Safeguarding children policy

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RELATED DOCUMENTS	Consent and disclaimer policy Following the death of a child policy Freedom to speak up: raising concerns/ whistleblowing policy ICPC/RCPC report template Recruitment and selection policy Record-keeping policy Safeguarding adults policy Local Safeguarding Partnership procedures Volunteer operational policy and handbook

Zoe's Place Baby Hospice is the operating name of Zoe's Place Trust, registered charity no 1092545. The names Zoe's Place Baby Hospice / Zoe's Place Trust / the Trust are used interchangeably within this policy.

Contents

1. Introduction and scope

1.1 The majority of children and young people have their needs met fully by their parents, extended family and friends and the communities within which they grow. However, children and their families may, from time to time, require the support of professional services (e.g. social care, health, police, mental health, voluntary organisations).

1.2 Zoe's Place Baby Hospice is committed to safeguarding children, promoting their welfare and safety, and protecting them from abuse. We seek to ensure that all our services achieve the best possible outcomes for children, in collaboration with other agencies. The welfare of the child is paramount, and this will be upheld at Zoe's Place Baby Hospice in all situations.

1.3 We will work alongside partner organisations and agencies to ensure that all children who access any Zoe's Place Baby Hospice service are safeguarded, supported, and protected from abuse, regardless of gender, ethnicity, disability, sexuality or religion.

1.4 Local Authorities, working with partner organisations and agencies, have specific duties to promote the welfare of all children in their area.

1.5 Safeguarding children is everybody's responsibility. Children who need help and protection deserve high-quality and effective support as soon as a need is identified (Working Together to safeguard Children 2018, updated 2023).

1.6 All staff must be able to recognise and respond appropriately to child safeguarding concerns and follow Local Safeguarding Partnership (LSP) procedures at all times.

1.7 This policy should be read and adhered to by all Zoe's Place Baby Hospice staff in all departments and including nursing students on placement, alongside applicable policies.

Policy aims:

1.8 To provide a background to child safeguarding, applicable legislation, and Local Authority procedures.

1.9 To provide a framework which identifies and promotes best practice and minimises uncertainty for staff and volunteers working with children.

1.10 To outline our commitment to ensuring that all staff are trained in accordance with the **Royal College of Nursing's intercollegiate document (Fourth edition) Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff** so that they have the correct knowledge and competence to take the required action according to their role.

1.11 To protect Zoe's Place Baby Hospice staff: by following the guidelines and procedures, everyone working or volunteering within Zoe's Place Baby Hospice should know what to do if they are concerned about a child's welfare, and be able to avoid inappropriate, misguided or wrong behaviour.

1.12 To protect Zoe's Place Baby Hospice as an organisation: this policy forms part of our commitment to best practice; it promotes the Organisation's integrity and ensures compliance with the Care Quality Commission essential standards of quality and safety (key lines of enquiry).

2. Roles and responsibilities

Hospice Trustees	Have overall accountability and responsibility for all matters relating to the safeguarding of children.
Clinical Governance Committee	Provides ratification of the policy within the governance process and provides the forum for governance of the safeguarding of children.
Director of Clinical Services	As chair of the Clinical Governance Committee, ensures that the policy is reviewed and approved in accordance with the agreed schedule of review **or** further to incidents, complaints, or evaluation of the service. Ensures that the policy is made available to sites. Ensures the policy is updated in accordance with new legislation. Has overall responsibility for patient safety. **Freedom to speak up Guardian** responsibilities (see next section)
SMT	Ensures that the policy is made available to all sites and all departments. Ensures that there are effective risk management processes meeting statutory guidance. Monitors any serious incidents that are reported relating to the safeguarding of children.
Heads of Care	Responsible for the implementation of the policy, ensuring that safeguarding documentation is maintained at their hospice (see Appendices). Investigates and takes any necessary action if there is a safeguarding incident. Ensures that: • mechanisms are in place to ensure that nursing staff are aware of and comply with the requirements of this policy at all times. • the policy is cascaded and understood by all staff. • the policy is updated in accordance with new legislation. **Safeguarding Lead** responsibilities (see next section)
Heads of Department (non-clinical)	Ensure that the policy is cascaded and understood by all fundraising and marketing staff. Ensure that the policy guidance is adhered to by all staff in their department. **Freedom to speak up Champion** responsibilities (see next section).
Deputy Head of Care	• Ensures that procedures are followed correctly and that the policy is followed in the absence of the Head of Care. • **Safeguarding Lead** responsibilities (see next section) in the absence of the Head of Care

Registered nurses	• Be accountable for their own conduct and practice according to the NMC Code of Professional Practice. • Abide by this policy and Local Safeguarding Partnership guidelines and bring to the attention of the Head of Care if there are any concerns about the safeguarding of children. • To attend and complete any training provided on safeguarding including e-learning modules in accordance with the Zoe's Place Baby Hospice **Learning and development policy**. • To be aware of and work within the confines of the policy.
All staff	• Operate within their agreed scope of practice and competence. • Be aware of and work within the confines of the policy. • Abide by this policy and bring to the attention of the Head of Care if there are any concerns about the safeguarding of children. • To attend and complete any training provided on safeguarding.

3. Additional safeguarding roles

Roles – Zoe's Place Baby Hospice

Safeguarding Lead: This is the Head of Care (or Deputy Head of Care in their absence). The safeguarding lead is the designated person within the hospice to whom safeguarding allegations or concerns should be reported and who will be available for advice and support regarding any safeguarding concerns.

The Safeguarding Lead will undertake safeguarding training to Level 3 in accordance with the RCN intercollegiate document and the Zoe's Place **Learning and development policy**. They will ensure that all staff complete mandatory safeguarding training and that staff are aware of their professional accountability and responsibility in relation to the safeguarding of children.

The Safeguarding Lead ensures that:

- the parent/carer is involved in the information-sharing process in accordance with Local Safeguarding Partnership procedures.
- staff can access Local Authority/ LSP procedures as a resource for making a safeguarding referral and that up-to-date contact details are available for these:
- the hospice's reporting system complies with LSP procedures, CQC Essential Standards of Quality and Safety 2010, and Working Together 2018 (updated 2023)

Freedom to speak up roles include: FTSU Guardian (Director of Clinical Services), FTSU Champions (Heads of Fundraising). Please refer to our **Freedom to speak up: raising concerns/ whistleblowing policy** for more information about.

