NORTH HERTS HOSPICE CARE ASSOCIATION

Safeguarding Children Policy

Approval

Date policy was formally approved: July 2016

Agreed by:

Signature of Chairman of Trustees:

Signature of Chief Executive: 

Type of change: Minor changes

Policy history:
Update of January 2016 version with minor changes suggested by Clinical Commissioning Group. December 2017 changes in line with the updates for HCSB September 2017. March 2017: minor changes to Dec 2015 version to reflect recommendations/alerts from the Charity Commission 2018. 2018: addition of Prevent duty and Channel Programme.

Next review

Person responsible for next review: Director of Patient Services

Committee responsible for next review: Clinical Governance Committee
Next review date: June 2019

Policy Statement

Garden House Hospice Care is committed to protecting and promoting the welfare of children who come into contact with our services at all times.

All line managers are responsible for ensuring all relevant new staff and volunteers read this document during their first week; all staff are reminded of their responsibility to keep up to date with all organisational policies and procedures.

This policy is to be read in conjunction with the Hertfordshire Children Safeguarding Board Manual (updated September 2017). If in any doubt about the procedure to follow, please access this at: http://hertsscb.proceduresonline.com/index.htm

Contents

1 Policy Statement

This policy applies to all employees including temporary and short-term staff and volunteers, who come into direct or indirect contact with children and their families/carers.

This policy determines the standards required by Garden House Hospice Care to ensure that Garden House Hospice Care complies with its legal obligations and national/local best practice. This policy does not form part of contracts of employment and Garden House Hospice Care reserves the right to amend this policy at any time in line with best practice and regulatory change.

1.1 Purpose of this Policy

The purpose of this policy is to:

- Identify the principles of safeguarding children and young people (age 0-18) with whom Garden House Hospice Care may have contact
- Provide education on recognising the signs of possible child abuse
- Provide staff and volunteers with guidance on procedures they must adopt in the event that they suspect a child or young person may be experiencing, or be at risk of, harm.

1.2 Principles

The principles upon which Garden House Hospice Care's Safeguarding Children policy is based are:

- The welfare of the child or young person is paramount
- The rights, wishes and feelings of children, young people and their families will be respected and listened to. Their needs will be identified and respected by the staff and volunteers working with them. Garden House Hospice Care will promote anti - discriminatory practice
- All concerns and allegations will be taken seriously by staff and volunteers and, where appropriate, referred to the Local Authority which has a duty to investigate under section 47 of the 1989 Children Act
- Clear instructions as to how allegations and concerns should be dealt with
- A commitment to share information with other appropriate agencies in the best interests of the child or young person and in line with the Department of Children Schools and Families Information Sharing guidance
- Children and their carers will, other than in certain circumstances, be kept informed about concerns and proposed action to be taken
- Allegations against Hospice Team members will be fully investigated and appropriate action taken under the Disciplinary Policy (HR05). The alleged individual must not be informed of the allegation
- There will be a commitment to safe recruitment, selection and vetting of all staff and volunteers.

2 Safeguarding Children

Professionals, employees, managers, helpers, carers and volunteers in all agencies must make a referral to the Children's Services Assessment Team:

- If it is believed or suspected that a child is suffering or is likely to suffer Significant Harm;

or

- Where a professional has identified unmet need in relation to a Child in Need including significant impairment of health or development.

A referral must be made as soon as possible when any concern of significant harm becomes known - the greater the level of perceived risk, the more urgent the action should be.

2.1 Prevent duty

GHHC is also subject to a duty under section 26 of the Counter-Terrorism and Security Act 2015 to have 'due regard to the need to prevent people from being drawn into terrorism'. This duty is known as the Prevent duty and it applies to 'specified authorities' that are described in Schedule 6 of the Act. The East and North Hertfordshire Care Commissioning Group places a contractual obligation on GHHC to comply with the duty.

All relevant staff will recognise vulnerability to being drawn into terrorism, (which includes someone with extremist ideas that are used to legitimise terrorism and are shared by terrorist groups), including extremist ideas which can be used to legitimise terrorism and are shared by terrorist groups, and be aware of what action to take in response, including local processes and policies. See 2.5.1 Channel Programme below.

IF YOU ARE WORRIED ABOUT A CHILD YOU HAVE A DUTY TO REFER

A referral must be made even if it is known that Children's Services are already involved with the child/family.

When abuse is disclosed or suspected, you should:

- React calmly
- Reassure the child that they were right to tell and that they are not to blame and take what they say seriously
- Be careful not to put words in their mouth. Do not ask direct questions
- Do not promise confidentiality
- Inform the child/individual what you will do next
- Make a full and *written statement* as soon as possible adding to your record, if necessary, at each stage
- Don't delay in passing on the information. Except where immediate medical attention is needed
- Inform the Safeguarding Children's Lead or Safeguarding Children's Champion. If they are not available inform the Line Manager or the Senior Manager on Call sharing of the information should be on a need to know basis only (see Section 2.5).

2.2 Immediate Danger Following Disclosure

If there is immediate danger following disclosure:

- Stay with the child; do not expose the child or yourself to further risk or imminent danger
- Contact the Police on 999 if there is risk of immediate harm
- Contact Children's Social Care on 0300 123 4043 and the appropriate emergency service
- Do as advised by the Police, Children's Services team or the ambulance control

- Complete a Garden House Hospice Care incident form as a matter of urgency and ensure it is escalated to the on-duty senior manager and adhere to confidentiality as highlighted within this policy. A copy must be sent to the Quality team
- When recording on the patient record, if relevant, identify the incident form number and advise that a concern has been raised.

