

SAFEGUARDING CHILDREN PROCEDURAL GUIDANCE

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PROCEDURE SUMMARY		
This procedure provides guidance to staff on safeguarding processes when working with children, young people and their families.		
The Trust monitors the implementation of and compliance with this procedure in the following ways:		
Services	Applicable	Comments
Trustwide	✓	

The Director responsible for monitoring and reviewing this procedure is
Executive Nurse

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

SAFEGUARDING CHILDREN PROCEDURAL GUIDELINE

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ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST**SAFEGUARDING CHILDREN PROCEDURAL GUIDELINE****Assurance Statement****Equality and Diversity Statement**

The Trust is committed to ensuring that equality, diversity, and inclusion is considered in our decisions, actions and processes. The Trust and all trust staff have a responsibility to ensure that they adhere to the Trust principles of equality, diversity, and inclusion in all activities. In drawing up this policy all aspects of equality, diversity, and inclusion have been considered to ensure that it does not disproportionately impact any individuals who have a protected characteristic as defined by the Equality Act 2010

1.0 INTRODUCTION

- 1.1 Safeguarding is everyone's responsibility and as such the Trust is committed to Safeguarding and promoting the welfare of children and young people. A child is defined as those up to their 18th birthday and it is the responsibility of all Trust staff to follow these procedures and the associated policy to safeguard children/young people regardless of which member of the family is the primary service user.
- 1.2 These procedural guidelines provide the knowledge base and guidance on what actions to take when there are concerns, allegations or disclosures of actual harm or risk of harm to children/young people. The appendices outlined provide additional information on key statutory guidance and local Safeguarding Partnership procedures.
- 1.3 Staff should follow these overarching procedures but note that there are also a number of local Operational Protocols that may be relevant for specific areas. These should be referred to where required and are available on the Trust intranet. Members of the Safeguarding Team are available for advice, support and assistance for any Safeguarding matter.
- 1.4 These procedural guidelines and the associated policy should be read in conjunction with the Local Safeguarding Partnership arrangement procedures of areas staff may work in.

2.0 PROCESS AND DEFINITIONS**2.1 Incident Reporting**

- 2.1.1 Any Patient Safety Incident or unexpected deaths involving children must be reported to the Trust Risk Department via Datix. Child Deaths are also reported to the Local Child Death Review Administrator in line with the Child Death and Learning Disabilities Mortality Review process. (Appendix 9)
- 2.1.2 Regular meetings are in place between the Serious Incident and Safeguarding teams to share information and ensure consistent notification, processing and learning from any Patient Safety Incidents that involve a safeguarding issue.

- 2.1.3 The Care Quality Commission is the independent regulator of health and adult social care services in England. The CQC has a set of essential levels of safety and quality that are to be maintained.
- 2.1.4 The Trust reports on all Local Child Safeguarding Practice reviews, Domestic Homicide Reviews, and safeguarding referrals to the CQC via the Local Safeguarding Partnership arrangements and Designated Nurse within the Integrated Care Boards (ICB). (Appendix 8 Local Child Safeguarding Practice Reviews).
- 2.1.5 The Trust Safeguarding team meet regularly with the CQC Relationship Manager to discuss cases where a safeguarding concern is identified. The team monitors these and updates are provided to the Relationship Manager until the safeguarding concerns have been investigated and are closed.

2.2 Definition, Recognition & Indicators of Child Abuse

Concerns for a child's welfare may arise when a member of staff is not entirely satisfied with the clinical, social or emotional picture that is presented or where abuse is suspected. The Children Act 1989 (Section 47) introduced the concept of significant harm as a definition of abuse;

- Harm means ill treatment or the impairment of health or development, including for example, impairment suffered from seeing or hearing the ill-treatment of another e.g. domestic abuse;
- Significant relates to the child's health and development and the comparison with that which could reasonably be expected of a similar child.

Significant harm relates to four categories of abuse, these are physical, emotional, sexual abuse and neglect.

2.2.1 Physical abuse

Physical abuse includes any form of abuse which may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, female genital mutilation 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. (Appendix 6 gives further guidance).

- 2.2.2 Bruising/injury to an immobile baby must be referred to Children's Social Care, with the expectation that a Child Protection Medical will be undertaken. Further guidance is available within Local Safeguarding Partnership procedures for the management of suspicious, unexplained injuries or bruising in children available on the local working area intranet site.

- 2.2.3 Any bruise/mark on a child should be considered in light of the history provided; location of the bruise/mark; and the age and developmental stage of the child/infant. If the child is under 6 months of age; not independently mobile; or under 18 years of age and there is suspicion of non-accidental injury; the professional must refer the child/family into Children's Social Care, following the Local Child Protection and Safeguarding Procedures.

- 2.2.4 If the child/infant is under 6 months of age, and/or immobile, Health/Medical professionals may use a pre-assessment tool to assist in an assessment of the bruise/mark. If in any doubt the professional must refer the child/family into Children's Social Care, following local area procedures.

2.2.5 Emotional Abuse

Emotional abuse is the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to a child that they are worthless or unloved, inadequate, or valued

only in so far 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, radicalisation or corruption of children. Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.

2.2.6 Neglect

Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy because of maternal substance abuse. (Appendix 5 for further guidance) 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.

2.2.7 Sexual Abuse

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

2.2.8 Sexual abuse 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, child sexual exploitation, grooming a child in preparation for abuse including via the internet or the use of technology. Sexual abuse can be perpetrated by men, women or other children. Sexual abuse should be considered for those children who run away from home. Pregnancy in a young person or a concealed pregnancy may also raise concerns of sexual abuse.

2.2.9 Sexual Activity and Legal Implications

Cases of underage sexual activity that present a cause for concern should be handled sensitively and staff should seek advice where required. The Law clearly states that;

2.2.10 Under 13 years

Sexual activity with a child under 13 years is a criminal offence as the child is not legally capable of consenting to sexual activity (Sexual Offences Act 2003). Trust staff must report any known cases to their line manager, the Trust Safeguarding Team. Such cases must always be referred to Children's Social Care or police.

