Doctors of the World

Child Safeguarding Policiesand Procedures

Version 11

The information in this document is proprietary to Doctors of the World and is supplied on the understanding that it shall not be copied, stored in a retrieval system, or transmitted in any form by any means, electronic, mechanical, photocopying, recording or otherwise, or supplied to a third party without the prior written consent of Doctors of the World.

Version: 11
Effective date 04/04/2023
Review date: 04/04/2025

Commercial in Confidence
When printed, this document is uncontrolled and should not be used without checking the current issue from a formally controlled document.

Child Safeguarding Policies and Procedures

TABLE OF CONTENTS

1 POLICY STATEMENT 3

2 DEFINITIONS 4

2.1 AT RISK GROUPS 4
2.2 TYPES OF ABUSE 5
2.3 UNBORN CHILDREN 5

3 PROCEDURE 6

3.1 PURPOSE AND AIMS 6
3.2 DUTIES AND RESPONSIBILITIES 7
3.3 FLOWCHART 9

4 MAKING A REFERRAL TO SOCIAL SERVICES 10

4.1 Early Intervention 11
4.2 PRE-BIRTH REFERRAL AND ASSESSMENT 12
4.3 CONCERNS ABOUT RESPONSES TO REFERRALS 12

5 ALLEGATIONS AGAINST STAFF OR VOLUNTEERS THAT WORK WITH CHILDREN 12

6 CAPACITY 13

APPENDIX A TYPES OF ABUSE 15

APPENDIX B RESPONDING TO DISCLOSURES OF ABUSE 20

APPENDIX C RESPONDING TO CONCERNS FROM MEMBERS OF THE PUBLIC 21

APPENDIX D USEFUL CONTACT DETAILS 22

APPENDIX E INCIDENT FORM FOR REPORTING SAFEGUARDING CONCERNS 23

Child Safeguarding Policies and Procedures

1 POLICY STATEMENT

In England the law states that people who work with children and young people have to keep them safe. This safeguarding legislation is set out in the 1989 and 2004 Children Acts in which a child or young person is anyone under the age of 18 years. It also features in the **United Nations Convention on the Rights of the Child** (to which the UK is a signatory) and sets out the rights of children to be free from abuse.

Doctors of the World UK (DOTW) believes that it is always unacceptable for a child or young person to experience harm or abuse of any kind and recognises its responsibility to safeguard the welfare of all children and young people, by a commitment to practice which protects them. We recognise that:

- The welfare of children and young people is paramount.
- All people, regardless of age, disability, gender, racial heritage, religious belief, sexual orientation or identity, have the right to equal protection from all types of harm or abuse.
- Working in partnership with children and young people, parents, carers and other agencies is essential in promoting children and young people's welfare.
- It is the responsibility of all adults to safeguard and promote the welfare of children and young people. This responsibility extends to a duty of care for those adults employed, commissioned or contracted to work with children and young people.
- Some children are additionally vulnerable because of the impact of previous experiences, their level of dependency, communication needs or other issues
- Extra safeguards may be needed to keep children who are additionally vulnerable safe from abuse.

This policy refers to all children under the age of 18 years as well as to unborn children and will be updated every two years (or sooner if national guidelines are updated).

This policy applies to all DOTW staff, volunteers and trustees.

This policy should will be reviewed every two years in conjunction with the **London Safeguarding Children Procedures** (all subsections hyperlink to online guidance for more information) and, where neccessary the following legislation and guidance relevant tosafeguarding and promoting the welfare of children:

Children Act 1989 and 2004

Working Together to Safeguard Children – statutory guidance
This guidance highlights the role of voluntary, charity, social enterprise (VCSE) and private sector organisations and agencies in safeguarding children through the services they deliver (see page 71).

Promoting the Health and Wellbeing of Looked After Children – statutory guidance (2015)

Safeguarding children and young people: roles and competences for health care staff - RCN intercollegiate document

The Female Genital Mutilation Act 2003 amended by the Serious Crime Act 2015

Child Sexual Exploitation - Definition and Guide for Practitioners February 2017

Care of Unaccompanied Migrant and Trafficked Children - Statutory guidance for local authorities November 2017

2 DEFINITIONS

Safeguarding is defined under the Children Act (2004) as:

- promoting the welfare of children
- protecting children from maltreatment through abuse or neglect
- preventing impairment of a child's health or development
- ensuring children grow up in circumstances consistent with the provision of safe and effective care that enables them to have optimum life chances and enter adulthood successfully.

Significant harm - the Children Act 1989 introduced this concept as the threshold that justifies compulsory intervention in family life in the best interests of children, and gives local authorities (LA) a duty to make enquiries (**Section 47**) to decide whether they should take action. Significant harm also includes "impairment suffered from seeing or hearing the ill treatment of another", e.g in cases of domestic abuse.

Child Protection refers to the activity that is undertaken to protect children who are suffering or at risk of suffering significant harm. All agencies and individuals should be proactive in safeguarding and promoting the welfare of children.

Child in Need is defined in the Children Act (2004) as 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. Children with a new or enduring significant disability are also defined as a child in need.

Child Abuse is when a child is intentionally harmed by an adult or another child – it can be over a period of time but can also be a one-off action. It can be physical, sexual or emotional and it can happen in person or online. It can also be a lack of love, care and attention – this is neglect.

