

## SAFEGUARDING CHILDREN POLICY

|   |  |                                |                         |
|---|--|--------------------------------|-------------------------|
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| Standards, legislation and key related documents:         | Children's Act 1989 & 2004<br>Department of Health Working Together to Safeguard Children 2023.<br>Domestic Abuse Act 2021.  |                                |                         |
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## Version Control

| Version | Date          | Author   | Amendments:  |
|---------|---------------|----------|--|
| 4.2     | November 2024 | Sam Hunt | This policy, has had a full review and complies with Trust format. |
|         |               |          |  |

### Quick Reference Points.

- **IF YOU IDENTIFY OR RECOGNISE A CHILD AT IMMEDIATE RISK OF SIGNIFICANT HARM AN IMMEDIATE REFERRAL MUST BE MADE TO THE POLICE, THE LOCAL CHILDREN'S SOCIAL CARE, AND THE TRUSTS SAFEGUARDING TEAM INFORMED.** (Appendix 9 List of Local Children's Social Care Contacts).
- A CHILD is defined as anyone who has not yet reached their 18<sup>th</sup> birthday, for the purpose of this policy this includes the unborn baby. (Children Act 1989).
- Staff will be aware of their accountability to initiate safeguarding and/or child protection procedures where they have identified a child that has been subject to, or is at risk of, significant harm. Trust staff are encouraged to seek specialist support and advice and act on these matters.
- Staff must remember the child is at the heart of all that we do: this means that we need to take account of the child's views and feelings and understand the impact of the situation and our actions on them and their family.
- If Trust staff consider that a child is in immediate danger of harm, then they must dial 999 and contact the Police.
- Unless there is an urgent need to safeguard any child, Trust staff can collect information, about the situation then seek specialist advice and support from the Trusts Safeguarding Team.
- A referral to the relevant Local Authority Children's Social Care **MUST** be sent on any child who is thought to be at risk of significant harm.
- Where there are concerns raised about the welfare of any baby, child or young person under the care of the Trust, staff must ensure that the healthcare records include accurate documentation, of those concerns and action taken.
- All staff will be trained in safeguarding children matters and child protection procedures, the details of the training programmes in accordance with their level of contact with children, in line with Safeguarding Children and Young Peoples: Roles and Competences for Health Care Staff (2019).

## MAKING A REFERRAL TO SAFEGUARD A CHILD.

Please forward a copy of the safeguarding referral to the Trusts Safeguarding Team. Support, advice, and guidance can be accessed from the Safeguarding Team.

Telephone 01733 836097.

Email [safeguardingthinkfamily@cpft.nhs.uk](mailto:safeguardingthinkfamily@cpft.nhs.uk)

In an emergency where a child is in immediate risk of significant harm. Dial 999 to contact the Police giving information as listed below.

Then contact the local authority and the Trusts Safeguarding Team.



### Information to include, wherever possible.

- Full names, date of birth, and genders of children and adults living in the household.
- Identity of adult with Parental Responsibility (PR).
- Address of the family home.
- General practitioners name and address.
- Ethnicity, first language and religion.
- Salient events in the family's history.
- What is the cause for concern, the referral must clearly identify the concerns and the impact on the child at risk, as well as what support has been provided previously to help address these concerns and what strengths and resilience is within the family.
- Details of the alleged perpetrator and relationship to the child.
- Child's current whereabouts.
- Perpetrators current whereabouts.
- Any special needs of child or parent.
- Consent should always be sought from the family before passing information about them to social care, unless seeking consent would place them at increased risk of immediate and significant harm or may lead to the loss of evidence for example destroying evidence of a crime or influencing about a disclosure made.
- When a child is at risk and the parent disagrees, we should still seek to make them aware of the referral with reasons why, unless to do so would increase risk.
- Other agencies currently, or in the past, involved with the family.

|   |   |
|---|---|
| <p><b>Peterborough.</b></p> <p><b>Make a referral</b></p>   | <p><a href="https://safeguardingcambspeterborough.org.uk">Professionals – Making a Referral   Cambridgeshire and Peterborough Safeguarding Partnership Board (safeguardingcambspeterborough.org.uk)</a></p> <ul style="list-style-type: none"> <li>• MASH General Enquiries - 01733 864170</li> <li>• Professional Consultation Line – 01733 864180</li> <li>• Emergency Duty Team Out of hours 01733 234724</li> </ul> |
| <p><b>Cambridgeshire.</b></p> <p><b>Make a referral</b></p> | <ul style="list-style-type: none"> <li>• Telephone 03450455203</li> <li>• Out of Hours Duty Team 01733 234724</li> </ul> <p><a href="https://safeguardingcambspeterborough.org.uk">Professionals – Making a Referral   Cambridgeshire and Peterborough Safeguarding Partnership Board (safeguardingcambspeterborough.org.uk)</a></p>  |

### Safeguarding Team

|   |   |
|---|---|
| <p>Sam Hunt Associate Director of Nursing for Safeguarding.</p> | <p>Via Teams</p>  |
| <p>Jayne Fox Named Nurse for Safeguarding Children.</p>         | <p>Via Teams</p>  |
| <p>Linda Coultrup Named Nurse for Adult Safeguarding.</p>       | <p>Via Teams</p>  |
| <p>Trusts Safeguarding Team.</p>                                | <p>Telephone 01733 836097</p> <p>Email <a href="mailto:safeguardingthinkfamily@cpft.nhs.uk">safeguardingthinkfamily@cpft.nhs.uk</a></p>                                     |
| <p>Police</p>   | <p>999 Emergency Contact</p> <p>101 non- emergencies.</p> <p>Police website. <a href="https://cambspolice.uk">Report   Cambridgeshire Constabulary (cambspolice.uk)</a></p> |

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## 1.0 INTRODUCTION

1.1 Nothing is more important to Cambridgeshire and Peterborough NHS Foundation Trust (hereby known as the Trust) than a child's welfare. This is evidenced in The Protection of Children in England, a progress report by Lord Laming (2009) where children clearly stated *please keep me safe*. Children are suffering, or are likely to suffer, significant harm unless there is substantial and sustained change to their circumstances. This harm can come from inside or outside the home. Harm can be the result of actions by parents, carers, or other individuals in the family, or a consequence of the context and environment children experience outside of their home, including online and where children go missing from home.

1.2 The welfare of any child is paramount and all children, without exception, have the right to receive protection from abuse regardless of gender, ethnicity, disability, sexuality, or beliefs. Safeguarding is a term which is broader than 'Child Protection' and relates to the actions taken both to promote the welfare of children and protect them from harm. Effective safeguarding means practitioners should understand and be sensitive to factors, including economic and social circumstances and ethnicity, which can impact children and families' lives.

1.3 The National Service Framework for Social Care (2023) discusses that principles for working with parents and carers to centre the importance of building positive, trusting, and co-operative relationships to deliver tailored support to families, and expectations for multi-agency working that apply to all individuals, agencies and organisations working with children and their families, across a range of roles and activities.

## 2.0 OBJECTIVES and AIMS

2.1 All children should receive optimal care in respect of safeguarding them at all times. All Trust staff have a responsibility to safeguard children, and this policy is designed to ensure that all Trust staff are aware of their roles and responsibilities and the procedures to be followed.

2.2 This policy applies to locum, permanent, and fixed term contract employees who hold a contract of employment or engagement with the Trust, those who work face-to-face with people at risk. Further it applies to secondees (including students), volunteers, bank staff, Non-Executive Directors and those undertaking research working within the Trust, in line with the Trust's Equality, Diversity and Human Rights Policy. It also applies to external contractors, agency workers, and other workers who are assigned to the Trust.

## 3.0 DUTIES, ROLES and RESPONSIBILITIES

### 3.1 Chief Executive

Overall responsibility for the Safeguarding of Children within the Trust belongs to the Chief Executive but is devolved to the Chief Nurse.

### 3.2 Chief Nurse

The Chief Nurse is the Safeguarding Executive Lead on the Trust Board. The Chief Nurse will represent the Trust on the Local Safeguarding Partnership Board or designate a deputy.

The Chief Nurse also chairs the Trust's Safeguarding Committee that has direct links to the Trusts Quality and Safety Committee. This committee reports directly to the Trust's Board.

The Trust Board must co-operate with the Local Authority in the operation of the Local Safeguarding Partnership Boards, and as statutory partners share the responsibility for the effective discharge of its functions in safeguarding and promoting the welfare of children.

### 3.3 Associate Director of Nursing for Safeguarding

The Associate Director of Nursing for Safeguarding is operationally accountable for Children's Safeguarding. The Trust is committed to supporting a safe environment that encourages safeguarding to be interwoven into daily practice and encourages a safe culture where all Trust staff feel able to raise concerns if they suspect or witness any wrong practice or abuse.

### 3.4 Safeguarding Team

The Safeguarding Team's responsibilities are to be the central point of contact where there are safeguarding or child protection concerns. (See appendix 7 for Trust's Safeguarding Team Structure)

The Trust has a safeguarding Duty Team contactable via a single number for all internal and external professionals to use as a point of contact

Telephone 01733 836097 Email [safeguardingthinkfamily@cpft.nhs.uk](mailto:safeguardingthinkfamily@cpft.nhs.uk)

Their role is to offer support, provide guidance, act directly on concerns and to deliver safeguarding training to all staff within the Trust. Training will be delivered to the levels specified within Working Together (2023) and the Royal College of Nursing safeguarding Children and Young People: Roles and competencies for Healthcare Staff (2019). The Children's Safeguarding Team will use these levels to audit compliance within the Trust.

### 3.5 Freedom to Speak Up Guardians

The Trust has dedicated Freedom to Speak up Guardians whose role is recognised as being both independent and impartial, with time directly devoted to undertaking the role. Their role and responsibilities include expertise in all aspects of raising and handling concerns, safeguarding the interests of the individual and ensuring that there are no repercussions for them either immediately or in the longer term. They take an objective view where there are other factors that may confuse the issue, such as pre-existing performance issues, to enable these to be pursued separately. They are responsible for identifying common themes and ensuring that learning is shared, whilst working with Human Resources to develop a culture within the Trust where speaking up is recognised and valued. (See Freedom to Speak Up Policy).

### 4.6 Service Managers

Managers are responsible for ensuring all staff in their area are aware of procedures to be followed if abuse or neglect are suspected. They should ensure all staff in their area receive the training and supervision they need to act on child welfare concerns and to respond to their needs. They should ensure that all staff in their area have access to children's safeguarding advice, information, resources, and support and, if a young person is admitted to an adult area, ensure that a complete assessment of their needs is undertaken. If staff are unable to complete this, managers must ensure that they know who is available to help. Managers must ensure that their staff routinely ask adult patients about their dependants such as children and their caring responsibilities considering Contextual Safeguarding.

## 4.7 All Staff

Trust-wide: This policy is to be followed by all staff employed by Cambridge and Peterborough NHS Foundation Trust. This applies to all children, including the unborn child, inpatients, outpatients, visitors, and those undertaking work experience.

All Trust staff must consider “Think Family” and recognise holistically the daily life of a child taking a comprehensive account of ALL household members for each person admitted to the Trust. Staff should work transparently and be open with families; and this begins with openness around this policy. This is paramount and should be considered in all situations.

## 4.0 TRAINING and COMPETENCY

4.1 All Staff receive mandatory children’s safeguarding training in line with Safeguarding Children and Young Peoples: Roles and Competences for Health Care Staff (2019). [Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff | Royal College of Nursing \(rcn.org.uk\)](#)

4.2 All service managers have the responsibility to ensure that all staff working with families and children are familiar with the contents of this policy and able to discharge their responsibilities.

## 5.0 PROCESS and CONTENT

### 5.1 THE LEGAL FRAMEWORK.

The legal framework stipulates inter-agency action takes place to safeguard the welfare of children in need, including those in need of protection, is formed by:

- Department of Health (Department of Health 1989/2004) Children Act.
- HM Government (DCSF 2023) Working Together to Safeguard Children: A guide to interagency working to safeguard and promote the welfare of children, London, HM Government.
- Information Sharing. Advice for practitioners providing safeguarding services to children, young people, parents, and carers (HM Gov July 2018).
- Children’s and Social Care Act (2017).
- NHS England Accountability and Assurance Framework (HM Gov 2019/2020).
- The Domestic Abuse Act (2021).
- The Equality Act (2010).
- The Children’s Social Care National Framework (2023).
- The Criminal Justice Bill (2023).
- Serious Violence Duty (2022).

A child-centred approach is fundamental to safeguarding and promoting the welfare of every child. All practitioners should follow the principles of the Children Acts 1989 and 2004. These Acts make clear that the welfare of children is paramount and that they are best looked after within their families, with their parents playing a full part in their lives, unless compulsory intervention in family life is necessary.

This is supported by other legislation, 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. Whilst The Domestic Abuse Act 2021, recognises that a child is a victim of domestic abuse in their own right if they see, hear, or experience the effects of domestic abuse.

The Children's Social Care National Framework, published in 2023, is statutory guidance that sets out the purpose of children's social care as existing to support children and families, to protect children by intervening decisively when they are at risk of harm and to provide care for those who need it, so they grow up and thrive with safety, stability, and love.

## **5.2 AN EXPLANATION OF SAFEGUARDING AND YOUR ROLE IN IT.**

### 5.2.1 A Child

A child is anyone, including unborn infants, up to their eighteenth birthday. All unborn, infants, children and young people will be referred to as child or children within the body of this policy.

### 5.2.2 Trust Staff

For this policy everyone working for/in or volunteering within the Trust will be referred to as Trust staff.

### 5.2.3 What is Abuse and Neglect

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

### 5.2.4 Forms of Child Abuse

Include: Physical Abuse, Sexual Abuse, Emotional Abuse and Neglect. (See Appendix 1 for further information).

### 5.2.5 Safeguarding

Safeguarding and promoting the welfare of children is defined by Working Together to Safeguarding Children (2023) and for the purposes of this policy as:

- Providing help and support to meet the needs of children as soon as problems emerge.
- Protecting children from maltreatment, whether that is within or outside the home, including online.
- Preventing impairment of children's mental and physical health or development.
- Ensuring that children grow up in circumstances consistent with the provision of safe and effective care.
- Promoting the upbringing of children with their birth parents, or otherwise their family network through a kinship care arrangement, whenever possible and where this is in the best interests of the children.
- Taking action to enable all children to have the best outcomes in line with the outcomes set out in the Children's Social Care National Framework.

