

Policy

Title: Safeguarding

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History Revision	Revision Date	Revised paragraphs	What has been changed; New directive Wording	Originator
July 2011		Throughout		JCB
November 2013	01/11/2013	Throughout	Wording & new directive	JCB
March 2014	11/03/2014	Throughout	All references checked, some wording amended	KV
May 2014	12/05/2014	Throughout	Title of the policy, some references & wording amended	DB
March 2016	17/03/2016	Throughout	All references and links checked, some wording amended, the main changes made in section 2.14-2.17	DB
July 2018	18/07/2018	Throughout	Information added based on CCG checklist, updated references due to new legislation, amended wording	CG

Overarching Principle of Child Protection Practice

The investigation and management of a case of possible deliberate harm to a child must be approached in the same systematic and rigorous manner as would be appropriate to the investigation and management of any other potentially fatal disease.

Laming. H, The Victoria Climbié Inquiry, 2003, Recommendation 83

INTRODUCTION

PURPOSE AND SCOPE

This document is designed to provide details and information for staff working in the Auditory Implant Service, University of Southampton (USAIS) about safeguarding issues and child protection procedures.

Patients who attend USAIS may be children and adults with listening and hearing difficulties (ranging from mild to profound hearing loss). Some hearing impaired patients may also have additional disabilities, which put them at greater risk of abuse and neglect. This policy concerns all patients under the age of 18. For information regarding vulnerable adults, please refer to the USAIS Safeguarding Adults Policy.

The procedures outlined below are designed to ensure that all members of staff are well informed about the action they may need to take if they suspect any form of abuse to a child/young person. Types of abuse are also described.

Safeguarding is a multi-agency, multi-disciplinary activity. All members of USAIS must work together with other agencies using common guidelines to ensure the safety and well-being of all children in our care. Working together to safeguard children (2018) defines safeguarding and promoting the welfare of children as:

- protecting children from maltreatment
- preventing impairment of children's health or development
- ensuring that children grow up on circumstances consistent with the provision of safe and effective care
- taking action to enable all children to have the best outcomes

“Nothing is more important than children’s welfare. 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)

This policy should be read in conjunction with:

- Working Together to Safeguard Children – July 2018
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/722305/Working_Together_to_Safeguard_Children_-_Guide.pdf
- The University of Southampton Code of Practice- Safeguarding Children and Vulnerable Adults
http://www.southampton.ac.uk/hr/services/safeguarding_children/how_do_i.php
- Local Safeguarding Children Board (LSCB) Procedures
<http://4lscb.proceduresonline.com/southampton/contents.html>
- USAIS Was Not Brought Policy found on Sharepoint
- USAIS Code of Conduct Policy found on Sharepoint

DEFINITION OF A CHILD

A child is anyone who has not yet reached their 18th birthday. This is regardless of domicile, marital status or any legal order in force. Although an unborn child does not have legal status as a child, consideration should be given to their needs and any risk factors taken into account and acted on.

1. STAFF RESPONSIBILITIES

1.1 All those working in the department must;

- know the signs and symptoms of actual and potential abuse or neglect in children
- be alert and observant for risk factors and any indications of abuse, including parental conditions that can impact on children
- discuss any safeguarding concerns with the USAIS Safeguarding Team in the first instance
- know how to act effectively on their concerns, with reference to the USAIS Safeguarding Procedure and the USAIS Safeguarding Guidance for Clinicians (Sharepoint)
- be aware that an allegation of child abuse or neglect may lead to a criminal investigation; it is therefore important not to do anything that might jeopardise a police investigation (such as asking a child leading questions or attempting to investigate the allegations of abuse)
- be able to make explicit referrals to Children's Social Care (known in Southampton as MASH (multi-agency safeguarding hub) when required
- work as part of the multi-agency team along with Children's Social Care and Police colleagues
- provide a written statement/report to the Police and Children's Social Care when requested for Child Protection Conferences
- maintain up to date knowledge and competent skills in these areas, through regular training and supervision, as stipulated in the intercollegiate document produced by the Royal College of Paediatrics and Child Health (Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff, Intercollegiate Document 3rd Edition, March 2014).
- be prepared to appear as a witness to give oral evidence in court

proceedings

- prioritize all child protection/safeguarding cases in the best interests of the child
- have access to expert professional advice to talk over their concerns

- 1.2 If a staff member is not satisfied with the outcome of the discussion with the USAIS Safeguarding Team, it is the responsibility of the individual health care professional to escalate his/her concerns. In the first instance the concerns should be raised with the staff member's Team Leader and/or the Director of USAIS. If further advice and guidance is required, concerns can also be discussed with the Designated/Named Nurse for Safeguarding Children within Southampton City CCG. Reference can also be made to the Local Safeguarding Children Board (LSCB) websites for the area in which the child resides when there may be a need to resolve professional disagreements.
- 1.3 Staff must maintain up to date knowledge and competent skills through regular safeguarding training.
- 1.4 All staff should take individual responsibility for knowing the contents of the Safeguarding Policy, Safeguarding Procedure, and related documents.
- 1.5 All staff who work with children must have an enhanced DBS Check.
- 1.6 In the induction period, a new member of staff whether paid or unpaid must be informed about the Safeguarding Policy and the designated named Safeguarding Lead and the supporting safeguarding officers.
- 1.7 Members of the USAIS Safeguarding Team must prioritise safeguarding concerns and offer timely and accurate advice to other members of staff. The Safeguarding Team must also record relevant information about cases where safeguarding concerns are raised, and coordinate liaison with other agencies as appropriate.
- 1.8 Members of the USAIS Safeguarding Team will have regular supervision with the Designated /Named Nurse for Safeguarding Children for Southampton City CCG. This will take the form of a face-to-face meeting every 3 months, and ad hoc telephone and email contact when concerns are raised.
- 1.9 Resources and references for staff who work with children and families are

listed below:

- Children and Social Work Act, 2017.
<http://www.legislation.gov.uk/ukpga/2017/16/contents/enacted>
- Care Quality Commission Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 13: Safeguarding service users from abuse and improper treatment. <https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-13-safeguarding-service-users-abuse-improper>
- Care Quality Commission Regulation 20: Duty of Candour. CQC 2015.
http://www.cqc.org.uk/sites/default/files/20150327_duty_of_candour_guidance_final.pdf
- Counter-Terrorism and Security Act 2015.
<http://www.legislation.gov.uk/ukpga/2015/6/contents>
- Data Protection Act 2018. London: HMSO
<http://www.legislation.gov.uk/ukpga/2018/12/contents/enacted>
- Department of Health and Department for Education and Skills (2004) National Service Framework for Children, Young People and Maternity Services.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/199952/National_Service_Framework_for_Children_Young_People_and_Maternity_Services_-_Core_Standards.pdf
- GMC Confidentiality: good practice in handling patient information (2009).
https://www.gmc-uk.org/-/media/documents/confidentiality-good-practice-in-handling-patient-information---english-0417_pdf-70080105.pdf
- Hampshire4LSAB Multi-Agency Risk Management framework (2016).
<http://www.hampshiresab.org.uk/wp-content/uploads/Multi-Agency-Risk-Management-Framework-16-02-16.pdf>
- Hampshire 4LSAB Multi-Agency Safeguarding Adults Policy & Guidance (2016).
http://www.hampshiresab.org.uk/professionals-area/hampshire_4lsab_multiagency_safeguarding_adults_policy_guidance/