The **Senior Management Team** will seek to support and empower staff and volunteers to carry out their safeguarding responsibilities. Safeguarding will be introduced at induction training, and all staff are encouraged to use the Safeguarding Resource Board in each hospice.

Roles – Local Authority

Local Safeguarding Partnership (LSP) or **Local Safeguarding Children Partnership (LSCP**): The Children and Social Work Act 2017 replaced Local Safeguarding Children Boards (LSCBs) with new local safeguarding arrangements led by the three named statutory safeguarding partners: local authorities, chief officers of police, and clinical commissioning groups (health).

These safeguarding partners have assumed the responsibilities for safeguarding arrangements that previously sat with LSCBs. The professionals from each of the three sectors have a shared and equal duty for new safeguarding arrangements and for working together to safeguard and promote the welfare of children in the area.

Local Authority Designated Officer (LADO): This is the person who should be notified when it has been alleged that a professional or volunteer who works with children has:

- behaved in a way that has harmed a child, or may have harmed a child
- possibly committed a criminal offence against or related to a child
- behaved towards a child or children in a way that indicates she or he may pose a risk of harm to children
- behaved or may have behaved in a way that indicated they may not be suitable to work with children

4. Definitions (See also Appendix 6, Further definitions and information)

Abuse: This is 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.

Child: In the Children Act (1989 and 2004) respectively and Working Together to Safeguard Children 2018 (updated December 2023), a "child" is anyone who has not yet reached their 18th birthday.

Child-centred approach: Working Together to Safeguard Children 2018 (updated 2023) promotes a child-centred approach at all times. This approach is fundamental to safeguarding and promoting the welfare of every child and means keeping the child in focus when making decisions about their lives and working in partnership with them and their families.

Children in need: Children who are defined as being 'in need' under Section 17 of the Children Act 1989 are those whose vulnerability is such that they are unlikely to reach or maintain a satisfactory level of health or development, or their health and development will be significantly impaired, without the provision of services; and children who are disabled.

The critical factors to be considered in deciding whether a child is "in need" under the Children Act 1989 are what will happen to a child's health or development without services being provided, and the likely effect the services will have on the child's standard of health and development.

Child protection: Child protection is a part of safeguarding and promoting welfare. It refers to the activity undertaken to protect all children who are recognised as suffering, or are likely to suffer, **significant harm** (see below). Zoe's Place encourages working in partnership with children, young people, advocates, parents and carers in all circumstances, especially where there are concerns or suspicions about child abuse.

Harm: Under section 31(9) of the Children Act 1989 as amended by the Adoption and Children Act (2002), harm means ill-treatment or the impairment of health or development, including, for example, impairment suffered from seeing or hearing the ill-treatment of another.

Safeguarding and promoting the welfare of children means protecting children from maltreatment, preventing impairment of children's health or development, and ensuring that children are growing up in circumstances consistent with the provision of safe and effective care. Safeguarding and promoting the welfare of children is defined in Working Together to Safeguard Children 2018 (updated 2023) as:

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

Significant harm: Some children are in need because they are suffering, or likely to suffer, significant harm. The Children Act (1989) introduced the concept of significant harm as the threshold that justifies compulsory intervention in family life in the best interests of children and gives Local Authorities a duty to make enquiries to decide whether they should take action to safeguard or promote the welfare of a child who is suffering, or likely to suffer, significant harm.

A court may make a specific care or supervision order, committing a child to the care of the Local Authority, if it is satisfied that:

- The child is suffering, or is likely to suffer, significant harm; and
- That harm, or likelihood of harm, is attributable to a lack of adequate parental care or control (Section 31, Children Act, 1989).

4.1 **Acronyms**

ACE: Adverse Childhood Event

CIN: Child/children in need

CPP: Child Protection Plan

SCR: Serious Case Review

MASH: Multi-agency Safeguarding Hub

MACH: Multi-agency Children's Hub (Middlesbrough)

5. Legislation

- **The Children Act 1989 & 2004**: The Children Act 1989 is the primary legislation which underpins and governs working with children who require services to meet their needs. The Children Act 2004 provides guidance on inter-agency work and cooperation in meeting the needs of children and provides legislative requirements for governance of child protection intervention.

  Under section 17 of the Children Act, Local Authorities have a duty to safeguard and promote the welfare of children in need (see **section 4 Definitions)**. The Children Act Section 47 requires the Local Authority to undertake enquiries if they believe a child (who lives or is found in their area) has suffered or is likely to suffer significant harm.

  Children and Families Act (2014) part 3 promotes the physical, mental health and emotional wellbeing of children and young people with special educational needs or disabilities.

- **Children and Social Work Act 2017**: amended the Children Act 2004 to establish new local arrangements for safeguarding and promoting the welfare of children. A central feature of the new arrangements is that three safeguarding partners – the Local Authority, NHS Integrated Care Boards (ICBs) and police forces – are responsible for determining how safeguarding arrangements should work in their area for them and relevant agencies.

- **Domestic Abuse Act 2021 and statutory guidance:** aims to provide clear information on what domestic abuse is, provide and signpost support to those organisations who need to respond, and convey standards and best practice for agency and multi-agency response.
- **The Safeguarding Vulnerable Groups Act 2006**
- **Children and Young Persons Act 2008**
- **Education Act 2011**
- **The General Data Protection Regulation (GDPR) and the Data Protection Act 2018**

6. Impact of child abuse

Abuse in all its forms can affect a child at any age.

Sustained abuse, whether physical, sexual or emotional abuse or neglect, and regardless of who was the perpetrator, can have long-lasting and potentially devastating effects on all aspects of a child or young person's health, development and wellbeing. There is likely to be a deep and lasting impact on self-image and self-esteem, forming and sustaining relationships (with adults and/or children).

All children and young people (regardless of their age, racial/cultural origin, disability or illness) may receive much comfort and support from some professional intervention, with and through those close to the child.

All allegations of abuse or maltreatment of children – regardless of who is alleged to have perpetrated the abuse - must be taken seriously and treated in accordance with the Local Safeguarding Partnership procedures.

