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NHS
Sussex Partnership
NHS Foundation Trust

Safeguarding Children Policy and Procedures

(Replaces Policy No. TP/Cl/021 V.5)

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1.0 Introduction

As part of its work in safeguarding and promoting the welfare of children, Sussex Partnership NHS Foundation Trust has a statutory duty under Section 11 of the Children's Act (2004) to protect children from harm.

Safeguarding children and adults and the promotion of the welfare of children is everyone's responsibility. This applies to all staff at Sussex Partnership NHS Foundation Trust (SPFT) who come into contact with either children, young people or adults who have contact with children.

Safeguarding and promoting the welfare of children is defined in Working Together to Safeguarding Children (HM Gov 2018) guidance as:

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

Additional to this, the Trust will fulfil its responsibilities to safeguard and promote the welfare of children by;

- Senior management commitment
- Clear lines of accountability and structure
- Promote a positive culture that enables the raising of safeguarding concerns and the promotion of children's welfare to be addressed
- Paying due regard to issues of equality and diversity
- All staff receive the appropriate training to enable them to actively safeguard children within their work
- Utilising effective reporting systems promote accurate record keeping with regards to safeguarding actions

This policy incorporates the statutory government guidance in Working Together to Safeguard Children 2018 (HM Gov, 2018) which can be found here.

The Trust is a partner agency within the Safeguarding Children Partnerships (SCP) formerly Local Children Safeguarding Boards (LSCB) and therefore this policy should be read in conjunction with the Pan Sussex Child Protection and Safeguarding Children Procedures.
https://sussexchildprotection.procedures.org.uk/
Hampshire CAMHS staff should access the HIPS Procedures.
http://hipsprocedures.org.uk/

1.1 Purpose of policy

The Trust provides mental health and learning disability services across Sussex. These services are organised into care groups; Working Age Adults, Older People, Child and Adolescent, Secure and Forensics, Assessment and Treatment, Learning Disabilities and Prison Healthcare. In Hampshire we provide Child and Adolescent Mental Health services only. All care groups have a responsibility to safeguard and promote the welfare of children and this policy is applicable to all staff working across the organisation.

The purpose of this policy is to provide clear and consistent guidelines and policy directives when safeguarding children and young people.

- **The Children Act (1989)** introduced the framework of significant harm which requires the compulsory intervention into family life in order to safeguard children. The Local Authority has a duty to investigate where there is reason to suspect that a child is suffering or likely to suffer significant harm.

- **The Children Act (2004)** states the requirement of each Local Authority, health provider and partner agency to make arrangements to promote co-operation between the authorities. Section 11 (Children's Act 2004) places a range of duties on organisations and individuals to ensure their functions are discharged with regard for the need to safeguard and promote the welfare of children.

- **The Equality Act 2010** places a responsibility on public authorities to have due regard for the need to eliminate discrimination and promote the equality of opportunity. This applies to the identification and risk faced by individual children and states that no child or group of children should be treated any less favourably than other in being able to access effective services to meet their specific needs.

- **The NHS England Accountability and Assurance Framework** (2019): Safeguarding Children, Young people and Adults at risk in the NHS

This policy is a live document and therefore subject to change in line with local and national guidance. Please ensure that you are accessing the latest version of this document via the Sussex Partnership intranet.

This policy is developed in conjunction with the Pan Sussex Child Protection and Safeguarding Children Procedures and the Hampshire Safeguarding Children procedures.
Pan Sussex: https://sussexchildprotection.procedures.org.uk
Hampshire CAMHS staff should access the HIPS Procedures.
http://hipsprocedures.org.uk/

1.2 Definitions

1.2.1 Definition of a child (Children Act 2004)

A child is defined as anyone who has not yet reached their 18th birthday. The factors below do **not** change the definition of a child if they are:

- Living independently
- In further education
- A member of the armed forces
- In hospital
- In custody
- In secure accommodation for children and young people

These children and young people are entitled to services or protection under the Children's Act 2004. Safeguarding concerns should also be factored in when considering the needs of any unborn child.

1.2.2 Definitions of categories of abuse

Working together to Safeguard Children (2018) define the following categories of abuse (HM Gov, 2018)

"A form of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting by those known to them or, more rarely, by others. Abuse can take place wholly online, or technology may be used to facilitate offline abuse. Children may be abused by an adult or adults, or another child or children."
(pg. 103 Working together to safeguard children, HM Gov 2018).

1.2.3 Physical Abuse

May involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces illness in a child.

1.2.4 Neglect

Neglect is defined by 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 can impact on any age child and consideration should be given to the incidence and impact of adolescent neglect. Neglect may occur during pregnancy and there are specific guidelines within the Pan Sussex Safeguarding Children Procedures for responses to safeguarding concerns in unborn children. 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); or
- ensure access to appropriate medical care or treatment, this includes accessing appropriate mental health care.
- neglect of, or unresponsiveness to a child's basic emotional needs.

Sussex Partnership NHS Foundation Trust Child Neglect Strategy offers specific guidance and tools for the identification of, and interventions in relation to neglect. Concerns around neglect should be responded to in accordance with this policy and supported by the Child Neglect Strategy (appendix 4).

1.2.5 Emotional Abuse

Is the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person.

It may include not giving the child opportunities to express their views, deliberately silencing them or 'making fun' of what they say or how they communicate. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond the child's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction.

It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying (including cyber bullying), causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone**.**

1.2.6 Sexual Abuse

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

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

1.2.7 Child Sexual Exploitation

Child sexual exploitation is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology.

Sussex Partnership has a specific policy relating to the sexual exploitation of children which can be found on the staff Intranet.

1.2.8 Child Criminal Exploitation

Child Criminal Exploitation is common in county lines (see definition section 1.2.12) and 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.

1.2.9 Female Genital Mutilation (FGM)

FGM is a procedure where the female genital organs are injured or changed and there is no medical reason for this. It is frequently a very traumatic and violent act for the victim and can cause harm in many ways. The practice can cause severe pain and there may be immediate and/or long-term health consequences, including mental health problems, difficulties in childbirth, causing danger to the child and mother; and/or death.

The Trust has a specific policy related to Female Genital Mutilation which can be found on the staff Intranet.

1.2.10 Online Abuse

Social networking sites and online gaming can be used by perpetrators as an easy way to access children and young people for sexual abuse, including sexual exploitation, or to attract children and young people into extremist ideology.

Perpetrators use a number of grooming techniques including building a relationship of trust with a child, the use of enticements, or coercion and / or blackmail. Perpetrators may create different online personas to draw the child in. This can be followed by the perpetrator encouraging the child to meet with them, encouraging them to undertake harmful actions, or engaging the chid in more intimate forms of communication, for example through the use of images and webcams.

1.2.11 Harmful Practices

An example of harmful practice is breast ironing also known as “breast flattening” is the process whereby young pubescent girls breasts are ironed, massaged and/or pounded down through the use of hard or heated objects in order for the breasts to disappear or delay the development of the breasts entirely. It is believed that by carrying out this act, young girls will be protected from harassment, rape, abduction and early forced marriage and therefore be kept in education.
There is no specific law within the UK around breast flattening, however it is a form of physical abuse should be treated as such. See your local safeguarding children procedures.

1.2.12 Gangs

A gang is defined as a “relatively durable group who have a collective identity and meet frequently. They are predominantly street-based groups of young people who see themselves (and are seen by others) as a discernible groups for whom crime and violence is integral to the groups’ identity” See your local safeguarding children procedures.

1.2.13 County Lines

County lines is a term used to describe gangs and organised criminal networks involved in exporting illegal drugs into one or more importing areas within the UK, using dedicated mobile phone lines or other form of “deal line”. They are likely to exploit children and vulnerable adults to move and store the drugs and money and they will often use coercion, intimidation, violence (including sexual violence) and weapons.

1.2.14 Modern Slavery

Modern slavery is when a person(s) hold another person in a position of slavery, servitude forced or compulsory labour, or facilitating their travel with the intention of exploiting them soon after. Although human trafficking often involves an international cross-border element, it is also possible to be a victim of modern slavery within your own country. Children are trafficked either being moved internationally or domestically so they can be exploited. This exploitation can include sexual or criminal exploitation, forced labour and debt bondage

It is possible to be a victim even if consent has been given to be moved. Children cannot give consent to being exploited therefore the element of coercion or reception does not need to be present to prove an offence. The National Referral Mechanism is a framework for identifying victims of human trafficking or modern slavery which can be found in the references section.

1.2.15 Trafficking

A person is trafficked by the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force. A person can be coerced, abducted or by the abuse of power/position of vulnerability. Trafficking achieves a person having control over another person, for the purpose of exploitation.

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

Any child transported for exploitative reasons is considered to be a trafficking victim, whether or not they have been forced or deceived. This is partly because it is not considered possible for children in this situation to give informed consent. Even when a child understands what has happened, they may still appear to submit willingly to what they believe to be the will of their parents or accompanying adults. It is important that these children are protected also. (Pan Sussex Child Protection and Safeguarding Procedures Manual 2018)

The National Referral Mechanism is a framework for identifying victims of human trafficking or modern slavery which can be found in the references section.

