Yeovil District Hospital NHS
NHS Foundation Trust

Child Protection Policy

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Child Protection Policy

1. PURPOSE

1.1. The responsibility for safeguarding and promoting the welfare of children in need, including those in need of protection, cannot fall entirely to one agency. Section 11 of the Children Act 2004 places a legal duty on all health organisations to ensure that in discharging their functions, they have regard to the need to safeguard and promote the welfare of children. Health care organisations must also ensure that the services they contract out to others, e.g. GPs, private health care organisations or other providers are also provided having regard to that need.

1.2. All staff employed by Yeovil District Hospital NHS Foundation Trust have a responsibility to safeguard and promote the welfare of children, even when the staff member may not be working directly with that child, but may be working with the child's carer / parent, or other significant adult.

1.3. The policy applies to all staff, including those in temporary / locum posts

1.4. This policy is written in accordance with Working Together to Safeguard Children (2013), Child Protection Companion (RCPCH 2006) and the South West Child Protection Procedures (2010).

1.5. The purpose of this policy is to ensure adherence to the Children Act (2004), and implementation will ensure that staff act appropriately and in a timely manner by providing a consistent and effective response to any concern about a child's welfare.

2 DEFINITIONS

2.1 Safeguarding has two elements;

- Protecting children from maltreatment; and
- Preventing impairment of children's health and development

2.2 Promoting welfare is a proactive responsibility;

- Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care; and
- Creating opportunities to enable children to have optimum life chances such that they can enter adulthood successfully

2.3 In this policy, in accordance with the Children Act 1989 and 2004 and statutory guidance, the term 'child' refers to any young person up to their eighteenth birthday. After a person's eighteenth birthday they are legally regarded as an adult. If Trust staff have any concerns that an adult may have been deliberately harmed or abused they should refer to the Trust's Safeguarding Vulnerable Adults Policy

2.4 Children in Need; a child in need is defined as a child who is unlikely to reach or maintain a satisfactory level of health or development, or their health of development will be significantly impaired without the provision of services, or a child who is disabled.

2.5 Child Protection; child protection is the activity that is undertaken to protect specific children who are suffering, or are likely to suffer, significant harm.

2.6 Significant Harm; Significant harm is the threshold that justifies Local Authority compulsory intervention in family life in the best interests of the child

2.7 Local Safeguarding Children's Board (LSCB); The LSCB is the key statutory mechanism for agreeing how the relevant organisations in Somerset will co-operate to safeguard and promote the welfare of children in that locality, and for ensuring the effectiveness of what they do.

3 AIM

3.1 The Trust's duty under Section 11 is wider than child protection. To be effective it requires staff members to acknowledge their individual responsibility for safeguarding and promoting the welfare of children as well as the commitment of Trust management to support them in this. This includes ensuring that staff have access to appropriate training, advice, support and supervision in relation to this responsibility. The aim of this policy

is to ensure that all staff members are aware of their role and responsibilities in relation to child protection, and have the necessary resources to undertake them.

3.2 The responsibility for safeguarding and promoting the welfare of children in need, including those in need of protection cannot fall entirely to one agency. Although the Children's Social Care Social Services (SSDCSC) are the lead agency for within Child protection, all professionals have a responsibility to support them in all the stages of the process:

- identifying children in need of support or protection or families in need of extra help with parenting
- contributing to enquiries about a child and family
- assessing the specific needs of children, including the parental capacity to meet those needs
- planning and providing support to vulnerable children, especially those at risk of significant harm, and their families
- participating in meetings about children especially child protection conferences and core groups

3.3 The Children Act 1989 places two specific duties on Health Authorities and NHS Trusts to co-operate with a local authority in the interests of vulnerable children. Section 27 in relation to providing support for children in need and section 47 in relation to making enquiries about children thought to be suffering or at risk of suffering significant harm. The Children Act (2004) clarifies roles and responsibilities, and is reflected in this policy.

4 DUTIES / ROLES AND RESPONSIBILITIES OF LEAD PROFESSIONALS

4.1 The **Chief Executive and the Board of Directors** have overall responsibility for ensuring that Yeovil District Hospital NHS Foundation Trust fulfils it's obligation to ensure that children attending the hospital are appropriately safeguarded in accordance with Section 11, Children Act (2004). They must cooperate with the Local Authority in the establishment and operation of the LSCB and, as statutory partners, share responsibility for the effective

discharge of LSCB functions in safeguarding and promoting the welfare of children. The Trust will ensure representation on the LSCB at an appropriate level of seniority. The contact details for the Safeguarding Team can be found on the Safeguarding YCloud page.

4.2 Responsibilities of the **Trust Executive Lead for Safeguarding**;

- The Director of Nursing is the Trust Board executive lead for Safeguarding Children and Vulnerable Adult.
- Represents the Trust Board at LSCB as required
- Chairs the Trust Safeguarding Children Working Group

4.3 **The Named Doctor for Child Protection**;

4.3.1 The Named Doctor works closely with the Named Nurse for Child Protection and Designated Professionals in supporting the activities necessary to ensure that the Trust meets its responsibilities to safeguard and promote the welfare of children.

4.3.2 The Named Doctor represents the Trust on the Local Safeguarding Children Board and participates in LSCB subgroups as required

4.3.3 Other responsibilities of the Named Doctor:

- To offer advice and support to staff on all aspects of safeguarding children including identification of child abuse and vulnerable children, preparation for child protection meetings, legal matters relating to child protection, and liaison with lawyers and police as appropriate.
- With the Named Nurse, to conduct Internal Management Reviews for Serious Case Reviews unless they themselves have been substantially involved in the case
- Has an active clinical duty in managing child protection cases as part of the team of paediatricians at Yeovil District Hospital
- As part of the Trust Safeguarding Working Group, and with the Named Nurse for Child Protection ensures that the Trust has the appropriate policies and procedures for safeguarding children in place.

- With the Named Nurse for Child Protection, to identify training needs according to agreed training standards and to facilitate the delivery of training
- To advise the Chief Executive and Directors on safeguarding matters

4.4 **Named Nurse for Child Protection**.

4.4.1 The Named Nurse works with the Named Doctor in the roles detailed, and in addition the named nurse takes responsibility for liaising between departments within the Trust, other health agencies and members of the multi agency teams. Gathering and sharing relevant information is crucial in safeguarding children.

4.4.2 The Named Nurse, supported by the Named Doctor, is responsible for ensuring the provision of supervision in safeguarding practice for Trust employees as required.

4.5 **Designated Professionals**: The Named Professionals are, Designated Nurse in Child Protection, and Designated Doctor in Child Protection. The Designated professionals are responsible for strategic direction in Child Protection and Safeguarding management throughout Somerset. The Designated Doctor provides supervision for the Named Doctor, and the Designated Nurse provides supervision for the Named Nurse.

4.6 **Responsibilities of the Trust Safeguarding Children Working Group:**

- To assure the Trust Board that the effective implementation of the infrastructure and processes for safeguarding children are embedded within corporate and directorate bodies
- To produce and annual report to the Board detailing the Trust's safeguarding activity and performance
- To consistently work towards strengthening multi-agency partnership working and act on any concerns identified
- To oversee and monitor the Trust's response and action plan implementation to the findings of Serous Case Reviews
- To agree an annual audit plan

5 POLICY

Every member of staff working within the NHS has a mandatory responsibility to safeguard all children and to inform someone if they have a concern about a child.

All staff working in Yeovil District Hospital NHS Foundation Trust are expected to be familiar with, and comply with, the guidance in the South West Child Protection Procedures available on www.swcpp.org.uk and 'What to do if You're Worried a Child is Being Abused' (DFE 2015), as well as the procedures set out within this document. Additional local guidance on specific issues is also available on the Safeguarding Team Y cloud page on the Trust intranet web. Somerset Local Safeguarding Children Board. (www.somersetsafeguardingchildrenboard.org.uk) https://slp.somerset.org.uk/sites/somersetlscb/SitePages/Home.aspx

5.1 The internet and Trust Intranet will be the source of up-to-date multi-agency procedures, to ensure the currency of information available.

5.2 All staff who, in the course of their work, come into contact with children will attend training to help them recognise children who may be suffering or at risk of suffering significant harm and to understand their own and other's roles and responsibilities in relation to these children. The must be supported in this by managers and training needs should be identified via the appraisal process.

5.3 The Trust will have a comprehensive Child Protection Training Strategy, complementing the LSCB Training Programme, in order to meet the needs of all staff working within the Trust and in accordance with Safeguarding Children and Young People: Roles and Competencies of Health Care Staff (2014).

5.4 All staff and managers will exercise their own professional accountability to safeguard children and promote their welfare.

5.5 Clinical supervision and professional support will be available in relation to child protection issues (See Annex A).

5.6 No guidance can cover every eventuality. Health professionals must exercise their professional judgement to ensure good and safe outcomes for children.

5.7 The Trust will ensure that robust recruitment and vetting procedures are in place, and that recruitment practices are in line with safer recruitment guidance. This will include appropriate mechanisms for undertaking relevant checks through the Disclosure and Barring Service (see Trust Recruitment and Selection Policy).