2.2.11 Age 13 - 15

Sexual activity with a child under 16 is an offence. Where it is consensual it may be less serious than if the child were under 13 but may nevertheless have serious consequences for the welfare of the young person. Staff should seek advice when they are concerned.

2.2.12 Age 16 – 17

It is an offence for a person to have a sexual relationship with a 16-17 year old if that person holds a position of trust or authority in relation to them e.g. teacher, doctor, Nurse. Staff must report any known cases to their line manager, the Trust Safeguarding Team and be referred to Children's Social Care or the police.

2.3 Child Sexual Exploitation (CSE) and Online based forms of abuse (E-Safety)

Information communication technology is a medium for a wide range of abuse and exploitation for physical, sexual and emotional abuse including bullying via mobile telephones or online (Internet) with verbal and visual messages. The sexual exploitation of children and young people involves exploitative situations, contexts and relationships where young people (or a third person or persons) receive 'something' (for example, food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of performing, and or others performing on them, sexual activities. It is a form of sexual abuse and occurs when an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive the child.

- 2.3.1 Child sexual exploitation can occur through use of technology without the child's immediate recognition, for example the persuasion to post sexual images on the internet/mobile phones with no immediate payment or gain. In all cases those exploiting the child/young person have power over them by virtue of their age, gender, intellect, physical strength and /or economic or other resources." The victim may have been sexually exploited even if the sexual activity appeared to be consensual. Exploited children should be treated as victims of abuse, not as offenders.
- 2.3.2 The term E-safety is the process of limiting the risks to children and young people when using Internet, Digital and Mobile Technologies (IDMTs) through a combined approach including policies and procedures, infrastructures and training. The aim is to reduce the risk of exploitation through online technologies. The impact of online based sexual abuse for children and young people includes the visual record of the abuse and the sharing of this over the internet re-victimises the victim each viewing. Youth Produced Sexual Imagery or sexting is defined as children under 18 years of age exchanging messages or images with or without consent. Grooming of a child online can include the development of a "special relationship" with the child which remains a secret in preparation for an offline meeting to take place. Abusers may use child sexual abuse images to break down a child's barriers to sexual behaviours and diminish the child's inhibitions.
- 2.3.3 The Trust has an Executive Director responsible for E-Safety within the Trust. The Trust has a number of policies and procedures aimed to protect staff and service users and which contain risk assessment tools. Trust sites contain leaflets and information on E-Safety measures for Young people and parents. Young people in Adolescent Mental Health Units have supervised access to mobile phones and the computers used in the schoolroom. However, staff should ensure that young people have access to information and resources, which aims to keep them safe. (Appendix 7)
- 2.3.4 The Trust are active members of Strategic Child Sexual Exploitation groups In Essex, Southend and Bedford and contribute toward the development of CSE Toolkits and

other resources to help staff respond to concerns and service users in gaining knowledge and support. The Trust Intranet Safeguarding site offers more information and advice such as the Child Exploitation and Online Protection Centre. <http://www.ceop.police.uk> and Childnet International website <http://www.childnet-int.org/>

2.4 Criminal Exploitation, County Lines and Cuckooing

Child Criminal Exploitation occurs where an individual or group takes advantage of an imbalance of power to coerce, control, manipulate or deceive a child or young person under the age of 18. The victim may have been criminally exploited even if the activity appears consensual. Child Criminal Exploitation does not always involve physical contact; it can also occur through the use of technology. Criminal exploitation of children includes for instance children forced to work on cannabis farms or to commit theft. (Home Office 2018)

- 2.4.1 Criminal exploitation involves taking advantage of vulnerable people, often the very young, the impoverished or the infirm. Forcing them to engage in various forms of criminal activity such as begging, pick-pocketing, credit card, benefit fraud and the cultivation of cannabis for drug dealers. The Home Office (2017) describes the Criminal Exploitation (CE) of children and vulnerable adults as “a geographically widespread form of harm that is a typical feature of County Lines activity”. County Lines is the term used by the police for urban gangs that supply drugs to suburban areas as well as market and coastal towns through the use of dedicated mobile lines referred to as “deal lines”.
- 2.4.2 County lines is about modern slavery, human trafficking and exploitation, alongside drug supply and violent crime. County lines may involve the commission of the offences of ‘slavery, servitude and forced or compulsory labour’ and ‘human trafficking’ as defined by the Modern Slavery Act 2015. Children’s travel may be ‘arranged and facilitated by a person, with the view to them being exploited’, which amounts to human trafficking according to section 2 of the Modern Slavery Act 2015. Children may then be forced to work for the drug dealer, often held in the vulnerable adult’s home against their will and under the force of threat if they do not do as they are told. This meets the definition of ‘slavery, servitude and forced or compulsory labour’ in section 1 of the Modern Slavery Act 2015.
- 2.4.3 The definition of a gang tends to fall into three categories Peer Groups, Street Gangs and Organised Crime Groups. It can be common for groups of children and young people to gather together in public places to socialise. Although some peer group gatherings can lead to increased antisocial behaviour and youth offending, these activities should not be confused with the serious violence of a street gang. A street gang can be described as a relatively durable, predominantly street-based group of children who see themselves (and are seen by others) as a discernible group for whom crime and violence is integral to the group’s identity. An Organised criminal group is a group of individuals normally led by adults for whom involvement in crime is for personal gain (financial or otherwise). This involves serious and organised criminality by a hard core of violent gang members who exploit vulnerable young people and adult.
- 2.4.4 The criminal exploitation of children includes a combination of:
 - Pull factors: children performing tasks for others resulting in them gaining accommodation, food, gifts, status or a sense of safety, money or drugs; often the hook is through the perpetrator supplying Class B drugs such as cannabis to the child or young person;

- Push factors: children escaping from situations where their needs are neglected and there is exposure to unsafe individuals, where there is high family conflict or the absence of a primary attachment figure;
- Control: Brain washing, violence and threats of violence by those exploiting the child particularly when the child or young person is identified by the police, they are expected to take full responsibility for the offences for which they are charged – i.e. possession and supply of illegal substances.