1.2.16 Forced marriage

A forced marriage is when one or both spouses do not (or, in the case of some vulnerable adults, cannot) consent to the marriage and duress is involved. Duress can include physical, psychological, financial, sexual and emotional pressure.

1.2.17 Non Recent Abuse

Non-recent abuse (also known as historical abuse) is an allegation of neglect, physical, sexual or emotional abuse made by or on behalf of someone who is now 18 years or over, relating to an incident which took place when the alleged victim was under 18 years old. Often childhood experiences of abuse are not reported until years after the offence. There may be a multitude of reasons for this, which is often complex and multifactorial:

- Fear of repercussions from said disclosure
- Perpetrator may be a close family member
- Lack of clarity / recall around alleged abuse incident and fear of not being believed
- Cultural or language barriers
- Poor understanding of the abuse experience impacted by developmental age at the time of offence
- All disclosures of non-recent abuse should be treated with the same level of curiosity and concern as a recent allegation.

The Trust has a specific policy for Non recent (historic) allegations of abuse policy which can be found on the staff Intranet.

1.2.18 Looked after Child (LAC)

A child is looked after by a local authority if he or she is in their care or if he or she is provided with accommodation for a continuous period of more than 24 hours by the authority in the exercise of its social services function. Children are taken into care for a variety of reasons, the most common being to protect a child from abuse or neglect. In other cases their parents could be absent or may be unable to cope due to disability or illness.

The Deputy Chief Nurse holds delegated strategic responsibilities for Looked After Children reporting to the Chief Nurse and attends the LAC NHS Professionals Forum. The overarching aims of the forum are to continually look through a contextual safeguarding lens for children and young people who are Looked After to identify what

is working well, share best practice and proactively collaborate to address areas that require support or intervention. The Lead Nurse for Safeguarding Children attends as part of delegated duties and contributes to the quality assurance, monitoring and reporting requirements in this domain.

1.2.19 Child in Need/Section 17 (Children's Act 1989)

Under the Children Act 1989, local authorities are required to provide services for children in need for the purposes of safeguarding and promoting their welfare.

A child in need is defined under the Children Act 1989 as a child who is unlikely to achieve or maintain a reasonable level of health or development, or whose health and development is likely to be significantly or further impaired, without the provision of services; or a child who is disabled. Children in need may be assessed under section 17 of the Children Act 1989 by a social worker and parental consent is required.

1.2.20 Section 47 (Children's Act 1989)

Under section 47 of the Children Act 1989, where a local authority has reasonable cause to suspect that a child (who lives or is found in their area) is suffering or is likely to suffer significant harm, it has a duty to make such enquiries as it considers necessary to decide whether to take any action to safeguard or promote the child's welfare. Such enquiries, supported by other organisations and agencies, as appropriate, should be initiated where there are concerns about all forms of abuse, neglect. This includes female genital mutilation and other honour-based violence, and extra-familial threats including radicalisation and sexual or criminal exploitation.
Consent- not required but parents should be informed unless it is unsafe or not appropriate to do so .If concerned seek safeguarding advice.

1.2.21 Local Authority Designated Officer (LADO)

The Local Authority Designated Officer (LADO) has overall responsibility for the management of allegations of abuse against adults who work with children or if there are concerns regarding institutional practice. The LADO provides advice and guidance, liaises with the police, social care teams, regulatory bodies such as Ofsted and other organisations as needed and ensures a consistent, fair and thorough process for both child and adult. It is imperative that allegations against staff who work with children are discussed with the LADO for your geographical area and the Associate Director for Safeguarding within 24 hours of the allegation being raised.

1.2.22 Corporate Parent

Some children as a result of their experiences of, for example; abuse or neglect will be removed from the family home and will become Looked after Children, also referred to as children looked after. In these instances the Local Authority has a duty under Section 22 (3) (a) of the Children's Act (1989) to safeguard and promote the welfare of the children they look after. Please see CHYPS Consent policy re. parental responsibility for more detail.

This translates to the Local Authority becoming the "Corporate Parent" for the child or young person.

Children Looked After includes

- Unaccompanied Asylum Seekers
- Children who are accommodated under voluntary agreement
- Children subject to a care order

- Children subject to emergency orders for their protection
- Children who are compulsorily accommodated

It is widely recognised that looked after children and young people frequently have significant health, mental health and psychological needs, many of these children will access our services as young people or when they reach adulthood. Please remember to understand the status of the individual, who is involved in care and treatment and any particular arrangements and special considerations and responsibilities in regards to the Corporate Parenting role.

1.2.23 Private fostering

Private fostering is when a child under the age of 16 (under 18 if disabled) is cared for by someone who is not their parent or a 'close relative'. This is a private arrangement made between a parent and a carer, for 28 days or more. Close relatives are defined as step parents, grandparents, brothers, sisters, uncles or aunts (whether of full blood, half blood or marriage/affinity). It is a requirement to report to local authority if there are known private fostering arrangements, kinship arrangements do not need to be reported.

1.2.24 Young Carers

Children and young people under the age of 18 who provide intentional or unintentional care, assistance or support to another family member/ They carry out a range of caring tasks and assume a role of responsibility that would be associated with an adult. This care may be carried out for a family member who has a need for care, support and/or supervision.

1.2.25 Child Not Brought (DNA)

Child not brought' refers to the non-attendance of health based appointments by a child or young person. The expectation is that a parent or carer has a responsibility to ensure a child's needs are met and that there is adequate consideration given to the significance of withdrawing or refusing health based services and the impact this may have on the welfare of the child. SPFT have a traffic light system (appendix 2**).** You may need to consider discussing the case with the Safeguarding Team and use time allocated for a missed appointment to ensure the child or young person is safeguarded.

1.2.26 Sexually active children

Under the Sexual Offences Act 2003, penetrative sex with a child under 13 years old is classed as statutory rape. Where the allegation concerns penetrative sex, or other intimate sexual activity occurs or it is alleged that one of the specific offences in relation to a child aged under 13 has occurred, there would always be reasonable cause to suspect that a child, whether girl or boy, is suffering, or is likely to suffer, significant harm. A children services/police referral should be completed.
Sexual activity with a child under 16 is also 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. Consideration should be given in every case of sexual activity involving a child aged 13-15 as to whether there should be a discussion with other agencies and whether a referral should be made to Children Services. The professional should make this assessment using the considerations below. Within this age range, the younger the child, the stronger the presumption must be that sexual activity will be a matter of concern. Cases of concern can be discussed with the Named professionals for safeguarding and with other agencies if required.

1.2.27 Parental mental ill-health, substance abuse and domestic abuse

Formerly known as ‘Toxic Trio’ or Trigger Trio has been used to describe the issues of domestic violence, mental ill Health and substance misuse (drugs and/or alcohol) which have been identified as common features in families where harm to children has occurred. They are viewed as indicators of increased risk of harm to children and young people. Parental mental ill-health, Substance Abuse and Domestic Abuse can have a serious impact on a child’s development and emotional well-being and lead to anxiety and stress.
Where professionals become aware that the indicators of the ‘toxic trio’ are present within the family home, either as a combination of all or a singular indicator, a referral to Children’s Services must be considered. Professionals are encouraged to discuss cases where there are concerns about with the named professionals for safeguarding and/or the MASH teams.

1.2.28 Domestic Violence/Abuse

A child safeguarding referral should always be made in a situation where a child witnesses domestic abuse or is linked to a home or relationship where domestic abuse if occurring.

Children can experience both short and long term cognitive, behavioural and emotional effects as a result of witnessing domestic abuse. Each child will respond differently to trauma and some may be resilient and not exhibit any negative effects.

Children’s responses to the trauma of witnessing domestic abuse may vary according to a multitude of factors including, but not limited to, age, race, sex and stage of development. It is equally important to remember that these responses may also be caused by something other than witnessing domestic abuse (Taken from https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/impact-on-children-and-young-people/)

The Trust has a specific Domestic Abuse Policy see link: https://policies.sussexpartnership.nhs.uk/clinical-3

1.2.29 Children from abroad

Children can arrive into this country from overseas every day some of these children will be seeking asylum. These circumstances for these children may include:

- In the care of adults who have no parental responsibility (PR) for them;
- In the care of adults who have no documents to demonstrate a relationship with the child;
- Alone;
- In the care of agents

1.2.30 Fabricated or induced illness

Fabricated or induced illness in a child is a condition whereby a child suffers harm through the deliberate action of her/his main carer and which is duplicitously attributed by the adult to another cause. There are 3 main ways of the carer fabricating or inducing illness in a child:

- Fabrication of signs and symptoms, including fabrication or exaggeration of past or current medical history;
- Fabrication or exaggeration of signs and symptoms and falsification of hospital charts, records, letters and documents and specimens of bodily fluids;

- Induction of illness by a variety of means.

The above are not mutually exclusive.

Any cases of suspected fabricated or induced illness should be discussed with the safeguarding team in the first instance and a plan made regarding case management.

Pan Sussex Fabricated or induced illness (FII) and Perplexing Presentations (including FII by carers) procedures can be found on your relevant SCP Board websites.

