Doncaster and Bassetlaw
Teaching Hospitals
NHS Foundation Trust

Safeguarding Children Policy

This procedural document supersedes: PAT/PS 10 v.9 Safeguarding Children Policy

Did you print this document yourself?

The Trust discourages the retention of hard copies of policies and can only guarantee that the policy on the Trust website is the most up-to-date version. **If, for exceptional reasons, you need to print a policy off, <u>it is only valid for 24 hours.</u>**

Executive Sponsor(s):	Karen Jessop Chief Nurse
Author/reviewer: (this version)	Vicki Baker - Named Nurse for Safeguarding Children
Date written/revised:	February 2025
Approved by:	DBTH Strategic Safeguarding Committee
Date of approval:	February 2025
Date issued:	March 2025
Next review date:	February 2028
Target audience:	Trust Wide

Amendment Form

Please record brief details of the changes made alongside the next version number. If the procedural document has been reviewed **without change**, this information will still need to be recorded although the version number will remain the same.

Version	Date Issued	Brief Summary of Changes	Author
Version 10	January 2025	Updated with new Statutory Guidance. Includes broader range of topics. Updated team structure. New links to Policy, Procedures and relevant online content.	Vicki Baker Named Nurse Safeguarding Children
Version 9	16 March 2020	Updated with new Government legislation. Contextual Safeguarding. Links to local safeguarding children partnership policies and documents.	Elizabeth Boyle, Named Nurse & Safeguarding Team Manager
Version 8	7 November 2019	Page 15: Fax numbers deleted and email addresses updated	
Version 7	3 March 2017	Updated contact details for Nottinghamshire FII Guidelines New report template (Doncaster) Updated team structure New CSE Definition	Elizabeth Boyle, Named Nurse & Safeguarding Team Manager
Version 6	22 February 2016	Policy format changed and re-written. Includes a broader range of topics and guidelines to ensure a user friendly approach. Note change in title.	Elizabeth Boyle, Named Nurse & Safeguarding Team Manager
Version 5	24 April 2014	**7** Changes to the definition of safeguarding children, which reflect new "Working Together" Statutory Guidance (HM Gov 2013). **3.1** changes regarding leadership roles, assurances and contact details **3.2** changes made to management responsibilities as reflected within the new "Working Together Guidance" (HM Gov 2013) and in line Trust requirements. **3.3** Changes made to individual staff responsibilities regarding access to safeguarding procedures. Child protection checklist- replaced by Child Protection prompt list for use within Children's Service CSU.	Gill Genders, Named Nurse

		Additionally, changes also relate to information sharing, use of interpreters and individual responsibilities. There is particular reference to individual responsibility with regard to any safeguarding concerns about the behaviours of volunteers and visiting celebrities. **4.5** Changed contact details for LADOs in both Doncaster and Nottinghamshire. **6** Changes made with regard to monitoring compliance with this policy **9** Information added to the policy re- associated Trust procedural documents.	

Contents

Page No.

1 INTRODUCTION 6

2 PURPOSE 7

3 DUTIES AND RESPONSIBILITIES 7

3.1 Safeguarding Assurances 8

3.2 Safeguarding Children when dealing with complaints 9

4 GUIDANCE 9

4.1 Information Gathering and Professional Curiosity 9

4.2 Recognising Abuse 10

4.3 Types of Abuse 10

4.4 Child's Voice and Lived Experience 12

4.5 Think Family 12

4.6 Parental / Carer Factors 13

4.7 Young Carers 13

4.8 Private Fostering Arrangements 14

4.9 Looked After Children / Child in Care 15

4.10 Children that have been in hospital for 90 days or more 15

4.11 Children in Adult Areas 16

4.12 Contextual Safeguarding 16

4.13 Child Exploitation 17

4.14 Child Missing 18

4.15 Domestic Abuse 19

4.16 MAPPA (Multi-Agency Public Protection Arrangements) 20

4.17 Female Genital Mutilation (FGM) 20

4.18 Culture, Religion and Harmful Practices 21

4.19 Children that are not brought to health appointments / Was Not Brought 21

4.20 Perplexing Presentation and Fabricated Induced Illness (FII) 22

4.21 Safeguarding risks to the unborn child 23

4.22 ICON Programme 24

4.23 Capacity and Consent 24

4.24 Death of a Child or Young Person 25

4.21 Sharing Information 26

5 PROCEDURE 28

5.1 Local Arrangements and Safeguarding Partnership Procedures 28

5.2 Early Help 28

5.3 Child at risk of harm 30

5.4 Making a referral to Children's Social Care 31

5.5 Injuries in non-mobile babies and children 33

5.7 Professional Challenge / Escalation and Resolution 36

5.8 Procedures for Managing Allegations against People who Work with Children 36

5.9 Allegations of non-recent abuse 37

5.10 Notifiable serious incidents 38

5.11 Volunteers and Visiting Celebrities 39

5.12 Safe Recruitment 39

6 TRAINING & EDUCATION 39

7 SUPERVISION AND SUPPORT 40

8 MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT 41

8.1 Evaluating Practice 41

9 DEFINITIONS 42

10 EQUALITY IMPACT ASSESSMENT 47

11 ASSOCIATED TRUST PROCEDURAL DOCUMENTS 47

12 DATA PROTECTION 48

13 REFERENCES 48

APPENDIX 1 - LINE OF ACCOUNTABILITY / ESCALATION 50

APPENDIX 2 – PROFESSIONAL CURIOSITY 51

APPENDIX 3 – ASSESSMENT TOOLS AND RESOURCES 52

APPENDIX 4 – DONCASTER DOMESTIC ABUSE REFERRAL FLOWCHART 54

APPENDIX 5 – NOTTINGHAMSHIRE DOMESTIC ABUSE REFERRAL FLOWCHART 56

APPENDIX 6 – SAFEGUARDING MEETINGS 57

APPENDIX 7 – GOLDEN RULES FOR INFORMATION SHARING 58

APPENDIX 8 – TRAUMA INFORMED PRACTISE 59

APPENDIX 9 -- EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING 60

1 INTRODUCTION

Everyone who comes into contact with children and families have a role to play to keep them safe, safeguarding children is everyone's responsibility.

Doncaster and Bassetlaw Teaching Hospitals (DBTH) has a statutory duty under Section 11 of the Children Act 2004 to ensure we consider the need to safeguard and promote the welfare of children when carrying out our role and functions.

This policy has been developed with acknowledgement to the Safeguarding Accountability and Assurance Framework (SAAF, NHS England 2024). This framework provides NHS care settings with an outline of expected Trust safeguarding arrangements, within the context of wider roles and responsibilities across the whole health system.

DBTH commit to the principles set out in Working Together to Safeguard Children (2023) and The Children's Act (2004):

- Protecting children from maltreatment
- Preventing impairment of children's health or development
- Ensuring that children grow up in circumstances consistent with the provision of safe and effective care
- Taking action to enable all children to have the best outcomes.

In England, a child is defined as anyone who has not yet reached their 18th birthday. Child protection guidance points out that even if a child has reached 16 years of age and is:

- living independently
- in further education
- a member of the armed forces
- in hospital; or
- in custody in the secure estate

They are still legally children and should be given the same protection and entitlements as any other child (Department for Education, 2023).

Working with children is complex, and all colleagues should be aware of boundaries between themselves as adults, and the children they come into contact with in a professional manner.

2 PURPOSE

The purpose of this policy is to ensure all DBTH colleagues have a point of reference and clear guidance in respect of their responsibilities in safeguarding children. It provides relevant information and processes for managing risks associated with safeguarding children and child protection within the Doncaster and Bassetlaw Teaching Hospitals NHS Trust (DBTH). This policy supports DBTH employees and volunteers to be aware of their duty to recognise and respond to safeguarding children by following local policy and procedures. This policy should be viewed in conjunction with:

- Working Together to Safeguarding Children 2023
- Children Act 1989
- Children Act 2004
- Doncaster Safeguarding Childrens Partnership Policies and Procedures
- Nottinghamshire Safeguarding Childrens Partnership Procedures
- DBTH Safeguarding Team Page – The Hive

3 DUTIES AND RESPONSIBILITIES

There are clear lines of accountability for safeguarding within DBTH. See appendix 2 for diagrammatic view.

Executive team
The Chief Nurse is the Executive lead for Safeguarding and is supported by the Deputy Chief Nurse to ensure that the importance of safeguarding throughout the organisation is championed and that systems and processes are in place.

Divisional leads
Ensure all people working on behalf of Trust Business in their areas comply with this policy, alongside other Trust safeguarding policies and national and local guidance that have been referenced. Ensure that the appropriate level of safeguarding training is undertaken by all employees within the divisions and in alignment to roles and responsibilities. Should ensure the appropriate level of support is in place and signpost to the Trust Safeguarding team where additional support is identified.

Safeguarding Professionals within the organisation

The Head of Safeguarding, supported by Safeguarding professionals working within the Trust should ensure any updates required to this policy are undertaken timely in line with local and national guidance. Provide support to Trust employees who may need additional guidance to understand and apply the principles of this policy.

All employees of the Trust

Have a duty to follow Trust policy and work in line with additional local and national procedures and guidance that has been outlined in Section 2 of this policy. Escalate to their line manager, other senior manager or member of the Trust safeguarding team any concerns they may have in relation to applying this policy to their practice. Ensure that Safeguarding procedures and processes are followed and safeguarding escalations are undertaken in line with Trust Safeguarding Policies.

3.1 Safeguarding Assurances

The Safeguarding Team within the Trust are required to provide assurances relating to the arrangements in place aimed to safeguard and promote the welfare of children to the following organisations;

The Care Quality Commission is the regulator of health and adult social care services. Their primary role is to make sure that providers have appropriate systems in place to safeguard people who use the service, and that those systems are implemented and followed in practice to ensure good outcomes for people who use the service.

Doncaster Integrated Care Board (ICB) are the lead commissioners for DBTH and the Trust are required to demonstrate compliance with safeguarding contractual obligations in line with Section 11 of the Children Act 2004. Doncaster ICB ensures that Nottinghamshire ICB is informed of the Trust's Safeguarding assurance status and relevant associated issues.

Doncaster and Nottinghamshire Safeguarding Children Partnerships coordinate the Section 11 audit requests, the completion of these provides evidence that as a partner of the Local Safeguarding Children Partnerships, the Trust is committed to safeguarding children and meets the Section 11 Children Act 2004 obligations.

Trust Safeguarding assurances are also provided via the Trust's Strategic Safeguarding Group (SSG) which has an unpinning safeguarding governance structure for the Trust, see appendix (include the governance flow chart).

The Trust's SSG provides leadership and strategic direction for maintaining, developing and implementing safe and reliable safeguarding systems and processes within the Trust, and engages all Divisional areas; representation from both ICBs are included. This group has a forward schedule of business and is the Trust's assurance and approval group for safeguarding matters.

The Trust Safeguarding team provide quarterly and annual reports to evidence further assurance and to ensure the Trust Board members are sighted on safeguarding annual activity. An annual safeguarding work plan and audit schedule is in place and oversighted by the SSG forward planning arrangements.

3.2 Safeguarding Children when dealing with complaints

When applying the Complaint's Policy within the Trust, with respect to either adults or children, colleagues should be aware that safeguarding of patients is an imperative consideration. All colleagues should ensure that where needed, actions are taken to safeguard children and this must not be delayed due to the Trusts complaint's process.

4 GUIDANCE

4.1 Information Gathering and Professional Curiosity

It is essential that practitioners think beyond the individual child when considering safeguarding risks. The Think Family approach underpins core services to children and adults, particularly to those experiencing multiple and complex problems (see section 4.5 for further information about Think Family). Neither adults nor children exist in isolation and 'Think Family' aims to promote the importance of a whole-family approach. Contact with any service offers an open door into a system of joined-up support and coordination between adult and children's services. It is good practice to ask who is in the family and what roles they take on. Names, dates of birth, relationship to child, address and school details (where relevant) should be recorded in the child's records. This includes where a child is a young carer for an adult service user. Family members don't always live together; it is important to consider wider family members / care givers or significant others who may impact on the family. Identification of Parental Responsibility is essential for all children accessing DBTH services. Practitioners must check that the adults who present with children have parental responsibility. Parental responsibility is defined as 'all the rights, duties, powers, responsibilities and authority which by law a parent of a child has in relation to the child and his property' (Children Act 1989).

Children and young people affected by abuse or neglect rarely tell us so directly – they may be frightened or experience feelings of shame or guilt, and often they don't realise that their lives are different to anyone else's. This makes it difficult for professionals to identify children who are experiencing or at risk of abuse – to do so we need to be curious about their lives, observant of their behaviour and to really listen to what they are saying to us.
Professional curiosity is a recurring theme in Child Safeguarding Practice Reviews. Professional curiosity means exploring every possible indicator of abuse or neglect and trying to understand what the life of that child is like on a day to day basis – their routines, thoughts, feelings and relationships with family members. A professional may have the opportunity to identify abuse and neglect even if they come into contact with a family for an unrelated reason. In order to be truly curious about a child's life professionals also need to maintain an attitude of respectful uncertainty. This means applying a critical eye to the

information given by a child’s carers rather than just accepting things on face value. Refer to appendix 3 for more information about professional curiosity.

4.2 Recognising Abuse

Practitioners need to be aware of the different types of abuse and the potential signs and indicators so that they can respond as early as possible. Children may experience abuse and neglect at any age and it may have a profound impact not only on their immediate safety and health but on their long-term development and wellbeing. All DBTH employees will attend statutory safeguarding training to support the identification of abuse. The Trust Safeguarding Training Schedule is underpinned by current policy and legislation and the Intercollegiate Document 2019.