- HM Government (2018). Information Sharing: Advice for practitioners providing safeguarding services to children, young people, parents and carers.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/721581/Information_sharing_advice_practitioners_safeguarding_services.pdf
- HM Government – Safeguarding Children in whom the illness is fabricated or induced.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/277314/Safeguarding_Children_in_whom_illness_is_fabricated_or_induced.pdf
- Home Office. Female Genital Mutilation Act 2003. Home Office Circular 10/2004.
<http://www.legislation.gov.uk/ukpga/2003/31/contents>
- Human Rights Act 1998. London: HMSO.
<http://www.legislation.gov.uk/ukpga/1998/42/contents>
- Information guide: Adolescent to Parent Violence and Abuse (APVA). Home Office.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/420963/APVA.pdf
- Local Safeguarding Children Board (LSCB) Procedures
<http://4lscb.proceduresonline.com/southampton/contents.html>
- Mental Capacity Act 2005. <https://www.legislation.gov.uk/ukpga/2005/9/contents>
- Modern Slavery Act, 2015.
<http://www.legislation.gov.uk/ukpga/2015/30/contents/enacted>
- NHS England Prevent Training and Competencies Framework
<https://www.england.nhs.uk/wp-content/uploads/2017/10/prevent-training-competencies-framework-v3.pdf>
- NICE guidance: Domestic violence and abuse: multi-agency working (2014).
<https://www.nice.org.uk/guidance/ph50/resources/domestic-violence-and-abuse-multiagency-working-pdf-1996411687621>
- NICE guidance: Looked After Children (2013).
<https://www.nice.org.uk/guidance/qs31/chapter/Introduction-and-overview>

- NICE guidance: Promoting the quality of life of looked-after children and young people (2010, updated 2015). <https://www.nice.org.uk/guidance/ph28>
- NICE guidance: When to suspect child maltreatment in under 18s (2009). <https://www.nice.org.uk/guidance/cg89/resources/child-maltreatment-when-to-suspect-maltreatment-in-under-18s-pdf-975697287109>
- Promoting the health and well-being of looked after children 2015. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/413368/Promoting_the_health_and_well-being_of_looked-after_children.pdf
- Revised *Prevent* Duty Guidance: for England and Wales. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/445977/3799_Revised_Prevent_Duty_Guidance_England_Wales_V2-Interactive.pdf
- Safeguarding Children and Young People: Roles and Competences for Healthcare Staff, Intercollegiate Document 3rd Edition, March 2014. https://www.rcoa.ac.uk/system/files/PUB-SAFEGUARDING-2014_0.pdf
- Safeguarding Policy NHS England 2015. <https://www.england.nhs.uk/wp-content/uploads/2015/07/safeguard-policy.pdf>
- Safeguarding Vulnerable Groups Act (2006): London HMSO and http://www.opsi.gov.uk/ACTS/acts2006/ukpga_20060047_en_1.html
- Sexual Offences Act 2003. London: HMSO. <http://www.legislation.gov.uk/ukpga/2003/42/contents>
- The Care Act, 2014. <http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted>
- The Children Act 2004 London: HMSO http://www.legislation.gov.uk/ukpga/2004/31/pdfs/ukpga_20040031_en.pdf
- The General Data Protection Regulation 2016/679. <http://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32016R067>

- UN General Assembly, **Convention on the Rights of the Child**, 20 November 1989, **United Nations, Treaty Series**, vol. 1577, p. 3. https://downloads.unicef.org.uk/wp-content/uploads/2010/05/UNCRC_united_nations_convention_on_the_rights_of_the_child.pdf?_ga=2.156459515.1305231253.1554290242-1601488327.1554290242
- 'We have the right to be safe'. Protecting disabled children from abuse. <https://www.nspcc.org.uk/globalassets/documents/research-reports/right-safe-disabled-children-abuse-summary.pdf>
- Working together to safeguard children – July 2018 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/722305/Working_Together_to_Safeguard_Children_-_Guide.pdf

2. PRINCIPLES OF PRACTICE

Responsibility for child protection belongs to everyone, and all organizations need to ensure that their safeguarding procedures are stringent and robust.

In all cases where there is concern that a child may have been abused or neglected the following principles should be applied:

- 2.1 Child-centered focus and multi-agency working.
- 2.2 In all cases where a child is thought to be at risk of harm, information must be shared with the multi-agency child safeguarding team (USAIS Keyworker, USAIS Safeguarding team, other professionals as appropriate, Consultant Otolaryngologist, Children's Social Care and Police) in accordance with national and local procedures. Safeguarding is a multi-disciplinary, multi-agency process and no agency or practitioner should act alone or in a unilateral manner.
- 2.3 A child protection investigation, led by Children's Social Care (the lead statutory agency) must be undertaken under section 47 of the Children Act (1989) if there is reasonable cause to suspect that a child has suffered or is likely to suffer significant harm due to physical abuse, sexual abuse, emotional abuse, or neglect.
- 2.4 The primary purpose of all those involved in the child protection process is firstly to prevent child abuse, and secondly to minimise any damage to the child and work towards the child's recovery in whatever way is relevant to that child's needs. In all such cases the child is of paramount importance with the professionals' duty of care being to the child.
- 2.5 The Children Act 1989 provides a legal framework for the care and protection of children, in which the welfare of the child is paramount. The Children Act 2004 reinforces but does not supersede The Children Act 1989.
- 2.6 Children have the right to a life free from abuse and neglect. A child who may have been abused needs to be treated with sensitivity, dignity and respect irrespective of the nature of that abuse.
- 2.7 When working with families from ethnic minorities staff should respect the ethnicity of the child and endeavor to provide a culturally sensitive service. "Whilst all individuals have a right to expect that their cultural values and beliefs are to be respected, all children whatever their religious or cultural background must receive the same care and safeguards with regard to abuse and neglect. Child abuse cannot be condoned for religious or cultural reasons."

