SAFEGUARDING CHILDREN POLICY & PROCEDURES

Version 1.4
Updated 03/02/22
Review Date: 03/02/24

Safeguarding Children Policy

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1. Introduction

1.1 Quad Medical Limited and its staff have a moral, professional and legal responsibility to safeguard its service user from harm. This policy establishes a framework to support staff in their practices and clarify the organisations expectations.

1.2 As a Care Quality Commission regulated company Quad Medical Limited have a duty to safeguard children and promote their welfare which includes:

- Protecting them from maltreatment or things that are bad for their health or development.
- Making sure they grow up in circumstances that allow safe and effective care.

1.3 This policy offers a mechanism (and separate practice guidance) to enable QML staff to raise any concerns which are then reported to the appropriate agencies, usually the Local Authority Children's Services Department, for consideration of further action. Children's Services and the Metropolitan Police (MPS) have statutory authority and responsibility to investigate allegations or suspicions about child abuse or neglect.

2. Scope

2.1 This policy applies to all staff and contractors that work for, in conjunction with Quad Medical Limited and who cares for children/young people or who comes into contact with children and young people up to the age of 18 years in the course of their work. Adherence to this policy/ procedure is the responsibility of all staff employed by QML. This policy/procedure also includes patients and the children of patients who are cared for by QML.

3. Objectives

3.1 To ensure that all QML employees and contractors are aware of their duties to uphold the welfare and rights of children and young people and fulfil their professional responsibilities to take action to prevent them from experiencing neglect, harm or abuse.

3.2. To ensure that all QML employees and contractors can recognise the signs of suspected neglect, harm or abuse and know how to record and report it in a timely manner.

4. Responsibilities

4.1 It is the responsibility of the safeguarding lead and the deputy safeguarding lead to:

- Identify clear lines of accountability
- Foster a culture within the organisation of listening to children and taking into account wishes and feelings
- Share information in an appropriate and timely manner
- Support other professionals in their agencies for safeguarding
- Ensure safe recruitment
- Provide appropriate support for staff
- Communicate with and collaborate with other professionals

4.2 The Safeguarding lead and the deputy safeguarding lead also have a responsibility to ensure that everyone is trained appropriately and that the training is updated at least every three years.

4.3 The Safeguarding lead and the deputy safeguarding lead are responsible for creating, disseminating, storing and maintaining key files and documents such as safeguarding procedures, policies and referrals and ensuring that they are up to date.

4.4 It is the responsibility of all QML staff and subcontractors to ensure they are up to date with their mandatory training and have read and understood QML's policies and procedures

4.5 It is the responsibility of QML staff and subcontractors to observe service users and raise safeguarding concerns with the safeguarding lead and to document their observations. It is also their responsibility to when necessary complete a formal safeguarding referral

4.6 It is the responsibility of the safeguarding lead and deputy safeguarding lead to listen to concerns raised by staff and to action any formal safeguarding concerns that have been submitted

4.7 The safeguarding lead and the deputy safeguarding lead must feedback the outcome of staff referrals to external agencies

4.8 The management team must recognise that there is a potential for emotional and psychological stress on staff members when raising and dealing with safeguarding issues and should provide reassurance and support to all staff that submit safeguarding referrals or raise safeguarding concerns. In some cases it may be necessary to attend meetings with the individual who is involved. It is important to

ask the individual what their preferences are in regard to on-going support. You may need to refer them for counselling or suggest leave if they are distressed.

4.9 It is the responsibility of the managing director and quality assurance manager to ensure that all members of staff have enhanced Disclosure and barring checks in place

4.10 It is the responsibility of the Local Authority to act as the lead agency with in coordinating the safeguarding children's process once a formal notification has been made through multiagency procedures.

5. Key Principles

5.1 Key Principles All children deserve the opportunity to achieve their full potential. In 2003, the Government published the Every Child Matters Green Paper alongside the formal response to the report into the death of Victoria Climbié. The Green Paper set out five outcomes that are key to children and young people's wellbeing:

6. Types and indicators of abuse

5.1There are four categories of child abuse. They are defined in the UK Government guidance Working Together to Safeguard Children 2010 as follows:

- Physical abuse
- Emotional abuse
- Sexual abuse
- Neglect

Bullying is not defined as a form of abuse in Working Together but there is clear evidence that it is abusive and will include at least one, if not two, three or all four, of the defined categories of abuse.

