FIRST PERSON PROJECT C.I.C.

# Policy

| | |
|---|---|
| **Policy Number:** | 002 |
| **Policy Title:** | Safeguarding and the Protection of Children |
| **Scope of this Document:** | All Staff (including employees and volunteers) |
| **Recommending Committee:** | Quality and Safety Committee |
| **Approving Committee:** | First Person Project Board of Directors |
| **Date Ratified:** | 16/06/21 |
| **Review Period:** | 2 Years |
| **Version number:** | 1.0 |
| **Lead Executive Director:** | Matty Caine |
| **Author(s):** | Matty Caine (MC) |

| | |
|---|---|
| **Contact:** | Matty Caine (Safeguarding Lead)<br><br>07824 395 328<br><br>matty@firstpersonprojectcic.co.uk |
| **Published by:** | First Person Project CIC<br><br>https://www.firstpersonprojectcic.co.uk/ |

**To be read in conjunction with: The relevant multi-agency Safeguarding Adults procedures developed by the local authorities covering the locality of FPP service delivery (all available online).**

| **Version Control:** | | | |
|---|---|---|---|
| **Version** | **Reason for Change** | **Change Author** | **Change Date** |
| 1 | Original Policy | MC | 16/06/21 |
| | | | |
| | | | |

FIRST PERSON PROJECT C.I.C.

**Contents** **Page**

FIRST PERSON PROJECT C.I.C.

## 1. PURPOSE AND RATIONALE

**1.1** The purpose of this policy is to ensure children are protected from maltreatment and to ensure their overall welfare is promoted in order to prevent impairment of their health and development.

The policy ensures a structured and systematic approach to child protection across the organisation. The Children Act 1989 places a statutory duty on Health Professionals to help Social Services with their enquiries so long as it is compatible with their own statutory duties or other duties and obligations and does not unduly prejudice the discharge of any of their functions.

## 2. Outcome Focused Aims and Objectives

**2.1** The objectives of the policy are to identify concerns that a child may be suffering or likely to suffer significant harm. Another key objective is to ensure children's needs are promoted in a way that prevents impairment of their health and development. Promoting a child's welfare includes creating opportunities to enable children to have optimum life chances in adulthood and ensuring that children grow up in circumstances consistent with the provision of safe and effective care.

**2.2** These aims and objectives and based on:

- The principles of the Children Act 1989 Section 11 of the Children Act 2004;
- The UN Convention on the Rights of the Child;
- The Human Rights Act 1998;
- The Data Protection Act 1999;
- The Adoption and Children Act 2002;
- Department of Health guidance on Working Together to Safeguard Children 2015;
- The Framework for the Assessment of Children in Need and their Families 2000;
- What to do if you are worried a child is being abused 2003-12-16;
- The Laming Report 2003;
- When to Suspect Child Maltreatment NICE Guidelines 2017;
- Handling Cases of Forced Marriage (Ministry of Justice, 2009);
- Safeguarding Children and Young People who may be affected by Gang Activity (DCSF 2010;

- Safeguarding Children from Abuse Linked to a Belief in Spirit Possession (DCSF 2007);
- The relevant multi-agency Safeguarding Children procedures developed by the local authorities covering the locality of FPP service delivery (all available online).

## 3. Scope

**3.1** Every member of staff has an individual responsibility for the protection and safeguarding of children. All levels of management must understand and implement the Organisation's Safeguarding and Protection of Children Policy and Procedure. These procedures are for all staff working within First Person Project C.I.C.

**3.2** Any volunteers, students, trainees or interns employed by First Person Project must identify their status when talking about clients to professionals in other agencies.

## 4. Definitions

**4.1** This policy is based on the expectation that staff must ensure the welfare of children in the course of their daily work.

**4.2** Service users must be made aware of the limitations of and exceptions to confidentiality in relation to child protection.

**4.3** When there is a conflict of interests between the needs of the adult and those of a child, the welfare of the child is paramount. (Paramountcy Principle, Children Act 1989).

**4.4** In circumstances where there are concerns that a child is suffering or likely to suffer harm, this must result in a referral to Children's Social Care. The local authority is obliged to consider initiating enquiries under Section 47 of the Children Act 1989 (Section 47 Enquiries) to find out what is happening to a child or whether action should be taken to protect a child.

**4.5** In circumstances where a child has been identified as 'in need' a referral should be made to the local authority under the Children Act 1998 section 17. The Children Act 1998 defines a child in need as:

*A child whose vulnerability is such that they are unlikely to reach or maintain a satisfactory level of health or development, or their health and development will be significantly impaired, without the provision of service Or a disabled child.*

**4.6** The Early Help Assessment Framework should be followed to promote multi-disciplinary and multi-agency working at an early stage in order to identify and provide services to Children in Need of additional support before their needs escalate.

**4.7** Working Together to Safeguard Children 2015 identifies four categories of abuse, these are defined as:

- Physical Abuse:

  A form of abuse which 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:

  The persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to a child that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may include not giving the child opportunities to express their views, deliberately silencing them or 'making fun' of what they say or how they communicate. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond a child's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction. It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying (including cyber bullying), causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.

- Sexual Abuse:

  Involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing,

rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet). Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.

