East and North Hertfordshire NHS
NHS Trust

Trust-wide Policy

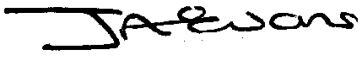
For

Safeguarding Children

A policy recommended for use

In:	All departments, wards and services where children are cared for
By:	All staff who treat, see, or care for children
For:	Children and Young People up to 18 Years
Key Words:	Safeguarding Child Protection
Written by:	Dr Olive Hayes Named Doctor Christina Kelly Named Nurse Bev Morrison Safeguarding Children's Nurse/Liaison HV Nicole Anderson Named Midwife
Supported by:	Women's and Children's Board
Approved by:	Angela Thompson, Director of Nursing Joint Safeguarding Children and Adult Committee

January 2016

Trust Ratification: 

J. Evans

15th January 2016

Policy issued:	January 2016
To be reviewed before:	January 2019
To be reviewed by:	Child Protection Team
Policy Registration No.	CSEC 046 **Version No.** 6

CONTENTS

Version	Date	Comment
1	October 2005	New Policy
2	December 2007	Scheduled Review
3	March 2010	Revised policy with updates
4	March 2012	Reviewed in light of new practices
5	September 2015	Scheduled Review (Incorporates Substance Misuse in Pregnancy)
6	January 2016	Scheduled Review

Equality Impact Assessment
This document has been reviewed in line with the Trust's Equality Impact Assessment guidance and no detriment was identified. This policy applies to all regardless of protected characteristic - age, sex, disability, gender-re-assignment, race, religion/belief, sexual orientation, marriage/civil partnership and pregnancy and maternity.

Dissemination and Access
This document can only be considered valid when viewed via the East & North Hertfordshire NHS Trust Knowledge Centre. If this document is printed in hard copy, or saved at another location, you must check that it matches the version on the Knowledge Centre.

Associated Documentation
This policy must be read alongside Hertfordshire Safeguarding Children Board

Review
This document will be reviewed within three years of issue, or sooner in light of new evidence.

1. INTRODUCTION

'Working Together to Safeguard Children' (2015) explains, all health professionals working with children and young people should ensure that safeguarding and promoting their welfare forms an integral part of all elements of care. Health professionals working with parents/carers need to understand their role in safeguarding children and promoting their welfare. Health professionals can be often the first to be aware that "families are experiencing difficulties in looking after their children".

It also stresses that the role of health professionals is important in many ways including: Recognising children in need of support and/or safeguarding; contributing to enquiries about children; assessing the needs of children and the capacity of parents to meet their children's needs; planning and providing support to vulnerable children; participating in child protection conferences; planning support to children at risk; providing therapeutic help to abused children and parents under stress; playing a part in safeguarding children; contributing to case reviews.

The diagnosis of child abuse should be approached in the same rigorous manner as any other potentially fatal disease. The diagnosis is very important because effective intervention can improve or save a child's life, and protect that child's siblings. Early diagnosis may prevent serious disability, and promote healthy development. Failure to recognise that children have been abused or are being neglected can have serious long-term consequences for those children, including death or disability.

2. SCOPE

This policy is applicable Trust wide.
It applies to all staff that develop and use Trust documents and to any network policies.

3. PURPOSE

All professionals of this Trust who work with children should not only be able to identify significant harm whenever possible, but also to play an active part in protecting children, in co-operation with other statutory agencies, and especially to provide appropriate services or advice to improve and promote their health and development. Apart from the immediate investigation of possible abuse, this may include medical follow up, investigation for sexually transmitted disease, advice on nutrition or immunisation, or assessment of special needs etc.

The purpose of this policy is to assist professionals within the Trust to carry out these important duties.

Health professionals who work with children, parents and other adults in contact with children should be able to recognise and know how to act upon indicators that a child's welfare or safety may be at risk.

The Trust is committed to ensuring that we provide a rigorous child protection service to the children and families of East & North Hertfordshire in line with the current editions of Hertfordshire Safeguarding Children Board Child Protection Procedures and 'Working Together to Safeguard Children'. In Hertfordshire, children's social Services are known as "Children's Services".

This policy must be read alongside Hertfordshire Safeguarding Children Board

4. DUTIES

All Health professionals who work with children, young people and their families should be able to:

- Understand risk factors and recognise children and young people in need of support and/or safeguarding
- Recognise that parental issues such as domestic violence, drug misuse, mental health issues may impact on the child's wellbeing and know where to refer.
- Recognise the risks of abuse and neglect on the unborn child.
- Communicate effectively with children and young people and be aware of the voice of the child.
- Liaise closely with other agencies, including other health professionals, and share information as appropriate.
- Contribute to child protection conferences, family group conferences and strategy discussions when requested.
- Participate in internal reviews, serious case reviews and child death reviews and their action plans to ensure ongoing learning and development of safeguarding processes within the organisation.

East and North Hertfordshire NHS Trust has a Named Doctor, a Named Nurse and Named Midwife for Child Protection. The named professional's role is safeguarding children within the organisation and working closely with the board lead to ensure that their safeguarding responsibilities are discharged correctly.

Details and contact numbers are found on the Knowledge Centre Safeguarding Children page.

5. TRAINING GUIDE

Training Grid	Level 1	Level 2	Level 3
All staff clinical and non-clinical	**X**		
All Clinical staff who have any contact with children, young people, parents or carers	**X**	**X**	
All clinical staff working directly with children and young people	**X**	**X**	**X**
Staff with a mixed caseload (adults and children) should be able to demonstrate a minimum of level 2 and be working towards attainment of level 3 core knowledge, skill and competence (RCPCH 2014).			

Health organisations have a duty to ensure all staff are trained to safeguard and promote the welfare of children (S11-Children Act 2004). Current training can be accessed in the training folder, under safeguarding on the knowledge centre.

6. SHARING INFORMATION

Sharing of information between professionals and local agencies is essential for effective identification, assessment and service provision. Early sharing of information is key to providing effective early help where there are emerging problems.
Serious case reviews have shown how poor information sharing has contributed to the death or serious injury of children.