### 5.2.6 Parental Responsibility

Parental responsibility in the UK is defined by the Children Act 1989 as 'all the rights, duties, powers, responsibilities and authority which by law a parent of a child has in relation to the child'. This means a parent has the responsibility to maintain and protect the child, make

decisions about their education and consent to any medical treatment for the child.

If the parents of a child were not legally married to each other when the child was born, the mother automatically has parental responsibility, the father will only have PR-(from 1st December 2003) if jointly registering the birth of the child with the mother. The father can, however, subsequently acquire parental responsibility through various legal routes.

If using a surrogate, the surrogate will be the child's legal parent at birth. If the surrogate is married or in a civil partnership, their spouse or civil partner will be the child's second parent at birth, unless they did not give their permission. Legal parenthood / parental responsibility can be transferred by parental order or adoption after the child is born. In the UK, if you have treatment using a donor at a licensed UK clinic, the donor will have no rights or responsibilities to any children conceived.

Same-sex partners will both have parental responsibility if they were civil partners at the time of the treatment, e.g. donor insemination or fertility treatment. For same-sex partners who are not civil partners, the 2nd parent can get parental responsibility by either applying for parental responsibility if a parental agreement was made or by becoming a civil partner of the other parent and making a parental responsibility agreement or jointly registering the birth. For further information see Gov.uk. Parental Rights & Responsibilities. [Parental rights and responsibilities: What is parental responsibility? - GOV.UK \(www.gov.uk\)](https://www.gov.uk/parental-rights-responsibilities)

### 5.2.7 Child Protection

The Childrens Act (1989) introduced the concept of significant harm as a threshold that justifies compulsory intervention into family life, in the best interest of children. It gives local authorities a duty under section 47 to make enquiries when they have reasonable cause to suspect that a child who lives or is found in their area is suffering, or likely to suffer, significant harm, to enable them to decide whether they should take action to safeguard or promote that child's welfare. If it is decided the case is a section 47 enquiry, there would be a joint agency visit with children's social care and the police working together.

Wate and Boulton (2023) state that significant harm is the threshold at which the local authority has a duty to intervene, there is no strict definition, and it is not described in detail anywhere.

There are two key principles that apply to child protection activity:

- Safeguarding is everyone's responsibility: for services to be effective each professional and organisation should play their part.
- A child-centred approach is vital: for services to be effective they should be based on a clear understanding of the needs and views of children.

Child protection is part of safeguarding and promoting the welfare of children and is defined as activity that is undertaken to protect specific children who are suspected to be suffering, or likely to suffer, significant harm. This includes harm that occurs inside or outside the home, including online.

### 5.2.8 Child in Need

A child in need is defined under the Childrens Act (1989) as a child who is unlikely to achieve or maintain a reasonable level of health or development, or whose health and development is likely to be significantly or further impaired or a disabled child. Children in need may be assessed under section 17 of the Childrens Act (1989) by a social worker. The critical factors for consideration when deciding whether a child is "in need" under section 17 are:

- What will happen to a child's health or development without services being provided.
- The likely effect the services will have on a child's standard of health and development.

### 5.2.9 Early Help

Early help is support for children of all ages that improves a family's resilience and outcomes or reduces the chance of a problem getting worse. It is not an individual service, but a system of support delivered by local authorities and their partners working together and taking collective responsibility to provide the right provision in their area. Some early help is provided through universal services, such as education and health services. They are universal services because they are available to all families, regardless of their needs. Other early help services are coordinated by a local authority and or their partners to address specific concerns within a family and can be described as targeted early help.

### 5.2.10 Strategy Discussion

If there is reasonable cause to suspect a child is suffering, or is likely to suffer Significant Harm, Children's Social Care should convene a Strategy Discussion.

Depending on the nature of the concerns and the urgency of the situation, this may be undertaken as an actual face to face meeting or via Teams and / or through a series of telephone discussions with the participants.

Strategy Discussions by telephone will usually be adequate to plan a straightforward enquiry or joint investigation. Face to face meetings are likely to be more effective in situations that involve complex abuse or neglect.

The purpose of a strategy discussion as discussed in Cambridgeshire & Peterborough Safeguarding Partnership Board Multi agency policies and procedures are to

- Share available information.
- Agree the conduct and timing of any criminal investigation.
- Decide whether a Child and Family Assessment and Section 47 Enquiry should be initiated or continued if it has already begun.
- Plan how the Section 47 Enquiry should be undertaken (if one is to be initiated), including the need for medical assessment (a decision to have a medical should not be made by the social worker and Police alone but may require a discussion with a Paediatrician) and who will carry out what actions, by when and for what purpose (see Section 47 Enquiries Procedure, Liaison between Children's Social Care, and the Police – Single or Joint Agency Enquiries/Investigations).
- 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.
- Determine what information from the Strategy Discussion will be shared with the family unless such information sharing may place a child at increased risk of Significant Harm or jeopardise police investigations into any alleged offence(s).
- Determine if legal action is required.

See Appendix 6 - Flowchart Strategy Discussion Meeting for further Information.

### 5.2.11 Forms of Child Exploitation

Child exploitation Including children missing from home or care, Child Sexual Exploitation, Gangs, County Lines, Trafficking and Modern Slavery, E-Safety, groups at risk of radicalisation. (See Appendix 2 for further information).

For further information please see (Documents that guide practice)  
PREVENT Policy CP 74 and Exploitation Policy PS69.

### 5.2.12 Parental and or Family Factors

Parental and family factors include, Domestic Abuse, Substance Misuse, Honour Based Violence, Mental Health issues, Forced Marriage, E-Safety, Groups at risk of radicalisation, Female Genital Mutilation (Appendix 3). For further information please refer to (Documents that guide practice) Domestic Abuse Policy CP 93, Violence Against Women and Girls (VAWAG) Policy PS70 and PREVENT Policy CP74.

### 5.2.13 Children at Increased Risk of Harm

There are groups of children that are known to be at an increased risk of harm, these include Looked after Children, Children transitioning from Children's to Adult Services, Young Carers, Private Fostering, Children with Mental Health and or Behavioural Issues, Children with disabilities, Fabricated/Inducted Illness. (See Appendix 5).

<https://www.safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/safeguarding-disabled-children/>

### 5.2.14 Adverse Childhood Experiences (ACE)

Adverse Childhood Experiences (ACEs) are highly stressful, and potentially traumatic, events or situations that occur during childhood and or during adolescence. They can be a single event, or prolonged threats to, and breaches of, the child's safety, security, trust, or bodily integrity. It is shown that chronic, severe stressors in childhood can cause toxic, traumatic biological responses to the developing brain, often with long term consequences for health and emotional well-being. It is also known that responsive relationships with care providers and strong community supports can buffer the effects of Adverse Childhood Experiences (ACEs).

Examples of ACEs are:

- Physical abuse.
- Sexual abuse.
- Emotional abuse.
- Living with someone who misuses substances
- Living with someone who abuses alcohol.
- Exposure to domestic abuse.
- Living with someone who has been or is in prison.
- Living with someone with serious mental illness.
- Losing a parent through divorce, death, or abandonment.

ACEs are prevalent. A report by Early Intervention Foundation Adverse Childhood Experiences: What We Know, What We Don't Know, And What Should Happen Next (2020) states that over 80% of the 399,500 children who were identified as being in need in England had experienced at least one ACE. This means that at least 2.5% of all children living in England are experiencing some form of maltreatment or family dysfunction at any given point in time. We also know that this statistic reflects only the tip of the iceberg, since many child maltreatment cases go unreported. Wate and Boulton (2023) suggest that recognising children and adults have and continue to experience trauma, have led many safeguarding partnerships to now aim to become better informed on the effects, adopting trauma informed practice in their work.

### 5.2.15 Trauma Informed Practice

Working definition of trauma informed practice guidance (2022) GOV.UK identify that trauma-informed approaches have are increasingly cited in policy and adopted in practice as a means for reducing the negative impact of trauma experiences and supporting mental and physical health outcomes.

Trauma results from an event, series of events, or set of circumstances that is experienced by a child or adult as harmful or life threatening to them.

There are six principles of trauma-informed practice: safety, trust, choice, collaboration, empowerment, and cultural consideration.

### 5.2.16 The Voice of a Child

Safeguarding Children (2023) states that anyone working with children should see and speak to the child, listen to what they say, observe their behaviour, take their views seriously, and work with them and their families and the people who know them well when deciding how to support their needs.

Practitioners should also be aware that children may find it difficult to always speak about what they need, what is happening to them or what has happened to them. Where the child is old enough it is good practice to speak to them without their carers to establish their version of events. In some cases, professionals may have to engineer this opportunity. Staff with serious concerns about harm to a child, should consider the need for a chaperone when seeing a child alone. For further information see the Trust Chaperone Policy CL86. Being reviewed

### 5.2.17 Child Centred Approach

A child centred approach is fundamental to safeguarding and promoting the welfare of every child. The principles of the Children Acts make clear that the welfare of children is paramount and that they are best looked after within their families, with their parents playing a full part in their lives, unless compulsory intervention in family life is necessary.

Children are clear about what they want from an effective safeguarding system: Working Together to Safeguard Children (2023) describes that children have said that they need:

**Vigilance:** to have adults notice when things are troubling them.

**Understanding and action:** to understand what is happening; to be heard and understood; and to have that understanding acted upon.

**Stability:** to be able to develop an ongoing stable relationship of trust with those helping them.

**Respect:** to be treated with the expectation that they are competent rather than not.

**Information and engagement:** to be informed about, and involved in procedures, decisions, concerns, and plans.

**Explanation:** to be informed of the outcome of assessments, and decisions and reasons when their views have not met with a positive response.

**Support:** to be provided with support in their own right as well as a member of their family.

**Advocacy:** to be provided with advocacy to assist them in putting forward their views.

**Protection:** to be protected against all forms of abuse, exploitation, and discrimination, and the right to special protection and help if a refugee.

### 5.2.18 Disguised Compliance

Disguised Compliance is where a parent or carer gives the appearance of cooperating with agencies to avoid raising suspicions, therefore hoping to allay concerns and ultimately to draw the attention away from allegations of harm. Examples of Disguised Compliance could be a sudden attendance for a series of hospital appointments, engaging with health for a limited time, a sudden increase in school attendances or cleaning the house prior to a home visit.

[Learning from case reviews: disguised compliance \(nspcc.org.uk\)](https://www.nspcc.org.uk/learning-from-case-reviews/disguised-compliance)

### 5.2.19 The Rule of Optimism

The rule of optimism' means that we are likely to give clients too many chances which is an adverse outcome for children in far too many cases. It exposes them to ongoing instability as child protection comes and goes without achieving successful outcomes.'

<https://www.socialworkhelper.com/2014/07/28/the-rule-of-optimism/>

Trust staff should be aware of and be vigilant against the potential of 'the rule of optimism', when staff may place undue confidence in the capacity of families to care effectively and safely, affecting perceptions thus impacting on the recognition of significant risk of harm, abuse, or neglect.

### 5.2.20 Section 85 of the Childrens Act (1989)

Under section 85 of the Children Act 1989 and 2004, hospitals have a legal requirement to inform the local authority (Children Social Care) when a child has been in hospital for more than or likely to exceed 90 days. As this is a legal obligation, consent is not required to share this information.

- This places a duty on local authorities to check the safety and welfare of a child and offer help and support if needed in readiness for the discharge from hospital.
- This provides a 'safety net' for children at risk who have been accommodated in the hospital for a long period.

### 5.2.21 Multi agency working

Strong multi-agency and multi-disciplinary working is vital to identifying and responding to the needs of both children and families. This is discussed in Safeguarding Children (2023) where it is stated that there are multi-agency expectations for direct practice.

**Collaborate:** practitioners working with the same child and family share information to get a complete picture of what life is like for the child. Collectively, they ensure the child's voice is at the centre and the right support is provided.

**Learn:** practitioners learn together by drawing on the best available evidence from their individual fields and sharing their diverse perspectives during regular shared reflection on a child's development, experiences, and outcomes.

**Resource:** practitioners build strong relationships across agencies and disciplines to ensure they support and protect the children with whom they work.

**Include:** practitioners recognise the differences between, and are confident to respond to, circumstances where children experience adversity due to economic and social circumstances and acute family stress, and situations where children face harm due to parental abuse.

**Mutual challenge:** practitioners challenge themselves and each other, question each other's assumptions, and seek to resolve differences of opinion in a restorative and respectful way.

## 5.3 LEGAL ORDERS

### 5.3.1 Police Powers of Protection (Formally known as a Police Protection Order PPO).

Police Powers of Protection sometimes referred to as Police Protection Orders or by the acronyms PPO or PPP. Police Powers of Protection are a way by which the Police, if they consider a child to be in imminent danger, can act to protect the child. The powers allow a police officer to remove the child to suitable accommodation and prevent any person from removing them from there. This may be a foster placement but may equally be the home of a relative, a family friend of the child or hospital. Police Powers of Protection are only used in exceptional circumstances for reasons relating to the **immediate safety** of a child and cannot last longer than 72 hours, however it can be revoked sooner than that. Police Protection does not change parental responsibility, this remains with the people who already have it.

The main reasons Police assistance will be required are:

Safety – where Police are required to urgently remove a child from known or suspected danger or to prevent a child from being removed from a place of safety.

Health – where Police are required to ensure a child receives medical examination or treatment.

Crime – where it is believed that a child, has been the perpetrator or victim of a crime.

In cases where the child has been judged to be at **extreme risk of significant harm** the parents **MUST NOT** be allowed to take the child home or leave the ward area with them. However, Trust staff do not have legal authority to detain them and if the parents or other family members or friends attempt to leave the ward area, the Police, Security and Children's Social Care should be contacted immediately quoting any relevant incident number.

### 5.3.2 Emergency Protection Order / Interim Care Order

If there is a need to take a child into protection, but there is no immediate danger, an Emergency Protection Order (EPO) or Interim Care Order (ICO) will be sought through the legal process.

An Emergency Protection Order is a Court Order, which gives parental responsibility to the Local Authority Children's Social Care. It lasts for 8 days, during which time Children's Social Care must present a case to Court for longer-term action.

Interim Care Orders are made at the commencement of and during Care Proceedings. The initial order will usually last for up to eight weeks but can be extended and give parental responsibility to the Local Authority Children's Social Care. Children's Social Care will apply for an Interim Care Order by submitting to the court an Interim Care Plan, which details where the child will live whilst the Interim Care Order is in place. The Interim Care Plan will also detail the level of contact allowed between a parent and child during this time. The Interim Care Order will end once replaced by a final care order. A care order is not an option when a child has reached the age of seventeen years.