2.3 No Immediate Danger

If you have concerns about a child's welfare or suspect abuse is taking place and there is no immediate danger:

- Record your observations or the information being shared with you
- Consult with your Line Manager, Safeguarding Children's Lead, Safeguarding Children's Champion or the Senior Manager on Call for action to be taken
- Complete an incident form and send to the Safeguarding Children's Lead or Champion; ensuring a copy is sent to the Quality team
- When recording on the patient record, if relevant, identify the incident form number and advise that a concern has been raised.

2.4 Reporting

The report for Garden House Hospice Care records and other relevant agencies should include:

- The child's known details including name and as many other details as you know e.g. date of birth, address, details of carer
- Whether the person making the allegation is expressing their own concerns or those of someone else
- The nature of the allegations, including dates, times and any other specific factors
- Keep to facts only and make clear if you state any opinion or hearsay
- Describe accurately any visible observations (Do not examine the child). Sketch on a body map any visible signs of bruising or injury (See Appendix 4)
- Describe any indirect signs such as behaviour
- Details of any other witnesses (name, role, organisation) to the incident
- State the child's account, in their own words if possible, of what happened and the accounts of others e.g. colleagues, parents.

NB: The CQC must be notified of any incident that has been investigated by the police or if any abuse or allegation of abuse in relation to a service user has occurred. Please use the notification form available at: http://www.cqc.org.uk/content/notifications-non-nhs-trust-providers

2.5 Method of Referring to Children's Services

The responsibility for reporting any safeguarding issues raised by GHHC services lies with the staff member who identifies the safeguarding concern.

If a child is in immediate danger then dial 999.

Escalate to the H@H/CHC Nurse in Charge or Sister on Call at weekends/out of hours. The Nurse in Charge or Sister on Call contacts the key worker DN/GP to identify if the concern has already raised.

If the issue has not been raised, then H@H/CHC Nurse in Charge or Sister on Call at weekends /out of hours should contact Children's Services by calling telephone: 0300 123 4043, email: CSF.hertsdirect@hertfordshire.gov.uk

If you are unsure then telephone the Customer Service Centre any time to discuss on 0300 123 4043. If the team advises a referral should be made, email the Safeguarding team via secure email to CSF.hertsdirect@hertfordshire.gov.uk

If you are unsure, advice may be obtained from Children's Safeguarding Lead/Champion at GHHC and/or the Children's Services.

All safeguarding incidents must be recorded on a GHHC incident form to highlight the safeguarding issue raised for information only as Safeguarding Lead at GHHC would not be the responsible person for community safeguarding issues.

The professional referrer must confirm the verbal referral in writing within 24 hours including details contained in the contemporaneous report and any other information subsequently recorded.

Where possible, written confirmation should be made using a multiagency referral form, available at the following link; http://www.hertfordshire.gov.uk/docs/pdf/c/childprotectionform.pdf Email submission is preferred; there is a link at the end of the referral form. The postal address is Customer Service Centre, PO BOX 153, Stevenage, Herts, SG1 2GH.

Children's Social Care must acknowledge referrals in writing within one working day of receipt. If no acknowledgment is received within three working days, the referrer must contact Children's Social Care again to establish the current status of the referral.

The referrer will be informed of what action has been, or will be taken, in writing, in line with data protection and parental/child consent guidelines. If the referrer made the referral on behalf of someone else or referred on information s/he received, they will be reminded that it is their responsibility to feedback the actions to the person they received the information from.

GHHC will:

- Participate, as required, in any further investigations instigated by the Children's Social Care
- Continue to support the child and family
- Ensure the referrer and any other Hospice Team Members involved are supported.

2.5.1 Channel Programme

Channel is a programme which focuses on providing support at an early stage to people who are identified as being vulnerable to being drawn into terrorism. The programme uses a multi-agency approach to protect vulnerable people by:

- Identifying individuals at risk
- Assessing the nature and extent of that risk
- Developing the most appropriate support plan for the individuals concerned.

Sections 36 to 41 of the Counter-Terrorism and Security Act 2015 set out the duty on local authorities and partners of local panels to provide support for people vulnerable to being drawn into any form of terrorism.

This guidance has been issued under sections 36(7) and 38(6) of the act to support panel members and partners of local panels.

The document:

- Provides guidance for Channel panel
- Provides guidance for panel partners on Channel delivery (that is, those authorities listed in Schedule 7 to the Counter-Terrorism and Security Act 2015 who are required to co-operate with Channel panels and the police in carrying out their functions in Chapter 2 of Part 5 of the Counter-Terrorism and Security Act 2015)
- Explains why people may be vulnerable to being drawn into terrorism and describes signs to look for
- Provides guidance on the support that can be provided to safeguard those at risk of being drawn into terrorism.

Channel may be appropriate for anyone who is vulnerable to being drawn into any form of terrorism. Channel is about ensuring that vulnerable children and adults of any faith, ethnicity or background receive support before their vulnerabilities are exploited by those that would want them to embrace terrorism, and before they become involved in criminal terrorist activity.