Some people have anxiety about when to share information but in general the law will not prevent you from sharing information with other practitioners if:

- Those likely to be affected consent
- The public interest in safeguarding the child's welfare overrides the need to keep information confidential
- Disclosure is required under a court order or other legal obligation.

6.1 MASH – Multi-Agency Safeguarding Hub

Hertfordshire Children's Services have recently introduced a MASH. The aim of this service is for partner agencies (including social care, police, health, education, probation, and early support services) to work closely together to safeguarding children in a timely manner and improve communication across these agencies which will assist identifying safeguarding concerns and promote appropriate early support for families. Under section 11 of the Children's Act 2004, East & North Herts NHS Trust has a duty to work with the partner agencies within the MASH to safeguard children in our care.

6.2 Information Sharing Forms (Isf)

Sharing Information forms (ISF) are located on the Knowledge Centre under Safeguarding Children. They are to be completed when information is going to be shared with a GP, health visitor or school nurse i.e. within health not Social Care.

They are used when there are concerns that do not meet the criteria for a referral to Children's Services but where extra support or a home visit may be required. Examples of cases may include parental anxiety, accidental or deliberate overdoses, bullying, dog bites, burns, head injuries in infants. This list is not exhaustive – it is best to complete one if you are in any doubt.

If abuse or neglect is suspected do not use this form. This is not a referral to social care. Referrals must be made on a single service.

Parents should be informed that a ISF is being completed and the professional needs to sign to say consent has been given, you must document if consent has been denied.

These forms are then placed in the liaison HV folder in Emergency Department (ED) where they are collected. In all other areas the forms are electronically sent by secure email to the liaison health visitor (address on the bottom of the form).

The concerns raised on ISF are discussed at the psycho- social meeting at Lister hospital every Wednesday. Should a referral be required following the psycho social meeting, the safeguarding team or the responsible Consultant will contact the family to inform them of referral to Children's Services.

6.3 Child Protection - Information Sharing (Cp-Is)

The 'Child Protection - Information Sharing' System is a National project that will improve the way that health and social care services work together across England to protect vulnerable

children. CP-IS links the IT systems of NHS unscheduled care to those used by social care child protection teams, so that information can be shared about three specific categories of child:
those with a child protection plan
those classed as looked after (i.e. children with full and interim care orders or voluntary care agreements)
any pregnant woman whose unborn child has a pre-birth protection plan.

All children who attend the hospital Emergency Department or Minor Injuries/Urgent care Centre are checked on the national spine to establish if they have a child protection alert. This is checked by the administrative staff at booking and checked by the nursing staff at triage. See Appendix

If a child has a child protection plan or is a looked after child, the Children's Social Care Department should be notified of all attendances.

In the event of a child who is on a Child Protection Plan presenting with an injury, a call should be made to the children's social care team prior to discharge to establish if a strategy meeting is needed to ensure the child's safety.

7. THINK FAMILY

Adults
Staff who work with adult patients are required to ascertain if their patient has children, if the children are resident with them and where possible record the names and dates of birth for the children.
Always consider the safety of children.
The safety and welfare of the children should always be recorded when parents/carers attend due to domestic abuse, substance misuse and/or mental health issues. It should be recorded in the record where the children are, with whom and if a referral has been made to children's social care.

Children
The Specialist Registrar in Paediatrics should be informed of children with a CP plan
A referral should be made to the paediatric team and Children's Services if there are signs that a child under the age of eighteen or an unborn baby:
Is suffering or has suffered abuse and/or neglect
Is likely to suffer abuse and/or neglect

8. REFERRAL TO CHILDREN'S SERVICES

Contacts for Children's Services

Hertfordshire **03001234043**

Bedfordshire Central **03003008225 - Out of Hours 03003008123**

All up to date Referral forms and contact numbers are on the Knowledge Centre

Complete referral form to Hertfordshire Children's Services found on Knowledge Centre (Red band single service form).

Phone Children's services and e mail form to protected referrals (address on the bottom of the form) **protectedreferrals.cs@hertfordshire.gcsx.gov.uk**

Copy the referral to the safeguarding team **strategydiscussions.enh-tr@nhs.net**
File copy in medical records/ED card/scanned onto electronic patient record.

If referring to social care in another county speak to their team to obtain the correct referral form for that area.

Any Health Professional can make a referral to Children's Services. The Consultant Paediatrician of the week will normally be actively involved in the management of any child who may have been abused or neglected and who has been admitted to the hospital or seen in outpatients or Accident and Emergency.

Every case referred, must be discussed with the Named Doctor or Named Nurse at some stage of the investigation and whenever possible before the child is discharged but the referral need not be delayed until this discussion has taken place.

Consent from the parents should be sought for a referral, unless doing so places the child at risk of significant harm, (if you suspect Fabricated or Induced Illness).
Document clearly in the child's records all conversations had, and if the parent does not consent to a referral, record the reason and continue to make the referral.

The referral should state clearly the reason for the referral and what the concerns are.

8.1 Common Assessment Framework (Caf)

For children who require early intervention, as opposed to the child/ren who are at risk of significant harm, consideration should be made to complete a CAF. Parental consent is always needed when making a CAF referral as the family are accepting early help from agencies who not necessarily involved with children's social care.

The CAF process should involve a meeting with the parents/carer of the child to identify what help or support is needed and a Team Around the Family (TAF) meeting should be arranged to establish who will be involved with that support. There should be an identified Lead Professional – this does not need to be the author of the CAF and needs to be agreed at the TAF meeting.

Staff who hold a caseload and are based in the community are more likely to be involved with the CAF process.

9. DEFINITIONS

Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces illness in a child.

Emotional abuse refers to a relationship rather than an event. There are persistent, non-physical harmful interactions with the child by the parent or care giver. This can include acts of commission e.g. telling the child repeatedly that they are worthless or exposing them to violence including domestic abuse. It may also be due to acts of omission through persistent emotional unavailability and unresponsiveness towards the child.