2.1 AT RISK GROUPS

Staff and Volunteers should be alert to the potential need for early help for a child who:

- is disabled and has specific additional needs
- has special educational needs (whether or not they have a statutory Education, Health and Care Plan)
- is unaccompanied or in a private foster care arrangement[1]

[1] Private fostering occurs when a child under the age of 16 (under 18, if disabled) is provided with care and

- is a young carer
- is showing signs of being drawn into anti-social or criminal behaviour, including gang involvement and association with organised crime groups
- is frequently missing/goes missing from care or from home
- is at risk of modern slavery, trafficking or exploitation
- is at risk of being radicalised or exploited
- is in a family circumstance presenting challenges for the child, such as drug and alcohol misuse, adult mental health issues and domestic abuse
- is misusing drugs or alcohol themselves
- has returned home to their family from care

2.2 TYPES OF ABUSE

The main categories of child abuse are:

- Physical abuse
- Sexual abuse
- Emotional abuse
- Neglect/failure to thrive
- Domestic abuse in relation to child abuse
- Child sexual exploitation
- Child trafficking
- Bullying and Cyberbullying
- Grooming
- FGM
- Online abuse

These are not exclusive however, and abuse in one of these areas may easily be accompanied by abuse in the others. These are detailed in **Appendix A.**

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

- Disclosure by a child or young person
- Physical signs and symptoms giving rise to suspicion of any category of abuse
- The child has an injury for which the explanation seems inconsistent or which has not been adequately treated
- The history is inconsistent or changes
- A delay in seeking medical help
- Extreme or worrying behaviour of a child, taking account of the developmental age of the child
- Accumulation of minor incidents giving rise to a level of concern, including frequent A&E and unscheduled care attendances

accommodation by a person who is not a parent, person with parental responsibility for them or a relative in their own home. A child is not privately fostered if the person caring for and accommodating them has done so for less than 28 days and does not intend to do so for longer

- Girls under 16 presenting with pregnancy or sexually transmitted disease or requesting contraception, especially emergency contraception

2.3 UNBORN CHILDREN

In some circumstances, agencies or individuals are able to anticipate the likelihood of significant harm with regard to an expected baby (e.g. domestic violence, parental substance misuse or mental ill health).

These concerns should be addressed as early as possible before the birth, so that a full assessment can be undertaken and support offered to enable the parent/s (wherever possible) to provide safe care. See Referral and Assessment Procedure, Pre-birth and Pre-birth conference.

Risk factors that may help to identify whether an unborn child may be a risk of significant harm may include:
Where mothers, fathers or partners or any other significant member of the household:

- Are involved in risk activities such as substance misuse, including drugs and alcohol;
- Have perinatal/mental illness or support needs that may present a risk to the unborn baby or indicate their needs may not be met;
- Are victims or perpetrators of domestic abuse (domestic abuse may start or get worse when a woman is pregnant);
- Have been identified as presenting a risk, or potential risk, to children, such as having committed a crime against children;
- Have a history of violent behaviours;
- Are not able to meet the unborn baby's needs e.g. significant learning difficulties and in some circumstances severe physical or mental disability;
- Are known because of historical concerns such as previous neglect, other children subject to a child protection plan, subject to legal proceedings or have been removed from parental care;
- Are known because of parental involvement as a child or adult with Children's Social Care;
- Are currently 'Looked After' themselves or were looked after as a child or young person;
- Are teenage/young parents;
- Are living in poor home conditions, homelessness or temporary housing;
- Any other circumstances or issues that give rise to concern.

3 PROCEDURE

3.1 PURPOSE AND AIMS

This document outlines the procedure that all Doctors of the World staff (including senior managers, the board of trustees and anyone working on behalf of DOTW) and volunteers are expected to follow to protect children and young people from abuse. All DOTW staff and volunteers must respond actively, promptly and in a coordinated way to allegations or suspicions of abuse or neglect that come to their notice. This includes a duty to report concerns of a child protection nature and a duty to cooperate with those agencies empowered to investigate such concerns and support plans to safeguard the welfare of the child(ren).

This policy aims to:

- protect children from maltreatment.
- prevent impairment of children's health or development;
- ensure that children grow up in circumstances consistent with the provision of safe and effective care; and

- take action to enable all children to have the best outcomes

We will seek to safeguard people by:

- Valuing them, listening to and respecting them
- Adopting child protection guidelines through procedures and a code of conduct for staff and volunteers
- Recruiting staff and volunteers safely, ensuring all necessary checks are made, including DBS checks, references and professional registration.
- Sharing information about child protection and good practice with service users, children, parents, staff and volunteers
- Sharing information about concerns with agencies who need to know, and involving service users, parents and children appropriately
- Providing effective management for staff and volunteers through supervision, support and training.

These guidelines are based on, and should be viewed in conjunction with, the 7th edition of the **London Safeguarding Children Procedures.** It should be noted that **services outside London refer to their local procedure when required.**

Doctors of the World staff and volunteers should not attempt to investigate a child protection matter as it may compromise any possible legal proceedings. There is a need only to establish sufficient details and information for a decision to be made about making a referral.

It is vital that any concerns are reported as soon as possible. Doctors of the World staff and volunteers have no powers to detain a child or to refuse to release a child to the parent/carer. If you are concerned, please discuss withthe Nominated or Deputy Safeguarding Leads who can discuss with the Police/Social Services.

3.2 DUTIES AND RESPONSIBILITIES

Board/Governance Lead

The Board Governance lead will report safeguarding children's activity, risks and/or achievements to the board. They will advise the board and make recommendations on how to meet safeguarding responsibilities in the development anddelivery of the organisation.

Executive Director

The Executive Director has overall accountability for implementation of this policy ensuring that staff receive appropriate support and resources in fulfilling their safeguarding duties creating a culture where all staff feel comfortable and confident that all expressions of concern or allegations/disclosures are taken seriously and are responded to appropriately regardless of the source of information. They will ensure that staff are supported in the event of an allegation of abuse.