Channel is part of the local Prevent strategy and is a multi-agency approach to identify and provide support to individuals who are at risk of being drawn into terrorism.

Success of the programme is very much dependent on the cooperation and coordinated activity of partners. It works best when the individuals and their families fully engage with the programme and are supported in a consistent manner.

Concerns about changes in the behaviour or attitudes of young people are most likely to be picked up by family members or schools/colleges in the first instance.

There is no single way of identifying who is likely to be vulnerable to being drawn into terrorism. Factors that may have a bearing on someone becoming vulnerable may include: peer pressure, influence from other people or via the internet, bullying, crime against them or their involvement in crime, anti-social behaviour, family tensions, race/hate crime, lack of self-esteem or identity and personal or political grievances.

In the first instance, it is likely that the most appropriate assessment should be via a CAF, with support from the Early Help CAF co-ordinators, to explore the issues of concern with the young person and their family.

Where risks of vulnerability to being drawn into terrorism are suspected or confirmed, practitioners should make a referral to the PREVENT team at prevent@herts.pnn.police.uk using the referral form in Appendix 6.

The Channel Police Practitioner (CPP) will review referrals received and consider whether a direct referral to the Channel Panel is appropriate, or whether a referral to Targeted Youth Support, in the case of a young person living with their family in the community or a referral

to Children's Social Work Services where a young person is looked after should be considered. A multi-agency professionals meeting should be convened and a referral to the Targeted Youth Support risk management panel should also be considered.

Where an agency or the CPP receives a referral indicating that a parent or family may be intending to leave the UK with their children to travel to a war zone such as Syria, an immediate child protection referral should be made to the Customer Services Centre so that a legal planning meeting can be arranged and an application to the High Court be made to prevent the children being removed from the jurisdiction can be made where available evidence meets the threshold for such an application.

2.6 Information Sharing

HM Government advice on Information Sharing (March 2015) states that sharing information is an intrinsic part of any front-line practitioners' job when working with children and young people. The decisions about how much information to share, with whom and when, can have a profound impact on individuals lives. It could ensure that an individual receives the right services at the right time and prevent a need from becoming more acute and difficult to meet. At the other end of the spectrum it could be the difference between life and death.

Information sharing between organisations is essential to safeguard children.

The Care Act sets out the duty of individuals and agencies to provide information under these procedures to enable children to be safeguarded. Garden House Hospice Care will fully support the statutory bodies by providing information that will enable them to make effective and timely decisions to safeguard children.

The decision whether or not to share information must be recorded by Garden House Hospice Care, which makes the decision about what information will be shared.

Key points for staff when sharing information:

- The general principle is that information will only be shared with the consent of the subject of the information.
- Sharing confidential information without consent will normally be justified in the public interest in limited circumstances described below.

2.6.1 The Seven Golden Rules for Information Sharing:

- Remember that the Data Protection Act 1998 and human rights laws are not barriers to justified information sharing but provide a framework to ensure that personal information about living individuals is shared appropriately.
- Be open and honest with the individual (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so.
- Seek advice from the Safeguarding Children's Lead or Champion if you are in any doubt about sharing the information concerned, without disclosing the identity of the individual where possible.
- Share with informed consent where appropriate and, where possible, respect the wishes of those who do not consent to share confidential information. You may still share information without consent if, in your judgement, there is good reason to do so, such as where safety may be at risk. You will need to base your judgment on the facts of the

case. When you are sharing or requesting personal information from someone, be sure about why you are doing so.

- Base your information sharing decisions on considerations of the safety and wellbeing of the individual and others who may be affected by their actions.
- Sharing of information must always be necessary, proportionate, relevant, accurate, timely and secure. Ensure that the information you share is:
    - Necessary for the purpose for which you are sharing it
    - Is shared only with those people who need to have it
    - Is accurate and up-to-date.
    - Is shared in a timely fashion; and
    - Is shared securely according to Garden House Hospice Care information management policies.
- Keep a record of your decision and the reasons for it - whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose.

Always seek advice from the Safeguarding Children's Lead or Champion and the Garden House Hospice Care Lead for data protection.

2.6.2 Information Sharing Advice for Practitioners

Information sharing: advice for practitioners providing safeguarding services (March 2015) states that:

"Wherever possible, you should seek consent or be open and honest with the individual (and/or their family, where appropriate) 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 and they have a genuine choice about this.

Consent in relation to personal information does not need to be explicit – it can be implied where to do so would be reasonable, i.e. a referral to a provider or another service. More stringent rules apply to sensitive personal information, when, if consent is necessary then it should be explicit. But even without consent, or explicit consent, it is still possible to share personal information if it is necessary in order to carry out your role, or to protect the vital interests of the individual where, for example, consent cannot be given. Also, if it is unsafe or inappropriate to do so, i.e. where there are concerns that a child is suffering, or is likely to suffer significant harm, you would not need to seek consent. A record of what has been shared should be kept.

It is also possible that an overriding public interest would justify disclosure of the information (or that sharing is required by a court order, other legal obligation or statutory exemption). To overcome the common law duty of confidence, the public interest threshold is not necessarily difficult to meet – particularly in emergency situations. Confidential health information carries a higher threshold, but it should still be possible to proceed where the circumstances are serious enough. As is the case for all personal information processing, initial thought needs to be given as to whether the objective can be achieved by limiting the amount of information shared – does all of the personal information need to be shared to achieve the objective?"