4.3 Types of Abuse

The Children Act 1989 introduced Significant Harm as the threshold that justifies compulsory intervention in family life in the best interests of child. The following are categories of significant harm and abuse; please refer to section 9 for definitions.

- **Physical Abuse** – may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer deliberately fabricates symptoms or induces illness in a child. Please refer to Section 5.5 for guidance on Non-accidental injury in non- mobile babies and children. Body maps are designed to support professionals to accurately record any concerns about possible physical injury / abuse, particularly if it is felt that the injury is non-accidental or thought to be following a pattern. The body map provides a visual record of physical injury / abuse and helps professionals to work together when deciding whether there is a safeguarding concern. Using a body map does not replace medical advice and so a diagnosis of the injury and correct treatment should be sought by a medical professional. The body map is simply a record of what can be seen and what has been said about the injury. Descriptions of a mark / injury should be clearly recorded within the child’s records and should indicate site, size, shape, and colour of the mark / injury. Please refer to the following link on the Hive to access electronic and printable versions of children’s body maps.

- **Emotional Abuse** – the persistent ill-treatment of a child that causes severe and continual adverse effects on the child’s emotional development. Emotional abuse is the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development, and may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person; not giving the child opportunities to express their views, deliberately silencing them or 'making fun' of what they say or how they communicate; imposing age or developmentally inappropriate expectations on children. These may

include interactions that are beyond the child's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction; seeing or hearing the ill-treatment of another e.g. where there is domestic abuse; serious bullying (including cyberbullying); causing children frequently to feel frightened or in danger; exploiting and corrupting children. Some level of emotional abuse is present in all types of abuse or neglect, though it can also exist on its own.

- **Neglect** – the persistent failure to meet a child's basic physical and/or psychological needs, which is likely to result in the serious impairment of the child's health or development. The Graded Care Profile 2 (GCPC2) is an assessment tool that helps practitioners take a strengths-based approach to measuring the quality of care a child is receiving and supports them to identify neglect. The following links provide further guidance and support around the assessment of neglect in Doncaster and Nottinghamshire.

- **Sexual Abuse** – involves forcing or enticing a child to take part in sexual activities whether or not they are aware of what is happening. Sexual abuse can include physical contact or non-contact activities such as involving the child in looking at, or the production of abusive images. Sexual abuse can take place online, and technology can be used to facilitate offline abuse. Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children. In the UK, the age at which young people can legally consent to sexual activity is 16. The Sexual Offences Act 2003 sets out key legislation in relation to sexual offences against children of different ages; those under 13, those under 16 and those under 18. The Children's Sexual Assault Referral Centre (SARC) based at Sheffield Children's Hospital provide a child and adolescent friendly environment for 0-18 year olds from across South Yorkshire and Bassetlaw who have been victims of acute and non-recent sexual assault or rape. The service provides forensic examination by specially trained doctors and are able to make recommendations for ongoing services and support as appropriate. Referral to SARC needs to be made by Children's Social Care or Police. The Centre of expertise on child sexual abuse provides useful practice resources and key messages from research to support practitioners to protect children.

Child abuse can take many forms and may involve the following. Please see hyperlinks to the relevant sections of the policy for additional information and guidance.

- Child Exploitation 4.10 4.11 4.12
- Domestic Abuse 4.13
- Female Genital Mutilation 4.14
- Culture, Religion and Harmful Practices 4.15
- Fabricated Induced Illness 4.17

- Radicalisation
- Modern Slavery
- Honour Based Abuse
- Human Trafficking

4.4 Child's Voice and Lived Experience

Working Together 2023 makes it clear that one of the core principles of effective safeguarding practice is a child centred approach, which aims to understand children's lived experiences and seeks their views about their lives and circumstances (Department for Education, 2023). Children can tell us so much about their experiences which effectively informs our assessments and the identification of appropriate support for them.

'The child's voice' not only refers to what children say directly, but to how they behave and how this could be an expression of their feelings or past trauma experiences. We need to consider what their behaviour could tell us. This means listening to them, observing them and seeing their experiences from the child's point of view; recording this information in the child's record is also vitally important.

Children should have a say when decisions are made which may affect them, practitioners need to understand the lived experience of the child. When practitioners are working with an adult who is a parent or has caring responsibilities for a child colleagues must capture the voice of the child as part of their assessment and keep the lived experience of the child at the fore of their work.

Practitioners must evidence in child's record that the voice of the child and their lived experience has been considered and subsequent action taken as a result of this. Wherever possible colleagues should ensure they are sharing the voice and lived experience of the child with other agencies, as appropriate.

4.5 Think Family

A Think Family approach refers to the steps taken by children's, young people's, maternity and adult's practitioners to identify wider family needs which extend beyond the individual they are supporting. For example, in relation to safeguarding, if you work primarily with adults, you should still consider the safeguarding needs of children, and if you work mostly with children, you should still consider the needs of adults at risk. In both cases, it is important to recognise that it may be necessary to work closely with wider services, to help enable families to overcome the challenges they experience. **Think Family** requires all partner agencies to recognise the strengths and needs, not just of individuals with whom they are working, but also of their families with whom they live and share their lives. It requires staff to recognise the wider challenges that families experience, and to seek to provide support that helps with both the immediate and underlying issues.

Adopting a family focus does not negate the need to providing individual care, but must be considered alongside it. This means thinking about the child, the parent/carer and the family, with adult and children's health and social care services working together to consider the needs of the individual in the context of their relationships and their environment.

All children and adults have equal rights to protection and access to services. Colleagues working at DBTH have a duty to ensure that they fulfil their safeguarding role and responsibilities in a manner that is consistent with the statutory duties of their employer.

4.6 Parental / Carer Factors

It is essential that assessments include consideration of parental /carer factors such as mental health problems; domestic abuse and alcohol and substance misuse / dependency, and the impact on any children that they have any caring responsibility for, as these factors can increase risk and vulnerability. Practitioners must consider:

- Parents / carers
- Stepparents or partners of parents
- Grandparents
- Any service users who have any caring responsibilities for children

Practitioners must document that parental/carer factors have been considered, including the impact of parental/carer mental health; substance misuse / dependency on the child(ren) within the child’s record including the impact of parental/carer mental health. This must include a narrative to evidence the decision made and actions following assessment. The following links provide further guidance and support around assessment of risk in Doncaster and Nottinghamshire.

4.7 Young Carers

A young carer is a person under 18 who provides or intends to provide care for another person (of any age, except generally where that care is provided for payment, pursuant to a contract or as voluntary work). It is important to consider that they may be caring for an adult who isn’t their parent, including a grandparent. Young carers take on caring responsibilities not just occasionally but as part of their everyday lives, often over a long period of time, meaning they also often miss out on opportunities that other children have to play, learn and be young. Many struggle educationally with being able to focus on school whilst overwhelmed by other worries or can be bullied for being ‘different’. They can become isolated, with no relief from the pressures at home, with 1 in 3 young carers saying that caring makes them feel stressed (Barnardo’s 2024).

4.8 Private Fostering Arrangements

A private fostering arrangement is one that is made privately (without the involvement of a local authority) for the care of a child under the age of 16 (under 18, if disabled) by someone other than a parent or close relative with the intention that it should last for 28 days or more. This might be a friend, a great aunt, a cousin or someone else known to the child or young person. A close relative is defined as a grandparent, aunt, uncle, brother or step-parent by marriage. This type of arrangement is completely different to fostering arrangements where children and young people are placed with local authority approved foster carers, or via friends and family (kinship care) foster carers.

There are many reasons why children and young people are privately fostered. Such examples include those listed below (but this is not an exhaustive list):

- parental ill health
- children or young people who are sent to this country for education or health care by birth parents from overseas
- children or young people who are living with a friend/boyfriend/girlfriend's family as a result of parental separation, divorce or arguments at home
- children or young people whose parents work or study long or antisocial hours
- children or young people on school holiday exchanges that last more than 28 days
- children or young people who are on sports or music sponsorships living away from their families

Many professionals who work in education, health, social care or who come into contact with children and families may identify private fostering arrangements. When private fostering arrangements are identified; DBTH colleagues have a duty to:

- Encourage the parent/carer to report the private fostering arrangement to the local authority.
- Provide information about private fostering.
- Report the arrangement if the parent or carer fails to the Local Authority.

For children living in Doncaster; private fostering arrangements should be reported to Doncaster City Council via the following contacts:

Tel: **01302 737789**

Email: fosteringandadoption@doncaster.gov.uk

For more information, refer to DSCP - Working to make our children's lives safer - Doncaster Safeguarding Children Partnership

For Children living in the Bassetlaw Area; private fostering arrangements should be reported to Nottinghamshire Children's Social Care Multi-Agency Safeguarding Hub (MASH) via the following contact:

Tel: **0300 500 80 90**

For more information, refer to Nottinghamshire Safeguarding Children Partnership

4.9 Looked After Children / Child in Care

A child who has been in the care of their local authority for more than 24 hours is known as a looked after child. Looked after children are also often referred to as children in care, a term which many children and young people prefer.

Each UK nation has a slightly different definition of a looked after child and follows its own legislation, policy and guidance. But in general, looked after children are:

- living with foster parents/carers
- living with friends or relatives, through kinship foster care
- living in a residential children's home
- living in residential settings like schools, secure units or semi-independent living accommodation
- in some cases, living with their parents.

Many children in care have experienced abuse, neglect or other forms of trauma. It is important that children in care are provided with the care and support they need to be healthy and safe, have the same opportunities as their peers and move successfully into adulthood (NSPCC 2024).

DBTH have a Named Doctor for Looked After Children who can provide advice and expertise to colleagues requiring additional support. Contact can be made via the Safeguarding Children page on the Hive.

4.10 Children that have been in hospital for 90 days or more

When a child stays or is likely to stay in a healthcare setting for 90 days or more, the appropriate Hospital Trust must inform the Local Authority - Children's Social Care. This is a requirement by law as per the Children Act 1989. Notifications to Children's Social Care should contain the following information:

- Childs name;
- Childs date of birth;
- Child's address immediately prior to admission (or that of mother immediately prior to delivery);
- Date of admission to hospital;

- Ward/Department;
- Name and contact details of parents/carers.

The notifying Hospital Trust must also inform the parents/carers that the information has been disclosed to Children's Social Care.

4.11 Children in Adult Areas

Young people aged 16 and 17 accessing care at DBTH are usually admitted to adult areas, (admission to children's wards is negotiated on an individual basis in consultation with the consultant with clinical responsibility) – refer to PAT/PA 9 Children and Young People Guidance for Care in Hospital). DBTH colleagues must comply with the Trust and Multi- agency Safeguarding Children Procedures where any safeguarding concerns are identified for those young people admitted to adult areas as outlined within this policy.

4.12 Contextual Safeguarding

At Doncaster and Bassetlaw Teaching Hospital (DBTH) we understand that the safety and wellbeing of children and young people are not only influenced by their immediate home environment but also by a range of external factors. Contextual Safeguarding understands that 'children may be vulnerable to abuse or exploitation from outside their families' (Working Together 2023). Children can be influenced by their wider environment including; peer relationships, school pressures, neighbourhood surroundings and/or online. All of these forms of contextual safeguarding can be referred to as extra-familial harms, this helps to understand that families can be doing all they can to safeguard their children but they are at risk from outside influences. Factors such as peer group dynamics, exposure to gangs, or living in high crime areas can increase a child's risk of harm. This can shape a child's behaviours, attitudes and vulnerabilities.

The threats can take a variety of forms and can include; exploitation by criminal gangs, organised crimes groups such as county lines, trafficking, online abuse, sexual exploitation and extremist views that can lead to radicalisation; see section 9 for definitions. Refer to CORP/RISK 25 - Prevent Policy for further guidance and procedure.

DBTH's approach to contextual safeguarding;

- Assessment of contextual risk; safeguarding assessments must look at the full range of risks that a child may face in their environment, ensuring to explore external influences such as peer groups, school or community factors and how these may affect a child's safety and wellbeing
- Early identification and intervention; identifying signs of harm and/or abuse that are arising from external factors early on is key to ensuring the safety and best outcomes for the child. Documenting and escalating any concerns, seeking advice

and support from the safeguarding children's team and ensuring that a children's social care referral is completed.

- Multi-agency collaboration; safeguarding children requires a combined effort from many different professionals and organisations. Ensuring that information is shared with members of the multi-disciplinary team, improves outcome for the child and family.
- Listening to children and families; a core component of contextual safeguarding is ensuring that children's voices are heard and families are actively involved. By having a deeper understanding of a children's life enables us to better support them.

Online Abuse

Online abuse is any type of abuse that happens on the internet. It can happen on any device that connected to the internet like, tablets, laptops and mobile phones and it can happen anywhere on line including:

- Social Networking sites
- Online gaming
- Online chats
- Live streaming sites
- Emails

Children and Young People may experience cyberbullying; emotional abuse; grooming; sexual abuse and exploitation. Online abuse can have a significant impact on children and must be treated as a form of abuse. Please refer to the following links for further guidance and support around assessment of risk in relation to online abuse:

Doncaster Nottinghamshire

4.13 Child Exploitation

Child Exploitation

Child exploitation is when someone uses a child for financial gain, sexual gratification, labour or personal advantage. The Home Office (2022) recognises that 'child exploitation can take a number of different forms and perpetrators may subject children and young people to multiple forms of abuse at the same time, such as criminal exploitation (including county lines) and sexual exploitation'.

Using cruel and violent treatment to force a child to take part in criminal or sexual activities often leads to physical and emotional harm to the child, to the detriment of their physical and mental health, education and social development.

Child Sexual Exploitation **(**CSE) is a form of child sexual abuse, it occurs when an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person into sexual activity in exchange for something the victim needs or wants, or for the financial advantage or increased status of the perpetrator. A victim can still be sexually exploited even if the sexual activity appears consensual. CSE does not always involve physical contact, it can also occur online and through the use of technology (Working Together 2023).