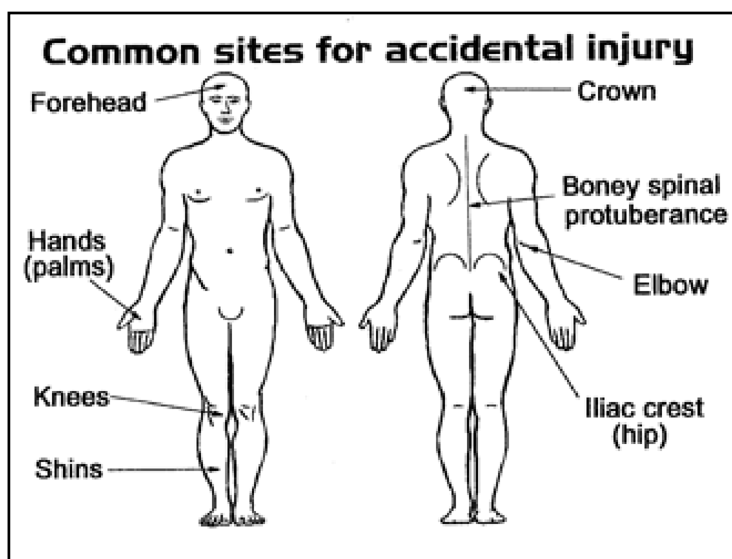
7. Identifying concerns

7.1 There are a wide range of indicators that may lead QML staff and subcontractors to be concerned that a patient may be being harmed or abused. The presence of one or more indicators does not confirm abuse but may indicate a need for further assessment. These may come to the attention of QML staff in a number of ways:

- They may witness poor practice, patient care or abuse
- They may be told about possible harm or abuse by another care provider, a colleague, a family member, the patient or another person
- They may identify a concern from a health care assessment or review of clinical information
- They may make observations about a person's behaviour or symptoms that lead them to suspect harm or abuse

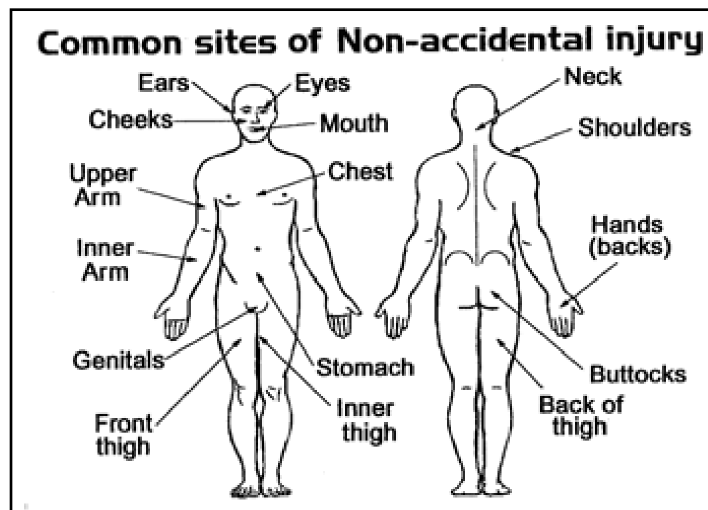
8. Signs of harm/abuse

8.1 Physical Abuse: We can all get cuts and bruises during our everyday life and these can also be part of a child's normal development. This can make it difficult to ascertain if an individual is being physically abused. When injuries have occurred it's always important to listen to what the individual tells you, if they are able to tell you. You need to consider if their story matches with the nature of the injuries and all other available information before reaching a conclusion.