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

Neglect may involve a parent or carer failing to provide adequate food, clothing, or shelter (including exclusion from home or abandonment). It includes failing to protect from physical danger through inadequate supervision or access to appropriate medical care or treatment.

Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities. This may involve assault by penetration (for example. rape, or oral sex) or non-penetrative acts such as masturbation and touching outside of clothing. Non-contact activities, such as involving children in sexual images, exposure to sexual activities or grooming a child in preparation for abuse also constitutes sexual abuse. Child Sexual Exploitation also falls under this category.

Children less than sixteen years of age cannot lawfully consent to sexual intercourse, although in practice may be involved in sexual contact to which, as individuals, they have agreed. A child of less than thirteen years is considered by law incapable of providing consent (Sexual Offences Act 2003).

Child Sexual Exploitation involves children and young people under 18 in exploitative situations, contexts and relationships where the children and young people (or a third person or persons) receive 'something' (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of them performing, and/or another or others performing on them, sexual activities which can involve the use of technology i.e. mobile phones/internet. The child or young person is often victim to violence, coercion and intimidation; and often, the child does not recognise the coercive nature of the relationship and does not see themselves as a victim of exploitation. Many sexually exploited children have difficulty distinguishing between their own choices and the sexual activities that they are coerced into. (UK National Working Group for Sexually Exploited Children and Young People, 2010)

Fabricated or Induced Illness (FII) and Perplexing Presentations
In both cases the child's clinical presentation is not adequately explained by any confirmed genuine illness, and the situation is impacting on the child's health or social wellbeing (RCPCH 2013). There is a spectrum ranging from "true" FII involving deception of services by the carer including induction of illness or falsification of specimens, and the more common "perplexing presentations" that should be considered in the same way but do not necessarily involve deliberate deception.

Domestic Abuse is any incident or pattern of incidents of controlling, coercive, 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. The abuse can be psychological, physical, sexual, financial or emotional. Domestic abuse also includes honour based violence, forced marriage and FGM. Children who witness domestic abuse can be affected both emotionally and physically. (Department of Health, 2013)

Toxic Trio is the term used to describe the issues of domestic abuse, mental health concerns and substance misuse which have been identified as common features of families where harm to women and child has occurred. They should be identified as indicators of increased risk of harm to children and young people. (Department of Health, 2014)

10. HISTORY, EXAMINATION & RECORDING OF INJURIES

It is understood that the urgent nature of emergency medicine sometimes makes detailed assessment difficult, but there are minimum standards which must be met.
However if there are concerns regarding the presentation or injury a child presents with it is important that a clear history is obtained and the injury or markings are clearly described, drawn, measured and labelled.

6 minimum standards:

1. Record the names, identities, and relationships to the child of all adults attending with the child.
2. Record the identity of the adult giving the history ("mother said that…").
3. Record the alleged time and date of the injury: ("yesterday 1.1.04 at about 2pm").
4. Record the exact alleged details of the circumstances of the injury ("the baby rolled off the sofa onto the carpet").
5. If possible examine the child for other injuries; if this is not possible or deemed for some reason inappropriate, record that it has not been done.
6. Draw injuries, on a body map, describing their size, shape, colour and position ("3cm x 2cm round blue discolouration on the soft tissue of the right cheek").

The checklist has been designed for use in assessing all children who attend with an injury. This checklist should be completed at triage and again if during the consultation concerns arise.

Mandatory Section

Safeguarding Children: Paediatric Injury <16 yrs	
	There is no delay between injury & seeking medical advice (If there was a delay, there is a satisfactory explanation)
	The history is consistent with the injury Carers/parents have given the same accounts at different times?
	On examination, the child has no unexplained injuries There is **no** pattern of injury typical of abuse (e.g. multiple facial bruises, scalds, cigarette burns, any unexplained injuries in non ambulant babies, bites, hand or implement marks, head injuries in babies, unexplained abdominal or genital injuries or fractures esp. in babies) **This is not a comprehensive list**
	The Childs behaviour and interaction is appropriate The parents/carers behaviour is appropriate The child seems well cared for

Adapted from **NICE** guidelines published in July 2009 "when to suspect child maltreatment" www.nice.org.uk/CG89

Any child who presents with unexplained injuries or a history that is inconsistent with the injury should be referred to the on call Paediatric team.

Children who attend the Emergency Department with significant head injury or intracranial haemorrhages should always be referred to children's social care at the outset and there

should not be a delay in waiting for medical results. This may result in limited information at the time of referral however social care can be updated as information materialises.

11. UNEXPLAINED BRUISING

Any unexplained bruising in a child may be due to abuse, and the child should be referred to the paediatric team for assessment. A full blood count and clotting should be considered when dealing with unexplained or excessive bruising in a child.

The Hertfordshire Safeguarding Children's Board has developed a bruising protocol please see links : http://hertsscb.proceduresonline.com/pdfs/bruising_flowchart.pdf

12. MENTAL HEALTH & SELF HARM

Children and young people who present with mental health concerns including self-harm, overdose, suicidal attempt or suicidal ideations should always be referred to the CCATT/RAID team for assessment. It is important that safeguarding risks are also considered and it should be clearly recorded within the child's record whether a referral to children's social care has been made or if an information sharing form has been completed. A referral should be made to children's social care for children and young people who have multiple attendances.

13. CHILD SEXUAL EXPLOITATION (CSE)

In the acute hospital the Emergency Department is the most likely place a child who is being sexually exploited will present for treatment however it is rare a child/young person will report they are being sexually exploited. It is more likely the child will present with mental health issues, over dose, suicidal ideations, self-harm, drug or alcohol intoxication, a victim of assault, sexually transmitted infections, pregnancies or miscarriage. Whenever a child/young person presents with one or more of these conditions it should be considered if the child or young person is at risk of being sexually exploited, especially if the child or young person is a regular attender.

In cases of child sexual exploitation the child or young person may be accompanied by their abuser. It is always important to try to speak to the child/young person by themself and to establish if they feel safe.

