Child Safeguarding and Child Protection Policy (including FGM and PREVENT)

Contents

1. Policy statement
2. Basic principles
3. Responsibilities
4. General physical examination of a child or young person
5. Identifying child safeguarding concerns
6. Immediate actions
7. Child protection: sources of advice and support
8. What to do with allegations of abuse from a child
9. Attitudes of parents or carers
10. Record keeping
11. Confidentiality
12. Responding to requests for safeguarding / child protection information
13. Training – in house
14. Prevent Policy
15. Female genital mutilation
16. Child Sexual Exploitation

Appendix A – Child abuse body map

1. Policy statement

- Under the 1989 and the 2004 Children Acts a child or young person is anyone under the age of 18 years.
- Safeguarding children is the action we take to promote the welfare of all children and protect them from harm.
- Child Protection refers to the activity that is undertaken to protect specific children who are suffering or at risk of suffering significant harm.
- Kingston GP Chambers (KGPC) recognises that all children have a right to protection from abuse and neglect and KGPC accepts its responsibility to safeguard the welfare of all children with whom staff may come into contact.

We intend to:

- Respond quickly and appropriately where information requests relating to child protection are made, abuse is suspected or allegations are made
- Provide children and parents with the chance to raise concerns over their own care or the care of others
- Have a system for dealing with, escalating and reviewing concerns.

- Remain aware of child protection procedures and maintain links with other bodies, especially the commissioning body's appointed contacts
- Ensure that all staff are trained to a level appropriate to their role, and that refresher training occurs at the recommended interval (every 3 years for level 3 training)

2. Basic principles

- The welfare of the child is paramount.
- It is the responsibility of all adults to safeguard and promote the welfare of children and young people. This responsibility extends to a duty of care for those adults employed, commissioned or contracted to work with children and young people.
- KGPC must have safe recruitment practices including appropriate use of the disclosure and barring service and safe whistle blowing processes.
- Staff who work with children are responsible for their own actions and behaviour and should avoid any conduct which would lead any reasonable person to question their motivation and intentions.
- Staff should work and be seen to work, in an open and transparent way.
- The same professional standards should always be applied regardless of culture, disability, gender, age, language, racial origin, religious belief and/or sexual identity.
- Staff should continually monitor and review their practice and ensure they follow the guidance contained in this document and elsewhere.
- KGPC will ensure children and their families are able to share concerns and complaints and that there are mechanisms in place to ensure these are heard and acted upon.

3. Responsibilities

Dr Antony Hughes is the Interim Clinical Safeguarding Lead within KGPC and Ann Cox is the administrative lead.

The Clinical Safeguarding Lead is responsible for all aspects of the implementation and review of the children's safeguarding procedure in KGPC.

4. General physical examination of a child or young person

As a general principal, when conducting a physical examination of a child or young person, a parent or carer should be present at all times, or a chaperone offered. Children should only be touched under supervision and in ways which are appropriate to, and essential for clinical care.

Permission should always be sought from a child or young person before physical contact is made and an explanation of the reason should be given, clearly explaining the procedure in advance. Where the child is very young, there should be a discussion with the parent or carer about what physical contact is required. Routine physical examination of an individual child or young person is normally part of an agreed treatment procedure and/or plan and should be understood and agreed by all

concerned, justified in terms of the child's needs, consistently applied and open to scrutiny.

Physical contact should never be secretive or hidden. Where an action could be misinterpreted, a chaperone should be used or a parent fully briefed beforehand, and present at the time. Where a child seeks or initiates inappropriate physical contact with an adult, the situation should be handled sensitively and a colleague alerted.

5. Identifying child safeguarding concerns

Common presentations and situations in which child abuse may be suspected include:

- Disclosure by a child or young person.
- Physical signs and symptoms giving rise to suspicion of any category of abuse and/or inconsistent with the history provided.
- A history which is inconsistent or changes over time.
- A delay in seeking medical help.
- Extreme or worrying behaviour of a child, taking account of the developmental age of the child.
- Self-harm.
- Accumulation of minor incidents giving rise to a level of concern, including frequent A&E attendances.