In the case that the local authority has successfully gained a legal order for a child to be taken into care, certain processes will happen:

A social worker will present at the Trust with either an Emergency Protection Order, or an Interim Care Order; these are legal orders giving the local authority parental responsibility.

The identification of that professional and the details of the legal order should be checked to ensure staff are happy that these are genuine.

A photocopy of the legal order must be placed in the child's healthcare record under safeguarding.

### 5.3.3 Voluntary Accommodation Section 20 Childrens Act 1989 Duty to accommodate a child

This is where the parents agree to voluntarily place their child into the care of the Local Authority, without the need of a legal order. If a child is to be taken into care following discharge from the Trust and the parents agree to voluntary accommodation, then a copy of all documentation must be placed in the healthcare record under safeguarding.

Trust staff must remember that the parents still have full parental responsibility and if there are any upcoming interventions to be undertaken parental consent must be sought and documented.

## **5.4 IDENTIFICATION OF SAFEGUARDING CONCERNS FOR A CHILD**

The first indications that a child is being abused may not necessarily be the presence of a severe injury. Indicators can present in numerous ways, such as by remarks made by the child, parents, carers, or friends, by changes in a child's behaviour or demeanour, by indications that the family is under extreme stress or by a series of events which, whilst not necessarily of concern in themselves, are significant if viewed in their entirety. It is important to remember that prompt help to a family in trouble may prevent minor abuse escalating into something more serious.

The needs of the child (including the unborn baby) must be considered in all aspects of care planning and management. A strength-based approach is promoted in all assessments, this is a collaborative process between the person supported by services and those supporting them, allowing them to work together to determine an outcome that draws on the person's strengths and assets.

The needs of the child (including the unborn baby) must be considered in all aspects of care planning and management. A strength-based approach is promoted in all assessments, this is a collaborative process between the person supported by services and those supporting them, allowing them to work together to determine an outcome that draws on the person's strengths and assets.

### 5.4.1 Recognising Links between Parenting Capacity and Safeguarding

There are times in both parents and children's lives when there are extra pressures and families may need extra support or specialist services. The following factors may impact on parenting capacity and increase concern that a child may have suffered or is at risk of suffering significant harm. It is, however, important to exercise professional judgement in each situation, and recognise that a referral may need to be made even when the factors below are absent. (See Appendix 3).

A substantial proportion of adults known to mental health services are parents and like all parents, they want what is best for their children. Parents affected by mental health illness face challenges; many are fully aware that their disorder affects their children even if they do not fully understand the complexities, and all children will be sensitive to their parent's state of mind and health.

Further guidance is available from: Child maltreatment: when to suspect maltreatment in under 18s NICE Clinical Guideline (CG89 2017).

[Overview | Child maltreatment: when to suspect maltreatment in under 18s | Guidance | NICE](#)

Working Together to Safeguard Children December (2023).

[Working together to safeguard children 2023: statutory guidance \(publishing.service.gov.uk\)](https://publishing.service.gov.uk)

Cambridgeshire and Peterborough Safeguarding Partnership Board.

[Multi-Agency Policies and Procedures | Cambridgeshire and Peterborough Safeguarding Partnership Board \(safeguardingcambspeterborough.org.uk\)](https://safeguardingcambspeterborough.org.uk)

#### 5.4.2 Child and Adolescent Mental Health Services. (CAMHS)

CAMHS is the name for the NHS Services that assess and treat children with emotional, behavioural, complex trauma or mental health difficulties.

CAMHS support covers [depression](#), [problems with food and eating](#), [self-harm](#), [abuse](#), violence or [anger](#), [bipolar disorder](#), [schizophrenia](#) and [anxiety](#), among other difficulties.

Children with mental health needs must always be seen as individuals who will have a range of support networks. There may be times when those networks need opportunity to come together to provide children and their families more coordinated support.

Within Cambridgeshire there is a partnership provided by Cambridgeshire and Peterborough NHS Foundation Trust, Cambridgeshire Community Service NHS Trust, Centre 33, and Ormiston Families.

The partnership is called YOUnited that provides emotional wellbeing and mental health help for children and young people aged 0 to 25 registered with a GP in Cambridgeshire and Peterborough, referral forms can be found at [Referral information | CPFT NHS Trust](#)

YOUnited should be used for all referrals to the Trusts Child and Adolescent Mental Health Services.

A mental health free text messaging support service has been launched in Cambridgeshire and Peterborough to help those struggling to cope. Launched by NHS Cambridgeshire & Peterborough and in partnership with the national service SHOUT, the free to use text service HEAR 85258 provides real-time support to people of all ages who are struggling with their mental health. [Shout - UK's 24/7 Crisis Text Service for Mental Health Support | Shout 85258 \(giveusashout.org\)](https://giveusashout.org)

When texting the word HEAR to 85258, the person will be connected to a trained volunteer who will take them from a place of crisis to a place of calm. During the confidential and anonymous conversation, the texter will be supported and signposted to local and national mental health services.

Texting HEAR to 85258 is free, discreet and runs 24/7. It won't appear on any bills and requires no app, data, password, or registration. It is available for anybody who lives, works, or studies in Cambridgeshire and Peterborough.

#### 5.4.3 Use of Restricted Practices

Restrictive practice means any practice or intervention that has the effect of restricting the rights or freedom of movement of a person. It is used for several reasons including to manage challenging behaviours, to keep people safe and to help people live a more positive life. Restrictive practice can include a variety of interventions. These can range between environmental, mechanical, pharmaceutical, and physical interventions.

It is important that anyone subject to any form of restrictive interventions is always safeguarded. If any restrictive interventions are carried out without the correct legal framework having been implemented, this could amount to a safeguarding matter and should be reported via the appropriate safeguarding mechanisms. Support, advice, and guidance can be sought from the Trusts Safeguarding Team.

[Mental Health Units \(Use of Force\) Act 2018: statutory guidance for NHS organisations in England and police forces in England and Wales – consultation outcome - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/consultations/mental-health-units-use-of-force-act-2018-statutory-guidance-for-nhs-organisations-in-england-and-police-forces-in-england-and-wales-consultation-outcome)

#### 5.4.4 Children with Special Educational Needs and Disabilities (SEND)

Children with additional needs (including SEND) are at an increased risk of abuse and neglect and sometimes indications of abuse are harder to identify.

The Safeguarding Network (2024) discusses that children with disabilities are more likely than other children to be abused or neglected. Sometimes this is because of high care needs, increased vulnerability or the range of other factors that affect other children. Parenting a child with disabilities comes with additional stresses or challenges, which can heighten the potential for abuse or neglect, especially in the context of a society where there remains much prejudice and barriers to disabled children and their families. Similar factors affect children experiencing mental health conditions. Most research suggests that disabled boys are at a greater risk of abuse than disabled girls when compared to non-disabled children. Professionals can sometimes miss signs of abuse due to the complexity of the child's needs, an acceptance of things being how they are, or allowing their recognition of the challenges facing parents to cloud their judgement leading to abuse or neglect being under-reported.

Children have a wide range of needs, and this considers children with a formal diagnosis or condition, as well as where issues are apparent but there is no formal diagnosis. These children are at greater risk of abuse or neglect and the barriers to identifying and intervening are also higher. It is therefore important that staff maintain an open mind about what they are seeing, and as suggested by Lord Laming (2006), maintain a professional curiosity. For example:

- Not accepting that an injury is a result of the needs of the child, but instead consider what other causes there may be and what the evidence suggests.
- Considering a behaviour such as self-harm as possibly being indicative of abuse.
- Recognising the potential for fabricated or induced illness.

It is important that there are also clear lines of communication between all involved in the child's care so that concerns can be discussed and referred as necessary.

#### 5.4.5 Care, Education and Treatment Reviews (CETR's)

An education, health, and care (EHC) plan details the education, health and social care support that is to be provided to a child who has Special Educational Needs.

Care, education, and treatment reviews are meetings about children, young people and adults with learning disabilities, autism, or both, who are at risk of being admitted to, or are currently in, hospital because of a mental health problem or challenging behaviour.

Care, education, and treatment reviews are used to look at how a person's care and treatment is going and how they may need to be improved. They are also used to ~~make a plan of~~ what care and treatment is needed and decide who will be involved in implementing actions from the plan.

#### 5.4.6 Admission of a child to an Adult Mental Health Ward

The Trust is committed to ensuring that the admission of a child to an Adult Mental Health Ward rarely happens. But when this does occur it takes place within a framework that minimises any risk of harm to the child, by being placed on an adult psychiatric ward. Ensuring that the child is discharged or transferred at the earliest opportunity to a more suitable therapeutic environment.

The care and treatment need of a child must be met in such a way that minimises any risk of harm by being placed on an adult in-patient ward. During any period that the child is on the adult ward, appropriate children's safeguarding arrangements must be in place.

For further information see (Documents that guide practice) Admission of a Young Person to an Adult Mental Health Ward Policy CL 36.

### **5.5 ACTION TO BE TAKEN IF THERE ARE CONCERNS AROUND A CHILD'S SAFETY AND WELFARE.**

5.5.1 Please see Children's Standard Operating Procedure for support in what roles and responsibilities are when there are concerns about a child's safety and welfare.

5.5.2 Please refer to Cambridgeshire & Peterborough safeguarding Partnership Board. Effective Support for Children and Families (Thresholds) Document.

#### [Cambridgeshire & Peterborough Safeguarding Partnership Board](#)

#### 5.5.3 Community Contextual Safeguarding.

Contextual Safeguarding is an approach to understanding and responding to children's experiences of significant harm beyond their family and home.

This approach recognises the different relationships children have in their schools, peer groups, online and in their community. Parents and carers may have little influence over these contexts and children's exposure to extra-familial abuse can negatively impact a parent-child relationship.

It is important that all staff understand the risks to children through exploitation and wider extra-familial harm within the local communities in which they live. Across Cambridgeshire, professionals come together under our Multi Agency Child Exploration (MACE) and Contextual Safeguarding Arrangements to share information about children at risk of exploitation, as well as potential perpetrators and locations that could pose a risk to children and young people (See Appendix 4 for Community Contextual Safeguarding and Partnership Pathway for Community Safeguarding Risks).

#### **5.5.4 IF YOU HAVE CONCERNS THAT A CHILD IS AT IMMEDIATE RISK OF SIGNIFICANT HARM DIAL 999 CONTACT THE POLICE GIVING RELEVANT INFORMATION. THEN CONTACT THE LOCAL AUTHORITY AND THE TRUSTS SAFEGUARDING TEAM.**

Please contact the Trusts Safeguarding Team for support, advice, and guidance.

Telephone 01733 836097.

## 5.6 PREPARING FOR A CHILD PROTECTION CONFERENCE

Trust staff are likely to be requested to participate in both Initial Child Protection Conferences (ICPC) and Review Child Protection Conferences (RCPC). The aim is to bring together family members, the child where appropriate, and those professionals most involved with the child and family.

Trust staff attending conferences should be there because they have:

- Professional expertise relevant to the case, and or
- Knowledge of the child and or family.

Trust staff will provide a report of their involvement with a child for a Child Protection Conference. The report should outline:

- A chronology of their involvement with the child and their family.
- Knowledge, they have concerned the child's health and development, the capacity of the parents and other family members to safeguard the child and their family and environmental factors which might affect parenting capacity.
- Their analysis of the implications of the information for the child's future safety and meeting of his or her developmental needs.
- Conference reports should be shared with parents in advance and submitted to the Conference and Reviewing Service at least 3 days before the conference if timescales allow.

The templates for Child Protection reports are embedded within the Trusts electronic record or can be found on the Trust's intranet. [Safeguarding | Intranet \(cpft.nhs.uk\)](https://cpft.nhs.uk)

All documentation relating to Child Protection Conferences are to be uploaded into the child's healthcare record on the appropriate electronic record.

## 5.7. DIFFERENCES OF OPINION

5.7.1 It is inevitable that, on occasions, members of Trust staff may have different perceptions, interpretations, or opinions. Assessing risk can potentially either underestimate or overestimate the danger to a child. The actual or potential risks often inform debate, and staff must ensure that the whole picture is considered. It is important that differences are discussed openly and there is complete transparency. All Trust staff need to be aware of their own responsibility to explore their concerns with other professionals and to consider other viewpoints.

5.7.2 Each member of Trust staff has ultimate responsibility, regardless of their position, to act on and follow up their own concerns. It is every professional's responsibility to safeguard children and to act in their best interests. This means that they should 'problem solve' where required to support effective multi-agency safeguarding work. It is also the responsibility of all professionals to present a challenge to the actions and decisions of other agencies where they believe they have evidence to suggest that the child's development or their safety may be compromised.

5.7.3 The Named Professionals should always be informed when there are issues relating to professional disagreement to support staff in resolving any professional disagreements at the earliest possible stage, always keeping in mind that the child's safety and welfare is paramount.

Differing opinions are most likely to arise because of:

- Differing views of thresholds
- Concerns regarding the actions or lack of action from other professionals
- Disagreement regarding the plan for an open case to be closed or de-escalated.
- Disagreement over the sharing of information.
- Disagreement arising from the professional's own experiences.

For further guidance see.

[Resolving Professionals Differences \(Escalation\) Policy | Cambridgeshire and Peterborough Safeguarding Partnership Board \(safeguardingcambspeterborough.org.uk\)](https://safeguardingcambspeterborough.org.uk)

## 5.8 INFORMATION SHARING

5.8.1 No single staff member can have a full picture of a child's needs and circumstances so the effective sharing of information between practitioners, local organisations and agencies is essential for early identification of need, assessment, and service provision to keep children safe.

Information sharing is a vital component to safeguarding and promoting the welfare of the child. Staff should weigh the risk of sharing information or not by determining whether they are sharing information with the aim of protecting someone. It is acceptable to share information in order to protect. It is very useful to consider two simple questions before sharing information with another professional or organisation. Does the professional or organisation *need to know* the information or is it the case of it being *nice for them to know*. Trust staff should aim to be as transparent as possible by telling families what information they are sharing and with whom, if it is safe to do so.

A key factor identified in many serious case reviews has been a failure by practitioners to record information, to share it, to understand its significance and then take appropriate action.

Information Sharing is essential to enable early intervention and preventative work, for safeguarding and promoting welfare and for wider public protection. It is a vital element in improving outcomes for all.

Information Sharing HM Gov 2018.

[Information sharing advice for safeguarding practitioners - GOV.UK \(www.gov.uk\)](https://www.gov.uk)

If a member of staff has concerns as to whether they should or should not or can or cannot share information, then in the first instance please discuss with your line manager. However further guidance can be sort from the Safeguarding Team, the Caldicott Guardian, and the Freedom to Speak Up Guardian, who are available for support, advice, and guidance.