2.4.5 Child Criminal Exploitation occurs as a result of gangs/groups using children or vulnerable people to distribute drugs and money. A base is established in the local area typically taking over the home of a vulnerable adult by force or coercion referred to as Cuckooing. Children may be sent to another area of the country to live with a vulnerable adult whose home has been taken over by the gang in exchange for a continued supply of drugs referred to as 'cuckooing'. It can affect both vulnerable adults and children and the activity may appear consensual. It is perpetrated by individuals, groups, males and females and young people or adults. There is typically a form of power imbalance which favours those perpetrating the exploitation and the power imbalance can be as a result of gender, cognitive ability, physical strength, status and available access to economic or other resources.

2.4.6 A key part of the exploitation is the presence of an exchange which could be carrying drugs in return for something. Children as young as 12 years old have been exploited by gangs/groups to courier drugs but the common age range is 15-16. Social media is used to make contact with young people and Class A drug users are targeted in order to take over their home for supply (cuckooing).

2.4.7 Some young people are more vulnerable to being exploited as a result of their vulnerability and this includes:

- Those who have experienced neglect, physical and or sexual abuse.
- Being in Care particularly those in residential homes
- Having mental health or substance misuse issues
- Having physical or learning disabilities
- Homeless or insecure accommodation
- Connections with other people involved in gangs
- Living in a chaotic and dysfunctional household.
- Attending school or being friends with young people who are sexually or criminally exploited
- Unsure about their sexual orientation or unable to disclose sexual orientation to their family
- Accompanied or unaccompanied migration or those that have been trafficked into the country

2.4.8 Staff should be alert to the indicators that a young person may be being exploited and any sudden changes in their lifestyle may be an indicator. Indicators of county liners and exploitation involvement are:

- Persistent missing episodes from school or home or found to be out of area.
- Sudden unexplained appearance of money, clothes or mobile phones.
- Excessive receipt of texts or phone calls
- Relationships with controlling/ older individuals or groups
- Suspicion of physical assault/ unexplained injuries
- Carrying a weapon
- Significant decline in school performance
- Self-harming and isolation from peer and social networks

Any staff member that is concerned that a young person may be being exploited should follow the local safeguarding procedures for referral to social care. Advice and

support is available from line managers and the Trust Safeguarding team. Staff should evaluate and record their concerns using the local assessment templates for CSE risk and vulnerabilities and make the appropriate referrals for support or protection as required.

2.5 Modern day slavery (see appendix 4)

The Government introduced the Modern Slavery Bill in March 2015. This recognises that modern slavery is one of the world's largest crime industries and the scale in the UK is significant, affecting adults and children under 18 years. Modern Slavery can take many forms and involves a whole range of types of exploitation, many of which occur together. These include but are not limited to:

- Trafficking of children
- Sexual exploitation
- Domestic Servitude
- Forced Labour
- Criminal exploitation
- Other forms of exploitation e.g. begging, forced marriage
- Drug dealing- most often linked to County Lines and drug mules or decoys
- Credit card and benefit fraud

- 2.5.1 Traffickers and slave masters use whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment. Trafficking is often an integral part of exploitation and should therefore be considered when identifying, assessing and responding to all forms of exploitation. Trafficking is the “act of recruitment, transportation, transfer, harbouring or receipt of persons by the means of the threat or use of force or other forms of coercion, abduction, fraud, deception, abuse of power or of position of vulnerability or of the giving/receiving of payments or benefits to achieve the consent of having control over another person”
- 2.5.2 Children (those aged under 18) are considered victims of trafficking, whether or not they have been coerced, deceived or paid to secure their compliance. They need only have been recruited, transported, received or harboured for the purpose of exploitation. From November 1st 2015 police and Local Authorities have a ‘duty to notify’ the Home Office of any one they believe is subject to slavery or human trafficking.
- 2.5.3 If staff have concerns or suspect slavery then a referral to social care must take place. Consent of the young person will not be required and staff should consult with the Trust Safeguarding team to discuss notifying police.

2.6 Female Genital Mutilation (FGM) (see appendix 13)

Female Genital Mutilation is a severe form of child abuse and violence against women. It comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons. FGM is a procedure where the female genital organs are injured or changed. It is frequently a very traumatic and violent act for the victim and can cause harm in many ways like severe pain, difficulties in childbirth or causing dangers to the child.

- 2.6.1 FGM is illegal in the UK and it is illegal to take or assist a person travelling abroad for the purposes of FGM. The procedure may be carried out when the girl is new born, during childhood or adolescence, just before marriage or during the first pregnancy. However, the majority of cases of FGM are thought to take place between the ages of 5 and 8 and therefore girls within that age bracket are at a higher risk. It is believed that FGM happens to British girls in the UK as well as overseas (often in the family's country of origin). Girls of school age who are subjected to FGM overseas are

thought to be taken abroad at the start of the school holidays, particularly in summer, in order for there to be sufficient time for her to recover before returning to her studies.

- 2.6.2 When working with families where there is good reason to suspect a child under 18 is at risk of FGM, a safeguarding children referral to Social Care must be made and the Safeguarding Team should be contacted. It is mandatory for all staff to report any concerns regarding FGM by speaking to a member of the Safeguarding team and record FGM or those at risk of FGM within the service user's records. The Trust records all reports of FGM on the enhanced data set system specific to NHS services.
- 2.6.3 Staff working in Adolescent Mental Health units must consider FGM as part of initial assessments. The Trust Safeguarding and Local Safeguarding partnership intranet sites contains additional advice & support for staff and service users.

2.7 Extremism (Appendix 11)

Extremism goes beyond terrorism and includes people who target the vulnerable – including the young – by seeking to sow division between communities on the basis of race, faith or denomination; justify discrimination towards women and girls; persuade others that minorities are inferior; or argue against the primacy of democracy and the rule of law in our society.