7. Recognition of child abuse

When child abuse occurs, it is not always recognised. Its impact is sometimes minimised, especially with disabled children (see **section 8, Children with a disability**) or for children who have a life-limiting illness. However, most child abuse, with appropriate intervention, can be stopped or prevented.

Certain medical conditions may cause changes to a child's behaviour or physical presentation. It will be necessary to carefully consider any concerns about possible symptoms of child abuse with the relevant medical practitioner. There may well be other reasons for changes in a child's behaviour such as: surgery, changes in prognosis, deterioration of physical or cognitive ability, changes in carers, or at home, a death or crisis in the family or the birth of a child.

Your knowledge of a child over a period of time may help you to understand whether there is cause for you to be concerned. If the concern is not a child protection matter, it may still require some attention or action to promote the welfare of the child.

Forms of oppression such as racism or discrimination based on disability or sexuality, and which may be prevalent amongst peers in group setting or in communities, can also impact on a child or young person's behaviour. Some behaviour (e.g. obsessional hand washing) may be indicators of abuse, or they may be connected to a particular form of disability, such as autism.

Always try to establish the context of an incident and avoid making judgments on the basis of stereotypes.

8. Children with a disability

Child protection and safeguarding issues are intricate and complex for every organisation. For Zoe's Place Baby Hospice there are specific areas that need consideration in view of the specialist services we provide; the children we support may experience a wide range of conditions and in some cases, this may mean they become increasingly disabled.

Children and young people who have disabilities are at increased risk of being abused compared with their non-disabled peers (Jones et al 2012) and are also less likely to receive the protection and support they need when they have been abused (Taylor et al 2014). Additionally, professionals sometimes have difficulty identifying safeguarding concerns when working with disabled children (NSPCC 2016). Children with a disability therefore rely on good assessments, information-sharing, and vigilant observation and review at all times.

Assessment of children with a disability

Assessments allow professionals to understand whether a child has needs relating to their care or their disability and/or whether the child is suffering/likely to suffer significant harm. A good assessment will give a picture of what is normal/typical behaviour for the child/young person, enabling us to notice and clarify when the child is behaving in ways that are not typical/ out of character for them. The assessment process should prioritise and give sufficient recognition to the specific needs of disabled children. As professionals we need to consider **any** issues or concerns raised and whether a situation would be acceptable for **any** child; if it would not be acceptable, we need to act.

9. Abuse carried out by another child or young person

Although adults perpetrate most child abuse, other children or young people can abuse children. Do not assume that if a young person perpetrates abuse that it is less serious or less significant for any of the children involved. Under the Children Act 2004, a "person who is a risk to children" is a person over the age of 10 years who has been convicted or accepted a caution of offences against children. 'Offences' in this context include physical and sexual offences where the offender would be deemed a person who is a risk to children.

10. A child disclosing information

A child may disclose worries to you which raise a potential safeguarding concern – for example they may disclose to you that they are being or have been abused. By confiding in you they have demonstrated their trust that you will act, and they have placed you in a position of trust - they trust you to help them, even if they ask you not to do anything or tell anyone. Bear in mind the following points:

- React calmly, so as not to frighten the child.
- Let the child know that they did the right thing to tell you, and that they are not to blame.
- Take what the child says seriously.
- Even if you feel you need more information about their concerns or worries, do not press the child for this if they do not provide it freely. Keep questions to the absolute minimum needed to ensure a clear and accurate understanding of what the child has said. Do not ask the child about explicit details.
- Reassure the child that the information will be kept private, but that you must tell certain people to make sure action is taken, and also that it is part of your job to make sure children are kept safe.
- Do not delay reporting the matter to Zoe's Place Baby Hospice Safeguarding Lead or other appropriate person (see LSP procedures) - don't wait until you have all the information.
- Consult the child's notes held by the hospice – they may contain relevant information.
- There may be records available relating to child protection which third parties (e.g. social services, police, the courts, solicitors) can access.
- When you report a concern that a child has disclosed to you, keep to the facts. Make a full record of what is being communicated, heard, and seen, as soon as possible.

10.1 Historical allegations of child abuse

A child protection issue or concern may come to your attention where a child/young person/adult tells you about their own or another's child abuse in the past. Even though the information may relate to events from some time ago, it's still relevant.

If anyone shares information regarding historical abuse with the team at Zoe's Place Baby Hospice, discuss this with the Safeguarding Lead and refer to Local Safeguarding Partnership procedures.

11. Allegations against a person working for or associated with Zoe's Place Baby Hospice

Children can be subjected to abuse by those who work with them, in any setting. All allegations of abuse or maltreatment must be taken seriously and followed up in accordance with Local Authority/LSP procedures and this policy. This applies whether the allegation is about an employee (including sessional staff), volunteer, or any practitioner or person whose role places them in 'a position of trust' with the children supported by Zoe's Place Baby Hospice.

Some allegations, further to investigation, might indicate that a person is unsuitable to continue to work with children (either in their present position or in any capacity). This would include allegations where a person who works with children has:

- behaved in a way that has harmed a child, or may have harmed a child
- possibly committed a criminal offence against or related to a child
- behaved in a way that indicates s/he is unsuitable to work with children.

It is essential that any allegation made against a person working for or associated with Zoe's Place Baby Hospice is dealt with promptly, fairly, and consistently. The allegation must be handled in a way that provides effective protection for the child and at the same time, supports the person who is the subject of the allegation. Any external investigation will be in accordance with the LSP procedures and will involve a senior manager of Zoe's Place Baby Hospice.

If any member of staff, visitor, volunteer or service user becomes aware of concerns that a person working at or known to Zoe's Place Baby Hospice has harmed or may harm a child, they must report this to their line manager as soon as possible. The line manager will contact the Police/emergency services if necessary and inform the Director of Clinical Services and/or a member of the SMT. The senior manager must inform the Local Authority Designated Officer.

12. Information sharing and consent

Sharing information is an intrinsic part of any frontline practitioner's job when working with children and young people. The decisions made about how much information to share, with whom and when, can have a profound impact on the life of a child and their family.

Information-sharing helps to ensure that an individual receives the right services at the right time and prevents the needs of a child (or family) from becoming more acute and difficult to meet. Sharing of information between practitioners and organisations is essential for effective identification and assessment of risk, risk management, and service provision. Information-sharing is essential for effective safeguarding and promotion of the welfare of children and young people.