5.8 Safeguarding responsibilities will be reflected in job descriptions

6 CONCERNS ABOUT A CHILD'S WELFARE

6.1 Recognition and Referral

6.1.1 The Appendix of the South West Child Protection Procedures (www.swcpp.org.uk) entitled 'Signs and Symptoms of Possible Child Abuse' provides additional guidance about indicators of abuse. See also NICE Guideline 'When to suspect child maltreatment (July 2009) (http://guidance.nice.org.uk/CG89)

6.1.2 All health professionals must always act in the best interests of the child whose welfare is of paramount importance. If you have concerns about the safety or welfare of a child, even if there is no firm evidence to substantiate child abuse or risk of significant harm, you must always do something, even if that is sharing your concerns with a colleague who has greater knowledge and experience in relation to child protection. Doing nothing is NOT an option.

6.1.3 **Third Party Concerns**: If information is received from a third party, for example a relative or neighbour of a child, you should:

- Suggest that they discuss the situation with Children's Social Care themselves and give them contact details
- Pass on the information that you have received to Children's Social Care

- Inform the family Health Visitor and / or GP
- Inform the Named Nurse or Doctor for Child Protection
- Document the information given and your actions

6.2 **Domestic Violence**; There is a clear link between domestic abuse and child abuse. The Adoption and Children Act 2002 (implemented February 2005) extends the meaning of 'harm' as defined in the Children Act 1989 to include the harm that children suffer by "seeing or hearing the ill treatment of another". This puts new obligations on all practitioners, when considering the needs of a child and the risk of significant harm, to consider the impact of hearing or witnessing domestic abuse on the child's emotional and psychological well being. If Trust staff suspect that domestic violence may have occurred within a family where there may be children, it is their duty to act upon this information to ensure that any children are safeguarded.

Somerset Multi-agency guidance on managing Domestic Violence is available via the Somerset LSCB website (http://www.somersetsafeguardingchildrenboard.org.uk) https://slp.somerset.org.uk/sites/somersetlscb

6.3 **Substance Misuse**; If staff have concerns about the well being or safety of children whose parents or carers have substance misuse problems, specifically where these difficulties are impacting, or likely to impact, on their ability to meet the needs of their children they must discuss the case with a member of the Trust safeguarding team, and a referral must be made to Children's Social Care. The Somerset Local Safeguarding Children Board website has a multi-agency protocol to provide professionals with guidance when managing such a case: (http://www.somersetsafeguardingchildrenboard.org.uk) https://slp.somerset.org.uk/sites/somersetlscb

6.4 **Substance Misuse in Pregnancy**; This protocol also applies to pregnant women, who have substance misuse problems, where their partners are known to have substance misuse problems or where someone with

substance misuse problems is living in a household where children are present.

6.5 **Children Missing from Care**; Staff from all agencies, including Yeovil District Hospital, have a responsibility to identify children missing from care, home or who are absent without authority. When a child is identified as absent without authority, information must be shared between agencies in order to ascertain if there is evidence of actual or potential risk to the child or whether he or she is a child in need. Where there is evidence of potential or actual risk of significant harm to a child or young person a Strategy Meeting must be held in accordance with South West child protection procedures (www.swcpp.org.uk) and agency guidance. Multi-agency guidance on what to do if you identify a child as missing from care is available on the Somerset LSCB website. (http://www.somersetsafeguardingchildrenboard.org.uk) https://slp.somerset.org.uk/sites/somersetlscb

6.6 **Physical Injury**:

If a child has an injury the following must always be taken into consideration when making an assessment:

- Is there an explanation for the injury?
- Is that explanation compatible with the injury and the developmental stage of the child?
- Has there been any delay in seeking help?
- Is the carer's response unusual in any way?

6.6.1 Where there are concerns that a child is at risk of significant harm, an assessment is carried out by Children's Social Care under Section 47 Children Act (1989). This is also known as a Section 47 enquiry. Following a strategy discussion between Children's Social Care, Police and Health, a decision may be made to request a Child Protection Medical Assessment. If this is necessary, then a referral should be made to the on-call paediatric registrar.

6.6.2 The purpose of a Child Protection Medical Examination is;

- To establish what immediate treatment the child may need
- To provide information (which may or may not support a diagnosis of child abuse or neglect) in conjunction with other assessments made, to Children's Social Care
- To provide information or evidence to support Criminal or Family Court proceedings as required
- To secure any ongoing medical care, monitoring and treatment as required

6.7 **Fabricated or Induced Illness** is a form of child abuse. It is when someone, often the carer, intentionally harms a child, or gives a false history of illness that may bring about harmful interventions in a well child. It makes up only a very small proportion of children who suffer abuse. If a member of staff has concerns that a child may be subject to fabricated or induced illness the named or designated professionals must be contacted promptly. Multi-agency guidance on managing suspected Fabricated or Induced Illness are available on the Somerset LSCB website (www.somersetsafeguardingchildrenboard.org.uk) and detailed guidance can be found in Safeguarding Children in Whom Illness is Fabricated or Induced (DCSF 2008).

6.8 Radicalisation

Concerns that a child may **be radicalised, involved in or supporting terrorism**; Where there are concerns that a child may be at risk of being exploited by those attempting to radicalise and draw them into terrorist activities, you should contact the Trust PREVENT & Safeguarding Adults Lead

6.9 Female Genital Mutilation (FGM)

Female genital mutilation comprises all procedures involving the partial or total removal of the female external genitalia or other injury to the female

genital organs for non-medical reasons. FGM is also known as “female circumcision / cutting” or “Sunna”. FGM is considered child abuse in the UK and a grave violation of the human rights of girls and women. There is no religious basis for FGM.

For more information on mandatory reporting requirements please refer to the Trust FGM Policy.

6.10 Child Trafficking

This is a form of child abuse and can be linked to Child Sexual Exploitation. It can have a long term and devastating effect on victims, who often experience multiple forms of child abuse.
Child trafficking is the recruitment and movement of children for the purpose of exploitation. This can be moving children from one country to another or moving children within a country. Trafficking can even be viewed as moving children across a town. In terms of child sexual exploitation children and young people are often moved across towns for the benefit of perpetrators.
In the UK the National Referral Mechanism (NRM) was set up in 2009, which is a framework for identifying and supporting victims. In 2012 it received 372 referrals of potential child victims. But as this is a hidden crime this may be just a small picture of what is actually happening.

Possible indicators of children that are being trafficked are:

- Having falsified documentation
- Being accompanied by an adult not the parent who insists on remaining with the child at all times
- Not having any money, but having a mobile phone
- Having no access to parents or guardians
- Looking intimidated and not behaving in a way that is typical of their age
- Having a history with gaps and unexplained moves or going missing for periods
- Not being registered with a school or GP
- Having no freedom of movement and no time for playing

- Receiving repeated and/or unexplained phone calls
- Performing excessive housework chores and rarely leaving the residence.

There are more detailed statistics in relation to the scale of this problem which can be found on the NSPCC website.

What can we do about child trafficking?

If you have concerns refer them onto Children's Social Care (initially through Somerset Direct), who can refer onto NRM if necessary. Further information: *www.nspcc.org.uk* or www.**swcpp**.org.uk

6.11 Sexual Exploitation

Sexual exploitation of children and young people under 18 involves exploitative situations, contexts and relationships where young people (or a third person or persons) receive 'something' (for example food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of them performing, and/or another or others performing on them, sexual activities. Child sexual exploitation can occur through the use of technology without the child's immediate recognition; for example, being persuaded to post sexual images on the Internet/mobile phones without immediate payment or gain. In all cases, those exploiting the child/young person have power over them by virtue of age, gender, intellect, physical strength and/or economic or other resources. Abuse, coercion and intimidation are common; involvement in exploitative relationships being characterised in the main by the child or young person's limited availability of choice resulting from their social/economic and/or emotional vulnerability.

Sourced from: Safeguarding Children and Young People from Sexual Exploitation: Supplementary guidance to Working Together to Safeguard Children 2009.

Child sexual exploitation involves the sexual exploitation through coercion or enticement of a vulnerable child or young person in sexual activity for cash or some other form of reward, such as drugs, alcohol, shelter or other material gifts. The exchange is exploitative because it happens in a relationship of unequal power with an adult. Children and young people under the age of 16 are legally unable to give informed consent to sexual activity.

However, research undertaken by the University of Bedfordshire has also highlighted the dangers of assuming that once a young person has reached the age of 16 they can give 'informed' consent.

A growing number of children and young people are being targeted and groomed for sexual exploitation by adults and other young people that they meet on the Internet. This on-line grooming contributes to the difficulties in identifying the prevalence of child sexual exploitation and highlights the importance of developing robust e-safety strategies.
The Barnardo's 'Puppet on a String' report identified three broad categories of child sexual exploitation. These were described as follows:

• **Inappropriate relationships**
This usually involves one perpetrator who has inappropriate power or control over a young person, whether this is physical, emotional or financial control.
One indicator of an inappropriate relationship may be a significant age gap, even if the young person believes that they are in a loving relationship.

• '**Boyfriend' model of exploitation and peer exploitation**
In this type of situation, the perpetrator befriends and grooms a young person into a 'relationship and then coerces the young person to have sex with friends or associates.