Child Criminal Exploitation (CCE) occurs when an individual or group takes advantage of an imbalance of power to coerce, control, manipulate or deceive a child or young person to commit crimes for them. It can involve bribery, intimidation, violence and/or threats. CCE does not always involve physical contact; it can also occur through the use of technology.

If you suspect a child is being exploited and is in immediate danger please contact the police on 999. If there is no immediate risk, a referral to Children's Social Care should be made as per the referral process outlined in section 5.4

The following links provide further multi-agency guidance around assessment of risk associated with child exploitation.

Doncaster - Child Sexual Exploitation Child Criminal Exploitation Nottinghamshire -

Child Sexual Exploitation Child Criminal Exploitation

4.14 Child Missing

Although the majority of children and young people who go missing return of their own accord, or are found quickly, all children and young people who go missing irrespective of the amount of time that they are missing for, are at risk. Missing children and young people are particularly vulnerable to trafficking, violent crime, drug and alcohol misuse and exploitation, including sexual exploitation. Significant evidence highlights that children and young people who go missing from home or care are at increased risk of being at risk of, or experiencing sexual exploitation and that missing, as either a cause or consequence, is a direct risk indicator of child sexual exploitation. The following links provide further guidance and support about risks associated with missing children:

Department for Education 2014 Doncaster
Nottinghamshire

4.15 Domestic Abuse

Domestic abuse and violence consists of abusive behaviour perpetrated by one person aged 16 and over against another person aged 16 and over with whom they are personally connected, for example, a partner, ex-partner, or family member regardless of gender or sexuality. The abuse can encompass, but is not limited to: psychological, physical, sexual, financial and emotional. It also includes issues which concern women from minority ethnic backgrounds, for example, forced marriage and female genital mutilation. Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from support, exploiting them for personal gain, depriving them of independence and freedom and managing their everyday behaviour. Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim. Prolonged or regular exposure
to domestic abuse can have a serious impact on a child's development and emotional well- being, despite the best efforts of the non-abusing parent to protect the child.
Domestic abuse impacts on children in a number of ways. The impact of domestic abuse is likely to be exacerbated when combined with any form of substance misuse or mental ill health. For children living in situations of domestic abuse, the effects may also result in behavioural issues (including anti-social behaviour), absence from school, difficulties concentrating, lower school achievement, ill health, bullying, substance misuse, self-harm, running away, anti-social behaviour, depression and anxiety and physical injury.

During pregnancy domestic abuse can pose a threat to an unborn child as assaults on pregnant women often involve punches or kicks directed at the abdomen, risking injury to both the mother and the fetus. In almost a third of cases domestic abuse begins or escalates during pregnancy and it is associated with increased rates of miscarriage, premature birth, fetal injury and fetal death. The mother may be prevented from seeking or receiving antenatal care or post-natal care. Please refer to Section 4.21 Sharing Information, for guidance around Third Party Reporting.

Part 1 of the Domestic Abuse Act 2021 outlines that any child that sees, hears, or experiences the effect of the abuse and is related to the victim or perpetrator, is identified as a victim of domestic abuse in their own right. DBTH have two Domestic Abuse Liaison Officers who provide an active front line service for victims of domestic abuse and specialist advice, support and education to the multi-professional team, patients and carers. Contact can be made via the Safeguarding Children Page on the HIVE.

Please refer to PAT/PS 12 Domestic Abuse Policy and resources on the HIVE for additional information and guidance. Refer to appendix 5 and appendix 6 for domestic abuse referral flowcharts for both Doncaster and Nottinghamshire.

The following links provide further multi-agency guidance about the assessment of risk in relation to domestic abuse:
Doncaster Nottinghamshire

4.16 MAPPA (Multi-Agency Public Protection Arrangements)

MAPPA is a process where the Police, Probation and Prison Services work together with other agencies to manage risks posed by offenders living in the community in order to protect the public. There are 3 categories of offenders who are managed by MAPPA:

Category 1: Registered sexual offenders
Category 2: Violent offenders
Category 3: Other dangerous offenders

DBTH colleagues should be aware that in addition to adults, children under the age of 18 can commit offences which may be subject to MAPPA. If DBTH colleagues become aware of any children in their care who are subject to MAPPA, contact must be made with DBTH Safeguarding Team for further support and advice. The following link outlines National Guidance in respect of MAPPA.

4.17 Female Genital Mutilation (FGM)

FGM is defined as a procedure that involves the partial or total removal of the external female genitalia, or other injury to the female genital organs, for non-medical reasons. It is nearly always carried out without consent. Female Genital Mutilation is an offence in the UK under the Female Genital Mutilation Act 2003.A person is guilty of an offence if
s/he excises, infibulates or otherwise mutilates the whole or any part of a girl’s labia majora, labia minora or clitoris. It is an offence for a UK national or permanent UK resident to aid, abet, counsel or procure this procedure for another person. FGM should be
considered as a public health, human rights and an adult and children’s safeguarding issue.
FGM is a complex and sensitive issue that requires professionals to approach the subject carefully.

There is a mandatory reporting duty which requires regulated health and social care professionals (and teachers) in England to report ‘known’ cases of FGM in under 18s which they identify in the course of their professional work. The mandatory reporting process involves contact to the Police via 101 (the non-urgent route), unless there is an imminent risk that requires escalation via 999. Imminent risk would include escalation to prevent the crime from occurring where there is an imminent risk or to prevent a child from being

taken abroad to have the procedure. Where an imminent risk is identified relating to FGM in under 18s, local safeguarding processes (both organisational and multi-agency) should be followed. Refer to PAT/T 64 FGM Policy for further guidance and procedure, in additional to resources that can be found on the Safeguarding Children page via the Hive. The Trust's Safeguarding team can also be contacted for advice by the FGM safeguarding lead and for support to understand how risk can be assessed. Please refer to links below for further guidance and support:
Doncaster Nottinghamshire

4.18 Culture, Religion and Harmful Practices

Parents and families can believe that an evil force has entered a child and is controlling them, the child is likely to suffer significant harm. The belief includes the child being able to use an evil force to harm others. This evil is also known as black magic, kindoki, ndoki, the evil eye, djinns, voodoo and obeah and the children can be referred to as witches and sorcerers. Parents can be initiated into and/or supported in the belief that their child is possessed by an evil spirit by a local community faith leader, indigenous healer or spiritualist.

A child may suffer emotional abuse if they are labelled and treated as being possessed with an evil spirit. In addition, significant harm to a child may occur when an attempt is made to 'exorcise' the evil spirit from the child. Practitioners need to remember that while recognising that child rearing practices are highly diverse and that all differences are to be valued and understood, it is also important that any judgements about the care and protection of children are based on objective assessment of facts. Sensitivity to parental behaviour, culture, religion or ideology must not mean that children from any background receive a lower level of care or protection. Refer to links below for further guidance and support:

Doncaster Child Abuse Linked to Faith or Belief

Nottinghamshire Child Abuse Linked to Faith or Belief

4.19 Children that are not brought to health appointments / Was Not Brought

There are many reasons why children do not attend appointments, however missed appointments for some children and young people may be an indicator that they are at an increased risk of neglect and/or abuse. Local learning has indicated that missed healthcare appointments is a theme that features in many children's safeguarding practice reviews; in view of this, further exploration and professional curiosity should be exercised from a

safeguarding perspective. Disguised compliance or apparent legitimate excuses for children/young people not brought to appointments should not be accepted at face value. Professionals need to be prepared to be curious and explore reasons for non-attendance to establish risk factors and the impact of the missed appointment on the child/young person at risk, in order in inform necessary next steps. Please refer to PAT/T 79 v1 Children, Young People and Adults at Risk who are not brought to Health Care Appointments, for relevant information and processes for responding to risks associated with 'Was Not Brought' within DBTH.

4.20 Perplexing Presentation and Fabricated Induced Illness (FII)

FII is a clinical situation in which a child is, or is very likely to be, harmed due to parent(s)'/Carers behaviour and action, carried out in order to convince doctors that the child's state of physical and/or mental health or neurodevelopment is impaired (or more impaired than is actually the case). FII results in emotional and physical abuse and neglect including iatrogenic harm (Royal College of Paediatrics and Child Health - RCPCH 2021).
Iatrogenic harm refers to that induced by medical examination or treatment.

The RCPCH Child Protection Companion 2013 extended the definition of FII by introducing the term Perplexing Presentations with new suggestions for management. The RCPCH Guidance 2021 provides procedures for safeguarding children who present with perplexing presentations and FII and offers practical advice for practitioners on when and how to recognise it, how to assess risk and how to manage these types of presentations in order to obtain better outcomes for children. DBTH are currently working to develop a standalone policy on FII; until such time, please refer to the following links for relevant information and processes for responding to risks associated with FII. Additionally the DBTH safeguarding team can be contacted for advice and support in how to manage any emerging concerns.

Doncaster

Nottinghamshire

Perplexing Presentations (PP)/Fabricated or Induced Illness (FII) in children – guidance - RCPCH Child Protection Portal

4.21 Safeguarding risks to the unborn child

Young babies are particularly vulnerable to abuse, and work carried out in the antenatal period can help minimise any potential harm if there is early assessment, intervention and support. Unlike many safeguarding situations, the antenatal period gives a window of opportunity for practitioners and families to work together to Identify risks and vulnerabilities at the earliest stage. Safeguarding risks to the unborn child can include (this is not an exhaustive list):

- Concealed pregnancy
- Parental alcohol and substance misuse
- Domestic Abuse
- Parental Mental Health difficulties
- Criminal behaviour
- Social Factors – for example, homelessness
- Parents that have prior adverse childhood experiences

Where risks have been identified, it is important that practitioners do not assume that Midwifery or other Health services are aware of the pregnancy. It is critical that all professionals work together and share information to provide a coordinated response, and appropriate interventions and planning at the earliest opportunity to optimise the outcomes and support for the child and their family. DBTH have a Named Midwife for Safeguarding who can provide specialist advice and expertise to colleagues requiring additional support. Contact can be made via the Safeguarding Children page on the Hive.

The following links provide further guidance about the assessment of risk in relation unborn children: DBTH Guideline for Care of Vulnerable Women in Pregnancy Doncaster Nottinghamshire

4.22 ICON Programme

The ICON programme is a preventative programme, based around helping parents cope with a crying baby and prevent abusive head trauma. The word 'ICON' represents the following message:

I - Infant crying is normal

C – Comforting methods can sometimes soothe the baby O –

It's OK to walk away

N – Never, ever shake a baby

Research points to persistent crying in babies being a potential trigger for some parents/caregivers to lose control and shake a baby. It also shows that around 70% of babies who are shaken are shaken by men (ICON 2024), so any prevention programme should include male caregivers and use the best opportunities to reach them as well as support all parents/caregivers with information about crying and how to cope with a crying baby. DBTH have adopted the ICON approach; practitioners in Maternity and Paediatric colleagues are trained on ICON and how to deliver the programme to parents in the antenatal period, after birth and prior to discharge. Translatable ICON resources are freely available on the ICON website for those families requiring translation services. For further information and guidance, please refer to the following link ICON.

4.23 Capacity and Consent

Patients Lacking Capacity

The Mental Capacity Act 2005, provides a framework to safeguard and empower people over 16 years of age who are unable to make all or some decision themselves.
The Act includes a range of powers and services which must be considered as part of a safeguarding plan where a person lacks capacity. PAT/PA 2 - The Mental Capacity Act Policy offers further guidance and procedure.

Sometimes it will be necessary to provide care and treatment to patients who lack the capacity to make decisions related to the content of this policy. In these instances colleagues must treat the patient in accordance with the Mental Capacity Act 2005 (MCA 2005).

- A person lacking capacity should not be treated in a manner which can be seen as discriminatory.

- Any act done for, or any decision made on behalf of a patient who lacks capacity must be done, or made, in the persons Best Interest.

There is no single definition of Best Interest. Best Interest is *determined on an individual basis. All factors relevant to the decision must be taken into account, family and friends should be consulted, and the decision should be in the Best interest of the individual. Please see S5 of the MCA code of practice for further information.*

Consent

For those children under the age of 16, the Fraser Guidelines and Gillick Competence can be used to assess a child's capacity to consent. Fraser Guidelines apply to advice and treatment relating to contraception and sexual health. Gillick competence is often used in a wider context to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions. Practitioners should always encourage a child to tell their parents or carers about the decisions they are making. If they don't want to do this, you should explore why and, if appropriate, discuss ways you could help them inform their parents or carers.
It is important to record in the child's record if they are assessed as 'Gillick competent' or whether the meet the 'Fraser guidelines' in the context of colleagues evidencing that a child is mature enough to make decision about things that affect them. Please refer to the PAT/PA 2 Consent to Examination or Treatment Policy for further guidance.

There may be occasions where a person under 18 years of age requires Depriving of their Liberties, and needs the appropriate Safeguards from the Court of Protection for these deprivations to be delivered lawfully. Please refer to PAT/PA 2 - The Mental Capacity Act Policy and Code of Practice for further guidance.

4.24 Death of a Child or Young Person

Working Together to Safeguard Children 2023 outlines the process to follow in the event of a child death. Local Safeguarding Partnerships are responsible for ensuring a review of each child death is undertaken. Procedures are in place to ensure a coordinated response which includes multi-agency partners and other relevant agencies/organisations; this inevitably will include hospital colleagues. DBTH Child Death Review Team can be accessed via the switchboard in the event of the death of a child under the age of 18 years. Please refer to the DBTH PAT/T 62 v2 Child Death Review Policy for further guidance and procedure.
Further Child Death review team resources are also available on the Hive.