The Trust has implemented a tool to help with the information sharing decision making - Assessment to Breach Patient Confidentiality Tool. (See appendix 10).

### 5.8.2 Seven Golden Rules for Information Sharing (HM Gov July 2018)

- The General Data Protection Regulations (GDPR) is not a barrier to sharing information.
- Be open and honest, from the onset about why, what, how and with whom information will or could be shared and seek agreement unless it is unsafe or inappropriate to do so.
- Seek advice.
- Share with informed consent where appropriate, consider the wishes of those who do not consent, but information can still be shared without consent.
- Consider safety and well-being of those who may be affected by your actions.

- Necessary, proportionate, relevant, accurate, timely and secure.
- Keep a record of your decision and the reason, and the information you have shared and with whom.

### 5.8.3 Receiving Third Party Information from non-Trust lay staff.

If Trust staff receive information about significant harm, or the risk of to a child from a third party the following advice and actions must be followed.

- Encourage the referrer to make a referral to Children's Social Care advising them that they may ask to remain anonymous if they wish.
- Record as much information as possible to report the third-party allegation yourself to Children's Social Care as appropriate. Advise the anonymous referrer that you will be doing this.
- Contact the Safeguarding Team to seek advice if you are unsure of what action to take, always remember that the welfare of the child is paramount at all times.

## 5.9 DOCUMENTATION

5.9.1 All health care professionals have a duty to keep up to date with, and adhere to, relevant legislation, case law, national and local policies relating to information and record keeping. The Trust requires that all staff record all information relating to safeguarding, and this must be accurate and written in such a way that the meaning is clear. This would include plans to assess and manage risk, any referrals to Children's Social Care for specialist assessment, and the outcome of any such referral. Records must clearly differentiate between fact, reported information and opinion. Professionals are advised to keep fact and opinion clearly delineated in the healthcare record.

5.9.2 Recording your safeguarding concerns and any actions taken to manage the risk should be completed using the safeguarding templates in the Trusts electronic record. There is a template for children and another for recording safeguarding information about family members. Guidance to do this can be found on the Trust safeguarding intranet pages:

[Safeguarding | Intranet \(cpft.nhs.uk\)](https://cpft.nhs.uk)

For further information please see (Documents that Guide Practice) Clinical Record Keeping Policy CL01.

5.9.3 Trust staff MUST send a copy of all safeguarding referrals made to their local authority to the Trusts Safeguarding Team, ensuring a copy is added to the individual's records. TRUST staff can seek safeguarding advice, guidance, and support from the Trusts Safeguarding Team: Email [safeguardingthinkfamily@cpft.nhs.uk](mailto:safeguardingthinkfamily@cpft.nhs.uk) or Telephone 01733 836097.

Cambridgeshire & Peterborough Safeguarding Partnership Board have resources for professionals including several risk assessment tools that can support and guide risk management:

[Resources For Practitioners | Cambridgeshire and Peterborough Safeguarding Partnership Board \(safeguardingcambspeterborough.org.uk\)](https://safeguardingcambspeterborough.org.uk)

## 5.10 DEBRIEFING AND SUPERVISION

5.10.1 Debriefing and supervision form an integral part of the safeguarding process for all staff. There are systems in place within the Trust for debriefing, which enable staff to discuss issues and concerns. Individual supervision is available for all staff, from the Named Professionals and the Trusts Safeguarding Team to support, manage and develop their skills within the safeguarding process.

Specialist safeguarding advice, guidance, support, and supervision can be accessed via a single point of contact:

Safeguardingthinkfamily@cpft.nhs.uk or 01733 836097

For further information please see (Documents that guide practice) Scope for Growth Policy HR100.

## 5.11 ALLEGATIONS AND SUSPICIONS OF CHILD ABUSE BY TRUST STAFF

5.11.1 If there are allegations or suspicions of child abuse by a member of Trust staff an urgent referral must be made to the Police, Children's Social Care as well as the Local Designated Officer (LADO) See Allegations Against Staff Policy. [POVA \(cpft.nhs.uk\)](https://cpft.nhs.uk/pova)

5.11.2 Immediate steps must be taken to ensure the safety of the child concerned and any other relevant children or adults at risk. Please refer to (Documents that guide practice) Allegations against Staff Policy HR101, Standard Operating Procedure Allegations Against Staff HR102.

## 5.12 CHILD DEATH

5.12.1 The death of a child is a devastating loss, that profoundly affects all those involved. The process of systematically reviewing the deaths of children is grounded in respect for the rights of children and their families, with the intention of learning what happened and why, and preventing future child deaths.

5.12.2 Most child deaths in England arise from medical causes. Enquiries should keep an appropriate balance between forensic and medical requirements and supporting the family at a difficult time. When a child dies, in any circumstances, it is important for parents and families to understand what has happened and whether there are any lessons to be learned.

5.12.3 The responsibility for ensuring child death reviews are carried out is held by the child death review partners. Child death review partners must plan to review all deaths of children normally resident in the local area and as indicated for any non-resident child who has died in their area. This should be done via Child Death Overview Panel (CDOP).

Cambridgeshire and Peterborough child death review queries can be sent via the single point of contact: [cpicb.cdop@nhs.net](mailto:cpicb.cdop@nhs.net)

Child Death Overview Panel (CDOP) Protocol and Terms of Reference for CDOP Partners. [safeguardingcambspeterborough.org.uk/download/cambridgeshire-and-peterborough-child-death-overview-panel-protocol/?wpdmdl=22876&refresh=65dde75b26b901709041499](https://safeguardingcambspeterborough.org.uk/download/cambridgeshire-and-peterborough-child-death-overview-panel-protocol/?wpdmdl=22876&refresh=65dde75b26b901709041499)

If a member of staff is seeking to report a child death they should do so via the [eCDOP online portal](#).

## 5.13 MULTI AGENCY REVIEWS

The Trust may be asked to contribute to multiagency reviews which involve children, this may include Child Safeguarding Practice Reviews (CSPR) or Domestic Abuse Related Death Reviews (DARDR), previously known as Domestic Homicide Reviews.

Child protection in England is a complex multi-agency system with many different organisations and individuals playing their part. Reflecting on how well that system is working is critical in improving our response to children and their families. Sometimes a child suffers a serious injury or death because of abuse or neglect, this is a trigger for a notifiable incident.

### 5.13.1 The Rapid Review.

Initially a rapid review will be undertaken to ascertain whether a local child safeguarding practice review is appropriate, or whether the case may raise issues which are complex or of national importance such that a national review may be appropriate. Rapid Reviews should assemble the facts of the case as quickly as possible to establish whether there is any immediate action needed to ensure a child's safety and the potential for practice learning.

5.13.2 Understanding not only what happened but also why it happened can help improve responses in the future. Appreciating the impact that organisations and agencies had on the child's life, and on the lives of their family members, and whether different approaches or those actions could have resulted in a different outcome, is essential. It is in this way that we can make good judgements about what might need to change at a local or national level.

### 5.13.2 Child Safeguarding Practice Review (CSPR)

The purpose of serious child safeguarding case reviews, at local and national level, is to identify improvements that can be made to safeguard and promote the welfare of children. These reviews should seek to prevent or reduce the risk of recurrence of similar incidents. They are not conducted to hold individuals, organisations, or agencies to account, as there are other processes for that purpose, including employment law and disciplinary procedures, professional regulation and, in exceptional cases, criminal proceedings. The responsibility for how the system learns the lessons from serious child safeguarding incidents lies at a national level with the Child Safeguarding Practice Review Panel and at a local level with the safeguarding partners.

<https://safeguardingcambspeterborough.org.uk/children-board/serious-case-reviews/>

### 5.13.3 Youth Justice Serious Incident Reviews

In 2021, the Youth Justice Board (YJB) reviewed how intelligence against serious incidents occurring in the community was gathered as part of its statutory responsibility for oversight. This highlighted that without a notification process of serious incidents in the community the YJB has limited oversight of these serious events. This limits the effectiveness of timely and appropriate responses both locally and nationally, the deployment of practical support and, when required, ministerial liaison. It also limits collation of national data where a fuller picture of performance, trends, themes, and lessons learnt could be extracted.

For further information see below.

[Serious incidents notification: standard operating procedures for YJSs - GOV.UK](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/91241/serious_incidents_notification_standard_operating_procedures_for_YJSs.pdf)  
([www.gov.uk](http://www.gov.uk))

#### 5.13.4 Domestic Abuse Related Death Reviews (DARDR)

Domestic Homicide Reviews were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (DVCA 2004) and came into force in 2011.

The Domestic Abuse Act 2021 introduced a statutory definition of domestic abuse that incorporates a range of abuses beyond 'violence, abuse and neglect' to include controlling or coercive behaviour, emotional abuse and economic abuse. The Domestic Abuse Act (2021) also provided clearer definition of which relationships domestic abuse can occur within, specifying that abusive behaviour between individuals who are 'personally connected' via intimate or family relationships can be classed as domestic abuse.

Under existing legislation, Domestic Homicide Reviews (DHR) did not align with the definition of domestic abuse provided by the Domestic Abuse Act (2021). To address these shortcomings in existing DHR legislation, the government held a public consultation inviting views on amending the Domestic Violence, Crime and Victims Act (2004). Following consultation, the home office confirmed that Domestic Homicide Reviews would be renamed to Domestic Abuse Related Death Reviews, this was tabled as an amendment to the Victims and Prisoners Bill. Which received Royal Assent on May 24<sup>th</sup> 2024, and the name change confirmed at Part 1 Section 19 of the Victims and Prisoners Act 2024.

[Victims and Prisoners Act 2024](#)

5.13.4.1 A Domestic Abuse Related Death Review (DARDR) is undertaken when a person aged 16 or over has died as a result of abuse, violence or neglect by a relative, intimate partner or member of the same household.

DARDRs are carried out by Community Safety Partnerships to ensure that lessons are learnt when a person has died as a result of domestic abuse, either by homicide or suicide. The purpose is not to investigate the death or apportion blame, but to:

- Establish what lessons can be learned from the homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
- Apply those lessons to service responses including changes to policies and procedures as appropriate.
- Prevent domestic abuse and domestic homicides and suicides and improve service responses for all domestic abuse victims and their children through improved intra and interagency working.

The DARDR will usually draw upon information obtained from:

- Interviewing family members.
- Interviewing significant people who may have known the victim.
- Obtaining information from participating agencies, either by way of an Individual Management Review (IMR), or by other means such as a chronology of events.

An independent chair is appointed and will aim to make contact with family and friends, to enable them to inform the review and build a complete picture of the circumstances leading up to the death.

## 6.0 ASSOCIATED DOCUMENTS

HM Government (DCSF 2023) Working Together to Safeguard Children: A guide to interagency working to safeguard and promote the welfare of children, London, HM Government

Department of Health (DoH 1989/2004) Children Act  
<https://www.legislation.gov.uk/ukpga/1989/41/contents>

Children's and Social Care Act (2017).

The Lord Laming (DCSF 2006) The protection of children in England: A progress report, London, The Stationery Office.

Child maltreatment: when to suspect maltreatment in under 18s  
<https://www.nice.org.uk/guidance/cg89> (NICE 2017)

Cambridgeshire and Peterborough Safeguarding Partnership Board Procedures  
<https://www.safeguardingcambpeterborough.org.uk/children-board/professionals/lscbprocedures/> (Cambridgeshire and Peterborough Safeguarding Partnership Board)

NHS England Accountability and Assurance Framework (HM Gov 2019/2020).

Royal College of Nursing safeguarding Children and Young People: Roles and competencies for Healthcare Staff to audit compliance within the Trust (2019). [Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff | Royal College of Nursing \(rcn.org.uk\)](https://www.rcn.org.uk/~/media/RCN%20org/Policy%20and%20Practice/2019/07/Safeguarding%20Children%20and%20Young%20People%20Roles%20and%20Competencies%20for%20Healthcare%20Staff%20-%20July%202019.pdf)

Cambridgeshire & Peterborough Safeguarding Partnership Board. Effective Support for Children and Families (Thresholds) Document.

Information Sharing. Advice for practitioners providing safeguarding services to children, young people, parents and carers (HM Gov July 2018)  
[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/721581/Information\\_sharing\\_advice\\_practitioners\\_safeguarding\\_services.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/721581/Information_sharing_advice_practitioners_safeguarding_services.pdf)

Multi-agency Safeguarding in a Public Protection World: 2<sup>nd</sup> edition A handbook for protecting children and vulnerable adults. (2023) Russell Wate QPM, Nigel Boulton.

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 13.

Care Quality Commission Regulation 13: Safeguarding service users from abuse and improper treatment (2023).

The Protection of Children in England, a progress report by Lord Laming (2009).

Children's Social Care National Framework. A government consultation on principles for practice, expected outcomes and indicators: statutory guidance. Department of Education (2023).

The Domestic Abuse Act GOV.UK (2021).

The Equality Act GOV.UK (2010).

The Children's Social Care National Framework GOV.UK (2023).

The Criminal Justice Bill GOV.UK (2023).

The Serious Violence Duty GOV.UK (2022).

Working definition of trauma informed practice guidance (2022) GOV.UK.

Mental Health Units (Use of Force) Act 2018: statutory guidance for NHS organisations in England and police forces in England and Wales.

Safeguarding Network Multi-Agency Working (2024).

Parental Rights & Responsibilities GOV.

The Victims and Prisoners Act (2024).

Modern Slavery Act (2015)

## 7.0 MONITORING COMPLIANCE

| Document Section |         | Control  | Check to be carried out   | How often will the check be carried out                 | Responsible for carrying out the check                                | Results of check reported to  | Frequency of reporting               |
|------------------|---------|--|---|---|---|---|--------------------------------------|
| Page             | Section | WHAT?  | HOW?  | WHEN?   | WHO?  | WHERE?  | WHEN?                                |
|                  |         | That if a child comes into the Trust and a concern is identified, the appropriate action is taken. | Self-Assessment and staff knowledge check.<br>Audit of Trust Safeguarding Compliance.<br>Analysis of incident trends, monitoring of attendance at training. | Two Yearly<br><br>PSIRF, Datix, complaints.<br>Monthly. | Safeguarding Board under section 11.<br><br>Trusts Safeguarding Team. | Safeguarding Committee.<br><br>Quality and Safety Committee..<br><br>Trust Board. | Two yearly.<br><br>As per timetable. |
|                  |         |  |   |   |   |   |                                      |

## APPENDIX 1: TERMS OF REFERENCE -FORMS OF CHILD ABUSE

It is paramount that all Trust staff are aware of the potential and actual risks of child abuse and that abuse may occur in many differing situations with varying presentations. Children may be at risk under one or more of these categories. Trust staff must remember the child is at the heart of all that we do: This means that we need to take account of the child's views and feelings and understand the impact on them and their family.