1.3 Scope of policy

All persons working within the Trust have a responsibility to safeguard and promote the welfare of children. Child safeguarding concerns all staff who come into contact with children, young people and their families. Child safeguarding concerns all staff who come into contact with children, young people and their families. This policy sets out the action to take if you have concerns about a child/young person during the course of your work. The policy is applicable to all employees of the Trust, including volunteers, and any staff working within the Trust on a service level agreement / honorary contract.

1.4 Principles

Health professionals and the Trust have a key role to play in the safeguarding and protection of children. The purpose of this policy is to fulfil the following principles;

- To help staff protect and safeguard children at risk of abuse or neglect. This includes the protection of the unborn child.
- To define the organisational structures and responsibilities in relation to safeguarding children.
- To ensure that staff in the course of their work are aware of their safeguarding responsibilities and understand that safeguarding is everyone's responsibility.
- To ensure that children and young people receive appropriate and timely preventative and therapeutic interventions and that safeguarding and promoting their welfare is an integral part of all stages of care.
- To clarify the roles and responsibilities of staff and to ensure that staff have adequate training and support to fulfil their safeguarding responsibilities.
- To ensure that all staff can recognise risk factors and can contribute to reviews, enquiries and child protection plans alongside providing promotional and preventative support through proactive work.

2.0 Policy Statement

This policy focuses on the core organisational and individual responsibilities, making it clear what individuals, organisations and agencies must and should do to keep children safe. The emphasis being that effective safeguarding is achieved by putting children at the centre of the system and by every individual and agency playing their full part**.** This policy is applies to children who are receiving care from Sussex Partnership NHS Foundation Trust but also those children who are associated to Sussex Partnership NHS Foundation Trust services by the nature of their family or carer network.

3.0 Duties

Duties within the organisation

3.1 Organisational arrangements

Chief Executive – The Chief Executive holds overall responsibility for the trust wide legislative compliance and management of risk in relation to safeguarding children.

Chief Nurse – The Chief Nurse has trust board responsibility for all aspect of safeguarding children and has delegated responsibility for ensuring that the board are fully informed of risk or serious incidents related to child safeguarding.

Director of Human Resources – Responsible for ensuring that safer recruitment standards are maintained. This includes ensuring that systems are in place for conducting criminal records check (DBS) for all staff who will be working with or have access to the records of children or vulnerable people. To ensure that the Trust has adequate policies and procedures in place to manage the allegation of abuse against staff or volunteers and that appropriate whistle blowing procedures are in place.

Deputy Chief Nurse – The Deputy Chief Nurse for Safeguarding holds responsibility for the development, management and implementation of the safeguarding duties within the organisation. This includes Section 11 compliance, quality assurance frameworks and to ensure there are reporting systems in place to work in partnership with the Safeguarding Children's Partnerships. Reporting to both the Trust Board and Local Safeguarding Children's Partnerships to provide assurance of the organisations ability to meet its safeguarding responsibilities. This also includes providing management of the Named and Deputy Named Nurses and support for the Named Doctors for Safeguarding Children. The Lead Nurse for safeguarding children supports on allegations made against SPFT staff who have access to children and young people.

Named / Deputy Named Nurses and Named Doctors – The Trust's named nurses and named doctors for safeguarding children are responsible for the co-ordination, management, development and implementation of safeguarding practice within the organisation. This includes providing specialist advice, training and supervision to support staff in the discharge of their safeguarding children responsibilities. It also includes partner agency liaison to ensure compliance with Section 11 duties.

All Sussex Partnership NHS Foundation Trust staff irrespective of grade, discipline or role, whether substantive, temporary, contracted or honorary have a duty to ensure that children are safeguarded from harm and are aware of and understand their responsibilities.

All staff will undertake mandatory Level 1 safeguarding training and should be able to recognise concerns and have an understanding of how to report concerns and seek additional guidance and support. All staff should be aware that the needs of the child are paramount and the child's needs should always be prioritised.

All clinical staff

All clinical staff must ensure they have undertaken the appropriate level of mandatory training appropriate to their role.

Staff should be aware of their local procedures for reporting concerns about children and how to seek additional support and guidance from their named professional.

Staff should utilise clinical supervision to discuss children's safeguarding cases and reflect on actions, complexity and any other factors.

4.0 Procedure

The Trust has a dedicated safeguarding team with deputy and named nurse provision across the Trust please see Appendix 1 for your local arrangements.

The Trust's safeguarding team are available to offer clinical consultation, review of complex cases, and offer training across the organisation. The Team are also members of the Safeguarding Children Partnerships (SCP) and relevant sub-groups.

Consideration must always be given to the safety of other children within the home and action must always be taken to ensure the immediate safety of a child. Therefore children must be identified on the adult inpatient acute care screening tool. At the point of initial service contact practitioners should seek to gain an understanding and document on Carenotes any children who may be associated to the home**.**

Staff should consider safeguarding in their observations of a child, parent or carer, and information relating to the relationship with a child and information obtained through third party sources (e.g. other healthcare providers). Staff will use their knowledge of the signs and indicators of abuse and their clinical assessment to be able to identify concerns of potential or actual abuse. Staff should utilise their clinical supervision, advice from safeguarding team and reflection to ensure every measure has been taken to safeguard those within our care.

Universal Services

Children have their needs met by their parents and family members, where they are protected and growing up healthy. Children and families can access services and early support through universal services; a midwife, health visitor, school nurse, children's centre, GP and schools are all available within the local community and support is available on-line.

Each local authority provides a Threshold Document which details the appropriate level of intervention for a range of services from universal services to child protection. These broadly follow a continuum of need with specific locality differences which are available on each partner LSCB website.

Early Help

Early help means providing support as soon as a problem emerges. An Early Help Assessment (EHA) should be undertaken by a lead professional within children's social care who should provide support to the child and family, act as an advocate on their behalf and coordinate the delivery of support services.

Any frontline practitioner working with children, young people and families, including the voluntary and community sector, can undertake an Early Help Assessment. Early Help Hubs have been developed to ensure that a co-ordinated response to the family's needs is achieved and the Named Professionals within the Trust may be asked to help to determine which avenue for assessment will meet the needs of the child and family best. Early Help requires consent from the person with Parental Responsibility (PR) before information can be shared with external agencies.

Professionals should, in particular, be alert to the potential need for early help for a child who:

- Is disabled and has specific additional needs;
- Has special educational needs;
- Is a young carer;
- Is showing signs of engaging in anti-social or criminal behaviour;

- Is in a family circumstance presenting challenges for the child, such as substance abuse, adult mental health problems and domestic violence;
- Has returned home to their family from care; and/or
- Is showing early signs of abuse and/or neglect.

Assessment and Children with acute need including child protection
Where there is reasonable cause to suspect that a child is suffering or likely to suffer significant harm the Local Authority shall make enquiries as considered necessary to enable them to decide whether they should take action to safeguard or promote a child's welfare (Working Together 2018).

Agencies are required in both circumstances to contact the Local Authority Children's Social Care to discuss their concerns and for Local Authority Children's Social Care Agency to decide upon the right pathway to support for the child and their family. If a decision is made that confirms suspicion of, or actual significant harm a social work will be initiated. A strategy meeting with Police, Health and Education and any other agency required may also be held to consider what needs to happen next to address risk and harm and will consider the need for Section 47 (CA 1989) enquiries to be made. The Section 47 enquiry must consider the need for an Initial Child Protection Conference to be convened.

Referrals
If staff are aware of or suspect that a child may be experiencing abuse or likely to suffer harm they should refer into their locality local authority children's social care agency.

All referrals will be triaged and assessed as to what the required local authority response should be. It should never be assumed that the process of referral has been undertaken by another professional or agency working with the child or family. The practitioner remains responsible for the referral and appropriate follow up of the outcome**.**

Children living in Hampshire - Hampshire Children's Services 0300 555 1384
csprofessional@hants.gov.uk
(Please NB Hampshire no longer use csprofessional@hants.gov.uk for any case info)

Children living in East Sussex - Single Point of Advice - 01323 464222
0-19.SPOA@eastsussex.gcsx.gov.uk

Children Living in West Sussex – MASH (Multi Agency Safeguarding Hub) 01403 229900 email mash@westsussex.gcsx.gov.uk

Children living in Brighton and Hove – Front Door for Families (01273) 290400
E-mail: FrontDoorForFamilies@brighton-hove.gcsx.gov.uk

All referrals should be documented in writing within 48hours. All referrals should be copied to the safeguarding team for internal monitoring.

Please copy the SPFT Safeguarding Team
safeguardingadults@sussexpartnership.nhs.uk on any referral you make.

While professionals should seek to discuss any concerns with the child and family and their agreement to making referrals to Children's Services, this should only be done

where such discussion and agreement seeking will not place a child at increased risk of suffering significant harm**. If you believe a child to be suffering harm or likely to suffer harm referrals can be made without parental consent**.

When raising and discussing child protection concerns with parents and relatives it is important to be as open and honest as possible ensuring that parents are made aware of each stage of the process and provided with reasons for decisions reached. Language used should not be confrontational or challenging and parents need to be offered as much positive comment as possible.