Information Sharing/Communication

- 2.8 Staff should ensure that the information shared is necessary and proportionate, relevant, adequate, accurate, timely and shared only with those who need to see it. Information must be shared securely. See Information Sharing guidance in section 1.7 of this policy for further details.
- 2.9 The child's best interests must be the overriding consideration when making any decision regarding information sharing. Sharing of information amongst practitioners working with children and their families is essential. In many cases it is only when information from a range of sources is put together that a child can be seen to be in need or at risk of harm. Sharing of confidential information without consent is justified if there is evidence that a child may be suffering or is at risk of suffering significant harm, or if there is reasonable cause to believe this, or to prevent harm, or if failure to disclose information may expose the child or others to risk of death or serious harm. If in doubt seek advice from an USAIS safeguarding team member.
- 2.10 If it is believed that a child or young person seeking advice, for example on sexual matters, is being exploited or abused, they should be counselled with a view to gaining their permission to share information with another agency. The law recognises that disclosure of confidential information without consent or a court order may be justified in the public interest to prevent harm to others.
- 2.11 Information obtained from a source outside the USAIS (e.g. GP or Health Visitor, etc.) should not be disclosed to a third party, i.e. Children's Social Care or Police. Instead they should be advised to make direct contact with that professional.
- 2.12 Before faxing confidential information, a call must be made to ensure the recipient is in a position to receive it and to clarify the identity of the recipient. Receipt of the fax should then be confirmed by telephone.
- 2.13 Information sent via email must be encrypted/password protected.

Consent

Examination without consent may be held in law to be an assault.

- 2.14 Valid consent

- Must be informed
- Must be freely given
- Written consent is advisable if a child is brought, without parents, by any other person (e.g. if they inform you that verbal consent has been obtained); this should be recorded in the USAIS and hospital notes if surgery takes place
- Attendance at a medical examination usually implies consent, but permission should be sought from the parents and it is also good practice to ask the child
- As with consent, the discussion with the child will depend upon his or her age and understanding: it will be unnecessary with a small baby, good practice with a young child and essential with an older 'Gillick/Fraser Competent' child

2.15 Who can consent:

- A child of 16 years and over
- A child or young person who has the maturity and understanding to make a decision
- A person with parental responsibility
- A Court - if the child is subject to an interim care order, emergency protection order or child assessment order the court may give consent (the local authority will transmit the request).
- The local authority if they have joint parental responsibility
- (Child Protection Companion 2nd Edition 2013, P49, para 7.2.8)

2.16 Obtaining consent

A child or young person is deemed to have Gillick competence, and therefore the right to consent to investigation or treatment if they are able to:

- Understand the nature, purpose, benefits, risks and consequences of not proceeding
- Retain the information discussed
- Use and weight this information
- Communicate their decision to others

Capacity is based more on understanding than age.

Children aged under 10 years are usually, but not exclusively, deemed not competent to give consent. You should explain the information relating to the decision to the child and obtain parental consent from the person who holds parental responsibility (PR). If the consent is not possible, act in the best interest of the child.

Children and young people aged between 10 and 16 years have increasing levels of competency. You should explain the information relating to the decision to the child / young person and make an assessment of his or her capacity. It is important that the child / young person is not pressured, and the consent should be for specific purposes. It is good practice to obtain consent from both the child / young person and the person with PR.

Young people aged 16 and 17 years are usually able to consent themselves, although in certain circumstances, such as special educational needs (SEN), it is important to consider their capacity to consent.

(Child Protection Companion 2nd Edition 2013, P50, para 7.3)

2.17 Mental Capacity Act

The Mental Capacity Act (MCA, 2005) is designed to protect and empower individuals who may lack the mental capacity to make their own decisions about their care and treatment. It is a law that applies to individuals aged 16 and over, and in the context of this policy it is therefore relevant for those children between the ages of 16 and 18. If concerns are raised about a young person's ability to consent to or refuse treatment within USAIS, please refer to the USAIS Mental Capacity and Deprivation of Liberties policy on Sharepoint, and the link to the MCA in section 1.7 of this policy, for further information.

2.18 Situations where consent is withheld or not available:

- If a **person with PR is unavailable** to give consent, then the decision to proceed will depend upon the circumstances of the assessment, such as who has attended with the child and the risk posed to the child. You should consider involving others and seek advice, obtain consent from local authority and always act in the child's best interests. Document the process which you followed.

- A **young person with capacity to consent, who refuses**, should be respected. The young person may agree to a limited examination and the process must be adapted, meeting the young person's agreement. The clinician should offer information about the consequences of refusal and offer a further opportunity. Any risks to the child should be discussed with experienced colleagues, including the USAIS safeguarding team.
- If **one person with PR consents but another person who holds PR refuses** consent, you should consider the case in its entirety and if you decide the examination is in the child's best interest and/or there is a public interest then you should refer to the local authority to obtain consent by court order. Advice can be taken from senior colleagues and indemnity organisations. However, consent from one party with PR is enough.
- If the **local authority wishes an examination to take place but the person with PR refuses** to give consent, you should consider the case in its entirety and if you decide the examination is in the child's best interest and/or there is a public interest then you should refer to the local authority to obtain consent by court order. The local authority will need a court order to override the refusal of the party with PR.
- Refused consent for photography should be respected and documented.

(Child Protection Companion 2nd Edition 2013, P50, para 7.4)

Documentation

- 2.18** Good record keeping is an important part of the accountability of professionals and well-kept records provide an essential underpinning to good professional practice. Full accurate records of history, events, contacts, decisions and actions must be kept. Records must be clear, factual and objective, legibly signed, timed and dated. Opinions should be stated as such. Comments from the child, family or others should be clearly stated as quotations. Assessments made, decisions, interventions and plans must be carefully recorded.
- 2.19** The departmental notes (hard copies and electronic notes) are multi-disciplinary documents. These documents may be the primary source of information about the child's care in safeguarding cases and therefore all disciplines must record relevant information chronologically.
- 2.20** A clear picture of the family structure should be recorded with names of parents, carers, siblings and other household members, and a note of who has parental

responsibility.

- 2.21** All incidents witnessed on or off-site should be logged in the journal section of the department's database, under the heading 'welfare'. These notes should be timed and dated, and the staff members name should be clearly visible. Evidence of unusual injury and/or excessive bruising may be logged in the same manner, or a 'welfare' folder may be created in the electronic record. Please note, any urgent concerns must be telephoned immediately and then written up fully.
- 2.22** In all cases every attempt should be made to ascertain and document the child's own feelings, views, wishes and concerns to ensure that the child's voice is heard and taken account of.

Duty of Candour

- 2.23** Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 refers to the duty of candour. The duty of candour applies to all care providers that are regulated by the Care Quality Commission (CQC). The intention of this regulation is to ensure that providers are open and transparent with service users and other 'relevant persons' in relation to the care and treatment provided to them. It also sets out specific requirements that providers must adhere to when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. See section 1.7 for a link to the full guidance provided by the CQC in relation to the duty of candour.

3 RECOGNISING ABUSE

Children may be abused or neglected through the infliction of harm or through the failure to act to prevent harm. Abuse can occur within the family or in an institutional or community setting.