- 2.7.1 Extremism is defined in the Counter Extremism Strategy 2015 as the vocal or active opposition to our fundamental values, including the rule of law, individual liberty and the mutual respect and tolerance of different faiths and beliefs. We also regard calls for the death of members of our armed forces as extremist. (Appendix 11 for further guidance)
- 2.7.2 Radicalisation is the process by which people come to support terrorism and violent extremism and sometime to participate in terrorist groups. There is no profile of a person likely to become involved in extremism and the process of radicalisation is different for every individual. Potential indicators include:
- Use of inappropriate language and the expression of extremist views
 - Possession of extremist literature
 - Association with known extremists and seeking to recruit others to ideology
 - Advocating violent actions and means

2.8 Vulnerability & Risk Factors

There are certain factors and situations that may place children at particular risk of suffering significant harm. The presence of one or more of these factors does not automatically imply that abuse will result, but may increase the likelihood. Staff should be aware of the vulnerability and risk factors for children living with a parent or carer with mental illness, learning disabilities, substance misuse, or in an environment where there is domestic abuse.

2.8.1 Mental Illness

The majority of parents who suffer significant mental ill health are able to care for and safeguard their children/young people and/or unborn child but it is essential always to assess the implications for any children involved in the family. Children most at risk of significant harm are those who feature within parental delusions and children who become targets for parental aggression or rejection, or who are neglected as a result of parental mental illness. The following parental risk factors may justify a referral to Children's Social Care for an assessment of the child's needs:

- Previous history of parental mental health especially if severe and / or enduring condition;

- Predisposition to, or severe post-natal illness;
- Delusional thinking involving the child;
- Self-harming behaviour and suicide attempts (including attempts that involve the child);
- Altered states of consciousness e.g. splitting / dissociation, misuse of drugs, alcohol, medication;
- Obsessive compulsive behaviours involving the child;
- Non-compliance with treatment, reluctance or difficulty in engaging with necessary services, lack of insight into illness or impact on child;
- Disorder designated 'untreatable' either totally or within time scales compatible with the child's best interests;
- Mental illness combined with domestic violence and/or relationship difficulties;
- Unsupported and/or isolated mentally ill parents;
- Parental inability to anticipate needs of the child.

Care Programme Approach (CPA) assessments, Multi-Disciplinary meetings (MDT) or Professionals meetings about parents who have mental health difficulties, must include consideration of any needs or risk factors for the children concerned. Psychiatrists should be involved in clinical decision making for services users who may pose a risk to children as above. This includes discharge planning and arrangements for home leave. Where an adult, who is also a parent / carer, is deemed to be a danger to self or others a referral must be made to Children's Social Care. Children's Social Worker and Community Health Services e.g. Health Visitor, School Nurse, midwife must be invited to any relevant planning meetings and contribute toward a risk assessment if required.

2.8.2 Safeguarding Children/Young People admitted or visiting a Psychiatric Ward (Appendix 12)

The Mental Health Act Code of Practice gives guidance on children visiting or having contact with adults or other young adults who are in a psychiatric unit. The guidance gives clarity to the processes to manage risks and safeguard the well-being of children/young people when on the wards. Safe and regular contact for children should be promoted with service users in psychiatric placements, whenever it is appropriate to maintain relationships, which are of importance to the child. The child's interests must remain paramount and take precedence over the interests of the adults involved when decisions are made about whether visits are appropriate. Any risks to the child should be identified and managed. These may be from the patient or from the environment in which visiting will take place and the setting may be potentially frightening for a child. (Appendix 12 for further guidance)

2.8.3 Drug and Alcohol Misuse

As with mental illness in a parent, it is important not to generalise, or make assumptions about the impact on a child of parental drug and alcohol misuse. Parental problem drug use can and does cause serious harm to children at every age from conception to adulthood. Parental misuse of drugs (prescribed and illegal) and/or alcohol is strongly associated with significant harm to children. A Child Protection referral to Children's Social Care must always be made when:

- Combined domestic abuse and mental illness;
- The substance misuse of a parent or carer is chaotic or out of control;
- Drugs and paraphernalia (e.g. needles) are not kept safely out of reach of children;
- Children are passengers in a car whilst a drug or alcohol misusing carer is driving.

2.8.4 Domestic Abuse (see Appendix 4)

The issue of children living with domestic abuse and violence is now recognised as a matter for concern in its own right by both government and key children's services agencies. The Domestic Abuse Act 2021, explicitly states that children are victims of domestic abuse if they see, hear or experience the effects of the abuse and the child is related to either the victim or the abuser.

2.8.4.1 Domestic abuse refers to threatening behaviour, violence or abuse including, psychological, physical, sexual, financial or emotional. It also includes Female Genital Mutilation, Modern Day Slavery and Honour Based Violence. (Appendix 4 for further guidance) The definition of domestic abuse is the "Behaviour of a person (perpetrator) towards another person (victim) if they are each aged 16 or over and are "personally connected" to each other, and the behaviour is abusive. The behaviour is defined as abusive if it consists of any of the following:

- (a) physical or sexual abuse;
- (b) violent or threatening behaviour;
- (c) controlling or coercive behaviour;
- (d) economic abuse;
- (e) psychological, emotional or other abuse; and it does not matter whether the behaviour consists of a single incident or a course of conduct.

2.8.4.2 Where there is evidence of domestic abuse, the implications for any children in the household must be considered and referral to Children's Social Care must be made where staff are aware of;

- A child's direct involvement with a domestic abuse incident or injury;
- A woman is pregnant. Pregnant women frequently experience punches and kicks directed at the abdomen, risking injury to both mother and foetus;
- Any child injured during episodes of violence or is witnessing the physical and emotional suffering of a parent.

2.8.4.3 The three objectives of any interventions when working with children and families where domestic abuse is a feature is:

- Protect the children
- Support the carer (non-abusive partner) to protect themselves and the children
- Hold the abusive partner to account for their violence and offer opportunities for change

2.9 Procedure where there are concerns that a Child has suffered or is likely to suffer Significant Harm. (See Annex 1 of this procedure (at end of document) for the National Assessment Framework tool to aid referral)

If staff are concerned that a child or unborn baby has suffered or is likely to suffer significant harm then a referral to the relevant Children's Social Care Department must be made using the appropriate referral form for the area the family is living in. All referral forms are available via the Trust Intranet or via Local Authority.