4.21 Sharing Information

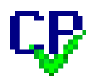
No single practitioner can have a full picture of a child's needs and circumstances so effective sharing of information between practitioners, local organisations and agencies is essential for early identification of need, assessment, and service provision to keep children safe. Rapid reviews and child safeguarding practice reviews have highlighted that missed opportunities to record, understand the significance of, and share information in a timely manner can have severe consequences for children. Fears about sharing information must not be allowed to stand in the way of the need to protect children. To ensure effective safeguarding arrangements, no professional should assume that someone else will pass on information which they think may be critical to keeping a child safe. If a professional has concerns about a child's welfare and believes they are suffering or likely to suffer harm, then they should share the information with local authority children's social care (Working Together 2023). The Caldicott review in 2013 made it clear that **"The duty to share information can be as important as the duty to protect patient confidentiality."** Information sharing advice for practitioners providing safeguarding services for children, young people, parents and carers (Department for Education, 2024), is a good resource to consider. The Trust Safeguarding team can also be contacted for support on advice if colleagues are unsure about sharing information.

CP-IS (Child Protection Information Sharing)

The Child Protection - Information Sharing (CP-IS) service helps health and social care workers share information securely to better protect children and young people who are known to social care because they are either:

- Looked after / Child In Care (CiC)
- Are subject to a Child Protection Plan
- Unborn subject to a Child Protection Plan

CP-IS links IT systems across health and social care in England to help organisations share information securely. As it covers 100% of local authorities in England, it's the only national register of social care status, and the only system to provide information when a child is out of area. CP-IS is mandated via the Information Standards Notice DCB1609: Child Protection - Information Sharing for children / Mothers of unborn children who visit NHS unscheduled care settings such as Emergency Departments (ED) and Minor Injury Units (MIU), Maternity settings and Childrens Assessment Units. At DBTH, this may be a manual check via National Care Records Service National Care Records Service using a Smartcard, or via an automatic alert that appears on an electronic patient record depending on which clinical area the child accesses. CP-IS alerts present within Symphony, the Electronic Patient Record used in ED and MIU will appear as the following icon in the top right hand corner of the record:



CP-IS holds the following information for each registered child or young person:

- NHS number
- Details of their plan - type, start date and end date
- Details of the 25 most recent CP-IS information accesses from approved care settings in England
- Name of the responsible local authority - together with their office hours phone and emergency duty contact numbers

All records in CP-IS are held against the patient's NHS number. It is therefore very important to use the correct NHS number for each patient. When a CP-IS alert is accessed by Health, an automatic notification is generated to the relevant Local Authority to inform them of the Child's attendance.

GDPR

The Data Protection Act 2018 and General Data Protection Regulation (GDPR) do not prohibit the collection and sharing of personal information, but rather provide a framework to ensure that personal information is shared appropriately. The purpose of GDPR is to harmonise data privacy laws across Europe by standardising definitions and addressing legal uncertainty and the public's perception that their data is at risk. GDPR protects an individual's fundamental rights and freedoms, in particular, their 'Right to the Protection of Personal Data'. It's important to remember that the GDPR is not a barrier to sharing information. Sharing information with the right people can be just as important as not disclosing to the wrong person.

Consent

You do not necessarily need consent to share information when there is a safeguarding concern. Wherever possible, you should seek consent and be open and honest with the individual from the outset as to why, what, how and with whom, their information will be shared. You should seek consent where an individual may not expect their information to be passed on. When you gain consent to share information, it must be explicit, and freely given. There may be some circumstances where it is not appropriate to seek consent, because the individual cannot give consent, or it is not reasonable to obtain consent, or because to gain consent would put a child's or young person's safety at risk.

Third Party Reporting

If you have been given information or believe that a crime has been committed, this must be reported to the police. Third parties should report on behalf of the victim with or without consent as safeguarding the victim takes priority over consent. On receiving crime reports, officers will investigate these. Third parties can advise the best route for this to ensure the

victim's safety, however crimes will be investigated as required. Please refer to the Home Office Crime Recording General Rules for further guidance.

Alerts

At DBTH, wherever there is an alert placed on a patient's / child's record, there must also be a robust process for the timely review and removal of the alert. Some examples of safeguarding alerts used at DBTH include, those alerting practitioners to adults and children at risk of Domestic Abuse (MARAC – Multi-Agency Risk Assessment Conference) and those children who are at risk of exploitation.

5 PROCEDURE

5.1 Local Arrangements and Safeguarding Partnership Procedures

DBTH provides services to children and families living within Doncaster, Mexborough, Bassetlaw and surrounding areas. All practitioners are expected to be aware of the relevant policies and procedures for safeguarding children and be able to apply them in their day to day practice. Both Doncaster and Nottinghamshire Safeguarding Children Partnerships provide online safeguarding practice guidance including core procedures, which can be accessed internally via the Safeguarding Children Hive Page or on the internet using the following links, NSCP and DSCP.

5.2 Early Help

Early Help is a way of thinking and working together as services with families that have additional or more complex needs. Early Help is focused on prevention, early intervention, and the provision of support for families to prevent or reduce the need for statutory services. By working with families to identify their strengths, Early Help is focused on building resilience and creating sustainable change that enables families to overcome any future challenges.

The Working Together to Safeguard Children 2023 document outlines that it is far more effective to be proactive and promote the welfare of children than to be faced with the need to implement reactive measures.

The situations a child and family may benefit from Early Help are wide ranging, the list below is not exhaustive:

- The child's needs are unclear, or broader than your service can address alone.
- A significant change or worrying feature in a child's appearance, demeanour, behaviour or health has been observed.

- A significant event in a child's life has occurred, or where there are worries about the parents or home.
- Where a child, parent or another practitioner has raised a concern or requested help.
- Parental elements e.g. Parental Conflict, substance misuse, domestic violence, physical or mental health issues or criminality.
- Missing developmental milestones or making slower progress than expected in their learning.
- Health concerns including disability, physical or mental ill health, regularly missing medical appointments or a sudden change in the child's health.
- Child presenting challenging or aggressive behaviours, misusing substances or committing offences.
- Child is undertaking caring responsibilities.
- Child is bereaved or experiencing family breakdown.
- Child is bullied or are bullies themselves.
- Disadvantage for reasons such as race, gender, sexuality, religious belief or disability.
- Homeless or being threatened with eviction and those living in temporary accommodation.
- Becoming a teenage mother / father or is the child of teenage parents.
- Not being ready to make the transition to post-16 services.
- Persistent absence from school or risk of permanent exclusion.

Any DBTH Practitioner can access advice and support from the DBTH Safeguarding Team Monday to Friday between the hours of 09.00am – 5.00pm on 01302 642437. Resources and links to useful documents can also be accessed via the Safeguarding Children HIVE Page.

Consent **IS** required for a referral to Early Help. If parents and/or the child do not consent to Early Help, then the practitioner should make a judgement as to whether, without help, the needs of the child will escalate to a level likely to cause significant harm. If so, a referral to Children's social care may be required.

Doncaster - Early Help Hub

The Team can be contacted on **01302 734110** by practitioners working with children, young people and families who are seeking advice and information about possible resources and advice on supporting children and families. Referrals to Early Help must be made using the DBTH Bespoke Safeguarding Referral Form on the Safeguarding Children Hive Page and be sent to childrenassessmentservice@doncaster.gov.uk A copy of the referral must also be sent to the DBTH Safeguarding Team generic email inbox at dbh-tr.safeguarding@nhs.net and a copy saved in the child's health record.

Nottinghamshire - Early Help Unit

The Team can be contacted on **0115 804 1248** by practitioners working with children, young people and families who are seeking advice and information about possible resources and advice on supporting children and families. Referrals to Early Help must be made using the

DBTH Bespoke Safeguarding Referral Form on the Safeguarding Children Hive Page and be sent to early.help@nottscc.gov.uk A copy of the referral must also be sent to the DBTH Safeguarding Team generic email inbox at dbh-tr.safeguarding@nhs.net and a copy saved in the child's health records.

5.3 Child at risk of harm

DBTH practitioners having contact with children and members of their families must make a referral to Children's Social Care if there are signs that a child or an unborn baby:

- Is suffering significant harm through abuse or neglect;
- Is likely to suffer significant harm in the future.

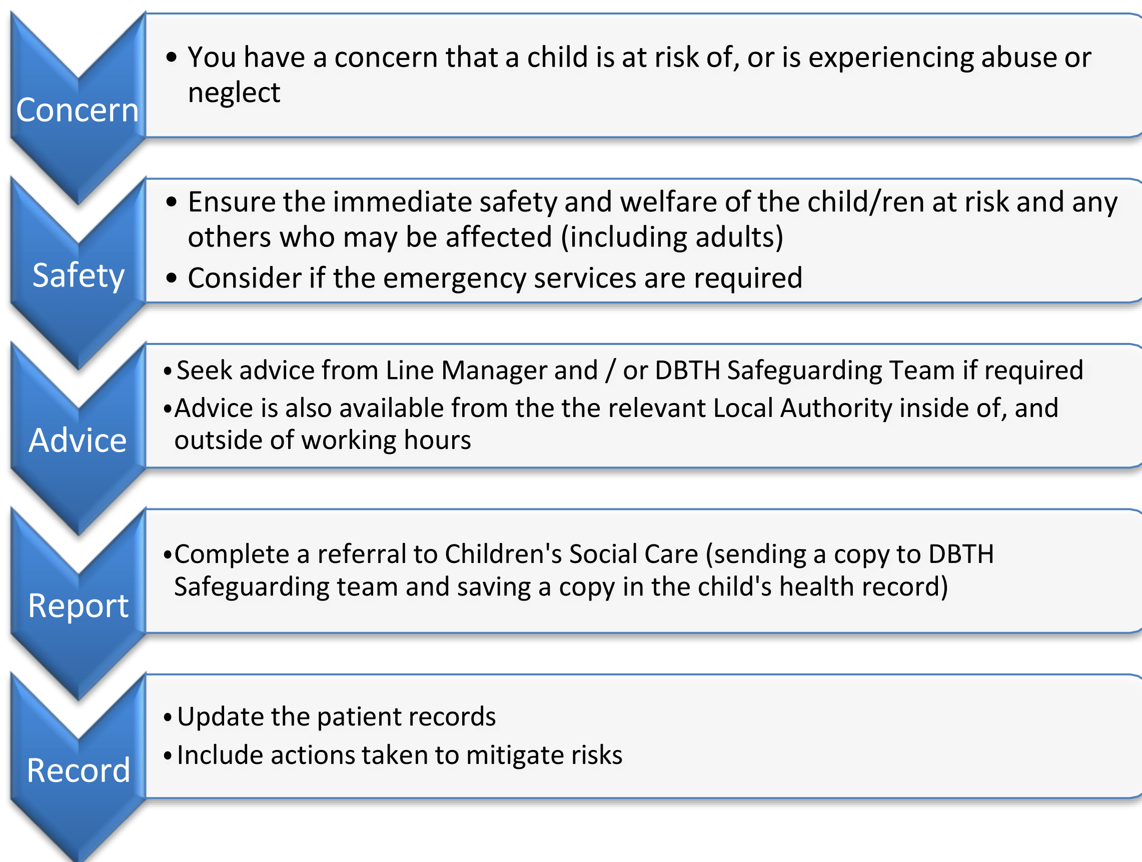
Significant Harm is the threshold which justifies compulsory intervention in family life in the best interest of children. Section 47 of the Children's Act places a duty on local authorities to make enquiries, or cause enquiries to be made, where it has reasonable cause to suspect that a child is suffering, or likely to suffer significant harm.

There are no absolute criteria on which to rely when judging what constitutes significant harm. Sometimes, a single traumatic event may constitute significant harm (e.g. a violent assault, suffocation or poisoning). More often, significant harm is a compilation of significant events, both acute and longstanding, which interrupt, change or damage the child's physical and psychological development.

Some children live in family and social circumstances where their health and development are neglected. For them, it is the cumulative impact of long term emotional, physical or sexual abuse that causes impairment to the extent of constituting significant harm.

To understand and establish significant harm, it is necessary to consider:
- The family context, including protective factors
- The child's development within the context of his or her family and wider social circle as well as cultural environment
- Any special needs, such as a medical condition, communication difficulty or disability that may affect the child's development and care within the family
- The nature of harm, in terms of ill-treatment or failure to provide adequate care
- The impact on the child's health and development
- The adequacy of parental care

Please refer to appendix 4 for tools and resources to support decision making. Threshold descriptors and continuum of need.



5.4 Making a referral to Children's Social Care

If you are the practitioner who identifies the child is at risk of harm or abuse, it is your responsibility to make the referral to Childrens Social Care. Do not pass this on for someone else to complete on your behalf.

Anyone who has concerns about a child's welfare should consider whether a referral needs to be made to local authority children's social care, and should do so immediately if there is a concern that the child is suffering significant harm or is likely to do so.

Any DBTH practitioner can access advice and support from the DBTH Safeguarding Team Monday to Friday between the hours of 09.00am – 5.00pm on 01302 642437. Resources and links to useful documents can also be accessed via the Safeguarding Children Hive Page

You may wish to refer to DSCP Multi-Agency threshold Document or NSCP Multi-Agency Threshold Guidance to support your decision making and the completion of comprehensive referral.

It is good practice for professionals to work in partnership with children and parents by obtaining consent to make a referral to Children's Social Care. It is important to understand the child's / parent's views of the referral and what support they would like to access.

However, there are some occasions when consent is **NOT** required, including if it places the child at significant / increased harm or if it could delay support.

If the child is in immediate danger contact the Police on 999

<table>
<tr><th colspan="2">How to make a Safeguarding Children's Referral</th></tr>
<tr><th>If the Child resides in Doncaster</th><th>If the Child Resides in Nottinghamshire</th></tr>
<tr><td>Make a telephone referral to the Doncaster Multi-Agency Safeguarding Hub (MASH)
On 01302 737777 (Monday to Friday 09.00 – 5.00pm).