The Halo team in Hertfordshire investigate suspected cases of CSE.
When there are concerns that a child/young person may be being sexually exploited a referral should be made to the Children's Social Care with recommendations it is referred to the CSE team. http://hertsscb.proceduresonline.com/chapters/p_chil_exploitation.html

14. FABRICATED & INDUCED ILLNESS OR PERPLEXING PRESENTATIONS

These are often challenging and complex cases. Professionals should follow local HSCB and RCPCH guidance (see Child Protection Companion on Bramble Suite or online via RCPCH website).

All cases of suspected FII should be discussed with the safeguarding team who will be able to assist in the development of a detailed chronology and in organising a professional's meeting if needed.

Paediatricians should avoid iatrogenic harm and only undertake tests or treatments that are clearly indicated. There should be a lead paediatrician for the child who is involved in treatment decisions.

Admission to hospital can be helpful to allow close observation and to differentiate between true and erroneous symptoms or signs.

15. ACUTE PAEDIATRICS - What to do if you suspect child abuse or neglect

Consider/Suspect /Exclude/Escalate child abuse

- **Consider** means that maltreatment is one possible explanation for the alerting feature or is included in the differential diagnosis.
- **Suspect** means a serious level of concern about the possibility of child maltreatment but is not proof of it.
- **Exclude** maltreatment when a suitable explanation is found for alerting features.
- **Escalate** concerns to children's social care or seek advice from the Trust Safeguarding Children Team.

Professionals should, in general, seek to discuss any concerns with the family and whenever possible seek their agreement to making referrals to Children's Services, provided that such discussion and agreement-seeking would not place a child at increased risk of significant harm. Parents refusal to consent should not stop a referral being made when there are safeguarding concerns.

16. ACUTE CHILD PROTECTION PAEDIATRIC ASSESSMENT

- A chaperone (Nurse) should always be present.
- All aspects of the Child Protection (CP) proforma must be completed; this is the basis for your report.
- Notes must be legible, signed and dated.
- Obtain consent.(check who has PR)
- Record the account from the parent and the child (record in their words)
- Record findings in words and diagrams
- Document size, shape of marks using body maps
- Medical Photography for all injuries (Photography is on call 24/7 for Child Protection Only)
- Discuss findings with the Consultant.

Remember for suspicion of abuse or neglect of children, a Consultant must see the child & a strategy discussion must be had with children's social services prior to discharge.

Three guiding principles

1. Is the account correct, is the injury consistent with that explanation and the child's stage of development

2 Is the injury typical of abuse? Are there slap marks, forced immersion scalds, bruises to the ears, cigarette burns etc?

3 Are there any serious risk factors? Is there a history of parental mental ill health, drug or alcohol abuse, domestic violence, or is the child out of school or not registered with a GP?

16.1 Consent for Paediatric Assessment

The Paediatrician is responsible for obtaining informed consent. The following may give consent to a medical assessment:

- A child of sufficient age and understanding (as per Gillick/Fraser guidelines – see appendix 5).
- Any person with parental responsibility (not foster or step parents)
- The local authority when the child is the subject of an emergency protection order /interim care order.
- The High Court when the child is a ward of court

A child will generally attend with a parent for consent to be gained. If a parent is in Police custody, the attending officer will call through to the custody suite, the consent form of the proforma **Must** be relayed to the parent and consent gained, this consent should then be verified by a Nurse, both the Dr and Nurse can sign to say consent has been achieved

17. THE VOICE OF THE CHILD

Assessment should always include asking the children/young person how they sustained an injury or if they have any concerns. They should be given the opportunity to speak without the parent or carer present. For children with disabilities and non-verbal children other communication aids should be used to help the child to communicate. The assessment should also document the interaction between child and carer/parent.

18. INTERPRETER SERVICES

Children and parents whose first language is not English, and who are not fluent in English must be interviewed with an interpreter who is not related to the child or a family friend. It should be a independent interpreter.

19. STRATEGY MEETINGS & SECTION 47 INVESTIGATIONS

When a child in hospital has been referred to Children's Services for possible abuse or neglect, there should be a strategy meeting carried out in the hospital.

This is attended by a Social Worker; Police, a Consultant Paediatrician and a member of the Safeguarding team. This is to clarify if a particular injury is likely, on a balance of probability to have been caused by abuse or neglect. The role of health is to explain, discuss and agree a plan for further medical investigations, such as a skeletal survey or blood tests and to provide a medical report of the examination, findings and a discharge plan.

20. MEDICAL PHOTOGRAPHY

Medical Photography is on call 24/7 for child protection only

Photographs should be taken by a trained Hospital photographer. Careful drawings of all injuries, accompanied by descriptions and measurements, should also always be made. These are not a substitute for photographs, and vice-versa.

Contact details during working hours (9am to 5pm Monday to Friday 4019).

Out of Hours Contact switch to page the on-call photographer.

For all photography

- Complete medical photography request form with instructions on body map (located on the back of the form)
- Consent signed on both proforma and photography request form and name and address of child should be on all of the forms.

Photographs should be reviewed by the examining clinician following the medical. A record must be made, should the photographs differ from what was observed by the examining clinician. Careful line drawings and maps must also be drawn as per RCPCH guidance (2008)

21. RADIOLOGY & IMAGING

Skeletal surveys are for children aged under 2 years and usually include CT of brain.

The indications for skeletal survey in children thought to have been possibly abused include

- Presentation with a fracture that suggests abuse.
- Physically abused children less than 2 years of age.
- Consider siblings less than 2years old – discuss with radiologist
- Child dying in suspicious or unusual circumstances.

In addition, suspicion of child abuse may first be raised by an unexpected radiological finding, for example undisclosed rib fractures in an infant, or subdural haematomata on CT scans of the head.

It is essential that Paediatricians discuss all suspicious findings with their Consultant Radiologist colleagues. If there is doubt, a second opinion should be obtained.

Repeat chest x ray is performed in 10-14 days to look for callus formation, which may also provide important evidence as to the timing of fractures.

Parents or carers should always be informed why their child is having a skeletal survey, and their consent must be obtained. If parents refuse consent, and in practice this rarely happens, then the procedure can only be carried out if a Court Order is obtained.