Some other situations which need careful consideration are:

- Repeated attendance of young baby under 12 months of age.
- Any bruising or injury in child under 24 months of age.
- Very young girls or girls with learning difficulties or disability requesting contraception, especially emergency contraception.
- Girls under 16 presenting with pregnancy or sexually transmitted disease, especially those with learning difficulties, chronic long term illness, complex needs or disability.
- Situations where parental factors such as mental health problems, alcohol, drug or substance misuse, learning difficulties, domestic abuse may impact on children and family life.
- Unexplained or suspicious injuries such as bruising, bites or burns, particularly if situated unusually on the body.
- The child says that she or he is being abused, or another person reports this.
- The child has an injury for which the explanation seems inconsistent, delayed presentation, or which has not been adequately treated or followed up.
- The child’s behaviour changes, either over time or quite suddenly, and he or she becomes quiet and withdrawn, or aggressive.
- Refusal to remove clothing for normal activities or keeping covered up in warm weather.
- The child appears not to trust particular adults, perhaps a parent or relative or other adult in regular contact.

- An inability to make close friends.
- Inappropriate sexual awareness or behaviour for the child's age.
- Fear of going home or parents being contacted.
- Disclosure by an adult of abusive activities, including activities related to internet and social media use.
- Reluctance to accept medical help.
- Fear of changing for PE or school activities.

6. Immediate actions

- The clinician seeing the patient is responsible for making an onward referral to social services. The local authority contact details are on the next section of this policy. In addition to making a safeguarding referral to the local authority safeguarding team, the safeguarding lead within KGPC should be informed of the concern and action taken by emailing anthonyhughes@nhs.net.
- Clear and detailed notes should be made in the patient's clinical notes. Where there is evidence of physical or sexual abuse, the body map in Appendix A should be used to document all injuries and marks.
- If the suspicions relate to a member of staff, the identifying clinician should contact the KGPC Safeguarding Lead and the administrative safeguarding lead and a plan of action decided; the local Safeguarding Children team and / or social services should be contacted directly. Allegations relating to a member of staff must be reported to CQC as a statutory notification. Consideration should be made to involving the Local Authority Designated Officer (LADO).
- Suspicions should not be raised or discussed with third parties other than those named above.
- Any individual staff member must know how to make direct referrals to the child protection agencies and should be encouraged to do so if they have directly witnessed an abuse action. Staff members taking this action in good faith will not be penalised.
- Where emergency medical attention is necessary it should be given. If necessary as ascertained by clinical judgement the child should be admitted to the care of the emergency paediatric service and a social services referral made. Any suspicious circumstances or evidence of abuse should be reported to the designated clinical Lead.
- If a Social Services referral is being made without the parent's knowledge and urgent medical treatment is required, social services should be informed of this need. Otherwise, if it is decided that the child is not at risk, suggest to the parent or carer that medical attention be sought immediately for the child.
- If appropriate the parent/carer should be encouraged to seek help from the Social Services Department prior to a referral being made. If parents do not consent to medical care or to a social care referral and they fail to do so in situations of real concern the safeguarding Lead will contact social services directly for advice.
- Where sexual abuse is suspected the attending clinician should contact the Social

Services or Police Child Protection Team directly. The clinician will not speak to the parents if to do so might place the child at increased risk

- Neither KGPC's Safeguarding Lead or any other KGPC team member should carry out any investigation into the allegations or suspicions of sexual abuse in any circumstances. The clinician will document exact details of the allegations or suspicion and provide this information to statutory child protection agencies: Social Care, the police or NSPCC, who have powers to investigate the matter under the Children Act 1989.

7. Child protection: sources of advice and support

Contact information:

		Phone	Email
KGPC Interim Clinical Safeguarding Children Lead	Dr Anthony Hughes	07788 415560	anthonyhughes@nhs.net
KGPC Administrative Lead	Ann Cox	07801057821	Ann.cox7@nhs.net

Further contacts:

Kingston Local Safeguarding Children Board	0208 831 6323	https://kingstonandrichmondsafeguardingchildrenpartnership.org.uk/
Richmond Local Safeguarding Children Board	0208 831 6323	https://kingstonandrichmondsafeguardingchildrenpartnership.org.uk/
Sutton Local Safeguarding Children Board	020 8770 6001	Online form London Borough of Sutton Children's First Contact Service (google.com) Email CFCS@sutton.gov.uk
Merton Local Safeguarding Children Board	020 8545 4226	Email candfhub@merton.gov.uk
Croydon Local Safeguarding Children Board	0208 255 2888	Online form Croydon MASH - Referral Form
Wandsworth Local Safeguarding Children Board	020 8871 6622	mash@wandsworth.gov.uk
NSPCC Child Line:	0800 1111	