- Neglect:
  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.

**Policy Standards**

**4.8** The following policy standards outline the broad statement of intent, which will be clarified in the relative sections throughout this policy document.

**4.9** Safeguarding children is the business of everyone in First Person Project CIC. All staff should be aware of their individual level of responsibility and accountability in relation to safeguarding children.

**4.10** Safeguarding children is monitored and managed through effective supervision and audit of practice.

**4.11** Safeguarding children concerns can only be assessed by local authority children and families assessment teams.

**4.12** The Safeguarding Lead manages child protection within the organization.

**4.13** The document clarifies the policy and procedure for Safeguarding children within the Organisation.

**4.14** All staff must be trained, in child safeguarding/protection awareness commensurate with their role within the Organisation.

**4.15** All child protection issues are managed within the legal framework; the Local Safeguarding Children Boards' and First Person Project CIC Organisational Policy.

**Corporate Procedure**

**4.16** The Organisation should work within the principles of the Children Act 1989, the Children Act 2004, and other relevant legislation.

**4.17** There are several key elements of this policy that staff must understand and adhere to:

**4.18** Making a safeguarding referral to the Local Authority – The process in later sections explains the process and contact details of appropriate professionals. This also details the process that should be followed prior to making a referral.

**4.19** The need for any information recorded or reported to be fact not opinion - Organisation staff may need to refer an allegation/concern for assessment to determine the facts. This must be clearly stated in the referral.

**4.20** NO MEMBER OF ORGANISATION STAFF should interview a child suspected or known to be at risk of harm as part of the formal child protection processes. This is the role of Social Care. This does not preclude staff from listening and offering support to any child in distress.

**4.21** Staff can establish whether the child or family is known to children's services, or whether a child is subject to a child protection plan, by contacting the relevant Social Services. (Explain who you are, and why you are requesting this information).

**4.22** All contact details for the relevant local authority can easily be found online.

## 5. Duties

**Roles, responsibilities and accountabilities of all staff**

**5.1** Anyone working or involved in the statutory, voluntary and independent sectors should bear in mind the welfare of children, irrespective of whether they are primarily working with adults or children and young people. They are likely to become aware of a broad range of children's needs in their daily work.

**5.2** All professionals should be aware of legislation concerning child protection, and informed about their local child protection procedures, the work of the Local Safeguarding Children's Boards, and of their responsibilities for safeguarding children. They may need to fulfill their duty to assist Social Care in assessments, as well as attending and reporting to child protection conferences when necessary.

**5.3** The mental health perspective is important in respect of many aspects of children's welfare. Local Safeguarding Children Boards should be able to call upon the expertise of adult mental health services, learning disability, forensic and substance misuse services to effectively share information in relation to parental mental health/substance misuse and learning disabilities and how this can impact on parenting capacity.

**5.4** Mental health services have a responsibility in safeguarding children when they become aware and identify a child at risk of harm. This may be as a result of services' direct work with young people, a parent, a parent to be, or a non-related abuser, or in response to a request for the assessment for an adult perceived to represent a potential or actual risk to a child or young person.

**5.5** Close collaboration and liaison between the mental health services and children's welfare services are essential in the interests of children. This will require the sharing of information where this is necessary to safeguard a child from significant harm. The Safeguarding Lead can help in facilitating communication between mental health services and children's social care, especially when there are concerns about responding appropriately both to the duty of confidentiality and the protection of children.

**Roles, responsibilities and accountability of the Safeguarding Lead**

**5.6** The Safeguarding Lead will take the professional lead within the Organisation on child protection matters. They should have expertise on children's health and development,

the nature of child maltreatment and local arrangements for safeguarding children and promoting their welfare.

**5.7** They provide a source of advice and expertise to fellow staff and other agencies. They have an important role in promoting good professional practice within the organisation in safeguarding children.

**5.8** They are responsible for conducting the Organisation's internal case reviews. They investigate and respond to safeguarding children complaints on behalf of the Organisation.

**5.9** They raise the standard and quality of care to vulnerable children and their families within the Organisation by adopting a multi-agency framework. They assist the Organisation to understand its safeguarding and protection of children role and responsibilities.

**5.10** They substantially contribute to the development of Organisation and multi-agency policy and procedure practice guidelines. They ensure that appropriate safeguarding and protection of children standards are adhered to.

**The responsibility of the Board of Directors**

**5.11** The Chief Executive, as the Accountable Officer, has overall responsibility for ensuring the implementation of an effective safeguarding and protection of children policy and procedure, for the development of corporate governance and for meeting all statutory requirements.

**5.12** The Board of Directors have a responsibility for ensuring that a Policy & Procedure for effective Safeguarding of Children and Young People is in place; that it is implemented effectively; that all staff are aware of and operate within the requirements and that systems are in place for the effective monitoring of the standards contained within the policy.

**5.13** The Quality and Safety Committee is an established part of the governance structures of the Organisation which has the responsibility to ensure that safeguarding of children arrangements are managed appropriately across the Organisation. The Committee ensures that the policy framework is appropriate and receives assurances in

relation to compliance with the requirements of this policy through the receipt of reports, audit activity and from the review mechanisms established by the Board of Directors.