For referrals made out of hours, call 01302 796000.

All telephone referrals must be followed up within 48 hours using the DBTH electronic Bespoke Safeguarding Referral Form found on the Safeguarding Children Hive Page and sent to childrenassessmentservice@doncaster.gov.uk

A copy of the referral must also be sent to the DBTH Safeguarding Team generic email inbox at dbh-tr.safeguarding@nhs.net

Document in the child / patient records:
Safeguarding concerns / risks identified
Discussions that have taken place with other professionals
Details of the referral made including rationale.</td><td>Make a telephone referral to the Nottinghamshire Multi-Agency Safeguarding Hub (MASH) On 0300 500 80 90.

For referrals made out of hours, call 0300 456 4546.

All telephone referrals must be followed up within 48 hours using the DBTH electronic Bespoke Safeguarding Referral Form found on the Safeguarding Children Hive Page and sent to mash.safeguarding@nottscc.gov.uk

A copy of the referral must also be sent to the DBTH Safeguarding Team generic email inbox at dbh-tr.safeguarding@nhs.net

Document in the child / patient records:
Safeguarding concerns / risks identified
Discussions that have taken place with other professionals
Details of the referral made including rationale.</td></tr>
<tr><td colspan="2">Where possible, referrals must include details of your concerns and the impact on the child, your involvement with the child / family, details of parents, significant others, details of any known perpetrators, if consent for the referral has been obtained and if not, why not. The outcome of any conversations had with social care as part of the referral process.</td></tr>
</table>

Out of area referrals

There may be occasions when a child or young person presents to DBTH who lives outside of Doncaster and Bassetlaw areas. Safeguarding referrals should be made to the Local Authority area in which the child lives; confirmation of the child's address is vital. Contact information for relevant Local Authority Children's Social Care can be found by undertaking a web search. Local referral processes and contact numbers will be on the Local Authority website. Colleagues can also contact the Safeguarding Team for support Monday to Friday 9am-5pm.

5.5 Injuries in non-mobile babies and children

Any injuries are unusual in this age group, unless accompanied by a full consistent explanation. Even small injuries may be significant, and they may be a sign that another hidden injury is already present. Such injuries include:

- Small single bruises e.g. On cheeks, ears, chest, arms or legs, hands or feet or trunk
- Bruised lip or torn frenulum (small area of skin between the inside of the upper and lower lip and gum)
- Lacerations, abrasions or scars
- Burns and scalds
- Pain, tenderness or failing to use an arm or leg which may indicate pain and an underlying fracture
- Small bleeds into the whites of the eyes (Sub-conjunctival Haemorrhage) or other eye injuries

Sub-conjunctival haemorrhages (bleeding of the conjunctiva of the eye) can occur as a result of a traumatic birth. Midwives and Paediatricians examining the baby must record these in the child's record, Newborn and Infant Physical Examination (NIPE) and in the Personal Child Health Record (Red Book). Where sub-conjunctival haemorrhage is noted on a non-mobile baby and there is no documented record or an explanation as a result of a birth injury, practitioners should consider the possibility of non-accidental injury. Please refer to DBTH Policy PAT/T 85 The Assessment of Sub-conjunctival Haemorrhage (SCH) in Infants for further guidance.

Occasionally an infant can be harmed in other ways, for example, Deliberate poisoning which can present as sudden collapse or coma; suffocation which can present as sudden death, collapse, cessation of breathing (apnoeic attack) or bleeding from the mouth and nose. Please refer to the following link on the Hive for electronic and printable versions of children's body maps as outlined in Section 4.3 of this policy.

DBTH colleagues should be aware that infants **do not** bruise themselves by lying on a dummy or banging themselves with rattles and other infant toys, or by flopping forwards

and banging their heads against their parents' faces. Rough play is not an appropriate activity or an acceptable explanation with infants. Young infants can have serious injuries such as fractured ribs or limbs without any external signs. They require paediatric assessment, X-rays and other tests to make a diagnosis as part of a Child Protection Medical Examination. Shaking injuries in young infants leading to severe brain damage can present with or without external injuries, such as a minor bruise of the head. Signs such as drowsiness or poor feeding may be either vague or overt. The pathway below outlines the process for managing injuries in non-mobile babies and children who present at DBTH, and what factors should be considered during the assessment of the child.

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Presentation with injury in non-mobile infants and children

A non-mobile infant/child is defined as:

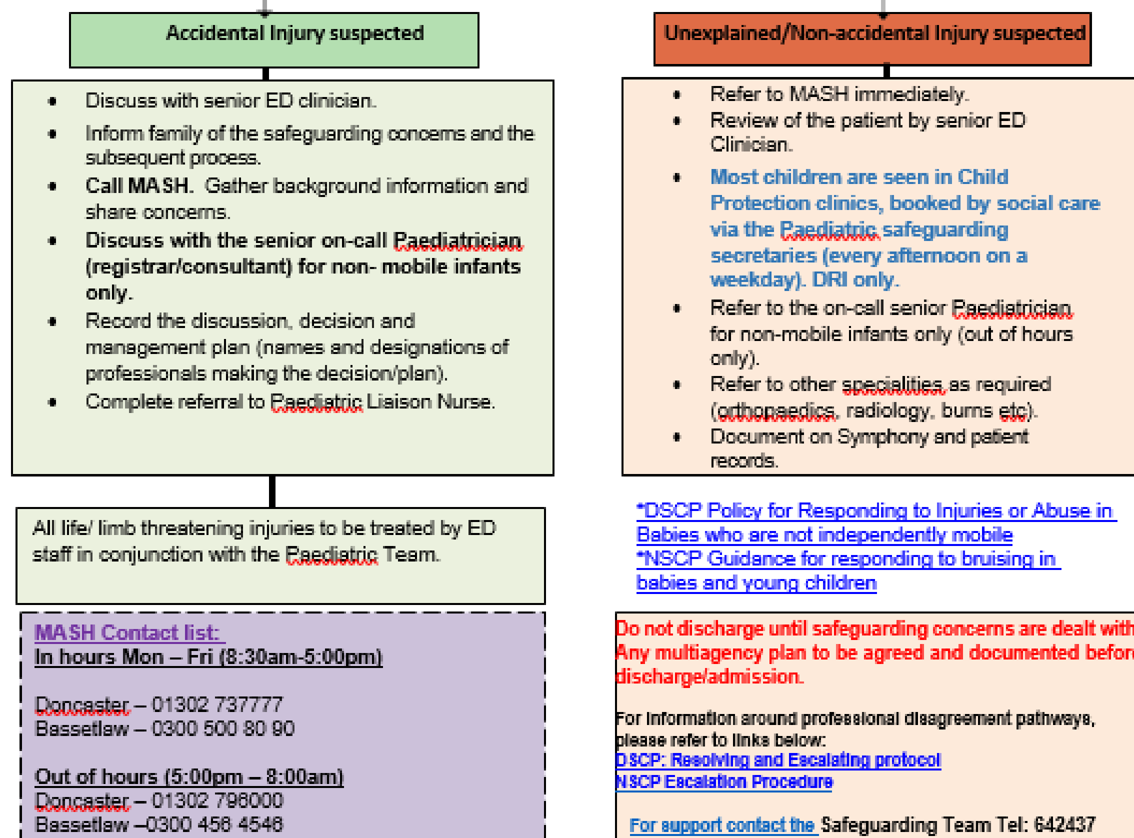
An infant who is not yet crawling, bottom shuffling, pulling to stand, cruising or walking independently (rolling over is NOT considered as self-mobile) and all children who are NOT independently mobile due to developmental delays/disabilities.

ED triage – non-mobile infant/child presents with a history of injury:

- Consider this group as high risk.
- Consider if delayed presentation
- Consider liaison with Maternity Services in those babies <28 days of age, or for relevant history in older children.
- Complete safeguarding checks as usual including, CP-IS, Multi-agency Safeguarding Hub (MASH), 0-19 service and review previous ED attendances.

Clinical Assessment (Dr/ACP)

Take history of mechanism of injury including explanation given. Examine thoroughly.
Gain background safeguarding history. Discuss any safeguarding concerns with Triage Nurse.
Refer to NIPE (red book), to confirm if any existing birth / trauma marks.
Refer to Risk Assessment Tool Safeguarding Children Risk Assessment tool
If there is no injury and /or mark of injury with no Safeguarding concerns identified – there is no need to follow this chart any further.
If an injury is suspected discuss with Senior ED clinician (Registrar/Consultant).
Document assessment on Symphony clearly including a **body map**. Document discussions amongst professionals.



Remember a copy of any referral to children's social care must be sent to: dbh-tr.safeguarding@nhs.net

With thanks to The Rotherham NHS Foundation Trust for permission to use and modify this document.

Please refer to the following links for further guidance and procedural information about injuries in non-mobile babies and children:

Doncaster Nottinghamshire

5.7 Professional Challenge / Escalation and Resolution

Multi-agency working will sometimes give rise to differences of opinion or concerns about safeguarding practice in relation to a child and/or family member. Disagreements can relate both to decisions about individual children or specific processes. Professional disagreements should be seen as part of 'healthy' professional working relationships and practitioners should be encouraged to give or receive professional challenge in a constructive, respectful and positive way. A key principle should be that it is everyone's professional responsibility to problem solve and come to an agreed resolution at the earliest opportunity, always
keeping in mind the child's safety and welfare. DBTH colleagues can contact the Trust Safeguarding Team for support and advice in relation to professional disagreement and both Nottinghamshire and Doncaster Safeguarding Children Partnerships have protocols in place for Resolving Professional Differences that can accessed via the following links:
Doncaster Nottinghamshire

5.8 Procedures for Managing Allegations against People who Work with Children

Where it is alleged that a person who works with children has:

- Behaved in a way that has harmed a child, or may have harmed a child
- Possibly committed a criminal offence against or related to a child or
- Behaved towards a child or children in a way that indicates they may pose a risk of harm to children.
- Behaved or may have behaved in a way that indicated they may not be suitable to work with children.

This may indicate that they are unsuitable to continue to work with children in their present position and until further investigation/assessments have taken place.

The issue could also be about the behaviour of an individual outside of their work environment and which would raise concerns about their suitability to work with children. For example where a domestic abuse incident has taken place or where there are concerns about the individual's own children.

Each area has a Local Authority Designated Officer (LADO). The role of the LADO is to oversee the investigation of all allegations that are made where the alleged adult undertakes paid or unpaid work on behalf of organisations providing services for children,

where those services are provided by the alleged adult within that specific area. This is regardless of where the alleged incident took place, the home address of the alleged adult or the office base of the organisation.

Doncaster LADO 01302 737748

Nottinghamshire LADO 0115 8041272

DBTH Safeguarding Team must be informed when there is an allegation made against a DBTH colleague that they have harmed or pose a risk to children. The allegation will then be explored in collaboration with the Human Resources Team, a DBTH Safeguarding representative, a relevant senior manager for the alleged person's clinical area and the LADO. DBTH are developing a stand-alone policy to guide colleagues on how to escalate allegations of this nature, until publication of this policy, emerging concerns should be escalated to the DBTH safeguarding team or the relevant HR representative for the Trust area of the alleged adult.

The following links provide further guidance and procedural information about allegations against people who work with children:

Doncaster Nottinghamshire

5.9 Allegations of non-recent abuse

Non-recent abuse (also known as historical abuse) is an allegation of neglect, physical, sexual or emotional abuse made by or on behalf of someone who is now 18 years or over, relating to an incident which took place when the alleged victim was under 18 years old.

Allegations of child abuse are sometimes made by adults and children many years after the abuse has occurred. There are many reasons for an allegation not being made at the time including fear of reprisals, the degree of control exercised by the abuser, shame or fear that the allegation may not be believed. The person becoming aware that the abuser is being investigated for a similar matter or their suspicions that the abuse is continuing against other children may trigger the allegation.

Reports of historical allegations may be complex as the alleged victims may no longer be living in the situations where the incidents occurred or where the alleged perpetrators are also no longer linked to the setting or employment role. Such cases should be responded to in the same way as any other safeguarding concerns. It is important to ascertain as a matter of urgency if the alleged perpetrator is still working with, caring for or having contact with any other children.

- There is a significant likelihood that a person who abused a child/ren in the past will have continued and may still be doing so;

- Criminal prosecutions can still take place despite the fact that the allegations are historical in nature and may have taken place many years ago.

In cases of allegations of non-recent abuse, DBTH colleagues should seek advice from the Safeguarding Team on 01302 642437. The following links will also provide additional guidance:

Doncaster Nottinghamshire

5.10 Notifiable serious incidents

Notifiable serious incidents are those that involve death or serious harm to a child where abuse or neglect is known or suspected, and any death of a looked after child. The Children Act 2004 states: Where a local authority in England knows or suspects that a child has been abused or neglected, the local authority must notify the National Child Safeguarding Practice Review Panel if:

(a) the child dies or is seriously harmed in the local authority's area
(b) while normally resident in the local authority's area, the child dies or is seriously harmed outside England.

The Trust Safeguarding Team should be informed of any serious incident relating to a child to ensure the immediate safety of the child; minimise the impact of any serious harm where possible, and to ensure Local Authority and other relevant Safeguarding partners are notified without delay. DBTH Safeguarding Team work closely with our Safeguarding Partners across both Doncaster and Nottinghamshire to manage notifiable safeguarding serious incidents.