Care should be taken in informing parents of suspicions regarding sexual abuse and advice should be sought from named professionals for safeguarding children. If involvement of children's services or the police is already underway, raising the issue of abuse with the parents/carers must be in conjunction with these professionals. When concerns are related to fabricated or induced illness the guidance on the pan Sussex or Hampshire child protection and safeguarding children should be followed in terms of discussion and documentation.

Multi Agency working and Information Sharing

Safeguarding is the responsibility of everyone who may come into any contact with children and their families or carers. Section 11 of the Children Act 2004 places a duty on key persons and bodies, such as the Trust, to make arrangements to ensure that in discharging their functions, they have regard to the need to safeguard and promote the welfare of children.

All practitioners who are involved with the child and family have a vital part to play – not just in information gathering, but also in contributing to the child protection or child in need plan. Practitioners should make every effort to attend child protection conferences and their presence should be facilitated as far as possible with negotiation and adequate notice.

With regards to information sharing practitioners should refer to the non-statutory guidance relating to information sharing 'Advice for practitioners providing safeguarding services to children, young people, parents and carers' (HM Gov, 2018) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/721581/Information_sharing_advice_practitioners_safeguarding_services.pdf

The overriding principles being;

- The most important consideration is whether sharing information is likely to support the safeguarding and protection of a child.
- Where practitioners need to share special category personal data, they should be aware that the Data Protection Act 2018 includes 'safeguarding of children and individuals at risk' as a condition that allows practitioners to share information without consent
- Information can be shared legally without consent, if a practitioner is unable to, cannot be reasonably expected to gain consent from the individual, or if to gain consent could place a child at risk.
- Relevant personal information can be shared lawfully if it is to keep a child or individual at risk safe from neglect or physical, emotional or mental harm, or if it is protecting their physical, mental, or emotional well-being.

Escalation protocols
If there is a difference of opinion between professionals from partner agencies this needs to be documented within the child/young person's records and must include any actions taken in an attempt to reach an agreement. If this has not been achieved then both viewpoints need to be documented within the child/young person's record.

If agreement cannot be achieved on the management of a case, staff should professionally challenge this. Discuss in the first instance with your manager then escalate to the Named / Deputy Nurse or Doctor and/or the General Manager.

Each locality safeguarding children board has a formal escalation policy which can be utilised in the event of an unresolved professional disagreement and can be found in the pan sussex safeguarding children policy and procedures or Hampshire procedures here http://hipsprocedures.org.uk/skyyty/safeguarding-partnerships-and-organisational-responsibilities/professional-challenge-and-resolution-of-professional-disagreement

Safeguarding Training

Level 1 Children safeguarding training	Mandatory for all staff.
Level 3 Face To Face (FTF) / online	For all clinical staff and we strongly advocate for FTF training in teams and care groups.
Level 3 Specialist	CHyPS / CAMHS / Perinatal / EI and Link practitioners
PREVENT	Mandatory and is currently available FTF / online
The Trust safeguarding team will run bespoke learning events / conferences and will advertise these on SUSI and Mylearning.	

All partner LSCB's offer an extensive range of training and we strongly support attendance.

Child Death Review
Following the Wood Review (2016) a number of changes occurred to systems and processes within safeguarding. This included a review of Child Death arrangements and process brining all of Sussex into one child death team, Hampshire has a similar arrangement. This is a statutory arrangement as per Working Together (2018). SPFT safeguarding Team are notified of all child deaths and process the child death reporting forms aside from stillbirths or planned terminations in order to review and consider all modifiable factors. When a child dies and they are under the care of SPFT staff will need to be actively involved we may be the lead agency for the child and therefore lead on the process. Namely: **Immediate Decision Making and Notification** when a child dies, investigating and information gathering and take part in and potentially chair the Child Death Review Meeting (CDRM). There may be a need for mental health staff to attend the Child Death Overview Panel which is the final independent part and conclusion of the CDOP process where learning is shared. For local arrangements and lead partner details please see:

Hampshire: http://hipsprocedures.org.uk/skyyth/safeguarding-partnerships-and-organisational-responsibilities/child-death-review-process/#s3879

Sussex: http://sussexchildprotection.procedures.org.uk/yykyqpo/child-death/sussex-child-death-review-practice-guidance#s617

Safeguarding Scrutiny panel

The Trust has developed a scrutiny panel to provide clear lines of governance, accountability and internal scrutiny of Safeguarding Adult Reviews, Safeguarding Practice Reviews (formerly Serious Case Reviews), Domestic Homicide Reviews and by exception high risk safeguarding cases involving Sussex Partnership staff or services. This is to ensure senior oversight and scrutiny in relation to all SARs, SCRs, and DHRs at the point of referral and as the process develops:

- To ensure links are established with the SI process
- To identify organisational risks arising from the Review process
- To scrutinise Recommendations and Action plans, monitor progress and implementation
- To ensure Trust wide learning is taken forward
- To make recommendations if further learning is considered appropriate
- Ensure there are effective arrangements for information sharing across Sussex Partnership which comply with the Data Protection Act 2018 and the General Data Protection Regulations
- To provide specialist oversight and scrutiny in relation to high risk safeguarding cases

See appendix 3 for the internal scrutiny process flowchart.

Safeguarding Practice Reviews

Formerly known as Serious Case Reviews, are undertaken when a child dies or is seriously harmed and there may be cause for concern regarding how agencies worked together. The SPFT team are notified and included in on all requests for information for cases that are being considered for Safeguarding Practice Reviews. If a case goes to review it may include conversations with practitioners and mangers working with children or parents / carers for children. Almost all reviews are available on Safeguarding Partnership websites and the NSPCC's

Missing Children / Child Abduction

It is known that children who go missing are at risk of suffering significant harm, and there are specific risks around children who run away. There is also a risk of child exploitation. Where the child's location or reason for absence is unknown and/or there is cause for concern for the child because of their vulnerability or there is a potential danger to the public the child should be reported as missing.

Definitions

Missing child: a child reported as missing to the police by their family or carers
Local police forces are the lead agency for investigating and finding missing children, and will respond to children going **missing** based on on-going risk assessments in line with current guidance.

The police definition of 'missing' is: ***"Anyone whose whereabouts cannot be established will be considered as missing until located, and their well-being or otherwise confirmed."***

https://www.app.college.police.uk/app-content/major-investigation-and-public-protection/missing-persons/#definition-of-missing

The Police use four 'risk based' categories of missing, all reports of missing people sit within a continuum of risk from 'no apparent risk (absent)' through to high risk cases that require immediate, intensive action.

- **High**: The risk of harm to the subject (child) or the public is assessed as very likely.
- **Medium:** The risk of harm to the subject (child) or the public is assessed as likely but not serious or there is a low chance of serious harm.
- **Low**: The risk of harm to the subject (child) or the public is assessed as possible not minimal
- **No apparent risk-** There is no apparent risk of harm to either the subject (child) or the public

https://sussexchildprotection.procedures.org.uk/tkypoh/children-in-specific-circumstances/joint-policy-for-children-missing/#s4270

http://hipsprocedures.org.uk/qkyylp/children-in-specific-circumstances/children-and-families-that-go-missing/#s3699

Child Abduction
Abduction: A person connected with a child under the age of sixteen commits an offence if he takes or sends the child out of the United Kingdom without the appropriate consent.
https://www.legislation.gov.uk/ukpga/1984/37/section/1 [Accessed on line 18 August 2020]

Pan Sussex Protocol
https://sussexchildprotection.procedures.org.uk/tkyqyp/children-in-specific-circumstances/child-victims-of-modern-slavery-and-trafficking/#s4356

Hampshire Protocol on abduction and child removal of children of concern from the UK
http://hipsprocedures.org.uk/assets/clients/7/Protocol%20on%20Child%20Abduction%20and%20Children%20of%20Concern%20from%20the%20UK%20September%202019.pdf

Absent without leave- Absconded from Inpatient Tier 4 clinical care
For children who are detained under the mental health act or are a voluntary admission to an inpatient unit who go missing during the admission the Trust absent without leave policy should be followed.

https://policies.sussexpartnership.nhs.uk/clinical-3/absent-without-leave-awol-policy
Role of men in safeguarding/child protection
"Men play an important role in children's lives and have a great influence on the children they care for. Despite this, they can be ignored by professionals who sometimes focus almost exclusively on the quality of care children receive from their mothers/female carers" NSPCC 2015.

When working with families, professionals should consider the following in regards to men within that family:

- Identifying new men within the child's life, record details of this person and check these details regularly. Think about new partners/older siblings partners that are present in the home
- Robust information sharing between partner agencies
- Relying too much on mother for essential information
- Overlooking the ability of estranged fathers to provide safe care for their children

Supervision
It is a requirement of the Trust supervision policy that safeguarding is addressed at all supervision sessions. To support this a safeguarding check list has been developed which is integrated into the supervision policy.
https://policies.sussexpartnership.nhs.uk/workforce

5.0 Development, Consultation and Ratification
This policy has been developed by the Sussex Partnership Safeguarding Team in conjunction with the localised procedures detailed in the Pan Sussex and Hampshire child protection and safeguarding procedures
The Policy is ratified by the Sussex Partnership NHS Foundation Trust Professional Policy Forum.