8.2 Indicators of Physical Abuse (Non-Accidental Injuries) may include:

- Injuries in unusual positions which it's hard to explain the nature of i.e. back, chest, torso, buttocks, neck, behind ears, inside thighs, face, head, genitals, back of hand
- Injuries inconsistent with the age, abilities or lifestyle of the individual
- Finger marks, slap marks, bites, fractures, abrasions, lacerations, burns and scalds
- Damage to the mouth such as burnt, bruised or cut lips, torn or bruised skin where the upper lip joins the mouth
- Clusters of injuries forming regular patterns
- Injuries at different stages of healing
- Object marks, clear outlines of objects
- Medication misuse
- The individual appears frightened
- An explanation of injuries is avoided or inconsistent (injured individual and/or family/carer)
- Delay in seeking treatment for injuries
- The individual behaving aggressively towards others



8.3 Psychological/Emotional Abuse: This type of abuse can be harder to detect than the other types of abuse and may need to be assessed over a period of time through monitoring the individual's behaviour with the responses of parents, carers, friends or family towards that individual. Due to the brief interactions that QML staff has with its patients it may be more appropriate to consider referral of children suspected of this type of abuse for more extensive observation.

Indicators of Emotional Abuse might include:

- Physical, mental and emotional developmental delays
- Needy or clingy
- Difficulty with genuine trust, intimacy and affection
- Negative, hopeless and negative view of self, family and society
- Lack of empathy, compassion and remorse
- Low self-esteem, deference and resignation
- Change in appetite
- Extremes of passivity and aggression
- Poor concentration
- Difficulty making friends
- Sudden speech disorders
- Unexplained fear, defensiveness, ambivalence
- Emotional withdrawal
- Sleep disturbance
- Carer constantly rejects and ignores the individual, depriving them of responsiveness and stimulation
- Carer isolates the individual and prevents them building relationships and making friends
- Carer shows little warmth and affection towards the individual
- Carer constantly criticises or humiliates the individual and appears unable to give praise

8.4 It is also important to consider the possibility of bullying and racism within the context of emotional harm. It may involve causing children to feel frightened or in danger which can include children living with domestic violence or an individual subjected to witnessing the ill treatment of another. For this reason if an adult presents with safeguarding issues it is essential to establish if these impact on any children in their lives. For example a child may not be subject to physical abuse directly but may witness an adult being abused. Due to the psychological and emotional impact this can have on a child it is then pertinent to complete a safeguarding referral for the child.

8.5 Sexual Abuse: Some children and adults at risk of harm are sexually abused from a very early age and may not know it's wrong until they are older, but even then they may not say anything due to feelings of guilt. They may experience threats from the perpetrator and they may also feel it's their own fault for not saying anything sooner. It may be the child's behaviour which initially alerts QML staff to the possibility that they may be being sexually abused. Evidence suggests that this type of abusive relationship is developed over time and that children and sometimes even the protective adults are 'groomed' by the perpetrator. There may be concerns observed about perpetrators behaviour, for example, making inappropriate or sexual comments to an individual.

- A detailed sexual knowledge inappropriate to the age and developmental stage of the individual
- Sexually explicit language/behaviour
- Increased frequency of visits to the toilet, bed wetting
- Behaviour that is excessively affectionate or sexual towards others
- A fear of medical examinations
- A fear of being alone
- Sudden loss of appetite, compulsive eating, anorexia nervosa or bulimia nervosa
- Excessive masturbation
- Sexual approaches or assaults on others
- Concerning behaviours by adults, for example, unusual interest in a specific child, individual or 'grooming' behaviour
- Unexplained gifts or new possessions
- Going missing from home or education
- Changes in mood or sudden withdrawal from activities
- Older boyfriends or girlfriends or relationships where there is a difference in power
- Urinary tract infections, sexually transmitted diseases and infections
- Bruising to the buttocks, lower abdomen thighs, and genitals and other rectal areas. Bruises may be confined to grip marks where an individual has been held so that abuse can take place
- Significant change in sexual behaviour or attitude
- Pregnancy
- Unusual difficulty walking or sitting
- Torn, stained bloody underclothing
- Drawing pornographic or sexually explicit images or writing about the same.
- Depression
- Low self esteem

8.6 Neglect and Acts of Omission: refers to a combination of factors which may develop quickly or over a period of time. It may not always be immediately obvious as everyone has different standards of living. An individual may experience neglect due to the family being in poverty and the carer being unable to provide adequate care. Neglect may also occur within a health or social care setting. It can also arise when an individual is forced to take on caring responsibilities beyond their capability. However, neglect may also be inflicted purposely and on one specific individual in a family. Long term, sustained neglect is damaging emotionally, socially and educationally and is likely to cause far more developmental delays and medical impairments than any other form of abuse.