Nominated/Deputy Leads for Safeguarding

The Safeguarding Leads are responsible for ensuring child safeguarding is an integral part of the operational delivery and governance arrangements for DOTW. They provide advice to all staff and volunteers on safeguarding issues. They provide oversight and reporting safeguarding children's activity, risks and/or achievements to the Safety and Quality meeting.

Managers and Clinic Supervisors

Managers are those individuals who have line management responsibility for other members of staff within the organisation. Clinic Supervisors are those who have responsibility for volunteers within DOTW's clinic settings. Managers and Clinic Supervisors have a duty to support clinic staff and/or volunteers who raise issues of concern or are involved in the investigation process. They are responsible for ensuring compliance with training, reporting concerns and that their staff are confident and competent in the area of safeguarding.

HR and Volunteer Recruitment teams

DOTW's HR and volunteer recruitment team will ensure that DOTW staff with direct service delivery responsibilities and volunteers are DBS checked in line with national recommendations for healthcare staff. They will also ensure that volunteers and staff are up to date with appropriate levels of safeguarding training.

All DOTW staff and volunteers

DOTW emphasises that safeguarding is everyone's responsibility, and that all staff, whether permanent, temporary or agency and all volunteers have an important role and a duty, outlined in law, to ensure that they safeguard and promote the welfare of children and young people. This policy applies to all staff groups working within DOTW and from individuals or from a third party. Safeguarding considerations are part of the assessment of all children and young people consulting DOTW, whether by telephone, or by attendance.

All staff and volunteers within their working role should be able to recognise any child where there is a safeguarding concern and respond appropriately. All staff and volunteers will be able to access and follow the agreed safeguarding guidance, procedures and advice in order to protect children and fully comply with all aspects of their responsibility. All staff and volunteers should understand the principles of information sharing when children are in need or at risk and refer to the appropriate agency within appropriate timescales. The timing of such referrals should reflect the levelof perceived risk of harm. In urgent situations or out of hours, the referral should be made immediately to the Local Authority duty social worker.

Staff members and volunteers should be encouraged to report their concerns. It is particularly important that people should not feel intimidated about discussing concerns that do not appear to have been taken up by the Supervisor or Safeguarding Leads. No member of staff or volunteer should be victimised or suffer adversely for reporting concerns. This also applies where there are concerns that a member of staff may have perpetrated abuse.

Training

There is a staged approach to training, with different staff being required to undertake training at different levels, dependent on the degree of contact or likelihood of contact with children and families.

There are 3 levels of child protection training required for the organisation. The level at which staff are required to attend depends on their role within the organisation. This is in line with the Local Safeguarding Children's Board.

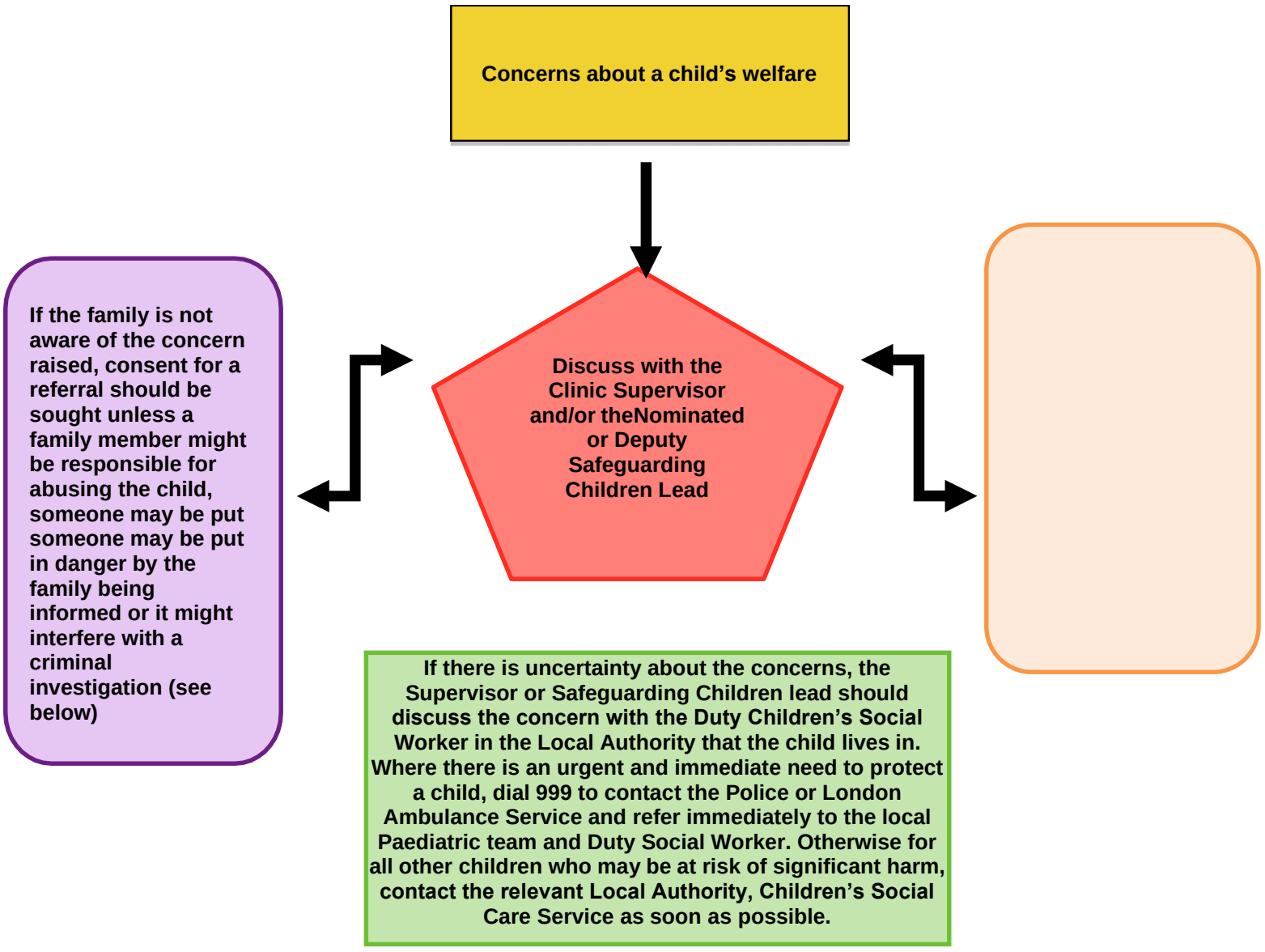
Level 1 provides a general awareness of Safeguarding. It includes possible signs and symptoms of abuse and neglect, individual responsibilities and internal procedures. All non-clinical volunteers access this training during their induction, provided by DOTW either face to face or through e-learning.