**5.14** The Quality and Safety Committee, including Safeguarding Lead, will provide the Board of Directors with assurance on all matters relating to safeguarding within the organization, including:

- The generation of annual reports to the Board in relation to safeguarding both children and adults;
- Makes recommendations to the Board on Safeguarding issues;
- Ensure compliance with safeguarding/protection of children and vulnerable adults, standards for OFSTED, Care Quality Commission, Local Safeguarding Children's Boards, Safeguarding Adults Boards and any other inspectorate;
- Ensure the production, implementation and review of LSCB and LSAB action plans devised as a result of Serious Case Reviews/Safeguarding Children Reviews and Internal Serious Untoward Incidents when there is a safeguarding dimension.

**5.15** The Board of Directors has ultimate responsibility for ensuring that an effective system for managing any risks associated with safeguarding children exists within the Organisation and that all staff working in the Organisation are aware of, and operate within the policy. The Board will assure itself of compliance with this policy through the accountability arrangements delegated to the Quality and Safety Committee and via consideration of an annual report prepared by the Safeguarding Lead.

**The voice of the Child**

**5.16** Children want to be respected, their views to be heard, to have stable relationships with professionals built on trust and for consistent support provided for their individual needs. This should guide the behaviour of professionals. Anyone working with children should see and speak to the child; listen to what they say; take their views seriously; and work with them collaboratively when deciding how to support their needs.

**5.17** A child-centred approach is supported by: the Children Act 1989 (as amended by section 53 of the Children Act 2004). This Act requires local authorities to give due regard to a child's wishes when determining what services to provide under section 17 of the Children Act 1989, and before making decisions about action to be taken to protect individual children under section 47 of the Children Act 1989. These duties complement requirements relating to the wishes and feelings of children who are, or may be, looked

after (section 22 (4) Children Act 1989), including those who are provided with accommodation under section 20 of the Children Act 1989 and children taken into police protection (section 46(3) (d) of that Act).

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

## 6. Process and Procedure

**Children in specific circumstances**

**6.1** All families may experience difficulties from time to time for a whole host of reasons which may have an impact on their children. There are circumstances either when sources of stress in families have an impact on a child's health development, and wellbeing, directly or because it affects the capacity for parenting. In these circumstances it is important not to generalize or make assumptions about the impact on the child, but the needs of the child must be properly assessed. This can only undertaken by children and family social workers.

**Domestic abuse and safeguarding children**

**6.2** Domestic abuse describes a continuum of behaviour ranging from verbal abuse, through threats and intimidation, manipulative behaviour, physical and sexual assault, to rape and even homicide.

**Fabricated or induced illness**

**6.3** Safeguarding Children in whom illness is fabricated or induced is a specific category of abuse (DH 2002).

**6.4** Concerns may be raised by staff, who may suspect that the health or development of a child has been, or is likely to be significantly affected, by a parent or carer who may have fabricated or induced illness in their child in order to gain attention.

**6.5** Staff may observe unusual behaviour or unexplained incidents which alert them to the possibility of Fabricated or Induced Illness. They should explore the presenting information to identify where it is on the continuum from parental concern, over anxiety, through to suspected significant harm.

**6.6** Health professionals would usually discuss any concerns about a child with the parent or carer and seek their consent to make a referral to Children's Services. However, in these circumstances it is imperative that the health professional does not discuss their concerns with the parents/carers as it may place the child at increased risk of significant harm.

**6.7** Staff should not make a referral to Children's Services without seeking advice from the Safeguarding Lead.

**6.8** Following advice, the relevant Local Authority Safeguarding Children Service should be contacted.

**Bruising in non-mobile infants**

**6.9** Bruising is the commonest presenting feature of physical abuse in children. Recent serious case reviews have indicated that clinical staff have sometimes underestimated or ignored the highly predictive value for child abuse, of the presence of bruising in children who are not independently mobile (those not yet crawling, cruising or walking independently).

**6.10** NICE guidance When to Suspect Child Maltreatment (2017) states that bruising in any child not independently mobile should prompt suspicion of maltreatment.

**6.11** If any staff member has cause for concern due to a bruise being evident in a non-mobile infant, this must be immediately reported to the relevant local authority as per this policy.

**Mental health of parent or carer and child protection**

**6.12** Mental illness in a parent or carer does not necessarily have an adverse impact on a child, but it is essential always to assess its implications for any children involved in the family.

**6.13** It has potential for impact in the following ways:

- Parental illness may markedly restrict children's social and recreational activities
- Children may have caring responsibilities inappropriate for their years
- Parents, if depressed, may neglect their own and their children's physical and emotional needs

- In some circumstances, some forms of mental illness may blunt parents' emotions and feelings or cause them to behave towards their children in bizarre or violent ways
- Post-natal depression can be linked to behavioural and physiological problems in the infants of such mothers
- Children most at risk of significant harm are those who feature in parent's delusions and children who become targets of parental aggression or rejection, or who are neglected as a result of parental illness. In all cases where a child features in a patients delusional beliefs, or is included in a suicide plan, a referral to children's services must be made.
- Unusually, but at an extreme, a child may be at risk of severe injury or even death
- Remember it is the behaviour and thought processes of the parents/carers rather than the diagnosis that identifies the risk to the child.
- Some parents may fabricate or induce illness in their child. If there is concern regarding this, then a referral to children's services should be actioned.

