior to discussing the matter with LA CSC.

4.2.13 Physical examinations

The number of physical examinations should be kept to an absolute minimum, and should always be conducted in a suitable environment by appropriately trained medical staff and in the presence of a trusted adult. Specific child protection medical examinations must be carried out by appropriately trained doctors. These are usually arranged via an urgent child protection referral to LA CSC or in consultation with the designated paediatrician within the CCG.

All relevant evidence from interviews and examinations must be carefully recorded after discussion with the multi-disciplinary team, and the essential points conveyed to the appropriate social worker.

CAMHS in-patient services and peri-natal services must have local policies to manage concerns about physical injury.

4.2.13 Actions following child protection/significant harm referral

Within one working day of a referral being received, the LA CSC must make a decision about the course of action to be taken. The social worker will need to make a professional judgment as to what type and level of help and support is needed, record this and feed back in writing to the referrer and the child and their family.

4.3. Possible Outcomes
4.3.1 **Strategy discussion/meeting**

Whenever there is reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm, there should be a strategy meeting.

The strategy meeting / discussion should be convened by LA children's social care. In addition to LA children's social care, the police and relevant health professionals, the meeting / discussion may need to involve the other agencies (e.g. schools and nurseries) which hold information relevant to the concerns about the child. If you are invited to a strategy meeting you will have a duty to attend even if you are not the referrer but have relevant knowledge of the family. If you attend a strategy meeting you must document attendance and the agreed plan on ePJS.

The strategy meeting will decide whether an assessment under s47 of the Children Act 1989 (s47 enquiries) should be initiated, or continued if it has already begun; consider the assessment and the action points, if already in place; plan how the s47 enquiry should be undertaken (if one is to be initiated), including the need for medical treatment, and who will carry out what actions, by when and for what purpose; agree what action is required immediately to safeguard and promote the welfare of the child, and / or provide interim services and support. If the child is in hospital, decisions should also be made about how to secure the safe discharge of the child.

If minutes from the meeting are shared then these should be saved in correspondence.

If the outcome of the strategy meeting is an s47 enquiry is instigated there will be a detailed full assessment of the concerns outlined in the strategy meeting by LA CSC. You will be expected to contribute to the enquiries.

The outcome of the s47 enquiries may reflect that the original concerns are:

- Not substantiated; although consideration should be given to whether the child may need services as a child in need;
- Substantiated and the child is judged to be suffering, or likely to suffer, significant harm and an initial child protection conference should be called.

4.3.2 **Child Protection Conferences**

The function of the child protection case conference is to establish all relevant facts about the child and family, from a child-focused perspective, with the objective of assessing the risk and identifying the protective factors for the child/ren and forming a multi-agency plan that can enable change.

Family participation at child protection conferences is actively encouraged. If you think that some of the information you will present cannot be shared with the parents/family, you should discuss this with the chair of the conference prior to the meeting, following a discussion with a senior member of your team.

The case conference will decide if a child is to be the subject of a protection plan and under which category and you will be expected to give your opinion. There is an expectation that SLaM staff will attend case conferences and to submit a written report prior to the conference from the care coordinator of allocated worker. See the SLaM safeguarding children site for guidance on reporting to child protection conferences.

4.3.3 **Child Protection Plans**
Case conferences are the only mechanism that can decide if a child will be the subject of a child protection plan, and under which category of abuse or no longer be subject of a plan.

Following a decision a child protection plan will be formulated. Trust staffs are expected to say what they believe they can offer to this plan. A key group (known as a Core group) of professionals and family/carers will be identified with the aim of working to enable change. SLaM staff are expected to be actively involved in this process if and as appropriate.

If there are any doubts as to whether a child or siblings may subject/s of a child protection plan, or the family known to Social Care LA CSC, the LA CSC should be consulted.

4.3.4 Allegations of historical abuse

Adults may disclose they or others in their family were abused in childhood. Response to allegations by an adult of abuse experienced as a child must be of as high a standard as a response to current abuse because of the likelihood that the perpetrator has continued to abuse children and may be doing so now, criminal prosecution may be possible if sufficient evidence can be collated.

Professionals must inform the adult of the professional duty to safeguard children and try to establish whether the past abuser is in contact with children who could currently be at risk of harm which may need to be referred to children’s social care or police.

The adult who has disclosed should be asked whether they want a police investigation and must be reassured that the police are able and willing to progress an investigation.

4.3.5 If you feel your referral is not being responded to

Where LA CSC has concluded that no further action is required but you remain seriously concerned about the safety of a child, you should seek further discussion with the social worker, their manager and/or the CAG/Borough Lead safeguarding professional and your manager. The concerns, discussion and any agreements made should be recorded in the client record.

If concerns remain, you should discuss with a named safeguarding children professional or the named doctor in SLaM.

You may be advised to escalate the concerns to the service manager or the child protection advisors within LA CSC. You may, following advice, formally request that LA CSC convene an initial child protection conference. LA CSC should convene a conference where one or more professionals, supported by a senior manager / named professional request one.

If this approach fails to achieve agreement, the procedures for resolution of conflicts in the London Child Protection Procedures

http://www.londoncp.co.uk/consultation/profess_conflict_res.html#profess_diff_rem
### 4.3.6 Referral Flowchart

- **Professional has concerns about a child’s welfare**
  - If concern is of a child suffering or likely to suffer significant harm, go straight to referral.
  - Professional discusses with manager and/or agency’s nominated safeguarding advisor, including consideration of seeking parental consent.
  - Professional checks whether a common assessment has recently been completed and whether there is a lead professional appointed.
    - If a common assessment has not been completed the professional completes one.
    - If a common assessment has been completed the professional adds to it and contacts the lead professional if there is one.
  - Still has concerns
    - Professional makes a referral to LA children’s social care, following up in writing within 48 hours.
      - LA social worker and manager acknowledge receipt of referral and decide next course of action within one working day.
        - Assessment required
        - Concerns about a child’s immediate safety
  - No longer has concerns
    - No further child protection action, though may need to follow up to ensure services are provided.
      - Feedback to referrer on next course of action.
        - No further LA children’s social care involvement at this stage, although other action may be necessary e.g. onward referral.

### 4.3.7 Sharing information

“The duty to share information can be as important as the duty to protect patient confidentiality”. (Caldicott 2 principle 7)

Effective sharing of information between professionals and local agencies is essential for effective identification, assessment and service provision.
Early sharing of information is the key to providing effective early help where there are emerging problems. At the other end of the continuum, sharing information can be essential to put in place effective child protection services. Serious Case Reviews (SCRs) have shown how poor information sharing has contributed to the deaths or serious injuries of children.

Fears about sharing information cannot be allowed to stand in the way of the need to promote the welfare and protect the safety of children. To ensure effective safeguarding arrangements:

No professional should assume that someone else will pass on information which they think may be critical to keeping a child safe. If a professional has concerns about a child's welfare and believes they are suffering or likely to suffer harm, then they should share the information with local authority children’s social care.

Information Sharing: Guidance for practitioners and managers (2008) provides guidance about sharing personal information on a case by case basis.

The Trust Information Sharing Policy and data protection department provide additional support and guidance.

Parents/carers should, in most cases, be informed of concerns before a referral is made and parents should be part of the process. Parents / carers are entitled to know what is going on and to be helped to understand the steps being taken. A referral to a LA CSC cannot be made anonymously by a professional.

If parents refuse permission for referral and it is still considered that there is a need:

- The reason for proceeding without parental agreement must be recorded
- LA CSC should be told that the parent has withheld his/her permission
- The parent should be contacted to inform her/him that after full consideration of their wishes a referral has been made.

Where sharing concerns with parents could increase risks to a child, for example sexual abuse within the family when there is a danger of the parents silencing the child, you should make the referral without informing the parents and record this in the notes”.

Children have a right to be told what is going on. They should not be given promises that cannot be kept. Their views and wishes should be taken into consideration, in accordance with their age and developmental status.