A key factor identified in many Serious Case Reviews (SCRs) is where poor information-sharing has resulted in missed opportunities to take action that keeps children and young people safe. See HM Government guidance: Information Sharing Guidance for practitioners 2018.

12.1 **Legislation relating to information sharing and consent**

- The UK GDPR and Data Protection Act 2018 place greater significance on organisations being transparent and accountable in relation to their use of data. All organisations handling personal data need to have comprehensive arrangements for collecting, storing, and sharing information. These arrangements are outlined in the Zoe's Place Baby Hospice **Data protection policy**, Privacy Notices, and supporting documents.

- The Data Protection Act includes 'safeguarding of children and individuals at risk' as a condition that allows practitioners to share information, including 'special category' personal data, **without** consent.

- Practitioners should be confident of the conditions which allow them to process, store and share the information they need to carry out their safeguarding role. This may include personal data which is considered 'special category', meaning it is sensitive and personal (see our **Data Protection policy**).

- The above legislation does not prevent, or limit, the sharing of information for the purposes of keeping children and young people safe. Fears about sharing information cannot be allowed to stand in the way of the need to safeguard and promote the welfare of children at risk of abuse or neglect.

- Sharing information in order to protect the welfare of a child is **in the public interest** and takes priority over protection of privacy – in other words, information can be shared without the consent of parents/carers if necessary.

12.2 **Working in partnership with parents/carers**

Generally, the most effective way of ensuring that children are safeguarded is by working in partnership with their parents and carers. This means:

- not making assumptions about the child's family based on your beliefs.
- acknowledging with parents that they are likely to know most about their own child.
- being open and honest with families, and if it safe and appropriate to do so, seeking consent from the family to share information.
- ensuring that parents/carers are aware of the **Safeguarding children policy** (parents are advised of this at the time of admission). A copy of the policy, or a notice for visitors advising them that we have a safeguarding policy, will be displayed within the hospice.

12.3 **Circumstances when it is not appropriate to seek consent/to work in partnership with parents/carers include:**

- The individual cannot give consent, or it is not reasonable to obtain consent.
- Fabricated or induced illness (FII) is suspected.
- There are concerns about sexual abuse.
- The practitioner believes that the child is at risk of, or has suffered, significant harm (see **Definitions** and **Appendix 6**).
- Discussion or information-sharing with the parent/carer may put the practitioner at risk.
- Discussion with the parent/carer may increase the risk to the child or another person.

Zoe's Place Baby Hospice as an organisation must remain child-centred at all times; working in partnership with parents/carers does **not** mean going along with the parents' wishes or requests regardless of what these are. **The child's safety and welfare is always uppermost in any consultation or course of action**.

If it is **not** appropriate to work in partnership with parents/carers, the practitioner must discuss their concerns with the Safeguarding Lead. Even if the Safeguarding Lead is unavailable, the practitioner should make the LSP referral, making it clear as part of the referral that they have not informed the family, and have not sought consent to share the information.

12.4 **Consent to share information - considerations:**

- It is good practice to seek consent and be open with parents/carers from the outset as to why, what, how and with whom, their information will be shared. You should seek consent in cases where an individual **would not expect** their information to be passed on. Consent to share information must be explicit and freely given by parents/carers.

- Relevant personal data 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 wellbeing. See the Department for Education document, **Information sharing: Advice for practitioners providing safeguarding services to children, young people, parents and carers** (July 2018).

- Local authorities are required to undertake enquiries if they believe a child in their area has suffered or is likely to suffer significant harm. This may mean Zoe's Place Baby Hospice being required to share information about a child **without** the consent of their parents/carers.

13. Recruitment and selection

Zoe's Place **Recruitment and selection policy** covers the procedures to be implemented for all Zoe's Place job applicants including: Enhanced Disclosure and barring service (DBS) check, written references, ID and right to work checks, evidence of qualifications, probationary period.

All applicants will be required to declare in writing any convictions (spent and unspent). This will be declared on the Organisation's application form and in addition, all applicants will also be asked to declare this verbally at interview. Applicants are made aware that the Rehabilitation of Offenders Act does not apply to all positions within Zoe's Place Baby Hospice.

Volunteers: anyone applying for a volunteer role where they will be in the hospice premises or grounds and/or have direct contact with the children and young people we support are required to complete an Enhanced DBS check.

DBS checks will be repeated for all employees and volunteers (including Trustees) every 3 years.

14. Staff training and support

14.1 **The RCN intercollegiate document (see section 1.10)** contains the following specific requirements in respect of training:

- All nurses, care assistants, team leaders, Deputy Head of Care, doctors, allied health professionals and volunteers in the clinical setting must complete Level 3 of Safeguarding Children face-to-face or e-learning training for a minimum of 8 hours. Then over a three year period they must complete refresher education, training and learning to a minimum of 8 hours.
- All counsellors who work with children are also to complete initial Level 3 of Safeguarding Children face-to-face or virtual initial training for a minimum of 8 hours and over a three year period.
- Non-clinical staff who have contact with children must complete level 2 safeguarding.

14.2 **Zoe's Place Baby Hospice staff:**

- Our **Learning and development policy** mandatory training requirements reflect the RCN intercollegiate document, and our own additional requirements for staff.
- All staff are required to complete e-learning and/or face-to-face training for safeguarding children appropriate to their roles.
- All staff must read and understand this policy.
- Clinical staff will receive annual face-to-face updates in safeguarding as part of the mandatory training programme as recommended by the Intercollegiate document.
- Clinical staff will receive supervision in relation to safeguarding, organised and delivered by an appropriately trained and skilled person through agreed formal arrangements.

14.3 Volunteers who come into contact with children and their families in their role at Zoe's Place Baby Hospice will be required to complete e-learning in accordance with our **Volunteer operational policy**.

14.4 Visiting practitioners and therapists will adhere to LSP procedures and guidelines at all times. The Head of Care will ensure that visiting practitioners and therapists have appropriate safeguarding training and certification in place.

14.5 **Support for staff involved in safeguarding concerns:** Zoe's Place Baby Hospice acknowledges that the process of dealing with child abuse is complex and can be anxiety-provoking. Professional support or counselling may be helpful for any worker or volunteer who becomes involved in a safeguarding referral – see list of Contacts at Appendix 1 that can offer support.