Some Indicators of Neglect and Acts of Omission:

- Failure to thrive
- Constant hunger and/or tiredness, malnutrition, steals food
- Poor hygiene
- Frequent accidental injuries and illnesses
- Untreated medical problems
- Developmental delays
- Poor state of clothing
- Unable to make friends, lack of social relationships
- Low self esteem
- Treated differently to others by their carer/family
- Carer/family appears stressed and unable to cope
- Physical condition of individual is poor e.g. bed sores, unwashed, ulcers
- Inadequate physical environment
- Inadequate heating
- Failure to give prescribed medication
- Failure to provide access to key services such as health care, dentistry, prostheses

8.7 Recognising abuse can be very complex; some indicators are really obvious whilst others are not so obvious. The Children Act 1989 states that abuse should be considered to have happened when someone's actions have caused a child to suffer significant harm to their health or development, or is likely to. Significant harm being defined as any form of abuse, neglect, accident or injury that is sufficiently serious to adversely affect progress and enjoyment of life. Harm is defined as the ill treatment or impairment of health and development. Some individuals will go to great lengths to try to hide any possible signs that something is wrong. This can make the identification process even more difficult. It is not the responsibility of the QML staff to investigate or draw conclusions from signs of abuse but rather to be mindful of the forms and presentations of harm/abuse and to observe and document what they see and to inform their safeguarding lead. Equally staff should not rule out harm and abuse purely on assumptions that there are other explanations.

8.8 QML's position is that doing nothing is not an option. If there is any doubt then an alert should be raised. An alert does not confirm abuse or constitute a formal referral to full external multiagency safeguarding teams.

9. Raising Alerts

9.1 Any member of staff who identifies a concern that a patient may be at high risk of harm or is being abused should ensure that the duty manager and safe guarding lead/ deputy lead are aware of the situation. They must also document their concerns on a children's & young person's safeguarding form

9.2 The safeguarding lead or deputy lead will review the alert and arising actions to ensure the safety of the patient and determine whether a referral should be made to the local multi-agency safeguarding team. In the absences of the safeguarding lead or deputy safeguarding lead the QML duty manager will assume this role and make decisions with the safeguarding lead and deputy safeguarding lead over the phone.

9.3 If a criminal offence is suspected, the event security should be notified immediately to offer assistance to keep the patient safe and the police called

9.4 If the concern is related to an incident arising within the QML team, the referral is scrutinised by the Safeguarding lead, and an adverse incident is also logged when appropriate. Appropriate actions are taken following QML's Incident reporting Policy, as well as consideration as to whether further safeguarding procedures are necessary.

9.5 In all circumstances of concern, a Safeguarding form is completed and sent to the Safeguarding lead via the duty manager. This does not constitute a formal referral to multiagency adult safeguarding procedures.

9.6 If there is a concern that the patient is at immediate risk of harm, protection requirements must be identified and implemented as appropriate.

The appropriate level of protection for an individual will be determined at local level, with management approval and support from the QML safeguarding lead and deputy lead, as needed. The protection plan will be clearly documented and communicated to the healthcare team who are caring for the patient.

10. Safeguarding, alcohol and recreational drug use

10.1 All children under 18year olds who are intoxicated or under the influence of recreational drugs need to have a prehospital assessment by a registered healthcare professional. Where there is no physical need for hospitalisation the legal parent or guardian must be contacted to inform them of the patient's presentation and to arrange safe transport home.

In all cases of discovering a patient is under 18 years of age at an over 18 event, the following principles need to be considered:

- If a patient is intoxicated or under the influence of recreational drugs. The duty manager and clinical lead should be informed to assess the child's health needs.

- The safeguarding or deputy safeguarding lead need to be informed.