• **Organised/networked sexual exploitation or trafficking**
Young people who are often connected to one another are passed through networks, possibly over geographical distances, between towns and cities where they may be forced or pressurised into sexual activity with numerous men.

The University of Bedfordshire research adds further categories:

• **Exploitation involving peers**
Where a young person, who themselves may be a victim of child sexual exploitation introduces other children or young people to the abuser/s and;

• **Exploitation linked to poverty and exclusion**

Where grooming is not necessarily involved but there is opportunistic abuse of a young person in need of help: for example; the offer of accommodation to a runaway in exchange for sex. The young person tends to view this arrangement, not as exploitation, but rather as a short term survival mechanism.

(Somerset LSCB CSE strategy 2013/15)

6.12 Concerns about the Welfare of an Unborn Baby

If there are concerns that an unborn child might be harmed or neglected you must act to safeguard the child. Such concerns can arise at any stage of pregnancy.

6.13 Non-Attendance at Hospital Appointments

If a child fails to attend a planned hospital appointment this may, in some circumstances, indicate neglect by parents or carers. In all cases where a child is not brought along for a planned hospital appointment, therefore, the Yeovil District Hospital paediatric department procedures for non-attendance of out-patient appointments must be followed, alerting the named professionals for child protection and other agencies as necessary. This guidance applies not only to appointments due to be held in the Children's Out-patient Department, but also to all other appointments made for a child under 18 years to see a practitioner or attend for investigations within the Trust.
(Trust Intranet pages: Clinical Services>Paediatrics>Guidelines and Protocols for Practitioners> Non-attendance flow chart, Non-attendance of appointments procedure)

7.0 Actions in suspected Child Abuse

The order in which actions are taken will depend upon the urgency of the situation and the degree of perceived immediate risk or threat to the child Seek or give appropriate

7.1 IF A CHILD IS IN IMMEDIATE DANGER AND URGENT ACTION IS REQUIRED TO PROTECT THE CHILD, CONTACT THE POLICE URGENTLY BY DIALLING 9 999 AND THE HOSPITAL SECURITY TEAM ON 2222

7.2 Concerns about a child's welfare should be discussed with a line manager, senior colleague, named safeguarding professional or the on-call consultant or middle-grade paediatrician.

7.3 Concerns can also be discussed with Somerset Direct (0300 123 2224) or the Emergency Duty Social Worker (01458 253241).

7.4 Medical attention for any of the child's injuries

7.4.1 If medical assessment is required to confirm a possible diagnosis of child abuse a referral should be made to the Consultant Paediatrician/Specialist Paediatric Registrar on call, who will normally undertake any examination of the child. Further advice about examination may be sought from the Consultant Paediatrician on-call or the Named Doctor for child protection.

7.4.2 Any medical examinations in relation to sexual abuse must be undertaken by a practitioner who has training and expertise in this area.

7.4.3 Repeated medical examination of children in respect of any type of child abuse should be avoided if possible.

7.5 You may wish to seek advice or consultation to clarify and evaluate the nature of your concerns, especially if there are suspicions of abuse but no clear evidence. Any or all of the following could be approached for further advice

- Named Nurse for Child Protection Safeguarding Children
- Named Doctor for Child
- Designated Nurse for Child Protection
- Designated Doctor for Child Protection
- your line manager
- other members of the clinical team
- GP and other members of Primary Health Care Team (e.g. Health Visitor)
- Children's Social Care, including on a "what if" basis without giving specific child details

7.6 If there are concerns about the immediate safety and welfare of the child, do not let consultation hold up action to safeguard the child

7.7 Finding out whether a child is subject to a Child Protection Plan may help in evaluating your concerns (See Annex B). If a child subject to a Child Protection Plan is seen at Yeovil District Hospital, the child's key-worker (Children's Social Care) must be contacted with information about the contact, even if it is believed to be unrelated to any child protection concern.

7.8 All concerns about a child's welfare, any discussions and all actions must be clearly documented in the child's health record. Details of injuries should be documented using body maps available within the Trust's Child Protection documentation booklet, available on Dillington Ward (Ward 10).

7.9 The following information should be checked and recorded:-

- Is the Child subject to a Child Protection Plan?
- Name
- Address
- Date of birth
- Name of primary carer - does this person have Parental Responsibility

- GP
- Health Visitor/School Nurse - as appropriate
- School/Nursery if appropriate
- Any other professional involved i.e. Social Worker
- Whether the child has had any attendance at hospital /MIU (a copy of any previous notes should be obtained)
- Details of ethnicity, language or method of communication
- Are there any other children within the family home
- Whether there is any reason why parental contact should be supervised
- If there are gaps in this information this should be passed on at the time of referral e.g. If the child is of School age and is not attending school
- A record must be kept of any injuries noted / disclosures made (as far as possible using the child s own words)

7.10 If there are any other children within the family home or otherwise connected to a child about whom there are safeguarding concerns, though must be given to their safety and this must be discussed with Children's Social Care.

7.11 If a child / family is not registered with a GP, the issue must be addressed before a child is discharged from hospital and registration must be offered. The consultant responsible for the child must ensure that before a child leaves hospital a practice where the family may register with a GP is identified to them. If the child is under 5 years old the health visitor at the GP practice should be contacted with details of the child / family.

8.0 HOSPITAL ADMISSION

8.1 Refer Child Protection Care Pathway (available in booklet form on the ward) And Flow Chart (Annex D)

8.2 On admission to hospital the child must receive a full physical examination within 24 hours of admission, except when doing so would compromise the child's care or their physical and emotional well being (if this is thought to be the case, this must be clearly recorded). Height and weight, including centiles must be documented.

8.3 Consultant Responsibility: The 'hot-week' consultant paediatrician will automatically become the lead paediatrician for child protection aspects of a child's care. However, if the child has been seen regularly by a consultant previously, then the care will default to this consultant. In the acute situation, the on-call consultant will take clinical responsibility and there will be close liaison between the 'hot-week' and on-call consultant to ensure comprehensive handover of information. The consultant in charge of the case will be clearly marked on the child's hospital notes.

8.4 When taking a history, enquiries must be made about previous admissions to hospital. Details concerning previous admissions must be obtained from the other hospitals.

8.5 The consultant in charge of the case must review the information from other hospitals when making decisions about the child's future care and management. If the notes are not requested the reasons for this must be documented in the notes

8.6 A clear record should be made in the notes:-

8.6.1 Who referred the child
8.6.2 Where they were seen
8.6.3 The date and time of the examination
8.6.4 Who was present during the examination
8.6.5 Was the incident witnessed, if so by whom (note down their names)
8.6.6 Is the story consistent with the developmental capabilities of the child
8.6.7 Is there delayed reporting of a serious injury

8.6.8 Does the story fit with the pattern of injures seen

8.7 Does the history of the injury episode vary with the person giving the story

8.8 When a child is admitted and there are concerns about any deliberate harm this must be discussed with a Paediatric Consultant, at any time of day or night. If needed advice should be sought from the Named Doctor or Nurse and information exchanged. The investigation and management of deliberate harm must be approached in a systematic and rigorous manner.

8.9 If there is any disagreement or difference of opinion about suspicions of abuse (either between healthcare professionals or between YDH NHS FT staff and those from other agencies), the child must remain in hospital until the situation has been resolved. The Named or Designated professionals should be contacted in such cases. 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. (See also the Local Safeguarding Children Board Escalation Policy)

(www.somersetsafeguardingchildrenboard.org.uk))

8.10 Where deliberate harm 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.

8.11 Consideration should be given to whether taking a history from the child on their own, is in the child s best interest. When that is so, the history should be taken even when the consent of the carer has not been obtained, recording the reason for dispensing with consent. Consent for investigation or treatment in case where deliberate harm is suspected should be sought by a Registrar or Consultant

8.12 Record the child's mode of communication. If the child's first language is not English and a history is to be taken directly from them, then an approved, independent translator, other than the carer, must be used. If the child communicates using alternate communication means such as signing someone other than the carer should be used to aid communication. Paediatric translation services can be accessed by telephoning 0845 310 9900 and quoting an identification code that can be provided by staff in the paediatric outpatient department and ward 10.

8.13 When deliberate harm is suspected the nursing care plan must take full account of this diagnosis and a Concern Diary must be commenced. These are available on Ward 10 (Dillington Ward).

8.14 Comprehensive and contemporaneous notes should be made documenting concerns. Doctors and nurses should write their own notes wherever possible but if someone writes notes on behalf of an individual, that individual should be clear about what they wish to have recorded on their behalf and should countersign what has been recorded.

8.15 A record must be made in the notes of all face to face discussions, including medical and nursing handovers. A record must be kept of all decisions made during conversations. A record must also be kept of who is responsible for carry out any actions agreed during conversations. Details of telephone conversations must be recorded in the notes. If the notes are not available when a discussion has occurred a record of that discussion must be documented and entered into the notes as soon as possible. Each concern should be separately addressed, accounted for and documented.

8.16 During the course of a ward round the doctor conducting the ward round should ensure that all available information is reviewed and taken into account before decisions on future management is taken.

