

Trust Guideline for Safeguarding Children

A clinical guideline recommended

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| For use in: | All Trust departments |
| By: | All Trust staff |
| For: | Children from birth to their 18 th birthday |
| Division responsible for document: | Corporate |
| Key words: | Safeguarding Children, Child protection |
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| Date of approval: | 12/05/2021 |
| Ratified by or reported as approved to (if applicable): | Hospital Management Board |
| To be reviewed before: This document remains current after this date but will be under review | 12/05/2024 |
| To be reviewed by: | Authors |
| Reference and / or Trustdocs ID No: | ID No: 1179 |
| Version No: | 10 |
| Compliance links: (is there any NICE related to guidance) | When to suspect child maltreatment (NICE guideline CG90 2009) |
| If Yes – does the strategy/ policy deviate from the recommendations of NICE? If so, why? | No deviation |

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Version and Document Control:

| Version Number | Date of Update | Change Description | Authors |
|----------------|----------------|---|----------------------------|
| 10 | 12/05/2021 | Addition of new safeguarding subject matters, and addition of appendices. | Dr R Reading Tina Chuma |
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This is a Controlled Document

Printed copies of this document may not be up to date. Please check the hospital intranet for the latest version and destroy all previous versions.

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Quick reference guideline/s

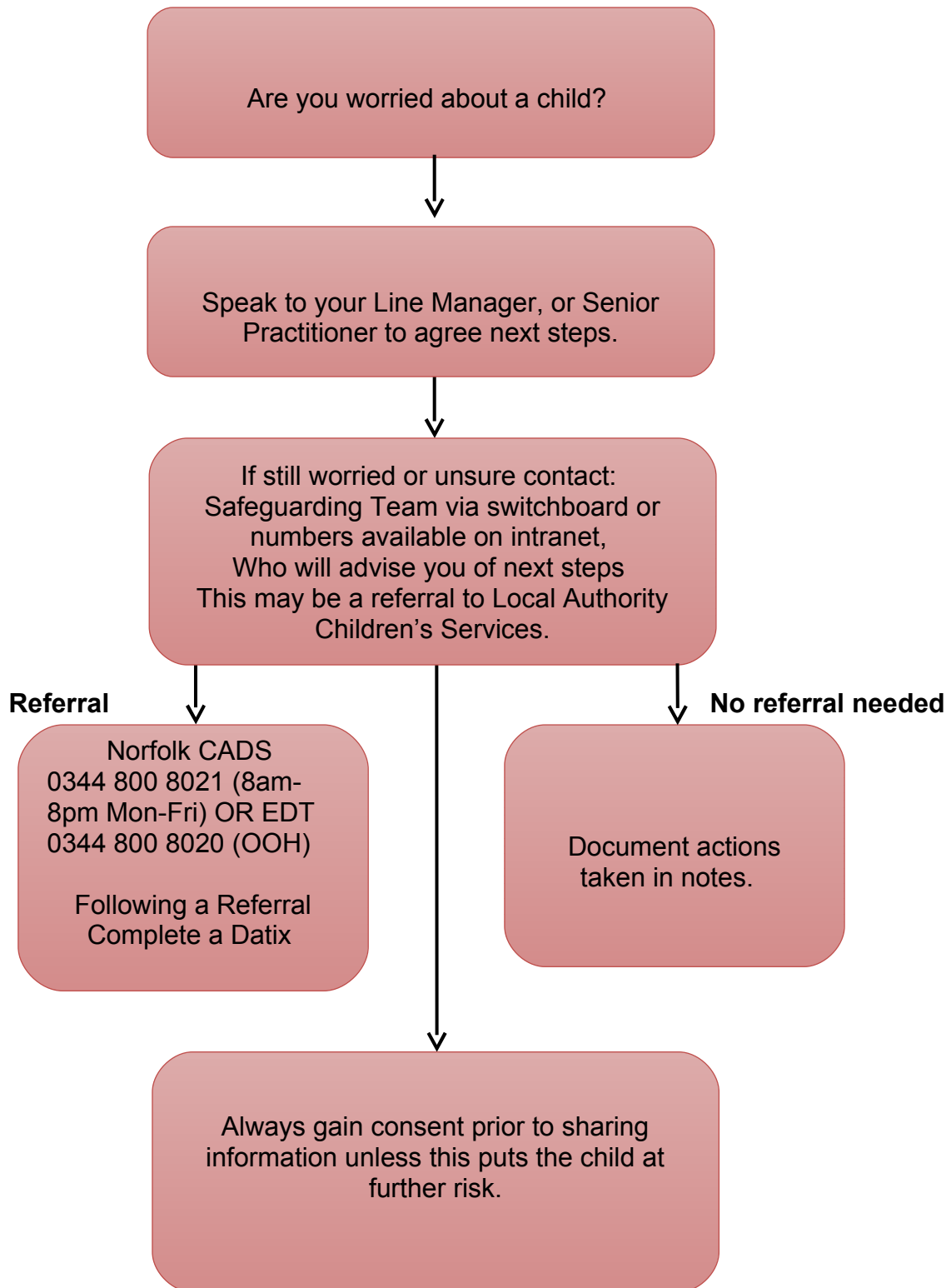
Please see the Norfolk Safeguarding Children Partnership Policy and Procedure Manual Chapter 3.13 on Child Protection Medical Examinations including injuries to non-mobile children <https://www.norfolkscb.org/about/policies-procedures/3-13-medical-examinations/> . Please also refer to NICE guidance CG89 Guidance on when to suspect child maltreatment <http://guidance.nice.org.uk/CG89>. This guidance provides details of the four categories of abuse; physical, emotional, sexual and neglect. The Norfolk Safeguarding Children Partnership also has helpful resources in relation to Child Sexual Exploitation, Child Sexual Abuse and Neglect. These resources can be accessed by following this link <http://www.norfolkscb.org/people-working-with-children/>.