**6.14** The interests of the child are paramount and initiating child protection procedures is not conditional on obtaining consent.

**6.15** There may be limitations with confidentiality, when there are concerns about children and in the greater public interest. Professionals should never promise complete confidentiality in these circumstances.

**6.16** Immediate response to make a child safe from harm may be necessary.

**6.17** Where there is cause for concern about what is happening, the ability of the parent or caregiver to ensure that the child's needs are being adequately responded to, must be considered.

**6.18** Specialist advice can always be sought from the Safeguarding Lead.

**6.19** If a child's needs are not being adequately responded to, then a referral to Social Care must be made.

**6.20** Social Care will gather information about the dimensions of parenting capacity to examine the parent's problems, the impact on the child and the effect of the parent on the child. The advice of a Mental Health Professional will be vital for the assessment of risk to children.

**Attendance at child protection conferences**

**6.21** Attendance at Child Protection Conferences is now sought from a wider range of professionals who work with parents, particularly in relation to substance misuse, domestic abuse and learning disability (DOH 2013). It is expected the First Person Project CIC staff attend Child Protection Conferences when required. On occasions

when this is not possible liaison with the Safeguarding Lead is required and a written report must be submitted to the Conference Chair or the Social Worker.

**6.22** For staff who are maybe inexperienced in managing child protection cases, a discussion with the Safeguarding Lead prior to attending a conference. Prior to attendance staff will be required to complete a pre-conference health report to support decision making. A copy of this report must be sent to the Local Authority safeguarding children's team a minimum of 2 working days prior to the conference.

**6.23** The pre-conference report must be completed using the relevant model of assessment dependent on the Local Authority area.

**6.24** The content of the report should clearly distinguish between fact and professional opinion, ambiguous language and abbreviations should not be used. The report should include information with regards to the child's health and development, parenting capacity, current and historical significant information.

**6.25** If support is required whilst developing a pre-conference report the Safeguarding Lead can provide support, guidance and advice with regards to the preparation of the report.

**6.26** Prior to attendance at the child protection conference, the member of staff must liaise with the allocated social worker to identify how many copies of the report will be required. One copy will be maintained by the Independent Reviewing Officer following the meeting. All other copies must be numbered to ensure the practitioner can ensure all copies are returned following the end of the conference.

**6.27** All staff must prioritise attendance when invited to a child protection conference to support the multi-agency process. Any issues should raised with service management.

**6.28** If staff disagree with the multi-agency outcome of the conference, he/she has a responsibility to declare his/her disagreement and reasons in order that it will be recorded appropriately.

**6.29** If the outcome is for the child/young person to be placed on a child protection plan, membership of the on-going core group will be decided at the time of the initial conference.

**6.30** Following the initial child protection conference, the member of staff will be required to attend the associated 'core' groups and any subsequent child protection conference meetings. Prior to each conference meeting a new pre-conference report will be required containing relevant information following the process above.

**6.31** If more than one service is involved with a family who are subject to child protection plan, it will be the responsibility of the core group member to share appropriate information in a timely manner with other colleagues across the organization.

**6.32** All staff who attend a child protection case conference must record the following information.

- Post Conference Report
- Date, time and venue of the conference
- A brief summary of the reason the child protection conference was convened
- The decision of the conference (category of abuse)
- Content /recommendations of the plan
- Outcome and action plan
- Copy to Safeguarding Lead
- Copy to GP

**6.33** As a member of a Core Group the member of staff should attend all future Core Group meetings, related meetings or reviews (this is essential for effective working with the family. In the circumstances that the practitioner is unable to attend, up to date information should be shared with the allocated Social Worker or alternatively a deputy (colleague) may attend the core group with a report on behalf of the professional. The deputy should feedback any relevant information and the outcome of the core group.

**6.34** If the staff member believes the Child Protection Plan is not effective or if new information comes to light, they should inform the Social Worker and the safeguarding children's team without delay in order to escalate concerns as appropriate and implement the relevant LSCB escalation policy if required.

Sharing of information about circumstances of family stress – domestic abuse, mental health of a parent or drug and alcohol misuse

**6.35** Research and experience have shown repeatedly that to keep children safe from harm requires Professionals and others to share information about:

- A child's health and development and exposure to possible harm
- Parents who may need help and may not be able to care for a child adequately and safely

**Those who pose a risk of harm to children.**

**6.36** There are a number of references in Department of Health documents, guidance on the legal framework and professional guidance papers, which will assist professionals in deciding what and if information should be shared.

**6.37** Social Care has a statutory duty to make enquiries and they need the help from other agencies to do this effectively. When approaching Health Professionals for information, consent for disclosure of information would normally be sought. Social workers should be clear about the nature and the purpose of the request, whether the consent of the subject of the information requested has been obtained, or whether in the view of Social Services, such consent seeking would itself place a Child at Risk of Significant Harm. A written consent form may be held by Social Services, a copy of which should be provided to Health Professionals if available.

**6.38** Guidance in those documents referred to above make it clear that in certain circumstances, disclosure is necessary in the interests of others. Adults who pose a risk of harm to a child and children, who may be the subject of abuse, are included in circumstances where information can be released, without the consent of the service user or client.