22. CHILDREN ADMITTED TO THE WARD - Nursing Admission

The Nursing care plan should take account of the reason for the child's admission. Nurses should explicitly record on the care plan the fact that a child has been admitted to hospital with suspicions of, or actually having suffered abuse or neglect.

Nurses should complete all sections of the admission pro-forma: i.e. Social Worker's name, Health Visitor's Name if applicable, and the school the child attends if of school going age. It should be clearly recorded who has parental responsibility and who the child resides with in the record.

Children of school age who are not attending school should be referred to Children's Services for this reason alone.

Nurses should obtain, and record in the child's case notes, the names of all relatives or friends who accompany the child to the ward or who stay with the child during the admission procedure.

The Consultant conducting the ward round should ensure that all relevant information is reviewed and taken into account before decisions are made on future management of a case.

23. PREVIOUS HOSPITAL ADMISSIONS

Make every effort to obtain medical case notes if a child has had previous admissions.
If the previous admissions were in another hospital, every effort should be made to obtain a copy of the notes, or details of the reason for admission.

24. DISCHARGE FROM HOSPITAL

No child, about whom there are child protection concerns should be discharged, whether from the ED, the Ward, PAU, or Maternity without review by a Consultant Paediatrician and liaison with children's social care.

- Ideally children about whom there are child protection concerns should remain in hospital until the next working day so sufficient background information can be gathered
- Discussions and the discharge arrangements should also be fully documented in the child's medical notes.
- When abuse or neglect is alleged, suspected or confirmed the child must not be discharged from hospital without a named GP.
- All children must have a discharge letter completed at the time of discharge on BIMS.
- Obtain the child's discharge address. If the child is being fostered obtain the foster parents name and address or officer in charge if in residential home. Obtain the name and address of the foster parents GP. If the child is to be cared for by a member of the extended family obtain that person's name, address and GP. Ensure this information is kept confidential if the child is being fostered. The foster parents' address should be put on the system in "Postal address field". Contact ward clerk to do this.
- The following information should be included in the discharge plan: The names of the social worker (with contact telephone number), the school nurse and school, the health visitor and the children's community nurse.

24.1 Discharging a Child into the Care of parents with Learning Difficulties

An assessment of the parents' competence to make up feeds, give medication, or undertake new skills must be completed and signed by a nurse. A record of this assessment must be inserted into the child's case notes. If a nurse or other health professional is still concerned about a parent's competence, she must record her concerns in the case notes and inform the senior nurse.

Liaise with the key worker who is normally the social worker if there are any outstanding concerns.

Refer to Children's Community Nurses if they are required to support the child and family with nursing duties in the community. This must be done prior to date of discharge to enable full assessment to be undertaken.

24.2 How to obtain a GP for Children diagnosed with Abuse or Neglect, or when there is Suspicion of Abuse or Neglect, prior to discharge

Whenever such a child is not registered with a General Practitioner (GP) and is being discharged home, contact David Eyre on the following numbers: telephone number 01707 369733, Secure Fax number 01707 367257 or email david.eyre@nhs.net

This service will organise registration with a GP and will give you the GP's name and address.

Document the GP's name, address and telephone number in the child's medical notes.

Inform the child's carer or parent and give them written details of the GP's name, address and telephone number. Complete Discharge Plan in Child's medical notes.

25. MISSED OUTPATIENT APPOINTMENTS - children and young people 0-18yrs

Children miss appointments for a variety of reasons. A letter should be sent to the parents, child/young person and GP to inform of non-attendance and the clinician will decide if another appointment is to be offered as per the Trust Access Policy.
Should the child /young person not attend or not be brought in for a second time, then the consultant must make a decision to discharge or follow up through health visitor, school nurse or children's social services.

If the child is subject to a Child Protection plan, then social services should be informed of non-attendance at appointments.
If non attendance at a hospital appointment impacts adversely on a child's health or development a referral must be made to Children's Social services.

Discuss with the hospital safeguarding team if you have concerns that non attendance to the appointment will have a negative impact on the child's health or if you require advice on referral.

26. CONFLICT

Differences of opinion infrequently arise in child protection work.

Recommendation 67 of the Lord Laming report states that

> *"When differences of medical opinion occur in relation to the diagnosis of possible deliberate harm to a child, a recorded discussion must take place between the persons holding the different views. When the deliberate harm of a child has been raised as an alternative diagnosis to a purely medical one, the diagnosis of deliberate harm must not be rejected without full discussion and, if necessary, obtaining a further opinion".*

Conflict between professionals should be resolved. It is important for all professionals to work closely together to achieve good outcomes for children who are neglected and abused. Conflict is not always a bad thing and it is often necessary in managing complex issues.

If two professionals disagree they should discuss the case together and attempt to resolve their differences within 24 hours.

If resolution is not possible opinion of a third party should be sought eg named or designated professional and aim for agreement within 24 hours.

If the situation is still not resolved it must be escalated to the Named Doctor for child protection.

27. COMMUNITY CHILD PROTECTION PAEDIATRIC MEDICALS

- Consultant Community Paediatricians available via a rota.
- The service is available Monday to Friday from 9am to 5pm.
- Referrers can arrange a CP medical via the CP hotline **07919 396676**
- Urgent referrals out of hours will need to be arranged with the acute paediatric on-call consultant who can be contacted via hospital switchboard.
- A secretary uses a proforma to take all relevant details and liaises with the doctor and nurse.
- The secretary requests medical records and arranges delivery to Lister hospital.
- Medical examination is carried out using the child protection proforma on Bramble Suite. A children's nurse assists with the examination.
- The need to assess any siblings must always be considered.
- CP medicals for non-acute cases of child abuse/neglect are seen by the community paediatricians within working hours.
- The child protection report should be dictated as soon as possible and a fast turnaround requested from Auden.
- Reports should be copied to the Named Doctor and Named Nurse

28. CHILD SEXUAL ABUSE

28.1. CSA - historic

These are mainly children who have actually made a disclosure about sexual abuse allegedly having taken place more than 7 days previously. Sometimes the allegation may be of abuse having taken place months or even years ago.