Clients and children should be made aware that confidentiality can never be absolute, as staffs have a duty to ensure they are protected from harm.

Information will be shared with parent or carer and with the child appropriate to their age and understanding. This includes all reports for child protection conferences and some planning meetings, which should always be shared with the family before any meeting.

There will be circumstances in which it will not be in the child’s best interests for information to be shared immediately.
Nevertheless, health professionals should not disclose without consent, information obtained in confidence, unless it is necessary to ensure the protection of a child at risk, or is necessary as part of a multi-agency comprehensive assessment to determine the level of risk.

The welfare of a child should always be considered whenever a letter is sent, for example to the GP/referrer, summarising involvement with a patient who is a parent or carer. This may include copying the letter to the relevant LA CSC where there are concerns.

Cases should not be declined or closed without the original referrer, and other key agencies, being advised that this is the proposed plan so that they can either question this decision or take over the responsibility for support and monitoring, where this is required. This is particularly important where a child is subject of a child protection plan or already known to LA CSC.

Generally, if LA CSC request information as part of a section 47 (child protection) assessment, clinicians have a duty to pass on information with or without client/parental consent. If LA CSC request information as part of a section 17 (child in need) assessment, then information should only be given with client/parental consent. Therefore, staff should clarify with LA CSC which section of the Children Act 1989 the assessment is being conducted under, in-order to know the minimum level of client consent required.

Where a child in the family is subject of a child protection plan or where there are safeguarding concerns, services should ensure copies of letters sent to GPs summarising involvement in the case are copied to children’s social care.

Data protection and the Caldicott Guardian

For further guidance on information sharing the Caldicott Guardian is a senior person responsible for protecting the confidentiality of a patient and service-user information and enabling appropriate information-sharing. Guidance can be obtained from:

http://sites.intranet.slam.nhs.uk/ICT/Services/TeamPortfolio/informationgovernance/caldicott/committee/default.aspx

4.3.9 Serious Case Reviews (SCR)

Working Together to Safeguard Children (DOH 2015) states that the LSCB should consider a Serious Case Review for every case where abuse or neglect is known or suspected and either:

- a child dies; or
- a child is seriously harmed and there are concerns as to the way in which the local authority, their board partners or other relevant persons have worked together to safeguard the child;
- child death review: a review of all child deaths up to the age of 18;
- review of a child protection incident which falls below the threshold for an SCR; and
- review or audit of practice in one or more agencies.

The purpose is to:
• establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to safeguard children;
• identify clearly what those lessons are, how they will be acted upon, and
• what is expected to change as a result; and as a consequence, and
• to improve inter-agency working and better safeguard children. Paste in new guidance

In SLaM, if an SCR is being considered where there has been involvement either with the child or parent or other relevant family member, SLaM will be required to participate in the review process. Any professional may be required to contribute to both the Trust and LSCB review process.

ePJS records and any paper files will be made available to the investigation team and any paper records secured.

The chief executive is the person initially informed. They will then inform the SLaM named nurse and doctor, who are responsible for facilitating and advising on requirements for serious case reviews for the Trust. There are parallel and linking processes with close working between the patient safety office, responsible for reporting mechanisms, monitoring and investigating serious incidents, the LSCBs and the Trust Executive Board.

The named professional/s / review team will follow the SLaM procedures for structured investigations and will follow the LSCB terms of reference for the review process. More information on SCR procedures are found in in chapter 4 of Working Together to Safeguard Children 2015.

The SLaM investigation team will conduct the IMR (internal management review) which will inform the LSCB and will consider the level of internal investigation required.

In SLaM, directorate CAG executive committees are responsible for facilitating the implementation of any local action plan. The final recommendations and action plans from review panels are considered by the Trust safeguarding children committee who may take a lead on some actions that require a Trust wide response, for example child protection structures and arrangements, Trust wide policy, training programmes and systems.

4.3.10 Support for staff

Arrangements for supporting staff in safeguarding children work include:
• SLaM safeguarding children leads, telephone advice line and Trust intranet site
• SLaM training advertised in the Trust education and training and safeguarding intranet sites.
• Team based safeguarding training
• LSCB training, accessible through local Borough training websites
• Professional supervision arrangements and team supervision.
• Staff support following serious incidents.

4.3.11 Allegations of abuse against staff (including Trust staff)

Despite all efforts to recruit safely there will be occasions when allegations of abuse against children are raised. Local Safeguarding Children Boards (LSCBs) should therefore have arrangements in place for monitoring and evaluating their effectiveness. These procedures should be applied when there is an allegation or concern that any person who works with children, in connection with their employment or voluntary activity, 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 he or she would pose a risk of harm if they work regularly or closely with children.

These behaviours should be considered within the context of the four categories of abuse (i.e. physical, sexual and emotional abuse and neglect). These include concerns relating to inappropriate relationships between members of staff and children or young people, for example:

• Having a sexual relationship with a child under 18 if in a position of trust in respect of that child, even if consensual (see ss16-19 Sexual Offences Act 2003);
• ‘Grooming’, i.e. meeting a child under 16 with intent to commit a relevant offence (see s15 Sexual Offences Act 2003);
• Other ‘grooming’ behaviour giving rise to concerns of a broader child protection nature (e.g. inappropriate text / e-mail messages or images, gifts, socializing etc.)
• Possession of indecent photographs / pseudo-photographs of children.

All references in this document to ‘members of staff’ should be interpreted as meaning all paid or unpaid staff and volunteers, including foster carers and approved adopters. This applies to any person, who manages or facilitates access to an establishment where children are present. London Child Protection Procedures, must be applied when there is an allegation or concern.

All allegations made against Trust staff must be brought to the attention of the relevant director immediately and advice sought from a Trust named nurse and the local authority designated officer (LADO) with overall responsibility for ensuring London CP Procedures are followed. The Trust policy on managing allegations against staff must be followed http://sites.intranet.slam.nhs.uk/childprotection/Trust%20Safeguarding%20Children%20Policies/AllegationsAgainstStaff2008.pdf

5. Training

All staff are expected to undertake training in accordance with the requirements described in the Safeguarding Children and Young People, Roles and Competencies for Healthcare Staff Intercollegiate Document (2014). Further detail as to how this will be delivered is outlined in the safeguarding training strategy

Safeguarding Children Training:
**Level 1:** All non-clinical staff at all levels, working in all service areas of the Trust, including medical and nursing professionals support staff, support services, volunteers, agency staff and students from all disciplines will receive awareness training in safeguarding children as identified in Level 1 requirements (see safeguarding training strategy). This is provided for staff at induction face to face or via a e-learning package.

**Level 2:** All clinical staff who come into contact with children and families as part of their work, except those eligible for Level 3, should attend Level 2 safeguarding training as identified in Level 2 requirements (see safeguarding training strategy). This is provided at induction only as all subsequent updates are delivered at Level 3.

**Level 3:** All clinical staff who have responsibilities for the management and provision of care to children and young people receive mandatory training at level 3 as identified in Level 3 requirements, i.e. Targeted teams (see safeguarding training strategy).

**Level 4:** All staff with specialist safeguarding roles should undertake additional specialist training at Level 4 as identified in Level 4 requirements (see safeguarding training strategy).

**Trust Board:** All board members must undertake Level 1 training as well as board specific training requirements (see safeguarding training strategy).

6. **Monitoring Compliance**

The policy implementation and training is monitored through the Trust safeguarding children committee which is responsible for maintaining and reviewing risk and assurance frameworks, audit, strategy implementation and reporting to the Trust quality committee and the Trust Board.

External review of safeguarding practice and joint working includes:-

- LSCB serious case reviews reported to Ofsted
- CQC
- Ofsted inspections and thematic reviews of children’s services and LSCBs
- Children Act 2004 section 11 audit reports and action plans to LSCB
- CCG safeguarding reporting mechanisms

Internal review includes:-

- Audit of training uptake via training registers and electronic staff record return
- Assurance and risk frameworks
- Clinical governance systems for review and implementation of SCR recommendations.