Level 2 focuses on the documentation relating to Safeguarding. It includes making referrals to external agencies, using the common assessment framework for assessment of children in need. In addition, issues relating to the legislative

requirements, factors affecting parenting capacity and threshold criteria are covered.

Level 3 –covers the principles of Working Together to identify, assess and meet the needs of children, Serious Case Reviews and Child Death overview panels, as well as vulnerable groups including domestic violence, substance misuse, mental illness and learning disabilities, children at risk of Female Genital Mutilation and Child Sexual Exploitation. All clinicians should attend an update every three years. All UK staff responsible for supervising DOTW's clinic services and all volunteer clinicians are required to be trained to level 3.

3.3 FLOWCHART



The following matters will always be investigated by the police:

- All alleged sexual assaults;
- Allegations of physical abuse amounting to offences of actual bodily harm (*s47 Offences Against the Person Act 1861*) and more serious assaults;
- Allegations of serious neglect / cruelty;
- Allegations and concerns involving minor offences where there are aggravating features.

Parental consultation

Where practicable, concerns should be discussed with the parent or carer and agreement sought for a referral to LA children's social care unless seeking agreement is likely to place the child at risk of significant harm through delay or the parent's actions or reactions, for example, in circumstances where there are concerns that a serious crime such as sexual abuse or induced illness has taken place.

If the decision is made not to seek parental permission before making a referral, the decision must be recorded in the child's file with reasons, dated and confirmed in the referral to LA children's social care.

A child protection referral cannot be treated as anonymous, so the parent will ultimately become aware of the identity of the referrer. Where the parent refuses to give permission for the referral, unless it would cause undue delay, further advice should be sought from the Nominated or Deputy Safeguarding Leads and the outcome fully recorded.

If, having taken full account of the parents' wishes it is still considered that there is a need for referral:

- The reason for proceeding without parental agreement must be recorded;
- The parent's withholding of permission must form part of the verbal and written referral to Children's Social Services for the borough that the child/young person lives in.
- The parent should be contacted (if considered safe to do so for the child) to inform them that, after considering their wishes, a referral has been made.

Sharing information and GDPR

The GDPR and Data Protection Act 2018 do not prevent, or limit, the sharing of information for the purpose of keeping children and young people safe. See: Information sharing advice for safeguarding practitioners July 2018.

4 MAKING A REFERRAL TO SOCIAL SERVICES

Referrals should always be in writing unless a child is at immediate risk of significant harm. In these circumstances, referrals should be made by telephone without delay to the Duty Children's Social Worker for the Local Authority in which the child resides, and a written referral sent within 48 hours. The referrer should outline their concerns and will be asked to provide information to explain what they are concerned about and why. **The referrer should not refrain from or delay making a referral because they lack some of the information as the welfare of the child is the priority.**

The Local Authority (LA) may ask that you complete their referral form. The form should be completed as fully as possibleand sent securely by encrypted email as soon as possible and within 48 hours of a verbal referral, and then uploaded onto the service user's DOTW case file. Receipt of the referral by the LA should be confirmed within 48

hours.

If there is no LA form, the following information should be included in referral letters if available:

- Full names (including aliases and spelling variations), date of birth and gender of all children and other members of the household.
- Family address and (where relevant) school / nursery attended
- Identity of those with parental responsibility
- Where available, the child's NHS number and education UPN number
- Ethnicity, first language and religion of children and parents
- Any special needs of children or parents
- Any significant / important recent or non-recent (historical) events / incidents in child or family's life
- Cause for concern including details of any allegations, their sources, timing and location.
- Child's current location and emotional and physical condition
- Whether the child needs immediate protection
- Details of alleged perpetrator, if relevant
- Referrer's DOTW designation and DOTW contact details.

LA children's social care should **within one working day** of receiving the referral make a decision about the type of response that will be required to meet the needs of the child. If this does not occur within three working days, the referrer should contact these services again and, if necessary, ask to speak to a line manager to establish progress. Doctors of the World staff and volunteers must keep a written record of all events in the SU's case file and in all cases an incident form must be completed via DOTW's incident reporting system**.** All safeguarding cases will be reviewed at DOTW's quarterly Safety and Quality meeting.

In some individual project instances, DOTW may hold working relationships with safeguarding representatives in local authorities. To achieve the swiftest possible outcome for a child, DOTW may make referrals through these routes. However, such referrals should always be followed up with a written referral to the LA through the correct referral channels, and followed up in accordance with this policy.

The referrer should document on the DOTW database:

- All discussions with the child
- All discussions with the parents/carers
- All relevant discussions with their managers
- Information provided to LA children's social care
- Decisions and actions taken (with time and date clearly noted, and name as signature)
- If the Nominated/Deputy Safeguarding Lead decides that it is not a child protection matter, but early intervention support is still required, an incident form for the episode must be filled in online.