- The patient should be supervised at all times

- An assessment of the patients welfare needs to be made, to consider the vulnerabilities of the child or young person based on their specific circumstances.

- If a child or young persons immediate safety are in danger then the police will be called.

- Parents or guardians of the child or young person should be contacted at the earliest opportunity and informed of their whereabouts. A safe way to transport the child or young person off of the event site and home should be agreed.

- The parents or guardians need to be made aware that a safeguarding referral will be made to ensure that the child or young person has access to local services.

- If in doubt support should be sought at the time from the safeguarding or deputy safeguarding lead.

- It is not necessary to criminalise individuals and our prime concern is for the welfare of the child or young person. If a crime is suspected due consideration should be given to the need to inform the police.

- A patient intoxicated or under the influence of recreational drugs under 18 years of age cannot be discharged into the community unaccompanied. A responsible adult, ideally a parent or legal guardian, must be contacted and asked to collect the patient.

- All demographic details must be captured on the PRF including the patient's name, address, contact number, school or college, GP and next-of-kin name and contact number. If it is not possible to establish the information this must be declared on the PRF. The patient's age must be communicated to all other clinicians who are subsequently involved in the patient's care including receiving hospitals.

10.2 Situations where adults who are intoxicated or under the influence of recreational drugs and who are supervising minors (under 18) need additional safeguarding consideration. It is against the law to be drunk and in charge of a child under seven years of age in a public place or on licensed premises. Nevertheless safeguarding needs to be at the top of the assessment process in all such cases and the welfare of the child needs to be considered as part of the assessment. Clinicians need to evidence that they have considered the needs of the child on the PRF and what action has been taken. It would be appropriate to complete a safeguarding form on behalf of the child in all cases where the child is under seven. It is considered best practice to refer in cases where the child is older than seven unless there was absolute clarity on the circumstances. If in doubt, advice can be sought at the time from the safeguarding lead.

11. Allegations against staff

11.1 When an allegation is made about a member of staff the QML will invoke the disciplinary procedure in line with Working Together to Safeguard Children guidance. The Safeguarding lead will refer the concern to the Local Authority Designated Officer. The managing director has a responsibility to ensure that the appropriate course of action is taken without delay, giving consideration to the following:

1. Consider referring to the police if the abuse suspected is a crime.

2. Make sure that other patients are not at risk.

3. Staff suspected of abusing a child or young person will be managed in accordance with the companies disciplinary procedure.

4. Ensure that any staff who have potentially caused risk or harm are not in contact with patients and others who may be at risk, for example, whistle blowers.

5. Inform the member of staff as they have a right to know in broad terms what allegations or concerns have been made about them.

6. Consider raising the allegation as a Serious Incident.

8. Maintain a high level of confidentiality.

12. Referrals requiring external agencies

12.1 Usually the decision whether to make a formal referral to external multiagency safeguarding children and young person's team will be made by the safeguarding lead, if appropriate. They will initiate a review and screening of the case to ascertain facts and (where possible) the likelihood of the allegation.

12.2 In cases where the safeguarding concern has arisen due to the actions or care given by QML staff, the Safeguarding lead or deputy safeguarding lead will grade the notification to establish if significant harm has occurred. In instances where there has been significant harm QML's regulating body the CQC shall be notified and the incident report policy initiated.

12.3 If a formal referral to external multiagency Safeguarding Adults teams is required the safeguarding lead shall contact the patient's local safeguarding children's board

13. Record and Report

13.1The outcomes of all safeguarding processes must be recorded appropriately (following QML's guidance on consent, record keeping)

13.2 Sharing the right information, at the right time with the right people, is fundamental to good safeguarding practice, but it has been highlighted as a difficult area of practice. The Care Act 2014 Section 45 'supply of information' duty xiii covers the responsibilities of others to comply with requests for information. Sharing information between organisations as part of day-to-day safeguarding practice is already covered in the common law duty of confidentiality, the Data Protection Act 1998 xiv, the Human Rights Act 1998 xv and the Crime and Disorder Act 1998 xvi. As a general principal people QML staff assume it is their responsibility to raise a safeguarding concern if they believe an adult at risk is suffering or likely to suffer abuse or neglect, and/or are a risk to themselves or another, rather than assume someone else will do so. They should share the information with the local authority and/or the police if they believe or suspect that a crime has been committed or that the individual is immediately at risk. Helpful guidance is set out in the Caldicott principles.