The policy will be reviewed every three years or sooner if there are changes in national, pan-London procedures or government policy. The Trust safeguarding children committee will consider breaches of the policy and proposed amendments in line with the annual report submission to the Trust executive.
7. **Associated Documentation**

All SLaM policies on safeguarding children can be accessed via the SLaM intranet page:


Allegations against Staff (2008)


Trust Domestic Violence Policy (2012)

http://sites.intranet.slam.nhs.uk/childprotection/SG%20Webpages/Domestic%20Violence.aspx

Protecting Children and the Public. SLaM guidance 2014.


Safeguarding children and young people: roles and competences for health care staff (Intercollegiate Document) 3rd edition: March 2014


8. **References**

A guide to inter-agency working to safeguard and promote the welfare of children

March 2013


Information sharing for practitioners and managers

Independent report; Munro review of child protection: final report - a child-centred system


London Safeguarding Children Board (LSCB) web pages
http://www.londonscb.gov.uk/

http://www.londonscb.gov.uk/procedures/

Social Care Institute for Excellence:
http://www.scie.org.uk/

Statutory guidance on making arrangements to safeguard and promote the welfare of children under section 11 of the Children Act 2004. HM Government.

Safeguarding Vulnerable People in the Reformed NHS Accountability and Assurance Framework 2013

Working Together to Safeguard Children 2015

9. **Freedom of Information Act 2000**

All Trust policies are public documents. They will be listed on the Trusts FOI document schedule and may be requested by any member of the public under the Freedom of Information Act (2000).
Appendix 1

Child Protection Conferences and Plans - Expectations of Trust Staff

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If you are working with a child who has a protection plan

- Know which child and families in your work are subject to child protection plans.
- Know what the child protection plan says and what you have to do.
- Know who the allocated social worker is and how to contact them.
- See the family as agreed within the child protection plan.
- Attempt to see the family at home.
- Report any concerns you have about the child to the allocated social worker immediately. In the absence of the allocated social worker please report your concerns immediately to the Children Social Care team manager and/or duty system as well as your own team manager and Consultant Psychiatrist.
- Attend all child protection conferences with a written report that you have given to the family and discussed with them before the meeting.
- Attend core groups and take a progress report on your work with the child / their family.
- Ensure that any meetings attended and contacts with the family and/or professionals are clearly documented.
- Ensure that all reports / child protection plans are labelled and scanned into the “Correspondence” section of ePJS.
- Do not close cases without verbal and written communication to the allocated social worker and document this on EPJs.

1.0 Scope

This guidance is equally applicable to staff in all Trust services who work with children, parents or other adults with substantial contact with or responsibility for children.

2.0 Background

This guidance is based on “Working Together to Safeguard Children” (2013), “What to do if you’re worried a child is being abused” (2006). It also takes account of recommendations from national and local (with Trust involvement) Serious Case Reviews as well as the lessons learned from the national Biennial Reviews of Serious Case Reviews.

All health professionals who work with children and families are expected to cooperate with other agencies to protect children and this includes contributing to and attendance at child protection conferences and strategy discussions

2.1 Responsibility for reporting to and attending conferences.

Reports for the conference must be prepared by the care coordinator, team manager/Consultant Psychiatrist or a delegated health professional who knows the child/parent well. They should attend and take a full part in decision making.

Where they cannot attend the team manager should attend or delegate responsibility for attendance to a team member and ensure that a report is sent.
If Trust professionals are invited to a Child Protection Conference for an individual who is not known to Trust services they should send referral and service information to the conference and seek advice from the relevant Trust safeguarding children lead regarding the need for any further action.

The paramount and central concern of any conference is to consider all information presented to it from a child focussed perspective with the objective of assessing needs and risks of children to inform the protection plan.

Staff will still be expected to make a decision on the category of abuse. The options will be:

- Emotional Abuse
- Physical Abuse
- Sexual Abuse
- Neglect

The child protection plan will then reflect this decision.

3.0 Types of conference

3.1 Initial

This brings together family members, the child (where appropriate), supporters / advocates and involved professionals to:

- Bring together and analyse, in an interagency setting, information about a child's developmental needs, and parents’ or carers’ capacity to respond to these needs to ensure the child’s safety and promote their health and development within the context of their wider family and environment
- Consider evidence presented to conference , make judgements about the likelihood of a child suffering significant harm in future, and decide whether the child is at continuing risk of significant harm; and
- Decide what future action is required to safeguard and promote the welfare of the child, how that action will be taken forward, and with what intended outcomes.

3.2 Review

For review reports, there is no need to repeat detail already known but, ensure that any changed circumstances and new information is recorded with an evaluation of how this new information affects your assessment.

The purpose of the review is to:

- Review safety, health and development of the child against planned outcomes set out in the child protection plan
- Ensure that the child continues to be safeguarded from harm; and
- Consider whether the child protection plan should continue in place or should be changed.
3.3 Pre-birth child protection conferences and reviews

Concerns that an unborn child may be at future risk of significant harm may result in an initial child protection prior to the child’s birth. Such a conference has the same status, and proceeds in the same way, as other initial conferences, including decisions about a protection plan. Review conferences also proceed the same way.

4.0 The report

- It is essential to review the client’s full history with the Trust to ensure that the full content of the historical record is appraised and reflected in the report. Some clients have a long history with the Trust and information that is critical to current child safeguarding concerns may be contained in old records and may not be known to other agencies.

- This can be critical in pre-birth conferences where there are the Trust records of prior parental peri-natal mental health contact.

- All Trust records must be checked. The request for a full Trust clinical record check should be made in writing to the Trust Clinical Records Department with the additional request of a search log to be provided as evidence that all records have been checked for information. A check on ePJS electronic records alone is not sufficient.

The report should summarise the service involvement with the child and / or family, as well as information concerning any knowledge of the child’s developmental needs and the capacity of the parents to meet the needs of the child within their family and environmental context. It should take account of what is known about other strengths in the wider family network. It is good practice to include a genogram (a diagram outlining the history of the behaviour patterns (as of divorce, abortion, or suicide) of a family’s members over several generations in order to recognize and understand past influences on current behaviour patterns).

The headings in the attached assessment framework triangle provide a helpful guide for the areas that should be considered and reflected in the report with a specific focus on the area of expertise in adult or child and adolescent services for example parental or child mental health. (Appendix 1 & 2)

- Care should be taken to distinguish between fact, observation, allegation and opinion. When information is provided from another source – i.e. it is second or third hand – this should be made clear.

5.0 Communication

Reports should be shared with the client in advance, in line with Trust policy. The conference will assume that the content of the report has been discussed with the parent or guardian who should not be confronted with new information at the conference.

- If you think that some of the information that will be presented cannot be shared with them, or is new to them, you must discuss this with the chair of the conference prior to the meeting.

Reports should reach the chair of the conference 24 hours before the meeting.

A record of the conference will be sent to attendees summarising essential facts, summary of discussion, decisions reached and reasons and a protection plan stating who is responsible for what actions. This should be summarised on the client’s (parent and / or child) ePJS.

6.0 What happens at a child protection conference
The purpose is to decide whether a child is at continuing risk of significant harm and whether s/he therefore requires a child protection plan to be put in place.

The test should be that either:

- The child can be shown to have suffered ill-treatment or impairment of health or development as a result of physical, emotional or sexual abuse or neglect, and professional judgement is that further ill treatment or impairment are likely; or
- Professional judgement, substantiated by the findings of enquiries in this individual case or by research evidence, is that the child is likely to suffer ill-treatment or the impairment of health or development as a result of physical, emotional or sexual abuse or neglect.

If they do not become subject to a plan they should consider the child’s needs and what future help the family needs to respond to the child. Such a child in need plan should be reviewed at least every six months.

If the child is subject to a plan the conference decides how each agency and professional should work together to safeguard the child.

6.1 What to expect

An experienced Children’s Social Care manager will chair the conference. It can last up to three hours.

Conferences can be large. They may include the child and involved members of their family and professionals who are working with the child and family. The child and family are invited to be present throughout.