4.1 EARLY HELP

Early help, also known as early intervention, is support given to a family when a problem first emerges. It can be provided at any stage in a child or young person's life.

Statutory guidance highlights the importance of providing early intervention, rather than waiting until a child or family's situation escalates (Department for Education (DfE), 2018; Department of Health, Social Services and Public Safety,

2017; Scottish Government, 2021; Wales Safeguarding Procedures Project Board, 2020).

Doctors of the World will assess a child's circumstances during a social consultation. Where additional needs or concerns are identified (for e.g., support with school enrollment), these should be shared with the Supervisor or Nominated/Deputy Safeguarding Lead who will consider all the available information and decide whether a referral should be made to the local authority Early help team.

4.2 PRE-BIRTH REFERRAL AND ASSESSMENT

Where agencies or individuals anticipate that prospective parents may need support services to care for their baby or that the unborn baby may have suffered, or be likely to suffer, significant harm, a referral to LA children's social care must be made as soon as the concerns are identified. See Section 2.3.

4.3 CONCERNS ABOUT RESPONSES TO REFERRALS

Where a situation is acute and a practical response from Children's Social Care is not forthcoming then the referrer can contact the **Police Child Abuse Investigation Team**. The Police Child Abuse Investigation Team will then contact the Advice & Assessment Team in Children's Social Care to discuss the matter and how it should be dealt with. In caseof any difficulty and the referrer is unsure what to do then they should call the Duty Social Worker for further assistance and escalate concerns with Nominated/Deputy Safeguarding Leads.

If you are worried about the initial response and feel a different response is needed, then please escalate your concerns. Where there is particular concern about the progress of cases involving allegations against members of staffthen you should contact the Local Authority Designated Officer – LADO for that Local Authority (see Appendix D).

If the referral relates to an Unaccompanied Minor, the clinic supervisor can call the NSPCC Helpline and Childline Service, whose team of social workers have statutory powers and may be able to follow up with the LA directly to ensure the correct process is being followed.

DOTW has a safe recruitment policy but in the event of any allegation or concern that any person (staff or volunteer) has:

- Possibly committed a criminal offence against or related to a child;
- Behaved in a way that has harmed a child, or may have harmed a child;
- Behaved towards a child or children in a way that indicates he or she would pose a risk of harm if they work with children.

These behaviours should be considered within the context of the categories of abuse as defined in Appendix 1. These include concerns relating to inappropriate relationships between members of staff andchildren or young people, for example:

- Having a sexual relationship with a child under 18 if in a position of trust in respect of that child, even if consensual (see ss16-19 Sexual Offences Act 2003);
- 'Grooming', i.e. meeting a child under 16 with intent to commit a relevant offence (see s15 Sexual Offences

Act 2003);
- Other 'grooming' behaviour giving rise to concerns of a broader child protection nature (e.g. inappropriate text / e-mail messages or images, gifts, socializing etc);
- Possession of indecent photographs / pseudo-photographs of children.

Then this should be reported as soon as possible to DOTW's Executive Director, and if not available, the Head of UK Services by email. DOTW must inform the local authority Designated Officer (LADO) within one working day when an allegation is made and prior to any further investigation taking place.

The Designated Officer will advise DOTW whether or not informing the parents of the child/ren involved will impede the disciplinary or investigative processes. Acting on this advice, if it is agreed that the information can be fully or partially shared, the DOTW should inform the parent/s. In some circumstances, however, the parent/s may need to be told straight away (e.g. if a child is injured and requires medical treatment).

The parent/s and the child, if sufficiently mature, should be helped to understand the processes involved and be kept informed about the progress of the case and of the outcome where there is no criminal prosecution. This will include the outcome of any disciplinary process, but not the deliberations of, or the information used in, a hearing.

The employer should seek advice from the Designated Officer, the police and / or LA children's social care about how much information should be disclosed to the accused person.

Subject to restrictions on the information that can be shared, DOTW should, as soon as possible, inform the accused person about the nature of the allegation, how enquiries will be conducted and the possible outcome (e.g. disciplinary action, and dismissal or referral to the DBS or regulatory body).

The accused member of staff should:
- Be treated fairly and honestly and helped to understand the concerns expressed and processes involved
- Be kept informed of the progress and outcome of any investigation and the implications for any disciplinary or related process
- If suspended, be kept up to date about events in the workplace

Every effort should be made to maintain confidentiality and guard against publicity while an allegation is being investigated or considered. Apart from keeping the child, parents and accused person (where this would not place the child at further risk) up to date with progress of the case, information should be restricted to those who have a need to know in order to protect children, facilitate enquiries, manage related disciplinary or suitability processes.

6 CAPACITY

In UK law, a person's 18th birthday draws the line between childhood and adulthood (Children Act 1989 s105), so in health care, an 18 year old enjoys as much autonomy as any other adult. To a more limited extent, 16 and 17 year-olds can also take medical decisions independently of their parents.

The right of younger children to provide independent consent is proportionate to their competence; a child's age alone is clearly an unreliable predictor of his or her competence to make decisions. Young people aged 16 or 17 are presumed in UK law, like adults, to have the capacity to consent to medical treatment. However, unlike adults, their refusal of treatment can, in some circumstances, be overridden by a parent, someone with parental responsibility or a court. However, parents cannot override consent or refusal from a competent 16/17-year-old. Neither can they consent on behalf of their competent 16/17-year-old.