15. References

- NSPCC (April 2021) Guidance on protecting deaf and disabled children from abuse (accessed online on 10/08/2021/updated September 2025). **[accessed October 2025]**
- Middlesbrough Safeguarding Children Partnership procedures (useful to all areas): Child Protection Procedures Document: A Guide to Developing a Child Protection Policy and Practice Guidance for Private and Voluntary Organisations http://www.teescpp.org.uk
- Local Safeguarding Partnership procedures
- HM Government-Department of Education: Working Together to Safeguard Children 2018 (updated online June 2025)
- HM Government: Information sharing Advice for practitioners providing safeguarding services to children, young people, parents and carers. (updated online May 2024)
- Royal College of Nursing Intercollegiate Document: Safeguarding Children and Young people: Roles and Competencies for Health Care Staff - 4th Edition 2019 (updated March 2025)
- CQC updates information on 'safeguarding' children and adults in England (update: https://www.cqc.org.uk/news/stories/cqc-updates-information-safeguarding-children-adults-england [accessed October 2025]

16. If you have concerns about a child's welfare

1. Inform the relevant person of your concerns - see Appendix 1 and Appendix 2 and follow local LSP procedures.
2. Record the safeguarding concerns/events according to Hospice procedures – see Appendix 3.

- Zoe's Place Baby Hospice does not expect staff members to be specialists in child protection. It is **not** the responsibility of Zoe's Place Baby Hospice staff to investigate safeguarding concern or to decide whether or not child abuse has taken place.
- Staff responsibilities in respect of safeguarding can be summarised by "the Five Rs": **Recognise – Respond – Report – Record – Refer**
- If in doubt, always ask. If you are not happy or are uncomfortable about a response or a situation, you should speak out.

Appendix 1: Local Safeguarding Partnerships and other useful contacts - 1 of 2

See also Local council/LSP web pages and local Safeguarding Resource Board.

If a member of the public considers that there is an emergency situation relating to child protection, they should dial 999 for the Police. If someone shares this information with a member of staff, we should encourage the person with the concerns to dial 999.

MIDDLESBROUGH, REDCAR AND CLEVELAND, STOCKTON

Tees Safeguarding Children Partnership	**www.teescpp.org.uk**
North Yorkshire Safeguarding Children Partnership	**www.safeguardingchildren.co.uk**
Redcar & Cleveland First Contact Team	01642 771500
Middlesbrough First Contact Team	01642 726004
Hartlepool and Stockton Hub	01429 284284
EDT for all areas above	01642 524552
North Yorkshire Safeguarding children partnership (office hours and EDT)	0300 131 2131

COVENTRY & WARWICKSHIRE

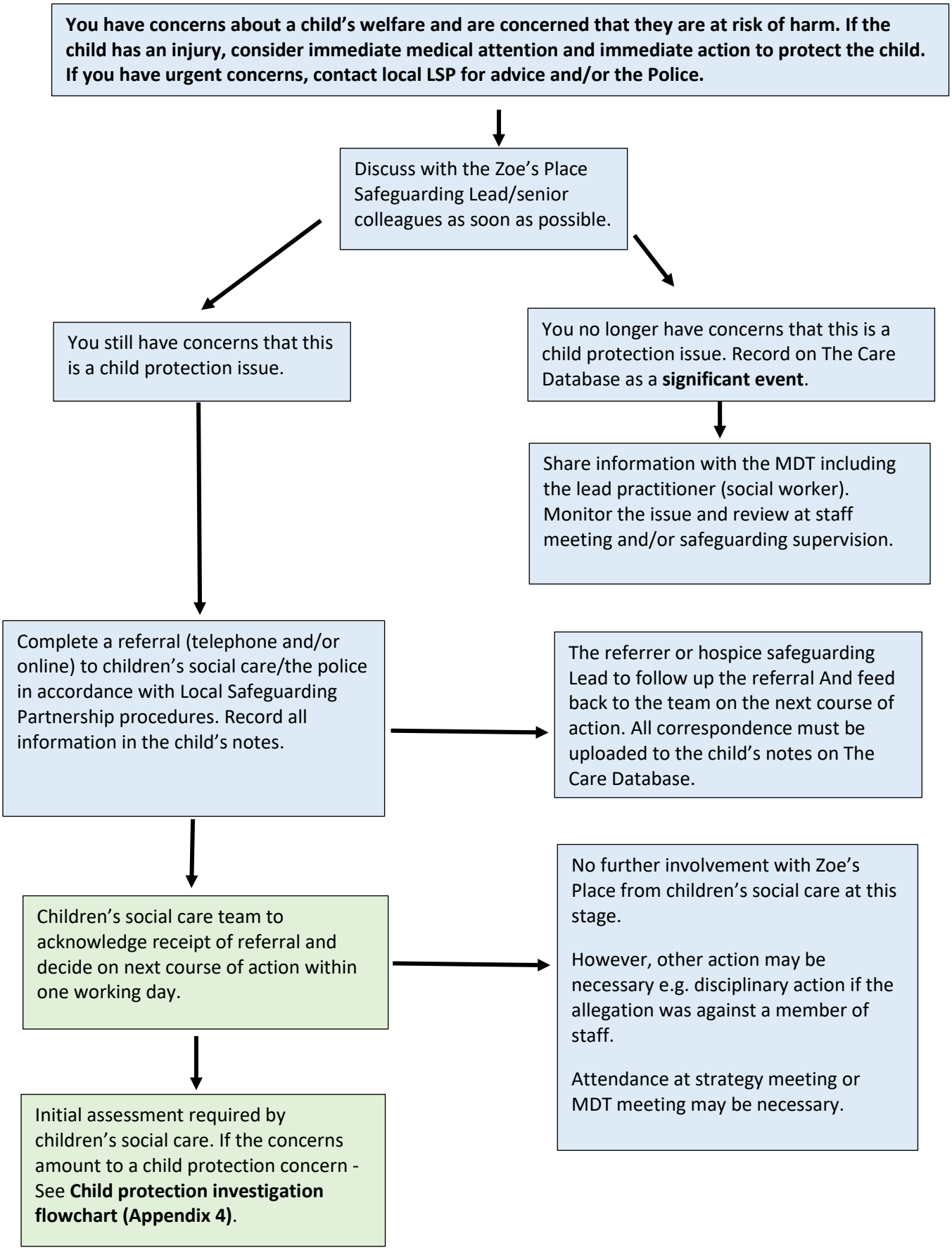
Warwickshire County Council Children's social care	**www.warwickshire.gov.uk/mash**
Coventry's multi-agency safeguarding hub	**www.coventry.gov.uk/children-families/coventrys-multi-agency-safeguarding-hub-mash**
Coventry multi-agency safeguarding hub	024 7678 8555
Coventry Emergency Duty Team	02476 832222
Warwickshire Children and Families Front Door	01926 414144
Warwickshire Emergency Duty Team	01926 886922