13.3 The Caldicott Committee Report on the review of patient-identifiable information recognises the need for disclosure in the best interest of the patient and discusses the appropriate circumstances and the safeguards to be observed. The principles that have not been covered elsewhere in this policy are summarised as follows:

- Information will only be shared on a 'need to know' basis when it is in the best interest of the person concerned.

- Confidentiality must not be confused with secrecy.

- It is inappropriate for agencies to give assurances of absolute confidentiality in cases where there are concerns about abuse, particularly in those situations where other vulnerable people may be at risk.

- Decisions about who needs to know and what needs to be known should be taken on a case by case basis.

- If it is necessary to email confidential information, the information must be attached to the email within an encrypted, password protected document, such as a Microsoft Word document. (Please note that when working with Microsoft Word documents, password protecting the document leads to the document being encrypted.) Passwords must then be sent in a separate email to the recipient.

- Child safeguarding records should be kept until the child's 25th birthday

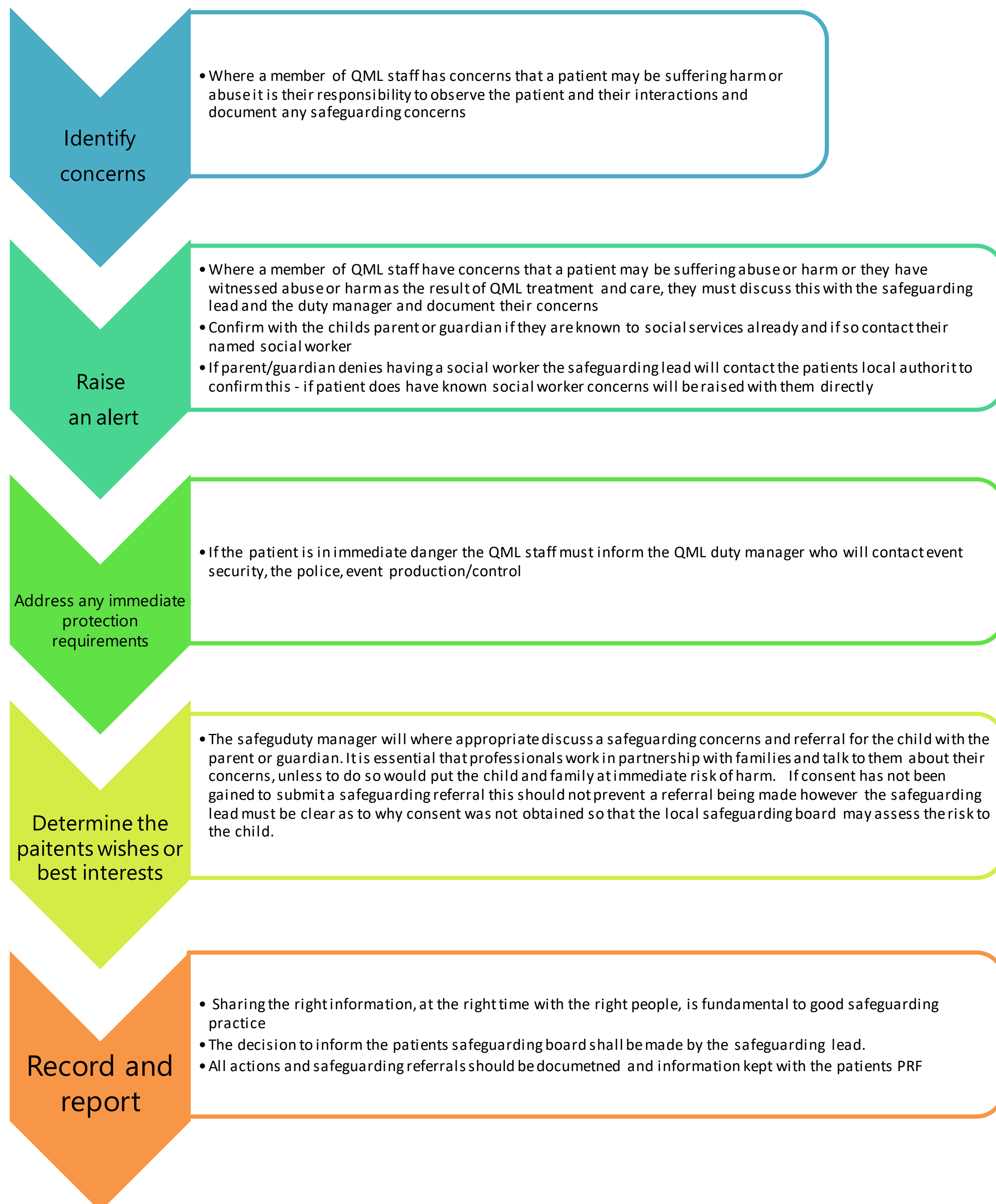
14. Training

14.1 Safeguarding children training is mandatory for all existing and new staff in line with QML's mandatory training policy and must be updated every three years at minimum as set out by the Core skills training framework

14.2 Safeguarding training from external providers will be accepted if it meets the Core skills for training framework.

15. QML Child Safe Guarding Reporting Process

15.1 The steps laid out in the following flow diagram are to be followed in the event a safeguarding concern needs to be raised or reported;



16. PREVENT strategy

Section 26 of the Counter-terrorism and security act 2015 places a duty in specified bodies to have “due regard to the need to prevent people from being drawn into counter terrorism”.

16.1 All QML staff will undertake prevent training as provided by the government : It is essential that staff are able to identify children who may be vulnerable to radicalisation, and know what to do when they are identified. Protecting children from the risk of radicalisation should be seen as part of wider safeguarding duties, and is similar in nature to protecting children from other harms (e.g. drugs, gangs, neglect, sexual exploitation), whether these come from within their family or are the product of outside influences.