You will be expected to take an active part in thinking about all the issues presented and consider how they inform the overall decision that needs to be made.

At the end each professional will be asked in turn in to give their own decision on whether the child should be subject to a continuing / protection plan, this will include you even though you may be working with the parent / carer and not the child.

6.2 Decisions that will be made

The conference appoints the lead agency (Local authority or NSPCC) and key worker.

Core group professionals and family members who will develop and implement the protection plan are identified. You may be a core group member.

Outlines the plan and timescales for review identifying what needs to change in order to safeguard and promote the welfare of the child.

Clarifies which professional has responsibility for what actions within set timescales, how this will be monitored and by whom and what action will be taken by whom if the required actions have not taken place.

Agrees a date for a review and what conditions it might be necessary to convene earlier.

7.0 Further information

The Trust safeguarding team members are available for consultation and support in preparing for and attending case conferences.

The Trust helpline may be contacted on 07659 152 223.

Source information is contained in:-
They can be found on the Trust child protection intranet site.

8.0 Training

Local Safeguarding Children Boards provide inter agency training on working with conferences. This is free and programmes for Lambeth, Lewisham, Southwark, Croydon and Bromley Safeguarding Boards can be found on the Trust Safeguarding Children Intranet site and the local Safeguarding Children Board internet sites.

Type of conference e.g. initial, review, pre birth.

Conference date:
Duration and nature of contact with SLaM services (check ePJ and spine and review files).

Biographical Details

Family name/s:
Address:
Phone:

Family members known to you including:

Adults:
Name   DOB   Relationship to child   Sex   Ethnicity

Children:
Name   D.O.B   School / nursery   Sex   Ethnicity

It is good practice to include a genogram.

Details of involvement

INITIAL CONFERENCE / FIRST REPORT:

Summarise your involvement in the investigation and / or circumstances leading to the conference.

If you made the referral, give the details of the referral and your current concerns

Summarise service involvement with the children and their family, including frequency and purpose of contact, knowledge of the child/ren and their family’s history, including relevant medical history where known.

Your concerns may also be around adults, other than parent/s that you know to be in regular contact with the child / parent particularly where these adults have their own needs such as, mental health including older adults, substance misuse, learning disability, forensic / violence.

Consider the changing needs & capacity of informal & formal carers. Include young & old carers, other children, grandparents and friends.
Be clear about any effect of the adult’s needs on the child/ren, for example mental health, substance misuse, forensic/violence, disability needs. You may be the only professional/team with information on this. Your contribution is critical.

Comment on each child separately including children about to be born.

Comment on the parent / child’s ability and willingness to engage with treatment and intervention and their response.

Comment on the likely prognosis of the mental health problem taking into account likely response to treatment and intervention and implications for the child.

**Current concerns**

Appraise factors in each dimension as relevant to your involvement. Bring them together to form the basis of a strength concern analysis.

From each of the summaries of the three domains describe the main factors that can be defined as carrying a strength or concern.

<table>
<thead>
<tr>
<th>Identified strengths</th>
<th>Identified concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child / young persons developmental need</td>
<td></td>
</tr>
<tr>
<td>Parenting capacity</td>
<td></td>
</tr>
<tr>
<td>Family and environmental factors</td>
<td></td>
</tr>
</tbody>
</table>

**DIMENSIONS OF CHILD’S DEVELOPMENTAL NEEDS**

<table>
<thead>
<tr>
<th>Strength</th>
<th>Satisfactory</th>
<th>Mild concern</th>
<th>Moderate concern</th>
<th>Serious concern</th>
</tr>
</thead>
</table>

Overall analysis

Summarise the overall assessment setting out the family’s main strengths and concerns highlighting any that need to be specifically addressed. Appraise the relative significance of the concerns and strengths that have been identified, and assign weight to them. When considering the strength of these factors, several mild or moderate concerns may add up to more in ‘real’ terms so you must both consider weight and number of concerns.

**REVIEW CONFERENCE:**

Summarise the outcome of your agreed actions relevant to the review and the protection of the children since the last conference.

Summarise any new concerns

Include any other actions relevant to the review and protection of the child/ren
PRE BIRTH CONFERENCE:

In pre-birth conferences, include what the parent/s have said about their attitude towards a new baby about to be born and how they feel it will affect them. Include observations about what preparations have been made for the baby, how to manage differences in their level of concern and yours, crisis and contingency plans. Consider the potential impact of the birth on partner and carer relationships and implications for safeguarding the newborn. Consider partners that you know little about.

**Views of parents and children concerning their current situation and the conference**

Include any information you have about the child’s / parent/s / carers views on the current situation, making it clear that these are their opinions and not necessarily the professional.

**Conclusions**

Summarise any conclusions you wish to make based on the information you have provided. Be specific about your concerns for the child / ren

Briefly provide any recommendations you would like to make to the conference about suitable services or work to be undertaken with the child or the family.

**Summary of key points to be included in the record**

Summarise any key points you want to be included in the conference record.

Keep a copy of the report for inclusion in the client ePJ record.

**Your details:**

Report by ......................................................  Your name,
Your role, ..........................................................
Your service ........................................................
Your contact details ..............................................
Appendix 2

Assessment Framework Triangle
for Children and Young People

DIMENSIONS OF CHILD’S DEVELOPMENTAL NEEDS

Health
Includes growth and development as well as physical and mental wellbeing. The impact of genetic factors and of any impairment need to be considered. Involves receiving appropriate health care when ill, an adequate and nutritious diet, exercise, immunisations where appropriate and developmental checks, dental and optical care and, for older children, appropriate advice and information on issues that have an impact on health, including sex education and substance misuse.

Education
Covers all areas of a child’s cognitive development which begins from birth. Includes opportunities: for play and interaction with other children to have access to books; to acquire a range of skills and interests; to experience success and achievement. Involves an adult interested in educational activities, progress and achievements, who takes account of the child’s starting point and any special educational needs.

Emotional and Behavioural Development
Concerns the appropriateness of response demonstrated in feelings and actions by a child, initially to parents and caregivers and, as the child grows older, to others beyond the family. Includes nature and quality of early attachments, characteristics of temperament, adaptation to change, response to stress and degree of appropriate self control.

**Identity**
Concerns the child’s growing sense of self as a separate and valued person. Includes the child’s view of self and abilities, self-image and self-esteem, and having a positive sense of individuality. Race, religion, age, gender, sexuality and disability may all contribute to this. Feelings of belonging and acceptance by family, peer group and wider society, including other cultural groups.

**Family and Social Relationships**
Development of empathy and the capacity to place self in someone else’s shoes. Includes a stable and affectionate relationship with parents or caregivers, good relationships with siblings, increasing importance of age appropriate friendships with peers and other significant persons in the child’s life and response of family to these relationships.

**Social Presentation**
Concerns child’s growing understanding of the way in which appearance, behaviour, and any impairment are perceived by the outside world and the impression being created. Includes appropriateness of dress for age, gender, culture and religion; cleanliness and personal hygiene; and availability of advice from parents or caregivers about presentation in different settings.

**Self-Care Skills**
Concerns the acquisition by a child of practical, emotional and communication competencies required for increasing independence. Includes early practical skills of dressing and feeding, opportunities to gain confidence and practical skills to undertake activities away from the family and independent living skills as older children. Includes encouragement to acquire social problem solving approaches. Special attention should be given to the impact of a child’s impairment and other vulnerabilities, and on social circumstances affecting these in the development of self-care skills.

**DIMENSIONS OF PARENTING CAPACITY**

**Basic Care**
Providing for the child’s physical needs, and appropriate medical and dental care. Includes provision of food, drink, warmth, shelter, clean and appropriate clothing and adequate personal hygiene.

**Ensuring Safety**
Ensuring the child is adequately protected from harm or danger. Includes protection from significant harm or danger, and from contact with unsafe adults/other children and from self-harm. Recognition of hazards and danger both in the home and elsewhere.