9.0 REFERRING TO SOCIAL SERVICES CHILDREN'S SOCIAL CARE

9.1 Guidance about referral to Social Services accompanies the Common Request for Involvement of/referral to Children and Young People Services. (Available on the safeguarding Children Y cloud page)

9.2 Social Services Departments Children's Social Care has a duty to provide services for children in need and to undertake enquiries into situation where children are suffering or at risk of suffering significant harm.

9.3 In most circumstances any concerns should be discussed with the parent(s)/carer(s) and, where possible, their agreement to a referral to Social Services being made. Where such discussion and agreement seeking could jeopardise the safety of the child a referral may be made without consent.

9.4 Referral should be made, making it clear that you are making a child protection referral. Referral details can be found on the Safeguarding YCloud page.

9.5 Details of the person taking the referral and details of actions to be taken, by whom and the timescale must be fully documented.

9.6 All referrals will be followed up in writing using the Common Request for Involvement of/referral to Children and Young People Services. A copy of the form should be sent to the Named Nurse for Child Protection and the child's GP and/or Health Visitor; a copy should also be retained in the health professional's record for the child. All professionals involved in the care of a child for whom there are concerns about possible deliberate self-harm must provide Social Services with a written statement of the nature and extent of their concerns. It is their responsibility to ensure that their concerns are properly. The Named Professionals can assist with this.

9.7 Blank copies of the referral form should be kept with the Child Protection policy and child protection guidelines; they are also available through Children's Social Care or the Named Nurse.

Blank copies of the Common Request for Involvement of/referral to Children and Young People Services are available from safeguarding Children Y Cloud page. (Trust intra Net – Teams –S - Safeguarding Children – trust wide documents)

9.8 Children's Social Care should acknowledge a written referral within one working day of receiving it. If the referrer has not received an acknowledgement within 3 working days they must contact Children's Social Care again.

10.0 CONFIDENTIALITY AND SHARING INFORMATION

10.1 Personal information about children and families held by health professionals is normally subject to a duty of confidence and would not normally be disclosed without the consent of the subject. However the law allows disclosure of confidential information necessary to safeguard the welfare of children.

10.2 Guidance from NMC and GMC on confidentiality is clear that information may and should be disclosed to third parties, if necessary without consent, to assist in the prevention and detection of child abuse. This relates to both children who may be the subject of abuse and adults who may pose a risk to children

10.3 Guidance about sharing information with other agencies is available via Safeguarding Children Y Cloud page

10.4 If you have any doubts about sharing information with other agencies it may be helpful to discuss it with the Designated and/or Named Nurse and/or Doctor for Child Protection. Also see the Trust Information Governance Policy.

10.5 See also the South West Child Protection Procedures (www.swcpp.org.uk)

11.0 ASSESSMENT

11.1 Health professionals have important contributions to make to the assessment of vulnerable children and their families.

11.2 The Framework for the Assessment of Children in Need and their Families (see Figure 1) provides a systematic way for agencies jointly to assess the needs of children. Initial and core assessments will normally be co-ordinated by Children's Social Care although any health professionals involved will be expected to contribute to the assessment.

The Threshold Document – Continuum of need and Intervention (see fig 1) provides a systematic way for agencies jointly to assess the needs of children. Initial and core assessments will normally be co-ordinated by Children's Social Care although any health professionals involved will be expected to contribute to the assessment. The threshold document and guidance is available on the Safeguarding Children Y Cloud page.

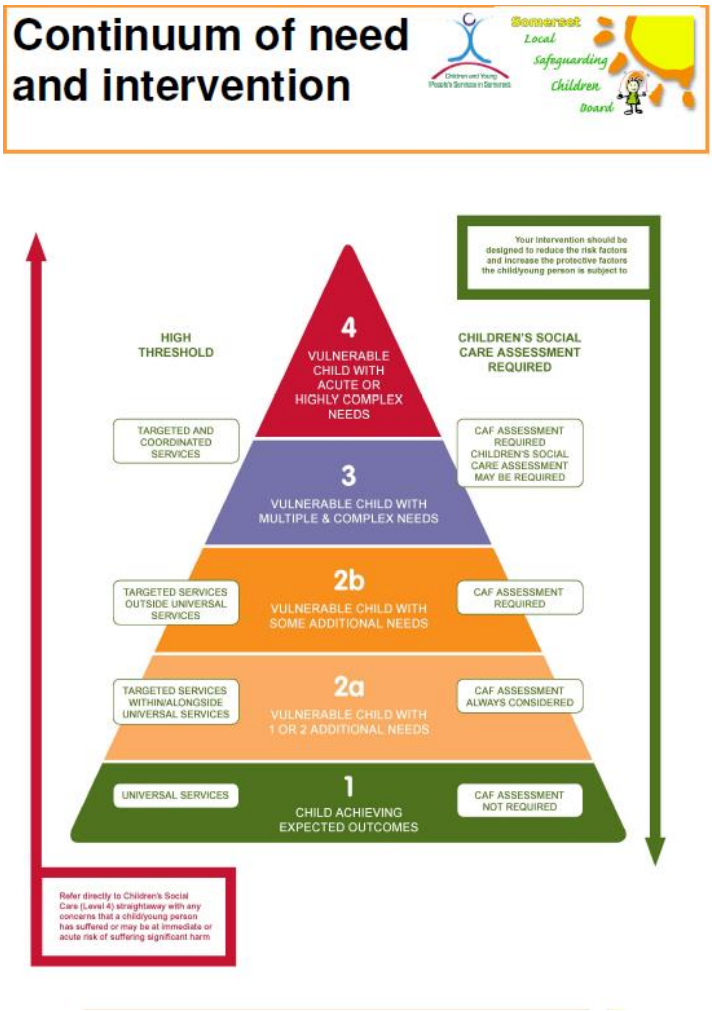


Figure 1: threshold document

11.3 Initial assessment is undertaken to ascertain: whether a child is in need, the nature of the services required and whether a more detailed core assessment should be undertaken.

11.4 The initial assessment will be completed within a maximum timescale of 7 days. If a core assessment is to be undertaken this will be completed within a further 35 days.

11.5 If at any stage during the assessment process it is judged that there is ongoing risk of significant harm a child protection conference will be held. This would normally be held within 15 days of the start of child protection enquiries under Section 47 of the Children Act.

11.6 All involvement of health professionals in assessments must be clearly documented in the child's health records kept by that professional

12.0 CHILD PROTECTION CONFERENCES

12.1 See also south west child protection procedures (www.swcpp.org.uk)

12.2 Health professionals are normally expected to attend child protection conferences if they have a significant contribution to make and they should be given priority. This applies to Initial, Review and Transfer Conferences

12.3 A written report must be compiled and provided in advance to the child protection conference, it is then made available to other conference members. A report should be provided whether a professional is able to attend or not. A pro-forma report is available. The report should be sent to the conference secretary in advance (preferably 5 days, although it is recognised that in the case of initial conferences short notice may preclude this) of the conference.

12.4 Health professionals may seek advice about the content of the report from the Named or Designated Professionals.

12.5 All Nursing, Midwifery and Health Visitor reports will be sent to the Named Nurse.

12.6 Reports should always be shared with parents and, where appropriate, children prior to child protection conferences. It is good practice for this to occur as part of a face to face contact, but where this is not possible a copy of the report should normally be sent to the parents prior to the conference. As far as possible reports should be shared with parents prior to the conference

12.7 Written and verbal information must distinguish between fact, observation, allegation and opinion. Information presented to the conference should include:

12.7.1 details of the professional's involvement with the family
12.7.2 information about the child's/children's health and development
12.7.3 information about the parental capacity to safeguard their children and promote their welfare
12.7.4 indications of the professional's planned ongoing work with the child and family

12.8 Health professionals, as part of a child protection conference, are expected to participate in the analysis of all the information available to the conference and contribute to decisions about ongoing risk and the need for a child protection plan.

12.9 If the need for a child protection plan is agreed at the conference a core group will be identified whose responsibility it is to agree a detailed child protection plan, in line with the broad recommendations of the conference, and to implement that plan. Health professionals will be identified as members of core groups and should contribute, within the scope of their practice, to the child protection plan and co-operate with other members to achieve its outcomes.

12.10 If a child protection conference is held in respect of an unborn child there must be an identified process for ensuring that the Maternity Department is aware of the situation and an clearly defined mechanism for informing Somerset Children's Social Care Services Department of the birth of the baby. The Midwifery Manager will be informed of all Child Protection Conferences in respect of unborn babies, either through direct invitation by Children's Social Care or, if this is not the case, by invitation from other health professionals in receipt of an invitation. A Midwife and/or a midwifery manager should attend all Child Protection Conferences in respect of unborn babies

12.11 All attendees at child protection conferences and core group members should ensure that they are fully prepared and supported by supervision.

12.12 Child Protection conference minutes will be sent to all attendees. These must not be shared with others or circulated outside the attendees of the conference and must be stored securely or, if this is not possible, destroyed or returned to the Somerset Children's Social Care Services .

13.0 CONTACTS WITH CHILDREN FOR WHOM THERE IS A CHILD PROTECTION PLAN

13.1 All health professionals will document in full any contacts made with the child and/or family and will maintain a chronology of significant events that will then be shared with the key worker.