2.9.1 Some Local Safeguarding Partnerships (LSP) may use models as part of their child protection framework to support assessment of risk and provide a proforma on how child protection referrals should be made to share information and make decisions on whether a protection plan is needed reducing the risk of harm to a child. Three such models used by the LSP that EPUT work with are the Strengthening Families approach, Graded Care Profile and Signs of Safety. Staff can access further information and support with these approaches through the safeguarding clinical team.

2.9.2 When there has been a serious injury or death of a child, staff are responsible for considering the welfare of other children in the household and reporting those concerns to their line manager, Safeguarding Team or Children's Social Care accordingly. All actions taken must be clearly recorded. Where a child or parent discloses information to staff the staff member should record a clear and exact account of what was observed or said to them: In reference to child disclosures staff should:

- Listen to the child rather than directly questioning further.
- Never stop a child who is freely recalling significant events.
- Write what was said verbatim, as well as time, setting and people present.

2.9.3 Staff should discuss any referral to Children's Social Care with the family unless this may:

- Place a child at increased risk of significant harm e.g. by the behavioural response from parent/ carer
- Place the staff member at risk;
- Lead to the risk of loss of evidential material.

Reasons for not discussing the referral with the family should be recorded in case notes and within the referral. Staff should not rely on a parent to pass on information about family difficulties to other professionals. Referrals to Children's Social Care should be made within one day and may be made by telephone in some Local Safeguarding Partnership arrangement areas but must be followed up in writing within 48 hours using the relevant referral form depending on the Local Authority area. Forms are accessible via the Trust Intranet Safeguarding page or for electronic systems directly on the appropriate safeguarding partnership website. The National Assessment Framework tool to aid referral can be found at Appendix 1 of this guidance. The responsibility for undertaking section 47 enquiries lies with the local authority children's social care in whose area the child lives or is found.

2.9.4 Whenever a referral is made staff should make clear exactly what the risks are or category of abuse. As much information as possible relating to the concern is required in order for Children's Social Care to make informed decisions regarding action to be taken. This includes an Early Help Assessment if used, relevant past medical/social history, staff involvement with family members, previous referrals, and views on parenting capacity. All decisions and actions taken must be recorded in the relevant child/ adult/family records.

2.9.5 Children's Social Care must acknowledge referrals within 1 working day of receipt of the written referral. Where no acknowledgement is received within 3 working days, the referrer must contact Children's Social Care again. Where Children's Social Care decides to take no action, the referrer should anticipate feedback about that decision and its rationale. Where there is a disagreement or concern regarding actions taken following a child protection referral then the Team Manager of the Social Care Team or the Trust Safeguarding Team should be contacted as per the local agreed escalation procedure. Where there is a difference of opinion between Trust senior professionals regarding a risk to a child, the Named Nurse /Practitioner, Trust Safeguarding Team or the Service Director should be contacted.

2.9.6 If a referral needs to be made outside normal working hours then the Local Authority Emergency Duty Team or Police should be contacted Staff should contact the Manager on call via switchboard and record all discussions information and actions taken in the child/adults record.

2.9.7 Staff working with pregnant women should consider the need for a referral as soon as possible to Children's Social Care, so that assessments are undertaken and

family support services can be provided as early as possible. (Appendix 5 for further guidance)

2.9.8 When a patient is admitted to an Adolescent Mental Health Inpatient Unit the admitting professional should contact Children's Social Care to check if a young person is known to them. Staff should record any safeguarding concerns that do not meet the threshold for a referral to social care and store in the young person's records. If a young person does not have an allocated social worker the young person/ family should be offered a referral to social care for early help provision or as a child in need if required. Where a young person has been referred to Children's Social Care, the Police and Social Care must be invited to all discharge planning meetings where appropriate. Where a Looked After Child is admitted to an adolescent mental health inpatient unit the LAC Nurse and Social Worker must be informed and invited to all meetings including the discharge planning meeting. The admitting professional must request a copy of most recent LAC review including care plan from the allocated social worker.

2.9.9 Reports of suspected child abuse by a third party must be taken seriously and staff have a duty to advise the reporter to contact Children's Social Care directly. Staff cannot keep information confidential and have a responsibility to contact Social Care to ensure the concerns have been reported. All information and actions taken must be recorded in the child/adults records as appropriate.

2.10 Parental Responsibility

Staff working in partnership with families should have knowledge of who holds parental responsibility as this will guide staff on how they share information and whose consent should be gained for actions taken on behalf of a child who is not old enough to have the capacity to make decisions. Parental responsibility gives a parent the rights, duties, powers, responsibilities and authority of a child by law. A mother always has parental responsibility. A father has parental responsibility if married to the mother at the time of birth or has acquired legal responsibility through:

- Jointly registering the birth of a child with the mother (from Dec 1st 2003)
- By parental responsibility agreement with the mother
- By a parental responsibility order via a court.

The Family Court system can also grant parental responsibility in circumstances such as, emergency protection orders, adoption, or court orders etc. The Local Authority can acquire parental responsibility via a Care Order.

2.11 Staff working with children and young people must give due consideration to the child's wishes and feelings as far as is reasonably practicable giving due regard to the child's age and understanding. There will be occasions when it is not possible to ascertain the child's wishes and feelings. In these circumstances, professionals should record in writing the reasons.

2.12 Cross Boundary referrals

If a child lives outside the Trust area then the referral will need to be made to the relevant Local Authority where the child usually resides.

2.13 Record Keeping and Liaison

The findings from a number of Local Child Safeguarding Practice Reviews have identified record keeping as a significant concern. The consequence of inadequate record keeping can result in confusion for professionals and may directly place a child or young person at risk. All recordings regarding a child or adult constitute a legal document and can be used in court proceedings; therefore it is important to include all relevant information for all household members regardless of who the primary service user is.

2.13.1 All staff working directly with parents or carers should routinely record details of children in appropriate service user record e.g. Care Programme Approach (CPA) records, electronic records etc. Information must include the name, age and where the child is living. Additional information i.e. is the child registered with a GP and regularly attending school are important factors. Genograms must be used by all professionals where there are complex family structures or where this assists in identifying support needs or risks for the child. Genograms within CPA should be completed and updated regularly.