Useful websites:

RCGP Safeguarding Children Toolkit	https://www.rcgp.org.uk/clinical-and-research/resources/toolkits/child-safeguarding-toolkit.aspx#targetText=Welcome%20to%20the%20updated%20RCGP,safeguarding%20practice%20in%20Primary%20Care.&targetText=It%20also%20serves%20as%20a,from%20within%20their%20own%20families
NSPCC	https://learning.nspcc.org.uk/safeguarding-child-protection/

8. What to do with allegations of abuse from a child

Keep calm

- Reassure the child that they were right to tell you, and that they are not to blame and take what the child says seriously.
- Be careful not to lead the child or put words into the child's mouth – ask questions sensitively and do not promise confidentiality.
- Fully document the conversation on a word by word basis immediately following the conversation while the memory is fresh.
- Fully record dates and times of the events and when the record was made, and ensure that all notes are kept securely.
- Inform the child/ young person what you will do next.
- Refer to KGPC's Safeguarding Lead clinician or Administrative Lead.
- Decide if it is safe for a child to return home to a potentially abusive situation. It might be necessary to immediately refer the matter to social services and/or the police to ensure the child's safety.

9. Attitude of parents or carers

Parental attitude may indicate cause for concern:

- Unexpected delay in seeking treatment.
- Reluctance to have child immunised.
- Failure to take child for dental care.
- Failure to attend scheduled appointment with GP or other healthcare providers.
- Denial of injury, pain or ill-health.
- Incompatible explanations, different explanations or the child is said to have acted in a way that is inappropriate to his/her age and development.
- Reluctance to give information or failure to mention other known relevant injuries.
- Unrealistic expectations or constant complaints about the child.
- Alcohol misuse or drug/substance misuse. n Domestic Abuse or Violence between adults in the household.
- Appearance or symptoms displayed by siblings or other household members.

10. Record keeping

It is vital that full records are kept of any allegations, suspicions or concerns about the welfare of a child. All clinical staff must make a full contemporaneous note in the patient's record each time there is any contact with the child or their parent/guardian.

In addition to narrative records, all safeguarding concerns much be appropriately coded on the patient records system. Examples of SNOMED codes used are as follows:

Child is cause for concern: 287441000000101
Child is cause for safeguarding concern: 836881000000105
Family is cause for concern: 300731000000106
Social worker involved: 160770002
Child in care: 160870005
Child no longer vulnerable: 247661000000106

11. Confidentiality

Staff are required to have access to confidential information about children and young people in order to do their jobs, and this may be highly sensitive information. These details must be kept confidential at all times and only shared when it is in the interests of the child to do so; this may also apply to restriction of the information within the clinical team. Care must be taken to ensure that the child is not humiliated or embarrassed in any way.

If an adult who works with children is in any doubt about whether to share information or keep it confidential he or she should seek guidance from KGPC's clinical Safeguarding Children Lead. Any actions should be in line with locally agreed information sharing protocols, and whilst the Data Protection Act applies, it does not prevent sharing of safeguarding information. Whilst adults need to be aware of the need to listen and support children and young people, they must also understand the importance of not promising to keep secrets. Neither should they request this of a child or young person under any circumstances.

Additionally, concerns and allegations about adults should be treated as confidential and passed to KGPC's Safeguarding Lead or appointed person or agency without delay.

12. Responding to requests for safeguarding / child protection information

All requests for information relating to a child protection investigation or report for Case Conference will be passed to the Child Safeguarding Lead or Administrative Lead on the day received. A response will be made in a timely manner, preferably within 48 hours, and if this is not possible the Agency requesting information will be informed and a reason given.

13. Training

In line with intercollegiate guidance, all staff must complete formal child safeguarding training, with refresher sessions at least 3 yearly. Training must be completed to the following levels:

- Staff requiring Level 1 Safeguarding training - All staff
- Staff requiring Level 2 Safeguarding training - All non-clinical and clinical staff who have any contact with adults, children and young people and/or parents/carers.
- Staff requiring Level 3 Safeguarding training - All clinical staff working with adults, children and young people and/or their parents/carers

In addition to initial training, over a 3 year period, all staff at level 3 must be able to demonstrate refresher education, training and learning equivalent to a minimum of 8 hours (12-16 hours for those with specific Safeguarding responsibilities); these should include personal reflection and scenario-based discussion, drawing on case studies, serious case reviews, and lessons from research and audit.