**Emotional Warmth**
Ensuring the child’s emotional needs are met giving the child a sense of being specially valued and a positive sense of own racial and cultural identity. Includes ensuring the child’s requirements for secure, stable and affectionate relationships with significant adults, with appropriate sensitivity and responsiveness to the child’s needs. Appropriate physical contact, comfort and cuddling sufficient to demonstrate warm regard, praise and encouragement.
Stimulation
Promoting child’s learning and intellectual development through encouragement and cognitive stimulation and promoting social opportunities. Includes facilitating the child’s cognitive development and potential through interaction, communication, talking and responding to the child’s language and questions, encouraging and joining the child’s play, and promoting educational opportunities. Enabling the child to experience success and ensuring school attendance or equivalent opportunity. Facilitating child to meet challenges of life.

Guidance and Boundaries
Enabling the child to regulate their own emotions and behaviour. The key parental tasks are demonstrating and modelling appropriate behaviour and control of emotions and interactions with others, and guidance which involves setting boundaries, so that the child is able to develop an internal model of moral values and conscience, and social behavior appropriate for the society within which they will grow up. The aim is to enable the child to grow into an autonomous adult, holding their own values, and able to demonstrate appropriate behaviour with others rather than having to be dependent on rules outside themselves. This includes not over protecting children from exploratory and learning experiences. Includes social problem solving, anger management, consideration for others, and effective discipline and shaping of behaviour.

Stability
Providing a sufficiently stable family environment to enable a child to develop and maintain a secure attachment to the primary caregiver(s) in order to ensure optimal development. Includes: ensuring secure attachments are not disrupted, providing consistency of emotional warmth over time and responding in a similar manner to the same behaviour. Parental responses change and develop according to child’s developmental progress. In addition, ensuring children keep in contact with important family members and significant others.

FAMILY AND ENVIRONMENTAL FACTORS

Family History and Functioning
Family history includes both genetic and psycho-social factors. Family functioning is influenced by who is living in the household and how they are related to the child; significant changes in family/household composition; history of childhood experiences of parents; chronology of significant life events and their meaning to family members; nature of family functioning, including sibling relationships and its impact on the child; parental strengths and difficulties, including those of an absent parent; the relationship between separated parents.

Wider Family
Who are considered to be members of the wider family by the child and the parents? This includes related and non-related persons and absent wider family. What is their role and importance to the child and parents and in precisely what way?

Housing
Does the accommodation have basic amenities and facilities appropriate to the age and development of the child and other resident members? Is the housing accessible and suitable to the needs of disabled family members? Includes the interior and exterior of the accommodation and immediate surroundings. Basic amenities include water, heating, sanitation, cooking facilities, sleeping arrangements and cleanliness, hygiene and safety and their impact on the child’s upbringing.
Employment
Who is working in the household, their pattern of work and any changes? What impact does this have on the child? How is work or absence of work viewed by family members? How does it affect their relationship with the child? Includes children’s experience of work and its impact on them.

Income
Income available over a sustained period of time. Is the family in receipt of all its benefit entitlements? Sufficiency of income to meet the family’s needs. The way resources available to the family are used. Are there financial difficulties which affect the child?

Family’s Social Integration
Exploration of the wider context of the local neighbourhood and community and its impact on the child and parents. Includes the degree of the family’s integration or isolation, their peer groups, friendship and social networks and the importance attached to them.

Community Resources
Describes all facilities and services in a neighbourhood, including universal services of primary health care, day care and schools, places of worship, transport, shops and leisure activities. Includes availability, accessibility and standard of resources and impact on the family, including disabled members.
Appendix 3
Guidance for making child protection referrals.

Section 2 of the London child protection procedures 2013

1. Considering a referral:
Any concerns should be discussed with your manager/clinical supervisor, named child protection lead / lead nurse, or ring Trust advice line on 07659 153 333 (Monday to Friday 9-5) for access to the Trust Named nurse or doctor.

You can also discuss concerns, without necessarily identifying the child, with a senior practitioner in the local children’s social care referral and assessment team to develop an understanding of the child’s needs and circumstances. Details on SLaM intranet site “safeguarding children”

If concerns remain after discussions and the child is considered to be at risk of significant harm, a referral should be made to local children’s social care and followed up in writing within 48 hours using the appropriate form for your local area. These are on the SLaM intranet site “safeguarding children” or can be obtained from the local authority children’s social care.

If the child is considered to be a Child in Need or/and it seems the child and family would benefit from other services including Trust services decisions should be made about who to make a referral to. Please also see Trust internet site Safeguarding Children for local borough early help services.

If these concerns arise about a child who is already known to local children’s social care, the allocated worker should be informed of these concerns (or in their absence their manager or the duty social worker).

Parent’s permission should be sought before discussing a referral about them by name, unless this may itself increase the risk of significant harm. Consent is not required for referral of children at risk of significant harm.

A formal referral should always be completed where a family member wishes to self refer or refers a relative under 18.

All discussions about a child’s welfare should be recorded including the rationale for what has been agreed about who will be taking what action or reasons for no further action to be taken.

2. Details for a referral:
Comprehensive referrals increase the chance of an effective and timely response.

When you contact children’s services about a referral they will be looking for the following information to help them follow up on concerns. You may not have access to all this information at the time of the referral, this should not delay referral but include as much as you can.

- Full names, date/s of birth and gender of child/ren
- Family address and (where relevant) school / nursery attended
- Identity of those with parental responsibility
- Names and date of birth of all household members
- Ethnicity, first language and religion of children and parents / carers
3. **Formulating your referral:**

The initial children’s social services screening process will establish the nature of the concern, how and why it has arisen, what the child’s needs appear to be, whether the concern involves abuse or neglect and whether there is any need for urgent action to protect the child or any other children in the family. It is helpful to consider these questions in advance of the referral.

An initial assessment of each child referred will be carried out by children’s social care. Information will be gathered and analysed within the three domains of the Framework for the Assessment of Children in Need and their Families (2000), namely:

- Child’s developmental needs
- The parents’ or care givers’ capacity to respond appropriately to those needs
- Wider family and environmental factors

You may have considerable information in one or more of these domains depending on your role and service. Appendix 1, offers a framework for thinking about what you know about the child and family and how it impacts on the child’s welfare. Be clear about why you have referred and describe and summarise your concerns.

4. **Cumulative risk:**

In addition to risk indicators for abuse and neglect, it should be remembered that children in specific circumstances may be particularly vulnerable.

Include historical duration, nature, pattern and future prognosis of parental mental illness or substance misuse and how parenting may be different or the same during periods of illness or recovery. Also include the pattern and degree of exposure of the child to the parent / carer.

This will help identify the nature and degree of the child’s exposure and experience over time and therefore understand the cumulative impact of the child over time.

5. **Guidance on recognition of child protection issues in specific circumstances:**

London Child Protection Procedures 2013 and Working Together 2015 include guidance on the following:

- Pre-birth Referral and Assessment in the case of:
- Previous unexplained death of a child in the care of either parent
- A parent or other adult in the household, or regular visitor, has been identified as posing a risk to children
- Sibling in household who is on the child protection register or previously removed from the household
- Domestic violence known to have occurred or concerns of significant domestic abuse
- Parental substance misuse likely to impact on the baby’s safety or development (see also Southwark Joint Protocol)
- Degree of parental mental illness/impairment likely to significantly impact on the baby’s safety or development (see also Southwark Joint Protocol)
- Concerns about parental ability to self-care and / or to care for the child e.g. unsupported, young or learning disabled mother
- Any other concern that baby may be at risk of significant harm including a parent suspected of fabricating or inducing illness in a child.
- A child aged under 13 is found to be pregnant or have a sexually transmitted infection.