The Mental Capacity Act (MCA) 2005 applies to children 16 years and over. Mental capacity is present if a person can understand information given to them, retain the information given to them long enough to make a decision, can weigh up the advantages and disadvantages of the proposed course of treatment in order to make a decision, and can communicate their decision.

If there are reasons to believe a child aged 16 or over lacks capacity, an assessment of capacity to consent should be conducted and recorded in their notes. See the GMC Guidance on Mental Capacity and the BMA Mental Capacity Act Toolkit for further details.

The Liberty Protection Safeguards provide protection for people aged 16 and above who are or who need to be deprived of their liberty in order to enable their care or treatment and lack the mental capacity to consent to their arrangements.

Children under 16

Children under 16 may be competent to consent to treatment (**Gillick competence**) and records should show that this has been assessed before starting treatment. Parents cannot override a competent child's refusal to accept treatment. Where a competent child under 16 refuses a specific treatment which is in their best interests, but the parents support the recommendation for treatment, there should be evidence of that providers have attempted to understand both the child's and parents' position. There should also be evidence that alternative treatments have been considered or a compromise is not possible. However, ultimately the decision rests with the competent child.

The routine assessment of competence in under 16s should be appropriate to the child's age. For example, routine assessments of competence would not be expected in the case of eight and nine-year-olds but would be more usual for children aged 14 and 15. Where treatment is going ahead on thebasis of parental consent, records should show that the person(s) holding parental responsibility and legally capable ofconsenting on behalf of the child has been identified.

Consent to treatment

Evidence that valid consent to treatment has been obtained should always be recorded. Valid consent to treatment means that the medical professional has given the child and/or those with parental responsibility appropriate information about the purpose and nature of treatment, including any risks and any alternatives.

Evidence in the record, or gathered at interview, may include:

- Giving children and parents information about the reason for and nature of the treatment.
- Giving child-friendly information leaflets about different treatments and what they involve.
- Asking children for their views about treatment before starting treatment.
- Discussing with the child and/or parents other options available and the advantages/disadvantages of each option.

Where the child is deemed to be **Gillick competent**, and they are able to give consent to treatment, it is still good practice to provide parents with information and this should be documented in the clinical record. The extent of information shared should be discussed with the child and their agreement sought.

Where there are safeguarding concerns, information may need to be shared with parents in the absence of agreement.

Where a child is **not Gillick competent** and a parent(s) is consenting to treatment on their behalf, parent(s) must be given information about the nature and purpose of treatment and this must be documented in the clinical record.

Treatment refusal: where the child/parent refuses treatment, there should be evidence in the records that risks have been considered and explored. This includes whether refusal may result in significant harm to the child and that safeguarding concerns have been considered.

In an emergency situation, when a person with parental responsibility is not available to consent the child's best interests must be considered and treatment limited to what is reasonably required to deal with the particular emergency.

CQC Brief Guide Capacity and Consent in under 18s.

APPENDIX A TYPES OF ABUSE

PHYSICAL ABUSE

Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or causing physical harm in any other way to a child. These may be single traumatic events or repeated incidents.

Physical harm may also be caused when a parent fabricates the symptoms of, or deliberately causes illness in a child.

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

Sexual abuse also includes non-contact activities, such as involving children in looking at or in the production of pornographic materials, encouraging children to behave in sexually inappropriate ways or grooming a child in preparation for abuse.

Sexual abuse can be perpetrated by men, women and other children.

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**.

CHILD SEXUAL EXPLOITATION

Child sexual exploitation (CSE) is a type of sexual abuse. When a child or young person is exploited they're given things, like gifts, drugs, money, status and affection, in exchange for performing sexual activities. Children and young people are often tricked into believing they're in a loving and consensual relationship. This is called grooming. They may trust their abuser and not understand that they're being abused.

Children and young people can be trafficked into or within the UK to be sexually exploited. They're moved around the country and abused by being forced to take part in sexual activities, often with more than one person. Young people in gangs can also be sexually exploited.

Sometimes abusers use violence and intimidation to frighten or force a child or young person, making them feel as if they've no choice. They may lend them large sums of money they know can't be repaid or use financial abuse to control them.

Anybody can be a perpetrator of CSE, no matter their age, gender or race. The relationship could be framed as friendship, someone to look up to or romantic. Children and young people who are exploited may also be used to 'find' or coerce others to join groups.

CHILD TRAFFICKING

Trafficking is where children and young people tricked, forced or persuaded to leave their homes and are moved or transported and then exploited, forced to work or sold. Children are trafficked for:

- sexual exploitation
- benefit fraud
- forced marriage
- domestic slavery like cleaning, cooking and childcare
- forced labour in factories or agriculture
- committing crimes, like begging, theft, working on cannabis farms or moving drugs.

Trafficked children experience many types of abuse and neglect. Traffickers use physical, sexual and emotional abuse as a form of control. Children and young people are also likely to be physically and emotionally neglected and may be sexually exploited.

EMOTIONAL ABUSE

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;
- Serious bullying, causing children frequently to feel frightened or in danger, or the exploitation or corruption of children;

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

NEGLECT

Neglect is the persistent failure to meet a child's basic physical and / or psychological needs, likely to result in serious impairment of a child's health or development.

Neglect may occur during pregnancy as a result of maternal substance misuse or maternal mental ill health. 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 caregivers); Ensure access to appropriate medical care or treatment.
- It may also include neglect of, or unresponsiveness to, a child's basic emotional, social and educational needs.

CRIMINAL EXPLOITATIONS AND GANGS

Children and young people involved with gangs and criminal exploitation need help and support. They might be victims of violence or pressured into doing things like stealing or carrying drugs or weapons. They might be abused, exploited and put into dangerous situations.