All such disclosures should lead to a formal referral to Children's Services.
The Joint Child Protection Investigation team will liaise with the safeguarding team to arrange a CSA medical with a Community Paediatrician.

28.2. CSA - acute

These are mainly children who have made a disclosure about sexual abuse allegedly having taken place within the preceding 7 days.

Paediatricians must see the child with the Forensic medical examiner if the young person is:

- Less than 13 years of age
- 13-16 year olds if:
    - Intra-familial abuse.
    - Not sexually active.
    - Has special needs.
- Special needs children must be seen with a paediatrician
  16 to 18yrs

These cases are medical, social and forensic emergencies. An urgent referral to Children's Services and a strategy discussion should take place

The patient should be examined by a Consultant Paediatrician and a Forensic Medical Examiner. This latter will take the forensic swabs and other specimens for the police.

A nurse should always be present during the examination, as well as the child's parent, if the child so wishes.

28.3. CSA Examination

No child should be examined without their consent. The examination should be carried out in the presence of a trusted and caring adult, usually the child's mother. The written consent of the adult with parental responsibility should be obtained.

CSA Proforma needs to be completed fully with a clear record of any hymenal and anal signs and their location using a clock face notation (see below note on terminology). The examination should be recorded on the colopscope.

28.4. Terminology

Precise terminology is important when describing injuries to the genital area. The RCPCH recommended terms to describe hymenal disruptions are:

Depth of hymenal disruption	Terminology to use when acute	Terminology to use when non-acute
Partial	Laceration	Notch *
Complete to base of hymen	Laceration	Transection

*may be superficial or deep

The term transection should be reserved for a non-acute injury to the hymen, which is a discontinuity in the membrane that extends through the width of the hymen to its base, so there appears to be no hymenal tissue remaining at the location.

29. LEGAL ISSUES & REQUESTS FOR INFORMATION

The police and the local authority legal teams often make requests for statements and court reports to assist in criminal or family law cases. The safeguarding team should be consulted when this occurs and therefore if a request is made to an individual staff member they should liaise with the safeguarding team for support and guidance.

Staff will be supported in writing reports/statements, attending interviews and Court.

30. NEO-NATAL INTENSIVE CARE UNIT

Babies admitted to Neonatal Intensive Care Unit.

Babies who are known to social services should have a named social worker with whom staff from NICU should liaise. This information may be obtained from the sharing Information maternity minutes provided the woman is known to maternity services and/or Children's Social services. Not all babies admitted to NICU will be known to Children's Services or require a referral.

Child Protection plan

If a child protection plan exists for the baby it should be inserted into the baby's medical record

Discharge planning
Social workers may request a parenting capacity report as this enables future care to be arranged. Some babies may require foster placement or placement in residential mother and baby unit. Therefore discharge planning should be arranged as soon as possible, to enable the multiagency team to take appropriate and timely action. Legal planning may also be required and this can be a lengthy process dependent on courts.

NICU psycho social meeting
This meeting is held every month to discuss psycho social issues.

31. OBSTETRIC & MATERNITY STAFF

Please see the HSCB procedures via

http://hertsscb.proceduresonline.com/chapters/p_hospital_appoint.html#maternity

Pre-Birth Protocol http://hertsscb.proceduresonline.com/chapters/p_prebirth.html

A detailed history of the client and family is taken by the midwife at the 'booking appointment'. This appointment can be completed either at home, at the hospital or in the GP surgery.

If there are safeguarding concerns an 'Information Sharing Form' (ISF) must be completed. The woman is informed by the midwife that the form will be completed and that the information will be shared with other professionals at the monthly maternity information sharing meeting

The form is sent to the Maternity Safeguarding Team who will risk assess, give advice to the referrer for the immediate management of the case. If there are safeguarding concerns the information will be stored on the maternity database in a named file. The case and any updates will be discussed at the monthly meeting. Sharing information meetings are attended by the social work team, safeguarding midwives, child protection nurse specialist from both the relevant PCT and Acute Trust .

The Information Sharing Form is filed in the child protection folder organised by expected date of delivery [EDD] and kept on the delivery suite. The information is also available on the maternity safeguarding database. If further concerns arise during pregnancy a referral should be made to Children's Services.

If a decision is made at the sharing information meeting that a referral is required, the relevant 'booking' midwife will be contacted by the safeguarding midwife. The midwife will need to obtain detailed information from the family to complete the referral. The referral is then attached and e-mailed to: **protectedreferrals.cs@hertscc.gcsx.gov.uk.** A copy of the referral should also be sent to the **maternitysafeguarding.enh-tr@nhs.net** where it will be filed in the child protection folder and the individual file on the maternity safeguarding database.

The child protection folder is kept on the delivery suite where it is available to all midwives/doctors and obstetric staff to access where appropriate. The community midwife is expected to update the safeguarding midwives on a monthly basis in preparation for the information sharing meeting i.e. feedback or new information.

Records

The midwife should record in the woman's hand held records [under special instructions] that client has been referred to Children's Services, if there is a Child Protection Plan and the category i.e. Neglect or if there is a 'Child in Need' Plan. These are cases where the concerns have not met child protection thresholds but the family are in need of support. This may include support from Health organisations.

Once the woman is admitted in active labour the file from the child protection folder is transferred into the woman's maternity record and the child protection/child in need plan [where it exists] is followed. There should be no deviation from the plan prior to discussion with the client's social worker. All information should be filed in the woman's records and accompany her and the baby to the post natal ward.

If the baby is transferred to NICU a copy of all concerns from the woman's file must be filed in the neonatal record, so that Paediatricians or nurses caring for the baby are aware of all relevant information. Contact details of the social worker must be made available to ensure effective liaison and feedback occurs between the social worker and health staff.

Women who present on labour ward and who are un-booked should automatically be referred to Children's Services. The CP status of the UBB should be checked on CP-IS via the smartcard. The missing Unborn Baby (UBB) file on the maternity database must also be checked.