**Physical Abuse:** A form of abuse which may involve hitting, shaking, throwing, poisoning, burning, or scalding, drowning, suffocating, Female Genital Mutilation, Breast Ironing 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 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.

**Emotional Abuse:** 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, though it may occur alone.

**Neglect:** can be complex and is often hard to define clearly. It differs by type, severity, frequency, and impact. Neglect often co-exists with other forms of abuse and is often a pre-condition to allowing other abuse to take place. Increasingly, the psychological impact of neglect is being recognised. Neglect remains the most common form of child abuse across the UK and is usually the most common cause for a child being the subject of a child protection plan. It is well documented that neglect can cause significant distress to children and young people and lead to both poor short- and long-term outcomes. In addition, research and findings from Serious Case Reviews also inform us that in extreme cases neglect can be fatal.

<https://www.safeguardingcambspeterborough.org.uk/wp-content/uploads/2021/02/Neglect-Strategy-2018-21.pdf> <https://democracy.peterborough.gov.uk/documents/s29357/8%20-%20App%20%20Missing-Person-Protocol-August-16%20COTISC.pdf>

Local Safeguarding Boards recognise and encourage the use of a variety of assessment unit tools to both assist with the assessment process and as an alternative way of engaging families.

[https://www.safeguardingcambspeterborough.org.uk/wp-content/uploads/2017/12/Graded\\_Care\\_Profile\\_PDF\\_Sept\\_2016.pdf](https://www.safeguardingcambspeterborough.org.uk/wp-content/uploads/2017/12/Graded_Care_Profile_PDF_Sept_2016.pdf)

<https://www.safeguardingcambspeterborough.org.uk/children-board/professionals/child-neglect/>

## APPENDIX 2: CHILD EXPLOITATION

### Children Missing from Home.

A missing person is anyone whose whereabouts are unknown, whatever the circumstances of disappearance. The term “young runaway” and “missing” refer to a child up to the age of 18 years who has run away or has been forced to leave their home or care placement.

Reasons why children run away are complex and can include:

- Problems at home, such as family break up, where young people are drawn into their parents’ conflict.
- Mental health problems.
- Bullying, racism, racial harassment, or homophobia.
- Teenage pregnancy.
- Grooming for sexual exploitation.
- Child trafficking or forced marriage, where a young person might run away because they are at risk of or in a forced marriage.

Children who have run away are at high risk of harm including:

- No means of support or income which could lead to high-risk activities.
- Criminality.
- Abuse.
- Child Sexual Exploitation.
- Substance Misuse – causing deterioration of physical and mental health.
- Missing out on education.

<https://www.safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/missing-from-home-or-care/>

[Statutory guidance on children who run away or go missing from home or care \(publishing.service.gov.uk\)](https://www.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/611111/statutory-guidance-on-children-who-run-away-or-go-missing-from-home-or-care.pdf)

### Child Sexual Exploitation (CSE)

Child sexual exploitation is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child under the age of 18 into sexual activity.

In exchange for something the victim needs or wants.

For the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur using technology. It is a crime with devastating and long-lasting consequences for its victims and families. Childhoods and family life can be ruined, and this is compounded when victims, or those at risk of abuse, do not receive appropriate, immediate, and ongoing support.

Like all forms of child sexual abuse, child sexual exploitation

- Can affect any child (male or female) under the age of 18 years, including 16- and 17-year-olds who can legally consent to have sex.
- Can still be abuse even if the sexual activity appears consensual; Can include both contact (penetrative and non-penetrative acts) and non-contact sexual activity.
- Can take place in person or via technology, or a combination of both.

- Can involve force and/or enticement-based methods of compliance and may or may not, be accompanied by violence or threats of violence.
- May occur without the child's immediate knowledge through others copying videos or images they have created and posted on social media, for example. See Appendix 10 to how these images can be removed, via Report Remove?
- Can be perpetrated by individuals or groups, males or females and children or adults.
- The abuse can be a one-off occurrence or a series of incidents over time and range from opportunistic to complex organised abuse.
- It is typified by some form of power imbalance in favour of those perpetrating the abuse. Whilst age may be the most obvious, this power imbalance can also be due to a range of other factors including gender, sexual identity, cognitive ability, physical strength, status, and access to economic or other.

All staff should remember *Child sexual exploitation is never the victim's fault, even if there is some form of exchange: all children under the age of 18 have a right to be safe and should be protected from harm.*

For further information see (Documents that guide practice) Trusts Exploitation Policy details to be added not on intranet yet.

For full advice follow link below - Child Sexual Exploitation. Definition and a guide for practitioners, local leaders and decision makers working to protect children from child sexual exploitation Department of Health 2017.

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/591903/CSE\\_Guidance\\_Core\\_Document\\_13.02.2017.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/591903/CSE_Guidance_Core_Document_13.02.2017.pdf)

<https://www.safeguardingcambspeterborough.org.uk/wp-content/uploads/2018/05/CSE-Strategy-Feb-2018.pdf>

### Gangs and or County Lines

It is known that there are gangs within Cambridgeshire and its surrounding Local Authorities with which children at risk are associated. These gangs will look to exploit at risk groups criminally and sexually.

- Some indicators of gang involvement and exploitation are listed below, with those at the top being considered the most common and highest risks:
- Persistently going missing from school or home and / or found out-of-area.
- Unexplained acquisition of money, clothes, or mobile phones.
- Excessive receipt of texts / phone calls.
- Relationships with controlling / older individuals or groups.
- Leaving home / care without explanation.
- Suspicion of physical assault / unexplained injuries.
- Parental concerns.
- Carrying weapons.
- Significant decline in school results / performance.
- Isolation from peers or social networks.
- Self-harm or significant changes in emotional well-being.

The above risk factors can also apply to County Lines.

County Lines is a national issue involving the use of mobile phone and the train network by groups to extend their drug dealing business into new locations outside of their home areas although not necessarily in different town or county – it may just be a different suburb or group of streets.

This issue affects most police forces. A 'county lines' enterprise almost always involves exploitation of persons at risk; this can involve both children and adults who require safeguarding – (National Crime Agency, 2015). Gangs from the larger cities including London, Manchester, Birmingham involved in county lines will look to establish a base in another town or area by exploiting the home of a vulnerable

adult or young person that is living independently, socially isolated, or is a known class A drug user. Children as young as 12 years have also known to be targeted in this form of exploitation. These children may have additional vulnerabilities for example.

- Chaotic household.
- Homeless.
- Connections with other gang members.
- Disability.
- Looked after child.

The Metropolitan Police Force are aware that there are 721 active county lines running in England and Wales. We also know that there are active lines local to our area.

If a child or young person is suspected of being involved in a gang, county lines, or exploitation then a referral into Children's Social Care must be made.

<https://www.safeguardingcambspeterborough.org.uk/wp-content/uploads/2018/05/Criminal-Exploitation-Strategy-and-Procedures.pdf>

For further information see (Documents that guide practice) Trusts Exploitation Policy details to be added not on intranet yet.

### Trafficking and Modern Slavery

The trafficking and slavery of children into the United Kingdom has become an issue of considerable concern. Most children are trafficked for financial gain; this can include financial payments involving their parents.

Trafficking is carried out by organised gangs, individual adults, or agents. The act which supports the police with these concerns is the Modern Slavery Act 2015. Trafficked children may be used for:

- Sexual exploitation.
- Domestic service, including restaurant or other catering work.
- Benefit fraud – begging or pick pocketing.
- Drug mules.
- Illegal inter country adoptions.

<https://www.safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/children-from-abroad-including-victims-of-modern-slavery-trafficking-and-exploitation/>

For further information see (Documents that guide practice) Trusts Exploitation Policy PS 69.

### E–Safety

Modern information and communication technology has developed rapidly in recent years and continues to develop at pace. Online social media has changed children's attitudes to information and how they share information, not only with friends, but sometimes inadvertently with other people, who may use this information to groom, exploit or abuse them. No single policy can hope to keep up with all developments. Trust staff need to be aware of the risks associated with the internet which, although they cannot be eradicated, can be minimised by safe practice.

- Children, parents, and carers can be advised by Trust staff that they should be aware of privacy settings.
- Friend requests should not be accepted from people who are not friends or known to them in the real world.
- Personal details including addresses or telephone numbers should never be shared on social media websites.
- Strong passwords need to be used and never shared.
- Never agree to meet a stranger who has only been an online acquaintance

- Take care when uploading images, status updates and messages as once online all of these can be shared widely and are difficult to block or remove.

<https://www.internetmatters.org/>

<https://www.ceop.police.uk/safety-centre/>

<https://www.thinkuknow.co.uk/>

<https://www.iwf.org.uk/>

<https://www.samaritans.org/>

### Groups at risk of radicalisation

The Government's Prevent Strategy aims to stop people becoming terrorists or supporting terrorism.

Prevent is supported by three objectives:

Responding to the ideological challenge of terrorism and the threat we face from those who promote it (ideology).

Preventing people from being drawn into terrorism and ensure that they are given appropriate advice and support (individuals).

Working with sectors and institutions where there are risks of radicalisation which we need to address (institutions).

One of the key requirements of Prevent is that all Trust staff know how to identify people at risk of radicalisation or extremism and the safeguarding pathways they should use.

If Trust staff have any concerns that an individual may be at risk of radicalisation, this should be considered as a safeguarding issue, and the Children's Safeguarding Team should be contacted. (Appendix 7). Please use the Trust PREVENT Policy alongside this policy to support and guide you (Documents that guide practice) CP 74.

<https://www.safeguardingcambspeterborough.org.uk/children-board/professionals/prevent/>

## APPENDIX 3: PARENTAL AND FAMILY FACTORS

All members of Trust staff must “Think Family” and consider the possibility of harm to a child at home when treating all adult patients.

### Parental Mental Health, Drugs and Alcohol Misuse.

Parental Drug and Alcohol misuse can affect children differently depending on their age and development. They often come from chaotic households where there is lack of supervision and poor parenting and is a common feature in Serious Case Reviews with at least one being present in 47% of cases. Children at most risk of harm are those that are in an environment where drug and or alcohol misuse, mental health and or domestic abuse are present.

68% of Women and 57% of men with a mental health illness are parents. Children are at increased risk of harm if their mother’s mental health begins between pregnancy and the child’s first birthday. Parental Mental Health issues are frequently present in cases of child abuse or neglect, the risk to the child increases if domestic abuse is also present. Children can often become isolated from friends and family due to the responsibility of caring for their parent and due to the stigma or discrimination that is associated with mental illness. The parent may not be able to respond to the child’s emotional and physical needs which will have an impact on their social, emotional, and intellectual development.

### Domestic Abuse.

Domestic abuse is both cruel and complex, which can affect anyone, leaving both physical, mental, and emotional scars that can last a lifetime.

In the year ending March 2020, an estimated 2.3 million adults aged 16 to 74 years experienced domestic abuse in the previous year (1.6 million women and 757,000 men). *Domestic Abuse Act Overarching Factsheet 2022. Home Office.*

In April 2021 the Government introduced a landmark Domestic Abuse Act and accompanying statutory guidance, as we know that far too many individuals have their lives destroyed by domestic abuse, and it has a devastating impact on children and young people. The NHS has a particular contribution to make because it is the one service with which almost all victims or survivors of domestic abuse will come into contact at some point in their lives.

There is a strong, evidence-based link between domestic abuse and child abuse. Exposure to domestic abuse always affects children although the impact on them may vary. Research suggests that 62% of children exposed to domestic abuse are also directly harmed due to physical or emotional abuse or neglect. Almost all of those who are physically abused are abused by the perpetrator of the domestic abuse. There is increasing recognition of the damaging psychological impact that domestic abuse has on children.

Domestic abuse is acknowledged as a primary indicator for children to become subject to Child Protection Plans.

For further information see (Documents that guide practice) Domestic Abuse Policy CP93.

<https://www.cambsdasv.org.uk/website>

[How to Protect Children from Domestic Abuse | NSPCC](#)

### Honour Based Violence (HBV).

This is a violent crime or incident to protect and defend the honour of the family or community. It is often linked to family members or acquaintances who believe someone has brought shame to their family or community by undertaking something that is not keeping with the traditional beliefs and values of their culture.

HBV might be committed against people who:

- Become involved with a boyfriend or girlfriend from a different culture or religion.
- Become pregnant by a boyfriend from a different culture or religion.
- Want to get away from an arranged or forced marriage.
- Wear clothes or take part in activities that might not be considered traditional within a particular culture.

Honour crimes can occur at any age however many victims are in their late teens and twenties, often around the age of their first marriage.

Further information and support can be found in (Documents that guide practice Violence Against Women and Girls (VAWAG) PS70).

### Forced Marriage.

A Forced Marriage is where one or both individuals' do not (or in cases of people with Learning Disabilities cannot) consent to a marriage and pressure or abuse is used to force a person into the marriage. It is an indefensible practice and is recognised in the United Kingdom as a form of violence against women and men, domestic abuse, child abuse and a serious abuse of human rights. The pressure put on people to marry against their will can be physical (including threats, actual physical violence, and sexual violence) or emotional and psychological (for example, when someone is made to feel like they're bringing shame on their family), financial abuse (taking a person's wages or not giving them any money) can also be a factor.

People trapped in a forced marriage often suffer violence, rape and forced pregnancy. Some are taken and left abroad for extended periods, which isolates them from any help and support. Acts include interrupted education that limits choices, so that often marriage is the only option. If the person manages to find work, however basic, they may not be able to take the job, or their earnings may be stopped. This leads to economic dependence, which makes the possibility of leaving the situation even more difficult. Some may be unable to leave the house unescorted living virtually under *house arrest*.

<https://www.gov.uk/guidance/forced-marriage>

<https://www.safeguardingcambspeterborough.org.uk/children-board/professionals/hba-forcedmarriage/>

Further information and support can be found in (Documents that guide practice) Violence Against Women and Girls (VAWG) PS70).

### Female Genital Mutilation (FGM).

FGM is not an issue that can be decided on by personal preference, it is illegal and a form of child abuse. It has been estimated that approximately 60,000 girls from birth to 14 years have been born to mothers who have undergone FGM.