- Child pornography and the internet
- Domestic Violence
- Racial and religious harassment, race and racism
- Forced marriage of a child
- Parents or children involved in prostitution including looked after children
- Disability of children or parents including learning disability and those with special communication skills or who require a signer or translation
- Parents who misuse drugs or alcohol (see also Southwark Joint Protocol)
- Enduring or severe parental mental illness (see also Southwark Joint Protocol)
- Young carers
- Self-harming and suicidal behaviour
- Pregnancy of a child and considerations for sexually active children under 18
- Looked after children and those living away from home in foster care, privately fostered, in hospital and in custody
- Surrogacy
- Begging
- Abuse by children and young people including peer abuse and bullying
- Children whose behaviour indicates a lack of parental control
- Abuse linked to belief in “possession” or “witchcraft” or in other ways related to spiritual belief
- Missing children, adult or family
- Children of families living in temporary accommodation
- Child trafficking & exploitation including those at risk of being trafficked / looked after
- Unaccompanied asylum seeking children and migrant children
- Children in whom illness is fabricated or induced
- Female genital mutilation

7. **Sources:**
   2. Working Together 2015
Appendix 4

Safeguarding children - Champion Role

1.0 Introduction:

The role of champion for safeguarding children works locally to support other lead safeguarding roles in the directorate or borough. For example adult mental health leads, CAMHS borough lead doctor and lead safeguarding children nurses.

Champions can be any member of staff of any discipline and should have the support of their safeguarding lead and team manager. They will need to have an interest in safeguarding children be prepared to help promote the Trust safeguarding agenda within their local service and participate in activities to promote safeguarding practice, as agreed by their team manager.

2.0 Key functions:

Agreeing to be included on local and Trust safeguarding champion’s mailing list

To be a part of the local safeguarding committee

Disseminate information from the local Safeguarding Children Committee and other forums to local team’s e.g. training, events, publications

Participate in relevant audits and activities to promote safeguarding practice with teams and across services

Attend occasional (if and when appropriate) LSCB / Trust meetings and local events where relevant, for example launch days, sub committees and by arrangement to stand in for leads.

Be aware of and pass on good practice and alert advisor/s of any concerns regarding safeguarding children practice.

Provide assistance to staff attempting to safeguard individual children, for example by putting them in contact with the relevant advisor, referring them, to relevant guidance, etc.

3.0 What you can expect in return:

Support and advice from any safeguarding advisor including the Trust Named Nurse and Doctor.

To be provided with information and updates through local Safeguarding Children’s Committee mailing lists including local training and events of interest.
Personal and professional development that contributes to KSF including opportunities for shadowing leads in this area of work and invitation to / notification of launch and development events for advisors for example LSCB multiagency events.

4.0 What is not expected:

You are not expected to provide specialist advice unless you feel competent to do so.

You are not expected to carry out any activity beyond the limit of your competence.

You are not expected to take on more than you have time for.
Appendix 5

ARRANGEMENTS FOR CHILD VISITS TO IN PATIENTS AND COMMUNITY SERVICES.

Contents

Section 1. Associated Documents

Section 2. Purpose

Section 3. Scope

Section 4. Background

Section 5. Course of action

Section 6. Inpatient Visiting

Section 7. Community Team Base Child Visiting Policy

Section 8. Responsibility of the Addendum

Section 9. References

Appendix 1 Information leaflet

Appendix 2 Standards for visiting facilities
Section 1

Associated Documents

Trust Safeguarding Children Policy 2014

Introduction

Section 2

Purpose

2.1 This addendum concerns children and young people, up to 18 years, visiting any inpatient (adult or adolescent) setting or community service.

The Trust as a public service is fully supportive of the Think Family Ethos. As a system that aims to ‘think family’, the Trust endeavours to ensure that both adult and children’s services join up around the needs of the family (HMSO publication 2008).

The Trust supports helpful and positive contact between children/young people and their parents/ carers who are Trust patients. However this must only occur if it is in the best interest of the child. The Trust will always aim to ensure that the needs of the child remain paramount.

2.2 In some cases there will be some concern about child visiting an in-patient service or attendance at a community service going ahead. Decision-making on these cases needs to be clear and consistent.

2.3 When a decision is made not to allow contact the reasons should be given. This should be clearly documented. If the parent/carer and other interested parties are unhappy with this decision, they can complain utilising the Trust Complaints procedure.

2.4 If there were concerns that the mental state and behaviour of the patient were likely to have a significant impact on the well-being of the child, then the visit would not be allowed. In these circumstances, other forms of contact such as telephone, letter or email, could be considered.
Section 3

Scope of this addendum

3.1 Targeted Audience

This addendum is directed at all Clinical staff.

3.2 Targeted Patient/Client/User Group

**All service users using SLAM services.**

This policy concerns children and young people visiting any inpatient (adult or adolescent) setting or attendance at any community setting. It can be used in conjunction with any local protocol that may be in existence in specific clinical academic groups.

Section 4

Background

4.1 This addendum is written within the guidance of the Revised Code of Practice on the Mental Health Act 1983, the Children Act 1989, Working Together to Safeguarding Children 2015 and also article 8 of the Human Rights Act 1998. New references

4.2 This policy should also be read in conjunction with the SLaM policy.

Section 5

Course of Action Required

5.1 General Protocol

5.2 The impact of mental health on parenting and on children should be assessed, both in the community and as part of the admission process and documented on the **Child Need and Risk Form** under the Patient Journey Risk tab.
Section 6

6.1 Inpatient Visiting

6.1.1 At the earliest opportunity, following admission, the multidisciplinary team should give consideration to the implications of child visiting, and a plan should be formulated and documented in the Child Need and Risk Form on ePJS by a member of the patient’s care team. This plan should follow discussion with the person that has parental responsibility and/or anybody else who is currently facilitating the care of the child. Please note that this may be a range of different individuals, for example another parent, other carer or social worker. Children should be asked about their wishes and feelings, according to their age and understanding. Particular consideration should be given to the vulnerability of babies and non-verbal children who cannot express their wishes.

All child visits should be pre-arranged.

6.1.2 Considerations should include impact on the child, (e.g. adult aggressive, impulsive, frightening, causing distress to child, being withdrawn, over-intrusive), the views of the child, ward atmosphere, frequency and duration of the visit.

6.1.3 Normally a responsible adult will accompany children on these visits.

Young people below the age of 18 years in most cases should be accompanied by an adult.

6.1.4 Visits should be in an area which is child safe and not accessible to any other service users. Children should be accompanied at all times when on the unit, by a responsible adult.

6.1.5 A staff member should be allocated to facilitate the visit.

6.2 Decisions to deny Visits

6.2.1 Decisions to deny visiting will always be based on the child’s best interest. It will depend on the adult’s mental state, the child’s wishes/needs and/or other factors on the ward including the general level of anxiety/disturbance that could compromise the safety or welfare of the child.

6.2.2 In certain circumstances, e.g. an acute change in the level of disturbance on the unit, the child visiting plan may need to be overruled. The decision will be the responsibility of the nurse-in-charge of the unit at that time.
When there is a decision to deny visits the reason for this should be documented.

Contact cannot ever be forced.

6.2.3 If a complaint is raised as a consequence of denial of a child visit, the Trust’s existing complaints procedure could be used for this purpose. In the first instance local resolution should be aimed for.

6.2.4 Decisions not to allow visits need to be continually reassessed. A decision not to allow access at the point of admission may not be appropriate two or three weeks later when the patients’ mental state has improved or other circumstances have changed.

6.3 Facilities

6.3.1 It is the responsibility of each clinical academic group to provide facilities to ensure visits by children and/or young people to their parent’s areas are as comfortable and beneficial as possible. This should not be contained in the ward area. It should be a suitable room with appropriate toys and books which can be made available at the time of the visit, nappy–changing facilities. See standards Appendix 2.

6.3.2 Units may decide to share facilities, where an appropriate room is not available on the unit. In certain situations it may be appropriate to arrange visiting in a venue away from hospital. Local children’s social care departments may be able to advise on suitable venues for such contact.