6.0 Equality and Human Rights Impact Analysis (EHRIA)
An Equality and Human Rights Impact Assessment has been completed.

7.0 Monitoring Compliance
Monitoring of this policy will be conducted on a bi-annual basis undertaken by the Named professionals for safeguarding in collaboration with the trust audit department.

It is notable that this is a live document which may be subject to change outside of this timeframe in relation to local and national policy and procedural change. All updates will be implemented by the safeguarding team and disseminated widely across the organisation.

8.0 Dissemination and Implementation of policy
This policy will be circulated widely through the organisation via internal communications. The named professionals for each locality have responsibility for promotion of the policy and ensuring correct use of procedures.

The dissemination and implementation of the policy will be covered in all levels of mandatory safeguarding training. Training data will identify any clinical areas where there has been a notable reduction in compliance rates.

Regular use of audit both internally and within the partner agency cycle will be used to identify the effectiveness of the implementation and allow for action plans to be placed if risks are identified.

9.0 Document Control including Archive Arrangements
The Governance Support Team are responsible for ensuring the trust procedural documents database is maintained. The Governance Support Team are responsible for ensuring procedural documents are uploaded to the trust website.

The onus for accuracy will be on the document's Sponsor not the Governance Support Team nor on the person maintaining the website. The Governance Support Team are responsible for notifying the sponsor when procedural documents are due for review.

10.0 Reference documents

- The Children Act 1989/2004 - The Children Act 1989
- Working Together to Safeguard Children (HM Government, 2018) – https://www.gov.uk/government/publications/working-together-to-safeguard-children--2
- What to do if you are worried a child is being abused (practitioners guide) (H M Government, 2015) - What to do if you are worried a child is being abused
- NICE clinical guidelines – When to suspect child maltreatment (2009) - NICE - When to suspect child maltreatment
- Information Sharing: Advice for practitioners providing safeguarding services to children, young people, parents and carers (HM Government, 2018) - https://www.gov.uk/government/publications/safeguarding-practitioners-information-sharing-advice
- Safeguarding Children and Young People from Sexual Exploitation (HM Government, 2009) - Safeguarding Children for Sexual Exploitation 2009
- Pan Sussex Child Protection and Safeguarding Procedures Manual https://sussexchildprotection.procedures.org.uk/
- Hampshire Safeguarding Children Procedures http://hipsprocedures.org.uk/
- Criminal Exploitation of children and vulnerable adults: County Lines guidance (Home Office 2018) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/741194/HOCountyLinesGuidanceSept2018.pdf
- The National Referral Mechanism is a framework for identifying victims of human trafficking or modern slavery. (http://www.nationalcrimeagency.gov.uk/about-us/what-we-do/specialist-capabilities/uk-human-trafficking-centre/national-referral-mechanism
- Safeguarding children and young people: role and competences for health care staff. Intercollegiate Document, Third edition: March 2014 https://www.rcpch.ac.uk/sites/default/files/Safeguarding_Children_-_Roles_and_Competences_for_Healthcare_Staff._Third_Edition_March_2014.pdf
- **The NHS England Accountability and Assurance Framework** (2019): Safeguarding Children, Young people and Adults at risk in the NHS

11.0 Cross reference

1. E-Safety Policy
2. Safeguarding Strategy
3. Child Visiting Policy
4. Safeguarding Adults at Risk Policy
5. Managing Allegations against Staff Policy and Procedure
6. CSE policy
7. FGM policy
8. PREVENT policy

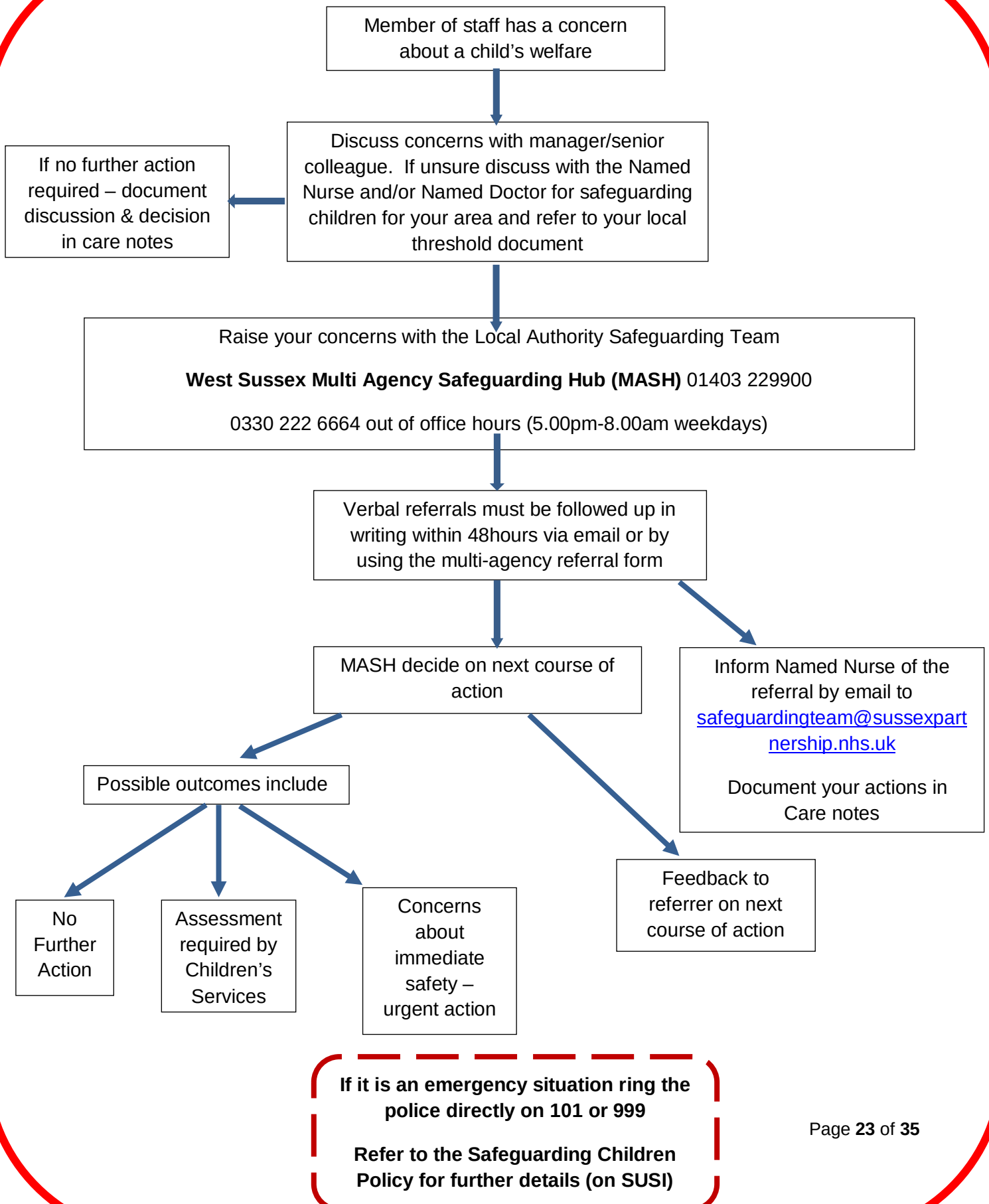
12.0 Appendices

Appendix 1 – Flowcharts
Appendix 2 – Sussex Partnership NHS Foundation Trust Child not brought procedure for Child & Adolescent Mental Health Teams
Appendix 3 - Interal Scrutiny Process - Safeguarding adults/ safeguarding children/domestic homicide reviews
Appendix 4 - SPFT Neglect Strategy