Where there is a clear risk of significant harm to a child, the public interest test will almost certainly be satisfied. However, there will be other cases where practitioners will be justified

in sharing some confidential information in order to make decisions on sharing further information or taking action. The information shared should be proportionate. Decisions in this area need to be made by, or with the advice of, people with suitable competence in Child Protection work such as named or designated professionals or senior managers.

3 Related Hospice Policies/Procedures/Guidelines - see Appendix 1.

4 Responsibilities/Accountabilities

4.1 Trustees

The Trustees are ultimately responsible for safeguarding and promoting the welfare of GHHC beneficiaries. The Trustees will identify a Trustee Safeguarding Lead and:

- Actively promote a safe culture and trusted environment
- Ensure adequate measures are in place to assess and address safeguarding risks
- Ensure adequate safeguarding policies, procedures and measures to protect people are in place
- Ensure adequate systems are in place to handle incidents and allegations, including reporting to the relevant authorities, including the Charity Commission.
- Attend relevant training.

All Trustees are responsible for ensuring this policy is approved at Board level and is robustly implemented. Some of these responsibilities may be delegated to the Chief Executive Officer.

4.2 Chief Executive Officer (CEO)

The CEO has overall responsibility for ensuring the hospice as a whole has sound and robust business processes and management throughout all areas of the hospice.

The CEO has delegated responsibility to ensure that serious incidents are reported to the Commission in accordance with its guidance and that safeguarding allegations, complaints or incidents are reported to other agencies in accordance with the law and best practice.

4.3 Director of Patient Services/Registered Manager

This person works closely with the CEO to ensure the organisation complies with all legislation and requirements in relation to safeguarding children. As the Registered Manager, this role is ultimately accountable for ensuring the hospice complies with the legislation and therefore has the relevant policies, procedures and practices in place.

The Director of Patient Services will present a six-monthly report on the management of safeguarding children at risk to the Hospice Care and Clinical Governance Committee.

4.4 Safeguarding Children Champion

This person is the source of expert advice and guidance to clinical teams. This person oversees and manages the safeguarding children policy and procedures; liaising with external statutory agencies, auditing practice and ensuring training of staff and volunteers to agreed national standards.

4.5 Human Resources Manager

When an allegation of abuse is made against a Hospice Team Member, the Human Resources Manager must report this using the Local Authority Designated Officer (LADO) referral form.

4.6 Managers

All Managers are required to ensure that relevant staff and volunteers attend statutory mandatory training as required and provide their full support with any child safeguarding issues, working closely with departments and other agencies as required. Managers also need to ensure that staff follow relevant policies and procedures.

4.7 All other staff including volunteers

All staff and volunteers have a duty to report when abuse, by another Hospice Team Member, is disclosed or suspected, following OM07 Raising Concerns about Poor Practice Policy (Whistleblowing).

All staff and relevant volunteers are required to attend statutory mandatory training, comply with policies and procedures and highlight any concerns at the earliest opportunity, ensuring that the needs of the child come first.

5 Policy Monitoring and Review

This policy will be reviewed following introduction of any new legislation or, as a minimum, every year.

All previous versions are archived as hard copies for no less than three years.

6 Audit

A yearly audit of compliance against this policy will be scheduled into the Clinical Audit programme and published in the Safeguarding Children Annual Report. The report on the outcomes of the findings and the improvement plan for any improvements to be made will be reported to the Board of Trustees committee via the Clinical Governance committee.

Audits will be against national, local and organisational policy and will include, where necessary audits resulting from incidents or complaints. Learning will be shared with front line staff and teams to promote improved future practice.

7 Related National Policies/Legislation

- Children Act 1989 and 2004
- Health & Social Care Act 2008 (Regulated Activities) Regulations 2014, regulations:
  11 – need for consent

  12 – safe care and treatment

  13 – safeguarding service users from abuse and improper treatment
- CQC Registration regulations 2009: Regulation 18- Notification of other incidents
- Working together to safeguard children 2013
- Data Protection Act 1998
- Human Rights Act 1998
- Common Law Duty of Confidentiality
- Crime & Disorder Act 1998
- Caldicott Guardian Principles
- Public Interest Disclosure Act 1998.
- www.gov.uk/government/publications/prevent-duty-guidance

- Section 26 of the Counter-Terrorism and Security Act 2015 to have 'due regard to the need to prevent people from being drawn into terrorism'.

8 Compliance with Statutory/Professional Requirements

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
Care Quality Commission (Registration) Regulations 2009

9 Training Requirements

9.1 Safeguarding Children Lead & Safeguarding Children Champion

These individuals will undergo a competency assessment framework at the commencement of their role which will be renewed three yearly. They must also attend a Safeguarding Children Train the Trainer programme before being able to teach Garden House Hospice Care staff. At least one Continuing Professional Development (CPD) event each year must relate directly to Safeguarding Children.

These staff must be trained to a minimum of level 3 national standards for Safeguarding Children; preferably level 4. Training must include Prevent duty.

9.2 Front Line Staff and Volunteers

All non-clinical staff and volunteers will receive level 1 training to national standards for safeguarding children.

Clinical staff and volunteers will be trained to level 2 training national standards for safeguarding children.