6.4 Recording

6.4.1 The decision of the team to agree or deny visiting by the child needs to be recorded clearly on the patient’s multi-disciplinary record child need and risk screen comments box, together with the reasons for the decision made.
Section 7

Community Team Base Child Visiting Addendum

7.1 The Community Team should always assess; balancing the risks with the care and treatment of the service user when considering whether it is appropriate for a child to come to the team base. The potential impact on the child of being brought to the Community Mental Health Team should be considered and all efforts should be made to find an alternative venue. Always consider the advantages of visiting within the home environment.

7.2 If a parent chooses to attend the team base with a child or this is unavoidable, then the child should stay with the carer at all times and should under no circumstances be left alone.

7.3 The child remains the responsibility of their parent or carer at all times.

7.4 Workers should provide advice to the service user regarding coming into the team base with a child so that they might consider attending their appointment with another responsible adult who could look after the child during the appointment time.

7.5 The child need and risk screen should be completed and this should reflect where the service user should ideally be seen with the child.

7.6 Care Coordinators should always be mindful of school age children attending appointments at the team base or being present on home visits when one would usually expect them to be at school and should explore this further.

7.7 The Care coordinator also needs to consider the appropriateness of the child/ young adult being present when distressing or difficult issues are being disclosed by their parent. Clinician’s may need to make a judgement regarding the involvement of the child/young persons, whilst being mindful of information the child/young person may have.

7.8 A selection of child appropriate toys/ activities should be kept in the waiting area or with the receptionist and should be checked regularly to ensure they are in a suitable condition.

8 Responsibility for the this Addendum

8.1 The clinical service lead is responsible for the overseeing this addendum, ensuring it operates smoothly, and ensuring that is reviewed at appropriate intervals.

8.2 Information about this addendum should be included in the Patient’s Information Booklet. Localized leaflets should be made available. Appendix 1
9 References


Appendix 1

Leaflets for Families and Clients

Visits by children and young people up to 18 years

We believe that helpful and positive contact between children and young people and their parents and carers who are in hospital can benefit both child and adult.

Occasionally the distress and behaviour of the person who is in hospital means that visiting would not be in the best interests of the child or young person and then other forms of contact such as phone, letter or email could be considered.

The care co-ordinator and the team will discuss this and draw up a child visiting plan. The visits will be pre-arranged and will take place in a safe and child friendly room, either on or near the ward.

When it is decided that visits would not be good for the child or young person, this decision will be continually re-assessed, and when it is safe, visits will then go ahead.

If you disagree with these decisions, you would be able to talk with the senior nurse or responsible doctor.

PALS Patient Advice and Liaison Service can also be contacted by Freephone on 0800 731 2864 where there is a possibility of resolution through less formal action

- www.pals.slam.nhs.uk
- pals@slam.nhs.uk

If you are still not happy with the decision you could contact the Complaints office by phone on: 020 3228 2444/2499.
Appendix 2

Child Visiting Facilities Standards

Things to consider when setting up a child visiting facility:

Ideally the room should be away from the main clinical area so children and only used for child visiting and family visiting. It could be a room off the entrance lobby to several wards and shared between them.

Toilet and baby change facilities should be easily accessible.

There should be vision into the room and also facility for mothers to activate blinds for privacy when breastfeeding. Guidance on supervision and observation is contained in the body of the policy.

There should be a child and family friendly sign on the door and in the entrance area with details of how to book the room.

For new build and refurbishments advice should be sought from planning on site and equipping.

Health and Safety

Identify a responsible staff member from the team who will ensure:

1. The room is restocked with paper and drawing materials as necessary.
2. Toys are cleaned.
3. Any broken toys are removed and replaced.
4. Monitoring, cleaning and maintenance of room.
Infection Control

Toys and equipment are great fun for children. However, toys can become contaminated through handling or by children putting their mouths to them. Some germs can remain on toys for long periods of time.

Do:

- Store toys in a clean plastic washable toy box.
- Clean toys after each session with Sani cloths ordered from NHS Logistics [code VJT077] or hot water and detergent. Plastic toys can be washed in the dishwasher. Dry before re storage.
- Use clean, hard or plastic toys only.
- Do add toys and equipment to a regular cleaning rota and identify a staff member responsible for this.

Don’t:

- Use any soft toys. They are an infection risks unless washed after each session in a washing machine.
- Do not provide play dough.

Room contents

- Furniture
- Comfortable chair for nursing mothers
- Small table and chairs for children.
- Other seating for other adults.
EQUALITY IMPACT ASSESSMENT

PART 1: Equality relevance checklist

The following questions can help you to determine whether the policy, function or service development is relevant to equality, discrimination or good relations:

- Does it affect service users, employees or the wider community? Note: relevance depends not just on the number of those affected but on the significance of the impact on them.
- Is it likely to affect people with any of the protected characteristics (see below) differently?
- Is it a major change significantly affecting how functions are delivered?
- Will it have a significant impact on how the organisation operates in terms of equality, discrimination or good relations?
- Does it relate to functions that are important to people with particular protected characteristics or to an area with known inequalities, discrimination or prejudice?
- Does it relate to any of the following 2013-16 equality objectives that SLaM has set?
  1. All SLaM service users have a say in the care they get
  2. SLaM staff treat all service users and carers well and help service users to achieve the goals they set for their recovery
  3. All service users feel safe in SLaM services
  4. Roll-out and embed the Trust’s Five Commitments for all staff
  5. Show leadership on equality though our communication and behaviour

<table>
<thead>
<tr>
<th>Name of the policy or service development: Safeguarding Children Policy, Principles and Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the policy or service development relevant to equality, discrimination or good relations for people with protected characteristics below?</td>
</tr>
<tr>
<td>Please select yes or no for each protected characteristic below</td>
</tr>
<tr>
<td>Age</td>
</tr>
<tr>
<td>-----</td>
</tr>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>

If yes to any, please complete Part 2: Equality Impact Assessment

If not relevant to any please state why:

Date completed: 31/07/15
Name of person completing: Paul Archer, Trustwide Safeguarding Children Lead (Named Nurse)
CAG: CAMHS
Service / Department: Trustwide

Please send an electronic copy of the completed EIA relevance checklist to: macius.kurowski@slam.nhs.uk

Your CAG Equality Lead
PART 2: Equality Impact Assessment

1. Name of policy or service development being assessed?
Safeguarding Children Policy, Principles and Guidelines

2. Name of lead person responsible for the policy or service development?
Paul Archer, Trustwide Safeguarding Children Lead (Named Nurse)

3. Describe the policy or service development

What is its main aim?
To support staff in safeguarding and promoting the welfare of children

What are its objectives and intended outcomes?
To provide staff with a point of reference in relation to their safeguarding duties and to inform staff of best practice.

What are the main changes being made?
Minor changes to reflect the publication of ‘Working together to safeguard children’ (2015)

What is the timetable for its development and implementation?
Policy was agreed by the safeguarding children’s committee on 09/07/2015 and will then be presented at the QSC for ratification prior to dissemination across the trust.

4. What evidence have you considered to understand the impact of the policy or service development on people with different protected characteristics?

The Children Act (1989)


Working together to safeguard children (2015)
5. Have you explained, consulted or involved people who might be affected by the policy or service development?

Consultation with staff at safeguarding children committee

6. Does the evidence you have considered suggest that the policy or service development could have a potentially positive or negative impact on equality, discrimination or good relations for people with protected characteristics?

(Please select yes or no for each relevant protected characteristic below)

<table>
<thead>
<tr>
<th>Age</th>
<th>Positive impact: Yes</th>
<th>Negative impact: No</th>
</tr>
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<tbody>
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</table>

Please summarise potential impacts:

It is anticipated the policy will have a positive impact on service users under the age of 18 by supporting staff to protect children from harm.

<table>
<thead>
<tr>
<th>Disability</th>
<th>Positive impact: Yes</th>
<th>Negative impact: Yes</th>
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<tbody>
<tr>
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</tbody>
</table>

Please summarise potential impacts:

Children with disabilities are at greater risk of abuse and neglect when compared to able bodied children. It is anticipated the policy will have a positive impact on disabled service users under the age of 18 by supporting staff to protect them from harm and respond effectively to safeguarding risks that...
The policy may have a negative impact on parents/carers with a disability as their capacity to fulfil their parental responsibilities may lead to safeguarding concerns. However, the policy outlines the need for ‘early help’ interventions which enables agencies to work with parents/carers before significant harm has taken place and therefore avoids statutory investigations.