Cross Boundary Cover

Liaison must take place where there are safeguarding concerns for women who are booked in another hospital but receive care from East & North Herts community midwives or vice versa. An ISF should be completed and forwarded to the Named Midwife who will share with the Named Midwife for the neighbouring organisation i.e Princess Alexandra Hospital/Bedford Hospital

The Named Midwife will ensure domestic abuse notifications received from the Hertfordshire Constabulary are forwarded to the relevant Community Midwife and Named Midwife in neighbouring hospitals as required and if relevant.

Domestic Abuse

Midwives should ask at least twice throughout a pregnancy if a woman is experiencing violence. If the question has been put to the woman this is evidenced by the midwife dating and ticking the A question on the sticker on the front page of the notes under the contact numbers.

If abuse has been disclosed the box on page 2 of the antenatal notes is ticked. Midwives should be aware that other units will have different processes in place, therefore, any disclosure of Domestic Abuse should be recorded on an ISF and filed in the child protection folder. In order to protect the woman the words Domestic Abuse are not recorded on her hand held records.

Please refer to the HSCB procedures on Domestic Abuse via link
http://hertsscb.proceduresonline.com/chapters/p_domestic_abuse.html

Other circumstances that may be identified in pregnancy and the HSCB procedures to be accessed via the following links

- Parental Learning Difficulties http://hertsscb.proceduresonline.com/chapters/p_hospital_appoint.html#discharingfor Parents with Learning Disability
- Substance Misuse http://hertsscb.proceduresonline.com/chapters/p_drugs.html
- FGM http://hertsscb.proceduresonline.com/chapters/p_female_mutilation.html

32. REFERENCES

1. Department of Health. June 2014 Guidance for Health Professionals on Domestic Violence. www.gov.uk
2. Department of Health March 2013 Domestic Violence and Abuse. www.gov.uk
3. Fabricated or Induced Illness by Carers. February 2002. Royal College of Paediatrics and Child Health.
4. Good medical practice (2006) Regulating doctors ensuring good medical practice. http://www.gmcuk.org/static/documents/content/GMC_GMP_0911.pdf
5. Guidance on Paediatric Forensic Examinations in Relation to Possible Child Sexual Abuse. April 2002. Royal College of Paediatrics and Child Health and the Association of Police Surgeons.
6. Hertfordshire Safeguarding Children Board Child Protection Procedures June 2015 www.hertsscb.proceduresonline.com
7. H M Government (2015) *Information Sharing: Advice for Practitioners providing safeguarding services to children, young people, parents and carers.* London: Department for Education.
8. National Institute for Health and Clinical Excellence. When to Suspect Child Maltreatment. National Institute for Health and Clinical Excellence London 2009. www.nice.org.uk
9. UK National Working Group for Sexually Exploited Children and Young People, 2010. www.nationalworkinggroup.org
10. Nursing and Midwifery Council (NMC) 2012. The Code, Professional Standards of practice and behaviour for nurses and midwives.
11. Physical Signs of Child Sexual Abuse (2nd edition). June 2015. Royal College of Paediatrics and Child Health.
12. Royal College of Paediatrics and Child Health. Safeguarding Children and Young People: Roles and Competencies for Health Care Staff. RCPCH 2014
13. Victoria Climbié Inquiry. Report of an Inquiry by Lord Laming. TSO. 2003.

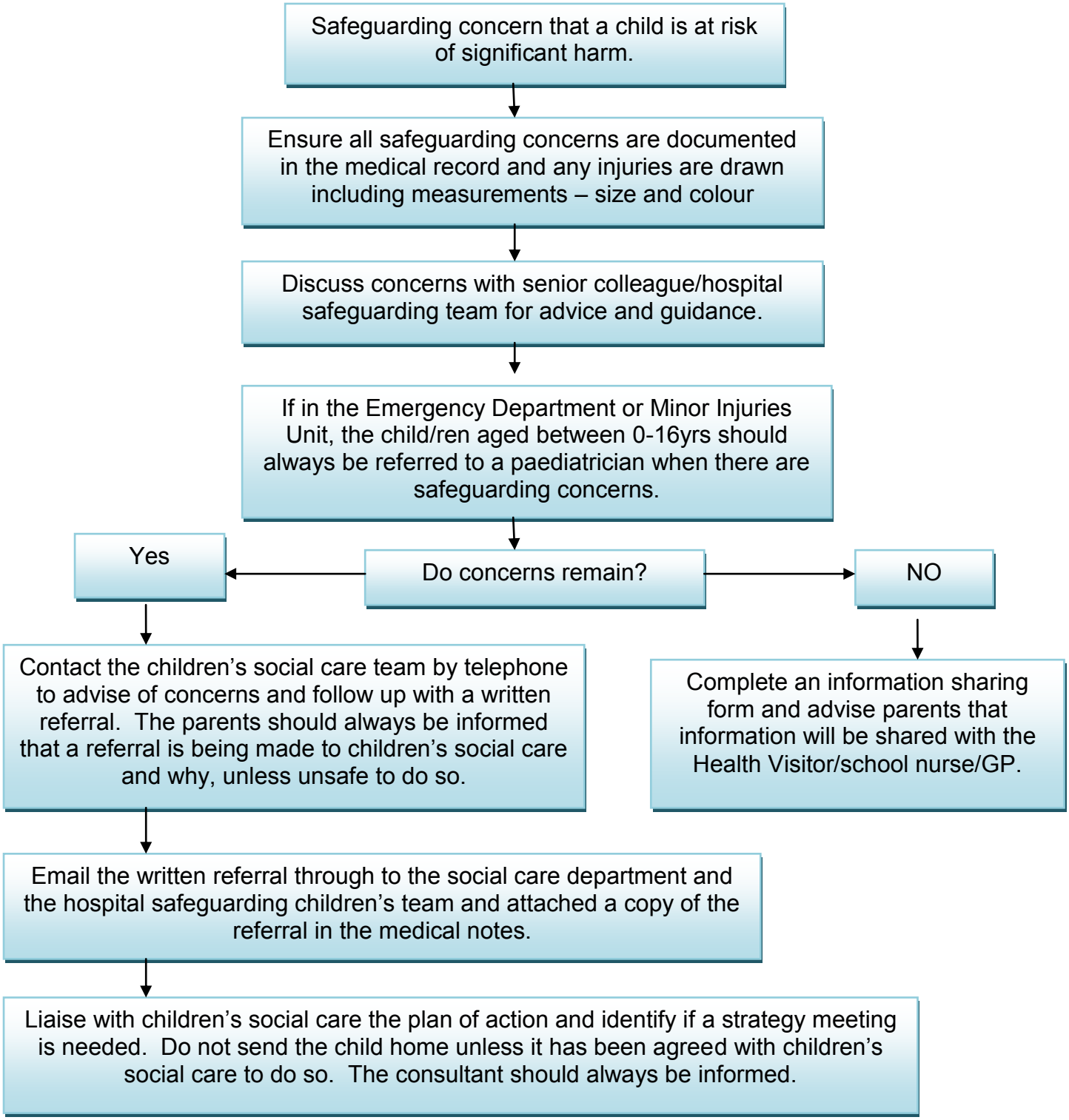
14. What to Do if You're Worried A Child is Being Abused. May 2003. Department Of Health, Home Office, Department For Education and Skills. Pg. 15-24. www.doh.gov.uk/safeguardingchildren/index.htm