Abuse can occur within all social groups regardless of religion, culture, socio-economic status, financial position or educational attainment. Children may be abused by those known to them or, more rarely, by a stranger. They may be abused by an adult or another child.

Presentations

3.1 Child abuse or neglect may present in a number of ways

- A child may present openly for assessment or treatment of abuse (a non-accidental physical injury, neglect, emotional or sexual abuse)
- Abuse or neglect may be suspected as a cause of an injury, condition or presentation
- Concerns about abuse or neglect may develop while a child is being seen for an unrelated condition

- A child may be at risk from the behaviour or condition of an adult in the household; in this case it may be the adult who is the patient
- There may be concern about risk to an unborn child
- Staff may witness an incident of abuse or neglect to a child patient or other child attending the USAIS
- A child (or someone who knows them) may disclose that they have been abused
- An abuser may disclose a history of abuse to a child or children

3.2 The following may be indicators of concern:

When a child presents with an acute injury

- An explanation/history which is inconsistent and/or incompatible with an injury or presentation
- Several different explanations provided for a single injury or presentation
- Injuries of different ages
- Injury incompatible with the child's age/development/ability
- Unexplained delay in seeking treatment
- Parents/carers uninterested or undisturbed by accident or injury
- Parents absent without good reason when their child is presented for treatment
- Poor parent/carer-child interactions
- Poor parent/carer-staff interactions
- Repeated presentations of minor injuries (which may represent a 'cry for help' and if ignored could lead to a more serious injury, or may represent fabricated or induced illness)
- Repeated use of different doctors, A&E departments and other forms of direct health provision
- Reluctance to give information or mention previous injuries

Child-related indicators of abuse/neglect (not related to an acute injury)

- Non - organic failure to thrive/faltering growth
- Delay in achieving developmental, cognitive and/or other educational milestones over and above that expected due to hearing loss
- A child who is unkempt or inadequately clothed or dirty or smells
- A child who is perceived to be hungry frequently

- Behavioural signs may include a child seen to be listless, apathetic and unresponsive with no apparent medical cause, anxious, aggressive and indiscriminate friendliness
- Failure of child to grow or develop within normal expected pattern with accompanying weight loss or speech/language delay
- Recurrent/untreated infections or skin conditions e.g. severe nappy rash, eczema or persistent head lice/scabies
- Unmanaged/untreated health needs/medical conditions including ear infections, poor dental health
- Frequent accidents or injuries
- Child frequently absent or late at school
- Poor self esteem
- Child thrives away from home environment
- Bruising in children who are not independently mobile

Indicators related to the care provided

- Failure by parents/carers to meet the basic essential needs e.g. adequate food, clothes, warmth, hygiene
- Failure by parents/carers to meet the child's health and medical needs, dental health; failure to attend or keep appointments with health visitor, GP, hospital or USAIS; lack of GP registration; failure to seek or comply with appropriate medical treatment; failure to address parental substance misuse during pregnancy
- A dangerous or hazardous home environment including failure to use home safety equipment; risk from animals
- Poor state of home environment e.g. unhygienic facilities, lack of appropriate sleeping arrangements, inadequate ventilation (including passive smoking) and lack of adequate heating
- Lack of opportunities for child to play and learn
- Child left with adults who are intoxicated or violent
- Child abandoned or left alone for excessive periods

3.3 Categories of Abuse

Physical Abuse (see Appendix 1)

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 fabricates the symptoms of, or deliberately induces illness in a child.

Emotional Abuse (see Appendix 2)

Emotional abuse is the persistent emotional maltreatment of a child such as to cause severe and persistent effects on the child's emotional development, and may involve:

- Conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person;
- Imposing age or developmentally inappropriate expectations 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;
- Seeing or hearing the ill-treatment of another e.g. where there is domestic violence and abuse;
- Serious bullying, causing children frequently to feel frightened or in danger;
- Exploiting and corrupting children.

Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.

Sexual Abuse (see Appendix 3)

Recognition of sexual abuse can be difficult as there may be no physical signs and the indications of sexual abuse are most likely to be emotional / behavioural. Boys and girls of all ages may be sexually abused and are frequently frightened to say anything due to guilt and/or fear. The child may fear that s/he will not be believed and/or be fearful of the repercussions due to threats that have been made; this form of abuse is therefore particularly difficult for a child to talk about.

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 (e.g. rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing.

Sexual abuse includes non-contact activities, such as involving children in looking at, including online and with mobile phones, or in the production of, pornographic materials, watching sexual activities or 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.

In addition, sexual abuse includes abuse of children through sexual exploitation. Penetrative sex where one of the partners is under the age of 16 is illegal, although prosecution of similar age, consenting partners is not usual. However, where a child is under the age of 13 it is classified as rape under s5 Sexual Offences Act 2003.

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 misuse, maternal mental ill health or learning difficulties or a cluster of such issues. Where there is domestic abuse and violence towards a carer, the needs of the child may be neglected.

Once a child is born, neglect may involve a parent failing to:

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

Evidence of neglect is built up over a period of time and can cover different aspects of

parenting e.g. neglect of the child's physical needs possibly causing non-organic failure to thrive/faltering growth; neglect of the child's developmental needs which may contribute to cognitive delay; neglect of the child's emotional needs resulting in behavioural markers.

Fabricated or Induced Illness (FII; see Appendix 4)

FII is a form of abuse, not a medical condition. Previously known as Munchausen Syndrome by Proxy, this label applies to the child, not the perpetrator. The label is used to describe a form of child abuse. There is a spectrum of fabricated illness behaviour, and FII may co-exist with other types of child abuse and/or with a genuine pathology. The range of symptoms and systems involved is very wide and it is usually the parent or care giver who is the perpetrator. FII includes some cases of suffocation, non-accidental poisoning and sudden infant death.

Additional Categories of Abuse (see Appendix 5)

- Domestic Abuse
- Female Genital Mutilation
- Forced Marriage
- Honour Based Violence
- Modern Slavery
- Trafficked Children

4 RISK FACTORS FOR ABUSE

4.1 Abuse crosses all boundaries, but some children are at higher risk than others, due

to one or more of the following risk factors:

- Babies and very young children
- Socially excluded families
- Domestic violence
- Mental illness of parent/carer
- Drug or alcohol misuse
- Chronically ill or disabled children (including hearing loss)
- Parental learning disability
- Children who abuse others (0-18 years)

4.2 Younger children

The younger the child, the greater the likelihood of abuse. Babies are particularly vulnerable because of their small size, their total dependency on caregivers, and their inability to communicate verbally. The homicide rates in babies under one year are four times higher than any other age group.

4.3 Socially excluded families

These families may face chronic poverty, social isolation, racism and the problems associated with living in disadvantaged areas, such as high crime rates, poor housing, lack of childcare, poor transport and poor education services, and limited employment opportunities. Many lack a wage earner. Social exclusion can also have an indirect effect on children through its association with parental depression, learning disability and long-term physical health problems, all of which can impact negatively on parenting capacity.