<table>
<thead>
<tr>
<th>Gender re-assignment</th>
<th>Positive impact: Yes</th>
<th>Negative impact: No</th>
</tr>
</thead>
</table>

**Please summarise potential impacts:**

The transgender community experience higher levels of abuse and discrimination when compared to the general population. It is estimated that a transsexual teenager is eight times more likely to attempt suicide, than their peers. It is anticipated the policy will have a positive impact on trans service users under the age of 18 by supporting staff to protect them from harm and respond effectively to safeguarding risks that are identified.

<table>
<thead>
<tr>
<th>Race</th>
<th>Positive impact: Yes</th>
<th>Negative impact: No</th>
</tr>
</thead>
</table>

**Please summarise potential impacts:**

It is anticipated the policy will have a positive impact on service users of all ethnicities under the age of 18 by supporting staff to protect them from harm and respond effectively to safeguarding risks that are identified.

There are further identified safeguarding risks associated with populations from specific ethnic backgrounds due to the risk of female genital mutilation, forced marriage, and honor based abuse.

<table>
<thead>
<tr>
<th>Pregnancy &amp; Maternity</th>
<th>Positive impact: Yes</th>
<th>Negative impact: No</th>
</tr>
</thead>
</table>

**Please summarise potential impacts:**

It is anticipated the policy will have a positive impact on pregnant service users under the age of 18 by supporting staff to protect them from harm and respond effectively to safeguarding risks that are identified.

<table>
<thead>
<tr>
<th>Religion and Belief</th>
<th>Positive impact: Yes</th>
<th>Negative impact: No</th>
</tr>
</thead>
</table>

**Please summarise potential impacts:**

It is anticipated the policy will have a positive impact on service users of all religions and beliefs under the age of 18 by supporting staff to protect them from harm and respond effectively to safeguarding risks that are identified.

There are further identified safeguarding risks associated with populations specific belief systems due to the risk of female genital mutilation, forced marriage, and honor based abuse.

<table>
<thead>
<tr>
<th>Sex</th>
<th>Positive impact: Yes</th>
<th>Negative impact: No</th>
</tr>
</thead>
</table>
Please summarise potential impacts:

Although there is an equal gender distribution of children subject to a child protection plan, girls are more susceptible to sexual abuse and child sexual exploitation than boys.

It is anticipated the policy will have a positive impact on service users of all sexes under the age of 18 by supporting staff to protect them from harm and respond effectively to safeguarding risks that are identified.

<table>
<thead>
<tr>
<th>Sexual Orientation</th>
<th>Positive impact: Yes</th>
<th>Negative impact: No</th>
</tr>
</thead>
</table>

Please summarise potential impacts:

The lesbian, gay, bisexual and transgender community experience higher levels of abuse and discrimination when compared to the general population. It is estimated that they are four times more likely to be bullied than their peers. It is anticipated the policy will have a positive impact on service users of all sexual orientations under the age of 18 by supporting staff to protect them from harm and respond effectively to safeguarding risks that are identified.

<table>
<thead>
<tr>
<th>Marriage &amp; Civil Partnership (Only if considering employment issues)</th>
<th>Positive impact: N/A</th>
<th>Negative impact: N/A</th>
</tr>
</thead>
</table>

Please summarise potential impacts: N/A

<table>
<thead>
<tr>
<th>Other (e.g. Carers)</th>
<th>Positive impact: Yes</th>
<th>Negative impact: Yes</th>
</tr>
</thead>
</table>

Please summarise potential impacts:

It is anticipated the policy will have a positive impact on parents/carers by supporting staff to protect children from harm and respond effectively to safeguarding risks that are identified.

The policy outlines the need for ‘early help’ interventions which enables agencies to work with parents/carers before significant harm has taken place and therefore avoids statutory investigations.

A safeguarding referral may impact negatively on a parent/carer as there will be statutory involvement from social care and/or the police. As part of their involvement, there will be an investigation under Section 47 of the Children Act (1989) which gives the local authority powers to carry out an investigation to establish if a child has suffered significant harm or is likely to suffer significant harm as the result of abuse or neglect. The Section 47 process may cause considerable stress to the parent/carer due to the nature of the investigation and the possible outcomes.
7. Are there changes or practical measures that you can take to mitigate negative impacts or maximise positive impacts you have identified?

YES:

8. What process has been established to review the effects of the policy or service development on equality, discrimination and good relations once it is implemented?

A review date has been set for three years after the current policy is ratified. The impact of the policy will be measured by staff identifying safeguarding concerns and taking appropriate action.

Date completed: 31/07/15
Name of person completing: Paul Archer, Trustwide Safeguarding Children Lead (Named Nurse)
CAG: CAMHS
Service / Department: Trustwide

Please send an electronic copy of the completed EIA relevance checklist to:
1. macius.kurowski@slam.nhs.uk
### PART 3: Equality Impact Assessment Action plan

<table>
<thead>
<tr>
<th>Potential impact</th>
<th>Proposed actions</th>
<th>Responsible/lead person</th>
<th>Timescale</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review actual equality impacts of policy</td>
<td>Review EIA</td>
<td>Trustwide Safeguarding Children Lead (Named Nurse)</td>
<td>July 2018</td>
<td></td>
</tr>
</tbody>
</table>

**Date completed:** 31/07/15  
**Name of person completing:** Paul Archer, Trustwide Safeguarding Children Lead (Named Nurse)  
**CAG:** CAMHS  
**Service / Department:** Trustwide

Please send an electronic copy of your completed action plan to:

1. macius.kurowski@slam.nhs.uk  
2. Your CAG Equality Lead
## Appendix 2 – Human Rights Act Assessment

To be completed and attached to any procedural document when submitted to an appropriate committee for consideration and approval. If any potential infringements of Human Rights are identified, i.e. by answering Yes to any of the sections below, note them in the Comments box and then refer the documents to SLaM Legal Services for further review.

For advice in completing the Assessment please contact Anthony Konzon, Claims and Litigation Manager [anthony.konzon@slam.nhs.uk]

<table>
<thead>
<tr>
<th>HRA Act 1998 Impact Assessment</th>
<th>Yes/No</th>
<th>If Yes, add relevant comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Human Rights Act allows for the following relevant rights listed below. Does the policy/guidance NEGATIVELY affect any of these rights?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Article 2 - Right to Life [Resuscitation /experimental treatments, care of at risk patients]</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Article 3 - Freedom from torture, inhumane or degrading treatment or punishment [physical &amp; mental wellbeing - potentially this could apply to some forms of treatment or patient management]</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Article 5 – Right to Liberty and security of persons i.e. freedom from detention unless justified in law e.g. detained under the Mental Health Act [Safeguarding issues]</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Article 6 – Right to a Fair Trial, public hearing before an independent and impartial tribunal within a reasonable time [complaints/grievances]</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Article 8 – Respect for Private and Family Life, home and correspondence / all other communications [right to choose, right to bodily integrity i.e. consent to treatment, Restrictions on visitors, Disclosure issues]</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Article 9 - Freedom of thought, conscience and religion [Drugging patients, Religious and language issues]</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Article 10 - Freedom of expression and to receive and impart information and ideas without interference. [withholding information]</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Article 11 - Freedom of assembly and association</td>
<td>No</td>
<td></td>
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<tr>
<td>HRA Act 1998 Impact Assessment</td>
<td>Yes/No</td>
<td>If Yes, add relevant comments</td>
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<tr>
<td>-------------------------------</td>
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</tr>
<tr>
<td>Article 14 - Freedom from all discrimination</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

| Name of person completing the Initial HRA Assessment: | Paul Archer |
| Date: | 23/07/2015 |
| Person in Legal Services completing the further HRA Assessment (if required): | |
| Date: | |