All staff working directly with children, including volunteers will receive training to level 3 training to national standards for safeguarding children, including the Prevent Duty.

They will receive refresher training at least every 2 years or as required in line with changes in legislation.

9.3 Trustee Training Requirements

The Trustee Safeguarding Lead must be trained to level 2 national standards for Safeguarding Children at Risk.

All Trustees will be trained to level 1 national standards for Safeguarding children at Risk, including Prevent duty training.

10 Incidents and Complaints

When incidents or complaints are highlighted, the leads for these areas and the department manager where the concerns originate from must be alert to potential safeguarding concerns. Where concerns are noted, these should be escalated in line with this policy and procedure.

All safeguarding incidents, as with all incidents, will be logged. Any incident form received must be reviewed no later than 24 hours after receipt. However, there is no reason for delay as the Safeguarding Lead or Champion, or line manager, will have been made aware as soon as concerns are raised.

Serious incidents are reported to the Commission in accordance with its guidance and that safeguarding allegations, complaints or incidents are reported to other agencies in accordance with the law and best practice in line with the policy Incident Reporting and Management Policy (including Serious Incidents Requiring Investigation) RM20.

10.1 Whistleblowing

Any employee of GHHC who suspects serious wrongdoing within the organisation can speak out safely. The NHHCA is committed to developing a culture where it is safe and acceptable for all Hospice Team Members to raise concerns without fear of recrimination, to bring to the attention of the appropriate level of management any deficiency in the provision of service, breach of procedure or impropriety. The NHHCA 'Freedom to Speak Up' Guardian will support any person who raises a concern under OM07 Raising Concerns about Poor Practice Policy.

11 References

- Hertfordshire Safeguarding Children Board Procedures Manual, updated March 2017, http://hertsscb.proceduresonline.com accessed July 2016
- NICE: CG89 When to suspect child maltreatment, https://www.nice.org.uk/guidance/cg89 accessed August 2015
- Meeting the needs of Children and Families in Hertfordshire, http://www.hertsdirect.org/docs/pdf/m/mtnfeb2010.pdf accessed September 2015
- Recognition of Abuse, 5th edition, Herts Direct, http://hertsscb.proceduresonline.com/pdfs/rec_ch_abuse.pdf accessed September 2015
- Working Together to Safeguard Children 2015: A guide to inter-agency working to safeguard and promote the welfare of children, March 2015, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf accessed September 2015
- Information sharing Advice for practitioners providing safeguarding services to children, young people, parents and carers March 2015
- Safeguarding children and young people: roles and competences for health care staff: Intercollegiate document version 3, March 2014, http://www.rcpch.ac.uk/sites/default/files/page/Safeguarding%20Children%20-%20Roles%20and%20Competences%20for%20Healthcare%20Staff%20%2002%200%20%20%20(3)_0.pdf Accessed August 2015
- Children Act (2004), http://www.legislation.gov.uk/ukpga/2004/31
- https://www.gov.uk/government/publications/strategy-for-dealing-with-safeguarding-issues-in-charities

Appendix 1. Related Policies, Procedures and Guidelines

CM02	Admission Policy
CM04	Discharge Policy
CM06	Consent Policy
OM06	Complaints Policy
OM07	Raising Concerns about Poor Practice Policy (Whistleblowing)
OM12	Confidentiality Policy
OM21	Dignity and Privacy Policy
OM31	Information Governance Policy
RM09	Lone Worker Policy
RM20	Incident Reporting and Management Policy (Including Serious Incidents Requiring Investigation)
HR05	Disciplinary Policy and Procedure
HR07	Education and Training Policy
HR21	Recruitment Policy and Procedure

Appendix 2. Definitions, Types and Recognition of Abuse

For full and detailed information about the recognition of abuse, please refer to Recognition of Abuse (5th Edition) at: http://hertsscb.proceduresonline.com/pdfs/rec_ch_abuse.pdf

Definition of Child Abuse:

A child or young person under eighteen years is regarded as abused where he or she has been the victim of, or is believed to be at significant risk of, physical injury, neglect, emotional abuse or sexual abuse. Most child abuse is committed by someone known to, and trusted by, them; either within the family, among their friends, or in the local community.

Garden House Hospice Care workers should be alert to signs of stress affecting the care and parenting of children and should feel able to offer help and support to parents to prevent a situation escalating to the point where a child may be at risk.

Child abuse is generally classified as (or a combination of) the following:

- Physical
- Neglect
- Emotional
- Sexual

Pointers to the possibility of abuse:

This summary gives a brief outline of some of the signs and indications that should alert you to the possibility of child abuse.

Physical abuse:

The first evidence of abuse may not be an obvious severe injury.

Bruises:

See Herts bruising protocol.

http://hertsscb.proceduresonline.com/pdfs/brusing_protocol.pdf and

http://hertsscb.proceduresonline.com/pdfs/bruising_distribution_of_bruising.pdf and

http://hertsscb.proceduresonline.com/pdfs/bruising_fc_colour.pdf

Burns and Scalds:

- Burns and scalds
- Burns with a clear outline are suspicious
- Circular burns from cigarettes
- Linear burns from hot metal rods or electric elements
- Burns of a uniform depth over a large area
- Friction burns from being pulled across the floor
- Scalds produced from a water line immersion or pouring of hot liquid
- Splash marks around the main burn area caused by hot liquid being thrown
- Old scars indicating previous injury.