16.2 Although it is not necessary to have distinct policies on implementing the Prevent duty, general safeguarding principles apply to keeping children safe from the risk of radicalisation as set out in the relevant statutory guidance; Working together to safeguard children. As such QML staff should report any child that they feel is at risk of radicalisation through the same procedure as any other safeguarding concern.

17. Female Genital Mutilation

Female Genital Mutilation (FGM) constitutes all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons. (WHO Fact sheet No: 241)

It is illegal to practice FGM in the United Kingdom (UK) and to assist in its practice on UK nationals or permanent residents abroad.

FGM is typically performed on girls between the age of 4 and 13, although in some cases it is performed on new born babies or young women prior to marriage or pregnancy. Performing FGM is seen by some as an essential part of their culture that must be preserved, it is founded on deeply held cultural and traditional belief systems. It is considered child abuse and a violation of the human rights of girls and women. In all circumstances where FGM is practised on a child it is a violation of the child’s right to life, their right to their bodily integrity as well as their right to health. FGM has been included within the revised (2013) Government definition of Domestic Violence and Abuse.

FGM is also known as Female Circumcision (FC) and Female Genital Cutting (FGC). These alternative definitions are better received in the communities that practice it, as they do not see themselves as engaging in mutilation.

Female Genital Mutilation is classified into four types:

Type 1 Partial or total removal of the clitoris and/or the prepuce (clitoridectomy).

Type 2 Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision).

Type 3 Narrowing of the vaginal orifice with creation of a covering seal by cutting and a positioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).

Type 4 Unclassified. This involves pricking, piercing or incising of the clitoris and/or labia; stretching of the clitoris and/or labia; cauterization by burning of the clitoris and surrounding tissue; scraping of tissue surrounding the vaginal orifice or cutting of the vagina; introduction of corrosive substances or herbs into the vagina to cause bleeding or for the purposes of tightening or narrowing it; and any other procedure that falls under the definition of female genital mutilation given above. Standard intimate genital piercing of a person under the age of 18 is illegal and should be reported.