Appendix 1: Local Safeguarding Partnerships and other useful contacts - 2 of 2

Other useful contacts and sources of support

NSPCC Child Protection Helpline	42 Curtain Road, London EC2A 3NH Helpline: 0808 800 5000 Textphone:0800 0560566 help@-nspcc.org.uk www.nspcc.org.uk	NSPCC provides Information, advice and support to: • anyone concerned about a child at risk of abuse. • Adults feeling stressed as a result of working with child abuse • Adults who have experienced child abuse • Training and resources in safeguarding and child protection
Childline	Freephone: 0800 1111 www.childline.org.uk	Free 24-hour helpline for children and young people (anyone under 19) in trouble or danger.
Ann Craft Trust	The Ann Craft Trust Centre for Social Work, Nottingham, Nottinghamshire, NG7 2RD Telephone: 0115 951 5400 ann-craft-trust@nottingham.ac.uk	National association working with staff in the statutory, independent and voluntary sectors in the interests of disabled people who may be at risk from abuse. Provides information, advice, support and training.
Respond	Respond Lenta Space 180/186 Kings Cross Road London WC1X 9DE Helpline: 020 7383 0700 Respond.org.uk	A national charity providing therapy and specialist support services to people with learning disabilities, autism or both who have experienced abuse, violence or trauma and people working with them.
Women's Therapy Centre	020 7263 6200	The Women's Therapy Centre London has been offering individual and group psychotherapy to women since 1976.

Appendix 2: Reporting child protection concerns flowchart



Appendix 3: Recording safeguarding concerns and significant events on The Care Database

All concerns must be properly recorded by Zoe's Place Baby Hospice, regardless of whether Social Services become involved, in line with our **Record-keeping policy** and this policy.

Non-clinical staff: inform the Safeguarding Lead and complete an Incident Report Form.

Clinical staff: follow the guidance below.

1. **Recording initial safeguarding concerns**

   If the child is attending Zoe's Place: Record the concern on The Care Database within the child's notes. Tick the **Safeguarding issue** box and tick the **Significant event** box if applicable. Record what has been shared, when and with whom and whether or not consent has been obtained.

   If the child is not attending Zoe's Place (e.g. they are a sibling): Complete an Incident Report Form and pass this to the Safeguarding Lead.

2. **Making a safeguarding referral to the LSP**

   In accordance with your Local Safeguarding Partnership procedures, complete the online referral form and/ or telephone referral as required. State whether or not consent from parents/carers has been obtained, and if not, the reasons why.

3. **Further recording on The Care Database**

   a) Within 24 hours of making the referral, record details of the referral in the child's notes within the **Safeguarding** topic and the **Safeguarding** thread. Always tick the **Safeguarding issue** box on The Care Database for any notes relating to a safeguarding concern or referral; this will highlight the notes in red.

   b) Upload the completed Local Authority/LSP referral form to The Care Database under the **Safeguarding** thread under the **Referral form** topic.

   c) Document any bruising or marks on the child's body using the Body map form: this is located in the **Care planning** tab on the **Child's body map** section. Include a description and upload a photograph if needed to accompany the description. Under the **Nursing Communication** thread ensure that you refer to the Body map.

   d) Ensure that all concerns regarding a child's welfare, information-sharing, referrals, and meeting attendances (e.g. MTD CIN meetings) are documented in the child's record, using the Safeguarding thread and the appropriate topic. Ensure that the **Significant event** box is ticked if applicable (see below).

4. Recording significant events on The Care Database

These are events which are of significance in relation to safeguarding and which, when recorded, may reveal patterns which could indicate child abuse or identify unmet needs. Some examples are shown below**.**

a) Record the event within the child's notes (e.g. under **Nursing communication** thread).

b) Tick the **Significant event** box, and the **Safeguarding Issue** box if applicable.

c) Update the table within the **Alerts** box with the time and date of the notes. This will allow members of staff to identify and view any concerns regarding the child applicable notes.

Examples of a significant event may include (the list is not exhaustive):

- The child not brought on two successive occasions with no explanation given by parents/carers.
- Parents/carers are more than an hour late to collect their child with no notice or explanation given, or they fail to collect their child.
- A child is collected by a person not known to Zoe's Place Baby Hospice or is not the person that the team expected to collect the child (see the **Safe collection of children procedure**).
- Concern about the child's hygiene/presentation on arrival or at family events
- Concerns about medication, for example medication not provided, or watered down.
- Concern that a parent/carer is under the influence of alcohol/drugs or other concerns about the health of parents/carers.
- The child arrives without the required equipment and there is a refusal to bring the equipment in when asked.
- A parent/carer is overly critical of child or has unreal expectations of the child on more than two occasions.

Follow-up to significant events

Every significant event recorded as above must be discussed and recorded at staff meetings and safeguarding supervision sessions. It may become apparent that concerns are mounting for the child/children during safeguarding supervision sessions and/or the staff meeting.

Once **four** significant events have been recorded (this will be shown in the table in the **Alerts** box) the practitioner will inform the hospice's Safeguarding Lead who will decide what actions to take. For example, it may be necessary to make a safeguarding or child protection referral and/or arrange a supervision session. The actions agreed and date of supervision will be documented on the **Safeguarding** thread, **Agreed actions** topic.

However, depending on the severity of the event, a **single event** could require immediate safeguarding referral following LSP procedures. If an event or cause for concern takes place out of normal working hours, the Nurse in charge must assess whether the concerns warrant a referral to children's duty social care team following LSP procedures (e. g. if they consider the child to be at immediate risk of harm).

Appendix 4: Myth-busting guide to information-sharing (extract from Working Together to safeguard children)

Sharing information enables practitioners and agencies to identify and provide appropriate services that safeguard and promote the welfare of children. Below are common myths that may hinder effective information sharing.