If concerns are identified then:

- Get advice from your line manager, senior practitioner or a member of the safeguarding children team.
- A paediatrician, member of the safeguarding team or safeguarding midwife should be involved if there are concerns about an immediate risk to a child or an unborn baby.
- If the child has been identified to be at risk of harm and/or neglect then the child should be referred by telephone to children's social care services via the Children's Advice and Duty Service (CADS) 0344 800 8021 8am-8pm Mon-Fri, or by contacting the Emergency Duty Team (EDT) 0344 800 8020 out of hours.
- For all safeguarding referrals a Datix report must be completed. Instructions on how to complete this easily and rapidly are available on the Safeguarding Children Intranet page (Press "SAFE" button on Intranet home page) See appendix 6.
- It is the responsibility of the professional identifying the concern to ensure that a referral to children's social services is made, if appropriate, and for that professional to access any support they may require either in making the referral or for support following the referral being submitted.
- Although professionals have a duty of confidentiality, in certain circumstances the law and professional regulating bodies permit the disclosure of confidential information necessary to safeguard a child.
- Best practice should ensure consent is obtained from the parents/carers prior to a referral being made. However if the professional feels that by disclosing a referral to Children's Services is being made, will put the child at immediate risk of further harm or abuse disclosure to parents is not required. The decision not to seek consent from parents must be fully documented.
- Document clearly what concerns you have and what actions have been taken.
- Inform a member of the safeguarding team when appropriate; by telephone or by completing a cause for concern form, which are available on the intranet, and email to SafeguardingChildren@nnuh.nhs.uk There are separate paediatric and maternity forms and they should be fully completed and detail exactly what the issues are as well as the planned interventions or actions taken. Please note these are information sharing forms only, the safeguarding responsibility remains with the clinician.

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Safeguarding Children Reporting Flow Chart



If the child is already open or active to a Social Worker (SW) under section 17, section 47 or LAC, escalate any new concerns directly to the SW. If you are unable to speak to the SW, do this via CADS or EDT

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Useful Contacts

Norfolk and Norwich University Hospitals (NNUH) Children`s Safeguarding Team

- Named Doctor for Safeguarding Children- via switchboard 01603 286286.
- Associate Director for Complex Health and Safeguarding- internal ext 2300, external 01603 286300.
- Named Nurse for Safeguarding Children – internal ext 2914, external 01603 286914.
- Named Midwives for Safeguarding- internal exts 2833/ 3056, external 01603 286833 / 01603 287056.
- Specialist Safeguarding Practitioner for child and adult safeguarding- internal ext 3873, external 01603 287873.
- A&E Safeguarding Practitioner- internal ext 3449, external 01603 286286 ext 3449.
- Safeguarding Assistant Practitioner- internal ext 3318, external 01603 287318.
- Safeguarding Administrator- internal ext 3835, external 01603 287835.
- Named Nurse for Safeguarding Adults- 01603 286286 ext 6028.
- MCA / DOLS Lead- 01603 286286 exts 4176 / 7479.
- Generic email- SafeguardingChildren@nuh.nhs.uk.

Other useful contacts

- Norfolk Children`s Advice and Duty Service (CADS) - 0344 800 8021 8am-8pm Mon-Fri for professionals only.
- Norfolk Emergency Duty Team (EDT) - 0344 800 8020 out of hours.
- Members of the public can contact Norfolk Children`s Service on 0344 800 8020.
- Norfolk Safeguarding Children`s Partnership <https://www.norfolkscb.org/>.
- Norfolk Designated Safeguarding Children`s Team (Norfolk & Waveney CCGs) - 01603 257164.
 - NSPCC National Helpline - 0808 800 5000.
 - ChildLine - 0800 1111.
 - Child Exploitation and Online Protection (CEOP) - 0870 000 3344.