4.4 Domestic violence

When there is domestic violence, the implications for children (including the unborn child if the victim is pregnant) in the household must be considered because research indicates a strong link between domestic violence and all types of abuse and neglect. Prolonged and/or regular exposure to domestic violence can have a serious impact on a child's development and emotional well-being, despite the best efforts of the victim's parent to protect the child. Families who are known to have issues can be referred for a multi-agency risk assessment conference (MARAC).

4.5 Mental illness of parent/carer

For the purposes of safeguarding children the mental health or mental illness of the parent or carer should be considered in the context of the impact of the illness on the care provided to the child. Mental illness in a parent or carer does not necessarily have an adverse impact on a child's developmental needs, but it is essential to always assess its implications for each child in the family.

4.6 Drug or alcohol misuse

Parental misuse of drugs or alcohol becomes relevant to child protection when the misuse of the substances impact on the care provided to their children. The effects on children are complex and require a thorough assessment. Children are particularly vulnerable when parents are withdrawing from drugs. The risk is greater when the adult's substance misuse is chaotic or otherwise out of control, and when both parents are involved. The risk is also greater where there is a dual diagnosis of mental health problems and substance misuse.

4.7 Chronically ill or disabled children

Disabled and chronically ill children may be especially vulnerable to abuse for a number of reasons, i.e. fewer outside contacts, communication difficulties, impaired capacity to resist, and the need to receive intimate personal care which may both increase the risk of exposure to abusive behaviour and make it more difficult to set and maintain physical boundaries. UK evidence suggests that disabled children are at increased risk of abuse and that the presence of multiple disabilities appears to increase the risk of both abuse and neglect. Where a disabled child has communication impairment or learning disabilities, special attention should be paid to communication needs and to ascertaining the child's perception of events and his/her wishes or feelings.

4.8 Parental learning disability

Where a parent has a learning disability it is important not to generalise or make assumptions about their parenting capacity. However, learning disabled parents may need support to develop the understanding, resources, skills and experience to meet the needs of their children. Such support is particularly needed where they experience additional stressors. It is these additional stressors, when combined with a learning disability, that are most likely to lead to concerns about the care a child or children may receive.

4.9 Children who abuse (up to 18 years)

Those who work with children and young people who abuse others- including

those who sexually abuse/offend – should recognise that such children are likely to have considerable needs themselves. Such children and young people are likely to be children-in-need and some will, in addition, be suffering, or at risk of suffering, significant harm and may themselves be in need of protection. They may, however, pose a significant risk of harm to other children, particularly in a hospital setting.

5 PROCESS

- 5.1** If actual or potential abuse or neglect is known or suspected a referral to Children's Social Care must be made by telephone by a member of the USAIS Safeguarding Team

within 24 hours. This referral is made to the Multiagency Safeguarding Hub (MASH), or the emergency duty team if the concern is raised out of office hours.

- 5.2 If you are unsure whether a referral to Children's Social Care is appropriate, you should discuss the child with the USAIS Safeguarding Lead or supporting safeguarding officers (or the MASH team/emergency duty team if no members of the USAIS Safeguarding Team are available).
- 5.3 Referrals to Children's Social Care should usually be made with the knowledge of the child's ENT Surgeon. However, if the Consultant is unavailable this should not delay the referral.
- 5.4 Referrals made verbally must be followed up in writing within 48 hours. Children's Social Care must acknowledge referrals within one working day of receipt of the written referral. If no acknowledgement is received within three working days, the referrer must contact Children's Social Care again.
- 5.5 Staff must be prepared to offer a prima facie opinion to the investigating social worker or to the police about the likelihood of abuse or neglect.
- 5.6 Professionals must always discuss the timing and the way parents/carers are told about the referral with the multi-agency child protection team in the first instance. In some cases, Police and/or Children's Social Care may decide not to inform the parents/carers until after a strategy meeting because of concerns about increased risk of significant harm especially in cases of sexual abuse and FII.
- 5.7 USAIS Staff must remember not to promise confidentiality to a child in case of a disclosure.
- 5.8 It is important that comprehensive information is given to families at the appropriate time and that they understand the implications of a referral to Children's Social Care. Where information regarding a strategy meeting is given to the family, the name of the consultant and the contact numbers of the relevant social work team should be given in writing to them at the time of that discussion.
- 5.9 From this point onwards Children's Social Care are responsible for taking the lead for the process of the child protection procedure. However, staff will need to contribute as

appropriate to any strategy discussion, investigation, child protection conference, child protection plan, reports and in some cases court proceedings.

- 5.10** “All doctors involved in the care of a child about whom there are concerns about possible deliberate harm must provide Children’s Social Care with a written report/statement of the nature and extent of their concerns. If misunderstandings of medical diagnosis occur, these must be corrected at the earliest opportunity in writing. It is the responsibility of the doctor to ensure that his or her concerns are properly understood.”

Initial child protection conference

- 5.11** A Child Protection Conference is held when the above enquiries indicate that the child may continue to suffer, or be at risk of suffering, significant harm. It should take place within 15 working days of the strategy discussion at which section 47 enquiries were initiated.
- 5.12** The purpose of the Child Protection Conference is to bring together the child (if of appropriate age), the family and those professionals most involved with the child and family following S47 enquiries. It provides them with an opportunity to exchange information, analyse risk, plan together and decide what further action is required to safeguard and promote the welfare of the child, how that action will be taken forward and with what intended outcomes.
- 5.13** Professionals attending a conference should have a significant contribution to make arising from their professional expertise, knowledge of the child or family, or both.
- 5.14** All professionals are expected to prepare their information in advance, and must provide a written report.
- 5.15** Parents, and if appropriate the child, will be present and it is good practice to ensure that opinions and concerns expressed in the report have previously been shared with the family, unless doing so would have placed the child at further risk.
- 5.16** Staff attending the conference are responsible for making a note of the outcome on the Safeguarding Pro-forma/medical notes, and informing team members of the protection plan.

5.17 When Child Protection Conference minutes are received by attendees they should be checked for accuracy and then the appropriate sections of the minutes are placed in the child's USAIS notes, typically in a password protected 'Welfare' folder.

Child Protection Core Group meeting (Planning meeting)

5.18 A core group of professionals meet with the family to agree a protection plan within 10 days of a child protection conference.

Review Child Protection Case Conferences

5.19 Attendees of the initial Child Protection Conference will be invited to the review. The USAIS Keyworker should attend, or arrange for another member of staff with current involvement to attend.

Requests for statements and reports from staff

5.20 All USAIS staff involved in the care of a child about whom there are concerns about actual or suspected abuse or neglect must provide the Police, Children's Social Care, Court, etc with a written report/statement of the nature and extent of their concerns and/or input to that child. If USAIS staff are asked to give statements to the Police or any other agency, the USAIS Safeguarding Team must be informed before the statement is given.