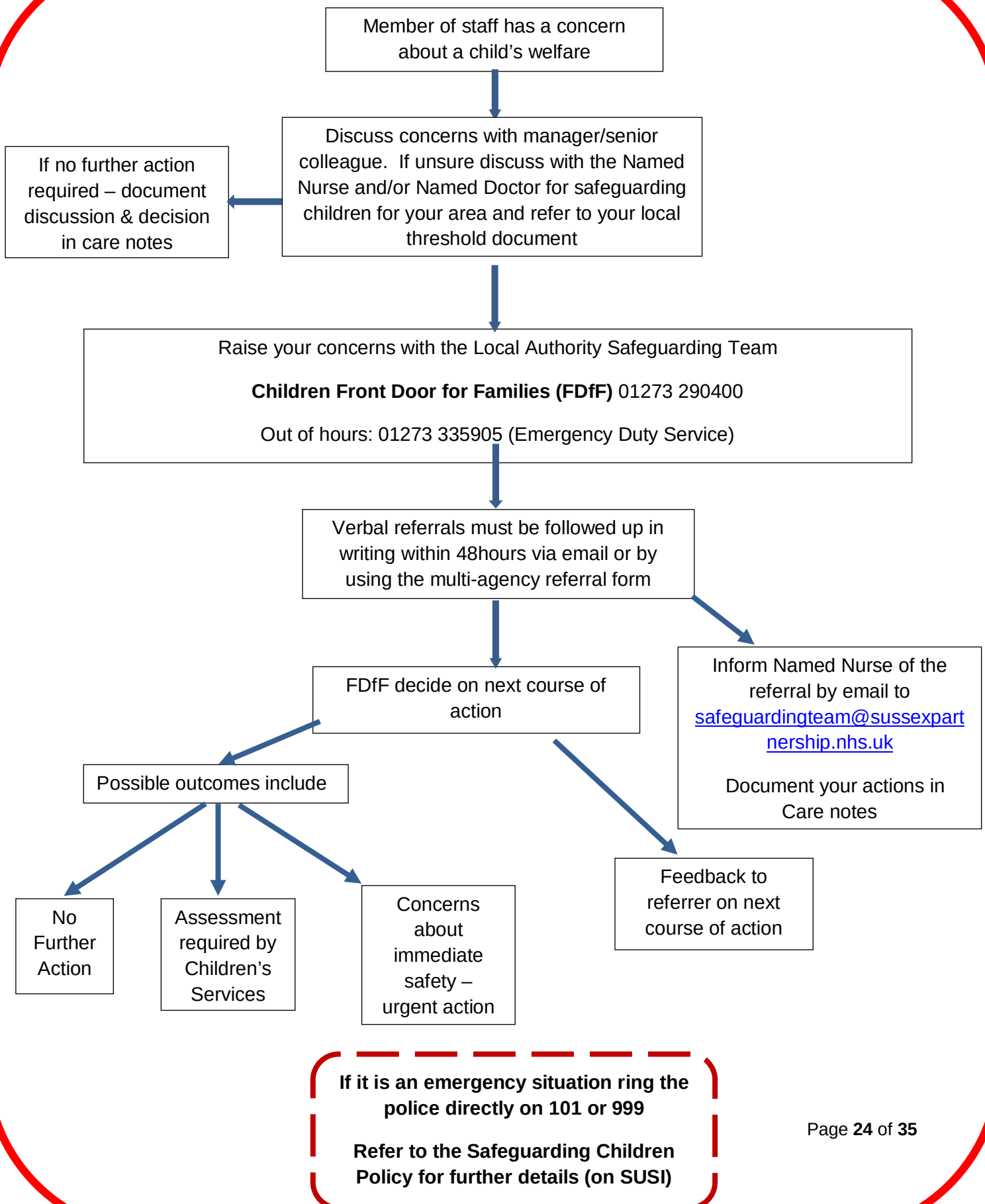
Sussex Partnership NHS Foundation Trust

West Sussex

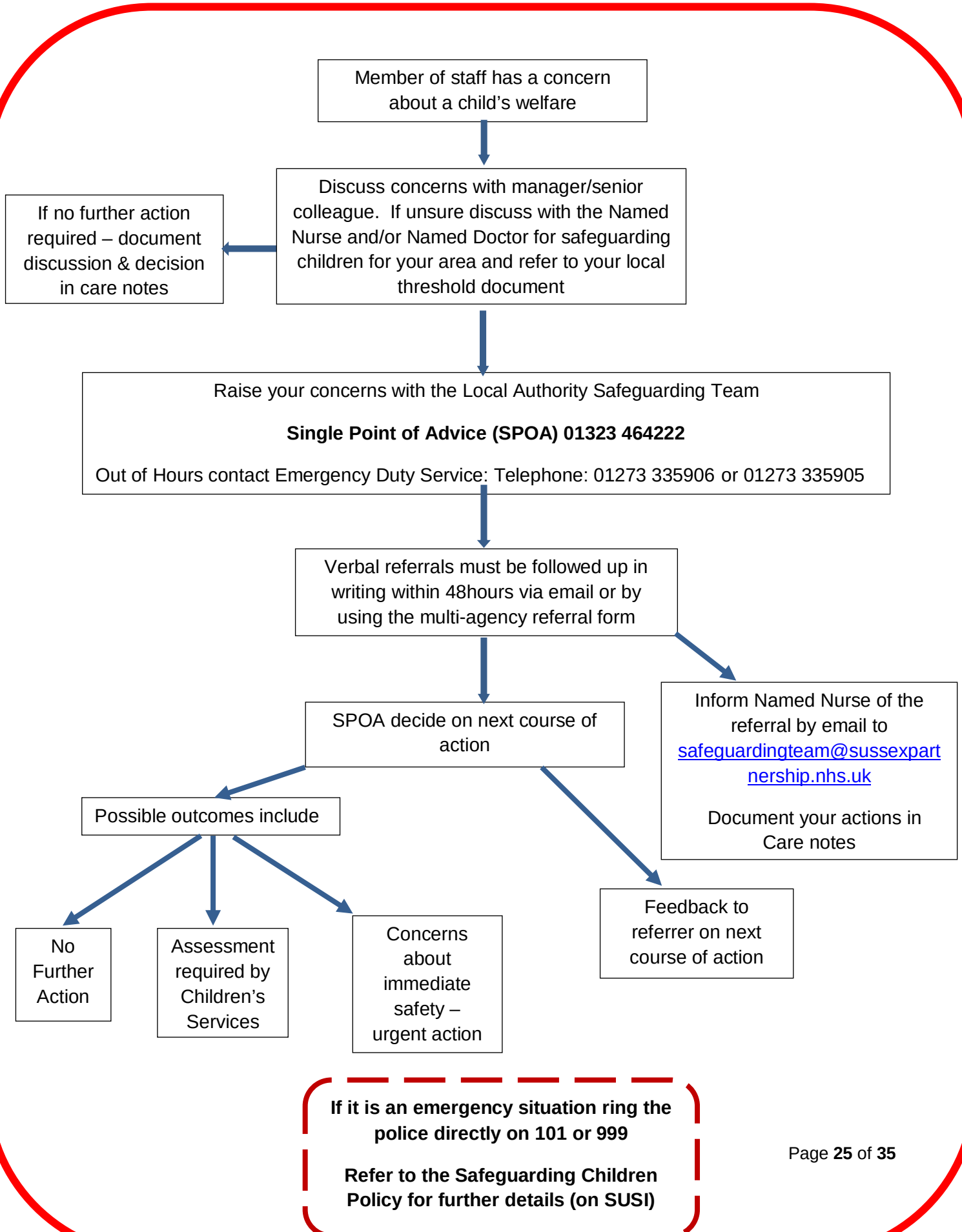
Safeguarding Children – What to do if you are worried in flow chart



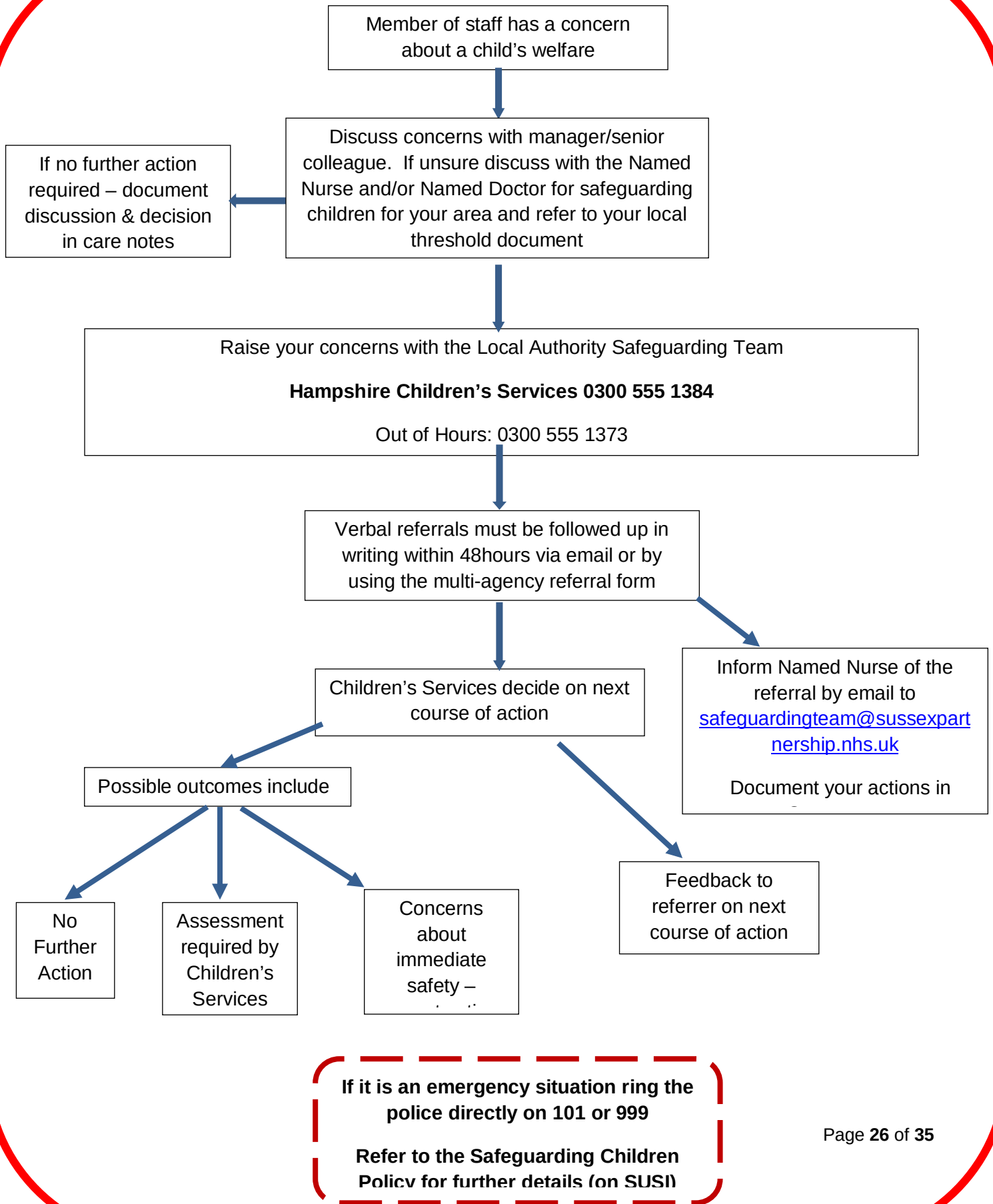
Safeguarding Children – What to do if you are worried in flow chart