Fractures:

Any fractures in young children should be assessed. If the clinician is unable to rule out abuse or neglect the case should be investigated by Children's Social Care.

Neglect:

This is often difficult to identify but leads to the physical and emotional harm of a child. The signs and indicators include:

- Failure of a parent to provide adequate food, clothes, warmth, hygiene, medical care or supervision
- Failure of a child to grow within the normally expected pattern, they show pallor, weight loss and signs of poor nutrition
- Failure of parents to provide adequate love and affection in a stimulating environment
- A child may look listless, apathetic or unresponsive with no apparent medical cause
- A child may be observed thriving when away from the home environment.

Emotional abuse:

Again, this is difficult to identify. It is the result of ill treatment in the form of:

- Coldness
- Hostility and rejection
- Constant denigration
- Seriously distorted emotional demands
- Extreme inconsistency when parenting.

Some signs and indicators that might suggest this are:

- Low self-esteem apathy
- Being fearful and withdrawn or displaying "frozen watchfulness"
- Unduly aggressive behaviour
- Attention seeking behaviour
- Constantly seeking to please
- Over-readiness to relate to anyone, even strangers.

Sexual abuse:

Can be suspected based on physical signs, the child's behaviour or following a direct statement by the child. It is often investigated because of a combination of these signs.

Signs of possible sexual abuse:

- A level of sexual knowledge inappropriate to the child's age
- Sexually provocative relationships with adults
- Sexualized play with other children
- Self-harm, mutilation, or suicide attempts or threats
- Recurrent urinary tract infections
- Sudden onset of soiling or wetting
- Truancy, running away from home
- Uncharacteristic difficulty in learning, poor concentration

- Recurrent abdominal pain
- Promiscuity
- Requests for contraceptive or other sexual advice
- Severe sleep disturbance
- Change of eating habits
- Social isolation and withdrawal.

Children may communicate the abuse through other methods than the use of language e.g. through drawings, painting, play behaviour and so on.

Other abuse:

The following do not fall within the four main categories of child abuse but require further investigation:

- Honour Based Violence
- Forced Marriage
- Female Genital Mutilation
- Child Sexual Exploitation
- Trafficking
- Modern Day Slavery
- Radicalisation

Appendix 3. GHHC Safeguarding Children at Risk of Abuse Flowchart

SAFEGUARDING OF CHILDREN AT RISK OF ABUSE FLOWCHART

Child Safeguarding Lead: Jayne Dingemans

Child Safeguarding Champion: Tracey Swinburne

Is the child at risk of abuse?
Suspicion, allegation, observation or disclosure
Never Investigate

Immediately inform the Senior Nurse and Director of Nursing
Follow RM08 Safeguarding Children Policy

Make the immediate situation safe
If immediate risk to life, others or yourself,
Call the Emergency Services on 999

CONTACT Hertfordshire Children's Social Care

0300 123 4043

Child not known to FSS
Document in records of patient / client making the disclosure;
"Child safeguarding disclosure made, record held in FSS Office"
Create and document clearly in a new record.

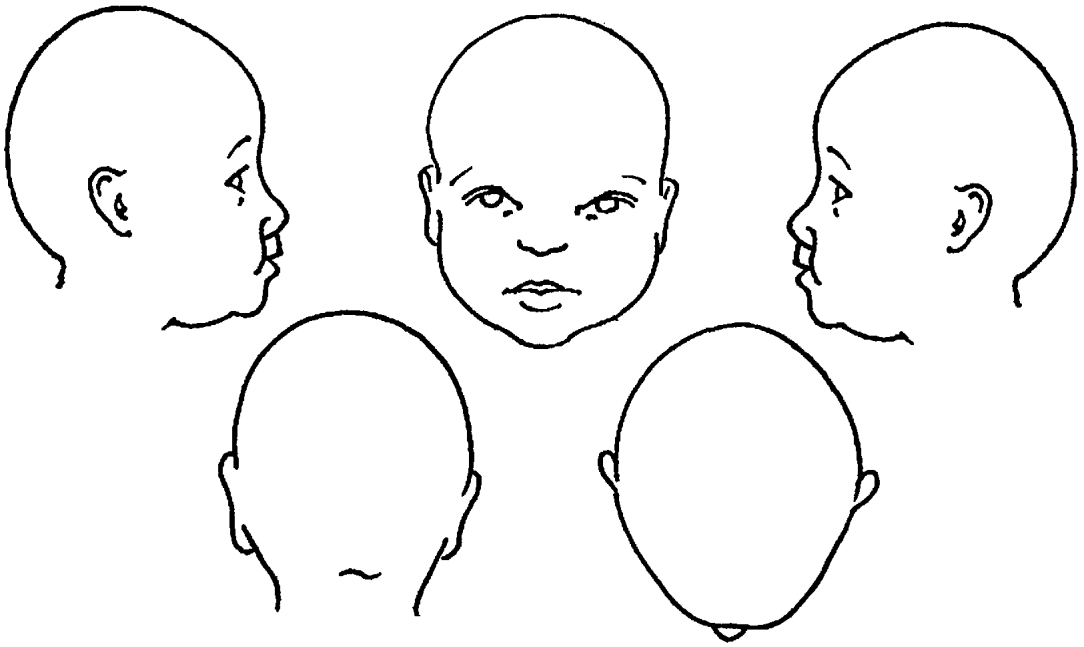
Child known to FSS
Document clearly in the child's case notes if concern has/hasn't been raised and what action you have taken.