Data protection legislation is a barrier to sharing information

No – the Data Protection Act 2018 and GDPR do not prohibit the collection and sharing of personal information but rather provide a framework to ensure that personal information is shared appropriately. In particular, the Data Protection Act 2018 balances the rights of the information subject (the individual whom the information is about) and the possible need to share information about them.

Consent is needed to share personal information

No – you **do not** need consent to share personal information. It is one way to comply with the data protection legislation but not the only way. The GDPR provides several bases for sharing personal information. It is not necessary to seek consent to share information for the purposes of safeguarding and promoting the welfare of a child if there is a lawful basis to process any personal information required. The legal bases that may be appropriate for sharing data in these circumstances could be 'legal obligation', or 'public task' which includes the performance of a task in the public interest or the exercise of official authority.

Each of the lawful bases under GDPR has different requirements. It continues to be good practice to ensure transparency and to inform parent/ carers that you are sharing information for these purposes and seek to work cooperatively with them.

Personal information collected by one organisation/agency cannot be disclosed to another

No – this is not the case, unless the information is to be used for a purpose incompatible with the purpose for which it was originally collected. In the case of children in need, or children at risk of significant harm, it is difficult to foresee circumstances where information law would be a barrier to sharing personal information with other practitioners.

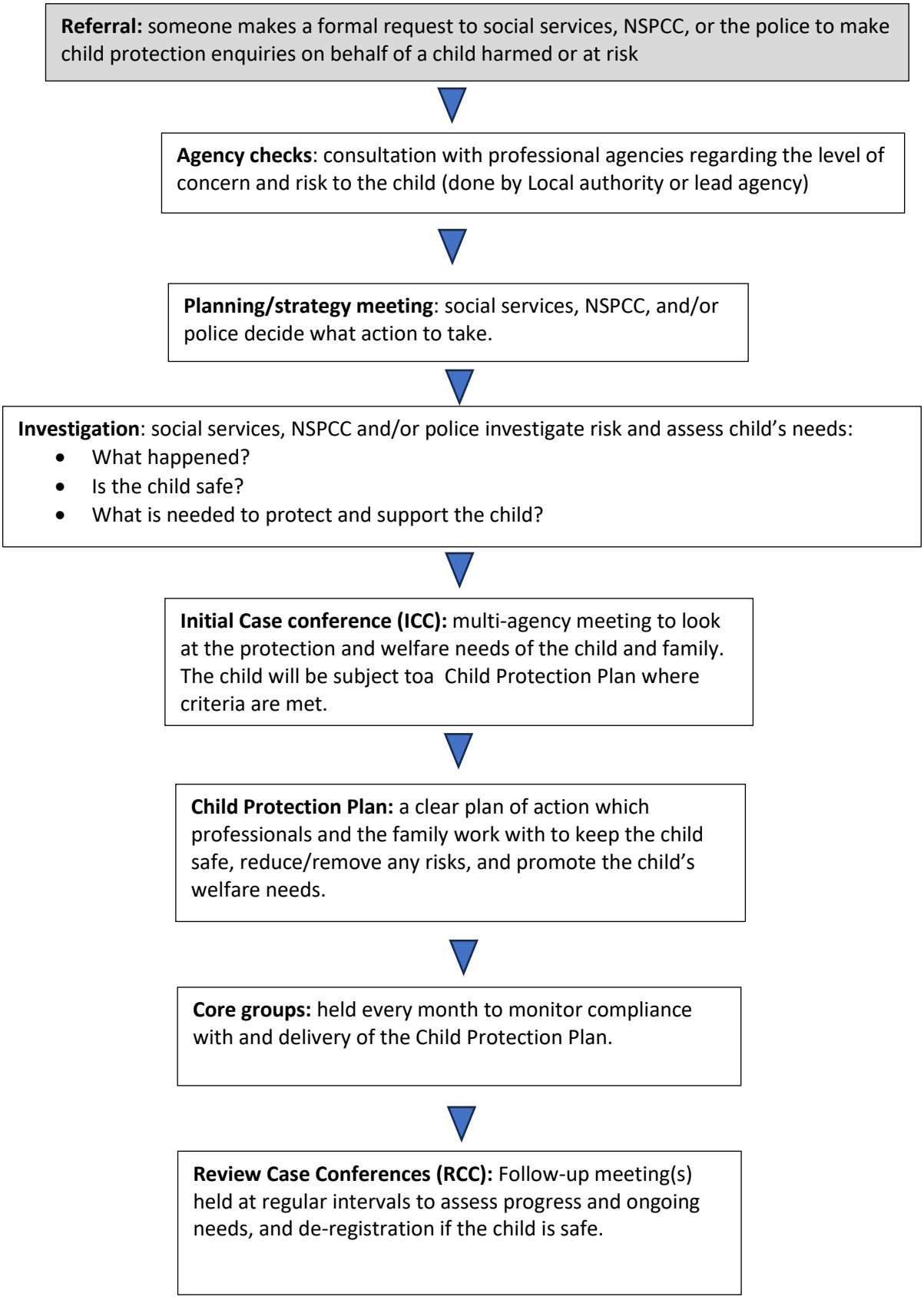
The common law duty of confidence and the Human Rights Act 1998 prevent the sharing of personal information

No – this is not the case. In addition to the Data Protection Act 2018 and GDPR, practitioners need to balance the common law duty of confidence and the Human Rights Act 1998 against the effect on individuals or others of not sharing the information.

IT Systems are often a barrier to effective information sharing

No – IT systems, such as the Child Protection Information Sharing project (CP-IS), can be useful for information sharing. IT systems are most valuable when practitioners use the shared data to make more informed decisions about how to support and safeguard a child.

Appendix 5: Child protection investigation flowchart



Appendix 5: Child protection investigation flowchart guidelines

The diagram (above) shows a complete process. However, any investigation will only go onto the next stage if it is deemed necessary. All child protection professionals, including social workers, have to work within the laws and guidance determining their roles, duties and responsibilities. The most important consideration is whether the child is safe.

Sometimes, the home circumstances may pose such a risk to the child that as a last resort he/she has to be removed. If this is the case social workers will try to identify family or friends where it is safe for the child to go and stay. However, more often the family will be given help and support in making sure the child is not at risk of abuse. It is a myth that children will automatically be taken into care once social services become involved.