13.2 Any changes or concerns about the family must be reported to the key worker.

13.3 Health professionals with children subject to child protection plans on their active caseloads should receive regular supervision to ensure that the focus of the work is maintained.

13.4 Any change in circumstances for children with child protection plans must be notified to the Named Nurse as well as the key worker.

14.0 REPORTS AND STATEMENTS

14.1 It may be necessary for health professionals to make verbal or written statements to the police, solicitors, and CAFCASS officers in relation to child protection matters. They should always seek advice from their manager, the Named Nurse, the Designated Nurse or the Named/Designated Doctor.

14.2 Any direct approach, either in writing or verbally, to a Health Professional from a solicitor in relation to a child should be redirected to the Manager and the Named Nurse should be informed.

14.3 All Nursing, Midwifery or Health Visiting reports or statements should be scrutinised by the Named Nurse or the Named Doctor

14.4 The health professional should always ensure that they retain a copy of any report or statement made.

14.5 Staff who are required to give evidence in court in relation to a child protection matter will be given appropriate advice and support before, during and after their court appearance from the Named Nurse, the Designated Nurse and/or the Named Doctor for child protection.

14.6 Managing Cases where a child's carers and / or family members are also members of Trust staff

14.7 It may occasionally be the case that a child about who there are child protection concerns is related or otherwise personally known to a Trust staff member. In such cases it is imperative that the case is managed appropriately and sensitively, and that the best interest of the child remain paramount at all times. See the LSCB Confidential Casework Guidance www.somersetsafeguardingchildrenboard.org.uk.

https://slp.somerset.org.uk/sites/somersetlscb

15.0 ALLEGATIONS AGAINST STAFF

Also See Trust Grievance and Disciplinary Procedures and Annex F

15.1 Children can be subject to abuse by those who work with them in any and every setting. All allegations of abuse or maltreatment of children by a

professional, staff member or volunteer must be taken seriously and treated in accordance with consistent procedures.

15.2 The procedure detailed in Annex E should be followed in respect of any allegation 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 or related to a child; or,
- behaved towards a child or children in a way that indicates s/he is unsuitable to work with children,

15.3 In connection with the person's employment or voluntary activity. If concerns arise about the person's behaviour in regard to his/her own children, the police and/or social care will consider informing the person's employer in order to assess whether there may be implications for children with whom the person has contact at work.

16.0 TRAINING

To protect children and young people from harm, all health staff must have the competences to recognise child maltreatment and to take effective action as appropriate to their role. They must also clearly understand their responsibilities.

16.1 All staff must attend child protection training as part of their mandatory Trust induction programme at commencement of employment by the Trust. There is a robust Child Protection training strategy within YDH NHS FT. Attendance at Child Protection training of the appropriate level is mandatory for all trust staff, and is monitored by the Somerset Academy. Details of the Child Protection training programme and the levels of training required for individual staff members can be obtained from the Somerset Academy.

17.0 IMPLEMENTATION, MONITORING AND EVALUATION

17.1 This Policy will be implemented, monitored and evaluated in line with the requirements of the Policy on Policies.

17.2 Staff training records will be retained by the Somerset Academy.

17.3 A rolling programme of audit, coordinated by the Trust Clinical Governance department, will monitor and evaluate Child Protection processes within Yeovil District Hospital NHS Foundation Trust.

17.4 The Trust Safeguarding Team will submit an annual report on Safeguarding to the Trust Board of Directors, and will undertake to update the Trust board regularly (at least every 6 months) on Safeguarding activity within the Trust.

18.0 **LIST OF APPENDICES**:

Annex A – Policy For Clinical Supervision In Child Protection
Annex B – Policy for Enquiring whether a child is subject to a Child Protection Plan
Annex C – Child Protection Pathway (including checklist)
Appendix 1 - Framework For The Assessment of Children In Need And Their Families
Annex D - Paediatric Department Parent Information Sheet
Annex E – Child Protection Flowchart
Annex F – Managing Child Protection Allegations against Staff
Appendix 2 – Equality Impact Assessment Tool

ANNEX A – POLICY FOR CLINICAL SUPERVISION IN CHILD PROTECTION

1 INTRODUCTION

1.1 It is a recognised that working in the field of child protection entails making difficult and risky professional judgements. It is demanding work that can be distressing and stressful. There are multi-disciplinary and inter-agency aspects and often cross-cultural issues. Therefore all staff that are in the front line of practice must be well supported by effective supervision. Clinical supervision is an accepted part of the development of the nursing, midwifery and health visiting professions although less embedded into practice in other professions. Child Protection supervision has a specific focus but principles are the same

2 DEFINITION

2.1 Clinical supervision is a term used to describe a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance patient/client protection and safety of care in complex clinical situations.

2.2 It can be defined as “an exchange between professionals to enable the development of professional skills. “(Butterworth and Faugier 1993)

2.3 Bentovim and Bingley Miller state ‘Supervision of workers carrying out family assessments is essential, as the assessment can have far reaching effects on the planning of the care and whether families can respond to children’s need within their time scales’.

2.4 Working Together (2006) states “Working to ensure children are protected from harm requires sound professional judgements to be made. It is demanding work that can be distressing and stressful.

2.5 For many practitioners involved in day-to-day work with children and families, effective supervision is important to promote good standards of practice and to support individual staff members. Supervision should help to ensure that practice is soundly based and consistent with LSCB and organisational procedures. It should ensure that practitioners fully understand their roles, responsibilities and the scope of their professional discretion and authority. It should also help to identify the training and development needs of practitioners, so that each has the skills to provide an effective service.” P141

3 POLICY STATEMENT

3.1 Any health practitioners working within child protection processes should be able to access skilled advice and support and where appropriate formal supervision with respect to their child protection activity.

4 AIMS

4.1 To ensure safe consistent practice in relation work with vulnerable children and their families

4.2 To expand clinician’s knowledge and increase confidence and competence

4.3 To assist in developing clinical proficiency and creative professional development

4.4 To provide an environment where reflection on clinical practice is encouraged and supported

4.5 To improve clinical standards and contribute to clinical effectiveness and the Trust's strategy for clinical governance

4.6 To identify and manage stress factors in clinical practice

5 SUPERVISION PROCESS

5.1 The regularity and frequency of child protection supervision will vary depending on the involvement with child protection processes, for example the Named Nurse for Safeguarding Children will access supervision with the Consultant Nurse for Safeguarding children at least monthly.

5.2 Any member of Trust staff who is part of a child protection plan or a member of a child protection core group will have supervision with either the Named or Consultant Nurse for Safeguarding children at least quarterly.

5.3 Any member of staff who is regularly involved in the examination of children in relation to allegations of child abuse will access child protection supervision at least quarterly from one of the Named or Designated professionals.

5.4 Other staff who are involved irregularly should seek supervision from the any of the Named or Designated professionals.

5.5 The Named and Designated professionals are available on a daily basis for all staff, working with or contracted to work with the Trust who wish to discuss issues in relation to the safety of children.

5.6 Child Protection Supervision is available to all health professionals' pre and post Child Protection Case Conferences to support with report writing and contributions to child protection plans.

5.7 Child Protection supervision is available to these staff on request, either individually or in groups. Many of these practitioners have supervisory

processes in place, and should inform their managers if they feel that Child Protection Supervision is needed. All supervisory discussions should be documented in the health records by the health professional seeking supervision.

5.8 Debriefing sessions are available to all staff working for or contracted to work for the Trust following any Child Protection incident where it is felt support and supervision is needed. This may follow a child death, violence or intimidation to staff, attendance at court etc. This will be offered by one or more of the Named and Designated professionals

REFERENCES

Bentovim, A and Bingley Miller L cited in Framework for the Assessment of Children in Need and their Families (2000) Department of Health.

Department of Health (1997) Child Protection – Guidance for Senior Nurses, Health Visitors and Midwives and their Managers

Butterworth, T and Faugier, J (1993) Clinical Supervision: A Position Paper, University of Manchester

HM Government (2006) Working Together to Safeguard Children, TSO Norwich

Morrison, T (2001) Staff Supervision in Social Care, Pavilion, Brighton

Richards, M and Payne, C (1990) Staff supervision in child protection work National Institute for Social Workers

UKCC (1995) Position Statement on Clinical Supervision for Nursing and Health Visiting

ANNEX B – POLICY FOR ENQUIRING WHETHER A CHILD IS SUBJECT TO A CHILD PROTECTION PLAN

CHILD PROTECTION PROCEDURES

Enquiring whether a child who is under the age of 18 years is subject to a Child Protection Plan

1 INTRODUCTION

1.1 A shared responsibility and the need for effective joint working between agencies and professionals that have different roles and expertise, are required if children are to be protected from harm and their welfare promoted.

1.2 Health professionals and organisations have a key role to play in safeguarding and promoting the welfare of children and young people.

2 BACKGROUND

2.1 Laming (2009) states in his Progress Report to Government on Safeguarding, The Department of Health and the Department for Children, Schools and Families must strengthen current guidance and put in place the systems and training so that staff in Accident and Emergency departments are able to tell if a child is the subject of a Child Protection Plan.