**GP registration**

**6.39** Families often move into an area and do not immediately register with a local GP or school; this may be for a variety of reasons and not necessarily mean that they are avoiding contact with professionals. However, it must be acknowledged that sometimes children and families become "invisible" to services and therefore any risk may be increased.

**6.40** If a member of staff becomes aware of a child living within the area who is not currently registered with a GP or school, they should make contact with the Safeguarding Lead who will alert the appropriate Community Health Service.

**6.41** If there are any concerns identified which would require a referral to Children's Services, this should be made following the same process for any other referral.

**Gun and gang crime/Criminal exploitation**

**6.42** Young people at serious risk of harm from community based violence such as gang, group and knife crime are likely to have significant needs. The safeguarding process needs to respond effectively to the needs of the individual.

**6.43** Children at risk of suffering violence within the community. This may involve both the perpetrators and victims of violent activity.

**6.44** In incidences where service users who are either young people or are parents/carers are known to be involved in gun and gang related crime, advice should be sought from Social Care, the Police and the Safeguarding Lead.

**Forced marriage and honour based violence**

**6.45** Forced marriage and honour based violence affects victims from many communities. The majority of cases reported to date in the UK involve South Asian families, but there have been cases involving families from across Europe, East Asia, the Middle East and Africa. Some forced marriages take place in the UK with no overseas element, while others involve a partner coming from overseas or a British national being sent abroad (DOH 2010).

**6.46** If there are concerns that a young service user, (male or female) or a child of a service user, is at risk from forced marriage or honour based violence, a referral to Social Care is required. Do not inform the victim's family of the disclosure as this will greatly increase the risk.

**6.47** The Safeguarding Lead should also be contacted who will alert The Forced Marriage Unit.

**Abuse linked to spirit possession**

**6.48** There are a number of common factors which put a child at risk of harm, including rationalising misfortune by attributing it to spiritual forces and when a carer views a child as being 'different', attributes this difference to the child being 'possessed' or involved in 'witchcraft', and attempts to exorcise him or her. A child could be viewed as 'different' for a variety of reasons such as: disobedience; independence; bedwetting; nightmares; illness; or disability. The attempt to 'exorcise' may involve severe beating, burning, starvation, cutting or stabbing, and/or isolation, and usually occurs in the household where the child lives (DOH 2010).

**6.49** When concerns exist regarding a belief in spirit possession, Safeguarding Children principles including: sharing information across agencies; being child focused at all times; and keeping an open mind when talking to parents and carers should be applied. The Safeguarding Lead should be alerted and appropriate referrals to Children's Social Care should be undertaken.

**Child sexual exploitation (CSE)**

**6.50** Children who are /at risk of being sexually abused or sexually exploited should be treated as victims of abuse and their needs require careful assessment.

**6.51** Children who are being sexually exploited are highly likely to be in need of welfare services and may need protection under The Children Act 1989. Even when the child/young person appears to believe that they are making their own decision about whether to be involved in prostitution, it is highly likely that they are being manipulated or coerced into such behaviour.

**6.52** Gaining the child's trust is vital if he or she is to be helped to be safe and well and provided with the opportunity and strategies to exit from prostitution. However, it is not acceptable practice for Professionals to withhold information from Children's Services about children and young people involved in prostitution on the grounds of confidentiality.

**6.53** If a member of First Person Project staff has concerns about a child/young person who they think may be being abused, or is at risk of being abused through CSE, they must discuss those concerns with the Safeguarding Lead.

**6.54** If a child under 13 years of age discloses they have had any aspect of a sexual relationship or are seeking support from sexual health services this must result in an immediate referral to the relevant Local Authority.

**Safeguarding children who may have been trafficked**

**6.55** The organised crime of child trafficking into the UK has become an issue of considerable concern to all professionals with responsibility for the care and protection of children.

**6.56** Any form of trafficking children is an abuse. Children are coerced, deceived or forced into the control of others who seek to profit from their exploitation and suffering. Some cases involve UK-born children being trafficked within the UK.

**6.57** It is essential that professionals working across social care, education, health, immigration and law enforcement develop an awareness of this activity and an ability to identify trafficked children.

**6.58** The definition of trafficking contained in the "Palermo Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children" (ratified by the UK in 2006) is as follows:

"Trafficking of persons" shall mean the recruitment, transportation, transfer, harbouring or receipt of person, by means of the threat of or use of:

Force; or other forms of coercion;, abduction; fraud; deception; the abuse of power; or of a position of vulnerability; or the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation.

Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs.

**6.59** Most children are trafficked for financial gain; this can include payment from or to the child's parents. In most cases, the trafficker also receives payment from those wanting to exploit the child once in the UK. Trafficking is carried out by organised gangs and individual adults or agents.

**6.60** Trafficked children may be used for:

- Sexual exploitation
- Domestic servitude
- Sweatshop, restaurant and other catering work
- Credit card fraud
- Begging or pick pocketing or other forms of petty criminal activity
- Agricultural labour, including tending plants in illegal cannabis farms
- Benefit fraud
- Drug mules, drug dealing or decoys for adult drug traffickers
- Illegal inter-country adoptions

**6.61** If any member of staff suspects that a child or young person maybe a victim of trafficking or that a property is being used to house victims of trafficking they must contact the Safeguarding Lead immediately.