Please refer to the following links for further procedural information: Doncaster Nottinghamshire

5.11 Volunteers and Visiting Celebrities

DBTH colleagues who observe concerning behaviours from visiting celebrities or volunteers, should take immediate action in order to ensure that patients are protected. Colleagues should ensure their individual managers are aware of the concerns. The issue should be reported to the Safeguarding Team and escalated to senior hospital managers. All volunteers should access Safeguarding training. Please refer to the following Trust policies for further guidance. CORP/RISK 21 – Recruitment and Management of Volunteers Policy.
CORP/COMM 29 - Management of visiting dignitaries, celebrities, media representatives and other invited visitors to the Trust

5.12 Safe Recruitment

Working Together to Safeguard Children 2023 dictates organisations should have specific policies in place to ensure that safe recruitment practices are robust and criminal record checks are completed when employing individuals whom the organisation will permit to work regularly with children. The Trust ensures that a safe recruitment process is in place for all new colleagues and volunteers expected to have contact with children and families. This involves a Disclosure and Barring Service check and uptake of references prior to appointment. The Trust is required to report any concerns regarding the suitability of employees, agency workers and volunteers who work with adults or children to the Disclosure and Barring Service. Please refer to the following policy for further guidance.
CORP/EMP 17 – Working with Vulnerable Adults & Children – Disclosure and Barring Service (DBS).

6 TRAINING & EDUCATION

All DBTH colleagues are trained and competent to be alert to potential indicators of abuse and neglect, know how to act on those concerns and fulfil their roles and responsibilities for safeguarding children. Different staff groups require different levels of competence depending on role and level of contact with children, young people and families as per the Intercollegiate Document 2019. The DBTH Safeguarding Training offer is underpinned by the following legislation and guidance:

Working Together to Safeguarding Children 2023 Children Act 2004
Children Act 1989
RCN Looked After Children: roles and competencies of health care staff 2020 Mental Capacity Act 2005
SAAF 2024

DBTH provides role aligned safeguarding training via face to face sessions and E-learning for Health which can be accessed through the DBTH Training Framework on the HIVE. The Trust also supports colleagues to access additional learning opportunities via resources on the HIVE and links to Buy Doncaster and NSCP where multi-agency training can be accessed.
Bespoke packages of training and education have and continue to be developed and disseminated where any learning is identified internally or via the Safeguarding Partnership. Where any DBTH area identifies any bespoke requirement for additional Safeguarding training and resources, contact can be made with the Safeguarding team to discuss further. Training dates can be accessed via the DBTH Safeguarding Children page on the Hive.

7 SUPERVISION AND SUPPORT

DBTH provides a formal safeguarding supervision framework to support practitioners who work predominantly with children and their families. Safeguarding supervision is a formal, accountable process, which supports, assures and develops the knowledge, skills and values of an individual, groups or team. Restorative supervision aims to improve the quality of the practitioners work, achieve agreed objectives and outcomes whilst promoting good standards of practice to ensure children and young people are protected from harm through sound professional judgement, critical reflection, and legislation and research findings.
Please refer to the PAT/PS 13 v5 Safeguarding Supervision Policy for further information.

Opportunities for Ad-Hoc supervision are also available to practitioners as part of the regular Safeguarding Liaison Meetings (SLM) that occur across Trust areas and through open access to the Safeguarding Team by telephone, as and when practitioners require support.

DBTH colleagues are reminded that should they be approached by Solicitors, Child and Family Court Advisory Support Service (CAFCASS), Police or any other agency or individual requesting legal statements, DBTH have a dedicated legal team who will facilitate the process from the initial request through to quality assurance of written statements and final submission of the document. The DBTH legal team can be contacted at dbth.legalservices@nhs.net

Where DBTH colleagues are required to participate in, or contribute to Childrens Safeguarding Practice Review processes, the Safeguarding Team will provide appropriate support and opportunities for debriefing and where required, referral and signposting to other support services for example, Professional Nurse/Midwifery Advocate.

8 MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT

8.1 Evaluating Practice

What is being Monitored	Who will carry out the Monitoring	How often	How Reviewed/ Where Reported to
Audit of quality of children's safeguarding referrals	Named Nurse for Children / Children's safeguarding specialist nurses	Annual	Strategic Safeguarding Group (SSG)
Section 11	Head of Safeguarding / supported by Deputy Head of Safeguarding / Named safeguarding leads	Annual – Bi-annual (when requested by Nottinghamshire and Doncaster Safeguarding Partnerships	Final submission authorised by Deputy Chief Nurse before submission to relevant Safeguarding Partnership. Section 11 outcome and action plan presented at SSG
Annual Safeguarding Declaration	Head of Safeguarding / supported by Deputy Head of Safeguarding / Named safeguarding leads / relevant Trust leads	Annual	Final submission authorised by Deputy Chief Nurse before submission to ICB. Annual outcome and identified actions added to Safeguarding work plan / presented at SSG
Evaluation of Safeguarding training	Named safeguarding leads	At each planned safeguarding training. Bi-annual review of training data – to consider impact and future planning	Completion of training evaluation forms, summary of training impact completed bi-annually and presented at SSG.
Compliance with CP-IS mandatory checks	Relevant Divisional areas (Maternity / Paediatrics / Emergency Department	Monthly	Reported at relevant Divisional governance. Compliance reported quarterly at SSG.
Safeguarding supervision compliance	Relevant Divisonal area (Maternity / Paediatrics / Emergency Department / Clinical Specialities	Quarterly	Compliance reported via Divisional highlight reports at SSG

9 DEFINITIONS

Term	Definition
Child/Children	Anyone who has not yet reached their 18th birthday. The fact that a child has reached 16 years of age, is living independently or is in further education, is a member of the armed forces, is in hospital or in custody in the secure estate, does not change their status or entitlements to services or protection.
Physical abuse	Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces, illness in a child.
Emotional Abuse	Emotional abuse is the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may include not giving the child opportunities to express their views, deliberately silencing them or 'making fun' of what they say of how they communicate. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond the child's development 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), (discussed in specific detail in the Tees Safeguarding procedures) causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.
Sexual Abuse	Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, 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. Woman can also commit acts of sexual abuse, as can other children. Please note, the fact that it is abusive to allow or coerce children into witnessing acts of a sexual nature between adults may be particularly relevant where children are on the premises and are exposed to adult focused activities where sexual themes are prevalent.
Neglect	Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to: provide adequate food, clothing and shelter (including exclusion from home or abandonment) protect a child from physical and emotional harm or danger ensure adequate supervision (including the use of inadequate care-givers) ensure access to appropriate medical care or treatment It may also include neglect of, or unresponsiveness to, a child's basic emotional needs. Neglect can also include ignoring a child's basic emotional needs. This includes children being present with or without their parents, at venues unsuitable for their age: where events of a sexual nature take place where there are convictions of current members of staff for serving alcohol to minors premises where gambling is the main activity and or premises where the supply of alcohol is the main activity and there are no activities for children or families.

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 impact negatively a parent-child relationship.
Child Exploitation	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 or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) 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 through the use of technology. Child criminal exploitation (CCE) As set out in the Serious Violence Strategy 2018, published by the Home Office, where an individual or group takes advantage of an imbalance of power to coerce, control, manipulate or deceive a child or young person under the age of 18 into any criminal activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial or other advantage of the perpetrator or facilitator and/or (c) through violence or the threat of violence. The victim may have been criminally exploited even if the activity appears consensual. Child criminal exploitation does not always involve physical contact; it can also occur through the use of technology.
County Lines	The 2018 Home Office Serious Crime Strategy states the definition of a County Line is a term used to describe gangs and organised criminal networks involved in exporting illegal drugs into one or more importing areas [within the UK], using dedicated mobile phone lines or other form of "deal line". They are likely to exploit children and vulnerable adults to move [and store] the drugs and money and they will often use coercion, intimidation, violence (including sexual violence) and weapons.

Trafficking	Human trafficking involves the recruitment or movement of people for exploitation by the use of threat, force, fraud, or the abuse of vulnerability. Trafficking is a crime that can occur across international borders or within a country. It often crosses multiple geographic and legal boundaries. Men, women and children may be trafficked for various purposes. They include labour sectors domestic servitude, forced begging and petty theft and sexual exploitation.
Modern Slavery	Modern slavery is defined as the recruitment, movement, harbouring or receiving of children, women or men through the use of force, coercion, abuse of vulnerability, deception or other means for the purpose of exploitation. It is a crime under the Modern Slavery Act 2015 and includes holding a person in a position of slavery, servitude forced or compulsory labour, or facilitating their travel with the intention of exploiting them soon after.
Cuckooing	A tactic where a drug dealer (or network) takes over a vulnerable person's home to prepare, store or deal drugs. It is commonly associated with exploitation and violence.
Adverse Childhood Experiences	Adverse childhood experiences (ACEs) are highly stressful and potentially traumatic events or situations that occur during childhood and/or adolescence. It can be a single event, or prolonged threats to (and breaches of) the young person's safety, security, trust or bodily integrity. These experiences directly affect the young person and their environment, and require significant social, emotional, neurobiological, psychological or behavioural adaption (YoungMinds 2018).
Domestic Abuse	The Domestic Abuse Act (2021) definition: Behaviour of a person ("A") towards another person ("B") is "domestic abuse" if — A and B are each aged 16 or over and are personally connected to each other, and the behaviour is abusive. Behaviour is "abusive" if it consists of any of the following — physical or sexual abuse; violent or threatening behaviour; controlling or coercive behaviour; economic abuse;

	psychological, emotional, or other abuse; and it does not matter whether the behaviour consists of a single incident or a course of conduct.
Female Genital Mutilation	A collective term (also known as genital cutting and female circumcision) for all procedures that involve partial or total removal of the external female genitalia or other injury to the female genital organs for cultural or non-medical reasons. Female Genital Mutilation is a criminal offence in the United Kingdom.
Forced Marriage	A marriage in which one or both spouses do not (or in the case of some adults with learning or physical disabilities or children, cannot) consent to the marriage and duress is involved. Duress can include physical, psychological, financial, sexual and emotional pressure. The Anti-social Behaviour, Crime and Policing Act 2014 made it a criminal offence (which can result in a sentence of up to 7 years in prison) to force someone to marry. This includes: Taking someone overseas to force them to marry (whether or not the forced marriage takes place).
Parental Responsibility	Parental responsibility is defined in Children Act 1989 as being: "all the rights, duties, powers, responsibilities and authority which by law a parent of a child has in relation to the child and his property". The term 'parental responsibility' attempts to focus on the parent's duties towards their child rather than the parent's rights over their child.
Early Help	Early help means providing support as soon as a problem emerges, at any point in a child's life, from the foundation years through to the teenage years.
Child In Need	Under Section 17 (10) of the Children Act 1989, a child is a Child in Need if: •the child is unlikely to achieve or maintain, or have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him/her of services by a local authority

	• the child's health or development is likely to be significantly impaired, or further impaired, without the provision for him/her of such services • the child is disabled
Looked after Child / Child In Care	Under the Children Act 1989, a child is looked-after by a local authority if he or she falls into one of the following: • is provided with accommodation, for a continuous period of more than 24 hours [Children Act 1989, Section 20 and 21] • is subject to a care order [Children Act 1989, Part IV] • is subject to a placement order

10 EQUALITY IMPACT ASSESSMENT

The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are disadvantaged over others. Our objectives and responsibilities relating to equality and diversity are outlined within our equality schemes. When considering the needs and assessing the impact of a procedural document any discriminatory factors must be identified.

An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Analysis Policy (CORP/EMP 27).

The purpose of the EIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified.

11 ASSOCIATED TRUST PROCEDURAL DOCUMENTS

- PAT/PS 12 Domestic Abuse Policy
- PAT/PS 12 Female Genital Mutilation
- PAT/T 79 Children, Young People and Adults at risk who are not brought to Health Care appointments 'was not brought'
- PAT/T 85 The Assessment of Sub-conjunctival Haemorrhage (SCH) in Infants
- PAT/PS 13 Safeguarding Supervision Policy
- PAT/PS 15 De-escalation: Principles and Guidance including Restraint
- PAT/PS 19 Abduction / Suspected Abduction of Infant / Child Policy
- PAT/PS 25 Use of Force Policy
- PAT/PS 1 Missing Patient Policy

- PAT/PA 19 Mental Capacity Act 2005, Policy and Guidance, including Deprivation of Liberty Safeguards (DoLS)
- PAT/PS 8 Safeguarding Adults Policy
- PAT/PA 2 Consent to Examination or Treatment Policy
- CORP/RISK 25 Prevent Policy - Protecting those who are vulnerable to radicalisation through a multi-agency approach
- PAT/T 62 v2 Child Death Review Policy
- PAT/PA 28 Privacy and Dignity Policy
- PAT/PA 2 Consent to Examination or Treatment Policy.
- CORP/RISK 21 Recruitment and Management of Volunteers Policy

12 DATA PROTECTION

Any personal data processing associated with this policy will be carried out under 'Current data protection legislation' as in the Data Protection Act 2018 and the General Data Protection Regulation (GDPR) 2016).

For further information on data processing carried out by the trust, please refer to our Privacy Notices and other information which you can find on the trust website: https://www.dbth.nhs.uk/about-us/our-publications/uk-data-protection-legislation-eu- general-data-protection-regulation-gdpr/

13 REFERENCES

Barnardo's. (2024) *Young carers*. Available at: Young carers | Barnardo's

Department for Education. (2024) *Information sharing advice for safeguarding practitioners*. Available at: https://www.gov.uk/government/publications/safeguarding-practitioners- information-sharing-advice

Department for Education. (2014) *Statutory guidance on children missing from care*. Available at: https://assets.publishing.service.gov.uk/media/5a7e089340f0b62302688bd0/Statutory_Gui dance_-_Missing_from_care___3_.pdf

Department for Education. (2023) *Working together to safeguard children*. Available at: https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

Deprivation of Liberty Safeguards: Code of Practice (2008). Available at: Code of Practice.