3 DEFINITIONS

3.1 Throughout this document, the term ‘child’ is used to include babies and children, and young people to cover all under 18s. The term ‘parents’ includes mothers, fathers, carers and other adults with responsibility for caring for a child or young person, including for example, those with responsibilities for looked after children and young offenders.

3.2 A child protection plan is a working tool (lead by Local Authority Children's Social Care) that should enable the family and professionals to understand what is expected of others in order to safeguard a child from harm.

3.3 The aims of the plan are:-

- To keep the child safe and prevent them from suffering further harm
- To promote the child's health and development.
- Provided it is in the best interests of the child, to support the family and wider family to care for them.

4 PURPOSE

4.1 This policy is written to ensure all Trust staff are aware of when and how to enquire whether a child is subject to a Child Protection Plan.

5 PROCEDURE

5.1 When children attend the Emergency Department where concerns are identified that a child may be at risk of harm, enquiries should be made to Somerset Direct to establish if there is a child protection plan in place for the child. The custodial guardian will inform Children's Social Care of any enquires that are made for children with regard to child protection plans. Out of hours enquires about concerns in relation to a child and whether they have a child protection plan should be made to the Emergency Duty Team.

5.2 Enquiries should only be made to Somerset Direct or to the Emergency Duty Team out of hours, for those children where a concern has been identified. This will include the following circumstances:

- Domestic Abuse
- Substance Misuse
- Overdoses/Deliberate Self Harm
- Inconsistent history

- Injury incompatible with mechanism or history
- Delay in presentation
- Non attendance at hospital appointments
- Poor parental/child interaction

The above list is not meant to be exhaustive but to act as a guide.

6 CONTACT NUMBERS

Somerset Direct (Children Social Care)
0300 123 2224

Out of Hours
Emergency Duty Team
01458 253241

7 DOCUMENTATION / INFORMATION SHARING

7.1 If a child is in receipt of a child protection care plan you must inform the personnel listed below of their attendance –

- Allocated Social Worker
- Health Visitor or GP
- Trust Named Nurse for Safeguarding (Glen Salisbury 01935 384811)

7.2 Clearly document your concerns and conversation with children's social care in the A&E record and/or medical notes. If there is a cause for concern, staff must act accordingly, contacting other professionals, conducting further medical examinations of the child as appropriate and necessary, and ensuring no child is discharged whilst concerns for their safety or wellbeing remain.

Acknowledgement
References

Working Together to Safeguard Children (2015)
HM Government
Laming (2009) The Protection of Children in England: A Progress Report.

ANNEX C - PAEDIATRIC DEPARTMENT PARENT INFORMATION SHEET

Referral to Children's Social Care – Safeguarding Children

This information sheet has been written to help you understand why your child has been referred to Children's Social Care (Social Services) and to answer some of the questions you might have.

Does this mean you think I have harmed my child?

Our job is not to make any judgement, but to ensure the welfare of all children. Where there is a reasonable concern that intentional harm may have occurred, or where a child or family may need extra services, a referral to Children's Social Care will be made. By referring all such children, we will not miss the few where there is a real danger of harm or who need essential additional services.

We are sure that you realise the importance of our vigilance in dealing with children. Sometimes there are features of a child's presentation that make us concerned and when this happens Children's Social Care can assess the situation further. In many of these cases the cause of concern proves to be innocent, and we are all relieved. It is better that we have properly checked things out though.

We may be concerned that your child is not getting all the help he/she needs.

We are aware that this process can be upsetting for parents and carers, but we are also sure that you want us to do the best for all children. This means being thorough with every child.

What happens now?

We will discuss our concerns with a social worker. A decision on how to proceed will be made, and either the social worker or one of the paediatric team will let you know what is happening next. We prefer to work in cooperation with parents, as in most cases we have the same interest – what is best for the child.

Will my child need to be admitted to hospital?

Children are often admitted in situations like these. It will depend on our initial discussion with the Social Worker. We will keep you fully informed of all those decisions.

If my child is admitted, will everyone know why?

No. No other patient/parent will know why your child has been admitted unless you tell them. Nobody put professionals will have access to your child's notes. The staff will know the reason for admission, but our job is to care for your child. It will not affect the way that anyone deals with you. The staff may be asked at a later time about your interaction with your child – they will only say what they have seen. They have dealt with cases like this before, and they know that often it is found that there is nothing to worry about, so they do not come to conclusions before the case has been fully investigated.

Will this affect my 'record' as a good parent?

No. If after investigation there is thought to be no risk to your child, this will be documented as the conclusion to the initial concerns. If further services are needed we can coordinate this. Where initially there are concerns, it is better for matters to be thoroughly assessed, rather than having a concern 'hanging over you'. We hope that you will see that you are part of a team who has the safety and welfare of your child at heart.

What do I do now?

You will be asked questions by other professionals. It is in everyone's interests that you cooperate as much as possible. We understand that it is difficult and upsetting for you, and we will try to make the process as straightforward as we can. We are trying to ensure we do the best for your child and we will keep you informed, and make sure you are an integral part of the process. We would encourage you to ask questions if you have any concerns or queries during this process.

ANNEX D – CHILD PROTECTION FLOWCHART

CHILD PROTECTION PATHWAY – PRACTICE POINTS

PP1. **Preserving evidence**

Any clothes or nappies removed should be collected and stored in a sealed plastic bag labelled and signed. If blood or urine is taken in the course of clinical investigations consideration should be given to saving some for toxicology/DNA etc that may be indicated at a later stage in the investigation.

PP2. **Nursing assessment**

The nurse assessing any child for whom there are concerns about deliberate harm must undertake an holistic nursing assessment of the child. In addition to the use of Roper's model the assessment should take account of the child's developmental needs in the context of the parent/carers capacity to meet those needs and the wider family and environmental factors using the Assessment Framework dimensions

PP3. **Accurate documentation**

All healthcare professionals must maintain comprehensive and contemporaneous records. If doctors are unable to make their own notes, they must be clear about what it is that they wish to have recorded on their behalf. A record must be kept in the child's case notes of any discussions about the child, including telephone conversations relating to the care of the child. If the case notes are not immediately available a record of all discussions must be entered in the case notes at the earliest opportunity so that it becomes part of the child's permanent health record. All decisions made during conversations or discussions about a child must be recorded. In addition a record must be made of who is responsible for carrying out any actions agreed during such conversations or discussions

PP4. **Content of examination**

A full medical examination must be completed within 24 hours for any child for whom there are concerns about deliberate harm. The medical examination will include

- Full baseline details of child including name(s), address, GP, School including details of carers names etc
- Full paediatric history including careful, detailed note of any explanations given for injuries.
- Developmental history
- Parents/carers expressed difficulties or concerns about the child – health, behaviour, development etc,

Detailed examination of whole child to include

- Growth – height, weight, head circumference all plotted on centile charts
- General demeanour and appearance, nutrition
- Signs of neglect, sexual abuse or emotional or behavioural distrurbance
- Development including language and social skills
- Full documentation of any injuries, marks etc using appropriate body maps – all signed, timed and dated

The examining doctor should consider whether taking a history directly from the child is in that child's best interest. When this is so the history should be taken even when the consent of the carer has not been obtained, with the reason for dispensing with consent recorded by the examining doctor

Where consent is required from a child's carer for investigation or treatment of any possible deliberate harm to that child this will be sought by a doctor above the grade of senior house officer

Necessary investigations e.g. skeletal survey, CTscans, photography will be discussed at consultant level.