It is the responsibility of the Extended Access Administrator (for Extended Access staff) and the Recruitment and Retention Manager (for KGPC internal staff) to monitor and record that all staff have completed the required training.

PREVENT

14. PREVENT Policy

PREVENT is part of the Government's counter-terrorism strategy and aims to stop people becoming terrorists or supporting terrorism; as such it is described as the only long term solution to the threat we face from terrorism. Prevent focuses on all forms of terrorism and operates in a pre-criminal space, providing support and re-direction to vulnerable individuals at risk of being groomed in to terrorist activity before any crimes are committed. Radicalisation is comparable to other forms of exploitation; it is therefore a safeguarding issue staff working in the health sector must be aware of.

Raising awareness of the health sector contribution to the PREVENT strategy amongst healthcare workers is crucial. We are one of the best placed sectors to identify individuals who may be groomed in to terrorist activity, with 1.3 million people employed by the NHS and a further 700,000 private and charitable staff delivering services to NHS patients, we have 315,000 patient contacts per day in England alone. Staff must be able to recognise signs of radicalisation and be confident in referring individuals who can then receive support in the pre-criminal space.

Acting on concerns
Any concerns that a child or young person is a victim of grooming, or that they are displaying beliefs or behaviours which indicate a risk of radicalised thinking or terrorist activity should be dealt with in line with the child safeguarding policy.

Staff training

All staff are required to complete PREVENT training. A Bluestream online training module is available to all staff; KGPC will also accept evidence of training externally completed. Training is to be repeated every five years.

In line with government guidance, the training module available to staff includes the following:

Competencies

Knowledge

- The objectives of the PREVENT strategy and the health sector contribution to the PREVENT agenda;
- What their professional responsibilities are in relation to the safeguarding of vulnerable adults, children and young people;
- Understand vulnerability factors that can make individuals susceptible to radicalisation or a risk to others; and
- Who to contact and seek advice from if they have concerns a vulnerable individual is being groomed in to terrorist activity.

Skills

- Able to recognise potential indicators that an individual might be vulnerable to radicalisation or at risk of involvement in acts of terrorism;
- Understand the impact of influence on vulnerable individuals (direct or internet);
- Know what action to take if they have concerns, including to whom you should refer your concerns and from whom to seek advice; and
- Have an understanding of the importance of sharing information (including the consequences of failing to do so).

Criteria for assessment

- Demonstrates an awareness and understanding of indicators of risk relating to vulnerable individuals being radicalised;
- Demonstrates an understanding of appropriate reporting mechanisms in own organisation i.e. knows who to contact (organisation's PREVENT Lead), where to access advice within the organisation and policies and how to make a referral.

- Is aware PREVENT aims to tackle all forms of terrorism and the health sector contribution operates in pre-criminal space.

Female Genital Mutilation (FGM)

15. Female Genital Mutilation policy

Definition

Female genital mutilation (FGM) is defined by the World Health Organisation (WHO) as "a traditional harmful practice that involves the partial or total removal of external female genitalia or other injury to female genital organs for non-medical reasons."

It is estimated that more than 200 million girls and women alive today have undergone female genital mutilation in the countries where the practice is concentrated. In addition, every year, an estimated 3 million girls are at risk of undergoing female genital mutilation, the majority of whom are cut before they turn 15 years old.

FGM has no health benefits. It can lead to not only immediate health risks, but also to long-term complications to women's physical, mental and sexual health and well-being.

The practice is recognised internationally as a violation of human rights of girls and women. As it is practiced on young girls without consent, it is a violation of the rights of children. FGM also violates a person's rights to health, security and physical integrity, the right to be free from torture and cruel, inhuman or degrading treatment, and the right to life when the procedure results in death.

FGM is a form of abuse which has been illegal in the UK since 1985. In November 2015 the Serious Crime Act strengthened legislation by adding extra requirements for health care professionals to report FGM.

The Act:

- Granted lifelong anonymity to alleged FGM victims.
- Made it an offence for parents to fail to protect their child from FGM.
- Introduced FGM Protection Orders, which can prevent potential victims from travelling abroad.
- Created a mandatory reporting duty for nurses, midwives, doctors, social workers and teachers to report to the police whenever they observe physical signs of

FGM on a person under the age of 18, or where a girl tells them it has been carried out on her.
- Made it an offence for FGM to be committed abroad against UK residents.