FGM is practised at any age. Females can be at an increased risk of harm if their mother, sisters, or female members of their family have themselves experienced FGM.

A Mandatory Duty has been passed as part of the Serious Crime Act 2015. Under this duty, if it is discovered that FGM has been carried out on a girl under the age of 18 years (either via disclosure by the victim herself, or by observing physical signs that suggest FGM has been undertaken) the professional MUST report their findings to the police.

Best practice is for reports to be made by the close of the next working day. It is recommended that the report is made verbally by calling 101. Comprehensive records MUST be kept of any discussions held and decisions made.

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/525405/FGM\\_mandatory\\_reporting\\_map\\_A.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/525405/FGM_mandatory_reporting_map_A.pdf)

Where staff believe a child is at risk of FGM, a formal referral to Children's Services must be made and the Children's Safeguarding Team notified.

<https://www.gov.uk/government/collections/female-genital-mutilation>

Further information and support can be found in (Documents that guide practice) Violence Against Women and Girls (VAWAG) PS70).

### Modern Slavery

Slavery is an umbrella term for activities that occur when one person obtains or holds another person in compelled service. 10 Modern slavery is a major issue in the United Kingdom (UK), victims and perpetrators include UK citizens and foreign nationals from a range of countries. People may be trafficked into the UK from abroad or may be trafficked internally between cities, towns, and rural areas. Modern slavery can take place anywhere – including villages and rural areas as well as large towns and cities. It is a crime that is happening in our communities, takeaways, hotels, car washes, nail bars, farms and other agricultural settings, and private homes.

For further information and support can be found in (Documents that guide practice) Exploitation Policy PS69.

## APPENDIX 4: COMMUNITY CONTEXTUAL SAFEGUARDING AND PARTNERSHIP PATHWAY FOR COMMUNITY SAFEGUARDING RISKS

[Community Contextual Safeguarding – Raising concerns about Spaces and Networks | Cambridgeshire and Peterborough Safeguarding Partnership Board \(safeguardingcambspeterborough.org.uk\)](#)



If you have a concern about a Contextual Community Risk make a referral using Form A [Community-contextual-risk-referral-Form-A-1.docx \(live.com\)](#)

Once completed please email the completed form to [Safeguardingboards@cambridgeshire.gov.uk](mailto:Safeguardingboards@cambridgeshire.gov.uk) and notify the Trusts safeguarding team.

Remember that this form is when raising concerns about a place, a peer group, or an adult of interest.

Do not use this form if you have a concern about one individual child.

If your concern is about a particular child, follow current child safeguarding referral pathway.

When you have submitted your referral:

The referral will be triaged identifying

- Emerging,
- Moderate, or
- Significant risk.

The triage process will determine who is responsible for pulling together more information and determining next steps.

Emerging Risk.

| Places  | Peers.  | Persons of Interest (adult)   |
|---|---|---|
| <ul style="list-style-type: none"> <li>Some evidence or concern of potential risk or danger in a location due to environmental hazards, community concerns or safety issues.</li> </ul> | <ul style="list-style-type: none"> <li>Some concerns that there a peer group that is having a negative impact. At this stage the peer group may be unknown</li> </ul> | <ul style="list-style-type: none"> <li>Some concerns that an unknown adult may present a risk to children they are associating with.</li> </ul> |

Moderate Risk – Specific, Corroborated Information.

| <i>Places</i>   | <i>Peers</i>   | <i>Persons of Interest (adult)</i>  |
|---|--|---|
| <ul style="list-style-type: none"> <li><i>Evidence/disclosure suggests that there is a potential of risk or danger at a specific location due to environmental hazards, community concerns or safety issues.</i></li> </ul> | <ul style="list-style-type: none"> <li><i>Some concerns that there is a known peer group which is having a negative impact.</i></li> </ul> | <ul style="list-style-type: none"> <li><i>Some concerns that known adults may be having a negative impact on the wellbeing of children/young people they are associating with.</i></li> </ul> |

Significant Risk – Specific corroborated information which identifies Risk of Significant Harm.

| <b>Places</b>   | <b>Peers</b>   | <b>Persons of Interest (adult)</b>  |
|---|--|---|
| <ul style="list-style-type: none"> <li><i>Evidence / disclosure suggests that there is an immediate and / or continuing risk or danger associated with a known location due to environmental hazards, community concerns, safety issues.</i></li> </ul> | <ul style="list-style-type: none"> <li><i>Evidence of immediate concerns that there is a known peer group having a negative impact and increasing the risk to others and locations.</i></li> </ul> | <ul style="list-style-type: none"> <li><i>Evidence of immediate concerns that a known adult(s) is significantly affecting the wellbeing of children/ young people in the area.</i></li> </ul> |

Tier 2 Context Interventions for example Changing the physical environment, Education Safeguarding Responses, Community Engagement Responses.

## APPENDIX 5: CHILDREN AT INCREASED RISK OF HARM

### Bruising in Pre- Mobile Babies.

A pre mobile baby is described as a baby who is not yet crawling, bottom shuffling, pulling to stand, cruising or walking independently, this will include all babies under the age of six months. Bruising is the most common presenting feature of physical abuse. The younger the child, the higher the risk that the bruising is non-accidental especially if the child is under the age of six months. Bruising in any child that is not independently mobile should prompt the professional to suspect child maltreatment. When assessing babies who are pre mobile, consideration must always be given to 'Shaken Baby' and appropriate investigations undertaken in accordance with RCPCH Child Protection Companion.

Body maps within the Child's Personal Health Record "Red Book" are used to document any injuries noted on a baby at birth.

[Bruising In Pre-Mobile Babies: A Protocol for Assessment, Management and Referral by Professionals | Cambridgeshire and Peterborough Safeguarding Partnership Board \(safeguardingcambspeterborough.org.uk\)](https://www.safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/safeguarding-disabled-children/)

### Children with a Disability.

It is a basic principle that disabled children have the same right as any other child to be protected from harm and abuse. To ensure the welfare of disabled children is safeguarded and promoted, it needs to be recognised that additional action is required. Disabled children have additional needs related to physical, sensory, cognitive and or communication requirements. Many of the problems they face are caused by negative attitudes, prejudice, and unequal access to things necessary for a good quality of life. Disabled children are likely to have poorer outcomes across a range of indicators including low educational attainment, poorer access to health services, poorer health outcomes and more difficult transitions to adulthood. Evidence suggests that disabled children are at an increased risk of neglect and abuse.

Reasons for increased risk:

- Social isolation.
- Their dependency on parents and carers for practical assistance in daily living including intimate personal care.
- Impaired capacity to resist or avoid abuse.
- Communication needs which may make it difficult to tell others what is happening.
- Lack of access to someone they can trust, being able to disclose that they have been abused.

Indicators of neglect or abuse of a disabled child include, but are not restricted to:

- A bruise in a site that might not be of concern on an ambulant child, such as the shin.
- Lack of nutrition, leading to malnourishment.
- Poor toileting arrangements.
- Lack of stimulation.
- Unjustified and/or excessive use of restraint.
- Rough handling, extreme behavior modification e.g. deprivation of liquid, medication, food, or clothing.
- Unwillingness to try to learn a child's means of communication.

<https://www.safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/safeguarding-disabled-children/>

## Looked After Children (LAC)

Looked after children are not only at risk to the same factors that exist for all children living away from home but are particularly susceptible to possible abuse because of their additional dependency on residential and hospital staff for day-to-day physical needs.

## Children transitioning from Children's to Adult Services.

[The Transition of children needs to be considered with regards to any child. Please ensure the Transition Policy is followed. \(SharePoint C1002\).](#)

## Young Carers.

Young carers are children who assume important caring responsibilities for their parents, siblings, or extended family members. Professionals might discover, through a child's attendance or admission to Trust services, that they are acting as a young carer to their parent or sibling.

There are times when family circumstances force children into adult roles and they take on the role of the carer. These might include

- Ill health or disability of one or both parents
- Parental substance misuse.
- Mental health issues.
- Separation or divorce.
- Bereavement.
- Domestic abuse.

The level of responsibility children face, and the severity of the effect can greatly differ. Children may take partial or sole responsibility for many actions such as:

- Domestic chores.
- Preparing meals.
- Caring for siblings.
- Earning money.
- Medical care for parents.

Children often show amazing resilience and ability to cope; often striving to maintain a normal childhood appearance to the outside world. It is important that they feel able to talk to professionals about how they feel. If a child discusses that he or she is acting as a young carer and that no additional services have been provided, then a referral to Children's Social Care must be made; the purpose being that a Social Worker from the local authority must visit to carry out a "young carer's needs assessment" to decide what kind of help they and their family might need.

## Private Fostering.

A Private Fostering Arrangement is one that is made without the involvement of the Local Authority for the care of a child or children under the age of 16 (under 18 if disabled) by someone other than a parent or close relative, with the intention that the arrangement should last for more than 28 days. A person who is a close relative of the child or children, as defined by the Children Act 1989 and 2004, will not be seen as a private foster carer. However, private foster carers may be from the extended family, or they may be a friend of the family or other non-relative.

Following the death of Victoria Climbié in 2000, who was privately fostered by her Great Aunt, the law governing private fostering changed dramatically. Following Victoria's death, legislation was enacted that requires local authorities to be proactive in investigating potential private fostering arrangements.

A private foster carer has a duty to notify the Local Authority that they are caring for a child as the Local Authority has a duty to ensure the welfare of the child.

If a private fostering arrangement comes to the attention of a staff member and they are not satisfied that the child's Local Authority has been notified, it is the responsibility of that staff member to make a referral to Children's Social Care. It must be remembered that a private foster carer does not have parental authority to give consent.

### Children with Mental Health and/or Behavioural Issues.

Children with mental health and/or behavioural issues are not only at risk to the same factors that exist for all children but are particularly susceptible to possible abuse because of their emerging needs and additional dependencies. It is known that over half of all mental health conditions occur before the age of 14 years and because of this they face unequal chances in life.

<https://www.gov.uk/government/consultations/transforming-children-and-young-peoples-mental-health-provision-a-green-paper/quick-read-transforming-children-and-young-peoples-mental-health-provision>

### Perplexing Presentations (PP) Fabricated/Induced Illness (FII).

Fabricated or Induced Illness is a clinical situation in which a child is, or is very likely to be, harmed due to a parent's or parents' behaviour and action, carried out to convince doctors that the child's state of physical and/or mental health or neurodevelopment is impaired (or more impaired than is the case). FII results in emotional and physical abuse and neglect including iatrogenic harm.

Fabricated illness is a relatively rare, but potentially lethal, form of abuse.

Risks include:

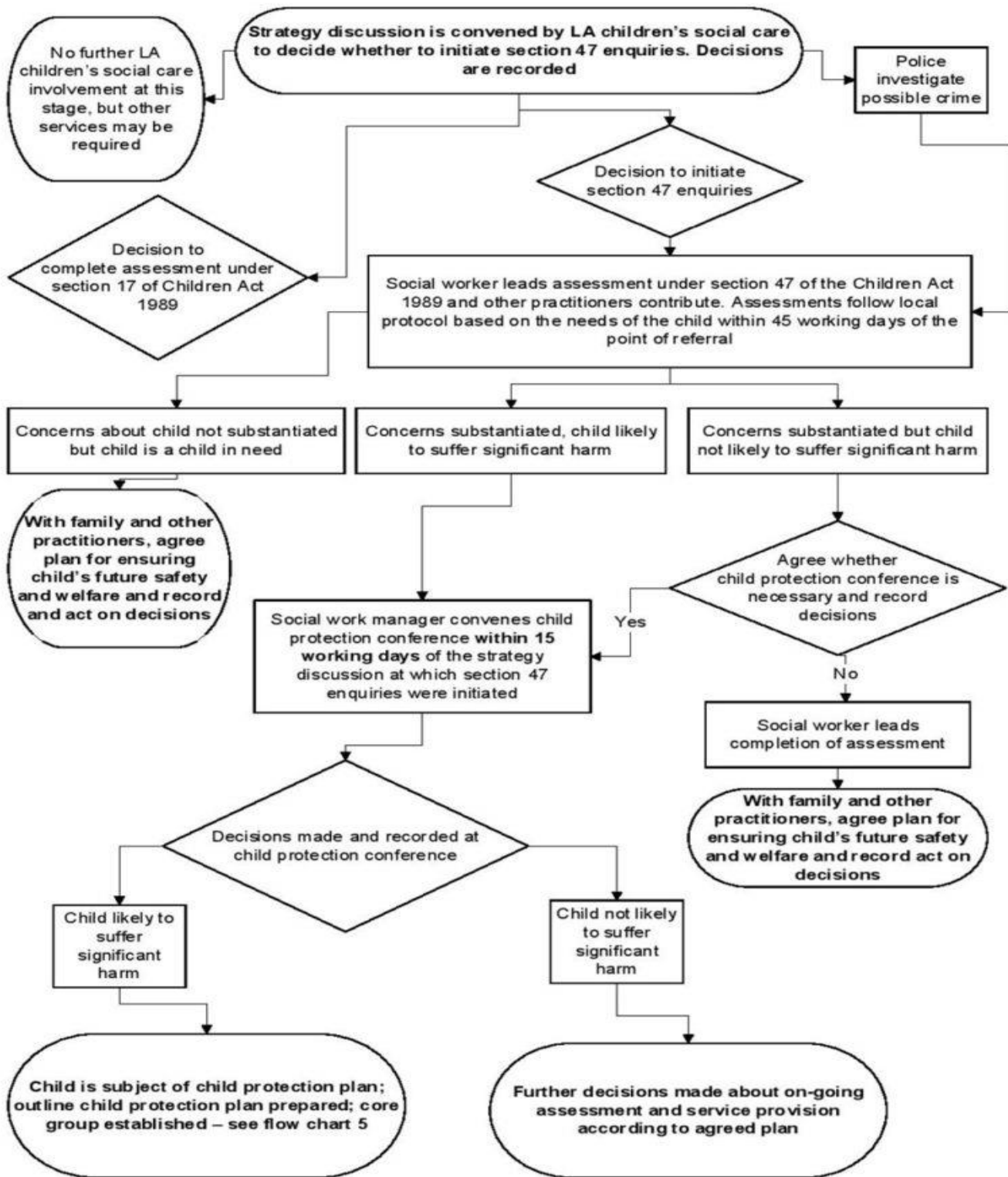
- Fabrication of previous history.
- Fabrication of signs and symptoms including falsification of hospital charts, records, letters, documents, and specimens of bodily fluids.
- Induction of illness by a variety of means.
- There are new symptoms reported when previous symptoms have resolved.
- Signs and symptoms not observed or reported when the carer is absent.
- The child is repeatedly presented with a wide range of symptoms, to differing professionals in a variety of settings.