FEMALE GENITAL MUTILATION (FGM)

FGM is when a female's genitals are deliberately altered or removed for non-medical reasons. It's also known as 'female circumcision' or 'cutting' but has many other names.

FGM is a form of child abuse. It's dangerous and a criminal offence in the UK. We know:

- there are no medical reasons to carry out FGM
- it iss often performed by someone with no medical training, using instruments such as knives, scalpels, scissors, glass or razor blades
- children are rarely given anaesthetic or antiseptic treatment and are often forcibly restrained
- is used to control female sexuality and can cause long-lasting damage to physical and emotional health.

FGM can happen at different times in a girl or woman's life, including:

- when a baby is new-born
- during childhood or as a teenager
- just before marriage
- during pregnancy.

GROOMING

Grooming is when someone builds a relationship, trust and emotional connection with a child or young person so they can manipulate, exploit and abuse them.

Children and young people who are groomed can be sexually abused, exploited or trafficked. Anybody can be a groomer, no matter their age, gender or race. Grooming can take place over a short or long period of time – from weeks to years. Groomers may also build a relationship with the young person's family or friends to make them seem trustworthy or authoritative.

Children and young people can be groomed online, in person or both – by a stranger or someone they know. This could be a family member, a friend or someone who has targeted them – like a teacher, faith group leader or sports coach. When a child is groomed online, groomers may hide who they are by sending photos or videos of other people. Sometimes this will be of someone younger than them to gain the trust of a "peer". They might target one child online or contact lots of children very quickly and wait for them to respond.

ONLINE ABUSE

Online abuse is any type of abuse that happens on the internet. It can happen across any device that's connected to the web, like computers, tablets and mobile phones. And it can happen anywhere online, including:

- social media
- text messages and messaging apps
- emails
- online chats
- online gaming
- live-streaming sites.

Children can be at risk of online abuse from people they know or from strangers. It might be part of other abuse which is taking place offline, like bullying or grooming. Or the abuse might only happen online.

FORCED MARRIAGE

A forced marriage is where one or both people do not or cannot consent to the marriage and pressure or abuse is used to force them into the marriage. It is also when anything is done to make someone marry before they turn 18, even if there is no pressure or abuse.

Forced marriage is illegal in the UK. It is a form of domestic abuse and a serious abuse of human rights.
The pressure put on people to marry against their will may be:

- physical: for example, threats, physical violence or sexual violence
- emotional and psychological: for example, making someone feel like they are bringing ‘shame’ on their family

- Financial abuse, for example taking someone's wages, may also be a factor.

DOMESTIC ABUSE IN RELATION TO CHILD ABUSE

Included in the categories of child abuse and neglect above, are a number of factors relating to the behaviour ofthe parents and carers which have significant impact on children such as domestic violence. Children can be affectedby seeing, hearing and living with domestic violence and abuse as well as being caught up in any incidents directly, whether to protect someone or as a target. The Home Office definition of domestic violence and abuse was updated in March 2013 as:

"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence and abuse between those aged 16 or over, who are or have been intimate partners or family members regardless of gender and sexuality."

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.

BULLYING AND CYBERBULLYING

Bullying is behaviour that hurts someone else. It includes name calling, hitting, pushing, spreading rumours, threatening or undermining someone.

It can happen anywhere – at school, at home or online. It's usually repeated over a long period of time and can hurt a child both physically and emotionally.

Cyberbullying is bullying that takes place online. Unlike bullying offline, online bullying can follow the child wherever they go, via social networks, gaming and mobile phone.

APPENDIX B RESPONDING TO DISCLOSURES OF ABUSE

Talking to someone who has told you that they or another individual are being abused

Whenever a child reports that they are suffering or have suffered significant harm through abuse or neglect, or have caused or are causing physical or sexual harm to others, the initial response from all staff and volunteers should be limited to listening carefully to what the child says to:

- Clarify the concerns;
- Offer re-assurance about how the child will be kept safe;
- Explain what action will be taken.
-

The child must not be pressed for information, led or cross-examined or given false assurances of absolute confidentiality, as this could prejudice police investigations, especially in cases of sexual abuse.

If the child can understand the significance and consequences of making a referral to Local Authority children's social care, they should be asked their view. However, it should be explained to the child that whilst their view will be taken into account, we have a responsibility to take whatever action is required to ensure the child's safety and the safety of other children.

APPENDIX C RESPONDING TO CONCERNS FROM MEMBERS OF THE PUBLIC

Responding to concerns from members of the public

When a member of the public telephones or approaches any volunteer or staff with concerns, about the welfare of a child or an unborn baby, the staff or volunteer should always:

- Gather as much information as possible, to be able to make a judgment about the seriousness of the concerns;

- Take basic details:
    - Name, address, gender and date of birth of child;
    - Name and contact details for parent/s, educational setting (e.g. nursery, school), primary medical practitioner (e.g. GP practice), professionals providing other services, a lead professional for the child.

Discuss the case with their Supervisor and/or Nominated/Deputy Safeguarding Lead to decide whether to:

- Make a referral to LA children's social care;
- Make a referral to the lead professional at social services, if the case known to social care;
- Make a referral to a specialist agency or professional e.g. educational psychologist or a speech and language therapist;
- Undertake an assessment.

Record the referral contemporaneously, with the detail of information received and given, separating out fact from opinion as far as possible.

The member of the public should also be given the number for their local LA children's social care and be encouraged to contact them directly. The agency receiving the initial concern should **always** make a referral to LA children's social care and to the lead professional if there is one, in case the member of the public does not follow through (a common occurrence).