Contributing to Investigations and Reviews

5.21 USAIS has a statutory duty to contribute to the investigation of significant incidents and reviews including serious case reviews, domestic homicide reviews, and section 11 audits. In accordance with legal and statutory guidance the clinician may be required to provide clinical and professional records, and may be interviewed regarding their involvement in a case.

5.22 Staff will be offered the support of the USAIS Safeguarding Team throughout the process.

5.23 Staff should be made aware of the purpose of the review or investigation, and should be informed when the review is completed and of any learning points that have been identified.

Management of allegations against staff

5.24 This section should be followed whether the allegation is contemporary in nature, historical, or both. The statutory guidance applies to a wider range of allegations that might indicate that the alleged perpetrator is unsuitable to continue to work with children i.e.

- Behaved in a way that has harmed, or may have harmed, a child
- Possibly committed a criminal offence against, or related to, a child, or
- Behaved towards a child or children in a way that indicates that he or she is unsuitable to work with children.

5.25 If any allegation of abuse or neglect of a child is made it is not appropriate for the person who is the subject of the allegations to be made aware of the allegations or challenged at this stage.

5.26 Where an allegation of a safeguarding nature (ie. inappropriate behaviour, abuse or neglect) is made against a member of staff, the employer must inform the local authority designated officer (LADO) within one working day (<http://southamptonlscb.co.uk/workersandvolunteers/allegations/>). Depending on the nature of the situation the organization may need to respond to the allegation prior to discussion with the LADO, for example if immediate action is required. In accordance with the University's employment procedures, a full investigation into the circumstances will be carried out; it may be necessary to suspend the individual for their own protection until this is concluded.

5.27 The USAS Safeguarding Team and University of Southampton Legal Services must be informed of the situation at the earliest opportunity.

5.28 The matter may be referred following advice to Children's Social Care and the Police in the same way as another concern about possible abuse, and the allegations investigated under the child protection procedures.

6. ADDITIONAL CONSIDERATION FOR USAIS PATIENTS WITH DISABILITIES

6.1 UK evidence suggests that disabled children are at increased risk of abuse and that the presence of multiple disabilities appears to increase the risk of both abuse and neglect.

6.2 The disabled child with a hearing loss is especially vulnerable due to:

- Carers and staff lacking the ability to communicate adequately with the child
- Carers working in isolation

- Communication or learning difficulties preventing disclosure
- Bullying or intimidation (possibly because the child has to wear CI equipment)
- Abuse by peers (possibly because the child has to wear CI equipment)
- Fear of complaining in case services are withdrawn
- Some sex offenders may target disabled children in the belief that they are less likely to be detected

Essential Safeguards for Disabled Children

6.3 Safeguards for disabled children are essentially the same as for non-disabled children and should include enabling them to:

- Make their wishes and feelings known: in an audiology setting this will include the provision of appropriate communication support e.g British Sign Language interpreters, speech to text typist
- If a deaf child has communication difficulties, special attention should be paid to those needs. When a child is unable to tell someone of her/his abuse s/he might convey anxiety or distress in some other way e.g. behaviour or symptoms and staff must be alert to this
- Have access to more than one adult with whom they can communicate

7. ADDITIONAL CONSIDERATION FOR ALL USAIS PATIENTS

7.1 The children attending the USAIS for audiological services have various levels of hearing impairment and deafness (some patients are also deaf/blind). Thus it is sometimes necessary to touch a patient to gain their attention, remove their aids and/or attach test equipment such as electrodes or ear plugs. Cochlear implant wearers must be touched on their shoulder or elsewhere to alert them if their processor is to be removed.

- 7.2 Staff should only touch children as necessary for performing the clinical tasks. Staff are encouraged to gain permission from the child or from the parents before touching the child.
- 7.3 Wherever possible a member of staff should avoid being alone with a child.
- 7.4 If a child or vulnerable adult is seen in a room on their own with a member of staff, there must be an observation panel in the door, or the door should be left open. Another member of staff should be in the vicinity.
- 7.5 Repeated non-attendance for essential appointments is considered to be 'a neglect of medical needs'. Children's Social Care can take Court Action and make a 'Specific Issues Order' compelling the family to address the situation.

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Appendix 1 Physical Abuse

Bruising

- Bruising is the commonest injury in children who have been physically abused and can occur on any part of the body
- Children can have accidental bruising, but the following bruising may mean physical abuse has taken place. It is vital that a full history is taken and that the USAIS professional is satisfied that the history is compatible with the injury and any bruises/marks, etc, are documented in medical records

Patterns of bruising that are suggestive of physical abuse:

- Bruising in children who are not independently mobile
- Bruising in babies
- Bruises that are seen away from bony prominences
- Bruises to the face, back, abdomen, arms, buttocks, ears and hands
- Multiple bruises in clusters
- Multiple bruises of uniform shape
- Bruises that carry the imprint of implement used or a ligature.
- Grasp marks on small children, i.e. fingertip bruising on limbs, face and chest wall

The evidence is that the age of a bruise cannot be accurately estimated from an assessment of colour – either by a clinical assessment or a photograph

Bruising may not be easily noticeable or distinguishable when children have darker skins (black / ethnic groups). Greater vigilance is required in noticing other possible indicators of injury e.g. wincing or demeanour of the child

Differential diagnosis of bruising:

- Clotting disorders
- Skin diseases
- Birth marks

'Mongolian blue spots' closely resemble bruising. They are typically grey/blue pigmented areas over the lower back, trunk and limbs, and may be extensive. There is no over-lying damage or

palpable swelling. They remain essentially unchanged in the first year of life and progressively disappear in childhood

I. Oral injuries

The commonest injury to the mouth is laceration or bruising to the lips

The oral cavity must be examined in all cases of suspected physical abuse and, if any abnormalities found, seek a maxillofacial/dental opinion

A torn frenum - the flap of tissue in the midline under the upper lip - is highly suspicious in non-mobile children, but occurs accidentally amongst those who are mobile

II. Bite marks

Bite marks can leave clear impressions of the teeth. Human bite marks are oval or crescent shaped

III. Thermal injury (burns & scalds)

It can be difficult to distinguish between accidental and non-accidental burns and scalds. A history of the injury is vital and a second opinion should be sought. Characteristics of inflicted scalds:

- Majority inflicted scald injuries are with hot tap water
- Forced immersion scald injuries are commonest
- Scald margins have clear upper limits
- Scald is symmetrical and/or bilateral
- Skin fold sparing is found, e.g. in popliteal area or central sparing of buttocks
- Circumferential (glove or stocking distribution) scalds to upper or lower limbs
- Uniform scald depth found
- Usually lower limbs

Characteristics of inflicted non scald burns:

- Contact burns are the most commonly described non scald burns
- Intentional burns were most commonly reported on back, shoulders and/or

buttocks

- Intentional burns had sharply demarcated edges which could be matched to the specific implement in many cases.
- Circular burns from cigarettes are characteristically punched out lesions
- Friction burns resulting from being dragged
- Linear burns from hot metal rods or electrical fire elements
- Burns of uniform depth over a large area
- Old scars indicating previous burns / scalds which did not have appropriate treatment or adequate explanation
- Non scald burns can also be caused by open flames, hot ovens/microwaves and caustic agents

IV. Non accidental head injury (NAHI)

Head injury is the commonest cause of death in physical child abuse

A significant number of subdural haemorrhages caused by trauma, excluding perinatal injury, in children under 2 years old are inflicted. Infants with NAHI present to hospital with a variety of symptoms, including lethargy, vomiting, fits, respiratory difficulty to sudden death

V. Fractures

It takes considerable force to produce a fracture in a child or infant. All fractures require appropriate explanation and this must be consistent with the child's developmental age.