These methods are not exclusive; harm to a child may be caused through invasive or unnecessary medical treatment, which could be harmful as symptoms were fabricated by the carer. Children who have had an illness induced or fabricated require help from a wide range of agencies. As these cases have many complexities joint working and communication is essential to ensure their safety and well-being.

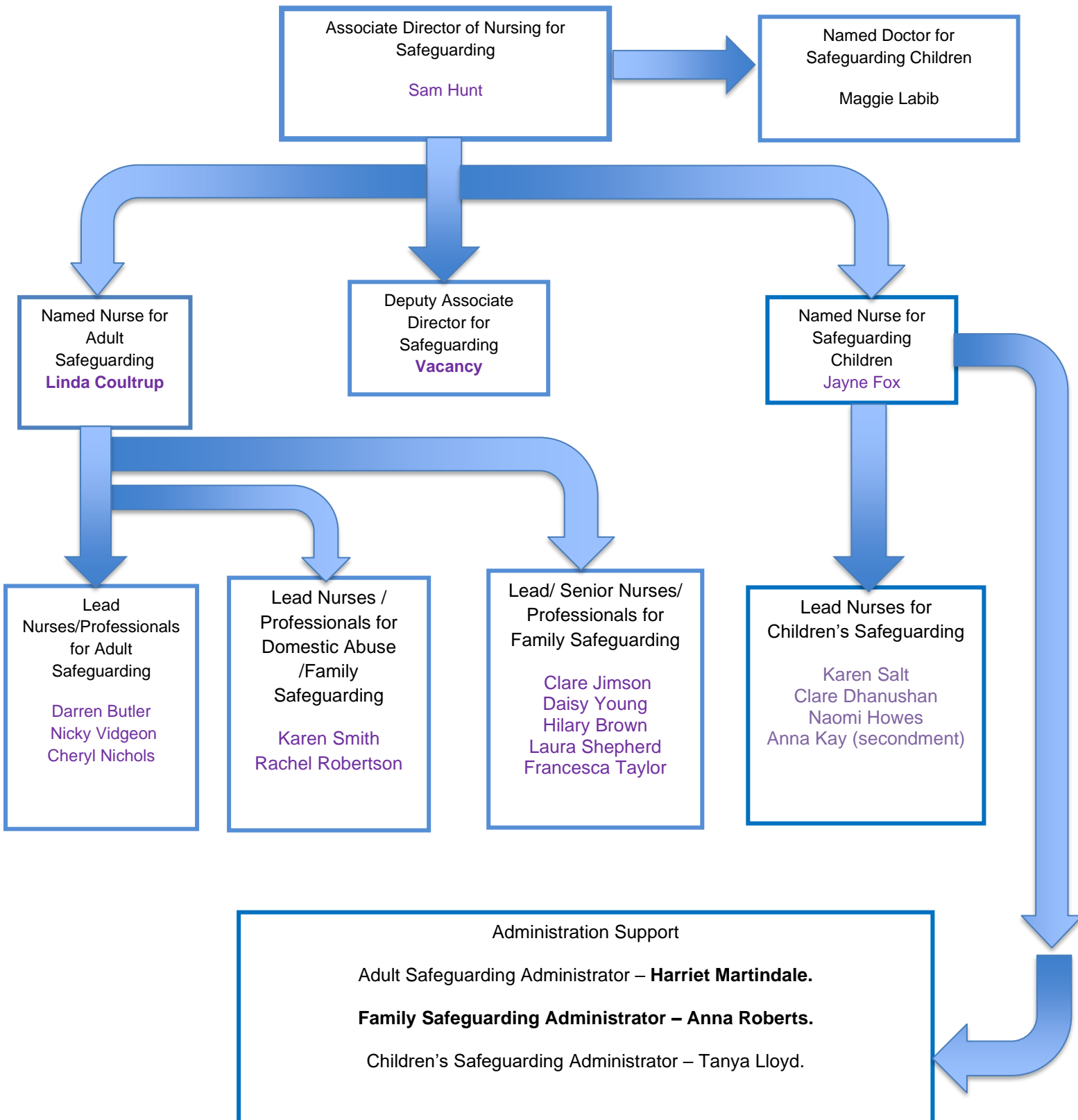
All children, where they may be at risk of fabricated or induced illness, MUST be discussed with the Named Nurse or Named Doctor.

[Perplexing Presentations \(PP\)/Fabricated or Induced Illness \(FII\) in Children Guidance | Cambridgeshire and Peterborough Safeguarding Partnership Board \(safeguardingcambspeterborough.org.uk\)](https://www.safeguardingcambspeterborough.org.uk)

# APPENDIX 6: FLOW CHART STRATEGY DISCUSSION MEETING



# APPENDIX 7: TRUSTS SAFEGUARDING TEAM STRUCTURE



## APPENDIX 8: ASSESSMENT TO BREACH PATIENT CONFIDENTIALITY

### Quick Reference Guide and Risk Balancing Sheet.

This form should be completed every time that a CPFT staff member considers a possible need to breach a service user's confidentiality ideally; the form should be completed and signed before confidentiality is breached. However, there may be circumstances that confidentiality needs to be breached without notice, in which case this form must be completed as soon as possible retrospectively. Once completed, this form must be uploaded onto the patient's electronic clinical record (SystemOne, etc.) and a copy must be emailed to the Trust Information Governance Team: [informationgovernance@cpft.nhs.uk](mailto:informationgovernance@cpft.nhs.uk) who will record the confidentiality breach on the Trust database and report to the Trust's Caldicott Guardian.

|  |  |
|--|--|
| Service User:  |  |
| Date of Birth:   |  |
| Address:   |  |
| SystemOne ID<br>NHS number   |  |
| Information the professional wishes to disclose:   |  |
| To whom does the professional wish for the disclosure to be made to, and will they disclose it to others?                                  |  |
| The purpose / aim of the disclosure  |  |
| Has the Service user been treated fairly?<br>(What information has the Service User been given about how their information is to be used?) |  |
| Date this was discussed with the Service User.   |  |
| If not discussed with the Service User, the reason why   |  |
| Reasons why the Service User does not consent to the disclosure.   |  |
| The urgency of the need for a decision.  |  |

### Risk Balancing Exercise.

There are some decisions that can be automatically disclosed and do not need the balancing exercise. You must disclose information to satisfy a specific statutory requirement, such as notification of a known or suspected case of certain infectious diseases, terrorism or when a child is being subject to significant harm. You must also disclose information if ordered to do so by a judge or presiding officer of a court. However, you should object to the judge or the presiding officer if attempts are made to compel you to disclose what appears to you to be irrelevant information. For all other decisions about disclosing without consent, please complete the balancing exercise below by adding qualitative information into the relevant boxes in the table.

| Disclose.  | Don't disclose.  |
|--|--|
| Yes according to the source.   | The reality of the risk is in question.  |
| The risk is immediate.   | The risk is not immediate.   |
| Yes the risk is serious.   | The risk is not immediate.   |
| The risk is likely to be reduced by disclosure.  | The risk will not necessarily be reduced by disclosure.  |
| Yes there is a risk that a crime has or is about to be committed.  | There is no risk that a crime has or is about to be committed.                                 |
| Yes there is a risk to others.   | The risk is to the individual only.  |
| Yes the disclosure is no greater than what is reasonably necessary to minimise the risk.   | The disclosure is greater than what is reasonably necessary to minimise the risk.              |
| Yes the need to minimise the risk in the public interest outweighs the damage to the patient /public in breaching confidentiality. | The need to protect the patient's confidentiality outweighs the risk to the patient or others. |

To disclose Special Category personal data, at least one criterion from UK GDPR Article 6 (1) AND one safeguarding criterion from UK GDPR Article 9 (2) MUST be present. Tick all that apply.  
 Article 6 (1) is supplemented with DPA 2018 sections 8,15 and Part 1 Schedule 2 of DPA 2018, and Article 9 (2) is supplemented with DPA 2018 section 10 (and Schedule 1) and 11  
 NB Personal data is anything that will identify the person

Special Category personal data is anything concerning their care and treatment.

| Personal Data UK GDPR Article 6 (1) (c) and DPA2018 Section 8 and Sch 2 Part 1 Para 2 The Disclosure is:  |  |
|---|--|
| <ul style="list-style-type: none"> <li>• A Legal obligation. For example (tick the relevant law):</li> <li>• In accordance with a court order (please specify).</li> <li>• Prevention and detection of crime (Crime and Disorder Act 1998 s115).</li> <li>• Prevention / detection or crime and / or apprehension or prosecution of offenders (DPA 2018 Sch 2 Part 1 Para 2) *</li> <li>• Right to be free from torture, of inhuman or degrading treatment (Human Rights Act, Art. 2 &amp; 3)</li> <li>• Child protection (Children's Act 1989; cooperation with Local Safeguarding Children's Board Children's Act 2004).</li> <li>• Obligation to cooperate with MAPPA arrangements (Criminal Justice Act 2003 s.235)</li> <li>• Duty to consult a Nearest Relative (Mental Health Act 1983 s. 11).</li> <li>• Road Traffic Act 1988.</li> <li>• Terrorism Prevention and Investigation Measures Act 2011</li> <li>• Public Health (Control of Disease) Act 1984</li> <li>• Other (please specify)</li> </ul> |  |
| UK GDPR Article 6 (1) (d) To protect the vital interests of the data subject or of another person (immediate threat to life)  |  |
| UK GDPR Article 6 (1) (e) & (DPA Part 2 chapter 2) for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller.  |  |
| <b>Special Category Data UK GDPR Article 9 (2) with DPA2018 Schedule 1 Parts 1-2 for (g) and (h): The Disclosure is:</b>  |  |
| (a) With explicit consent.  |  |
| (c) To protect the vital interests of the person (data subject) or another person, where the data subject is physically or legally incapable of giving consent (immediate threat to life situation)   |  |
| (g) Processing is necessary for reasons of substantial public interest, on the basis of union or member state law which shall be proportionate to the aim pursued, respect the essence of the right to data protection and provide for suitable and specific measures to safeguard the fundamental rights and interests of the data subject.  |  |
| (h) The processing is necessary for medical purposes and is undertaken by a health professional, or a person with an equivalent duty of confidentiality.  |  |
| <b>If there is an immediate risk to life of the person or others, disclosure will be in the public interest, even in the absence of consent.</b>  |  |

### Outcome

|  |  |
|--|--|
| Outcome of decision to disclose or not disclose. |  |
| Service user notified on (date).                 |  |
| Service user not notified because.:              |  |
| Date the information was shared.                 |  |
| Agency and named person informed.                |  |
| Method of contact.                               |  |
| Legal authority for each agency.                 |  |

### Persons involved and Signatures.

|  |  |
|--|--|
| Name of practitioner making assessment.  |  |
| Signature.                               |  |
| Date.                                    |  |
| Managers name.                           |  |
| Date discussed & agreed by line manager. |  |
| Signature.                               |  |
| Date.                                    |  |

Information Sharing Quick Reference Guide.

|  | Consent.   | Information which can be shared.  | Legal basis for sharing information.  |
|--|--|---|---|
| Service User with capacity.                          | Service user gives consent.  | Any information can be disclosed for which consent is given.  | Service user consent - UK GDPR A 6 1(a) & 9 2(a)  |
| Service user lacks relevant capacity.                | Service user unable to give informed consent.  | Can share relevant information in line with Mental Capacity Act– requires capacity assessment and best interest’s decision.             | UK GDPR UK GDPR A 6 1(e) A 9 2 (c) & Schedule 1 Part 2 DPA 2018<br>DPA 2018, Schedule 2 Part 1 Human Rights Act 1998 (HRA) 1998 Art. 2 & 3. 2) Mental Capacity Act.                                 |
| Service User with capacity.                          | Consent not obtained but not refused (e.g. physically unable to contact ex-service user or inability to seek consent due to time constraints). | Necessary, proportionate, and relevant information shared, in an emergency situation only where it is not reasonable to obtain consent. | UK GDPR A 6 1(e) UK GDPR A 9 2 (c) & Schedule 1 Part 2 DPA 2018<br>DPA2018 Schedule 2 Part 1 Perhaps Human Rights Act 1998 Art. 2 & 3.  |
| Service User with capacity.                          | Service user refuses consent. Risk to service user only and harm is not serious.   | No information can be shared.   | None.   |
| Service User with capacity.                          | Service user refuses consent. Risk to service user only and harm is serious (e.g. risk of murder, rape, manslaughter).                         | Necessary proportionate and relevant information.   | UK GDPR A 6 1(e) & A 9 2 (g) & Schedule 1 Part 2 DPA 2018.<br>DPA2018 Schedule 2 Part 1 Public interest in safeguarding outweighs duty of confidentiality Perhaps Human Rights Act 1998 Art. 2 & 3. |
| Service User with capacity.                          | Service User refuses consent. Risk to other adults or significant harm to children.  | Necessary proportionate and relevant information.   | UK GDPR A 6 1(e) & A 9 2 (g) & Schedule 1 Part 2 DPA 2018.<br>DPA2018 Schedule 2 Part 1 Perhaps Human Rights Act 1998 Art. 2 & 3. -Children’s Act 1989.   |
| Service User who is alleged to have committed abuse. | Consent not sought (due to risk to others).  | Necessary proportionate and relevant information about risk to others.  | UK GDPR A 6 1(e) A 9 2 (g) & Schedule 1 Part 2 DPA 2018.<br>DPA 2018 Schedule 2 Part 1 Perhaps Human Rights Act 1998 Art. 2 & 3. Criminal Justice Act 2003 Schedule 2 35.                           |
| Service User who is alleged to have                  | Consent either not sought or withheld.   | Necessary, proportionate, and relevant information on   | UK GDPR A 6 1(e) A 9 2 (g) & Schedule 1 Part 2 DPA 2018.  |

|  |  |   |   |
|--|--|---|---|
| Committed significant harm against children.       |  | significant harm to children, unless this would be unreasonable in all the circumstances of the case.   | DPA 2018 Schedule 2 Part 1 Possibly Human Rights Act 1998 Art. 2.<br>Criminal Justice Act 2003 s.235.<br>Children's Act 1989.                                   |
| Former service user.                               | Unable to obtain consent within timescale. | Limited information – was the person known to Cambridge & Peterborough Foundation Trust.  | UK GDPR A 6 1(e) A 9 2 (g) & Schedule 1 Part 2 DPA 2018<br>DPA 2018 Schedule 2 Part 1 Possibly Human Rights Act 1998 Art. 2.<br>Criminal Justice Act 2003 s.235 |
| Service user at risk of exploitation by terrorists | Consent either not sought or withheld      | Necessary, proportionate, and relevant information on risk of harm to patient and others.   | UK GDPR A 6 1(e) A 9 2 (g) & Schedule 1 Part 2 DPA 2018.<br>Prevention of Terrorism Act 2000 19<br>DPA 2018 Schedule 2 Part 1                                   |
| A dead service user.                               | Consent not possible.                      | When disclosure is required by law when a person has a right of access to records under the Access to Health Records Act 1990 (Executor of the will/Proof of Claim) and the service user had not stated that it should not be shared. All requests for sharing information must be passed to the Trust's Access to Records Department for processing. | DPA 2018 Schedule 2 Part 1 (5)<br><br>Access to Records Act 1990 section (3)(1)(f)  |

\*DPA 2018 Schedule 2 Part 1 (2) has replaced the DPA 1998 S29 exemption.