Safeguarding Children – What to do if you are worried in flow chart



Safeguarding Children – What to do if you are worried in flow chart



Appendix 2 – Sussex Partnership NHS Foundation Trust Child not brought procedure for Child and Adolescent Mental Health Team. What to do when a child is not brought or misses an appointment

Always think about the impact on the child of missing an appointment			
Level of Concern	**Low** • No safeguarding concerns • Low levels of professional concern regarding emotional well -being/developmental assessment • No other medical issues	**Medium** • Early Help Cases • Children with disability with no safeguarding concerns • 2 previous missed appointments but no other concerns • Children with emotional difficulties considered to be medium risk	**High** • Children in Care • Children Subject to CP Plan • Children Subject to CIN Plan • High level of concern regarding emotional well being • Children with disability and safeguarding concerns • Children with parents who are known to have mental health issues, domestic abuse, substance misuse • Disguised compliance cases
Think	• What is the impact of the child missing an appointment?	• Discuss case with Team Manager/Safeguarding Lead • If open to early help contact support worker as they may be able to support attendance (check consent)	• Discuss with Safeguarding • **If case is open to a Social worker inform SW as they may be able to support attendance**
Action	• Contact family by phone to follow up • **Check demographics** consider change in details • Send another appointment with child not brought leaflet- **c.c not brought letter to GP** • Not brought letter to provide details of previous appt/s offered • Consider liaison with referrer to check appointment still required	• Contact family by phone to follow up • **Check demographics** consider change in details • Send another appointment with child not brought leaflet • Not brought letter to provide details of previous appt/s offered- **cc.not brought letter to GP** • **Consider liaison with other professionals GP, School, school nursing, HVs**	• Contact family by phone to follow up • **Check demographics** consider change in details • Send another appointment with child not brought leaflet • Not brought letter to provide details of previous appt/s offered- **cc. not brought letter to GP and SW if Child protection** • **Consider liaison with other professionals GP, School, school nursing, HVs etc**
2 Missed Appts.	• **Advise GP plan** • **Consider safeguarding**	• **Discuss with team manager/ safeguarding**	• **May require multiagency discusson- liaise with network**
Must Do	**High risk cases**-discuss with Team Manager/safeguarding. • **Any** child with 2 consecutive missed appointments **must** be discussed with safeguarding. • Any cases with patterns of one or two attendances followed by cancellations and regular rearranging of the appointments has to be considered as a case of **potential disguised compliance** especially if there are other risk factors and should be discussed with safeguarding. **Multi agency discussion/ planning maybe required.**		
Outcome	Plan communicated with GP, family and any other professionals the family have given consent to share information	Family receive support to continue engagement with Health. Plan communicated to relevant professionals and family	Family receive support to continue engagement with Health. Plan communicated to professionals involved. If family are refusing to engage this information is known by professionals involved in care.

Appendix 3

Sussex Partnership NHS Foundation Trust

Internal Scrutiny Process

Safeguarding Adults/Safeguarding Children/ Domestic Homicide Reviews

Stage One - notification

- Designated internal safeguarding lead informed that review is to be undertaken
- Review added to agenda for Internal Scrutiny Panel and to safeguarding database
- Designated internal safeguarding lead informs CDS, Governance team and Chief Nurse
- Governance team complete check for any known related incidents

Stage Two – IMR

- Designated internal safeguarding lead joins membership of external Review Panel
- Designated internal safeguarding lead agrees with CDS who will be nominated IMR author and supports IMR completion
- Completed IMR report signed off by Designated internal safeguarding lead joins and presented to Internal Scrutiny Panel

Stage Three – Review process and completion

- Independent author produces draft report
- Designated internal safeguarding lead attends external panel and shares ongoing actions with CDS, IMR author and Internal Scrutiny Panel
- Final draft review recommendations shared with Chief Nurse, CDS and Internal Scrutiny Panel

Stage Four – publication and follow up actions

- Review agreed by external Board (e.g. SAB, LSCB, multi agency review panel Safer Communities). Designated internal safeguarding lead briefs CEO/Chief Nurse/ Comms/CDS including publication dates and likely media interest
- Designated internal safeguarding lead to support CDS implementation of identified actions
- Designated internal safeguarding lead to monitor action plan progress and report to Internal Scrutiny Panel
- Designated internal safeguarding lead agree methods for cascading learning with Internal Scrutiny Panel/ Chief Nurse/CDS/Governance leads

Appendix 4

Sussex Partnership NHS Foundation Trust

Child Neglect Strategy

This strategy should be read in conjunction with the Safeguarding Children policy and the Safeguarding supervision checklist

Why do we need a Child Neglect Strategy?
Child Neglect remains the most common form of child maltreatment in England (Department for Education, 2013). Almost half of all child protection plans across England and Wales were made in response to neglect (NSPCC, 2018).

Neglect also impacts significantly on all areas of a child's life and development. There are potential long term negative effects of brain and physical development, behaviour, educational achievement and emotional wellbeing (Stevenson, 2007)

Child Neglect is also a feature in serious case reviews where a child has died or suffered significant harm. Learning from reviews has identified that professionals have difficulty identifying neglect, assessing what is sufficient concern to take action and what the most appropriate course of action is.

Purpose and Scope of the Child Neglect Strategy

- Sussex Partnership NHS Foundation Trust works in partnership with the Safeguarding Children Partnerships (SCP) across the localities. Each of our SCPs has a Neglect Strategy. This overarching SPFT Neglect strategy encompasses the principles and tools within each strategy to enable SPFT practitioners to recognise and respond to child neglect
- This strategy is in conjunction to the Sussex Partnership Foundation Trust Safeguarding Children Policy and Sussex Partnership Foundation Trust Safeguarding Adults Policy.
- This strategy is for use by all practitioners working with adults and children across all Sussex Partnership Foundation Trust Care Delivery Service.

Recognising and responding to child neglect
All practitioners have a responsibility to identify and respond to cases where there are safeguarding concerns. Neglect can present in a variety of ways and is at times not overtly visible or disclosed by a child. Broadening our understanding and thinking of what constitutes neglect allows practitioners to be curious with families about the child's experience. It is also important to note that some forms of neglect are not intentionally harmful and may be a result of a particular set of circumstances and experiences; this does not negate the impact or the assessment that it is neglect. . However it is important to be able to address issues around neglect in a responsive way even in the absence of overt deliberate harm.

Howe Model of Child Neglect
The Howe Model of Neglect (2005) can assist those working with children and adults with caring responsibility for children, to reflect on whether a child is experiencing neglect and what type of neglect the child or children may be experiencing.

It also enables practitioners to articulate their concerns to other agencies in a shared language and understanding across partners working with children, young people and their families to ensure an effective, unified and consistent approach to address child neglect.

Disorganised Neglect	**Passive or Depressed Neglect**
• This ranges from inconsistent parenting to chaotic parenting • Families are frequently coming into contact with services and are often characterised as 'problem families' or 'crisis ridden' families • There is often little hostility towards professionals and a willingness to engage • Frequent change in family life	• Parents or carers are unmotivated or do not understand the child's needs • Parents or carers do not believe that anything can change and feel passive or helpless • Frequently there is a failure to meet the child's emotional or physical needs • This is may sometimes be due to parental mental health issues
Severe Deprivation Neglect	**Emotional Neglect**
• This can range from a child being left to cry to a child being left to die • The children and their home can be dirty and smelly • Children can be deprived of love, stimulation, emotional warmth, or completely ignored • Children may be left unattended or let out inappropriately by themselves • In the most extreme cases the prognosis for change is usually poor	• This ranges from the child being ignored to being completely rejected • There is persistent ill treatment of the child • The child feels worthless and inadequate • Families may keep the child silent, scapegoat the child, withhold affection or emotion, and may not do things with or for the child

Professional Curiosity in relation to safeguarding and child neglect

"Professional curiosity is the capacity and communication skill to explore and understand what is happening within a family rather than making assumptions or accepting things at face value." (Mason 1993)

Learning from research and reviews tell us that professional curiosity is essential to safeguarding children and working effectively with families. Recognising neglect may not come through direct disclosure so it's essential that practitioners remain professionally curious even with families they consider that they know well.