17.1 FGM is a criminal offence and subject to prosecution. All HealthCare professionals have a mandatory duty to report this. This can be done to the Police via the 101 number and to Children's social care.

17.2 The Serious Crime Act 2015 requires regulated health and social care professionals in England and Wales to make a report to the police where, in the course of their professional duties, they either:

- Are informed by a girl under 18 that an act of FGM has been carried out on her; or observe physical signs which appear to show that an act of FGM has been carried out on a girl under 18 and they have no reason to believe that the act was necessary for the girl's physical or mental health or for purposes connected with labour or birth.

These must also be reported to the Police via the 101 number and to Children's social care.

17.3 Girls identified as at risk of having FGM must be referred to Children's Social Care following the QML safeguarding Children's processes and contact the QML Safeguarding Leads for advice and ongoing support.

17.4 It is mandatory to RECORD information given about FGM:

It is mandatory for health care professionals to record the presence of FGM in a patient's healthcare records (carenotes) whenever it is identified through the delivery of healthcare. The patients' health record should always be updated with whatever discussions or actions have been taken. If FGM has been identified then this should be included in any discharge documentation so that the patients GP is made aware of the patients FGM status. If a girl has been identified as at risk of FGM, this information must be shared with the GP, Health Visitor or School Nurse (dependant on the child's age) as part of Child Safeguarding actions.

17.5 Since April 2014 it has been mandatory to record the following:
- If a patient has undergone FGM
- What type of FGM
- If there is a family history of FGM
- If an FGM-related procedure has been carried out on the woman such as deinfibunlation

17.6 Professional Response - There are three circumstances relating to FGM which require identification, assessment and possible intervention.

- Where a child is at risk of FGM
- Where a child has been abused through FGM
- Where a (prospective) mother has undergone FGM

It is recognised that the majority of professionals have little or no experience of dealing with female genital mutilation. Coming across FGM for the first time they can feel shocked, upset, helpless and unsure of how to respond appropriately to ensure that a child, and/or a mother, is protected from harm or further harm.

The appropriate response to FGM is to follow usual child protection procedures to ensure:

Immediate protection and support for the child/ren; and that the practice is not perpetuated and identifies others who may be at risk

An appropriate response to a child suspected of having undergone FGM as well as a child at risk of undergoing FGM could include:
- Arranging for a professional interpreter if required
- Creating an opportunity for the child to disclose
- Using simple language and asking straightforward questions

-Using terminology that the child will understand e.g. the child is unlikely to view the procedure as abusive
-Being sensitive to the fact that the child will be loyal to their parents and to their cultural norms
- Giving the child time to talk
- Getting accurate information about the urgency of the situation, if the child is at risk of being subjected to the procedure

17.7 Professionals to be aware of 'indications' that FGM might take place, for example:

- Family comes from a community that is known to practice FGM
- Parents state that they or a relative will take the child out of the country for a prolonged period.
- A child may talk about a long holiday to her country of origin or another country where the practice is prevalent.
- A child may confide to a professional that she is to have a 'special procedure' or to attend a special occasion.
- A professional hears reference to FGM in conversation.
- Unaccompanied asylum seeking children, refugee families.
- Any female child born to a woman who has been subjected to FGM must be considered to be at risk, as must other female children in the extended family.
- Any female child who has a sister who has already undergone FGM must be considered to be at risk, as must other female children in the extended family.

To ensure ongoing protection to the girls and others around her who are at possible risk the following must be completed by professionals:
-QML Incident report form
- Referral to the childs local Multi Agency Safeguarding Hub

Appendix i

Legal framework

This policy has been drawn up based on law and guidance that seeks to protect children, namely:

- The Children's act 1989/2004
- Children & social work act 2017
- working together to safeguard children 2017
- Every child matters 2003
- United convention of the rights of the child 1991
- Data protection act 1998
- Human rights act 1998
- Sexual offences act 2003
- Safeguarding vulnerable groups act 2006
- Protection of freedoms act 2012
- Children and families act 2014
- Counter-terrorism and security act 2015
- Children first: National guidelines for the protection & welfare of children 2015 (Addendum 2019)