If there is a risk that the member of the public will disengage without giving sufficient information to enable agencies to investigate concerns about a child, the **NSPCC national 24 hour Child Protection Helpline (0808 800 5000)** and **Childline (0800 1111)** can be offered as an alternative means of reporting concerns. See **Roles and Responsibilities Procedure, NSPCC.**

Individuals may prefer not to give their name to LA children's social care or NSPCC. Alternatively, they may disclose their identity, but not wish for it to be revealed to the parent/s of the child concerned.

Wherever possible, staff and volunteers should respect the referrer's request for anonymity. However, there should be no guarantees of confidentiality, as there are certain limited circumstances in which the identity of a referrer may have to be given (e.g. the court arena).

Commercial in Confidence
When printed, this document is uncontrolled and should not be used without checking the current issue from a formally controlled document.

Child Safeguarding Policies and Procedures

APPENDIX D

USEFUL CONTACT DETAILS

Nominated Safeguarding Lead	Amardeep Kamboz (Head of Services) 020 7078 9629 AKamboz@doctorsoftheworld.org.uk (Head of Services)
Trustee Governance Lead	Hannah Theodorou; hannah.theodorou@doctors.org.uk
Deputy Safeguarding Lead / Advisers	Rita D'Alessio; rdalessio@doctorsoftheworld.org.uk (Senior Lead – Clinic and Remote Services) Durga Sivasathiaseelan: dsiva@doctorsoftheworld.org.uk (Senior Lead - Outreach)
Clinic Safeguarding Champions	Valentina D'Orazio (Volunteer and Remote Services Lead) vdorazio@doctorsoftheworld.org.uk Annie Reeve (Women and Children's Project Lead) areeve@doctorsoftheworld.org.uk Katherine Taylor (GP Clinical Lead) ktaylor@doctorsoftheworld.org.uk Roxsan Hussain (Clinic and Helpline Coordinator) rhussain@doctorsoftheworld.org.uk
London - Local Authority Children's Social Care	Find up to date details of each LA's Children's Social Care Team online
NSPCC Helpline:	0808 800 5000 or help@nspcc.org.uk
ChildLine	0800 1111
Forced Marriage Unit	020 7008 0151
24-hour FGM helpline	0800 028 3550

LADOs (Local Authority Designated Officer)

A Local Authority Designated Officer (LADO) works within each Local Authority area and is there to support staff across all organisations who work with children and young people if any concerns arise regarding any practitioner who works with children and young people.
The LADO should be alerted to all cases in which it is alleged that 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 a child/children

If a practitioner has concerns regarding the conduct of a colleague then they should in the first instance report this to the Designated Safeguarding Lead within their own organisation, who is required by law to report this concern to the LADO. However, it is important to note that anyone can contact the LADO if they need to do so for advice or support, especially if concerns are regarding the conduct with children and young people of management or holistic organisational practice.

Newham LADO: Nick Pratt and Alex Mihu lado@newham.gov.uk
Tower Hamlets LADO: Melanie Benzie LADO@towerhamlets.gov.uk

Every Local Authority has a LADO, their contact details can be quickly found online, or by contacting the relevant Local Authority directly.

Version: 10.1
Effective date 02/01/2022
Review date: 01/03/2023

Commercial in Confidence
When printed, this document is uncontrolled and should not be used without checking the current issue from a formally controlled document.

Child Safeguarding Policies and Procedures

APPENDIX E INCIDENT FORM FOR REPORTING SAFEGUARDING CONCERNS

Incident forms can be found online here

Incident Forms

Once logged, incidents should be reviewed by the appropriate person (Clinical Lead or Programme Manager) within one week.

*Required

Date of incident *

Date

Age

Your answer

Location
London Clinic
Mobile
Canary Wharf
Other:

UK Number

Your answer

Type of incident *

Version: 10.1
Effective date 02/01/2022
Review date: 01/03/2023

Commercial in Confidence
When printed, this document is uncontrolled and should not be used without checking the current issue from a formally controlled document.

Child Safeguarding Policies and Procedures

Urgent Referral (case referred directly from the clinic to NHS services e.g. A&E, UCC, as clinical need for same day review; or an urgent GP appointment if 2 week wait referral considered necessary). Please then email the clinical lead (Katherine - ktaylor@doctorsoftheworld.org.uk) to inform them an incident has been logged.)

Clinical Incident (case in which a person did or may have come to harm as a result of receiving care under DOTW) Please then email the Head of Services and Clinical Lead (ktaylor@doctorsoftheworld.org.uk, Akamboz@doctorsoftheworld.org.uk), who will pass on to other managers and clinical representative on board.

Operational incidents (any incident related to operational processes, e.g. data recording errors, breaches of confidentiality, health & safety etc.). Please then email the UK Head of Services (Amar AKamboz@doctorsoftheworld.org.uk) to make them aware an incident has been logged.

Safeguarding (case that involves children or vulnerable people at risk of harm discussed with Social Services and/or other relevant agencies) Please then email the UK Head of Services (Amar AKamboz@doctorsoftheworld.org.uk) to make them aware an incident has been logged

Data request (request to edit or delete records). Please email the UK Head of Services (Amar AKamboz@doctorsoftheworld.org.uk) to make them aware.

Infection Prevention Control. Please email the UK Head of Services (Amar AKamboz@doctorsoftheworld.org.uk) to make them aware.

Volunteer Name

Your answer

Coordinator Name

Your answer

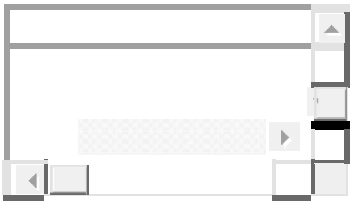
What happened?

Your answer

Child Safeguarding Policies and Procedures

What was the response?

Your answer



Date follow up needed

Date

Submit

Never submit passwords through Google Forms.