2.13.2 All records and assessments of parents and children must consistently record the racial, linguistic and religious identity and needs of the child and family. Staff should follow the Trust Record Keeping Policy. All discussions, decisions, actions and rationale for why no action is deemed necessary must be recorded contemporaneously with a date, name and signature. All recordings should be based on fact or professional opinion and made in the service user's records. At each new contact with a child or parent, the basic information about the child/ren/ young people should be checked and updated where applicable. The records of service users who have children with a Protection Plan should indicate this clearly e.g. on significant event sheet or the appropriate local forms.

2.13.3 Recording of relevant adult information by Community Health staff

Community Health staff should use the relevant electronic/paper record to record information regarding parents/carers and significant others including.

- Relevant adult's individual care plans
- All appropriate medical information/reports.
- Relevant social details and background, place of residence, relationship to child.

2.13.4 Where available, relevant child /adult records and electronic service users systems should indicate or use an alert flag, that a child has a Child Protection Plan and include the category of abuse or neglect the child has suffered and the decisions in the plan relating to the member of staff's role. Additional alerts can be used to indicate domestic abuse, looked after children and exploitation within children's community records.

2.13.5 Relevant information from the child protection plan, Child in Need Plan /Partnership meeting relating to the parents/carers or significant others should be recorded in the adult records. When a Protection Plan has been discontinued an entry in the Child Record/relevant adult record must indicate this. It is important that all records, including the parent/carers adult records are kept together and if appropriate transferred together. If part of the record has to be separated there must be an entry in the electronic/paper record stating where the retained record can be located.

2.14 Personal Child Health Record (Red Book)

- Normally contains all the findings and actions for the child from each visit.
- Should be used by all Community Health Professionals in contact with the child
- Will normally be completed with the parent /carer.

2.15 Child Community Health Record

- Contains all information relevant to the child e.g. chronology of significant event, domestic incident reports, case conference reports. (adult family member's information must be recorded in the appropriate record e.g. adult record).
- Records must indicate other Professionals involved including the GP
- Should reflect the needs assessment for the individual child.
- Include the discussions that have taken place with the family.

- Reflect points of discussion recorded in the parent held record.
- Child's views should be recorded.
- Observation of parent /child interaction or assessment of attachment should be recorded in the child's record
- A summary of assessment of need and outcome of the contact with a clear action plan should be made.

2.16 Use of body Maps

A Body Map must be completed whenever there are injuries or unusual findings including birthmarks, Mongolian Blue Spots and bruises or injury. On the body map record:

- The child's details (Name, Dob, NHS no.)
- The size, shape, appearance and position of all unusual marks/ injuries
- An explanation as how the injuries were sustained.
- The behaviour and demeanour of both carer and child.
- Print staff name, designation and date.

2.16.1 Information that should be recorded includes:

- If the mark has been present from birth or early life
- Mark in suspicious area, around mouth or eyes, on ear which you think is a bruise
- Any bruise in a pre-mobile infant (under six months old)
- Infant with nose bleed, mouth bleed
- Skin blister in newborn/ infant
- Infant unwell or injured in any way
- Mongolian blue spots are purple, present in sacral area and satellite spots.
- No general welfare concerns + looks like a birth mark
- In most cases of inflicted 'precursor' bruise, parents usually concede mark is a bruise but the explanation suggests unreasonable force, e.g. held while feeding, or is implausible e.g. lying on dummy.
- An entry should be made in the child's record referring to the body map.

2.17 Liaison

The Trust has liaison services and processes in place to support its Think Family approach. The process incorporates appropriate information sharing between Essex Accident and Emergency Departments, Essex Partnership University NHS Trust (EPUT) Mental Health Services and Essex Community Children's Service Providers regarding children and their parents/carers who attend hospital for emergency / unplanned care, the maternity unit or for babies admitted to Neo-natal Intensive Care.

2.17.1 When an Adult client is seen and assessed by the EPUT Assessment and Intervention or Crises teams in Essex A&E department's consideration will be given to whether there are safeguarding concerns where there is unborn – 18 year old child/children within the household. The Assessment and Intervention or Crises team will discuss any identified concerns with the hospital's safeguarding team and where appropriate will make a safeguarding referral. When a safeguarding concern is identified a mental health notification form will be sent to the relevant community practitioner via the Paediatric Liaison Service. (EPUT Standards for Paediatric Liaison Service)

2.17.2 When there are concerns from the midwifery department or Primary Care for pregnant women an early ante natal referral liaison will take place with the relevant community children and where appropriate Perinatal Mental Health Team. Consideration should always be given as to whether a pre-birth assessment is

indicated depending on the level of risk that is presented. (Appendix 5 for further guidance) Additionally if there are concerns from the in-patient midwifery team regarding additional care needs during the immediate post-natal period not previously identified it is expected that a liaison notification will be made to the relevant adult mental health or Children's Community Services practitioners involved in the clients care from the midwifery team.

2.18 ACCESS TO INFORMATION

All Trust staff have a duty to assist Social Care with Section 47 enquiries when a child is believed to be suffering or at risk of suffering significant harm. If a member of staff is approached via telephone for information on a child by a Social Worker or other professional, the member of staff must identify whom they are speaking to and if they do not recognise the caller phone back. Record details of caller and time and the action taken in the Child and relevant Adult Record. Safe sharing of information principles must be applied including:

- Ensuring information is to a secure email address or the document is password protected which is sent separately.
- Child/family details should not be emailed to any other agency outside of health unless a secure system is used in accordance to the Trust security policy.
- Posted information should be marked private and confidential and include a compliment slip from sender.

If any other person, including parents/carers, request information about a child, parent or third party staff should contact the line manager or the Safeguarding Team for advice. Health records will not normally be released to persons outside the Health Service except on Court Orders. However parents have a right of access to their child's records. If a request is made for access, contact the Line Manager in the first instance. Further advice can be sought from the Named Nurse Safeguarding Children or Trust Information Governance Manager or Trust Legal Representative. Further guidance can be found within the Trust 'access to records' policy.