Non-mobile children rarely sustain fractures accidentally. The younger the child, the greater the likelihood of abuse.

See Appendix 4 for details

The following fractures are more suspicious of abuse:

- Humerus -Spiral fractures of the humerus are uncommon and strongly linked with abuse
- Multiple fractures -Multiple fractures are significantly commoner in abused children

- Rib fractures- Highly suspicious in abuse in the absence of major trauma or underlying bone disease
- Femur fractures-Suspicious, particularly in children who are not mobile
- Spinal fractures- Usually result from forced extension and flexion injuries
- Metaphyseal fractures- Outside the neonatal period, under the age of 2 years may indicate abuse
- Skull fractures- Skull fractures require considerable force. A linear parietal fracture is the commonest accidental and non-accidental fracture. Other skull fractures require a greater degree of force, which should be reflected in the history. A history of a fall less than 3 feet rarely produces a fracture

All children under 18 months with a fractured bone, or of any age where there is a concern, should be referred to their GP immediately

VI. Scars

A large number of scars or scars of different sizes or ages, or on different parts of the body, may suggest abuse

Appendix 2 Emotional Abuse

Children at risk of emotional abuse may be:

- Perceived as the wrong sex, unwanted, disabled, abused as child, rejected
- Seen as ill or difficult
- Born into difficult situations – marital difficulty, separation, violence
- Born to vulnerable parents – alcohol or drug abuse, depressed, mentally or otherwise ill

Recognition of emotional abuse is usually based on a series of observations over time

Parent / carer & child relationship factors

- Abnormal attachment between a child and parent / carer e.g. anxious, insecure or avoidant, indiscriminate or no attachment
- Indiscriminate attachment or failure to attach
- Conveying to children they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person e.g. persistent negative comments about the child or 'scape-goating' within the family
- Developmentally inappropriate or inconsistent expectations of the child which is outside what is considered reasonable and acceptable cultural / legal norms e.g. over-protection, limited exploration and learning, interactions beyond the child's developmental capability, prevention of normal social interaction
- Causing children to feel frightened or in danger e.g. witnessing domestic violence, seeing or hearing the ill treatment of another Child presentation concerns
- Behavioural problems e.g. aggression, attention seeking, hyperactivity, poor attention
- Frozen watchfulness, particularly in pre-school children
- Low self-esteem, lack of confidence, fearful, distressed, anxious
- Poor peer relationships including withdrawn or isolated behavior

Parent / carer related issues

- Dysfunctional family relationships including domestic violence
- Parental problems that may lead to lack of awareness of child's needs e.g. mental

illness, substance misuse, learning difficulties

- Parent or carer emotionally or psychologically distant from child
- Child not brought for appointments

Appendix 3 Sexual Abuse

Behavioural indicators of sexual abuse

Behavioural indicators of sexual abuse may include:

- Inappropriate sexualised behaviour with other children or adults
- Inappropriate sexual knowledge
- Sexually explicit behaviour, play or conversation, inappropriate to the child's age
- Continual and inappropriate or excessive masturbation
- Self-harm (including eating disorder), self-mutilation and suicide attempts
- Involvement in prostitution or indiscriminate choice of sexual partners
- An anxious unwillingness to remove clothes for sports events (but this may be related to cultural norms or physical difficulties)
- Running away
- Hyperactive
- Withdrawn
- Acting out/disruptive behaviour
- Aggression
- Decreased academic achievements

Physical indicators

- Sexually transmitted diseases
- Vaginal soreness or bleeding, perineal itching, soreness, pain on micturition, bleeding
- Pregnancy
- Bruises, scratches or other injuries to the genital or anal areas, insides of thighs, or to other "sexual" areas such as breasts and lips: these injuries may be minor but inconsistent with accidental injury
- Ano-genital warts
- Semen in vagina, anus or on external genitalia
- Recurrent urinary tract infections
- Recurrent abdominal pain, headaches or other psychosomatic features
- 'Eccentric' sexual patterns of family interaction without other observable or reported symptomology

Appendix 4 Fabricated or Induce Illness (FII)

There are three main and not mutually exclusive ways of the carer fabricating or inducing illness in a child:

- Fabrication of signs and symptoms, including fabrication of past medical history, fabrication of hearing loss
- Fabrication of signs and symptoms and falsification of hospital charts, records, letters, documents and specimens of bodily fluids
- Induction of illness by a variety of means

It may also involve influencing the health beliefs of others.

Harm to the child may be caused through unnecessary or invasive medical treatment, which may be harmful and possibly dangerous, based on symptoms that are falsely described or deliberately manufactured by the carer, and lack independent corroboration.

The child may additionally suffer emotional harm through limitations placed on her/his development and social interaction e.g. overprotection, limitation of exploration and learning, prevention from participation in normal social interaction and frequent hospital attendances.

Think of FII when:

- Inconsistent or unexplained symptoms and signs
- Poor response to treatment
- Unexplained or prolonged illness
- Different symptoms on resolution of previous ones, or over time
- Child's activities inappropriately restricted
- Parents/carers unable to be assured
- Problems only in the presence of parent/carer
- Erroneous or misleading information
- Family history of unexplained illness or death
- Exaggerated catastrophes or fabricated deaths.

Non-accidental head injury (NAHI)

Important features of NAHI:

Such injury arises from impact to the head or as a result of severe repetitive rotational injury with or without additional impact. Combinations of mechanisms frequently occur.