The details of any action and the outcome of a child protection investigation is confidential to the child, family and professionals who need to know. However, it is appropriate for the staff member who made the referral to expect a level of feedback informing us that action has been taken and that the child is OK and safe.

It is reasonable to expect a staff member to attend case conferences and reviews; this will normally be the Safeguarding Lead for the hospice (Head of Care, or Deputy Head of Care in their absence). The Safeguarding Lead may be accompanied (if appropriate) by another staff member with more detailed knowledge of the child.

The local children's social care team will provide more advice and guidance about child protection processes and conferences in your area. (Refer to your Local Safeguarding Partnership Procedures

Appendix 6: Further definitions and information

1. Significant harm – definitions

Sometimes, a single traumatic event may constitute significant harm, for example, a violent assault, suffocation or poisoning. More often, significant harm is a compilation of significant events, both acute and long-standing, which interrupt, change or damage the child's physical and psychological development.

Some children live in family and social circumstances where their health and development are neglected. For them, it is the corrosiveness of long-term emotional, physical or sexual abuse that causes impairment to the extent of constituting significant harm.

In each case, it is necessary to consider any maltreatment alongside the child's own assessment of his or her safety and welfare, the family's strengths and supports, as well as an assessment of the likelihood and capacity for change and improvements in parenting and the care of children and young people.

To understand and identify significant harm, it is necessary to consider:

- The nature of harm, in terms of maltreatment or failure to provide adequate care
- The impact on the child's health and development
- The child's development within the context of their family and wider environment
- Any special needs, such as a medical condition, communication impairment or disability, that may affect the child's development and care within the family
- The capacity of parents to meet adequately the child's needs; and
- The wider and environmental family context.

The child's reactions, his or her perceptions, and wishes and feelings should be ascertained and the Local Authority will give them due consideration, so far as is reasonably practicable and consistent with the child's welfare and having regard to the child's age and understanding.

2. Types of abuse in children and young people

The following definitions are taken from the Department for Education's `Working Together to Safeguard Children' 2018 (updated December 2023).

Emotional abuse
Emotional abuse is the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to 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.

This 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 cyberbullying), 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.

Grooming
Abuse in which the perpetrator seeks out and 'grooms' vulnerable individuals usually with the intent to sexually abuse the child, young person or vulnerable adult.

Institutional abuse
Institutional abuse is the abuse of children by those who work with them and includes sexual abuse, physical and emotional abuse. Its prevalence is increasingly recognised in, for example, residential children's homes and schools. The culture of an organisation is crucial in addressing any form of institutional abuse. The values, attitudes and practice can either challenge or collude with abuse by an individual or group of workers.

Neglect
Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to:

- provide adequate food, clothing and shelter (including exclusion from home or abandonment);
- protect a child from physical and emotional harm or danger;
- ensure adequate supervision (including the use of inadequate care-givers); or
- ensure access to appropriate medical care or treatment.

It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

Physical abuse
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.

Position of trust
Zoe's Place Baby Hospice recognises an abuse of trust can also happen to vulnerable young adults and that parents can also be emotionally vulnerable at a time of crisis and loss. An Abuse of Trust relates to any person aged 18 years or over, who is in a position of trust (i.e. a professional or volunteer or student), developing a sexual relationship with a person under 18 years. A sexual relationship within a relationship of trust in this context is unequal and is unacceptable. The Home Office guidance should not be interpreted to mean that no genuine relationship can start between two people within a relationship of trust, but that the relationship of trust should end before any sexual relationship begins.

Secondary abuse
This term refers to the response to the child or young person who has disclosed abuse by a member of staff or an organisation and that this response is of itself abusive or in some way compounds the previous experience of abuse. Following these procedures will help ensure that best practice is adhered to and the child's experience of disclosing abuse is a positive one. All forms of abuse have extremely serious effects on young people

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

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.

3. Additional factors affecting children's safety and welfare include:

Bullying
Bullying can cause great distress and damage a child or young persons' health and development. Zoe's Place Baby Hospice staff should identify and deter any form of bullying behaviour. Bullying can escalate rapidly and can damage children significantly. Bullying is not always easy to define, but will often feature:

- Deliberate hostility and aggression towards a person.
- The victim will often be less powerful than the bully or bullies.
- The outcome is usually painful and distressing for the victim.

Bullying can also include:

- Physical pushing, kicking, hitting, pinching, spitting etc.
- Verbal name-calling, sarcasm, spreading rumours, persistent teasing. (Disabled children may be more vulnerable).
- Emotional tormenting, ridicule, humiliation and continual ignoring of individuals.
- Racial taunts, graffiti and gestures.
- Sexually abusive comments and unwanted physical contact.

Sources of stress for children and young people

Research has shown that children can be significantly affected by other factors such as domestic violence, parental drug or alcohol misuse or parental mental illness. These sources of stress may have a negative impact on a child's health and development because they affect the parent's capacity to respond to a child's needs. It is important that Zoe's Place Baby Hospice staff recognise if these factors are affecting a child or young person adversely and take similar steps for the other described forms of abuse.

Mixed Unclear and Unstable (MUU) ideology

Children may be affected by family or social situations where there are individuals who present a 'mixed, unclear, and unstable' (MUU) ideological profile instead of holding a single, clear and coherent extremist belief system. MUU could lead to an individual becoming fixated on more than one type of extremism or terrorism (e.g. misogyny contributing to extreme violence).

Female Genital Mutilation (FGM)

FGM is illegal in England and Wales under the FGM Act 2003 ("the 2003 Act"). It is a form of child abuse and violence against women. FGM comprises all procedures involving partial or total removal of the external female genitalia for non-medical reasons.

Section 5B of the 2003 Act introduces a **mandatory reporting duty** which requires regulated health and social care professionals and teachers in England and Wales to report to the police 'known' cases of FGM in under 18s which they identify in the course of their work. 'Known' cases are:

- Where a girl informs the person that an act of FGM – however described – has been carried out on her.
- Where the person observes physical signs on a girl appearing to show that an act of FGM has been carried out and the person has no reason to believe that the act was done for medical reasons.
- Where a person suspects that a girl may be at risk of FGM being carried out.