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Objective/s

To ensure that doctors, nurses, midwives, allied health professionals, clerical staff and any other employee of the trust, who may be in contact with a child, are aware of the procedures and their roles and responsibilities when a child is identified to be at risk of abuse or neglect. The purpose of this policy is to provide clear and consistent guidelines in relation to safeguarding children and unborns.

- **The Children Act (1989)** introduced the framework of significant harm which requires the compulsory intervention into family life in order to safeguard children. The Local Authority has a duty to investigate where there is reason to suspect that a child is suffering or likely to suffer significant harm.
- **The Children Act (2004)** states the requirement of each Local Authority, health provider and partner agency to make arrangements to promote co-operation between the authorities. Section 11 (Children`s Act 2004) places a range of duties on organisations and individuals to ensure their functions are discharged with regard for the need to safeguard and promote the welfare of children.
- **The Equality Act (2010)** places a responsibility on public authorities to have due regard for the need to eliminate discrimination and promote the equality of opportunity. This applies to the identification and risk faced by individual children and states that no child or group of children should be treated any less favourably than other in being able to access effective services to meet their specific needs.
- **The Children and Social Work Act (2017)** sets out how agencies must work together by placing new duties on the Police, Clinical Commissioning Groups, and the Local Authority to make arrangements to work together, and with other partners locally to safeguard and promote the welfare of all children in their area.
- **Working Together to Safeguard Children (2018)** is a statutory guidance on inter-agency working to safeguard and promote the welfare of children.
- **The NHS England Accountability and Assurance Framework (2019)** sets out clearly the safeguarding roles and responsibilities of all individuals working in providers of NHS funded care settings and NHS commissioning organisations.

Rationale

All Trust staff have a duty to safeguard children from harm and it is expected that staff familiarise themselves with their duty in this regard. A person is considered to be a child from birth until their 18th birthday. The factors below **do not** change the definition of a child if they are:

- Living independently.
- In further education.
- A member of the armed forces.
- In hospital.
- In custody.

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- In secure accommodation for children and young people.

This guideline outlines staff responsibilities, and who to contact when a child at risk is identified.

- All health service professionals, whether they work within adult or child services, have a responsibility to safeguard and promote the welfare of children as detailed in Section 11 of the Children Act 2004.
- Failure to initiate child protection procedures when required may present a risk of further harm to a child and also instigate an enquiry into the reasons why proper processes were not followed.

Clinical Audit Standards

Compliance with the processes and record keeping audits are regularly undertaken.

Summary of development and consultation process undertaken before registration and dissemination

The authors listed above, on behalf of the division, have agreed the final content after drafting the guideline. During its development it has been circulated for comment to: Paediatric, A&E consultants.

Members of the Safeguarding Team.

Distribution list / dissemination method

All areas in the Jenny Lind Children's Department.

Maternity Unit.

Consultant Paediatricians.

Accident and Emergency Department.

Practice Development and Education Department.

Trust Intranet – Safeguarding Children departmental page.

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GMC Guidance

The safety of the child is paramount and overrides the usual duties of confidentiality. Guidance from the General Medical Council states: “You can share confidential information without consent if it is required by law, or directed by a court, or if the benefits to a child or young person that will arise from sharing the information outweigh both the public and the individual’s interest in keeping the information confidential.

If a child or young person with capacity, or a parent, refuses to give consent to share information, you should consider their reasons for refusing, and weigh the possible consequences of not sharing the information against the harm that sharing the information might cause. If a child or young person is at risk of, or is suffering, abuse or neglect, it will usually be in their best interests to share information with the appropriate agency”.

For further advice see Protecting Children and Young People: The responsibilities of all doctors (2012) http://www.gmc-uk.org/guidance/ethical_guidance/13257.asp