Spotting the signs
Suspicions may arise in a number of ways that a child may be **at risk** of FGM. These include:-
- Knowing that a mother or older sibling has undergone FGM
- A girl talks about plans to have a 'special procedure' or to attend a special occasion/celebration to 'become a woman'.
- A girl's parents state that they or a relative will take the child out of the country for a prolonged period, or school holidays or when attending for travel vaccinations.
- A girl may talk about a long holiday to her country of origin or another country where the practice is present.
- The girl is a member of the community that is less integrated into UK society and whose country of origin practices FGM.

Signs that a child may have **already undergone** FGM:-
- Difficultly walking, sitting or standing
- Repeated urinary tract or vaginal infections, urinary incontinence, dysmenorrhea and difficulty becoming pregnant
- Spending longer than normal in the bathroom or toilet due to difficulties urinating
- Soreness, infection or unusual presentation noticed by practitioner when changing a nappy or helping with toileting
- Having frequent unusual menstrual problems
- A prolonged absence from school or college with personal or behaviour changes e.g. withdrawn, depressed
- Being particularly reluctant to undergo normal medical examinations
- Asking for help or advice but not being explicit about the procedure due to embarrassment or fear.

Reporting FGM

In line with this policy, a Safeguarding referral must be made in all cases where FGM involving a child is confirmed or suspected, or where a child is suspected as being at risk of FGM.

In addition to the Safeguarding referral, a referral to the Police (by dialing 999/101) must be made as soon as possible in cases where:
- A child tells you they have been cut
- You see physical evidence that a child has been cut

Further details about the Mandatory Reporting Duty can be found in the Department of Health's flowchart.

Requirement to code FGM
In addition to the requirements of the Serious Crime Act, it is now mandatory for all GP practices and Acute and Mental Health Trusts to submit FGM data to NHS Digital. Specific SNOMED codes have been produced for GPs and nurses to document FGM in patient records:

At risk of female genital mutilation: 713201008
History of FGM: 715477006
Family history of FGM: 902961000000107

16. Child sexual exploitation

Child Sexual Exploitation (CSE) is when an individual takes sexual advantage of a child or young person (anyone under 18) for his or her own benefit.

Signs of possible Child Sexual Exploitation

Physical Self-harm/attempted suicide

- Unexplained change in appearance and/or behaviour
- Repeated testing for sexually transmitted diseases /pregnancy
- Repeated symptoms of urinary infections
- Pelvic-inflammatory disease
- Repeated pregnancies/miscarriages/ terminations
- Repeated or prolonged alcohol abuse Drug/substance misuse
- Unexplained injuries Lack of personal hygiene/care

Psychological Mental health problems

- Low self-esteem/low self-confidence
- Eating disorders Suicidal thoughts/ideation
- Multiple personality disorders
- Dissociation
- Psychosis
- Depression
- Sleep disorders/nightmares
- Eating disorders
- Alcohol/drug/substance abuse
- Post-traumatic stress disorder
- Conduct disorder
- Learning disability/difficulty
- Poor attachment/attachment disorder
- Living in a chaotic or dysfunctional household (including parental substance use,

domestic violence, parental mental health issues)

Behavioural

- Absent from school or exclusion due to behaviour
- Staying out overnight with no explanation
- Regularly missing from home or care
- Receiving gifts from unknown sources
- Unaccounted for money/goods e.g. mobile phones/credit, drugs or alcohol
- Gang member or association with gangs
- Offering to have sex for money/other payment
- Change in physical appearance
- Overtly sexualised dress
- Associating with unknown adults; other sexually exploited children or vulnerable children
- Reduced contact with family, friends and other support networks
- Getting into cars with unknown adults or associating with known perpetrators
- Evidence of sexual bullying and/or vulnerability through the internet and/or social networking sites. Having a much older boy or girlfriend

When there is suspicion that a child or young person is being exploited, this suspicion MUST be shared with other appropriate agencies and the service's safeguarding lead, even where there may be issues with consent. Sharing information can mean the difference between life and death for a child or young person. Nothing should stand in the way of sharing information particularly in relation to sexual exploitation. The effective identification, disruption, intervention, protection and prosecution of perpetrators of this crime depend on effective multi-agency working.

Refer to children's social care or the Police if you suspect that a child is at risk of harm or is in immediate danger

Appendix A

Suspected Child Abuse Body Map

Child's name		Child's date of birth	
Date of incident (dd/mm/yyyy)		Person completing body map