Consideration of the child's lived experience and seeking to gain an understanding of their view. How does the child experience their life? How do they experience their parents/carers interactions? How do they experience their environment?
Ensuring that the focus is not only on the parent and their view/narrative. This can occur because the adult may present with a high level of vulnerability or when a child/young person has difficulty in expressing their view

Reliance or formation of a fixed view of the family, as practitioners we must remain open and curious regarding new information and how this changes our assessment and engagement.
Listening to information from other sources, other family members or members of the network around the family may have valuable information to share. They may offer information or a view which contributes to the assessment of neglect.
Referrals may have been made in the past and there may have been input. It's still important to re refer if there has been change (or no change). Referrals can be supported by the use of neglect tools. Practitioners may not feel they are qualified to assess for the impact of neglect but all agencies have a valuable contribution to make to safeguarding.
Families can be 'difficult to engage' and practitioners can be kept at a distance for a variety of reasons. Professional curiosity ensures that we remain interested in what is happening in the child's lived experience and that we remain engaged even when faced with hostility, ambivalence or avoidance.
As practitioners we may all have different thresholds for what is 'good enough' and what we are used to seeing. We know that practitioners can rationalise harmful behaviours and can underestimate the emotional impact of the work and the effect this has on their assessment of safeguarding concerns.

Children and young people with disabilities

Disabled children and young people are at increased risk of abuse and neglect and in terms of neglect practitioners must ensure that they are considering these risks when working with the children and/or the families.

Consideration should always be given to the child or young persons lived experience. Professional curiosity is key especially in circumstances where there may be aspects to the child or young person's presentation that are not your specific area of expertise.

Increased risk factors in this area;

- Child may be dependent on the abusing carer for a variety of physical, emotional and care needs. This may be a significant factor in the disclosure or identification of abusive behaviour.

- Children with communication difficulties may lack appropriate verbal vocabulary or aides to disclose.

- High levels of multi-agency involvement and at times complex medical needs can make identification and an understanding of the child's lived experience to be fully understood by the professional group.

- Disabled children and young people may be more vulnerable as they are seen as less able to articulate their experiences or be believed. Consideration should also be given to the importance of creating situations where they are able to freely articulate their views (both environmental situations and communication methods)

Adolescent Neglect

Older children and adolescents are particularly vulnerable to neglect and it may present in a variety of ways. The transition from Primary to Secondary education is a notably vulnerable time and children who are experiencing neglect may not be supported by their parents or carers to manage this period. Research suggests that young people experiencing neglect may present with challenging behaviours or and are particularly vulnerable to other forms of abuse (for example CSE/CCE)

In 2016 research by the Children's Society reported that 8% of adolescents experienced some form of neglect and within this the highest form was a lack of supervision. Young people also reported a lack of emotional support from parents/carers. The mental health impact on young people of experiencing neglect is significant and has potentially long term outcomes in terms of educational, social and emotional and physical health.

Learning from Serious Case Reviews show that practitioners can become focussed on the challenging behaviours of young people and those issues around neglect and abuse can be masked by this. There is also evidence to suggest that practitioners will treat older teenagers as if they are adults and this risks losing the focus that they are a child up until the age of 18.

Children not brought to appointments

Practitioners should consider children not brought to appointments in the context of potential neglect. Parent or carers who are unable to meet their children's emotional health needs require practitioner curiosity and context around the reasons for this. This can be complex when children are adolescents however it is essential that practitioners respond to all persons under 18 with the understanding that they remain children in respect of safeguarding procedures. The Child Not Brought protocol is contained in the Safeguarding Children Policy for further guidance.

Culturally competent practice

Neglect is present in all areas of society however practitioners should ensure that they are able to identify and respond to neglect taking into account cultural difference, social circumstances and faith. This is whilst ensuring that these factors do not detract from the practitioner's assessment of issues around abuse and neglect.

Factors may include

Poverty and associated challenges around employment and financial	Unstable/unsuitable accommodation/frequent moves	Language barriers - both verbal and written. Access to interpreters from

instability		appropriate setting
Faith based beliefs and the impact these have on child's experience	Stigma within widen community and/or within smaller defined community (for example local faith based community)	Family practices that are not accepted within UK law and put the child at risk (for example FGM)

It is notable that challenges around culture and family practices should also be considered across the wider socio-economic groups. Neglect occurs across society and research suggests that practitioners have difficulty in identifying and responding to neglect within families who are considered affluent. Family circumstances should not act as a barrier to practitioners identifying and responding to neglect particularly when working in a framework that considers a broad range of children's experiences of neglect.

Working with adults - A whole family approach

Adults who experience mental health difficulties may be at risk of self neglect, of neglecting their own children and may have also experienced neglect in their own childhoods. For those practitioners who work primarily with adults it is essential to approach this work with a view of the whole family. Identification of self neglect in an adult can lead to a practitioner being curious about how that self neglect is impacting the children and what their lived experience is. Being curious about how an adult with mental health difficulties responds to parenting and how that impacts on them and their children is key and is not about being critical. We do know from serious case reviews that parental mental health problems have a significant impact on children in relation to abuse and neglect and are a risk factor, therefore early recognition and response is indicated. It's also important to include non resident parents who use our services in our consideration children experiencing abuse and neglect.

Supervision

- Clinical supervision in safeguarding offers practitioners an opportunity to explore cases where there may be neglect and allows for reflection on progress and potential barriers to change.

- Do not presume to know what is happening in the family home and will ask questions and seek clarity if not certain

- Supervision is critical in identifying cases where there has been sustained low level concerns and allows practitioners to explore how this can impact on practice and decision making

- Neglect cases can be liable to 'drift' and supervision can redirect and reassess interventions

- Remain open to hearing the voice of the child throughout the process and always measure parents' assertions against the child's lived experience. They maintain "respectful uncertainty"

- Within supervision and group supervision practitioners have an opportunity to reflect on the family functioning and utilise chronologies to examine all the information known. This allows the child to remain at the centre of the discussion and for practitioners to have a view of the whole system both family and professional.

- Supervision can aid practitioners to assess and monitor change and to ensure there is evidence of improvement through the use of the tools. Parental reporting is not the only measure of improvement and change.

Toolkit for Practitioners

Day in My Life

The Day in my Life tool assists practitioners in developing an understanding of the child or young person's daily life. The tools act as a prompt to exploration of both the child's view and where appropriate the parents view. It can be completed and the 'What do we know, what next?' tool can inform care planning.

Pre Birth	https://staff.sussexpartnership.nhs.uk/document-library/safeguarding/7571-day-in-the-life-pre-birth
Baby	https://staff.sussexpartnership.nhs.uk/document-library/safeguarding/7576-neglect-baby-diml-final
Pre School	https://staff.sussexpartnership.nhs.uk/document-library/safeguarding/7572-day-in-the-life-pre-school-child
Primary age child	https://staff.sussexpartnership.nhs.uk/document-library/safeguarding/7575-neglect-primary-school-child-diml-final
Adolescent	https://staff.sussexpartnership.nhs.uk/document-library/safeguarding/7121-day-in-my-life-teenager-v-12-03-2020-pdf
Child with a disability	https://staff.sussexpartnership.nhs.uk/document-library/safeguarding/7574-neglect-child-with-disability-diml-final
What do we know what next?	https://staff.sussexpartnership.nhs.uk/document-library/safeguarding/7589-neglect-what-next-tool

Impact Chronology Tool

Chronology tool allows an overview of significant events, concerns and impact of events. This can assist us in assessing concerns over a time period especially where there is multi agency involvement and as an aide to the analysis of the impact of events on children.

Chronology Tool	https://staff.sussexpartnership.nhs.uk/document-library/safeguarding/7588-safeguarding-chronology-template

Both tools can add to a referral for Children's Social Care input and also inform our care planning for children, young people and families.

Neglect Matrix and SCP strategies

This tool aids mapping the child's experience against the social care intervention level.

West Sussex Neglect Matrix	https://www.westsussexscp.org.uk/wp-content/uploads/WSSCP-Neglect-Matrix-2019-17.02.2020-v2-PDF.pdf
West Sussex SCP Neglect Strategy	https://www.westsussexscp.org.uk/documents/neglect-strategy
East Sussex Neglect Matrix Neglect toolkit	https://czone.eastsussex.gov.uk/media/2969/neglect-matrix.pdf https://www.esscp.org.uk/wp-content/uploads/East-Sussex-Neglect-Toolkit-Web.pdf
East Sussex Neglect Strategy	https://www.esscp.org.uk/wp-content/uploads/East-Sussex-Neglect-Strategy-and-Operational-Practice-Guidance-v4.pdf
Brighton and Hove Neglect Matrix	Pending
Brighton and Hove Neglect Strategy	Pending

Adult Self Neglect

East Sussex SAB Self Neglect Learning Briefing	https://staff.sussexpartnership.nhs.uk/document-library/safeguarding/7577-east-sussex-self-neglect-briefing