Home Office. (2022) *Child exploitation disruption toolkit*. Available at: https://www.gov.uk/government/publications/child-exploitation-disruption-toolkit/child-exploitation-disruption-toolkit-accessible

Home Office. (2018) *Serious violence strategy*. Available at: https://assets.publishing.service.gov.uk/media/5acb21d140f0b64fed0afd55/serious- violence-strategy.pdf

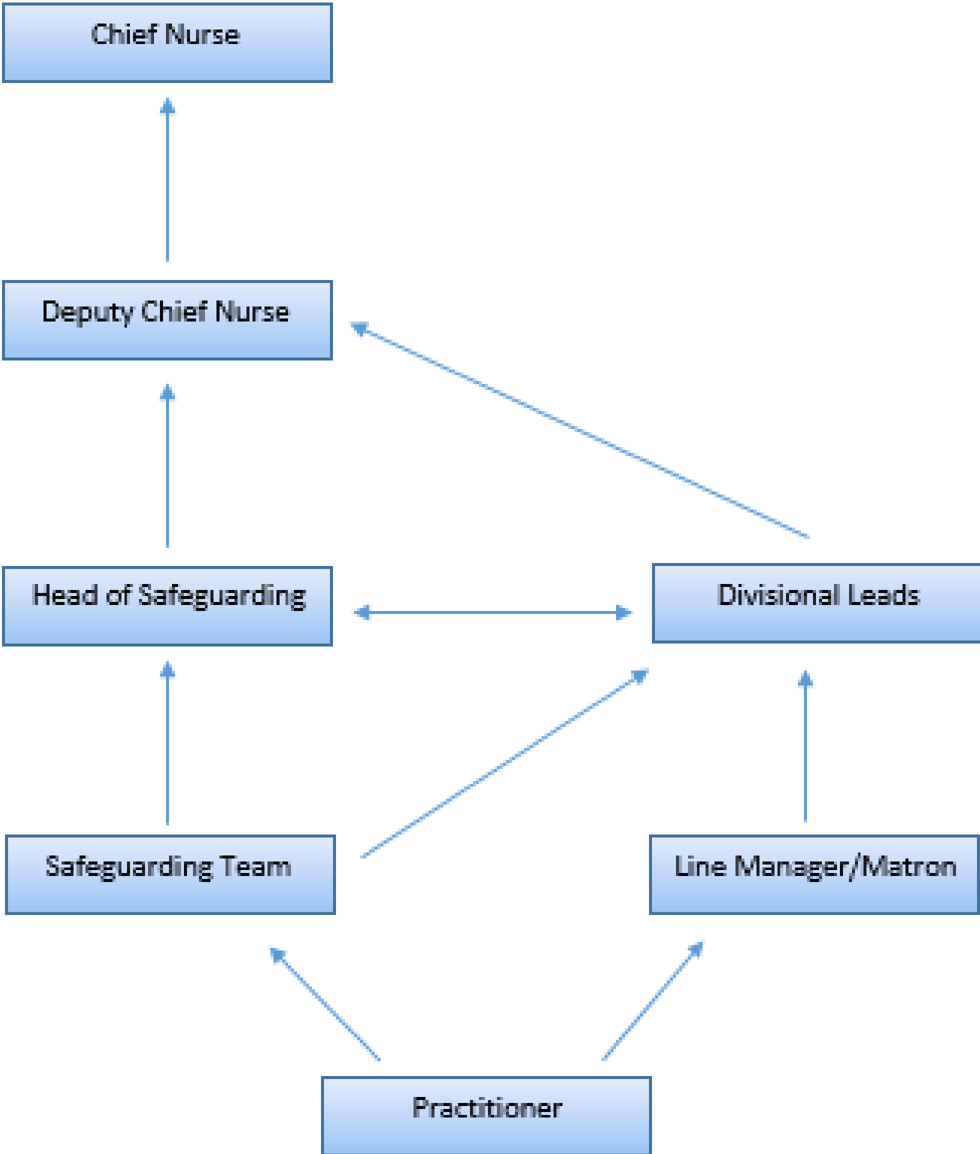
Legislation.gov.uk. (2014) *Anti-Social Behaviour, Crime and Policing Act 2014.* Available at: https://www.legislation.gov.uk/ukpga/2014/12/contents

Legislation.gov.uk. (1989) *Children Act 1989*. Available at: Children Act 1989

Legislation.gov.uk. (2004) *Children Act 2004*. Available at: Children Act 2004

APPENDIX 1 – LINE OF ACCOUNTABILITY / ESCALATION

DBTH Line of Accountability / Escalation flowchart



APPENDIX 2 – PROFESSIONAL CURIOSITY

What is professional curiosity and why is it important?

Professional curiosity is where a practitioner explores and proactively tries to understand what is happening within a family or for an individual, rather than making assumptions or taking a single source of information and accepting it at face value. It means:

- Testing out professional assumptions
- Considering information from different sources to gain a better understanding of family functioning which, in turn helps to make predictions about what is likely to happen in the future.
- Seeing past the obvious
- Questioning what is observed

It is a combination of looking, listening, asking direct questions, checking out and reflecting on ALL of the information received.

Professional curiosity is a recurring theme within safeguarding reviews, highlighting the need to fully understand a family's situation. Therefore professional curiosity is important, as it enables a practitioner to have a holistic view and understanding of what is happening within a family and what life is like for an individual and use this information to fully assess potential risks. Being professionally curious enables practitioners to challenge parents/ carers, in order to understand a child or young person's vulnerability or risk, while maintaining an objective, professional and supportive approach

How can practitioners be professionally curious?

Here are some considerations when seeking to be professionally curious:

- As practitioners, you should not presume to know what is happening in the family home and should ask questions and seek clarity if you are not certain.
- Don't be afraid to ask questions of families, and do so in an open way, so they know that you are asking to ensure that children are safe, not to judge or criticise.
- Be open to the unexpected, and incorporate information that does not support your initial assumptions into your assessment of what life is like for an individual.
- Seek clarity, either from the family or other professionals.
- Be open to having your own assumptions, views and interpretations challenged, and be open to challenging others.
- Consider what you see as well as what you're told. Are there any visual clues as to what life is like, or which don't correlate with the information you already hold?
- Use supervision as an opportunity to explore cases and exercise professional curiosity, for example by: playing 'devil's advocate'; presenting alternative hypotheses; and presenting cases from the child, young person, adult or another family member's perspectives.

What are potential barriers to professional curiosity?

Being professionally curious is not always easy. There may be barriers to this, including those from practitioners themselves such as:

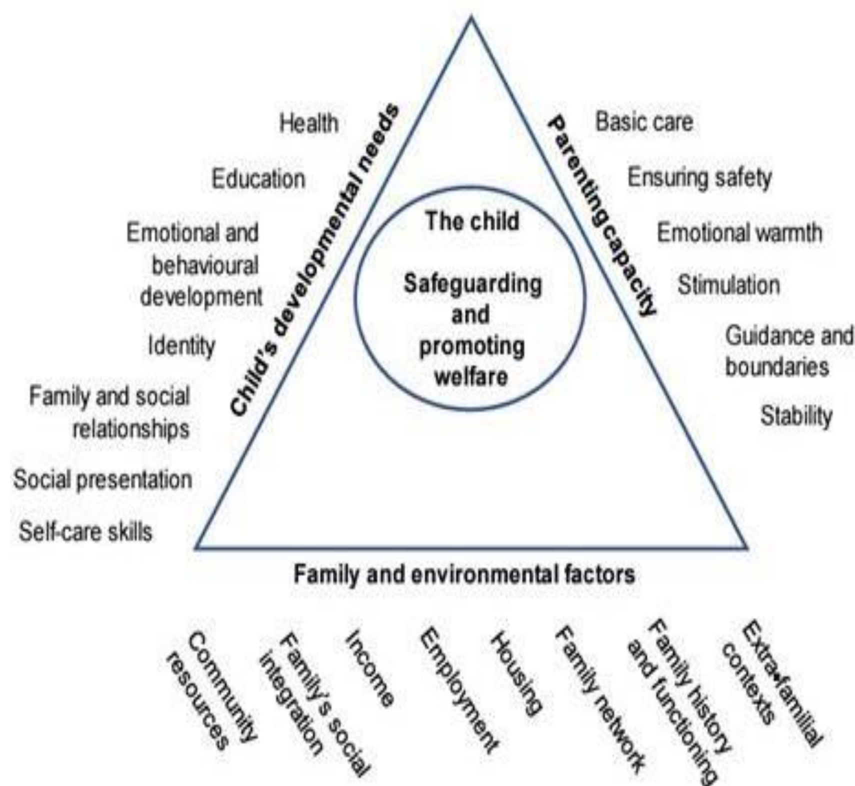
- Over optimism;
- Making assumptions;
- Lacking the confidence or assertiveness to ask sensitive questions; and
- Unconscious bias.

Barriers may also be presented by people we work with, such as not wishing to answer questions, questioning a practitioners' intentions and what some organisations call disguised compliance.

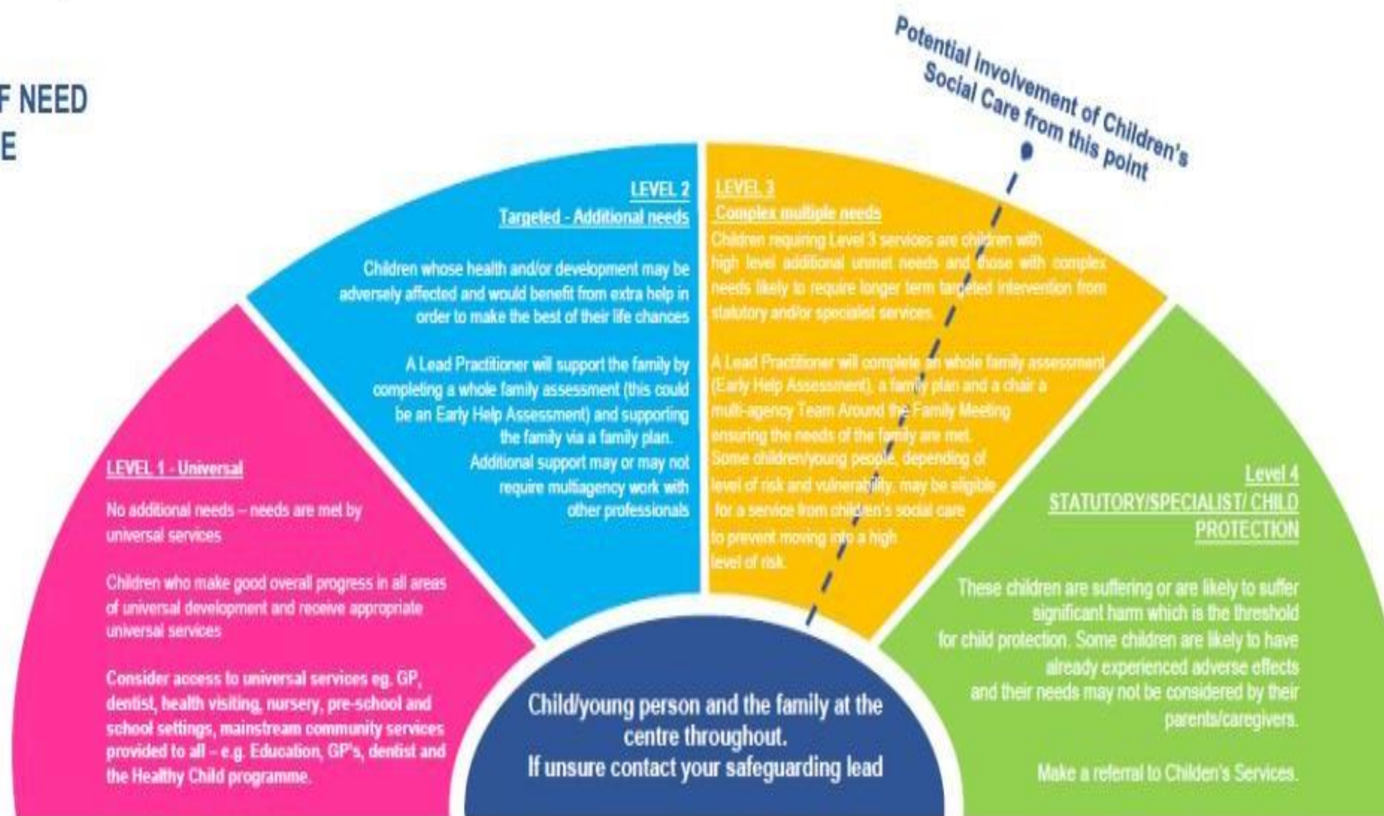
It is important to recognise any potential barriers and work with the child, young person or family to overcome these. When barriers may be coming from an individual or family it is important to work restoratively with them, explaining why you are asking questions or seeking clarification so they understand it is to help support them and their family with regards to their welfare and safety.

APPENDIX 3 – ASSESSMENT TOOLS AND RESOURCES

A good assessment is one that investigates the three domains, set out in the Assessment Framework Triangle. The aim is to reach a judgement about the nature and level of needs and/or risks that the child may be facing within their family and/or community. Importantly the assessment, in looking at the domains, should also consider where the strengths are in a child's circumstances and in what way they may assist in reducing the risk.