**6.62** A referral to Children's Services will need to be made and a strategy meeting will be convened to safeguard the child or young person effectively.

**Travelling families**

**6.63** The Local Authority has a duty to protect the children of travellers who are at risk of significant harm. Staff must refer any concerns about a child from a travelling family to Children's Services in the same way as every other child. The focus must be on the needs of the child and not on the needs of the parents.

**6.64** Children in travelling families do not always attend school and may not be known to the School Health Service or to Primary Care. Staff must always make contact with the Specialist Health Visitor for travelling families to make sure that appropriate health checks are made where possible.

**Asylum seeking families/Unaccompanied asylum seeking children (UASC)**

**6.65** The Local Authority has a duty to protect children of refugees, asylum seekers and migrant workers, who are at risk of significant harm.

**6.66** All staff must refer any concerns about any children of an asylum seeker, refugee or migrant worker to Services in the same way as every other child.

**6.67** It is important to give as much information as possible to assist Children's Services identify the status of the child and family. The focus should be on the needs of the child and not the needs of the parents.

**6.68** These children do not always attend school and may not be known to the School Health Services or to Primary Care Services. Staff must always make contact with the relevant School Nurse Team Leader, if the child is of school age, to ensure that appropriate health checks are made where possible.

**6.69** Good quality interpreting services are essential when dealing with families whose first language is not English.

**6.70** A UASC is an asylum-seeking child under the age of 18 who is not living with their parent, relative or guardian in the UK. In most cases UASC will be referred to local authorities by the UK Border Agency (UKBA) shortly after they arrive in the United Kingdom.

**6.71** Local authorities should adopt the same approach to assessing the needs of a UASC as they use to assess other children in need in their area. The child will not have a parent, relative or other suitable adult carer in the United Kingdom and is likely to have to be accommodated under section 20 of the Children Act.

**6.72** There are some children and young people whose age may be in dispute and may be undergoing the age assessment process which will determine whether or not they receive support from the Local Authority.

**6.73** Further advice in relation to refugees and asylum seekers can be sought from the Specialist Health Visitors/Asylum Seekers Refugees and Migrant Workers. For current contact details please contact the Safeguarding Lead.

**Unaccompanied children attending a walk in centre/other FPP service location**

**6.74** Unaccompanied children may attend walk in centres/services areas for a variety of reasons which may mean that they are particularly vulnerable, possible reasons:

- They may not wish to see their own GP or other professional involved.
- They do not wish for their parent/carer to know about their attendance
- The parent/carer may have been instrumental in the reason for the attendance e.g. an alleged assault or incidence of abuse.

**6.75** All unaccompanied children/young people should be made aware of the organisation statement of confidentiality and the limitations to confidentiality.

**6.76** Children and young people may disclose information which may be a cause for concern to staff such as:

- Incidents of abuse
- They are being sexually exploited
- They are involved in criminal activity or a lifestyle which may cause concern

**6.77** Staff may have to deal with children and young people about whom there are concerns that they may be a victim of sexual exploitation. A child involved in prostitution should always be treated as a victim of abuse.

**Female genital mutilation (FGM)**

**6.78** Female Genital Mutilation is a collective term for procedures which involve the removal of all or part of the external female genitalia for cultural or other non-therapeutic purposes. It is medically unnecessary, extremely painful and has significant health consequences for women/girls who experience it. FGM is typically performed on girls between the ages of 4 – 13 years but is also performed on new born babies and young women before marriage or pregnancy. Within the United Kingdom, FGM in any of its forms has been classed as a criminal offence since the Prohibition of Female Circumcision Act was passed in 1985. In 2003, The Female Genital Mutilation Act

superseded this and it became, for the first time, an offence for UK nationals or permanent residents to carry out FGM abroad, or to aid, abet, counsel or procure the carrying out of FGM abroad, even in countries where the practice is still legal.

**6.79** First Person Project CIC staff should be alert to the possibility of FGM amongst communities known to perform it. Staff should be aware of and work with the strengths and support systems available within families and communities. However, the FPP Safeguarding Children Procedures should be followed in circumstances where FGM is suspected or known to have either taken place or be likely to take place. Although illegal in the majority of countries worldwide, the World Health Organisation estimates that approximately 3 million girls a year are at risk from this procedure in Africa alone. In addition, 100-140 million girls and women worldwide are currently living with the consequences of FGM.

**6.80** Whilst the current incidence of the practice actually performed in this country is unknown, Liverpool is one of the cities within the UK that FGM is considered to be an endemic practice. It is thought that whilst some female children undergo FGM in the UK, despite it being illegal, there is also a likelihood that children are taken back to their country of origin in order to perform FGM.

**6.81** Factors which may alert First Person Project CIC staff to FGM:

- Midwives, Health Visitors and GP's may become aware that a woman who has undergone FGM herself already has female children or gives birth to a female child.
- Other siblings are known to have undergone FGM .
- Family belongs to a cultural group which is known to practice FGM.
- An allegation or disclosure of proposed or actual FGM is received by First Person Project staff.
- Suspicions are raised about a child being prepared for FGM e.g. preparations for a long holiday where the other family members are not intending to go or a disclosure by a child that a "special procedure" is taking going to take place.
- Children whose behaviour alters on return from a trip abroad, prolonged periods of absence from school or normal activities, bladder or menstrual problem, difficulty/ pain in walking and sitting.