The consequences may include:

- Bruising/abrasions or lacerations to the head including scalp or face
- Skull fracture(s) usually with overlying haematoma
- Intracranial bleeding – subdural, subarachnoid or intraventricular/parenchymal, Extradural haemorrhage is rare
- Subdural collections are often bilateral, and common sites are over the convexity of the cerebral hemisphere, along the falx or in the posterior fossa. In the acute stage they are typically small and do not cause mass effect
- Brain injury – includes hypoxic - ischaemic injury and direct traumatic injury of the brain substance
- Retinal haemorrhage in one or more usually both eyes
- Neck and cervical spinal cord injury
- Skeletal injury – fractures of ribs where the child is grasped, long bone fractures when child is held, swung or limbs flail. Vertebral injury is rare
- Bruising to body or limb

Appendix 5 Additional Categories of Abuse and their Definitions (from Southampton LCSB; 4lscb procedures)

Domestic Abuse

The definition of domestic violence and abuse now includes young people aged 16 - 17 and aims to increase awareness that young people in this age group do experience domestic violence and abuse.

"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse:

- Psychological;
- Physical;
- Sexual;
- Financial;
- Emotional.

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."

This definition includes Honour Based Violence, Female Genital Mutilation (FGM) and Forced Marriage, and is clear that victims are not confined to one gender or ethnic group.

While the cross-government definition above applies to those aged 16 or above, 'Adolescent to parent violence and abuse' (APVA) can involve children under 16 as well as over 16 (see link in section 1.5 for more information).

Where there is domestic violence and abuse, the wellbeing of the children in the household must be promoted and all assessments must consider the need to safeguard the children, including unborn child/ren.

Female Genital Mutilation

Female genital mutilation (FGM) is a collective term for procedures, which include the removal of part or all of the external female genitalia for cultural or other non-therapeutic reasons. The practice is medically unnecessary, extremely painful and has serious health consequences, both at the time when the mutilation is carried out and in later life. The procedure is typically performed on girls aged between 4 and 13, but in some cases it is performed on new-born infants or on young women before marriage or pregnancy.

FGM has been a criminal offence in the U.K. since the Prohibition of Female Circumcision Act 1985 was passed. The Female Genital Mutilation Act 2003 replaced the 1985 Act and made it an offence for the first time for UK nationals, permanent or habitual UK residents to carry out FGM abroad, or to aid, abet, counsel or procure the carrying out of FGM abroad, even in countries where the practice is legal.

Forced Marriage

There is a clear difference between a forced marriage and an arranged marriage. In arranged marriages, the families of both spouses take a leading role in arranging the marriage but the choice of whether or not to accept the arrangement remains with the young people.

In a forced marriage, one or both spouses do not consent to the arrangement of the marriage and some elements of duress are involved. Duress can include physical, psychological, financial, sexual and emotional pressure. Forced Marriage is an abuse of human rights and, where a child is involved, an abuse of the rights of the child.

Forced marriage involving anyone under the age of 18 constitutes a form of child abuse. A child who is forced into marriage is likely to suffer Significant Harm through physical, sexual or emotional abuse. Forced marriage can have a negative impact on a child's health and development, and can also result in sexual violence including rape. If a child is forced to marry, he or she may be taken abroad for an extended period of time which could amount to child abduction. In addition, a child in such a situation would be absent from school resulting in the loss of educational opportunities, and possibly also future employment opportunities. Even if the child is not taken abroad, they are likely to be taken out of school so as to ensure that they do not talk about their situation with their peers.

Honour Based Violence

Honour based violence is a collection of practices, which are used to control behaviour within

families or other social groups to protect perceived cultural and religious beliefs and/or honour. Such violence can occur when perpetrators perceive that a relative has shamed the family and / or community by breaking their honour code.

For young victims it is a form of child abuse and a serious abuse of human rights.

It can be distinguished from other forms of violence, as it is often committed with some degree of approval and/or collusion from family and/or community members. Women, men and younger members of the family can all be involved in the abuse.

Modern Slavery

Modern slavery is a form of organised crime in which individuals including children and young people are treated as commodities and exploited for criminal gain. Traffickers and slave drivers trick, force and/or persuade children and parents to let them leave their homes.

Grooming methods are used to gain the trust of a child and their parents, e.g. the promise of a better life or education, which results in a life of abuse, servitude and inhumane treatment.

Child trafficking or child modern slavery is identified as child abuse which requires a child protection response. It is an abuse of human rights, and all children, irrespective of their immigration status, are entitled to protection under the law.

Children are recruited, moved or transported and then exploited, forced to work or sold.

Children are not considered able to give 'informed consent' to their own exploitation (including criminal exploitation), so it is not necessary to consider the means used for the exploitation - whether they were forced, coerced or deceived, i.e. a child's consent to being trafficked is irrelevant and it is not necessary to prove coercion or any other inducement.

Boys and girls of all ages are affected and can be trafficked into, within ('internal trafficking'), and out of the UK for many reasons and all forms of exploitation - e.g. sex trafficking - children can be groomed and sexually abused before being taken to other towns and cities where the sexual exploitation continues. Victims are forced into sexual acts for money, food or a place to stay. Other forms of slavery involve children who are forced to work, criminally exploited and forced into domestic servitude. Victims have been found in brothels or saunas, farms, in factories, nail bars, car washes, hotels and restaurants and commonly are exploited in cannabis cultivation. Criminal exploitation can involve young people as drug carriers, begging and pick-pocketing. Debt bondage (forced to work to pay off debts that realistically they will never be able to), organ harvesting and benefit fraud are other types of modern slavery.

Victims often face more than one type of abuse and slavery, for example they may be sold to

another trafficker and then forced into another form of exploitation.

Children and young people may be exploited by parents, carers or family members. Often the child or young person will not realise that family members are involved in the exploitation.

Trafficked Children

'Trafficking of persons' means the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. 'Exploitation' includes, at a minimum, sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs.

Trafficked victims are coerced or deceived by the person arranging their relocation. On arrival in the country of destination the trafficked child or person is denied their human rights and is forced into exploitation by the trafficker or person into whose control they are delivered.

A 'Child' refers to children and young persons aged up to 18.

Any Child transported for exploitative reasons is considered to be trafficked (whether or not they have been deceived) because it is not considered possible for children to give informed consent; so it is simply the movement of a child into and within a country in order to exploit them.

Guidance procedure

1. If you think a child is in immediate danger, call the emergency services on 999. Then call extension 3311 within the University to allow security to help direct the emergency services.
2. If you are concerned about the general health, welfare and safety of any child, but feel there is no immediate danger, discuss this with your designated Safeguarding Lead for Children:

Devyanee Bele
25990
d.bele@soton.ac.uk

3. If the designated Safeguarding Lead is not available, speak to one of the Safeguarding Officers

Louise Lee
24945
L.K.Lee@soton.ac.uk

Caroline Gamble
24975
c.gamble@soton.ac.uk

4. If your Safeguarding Officers are not available, and you do not feel that the matter can wait until a member of the safeguarding team becomes available, contact Southampton MASH (multiagency safeguarding hub).

Tel: 02380 832 300 (Professionals number)

Out of hours contact: 02380 233 344 (emergency duty team)

5. If the child is from a different area then you can still contact the Southampton MASH to ask for the contact number of the patient's local safeguarding organisation.