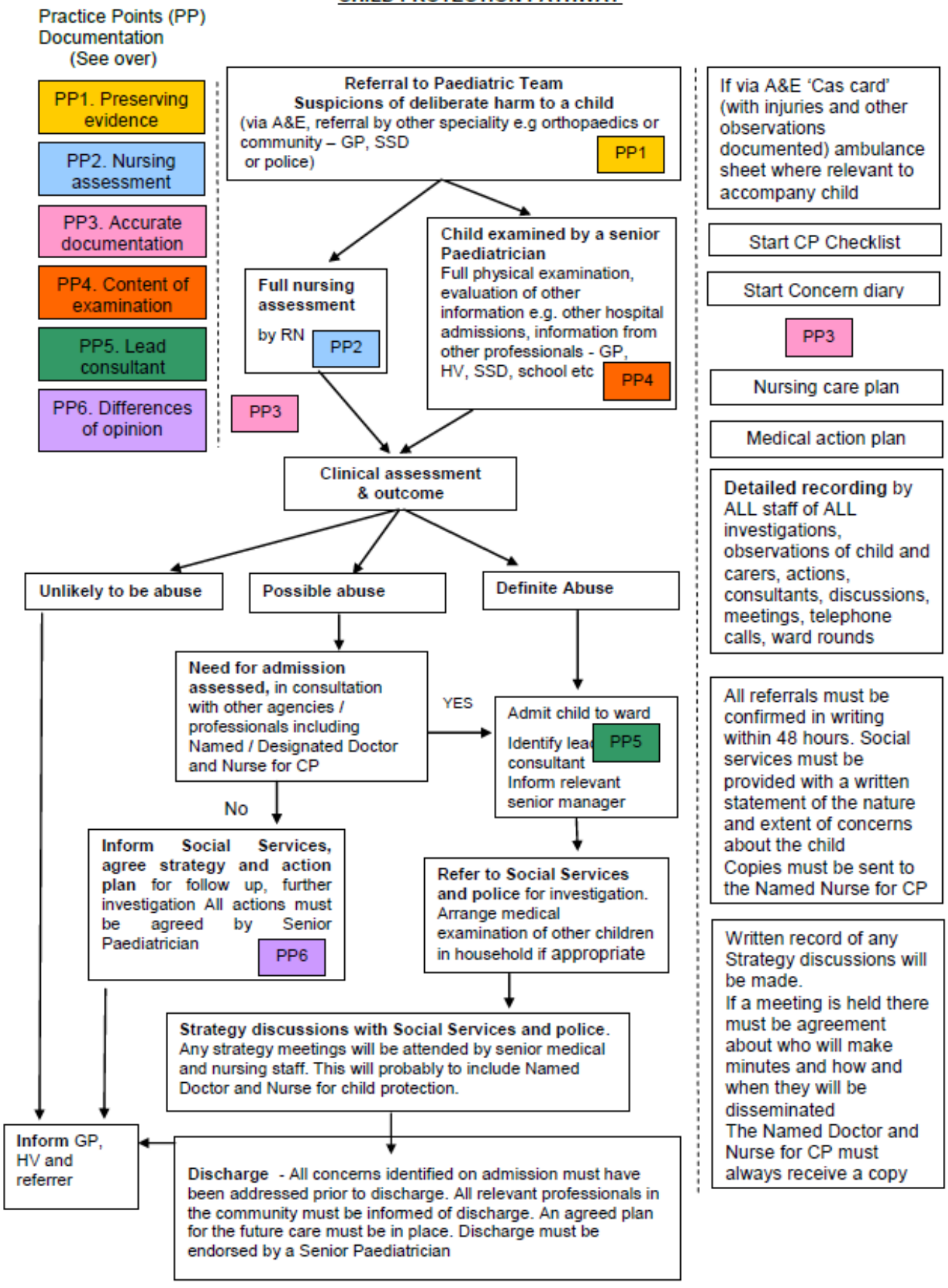
PP5. **Lead consultant**

It is essential that there is clarity about which medical practitioner has responsibility for the child protection aspects of a child's care. This will be a senior paediatrician even if the principal medical concerns fall within another speciality e.g. orthopaedics or surgery. The name of the Paediatrician in charge of the case must be clearly marked in the child's notes.

PP6 **Differences of opinion**

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 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. The Named Doctor and Nurse should be involved in any such discussions. If there is still disagreement there will be discussion with the Designated Nurse and Doctor. All discussions will be recorded

CHILD PROTECTION PATHWAY



ANNEX E – MANAGING CHILD PROTECTION ALLEGATIONS AGAINST STAFF

Also See Trust Disciplinary Procedures

1 Children can be subject to abuse by those who work with them in any and every setting. All allegations of abuse or maltreatment of children by a professional, staff member or volunteer must be taken seriously and treated in accordance with consistent procedures.

2 This procedure detailed here should be followed in respect of any allegation 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 or related to a child; or,
- behaved towards a child or children in a way that indicates s/he is unsuitable to work with children,

in connection with the person's employment or voluntary activity.

If concerns arise about the person's behaviour in regard to his/her own children, the police and/or social care will consider informing the person's employer in order to assess whether there may be implications for children with whom the person has contact at work.

3 **There may be up to 3 strands in the consideration of an allegation:**

- a police investigation of a possible criminal offence;
- enquiries and assessment by children's social care about whether a child is in need of protection or in need of services;
- consideration by an employer of disciplinary action in respect of the individual.

4 Every Trust employee has a responsibility to pass on concerns to their manager if they have concerns that another worker is maltreating a child. All such concerns will be immediately reported to the Director with responsibility for Safeguarding Children and the Director of Human Resources, via the relevant management structure for the employing department. The Named and Designated Professionals for the Trust should also be informed.

5 A decision must be made about who is the most appropriate person to make the referral to the Police or Children's Social Care and to act as the spokesperson for the Trust at strategy discussions and other key stages in the process.

6 If the allegation against a staff member is serious there should be immediate referral to Children's Social Care and the Police for investigation. Other allegations may be much less serious and at first sight might not seem to warrant consideration of a police investigation, or enquiries by children's social

care. However, it is important to ensure that even apparently less serious allegations are seen to be followed up, and that they are examined objectively by someone independent of the department concerned, therefore the Designated and/or Named professionals should also be involved in discussions about necessary actions.

7 The LA designated officer should be informed of all allegations that come to the employer's attention and appear to meet the criteria in paragraph 4.2, so that's/he can consult police and social care colleagues as appropriate. The LA designated officer should also be informed of any allegations that are made directly to the police (which should be communicated via the police force's designated officer) or to children's social care.

8 All such allegations must be reported to the Strategic Health Authority via the Serious Untoward Incident Policy.

9 If the parents/carers of the child concerned are not already aware of the allegation, consideration must be given to how and by whom they will be informed. The LA's designated officer should be consulted and in circumstances in which the police or social care may need to be involved, the LA officer will consult those colleagues about how best to inform parents.

10 The employer should inform the accused person about the allegation as soon as possible after consulting the LA designated officer. However, where a strategy discussion is needed, or it is clear that police or children's social care may need to be involved, that should not be done until those agencies have been consulted, and have agreed what information can be disclosed to the person. If the person is a member of a union or professional association s/he should be advised to seek support from that organisation.

11 If there is cause to suspect a child is suffering or is likely to suffer significant harm, a strategy discussion should be convened in accordance with normal child protection procedures, in these cases the strategy discussion should include a representative of the employer (unless there are good reasons not to do that), and take account of any information the employer can provide about the circumstances or context of the allegation.

12 In cases where a formal strategy discussion is not considered appropriate because the threshold of "significant harm" is not reached, but police investigation might be needed, the LA designated officer will conduct a similar discussion with the police, the employer, and any other agencies involved with the child to evaluate the allegation and decide how it should be dealt with. (N.B. The police must be consulted about any case in which a criminal offence may have been committed.) Like a strategy discussion that initial evaluation may not need to be a face to face meeting. It should share available information about the allegation, the child, and the person against whom the allegation has been made, consider whether a police investigation is needed and if so, agree the timing and conduct of that. In cases where a police investigation is necessary the joint evaluation should also consider whether there are matters which can be taken forward in a disciplinary process in parallel with the criminal process,

or whether any disciplinary action will need to wait completion of the police enquiries and/or prosecution.

13 If the complaint or allegation is such that it is clear that investigations by police and/or enquiries by social care are not necessary, or the strategy discussion or initial evaluation decides that is the case, the Trust's representative will discuss the next steps with the LA designated officer. The nature and circumstances of the allegation and the evidence and information available will determine which of the range of possible disciplinary options is most appropriate. If further investigation is needed to enable a decision about how to proceed this will be planned within the Trust in consultation with the Director of Human Resources, the Director with the Board lead for safeguarding children and the LA's designated officer. However in some circumstances appropriate resources may not be available in the employer's organisation or the nature and complexity of the allegation might point to the employer commissioning an independent investigation.

14 Suspension

14.1 Suspension of an individual may need to be considered pending investigations into allegations. The possible risk of harm to children posed by an accused person needs to be effectively evaluated and managed – in respect of the child(ren) involved in the allegations, and any other children in the individual's home, work or community life. Suspension should be considered in any case where there is cause to suspect a child is at risk of significant harm, or the allegation warrants investigation by the police, or is so serious that it might be grounds for dismissal. People must not be suspended automatically, or without careful thought. Employers must consider carefully whether the circumstances of a case warrant a person being suspended from contact with children until the allegation is resolved. This will be in line with Trust disciplinary procedures.

15 Action following completion of investigation by Police or Children's Social Care

15.1 The police and CPS will inform the Trust as soon as any criminal investigation or trial is complete, or if investigations are closed without charge or charges are not pursued to prosecution.

15.2 Information will be shared with the Trust by police and/or social care and further action with respect to disciplinary actions will need to be considered, taking full account of the different standard of proof required in disciplinary and criminal proceedings.

16 Decisions about referral to the POCA list or relevant professional or regulatory body must be made.

17 The fact that a person tenders his or her resignation, or ceases to provide their services, must not prevent an allegation being followed up in accordance with these procedures. It is important that every effort is made to reach a conclusion in all cases of allegations with bearing on the safety or welfare of children, including any in which the person concerned refuses to cooperate with the

process. Wherever possible the person should be given a full opportunity to answer the allegation and make representations about it, but the process of recording the allegation and any supporting evidence, and reaching a judgement about whether it can be regarded as substantiated on the basis of all the information available should continue even if that cannot be done or the person does not cooperate. It may be difficult to reach a conclusion in those circumstances, and it may not be possible to apply any disciplinary sanctions if a person's period of notice expires before the process is complete, but it is important to reach and record a conclusion wherever possible.