**6.82** If it is thought that a female child could be at imminent risk of FGM or has possibly recently undergone FGM, staff must contact the Safeguarding Lead immediately and make a referral to Children's Social Care.

**E-safety**

**6.83** Whilst the internet and the digital world such as social media should be embraced, it also poses a danger to children and young people, who may be exposed to pornography, cyber bullying, sexting etc. If First Person Project CIC staff are concerned that a child or young person is at risk, concerns should be discussed with the Safeguarding Lead and appropriate referrals to Children's Services should be made.

**Children with a disability**

**6.84** Disabled children are more vulnerable to abuse because they may:

- Have fewer outside contacts than other children;
- Receive intimate personal care, so increasing the risk of exposure to abusive behaviour;
- Have an impaired capacity to resist abuse;
  Have communication difficulties that make it harder to tell others of their concerns;
- Be more vulnerable to bullying, intimidation and abuse by both adults and peers.

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

**6.86** Where there are concerns about the welfare of a disabled child, these should be acted on in exactly the same way as with a non-disabled child. The same thresholds for action must apply. Where there are safeguarding concerns about a disabled child, there is a need for greater awareness of the possible indicators of abuse and/or neglect as the situation is often more complex. It is crucial that the disability is not allowed to mask or deter the need for an appropriate investigation of child protection concerns.

**Adults who pose a risk to children (Previously Schedule One Offenders)**

**6.87** The term 'adults who pose a risk to children' replaces the term schedule 1 offender. This term has commonly been used for anyone convicted of an offence against a child listed in schedule one of the Children and Young Person's Act 1933.

**6.88** Children's Services are required to undertake an assessment of risk to any child/children if an "adult who poses a risk to children" is known to be living in a household with children and will usually convene a Child Protection Case Conference.

**6.89** Any member of staff who becomes aware that an adult who poses a risk to a child/young person is:

- Living in a home with children, even on a temporary basis Or
- Will be visiting a member of the family or any other child on a hospital ward Or
- Is employed by First Person Project CIC

They must contact the Safeguarding Lead for immediate advice to discuss the referral into social care. It is essential that the case is not discussed with any other staff or colleagues.

**Disclosure of information about adults who pose a risk to children**

**6.90** The Home Office has produced guidance for dealing with the exchange of information about those persons convicted of, or cautioned for sexual offences and those considered a risk to children and others.

**6.91** A Sex Offenders Register exists for offenders convicted of a sexual offence.

**6.92** There are local inter-agency risk assessment protocols in place, which should be followed.

**6.93** For further advice and guidance, contact the Safeguarding Lead.

**Requests for information about service users – sharing information and consent**

**6.94** Professionals can only work together to safeguard children if there is an exchange of relevant information between them. This has been recognised by the courts. Any disclosure of personal information to others must always however have regard to both common and statute law.

**6.95** Normally personal information can only be shared with third parties (including other agencies) with the consent of the subject of that information. Wherever possible, consent should be obtained before sharing personal information with third parties.

**6.96** In some circumstances, consent may not be possible or desirable but the safety and welfare of the child dictate that the information should be shared. "Routinely professionals should explain to patients at the outset the parameters of confidentiality i.e., the duty are not absolute and there may be occasions when information has to be disclosed. If the patient does not consent, as a matter of public duty or under one of the exceptions listed in Schedule 3 of the Data Protection Act (1998) such as in furtherance of duties under the Children Act (1989).

**6.97** The law recognises that disclosure of confidential information may need to occur in the absence of consent.

Children missing from education

**6.98** Where staff identify a child or young person is not attending school referrals to appropriate Local Authority should be made.

**Escalation procedure**

**6.99** If you disagree with how your referred concerns have been progressed refer to the appropriate local authority Safeguarding Children service for further advice. There is an 'Escalation' procedure in place that they can guide you through.

**Allegations of abuse against children by First Person Project CIC staff**

**6.100** There are circumstances when staff will become suspicious / aware of allegations of, or disclosure of, abuse by a professional. This must be reported to the Safeguarding Lead who will inform the Local Authority Designated Officer Designated Officer for the Local Authority (previously known as (LADO) who will be involved in the oversight of

individual cases, providing advice and guidance to employers and liaising within a multi-agency context to establish suitability of an individual to work with children.

**6.101** This abuse may involve:

- A patient of client;
- A child in the professional's family;
- Any domestic abuse in a Health Professionals household where there are children.

**6.102** The Safeguarding Lead should be informed in such circumstances when the allegation concerns abuse of a child or vulnerable adult.

**6.103** The Safeguarding Lead is invited to attend strategy/network meetings as appropriate.

**6.104** There will be four possible strands to dealing with an allegation against Health Professionals:

- Safeguarding children enquiries;
- Designated Officer for the Local Authority investigation;
- Police investigation into a possible offence;
- Disciplinary to misconduct or gross professional misconduct on the part of staff.