2.19 Formal statements & Court Process (Appendix 10)

Staff are required to co-operate with police and the Local Authority when approached for a formal statement. In these circumstances staff must inform the relevant Safeguarding Team and their line manager. The Trust Legal Advisor can be contacted for advice and support. Appendix 11 gives additional guidance for those staff giving formal statements or attending court as a witness.

2.20 Missed Appointments

Parents/Carers failure to attend health appointments for a child/ren/ young people has been a feature of a number of Local Child Safeguarding Practice Reviews formally known as Serious Case Reviews and staff working with children should note all missed appointments and consider any safeguarding concerns. It is the weight and significance placed on missed appointments, in conjunction with their frequency and cumulative impact on the health of children which may constitute neglect by their parents, who either by omission or commission fails to safeguard their children's health by not attending a recommended contact with health services.

- 2.20.1 Missed appointments to health services should be notified to the referrer, the GP and relevant health professional (Health Visitor or School Nurse etc.). Staff should also consider if patterns of missed appointments has been seen in other children in the family. Where there are failed telephone contacts with other professionals or parents/carers regarding a child then staff should formalise this in writing requesting contact and stating how this can be achieved. If there continues to be no response then staff should escalate this to the named Social Worker (if child has one) and the

Safeguarding Team. The GP should be notified where appropriate. All attempts at contact should be fully documented in the health record.

2.20.2 Staff working with parents who fail to attend health appointments should consider the impact this may have on the parenting capacity of children or for pregnant women, the impact on the unborn. Mental health staff or those working in Community Drug & Alcohol or Adult Learning Disability Teams should consider discussing missed appointments with the relevant health visitor, school nurse or midwife in order to share information and assess levels of concern and risk.

2.20.3 Parents should be notified when failing to attend appointments and offered an alternative appointment or discussion on any assistance required in order to facilitate attendance. If staff are concerned regarding the impact of failing to attend appointments for an adult or child on a child's welfare they should:

- Discuss with their line manager or manager of service
- Discuss with a member of the Safeguarding Team
- Consider a partnership meeting
- Consider a referral to children's social care
- Add this information to the Chronology of significant events

2.21 Hostile or non-compliant parent/carers

Staff should ensure that the needs of the child in a family are paramount regardless of who the primary service user is. Hostile parents refer to those who are or have been violent, aggressive, threatening or intimidating in a physically, verbally or emotionally damaging way. This may be directed at staff, partners, children or animals. In these circumstances staff must consider the safety of any child/ren/ young people in the home and discuss with the parents key worker if a Trust service user, line manager or the Named Safeguarding Nurse/Practitioner.

2.22 Non-compliance

This includes a wide range of deliberate behaviours and attitudes intended to restrict the effectiveness of any intervention in place to safeguard the child/ren e.g. child protection plan. It can include actively undermining efforts to bring about change or passively not complying with plans or disguised compliance whereby parents do not admit to their lack of commitment to change but work subversively to undermine the process.

2.22.1 Staff working with the adult parent or child should be mindful of underlying reasons for non-compliance or lack of co-operation. Factors associated with hostility and non-compliance include Domestic Abuse, Fear of statutory services, Isolation, Immigration status etc.

2.22.2 It is important that staff should consider the impact of non-compliance on the child/rens/ young people welfare and safety and all identified risks should be shared with both health and multi-agency colleagues working with a particular family. This includes Children's Social Worker GP, Psychiatrist etc. Workers must recognise when the family is not engaging so as to avoid collusion or avoidance. Early recognition of family resistance is critical.

2.22.3 The line manager and the Named Nurse / Practitioner Safeguarding should be informed and staff should give regard to the Lone Working Policy. Community Health staff making home visits where there are child protection concerns must see the child. Any risk assessment should be recorded in the child's health records. Where staff are not entirely satisfied with compliance, the clinical, social or emotional picture that is presented or where maltreatment is suspected they should consider a child protection referral to Children's Social Care.

2.23 Historical Abuse Allegations

Adult or child service users who disclose they have been abused in the past e.g. sexual abuse or female genital mutilation must be treated sensitively. Service users should be offered information, support or counselling etc. Police must be informed about allegations of a crime at the earliest opportunity. Whether they become involved in an investigation will depend on several factors including the victim's wishes and public interest. Staff may discuss this with the Police Child Abuse Investigation Unit or the Trust Safeguarding Team.

2.24 Vulnerability, Complex Factors & Additional Needs

Staff working with children or adults must consider the support needs required to maintain a child's welfare in all aspects of their work. This should be considered within the Care Programme Approach (CPA), Community Health Service and Adolescent Mental Health or Children's Learning Disability assessments and revisited at each contact with a parent or child. When working in either adult or child settings, staff should be aware that a number of Vulnerability Factors will affect children's welfare such as; Social Exclusion, Bullying, Missing Children/Families, Forced Marriages, Honour Based Violence, Migrant Children, Disabled Children, Child Sexual Exploitation and Female Genital Mutilation, Modern day slavery and those at risk of violent extremism or radicalisation etc.

2.25 Community Based Violence

Significant harm and additional vulnerability factors can apply to young people, from community based violence such as gang, group and knife crime. In these circumstances staff need to ensure that the safeguarding process responds effectively to involve both the perpetrators and victims of violent activity. Exposure to, or involvement with, groups or individuals who condone violence as a means to a political end is a particular risk for some children. Children and young people can be drawn into violence themselves or they can be exposed to messages through direct contact with members or, increasingly, through the internet. This can put a young person at risk of being drawn in to criminal activity or recruited by violent extremists.

2.26 Prevent (Appendix 11 for further guidance)

CONTEST is the Government's national counter terrorism strategy, aims to reduce the risk to the United Kingdom and its interests overseas from international terrorism, so that people can go about their lives freely and with confidence.