If allegation is about a Hospice Team Member, the alleged individual must not be informed of the allegation

Complete Incident Form Immediately

Inform Care Quality Commission

Appendix 4. Children's Body Maps



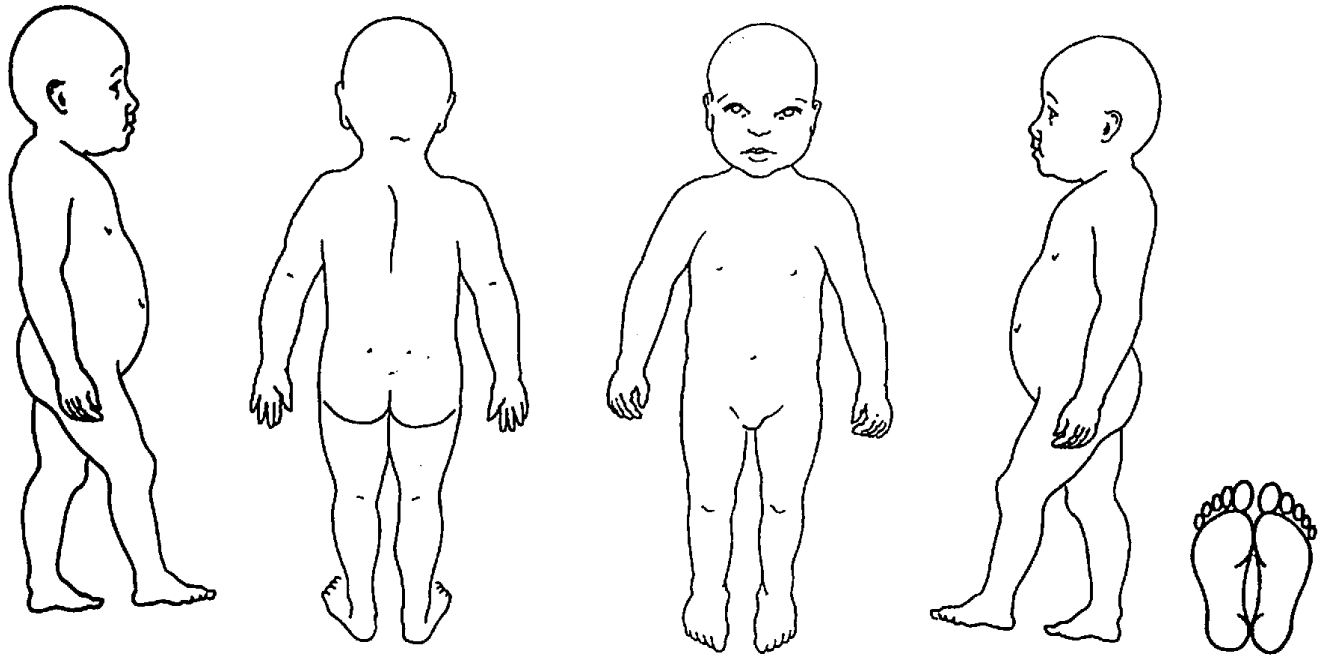
Name of Baby/Toddler:

Date of Birth:

Reporter's Name:

Date and time completed:

Baby/Toddler Body Map



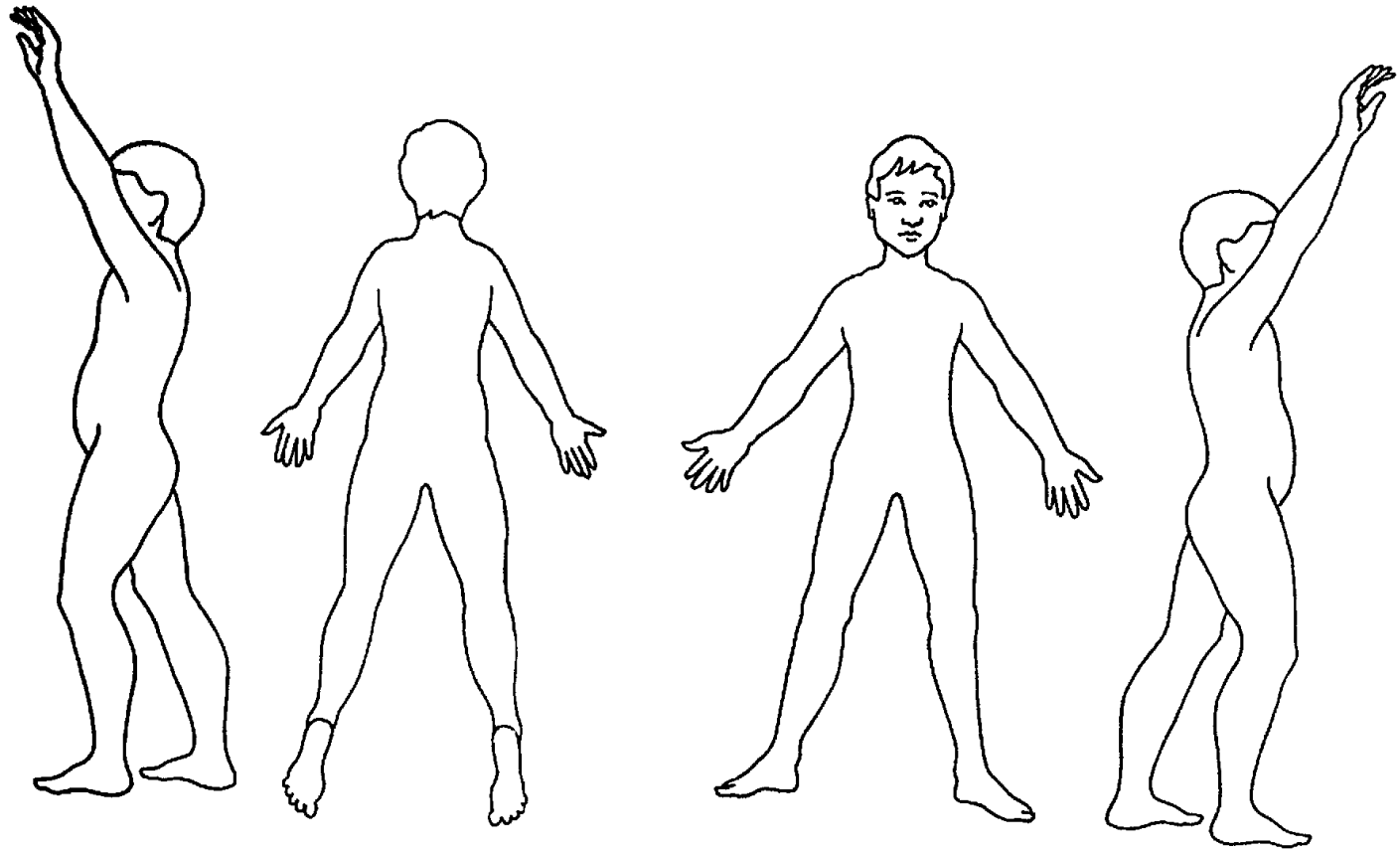
Name of Baby/Toddler:

Date of Birth:

Reporter's Name:

Date and Time Completed:

Child Body Map



Name of Child:

Date of Birth:

Reporter's Name:

Date and Time Completed:

Appendix 5. Channel Referral Form

Please forward completed forms to the PREVENT team at prevent@herts.pnn.police.uk

NOT PROTECTIVELY MARKED when incomplete

CHANNEL REFERRAL FORM

Name of Subject:		DOB:
Guardian:		Relationship:
Ethnicity:	Place of Birth:	Religion:
Address Telephone number		Referral Date
Author	Organisation	
Contact Details		

This form is to help you refer concerns to CHANNEL, regarding an individual who may be vulnerable to being drawn into terrorism. On the reverse are questions which may assist in helping you quantify and structure your concerns in order to better record them below.

They are intended as a guide to help communicate your professional judgement about what has led you to make this referral. Completed forms should be sent to the Channel team.

What is the behaviour / occurrence that has led you to make this referral?	
Assessment	Comment / Evidence
Faith / Ideology	
Personal / emotional & Social	
Risk / Protective factors	
Desire for change	

From what you know of the referral:

Faith / ideology

Are they new to a faith / faith strand? What was the context of their conversion?

Do they seem to have naïve, narrow or limited religious / political knowledge?

Are there concerns about a highly inconsistent vocalisation / practicing of their faith?

Have there been sudden changes in their observance, behaviour, interaction or attendance at their place of worship / organised meeting?

Have there been specific examples or is there an undertone of "Them and Us" language or violent rhetoric being used or behaviour occurring?

Is there evidence of increasing association with a closed tight knit group of individuals / known recruiters / extremists / restricted events?

Are there particular grievances either personal or global that appear to be unresolved / festering?

Has there been an increase in unusual or sudden travel abroad without satisfactory explanation?

Personal / emotional / social issues

Are there concerns over conflict with their families regarding religious beliefs / lifestyle choices?

Is there evidence of cultural anxiety and / or isolation linked to insularity / lack of integration?

Is there evidence of increasing isolation from family, friends or groups towards a smaller group of individuals or a known location?

Is there history in petty criminality and / or unusual hedonistic behaviour (alcohol/drug use, casual sexual relationships, and addictive behaviours)?

Have they got / had extremist propaganda materials (DVDs, CDs, leaflets etc.) in their possession?

Do they associate with negative / criminal peers or known groups of concern?

Are there concerns regarding their emotional stability and or mental health?

Is there evidence of participation in survivalist / combat simulation activities, e.g. paint balling?

Risk / Protective Factors

What are the specific factors which are contributing towards making the referral more vulnerable to radicalisation by others or moving towards violent extremism? E.g.; mental health, language barriers, cultural anxiety, impressionability, criminality, specific grievance etc.

Is there any evidence of others targeting or exploiting these vulnerabilities or risks?

What factors are there already in place or could be developed to firm up support for the referral or help them increase their resilience to negative influences? E.g. positive family ties, employment, mentor / agency input etc.

Desire for change

Do they have the ability to change with / without support? Why / Why not?

How motivated are they to make steps towards changing their attitudes and behaviour?

How sustainable do you think their motivation / desire is?