## APPENDIX 9: LOCAL CHILDRENS SOCIAL CARE CONTACTS

|  |   |  |
|--|---|--|
| Designated Nurse for Safeguarding.                               | Cambridgeshire ICB  | 07534227560                                  |
| Police Family unit.  | Cambridgeshire Police   | 01733 868425                                 |
| Coroner – in hours.<br>Contact out of hours.                     | Coroner's office<br>Via Thorpe Wood Police Station  | 01733 351010<br>0345 4564564                 |
| Local Authority Designated Officer (LADO)<br>LADO Trust contact. | Local Safeguarding Childrens Board.<br>Sam Hunt   | 01733 864038                                 |
| Peterborough.  | <a href="http://safeguardingcambspeterborough.org.uk">Professionals – Making a Referral   Cambridgeshire and Peterborough Safeguarding Partnership Board (safeguardingcambspeterborough.org.uk)</a><br><br>MASH General Enquiries -<br>Professional Consultation Line<br>Emergency Duty Team Out of hours | 01733 864170<br>01733 864180<br>01733 234724 |
| Cambridgeshire.  | <a href="http://safeguardingcambspeterborough.org.uk">Professionals – Making a Referral   Cambridgeshire and Peterborough Safeguarding Partnership Board (safeguardingcambspeterborough.org.uk)</a><br>Telephone<br>Out of Hours Duty Team  | 03450455203<br>01733 234724                  |
| Leicestershire.  | First Response Childrens Duty Team<br>24-hour phone line.   | 0116 3050005                                 |
| Lincolnshire.  | Office hours Mon – Fri 8am – 6pm<br>Outside office hours.   | 01522 782111<br>01522 782333                 |
| Northamptonshire.  | MASH<br><a href="http://northamptonshirescb.org.uk">How to make an online MASH referral - Northamptonshire Safeguarding Children Board (northamptonshirescb.org.uk)</a><br>Outside office hours.  | 03001267000<br><br>01604 626938              |
| Norfolk.   | Contact Number.   | 03448008020                                  |
| Rutland.   | Office hours<br>Outside office hours.   | 01572 758407<br>01163050005                  |



**Nude image of you online?  
We can help take it down.**

For a child, having a sexual image or video of themselves shared online can be an extremely distressing situation. This can also be difficult for parents and carers too, but there are ways which can help these children. If they're under 18, they can use Report Remove.

Report Remove is a tool that allows children to report an image or video shared online, to see if it's possible to get it taken down. This service is provided by Childline and The Internet Watch Foundation (IWF), it keeps the young person informed at each stage of their report and provides further support where necessary.

The Internet Watch Foundation (IWF) is a UK charity and is there to help remove sexual images and videos of under 18s posted online.

### How Does Report Remove Work.

To use Report Remove, children just need to follow three steps:

1. Follow the instructions to confirm their age. If they are 13 or older, they can choose to prove their age using an age verification service called Yoti, although this is optional. Children will need ID if they choose to do this.
2. Log in or create a Childline account, this is to enable the receipt of updates on their report.
3. Report and Remove share the image or video securely with The Internet Watch Foundation, where a specialist analyst will review it and work to have it removed if it breaks the law. They will give it a digital fingerprint to help spot the image or video across the internet and take it down.

To make a report that is easy, safe, and free use [Report Remove | Childline](#)

## APPENDIX 11: EQUALITY AND DIVERSITY IMPACT ASSESSMENT

An Equality and Diversity Impact Assessment has been completed to assess the potential impact this policy might have upon protected groups or how it is likely to influence the Trust's ability to comply with the Public Sector Equality Duty.

The author of this document has considered any potential impacts. There are *no* specific adverse impacts for people with protected characteristics identified.

If you require this policy in a different format (e.g. larger print, Braille, different language or audio) please contact the Corporate Governance Team ([corporateoffice@cpft.nhs.uk](mailto:corporateoffice@cpft.nhs.uk)).

|  |   |
|--|---|
| <b>Who will be affected by the content of this document?</b> (e.g. staff, patients, service users etc.)  | All Trust Staff, Service Users and Visitors   |
| <b>What are the desired outcomes of this document?</b>   | Trust staff are aware of their accountability to initiate safeguarding and/or child protection procedures where staff have identified a child that has been subject to, or is at risk of, significant harm. Trust staff have sought specialist support and advice and have acted appropriately on these matters. Children are kept safe by Trust staff. |
| <b>What does this policy, function, process link to in terms of wider business plans and objectives?</b> | Keeping children safe from harm addresses the wider agenda of children's health and wellbeing and will help protect the Trusts reputation and avoid media interest.   |

|  |
|--|
| <b>Evidence Considered:</b>  |
| <p>HM Government (DCSF 2023) Working Together to Safeguard Children: A guide to interagency working to safeguard and promote the welfare of children, London, HM Government. Department of Health (DoH 1989/2004) Children Act.</p> <p>Cambridgeshire and Peterborough Safeguarding Partnership Board Procedures.</p> <p>Information Sharing. Advice or practitioners providing safeguarding services to children, young people, parents and carers (HM Gov July 2018).</p> <p>Childrens Social care National Framework. A government consultation on principles for practice, expected outcomes and indicators: statutory guidance. Department of Education (2023).</p> |

**When assessing potential impacts of this document on equality groups, the following has been demonstrated, in accordance with General Duty of the Equality Act 2010:**

*(Please tick the appropriate boxes)*

|   |  |                               |                                   |                                  |
|---|--|-------------------------------|-----------------------------------|----------------------------------|
| <b>Age</b><br><i>Consider age ranges on old and younger people. This can include safeguarding, consent and child welfare.</i> | <input checked="" type="checkbox"/> Positive | <input type="checkbox"/> None | <input type="checkbox"/> Negative | <input type="checkbox"/> Comment |
| <b>Armed Forces Community</b>   | <input checked="" type="checkbox"/> Positive | <input type="checkbox"/> None | <input type="checkbox"/> Negative | <input type="checkbox"/> Comment |
| <b>Disability</b><br><i>Consider any attitudinal, physical and social barriers.</i>   | <input checked="" type="checkbox"/> Positive | <input type="checkbox"/> None | <input type="checkbox"/> Negative | <input type="checkbox"/> Comment |

|   |  |                               |                                   |                                  |
|---|--|-------------------------------|-----------------------------------|----------------------------------|
| <b>Carers</b><br><i>Consider part-time working, shift-patterns, general caring responsibilities.</i>  | <input checked="" type="checkbox"/> Positive | <input type="checkbox"/> None | <input type="checkbox"/> Negative | <input type="checkbox"/> Comment |
| <b>Gender Identify or Reassignment</b><br><i>Consider transgender and transsexual people. This can include issues such as privacy of data and harassment.</i>   | <input checked="" type="checkbox"/> Positive | <input type="checkbox"/> None | <input type="checkbox"/> Negative | <input type="checkbox"/> Comment |
| <b>Marriage and Civil Partnership</b>   | <input checked="" type="checkbox"/> Positive | <input type="checkbox"/> None | <input type="checkbox"/> Negative | <input type="checkbox"/> Comment |
| <b>Pregnancy and Maternity</b><br><i>Consider working arrangements, part-time working, infant caring responsibilities.</i>  | <input checked="" type="checkbox"/> Positive | <input type="checkbox"/> None | <input type="checkbox"/> Negative | <input type="checkbox"/> Comment |
| <b>Race</b><br><i>Consider difference ethnic groups, nationalities, Roma gypsies, Irish travellers, language barriers.</i>  | <input checked="" type="checkbox"/> Positive | <input type="checkbox"/> None | <input type="checkbox"/> Negative | <input type="checkbox"/> Comment |
| <b>Religion or Belief</b><br><i>Consider people with different religions, beliefs or no belief</i>  | <input checked="" type="checkbox"/> Positive | <input type="checkbox"/> None | <input type="checkbox"/> Negative | <input type="checkbox"/> Comment |
| <b>Sex (Gender)</b><br><i>Consider men and women (potential to link to carers below).</i>   | <input checked="" type="checkbox"/> Positive | <input type="checkbox"/> None | <input type="checkbox"/> Negative | <input type="checkbox"/> Comment |
| <b>Sexual Orientation</b><br><i>Consider heterosexual people as well as lesbian, gay and bi-sexual people.</i>  | <input checked="" type="checkbox"/> Positive | <input type="checkbox"/> None | <input type="checkbox"/> Negative | <input type="checkbox"/> Comment |
| <b>Other</b><br><i>Consider and include the source of any evidence on different socio-economic groups, area inequality, income, resident status (migrants) and other groups experiencing disadvantage and barriers to access.</i> | <input checked="" type="checkbox"/> Positive | <input type="checkbox"/> None | <input type="checkbox"/> Negative | <input type="checkbox"/> Comment |

### Engagement and involvement

Have you consulted or engaged stakeholders in testing and/or gathering evidence to support the content of this policy?

N/A

### Action Planning for Improvement:

|                                    | Action/s required to address gap: | Target Date | Executive Lead |
|------------------------------------|-----------------------------------|-------------|----------------|
| Gaps and Challenges                | None.                             |             |                |
| Monitoring, evaluating & reviewing | With Policy updates.              |             |                |

| Agreement by:  | Signature:  | Date:      |
|--|---|------------|
| Equality, Diversity and Inclusion Lead (if required) | Sue Rampal<br>Equality And Diversity Lead                     | 03/12/2024 |
| Chair of Approving Executive Led Group (Level 2)     |   |            |
| Document Author                                      | Sam Hunt Associate<br>Director of Nursing for<br>Safeguarding | 21/11/2024 |

## Appendix 12: Equality Impact Assessment

|  |  |
|--|--|
| <b>Name of Proposal - policy, strategy, function, service being assessed:</b>                                | Children's safeguarding Policy and SOP   |
| <b>Is this a new or existing policy, practice or change to a service?</b>                                    | <i>Existing policy reviewed</i>  |
| <b>Directorate, Department / Service:</b>  | Safeguarding and Governance, Corporate   |
| <b>Details of the person completing this impact assessment form. Name, Job Title, Telephone / Extension:</b> | Sam Hunt, Associate Director of Nursing for Safeguarding. Telephone Via Teams please |
| <b>Those involved in the assessment:</b>   | As above   |
| <b>Date:</b>   | 20/11/2024   |

|  |  |
|--|--|
| <b>What are the intended outcomes of this work)?</b> (Include outline of objectives and function aims)   | To allow the introduction of an updated policy to support staff and patients and family/carers |
| <b>Who will be affected?</b> (e.g. staff, patients, service users etc.)                                  | staff and patients, family/carers  |
| <b>What are the desired outcomes?</b>  | To support staff when dealing with situations, provide them with knowledge and resources.      |
| <b>What does this policy, function, process link to in terms of wider Business plans and objectives?</b> | This policy forms part of the Safeguarding agenda.   |

### Evidence considered

**When looking at the impact on the equality groups, you must consider the following points in accordance with General Duty of the Equality Act 2010:**

In summary, those subject to the Equality Duty must have due regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation;
- advance equality of opportunity between different groups; and
- foster good relations between different groups

Consider how your assessment has been able to demonstrate Positive Impact, Negative / Adverse Impact or Neutral Impact?

|   |
|---|
| <p><b>What evidence have you considered?</b><br/> <i>List the main sources of data, research and other sources of evidence This can include national research, surveys, reports, research interviews, focus groups, pilot activity evaluations etc.</i></p> |
| <p><b>Disability</b> Neutral Impact</p>   |
| <p><b>Sex</b> Neutral Impact</p>  |
| <p><b>Race</b> Neutral Impact</p>   |
| <p><b>Age</b> Neutral Impact</p>  |
| <p><b>Gender reassignment (including transgender)</b> Neutral Impact</p>  |
| <p><b>Sexual orientation</b> Neutral Impact</p>   |
| <p><b>Religion or belief</b> Neutral Impact</p>   |
| <p><b>Pregnancy and maternity</b> Neutral Impact</p>  |
| <p><b>Carers</b> Neutral Impact</p>   |
| <p><b>Other identified groups</b> Neutral Impact.</p>   |

**Engagement and involvement**

|  |
|--|
| <p>Have you consulted on the proposal?<br/>         If so with whom? Safeguarding Committee Members</p>                      |
| <p>How have you engaged stakeholders in gathering evidence or testing the evidence available?<br/>         No</p>            |
| <p>For each engagement activity, please state who was involved, how and when they were engaged, and the key outputs: N/A</p> |

**Action planning for improvement:**

|   |
|---|
| <p>Outline key actions based on any gaps, challenges, and opportunities you have identified and will be addressed through consultation or further research.</p> |
|---|

| <b>Category</b>                               | <b>Actions required to address gaps and issue/s</b> | <b>Target date</b> | <b>Person responsible and their division</b> |
|---|---|--------------------|--|
| <b>Gaps and Challenges</b>                    | None  |                    |  |
| <b>Monitoring, evaluating &amp; reviewing</b> | With Policy updates                                 |                    | Sam Hunt                                     |

|                               |   |                            |
|-------------------------------|---|----------------------------|
| <b>Signed off by EDI Team</b> | <b>Name:</b><br>Sue Rampal<br>Equality and Diversity Lead | <b>Date:</b><br>03/12/2024 |
|-------------------------------|---|----------------------------|

**Completed form should be sent to:**

[EDI@cpft.nhs.uk](mailto:EDI@cpft.nhs.uk)

Sue Rampal - Equality and Diversity Lead