**Specific requests for information**

**Police**

**6.105** Contact with Police Officers from the Family Crime Investigation Units, or from any other departments may occur in a number of different ways. They may telephone or make arrangements by appointment to meet with Health Professionals. They may be seeking information for a variety of reasons – investigating a child protection matter, criminal offence, and domestic abuse allegations. Occasionally staff need to be interviewed as witnesses to certain events. There is an expectation that health services will co-operate with the police.

The consequences of inter-agency co-operation are that there has to be an exchange of information.

**6.106** However, do not give any information at all to a police officer without first talking to the Safeguarding Lead or a Company Director who is responsible for making the

decision whether or not to share information with the police, in the best interests of the child. Take the details of the information needed, the reason for the request and the details of the police officer including rank, department and contact telephone number. Advise the police officer that you need to receive a section 29 form from them detailing the request before information can be shared. Contact the Safeguarding Lead to discuss the request.

**6.107** In certain circumstances, police officers are working to very tight time constraints and may appear very insistent that you give them information immediately and quote all sorts of legislation and powers that they have. In those circumstances ask them to contact you again in an hour which will give you time to seek urgent advice.

**Solicitors in child-care proceedings – requests from the Local Authority or statements of evidence for court**

**6.108** A request should be received in writing from the relevant legal department of the Local Authority.

**6.109** Discuss the request with the Safeguarding Lead.

**6.110** Always have the statement checked by the Safeguarding Lead before sending the report.

**6.111** Under the Children Act 1989, Health Professionals have a duty to safeguard and promote the welfare of the child.

**6.112** The legal duty of confidentiality and consent is the same for children and young people as adults. The concept of 'Gillick Competence' is specifically relevant to this group.

**6.113** The Professional has to balance whether by indicating to a patient/client in advance that disclosure will take place or whether after disclosure is made information has to be relayed on and the patient may avoid seeking assistance in the future. Potentially this could compromise the service user's wellbeing and cause worse problems than already exist and from which the Professional is trying to protect the individual.

**6.114** Young people who may be being sexually exploited or misusing substances will cause a difficulty for the Professional in what to do with that information, particularly

when you are asked to keep the information confidential. There may even be some circumstances in which a young person discloses such an unsuitable lifestyle that Professionals will have to consider whether instant action needs to be taken via the local authority.

**6.115** Not-withstanding the previous point above, information given about the young person's lifestyle, which could cause him or her to be in need or at risk of significant harm, needs to be disclosed.

**6.116** Most people under the age of 18 will have an interest in sex and sexual relationships. When a professional working with a young person under the age of 16 becomes aware that the young person is engaged in sexual activity, clear procedures should be in place to assist accurate assessment of the likelihood of suffering Significant Harm in order to protect the welfare of the child or young person. As a minimum the professional should take advice from the Safeguarding Lead.

**6.117** After considering all the factors in each specific case and if the decision is made to refer to Social Services or in an emergency situation to the police, unless a particularly serious situation exists, the young person should be advised as to the intentions of the Professional and the nature of the information to be shared.

**6.118** Always seek expert advice before making a decision.

**6.119** Very detailed supporting documentation should be kept which includes any discussion on consent, confidentiality, discussion about parental involvement and the nature of what is to be disclosed and what is not to be disclosed.

**6.120** Staff have a duty to meet the legal responsibilities, which includes the legal and ethical issues on real or potential conflict between the interests of the child and the parents.

**6.121** Seek advice if there is a disagreement between a competent young person and their parent.

**Gillick competence**

**6.122** This term has been used since the House of Lord's ruling in the case of Victoria Gillick v West Norfolk and Wisbech Health Authority and the Department of Health and Social Security in 1985.

**6.123** It is used to decide whether or not a child is competent to give consent to treatment. As part of Lord Fraser's judgment he issues guidelines, which specifically refer to contraception, but the principles also apply to other treatment, including abortion. They apply to Health Professionals in England and Wales.

**PREVENT**

Prevent is the Government counter terrorism strategy (CONTEST) which aims to reduce the risks the UK faces from terrorism. This strategy aims to stop people becoming involved in or supporting terrorist activity. The Counter-Terrorism and Security Act 2015 requires specified authorities, in the exercise of their functions to have due regard to the need to prevent people being drawn into terrorism. The support available for individuals at risk of being radicalised is called Channel.

## 7. Training and Support

**7.1** All staff will receive safeguarding children training at induction. Training needs analysis are carried out on are regular basis and the feedback from these reviews help inform Safeguarding training updates.

**7.2** The Safeguarding Lead will ensure that all staff involved in safeguarding issues are provided with adequate training and support. Staff can contact the Safeguarding Lead for support and advice and also request face to face meetings should they feel this necessary.

## 8. Monitoring and Review

**8.1** The Quality and Safety Committee is responsible for monitoring the effectiveness of this policy and will provide an annual report detailing compliance to the Board.

FIRST PERSON PROJECT C.I.C.

**8.2** This policy should be used in conjunction with the Multi-Agency Procedures for Safeguarding Children of all the Local Authorities in which First Person Project may operate.

**8.3** Regular safeguarding audits will be undertaken to assure compliance with the Policy.