15. Working Together to Safeguard Children. Department for Children, Schools and Families, London. 2015. The Stationery Office.

16. Child Protection Companion 2013 (2nd Edition). Royal College of Paediatrics and Child Health

Appendix 1

Flow Chart what to do if safeguarding children concerns



Appendix 2

Children's Social Services Contact details

Hertfordshire Children's Social Care:

Telephone number 0300 1234043

Email: protectedreferrals.cs@hertscc.gcsx.gov.uk

Bedfordshire Children's Social Care:

Multi Agency Support Hub (MASH) 01234 718700 (office hours 09:00-17:00hrs)

or ring 0300 300 8123 (out of hours).

Barnet Children's Social Care:

Telephone number 020 8359 4066 (office hours 09:00-17:00hrs_
Or ring 0208359200 Emergency Duty team out of hours

Cambridgeshire Children's Social Care:

Telephone Number 0345 045 5203
Or ring Emergency Duty Team on 01733 234 724 out of hours

Enfield Children's Social Care:

Telephone number 020 8379 2507
or ring Out of hours 020 8379 1000

Essex Children's Social Care:

Telephone number 0845 603 7634
Or ring Out of hours 0845 606 1212

Luton Children's Social Care:

Telephone number 01582 547653.
Or ring Out of hours emergencies number 0300 300 8123

Appendix 3

CP-IS

PROCEDURE FOR NEW CHILD PROTECTION INFORMATION SHARING PROCESS

This is the procedure you need to follow for checking if Children are on a Child Protection Plan or Looked After.

1 Go into the Knowledge Centre

2 Go into Application Link

3 Select NHS Spine Portal

4 Select Launch Summary Care Record (SCR)

5 Enter the NHS Number

6 If the patient has a Child Protection record, the words **Child Care Alert** will appear

7 In the usual way you will write on the casualty card **YES/NO**

8 If for any reason you cannot access this then you always have the old CP Plan on your Desk Top. (this will be available for approx. a year)

9 If the child is on the Register Do Not go into it as it flags up on the child's social worker and we will receive a call asking why this has been accessed.

Appendix 4

Skills required when conducting a paediatric forensic examination (RCPCH guidance)

- An ability to communicate comfortably with children and their carers about sensitive issues
- An understanding of and sensitivity to the child's developmental, social and emotional needs and his/her intellectual level
- An understanding of consent and confidentiality as they relate to children and young people
- Competence to conduct a comprehensive general and genital examination of a child and skill in the different techniques used to facilitate the genital examination
- An understanding, based on current research evidence, the normal genital and anal anatomy and its variants for the age and gender of the child to be examined
- An understanding, based on the current research evidence, of the diagnosis and differential diagnosis of physical signs associated with abuse
- Competence in the use of the colposcope and in obtaining photo-documentation ensuring that the latter properly reflects the clinical findings and documenting if it does not.
- An understanding of what forensic samples may be appropriate to the investigation and how these samples should be obtained and packaged
- The ability to comprehensively and precisely document the findings in contemporaneous notes
- The competence to produce a detailed statement or report describing and interpreting the clinical findings
- An understanding of the importance of communicating and cooperating with other agencies and professionals involved in the care of the child; this may include attending a case conference, referral to other health professionals eg paediatricians, psychiatrists, genitourinary physicians
- The ability to present evidence, and be cross examined, in subsequent civil or criminal proceedings
- An understanding of the different types of post-coital contraception available, the indications and contraindications of the various methods, and the capacity to prescribe the hormonal types of contraception where appropriate
- Understanding of prophylaxis (including hepatitis B, HIV), screening and diagnosis of sexually transmitted infections.

Appendix 5

Assessing Gillick/Fraser Competence

Young people aged 16 years and over are presumed in law to be competent to consent to medical treatment.

Under 16 years competence needs to be assessed in each case. All children and young people should be involved in decisions relating to their care.

For a young person under 16 years to be competent they should have:

- The ability to understand the choices and that choices have consequences
- An understanding of the alternatives to the proposed intervention, and the risks attached to them
- The ability to weigh the information and arrive at a decision
- An understanding of the nature and purpose of the proposed intervention
- An understanding of the proposed intervention's risks and side effects
- An understanding of the alternatives to the proposed intervention, and the risks attached to them
- Freedom from undue pressure

Competent under 16 year olds are referred to as Gillick or Fraser competent.

Health professionals who assess competence need to be skilled and experienced in interviewing young patients and eliciting their views without distortion. The treating doctor is often the most appropriate person.

Key guidance
General Medical Council. 0-18 years: guidance for all doctors. Available at www.gmc-uk.org
BMA. Consent, rights and choices in health care for children and young people. Further information at www.bma.org.uk/ethics

Appendix 6

ORGANISATIONAL SAFEGUARDING STRUCTURE