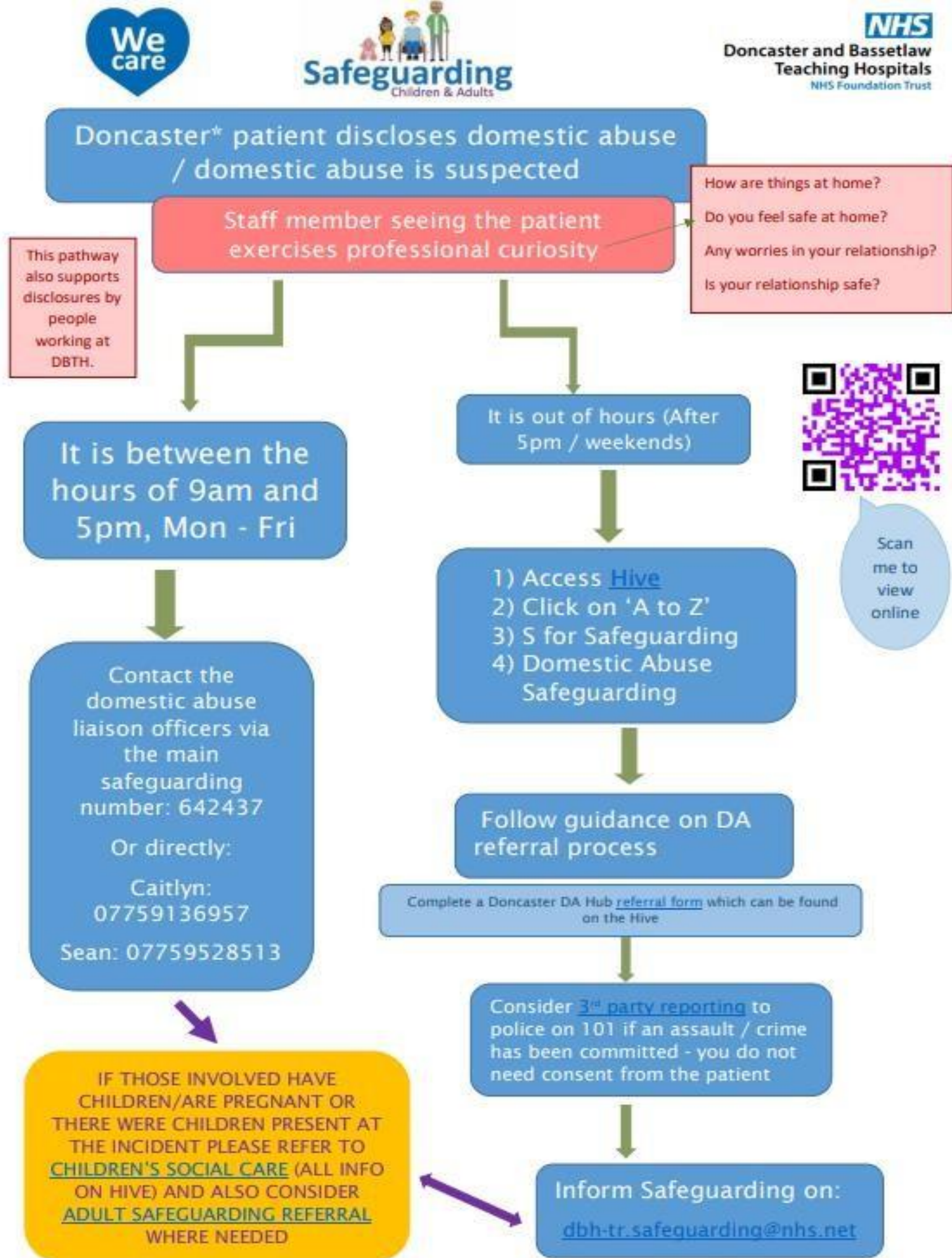


Working Together to Safeguarding Children (2023)

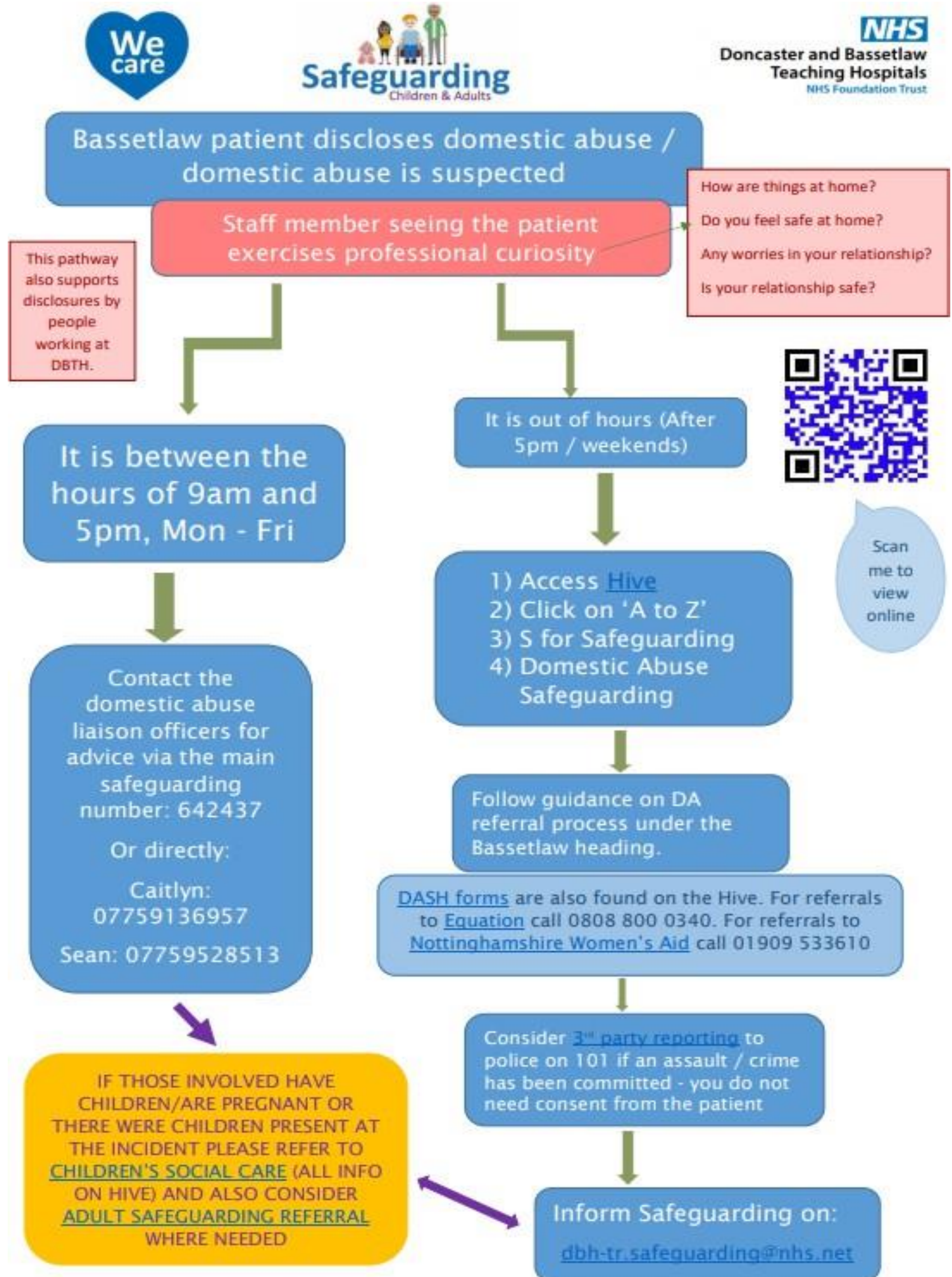


The windscreen and descriptors illustrate how Safeguarding Children's Partnerships will respond to the requirements of children and families across the four levels of need. All services and interventions seek to work openly with the family (or with young people on their own where it is appropriate) in order to support them to address identified needs at the right level of intervention. The following links provide further detail details about multi-agency threshold descriptors for both Doncaster and Nottinghamshire that can support assessment and decision making in respect of safeguarding children. DSCP & NSCP

APPENDIX 4 – DONCASTER DOMESTIC ABUSE REFERRAL FLOWCHART



APPENDIX 5 – NOTTINGHAMSHIRE DOMESTIC ABUSE REFERRAL FLOWCHART



APPENDIX 6 – SAFEGUARDING MEETINGS

There are a number of different safeguarding meetings that DBTH colleagues may be required to attend. Below are some examples. DBTH have an obligation to share information with other agencies to safeguarding children as part of the local multi agency safeguarding arrangements. DBTH Safeguarding Team can be contacted to discuss any support required in respect of meeting attendance.

MEETING	
Strategy Meeting	Whenever there is reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm, a strategy meeting/discussion should be held. Strategy discussions should ideally be face-to-face but telephone discussions (for example, by a conference call or virtual meeting) may be adequate in some circumstances. Strategy meetings should be multi-agency as far as possible and should involve all key professionals known to, or involved with, the child and family. Local authority children's social care, health and the police should always attend. Where the child is in hospital, the appropriate clinician should also be included.
Initial Child Protection Case Conference	A child protection conference is a meeting between parents or carers, the child or young person where appropriate), supporters or advocates and those practitioners most involved with the child, young person and family. There is an initial conference (ICPC) which is followed by review conferences (RCPC). The first RCPC takes place within three months of the ICPC to review progress of the Child Protection Plan; then again, at least every six months while the Child Protection Plan remains in place.
Core Group Meeting	The Core Group ensures that the Child Protection Plan for the child is implemented, progressed and reviewed regularly and amended accordingly to meet its aim of protecting and promoting the welfare of the child. Every member of the Core Group shares responsibility for successfully implementing the Child Protection Plan. It is, therefore, essential that all Core Group members are aware of their responsibilities and attend core group meetings.
Multi-agency meetings	Meetings may be convened to share worries or concerns with other professionals / agencies. Agency information is shared to determine any risks; what level of support is required for the child or young person and plan to reduce risks to the child and ensure safety.

APPENDIX 7 – GOLDEN RULES FOR INFORMATION SHARING

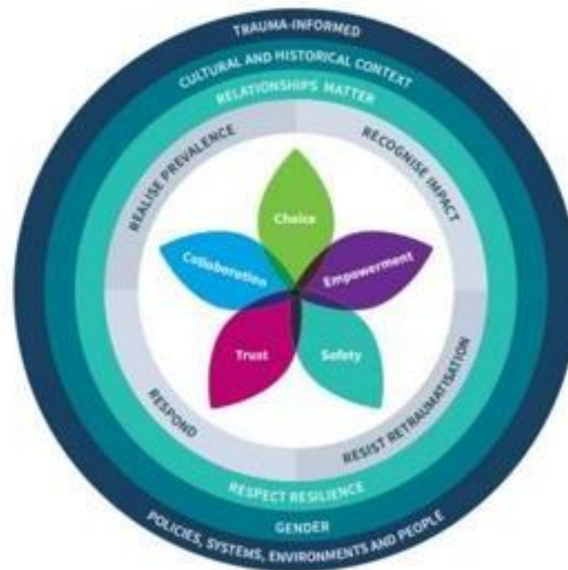
The seven golden rules to information sharing

1. **All children have a right to be protected from abuse and neglect**. Protecting a child from such harm takes priority over protecting their privacy, or the privacy rights of the person(s) failing to protect them.
2. When you have a safeguarding concern, **wherever it is practicable and safe to do so, engage with the child and/or their carer(s),** and explain who you intend to share information with, what information you will be sharing and why.
3. **You do not need consent to share personal information about a child and/or members of their family if a child is at risk or there is a perceived risk of harm.**
4. **Seek advice promptly** whenever you are uncertain or do not fully understand how the legal framework supports information sharing in a particular case.
5. When sharing information, ensure you and the person or agency/organisation that receives the information **take steps to protect** the identities of any individuals (e.g., the child, a carer, a neighbour or a colleague) who might suffer harm if their details became known to an abuser or one of their associates.
6. **Only share relevant and accurate information** with individuals or agencies/organisations that have a role in safeguarding the child and/or providing their family with support, and only share the information they need to support the provision of their services.
7. **Record the reasons for your information-sharing decision, irrespective of whether or not you decide to share information.**

Adapted from the government guidance: Information Sharing; Advice for Practitioners providing safeguarding service to children, young people, parents and carers (2024).

APPENDIX 8 – TRAUMA INFORMED PRACTISE

Trauma Informed Practise



Trauma informed working is an approach. It is moving from 'what's wrong with you?' to 'what has happened to you?' and 'what are you having to do to survive'. It is moving from 'what is your problem?' to 'what is your story?' and 'what are your strengths?'

APPENDIX 9 – EQUALITY INPACT ASSESSMENT – PART 1 INITIAL SCREENING

Service/Function/Policy/Project/ Strategy	Division	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
Safeguarding Children Policy	Safeguarding	Vicki Baker	Existing policy update	16.01.2025

1) **Who is responsible for this policy?** Name of Division/Directorate: Safeguarding Team DBTH

2) **Describe the purpose of the service / function / policy / project/ strategy?** Who is it intended to benefit? What are the intended outcomes? To provide guidance for all colleagues on safeguarding children, process and procedure.

3) **Are there any associated objectives?** Legislation, targets national expectation, standards: Working Together 2023, Children Act 2004. Children Act 1989.

4) **What factors contribute or detract from achieving intended outcomes?** – Adherence to policy.

5) **Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief?** Details: [see Equality Impact Assessment Guidance] – No.

- **If yes, please describe current or planned activities to address the impact** [e.g. Monitoring, consultation] –

6) **Is there any scope for new measures which would promote equality?** [any actions to be taken] N/A

7) **Are any of the following groups adversely affected by the policy?**

Protected Characteristics	Affected?	Impact
a) Age	No	
b) Disability	No	
c) Gender	No	
d) Gender Reassignment	No	
e) Marriage/Civil Partnership	No	
f) Maternity/Pregnancy	No	
g) Race	No	
h) Religion/Belief	No	
i) Sexual Orientation	No	

8) **Provide the Equality Rating of the service / function /policy / project / strategy – tick (☐) outcome box**

Outcome 1 ✓	Outcome 2	Outcome 3	Outcome 4

If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a* **Detailed Equality Analysis form – see CORP/EMP 27.

Date for next review: Feb 2028

Checked by: [signature] **Date: 16.01.25**