18 So called "compromise agreements" by which a person agrees to resign, the employer agrees not to pursue disciplinary action, and both parties agree a form of words to be used in any future reference, must not be used in these cases. In any event, such an agreement will not prevent a thorough police investigation where appropriate. Nor can it override an employer's statutory duty to make a referral to the Protection of Children Act list or DfES List 99, and/or the relevant professional regulatory body where circumstances require.

ANNEX F - PROCEDURE FOR MANAGING CASES WHERE CHILDREN DO NOT ATTEND PLANNED HOSPITAL APPOINTMENTS

Aim:

To describe a procedure to follow when a patient fails to attend their planned out-patient appointment

Background:

Patients commonly miss appointments. Adolescent patients, those with chronic disorders and psycho-socially disadvantaged children and families are at particular risk of doing so. Paediatric non-attendance is a special circumstance, because the patient (a child) is usually brought to the appointment by an adult (usually a parent). Thus non-attendance may reflect deficiencies in the level of care provided to the child by the responsible adult, in addition to all the more mundane causes for non-attendance common to adult and paediatric patients alike (appointment sent to wrong address, transport difficulties, inconvenience, forgetting, problem now resolved etc). **In certain cases persistent non-attendance may be an indicator of child abuse and neglect.**

Procedure:

When a patient does not attend a booked outpatient appointment, the clinician due to see the child will determine the next course of action, and will notify the out-patient booking team accordingly. This applies to patients that do not attend / are not brought along for appointments without due notice, and also to patients who repeatedly have appointments cancelled and re-booked by their carers, but who miss serial medical reviews as a consequence of this.

What needs to be done when a child fails to attend their OPA depends upon the circumstances, notably whether it is the initial appointment or a follow-up that has

been missed, whether there have been other non-attendances and whether child protection concerns exist about that child.

In every case, whether the child has missed a new appointment or a follow-up appointment, the clinician must review the child's medical notes, noting any ongoing medical and / or safeguarding / social concerns before a deciding upon the appropriate action to take.

First / New Appointments Missed:

A new appointment may be re-booked. Consider whether the address may be incorrect, and whether there is still a need for medical review. Write to the family and the referring GP, and, if the child is under 5 years old, the Health Visitor informing them of the non-attendance, and the planned new appointment.

When, after consultation, a new appointment is not considered necessary then this must be conveyed to the referring GP, the family and the Health Visitor (if under 5 years of age), notifying them of this decision.

If safeguarding concerns exist about the child, the appointment must be re-booked, and the Trust safeguarding team notified. Children's Social Care must also be informed of the child's non-attendance at the appointment.

Follow-up Appointments Missed:

If a child fails to attend a follow-up appointment, a further appointment should be sent to the family if there is ongoing medical need. If there is no ongoing medical need for clinic follow-up, and there are no safeguarding concerns about the child, they can be discharged from further clinic follow-up. This must be conveyed in writing to the GP, family and Health Visitor (if under 5 years).

If a child fails to attend 2 or more consecutive follow-up appointments, the child's GP (and HV if under 5 years old) must be contacted to check the child's contact details, to ensure the ongoing medical necessity of the clinic review, and to inform them of the non-attendance.
If, after consultation, the decision is made not to offer further appointments because there is no ongoing medical need, and no safeguarding concerns, this must be conveyed in writing to the family, GP and HV (if under 5 years).

If there is ongoing medical or social need for clinic review, a further appointment can be sent.

If a child does not attend for 2 or more consecutive appointments, and is assessed to have ongoing medical or social need requiring clinic review, the responsible clinician must contact Children's Social Care to discover whether or not the child is subject to a Child Protection Plan (CPP). If the child is in receipt of a CPP, the clinician must contact the child's key-worker within Children's Social Care to inform them of the child's non-attendance.

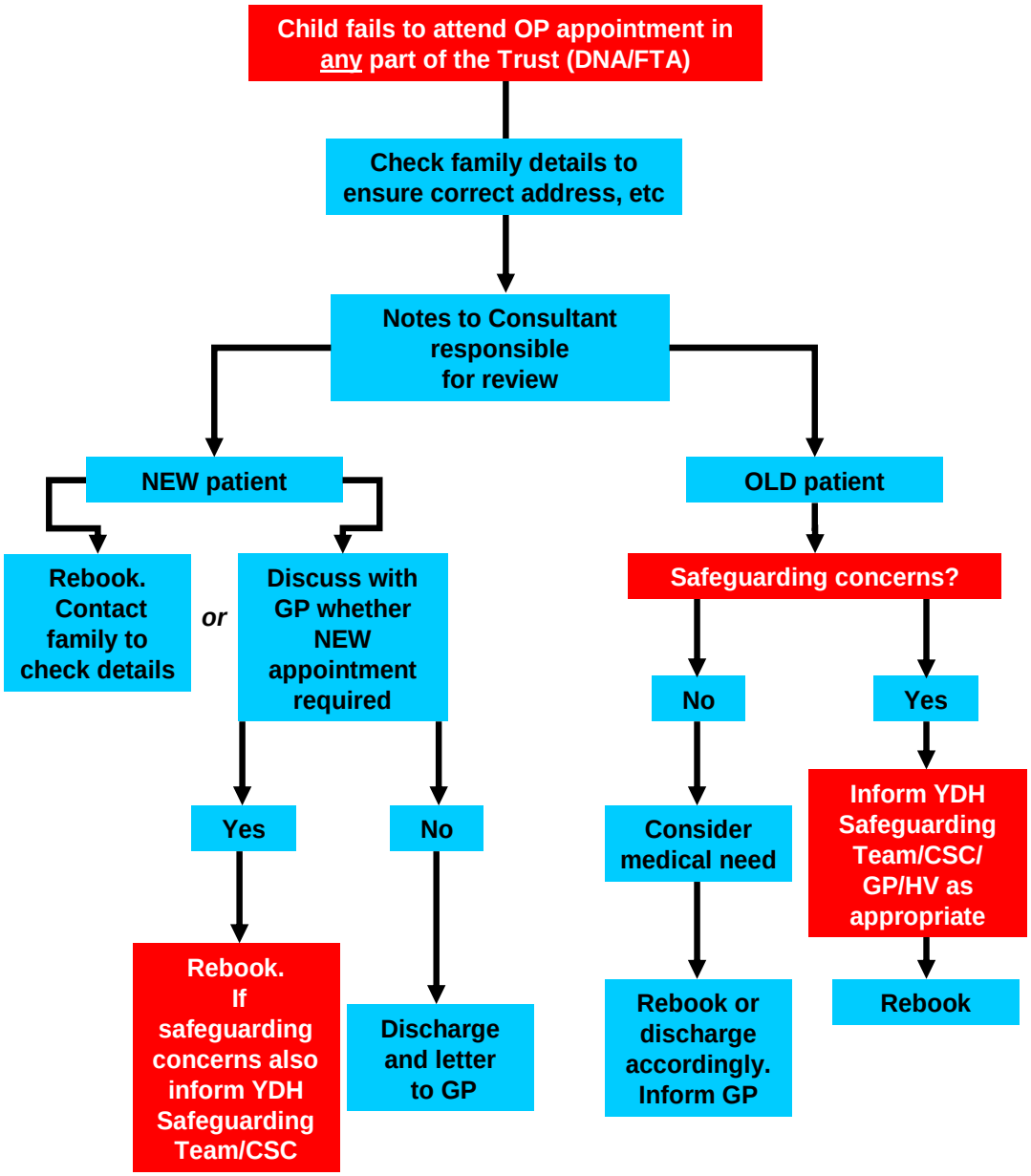
Whenever there are concerns about abuse &/or neglect, and/or the ongoing medical necessity of a clinic review +/- treatment, direct contact must be made with family, GP, and HV (under 5's). The Trust Safeguarding Team must also be informed, and the case discussed with Children's Social Care (Social Services). In all such cases, the Trust Safeguarding Team must be informed of the child's non-attendance in clinic.

(See Flow chart following)

Authors: Tamsyn Nicole, Paul Heaton, Chris Routley (2003)
Updated: Meridith Kane (Sept 2009)

Patient Non-attendance

(for children <18 years)



Note: Second or subsequent FTA/DNA – ALWAYS inform GP and consider referral to YDH Safeguarding Team/CSC re safeguarding procedures

APPENDIX 1 – EQUALITY IMPACT ASSESSMENT TOOL

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	Does the policy/guidance affect one group less or more favourably than another on the basis of:		
	Race	No	
	Ethnic origins (including gypsies and travellers)	No	
	Nationality	No	
	Gender	No	
	Culture	No	
	Religion or belief	No	
	Sexual orientation including lesbian, gay and bisexual people	No	
	Age	No	
2.	Is there any evidence that some groups are affected differently?	No	
3.	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	N/A	
4.	Is the impact of the policy/guidance likely to be negative?	No	
5.	If so can the impact be avoided?	N/A	
6.	What alternatives are there to achieving the policy/guidance without the impact?	N/A	
7.	Can we reduce the impact by taking different action?	N/A	

Approved by: Glen Salisbury, Head of Safeguarding Date: Dec 2015

If you have identified a potential discriminatory impact of this procedural document, please refer it to Yeovil Academy, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact Yeovil Academy.