The strategy has four work streams:

- Pursue: to stop terrorist attacks
- Protect: to strengthen our protection against terrorist attack
- Prepare: where an attack cannot be stopped, to mitigate its impact
- Prevent: to stop people becoming terrorists or supporting terrorism

- 2.26.1 Prevent aims to stop people from becoming terrorists or supporting terrorism. The Trust guidance on Prevent reflects the Home Office Strategy. The Prevent Strategy addresses all forms of terrorism including extreme right wing but continues to prioritise according to the threat posed to our national security. The aim of Prevent is to stop people from becoming terrorists or supporting terrorism and operates in the pre-criminal space before any criminal activity has taken place. The Trust Prevent protocol reflects the Home Office policy May 2015. Staff concerned that a child or family may be affected by violent extremism must consult their line manager, or a member of the Safeguarding Team.

2.27. Early Help Assessment (EHA)

All staff are required to identify emerging problems and potential unmet needs for individual children and families and to share information with other professionals to support early identification and assessment. Professionals should be alert to the potential need for early help for a child who:

- Is disabled and has specific additional needs
- Has Special Educational Needs (SEND) whether or not they have a statutory Education, Health Care Plan (EHCP)
- Is a young carer
- Is showing signs of being drawn into anti-social or criminal behaviour, including gang involvement and association with organised criminal groups
- Is frequently missing/goes missing from care or from home
- Is at risk of modern slavery, trafficking or exploitation
- Is at risk of being radicalised or exploited
- Is in a family circumstance presenting challenges for the child such as substance misuse, adult mental health problems or domestic abuse
- Is misusing drugs or alcohol themselves
- Has returned home to their family from care
- Is showing early signs of abuse or neglect.

2.27.1 The Early Help Assessment (EHA) is a holistic and generic assessment of a child or young person's needs for additional services. It is a helpful tool for staff working in partnership with parents to identify extra support when there is a concern about how well a child (or unborn baby) or young person is progressing, when their needs are unclear, or broader than Trust services can address on its own. A common assessment would help identify the needs, and provide a basis for getting other services involved. Providing early help is more effective in promoting the welfare of children than reacting later. Early help means providing support as soon as a problem emerges, at any point in a child's life, from the foundation years through to the teenage years.

2.27.2 Effective early help relies upon local agencies working together to:

- Identify children and families who would benefit from early help;
- Undertake an assessment of the need for early help; and
- Provide targeted early help services to address the assessed needs of a child and their family which focuses on activity to significantly improve the outcomes for the child. Local authorities, under section 10 of the Children Act 2004, have a responsibility to promote inter-agency cooperation to improve the welfare of children.

2.27.3 Children and families may need support from a wide range of local agencies. Where a child and family would benefit from coordinated support from more than one agency (e.g. education, health, housing, police) there should be an inter-agency assessment. These early help assessments should identify what help the child and family require preventing needs escalating to a point where intervention would be needed via a statutory assessment under the Children Act 1989.

2.27.4 The early help assessment should be undertaken by a lead professional who should provide support to the child and family, act as an advocate on their behalf and coordinate the delivery of support services. The lead professional role could be undertaken by a General Practitioner, family support worker, teacher, health visitor and/or special educational needs coordinator. Decisions about who should be the lead professional should be taken on a case by case basis and should be informed by the child and their family.

- 2.27.5 The EHA process must be undertaken in partnership with parents and children and the principles will also be incorporated into the Trust Care Programme Approach (CPA) Handbook, and the Trust Safeguarding Intranet Link. All Local Safeguarding Partnership areas within the Trust will use their own Early Help Assessment form so staff should refer to the Trust safeguarding or Local Safeguarding Partnership arrangements intranet sites for their local forms. If parents and/or the child do not consent to an early help assessment, then the lead professional should make a judgement as to whether, without help, the needs of the child are likely to escalate and place the child at risk of significant harm. If it is felt that this is so, a referral into local authority children's social care may be necessary.

3.0 PROCEDURE REFERENCES / ASSOCIATED DOCUMENTATION (EXTERNAL)

Central Bedfordshire <https://www.centralbedfordshirelscb.org.uk/lscb-website/home-page>
 Bedford Borough Council <https://www.bedford.gov.uk/social-care-and-health/children-and-families/safeguarding-children-partnership>
 Luton <https://lutonlscb.org.uk/>
 Southend, Essex & Thurrock www.escb.org.uk
 Suffolk www.suffolkscb.org.uk
 Pan London www.londoncp.co.uk
 The Framework for the Assessment of Children in Need and their Families (DoH 2000)
 Working Together to Safeguard Children (Department of Health DOH, 2018)

4.0 REFERENCE TO OTHER TRUST POLICIES/PROCEDURES (INTERNAL)

Adverse Incident Policy (CP3)
 Child Death & Learning Disabilities Mortality Review process (CLPG37 Appendix 9)
 Court Appearance and Formal Statements (CLPG37 Appendix 10)
 IT & T Information Governance & Security Policy (CP50)
 Lone Working Policy (RM17)
 Managing Allegations and Safer Working Practices (CLPG37 Appendix 7)
 Mobile Phone policy (CP54)
 Prevent (CLPG37 Appendix 11)
 Safeguarding Children/Young People admitted or visiting a Psychiatric Ward (CLPG37 Appendix 12)
 Safeguarding Practice Learning Reviews (CLPG37 Appendix 8)
 Welfare of Unborn Babies (CLPG37 Appendix 5)
 When Illness is Fabricated or Induced (LCPG37 Appendix 6)

5.0 GLOSSARY

Please list all technical terms, abbreviations and acronyms in the glossary table given below. Common acronyms such as 'NHS' or 'EPU' can be omitted. If the policy does not contain any technical terms or acronyms then a glossary is not required.

Term	Meaning
A&E	Accident and Emergency
CE	Criminal Exploitation
CPA	Care Programme Approach
CQC	Care Quality Commission
CSE	Child Sexual Exploitation
EHA	Early Help Assessment

CLPG37 SAFEGUARDING PROCEDURAL GUIDANCE

<i>EHCP</i>	<i>Education, Health Care Plan</i>
<i>ICB</i>	<i>Integrated Care Board</i>
<i>LAC</i>	<i>Looked after Child</i>
<i>LSP</i>	<i>Local Safeguarding Partnerships</i>
<i>SEND</i>	<i>Special Educational Needs</i>

END