Guidance for specific staff groups

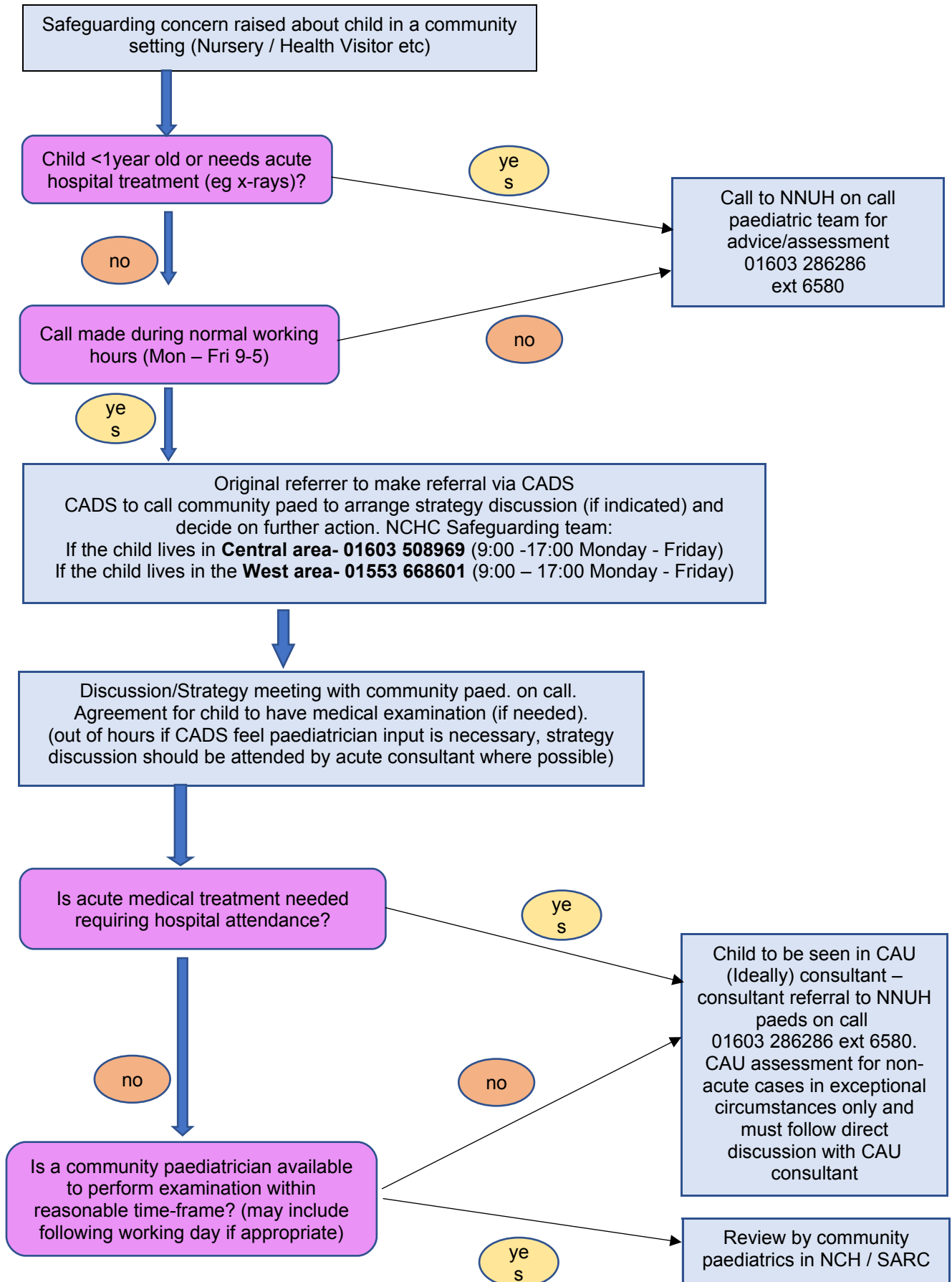
Non-paediatric medical or surgical teams

Child abuse or neglect needs to be considered with any injury or unexplained recurrent problem (including self harm) presenting to specialist services. Clinicians from many specialties (especially orthopaedics, plastic surgery and ENT) need to consider child abuse when they are seeing children.

Referrals for further investigation or management should come to the consultant paediatrician on-call either via switchboard or, for in-patients on the paediatric wards, by discussion with the on call paediatric team for the ward and documenting the referral/discussion outcome in the medical records.

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Roles and Responsibilities of Acute and Community Paediatricians



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Consultant responsibility for any case is best considered according to the patient journey. If the child is being assessed outside of hospital, the consultant community paediatrician is generally responsible. If the child is being assessed in the Emergency Department and has not yet been admitted, consultant responsibility is with the ED consultant (who may be a paediatrician).

Once a child has been admitted to CAU for assessment, but not yet formally admitted to the ward, consultant responsibility is with the CAU consultant. Thereafter, the ward Consultant of the Week takes responsibility for all patients admitted over that week and continues to be responsible for the case. If another consultant is covering out of hours work when a child is admitted, careful handover to the consultant of the week is vital.

This is the default. There may be occasions when another consultant is prepared to take responsibility (for example, if they have been extensively involved in the assessment or have a special area of expertise).

In any case of doubt the consultants involved must agree and document who takes overall clinical responsibility! Please refer to the flowchart above.

Acute paediatrics

Children presenting acutely (usually via ED [see supplement 'For use in the Accident and Emergency department at the back of this guideline, appendix 8'] or primary care) for the management of illness or injury where child abuse is included in the differential diagnosis are the responsibility of the acute paediatric team. This will include children whose injuries are sufficiently severe to require urgent assessment including investigations and admission while initial enquiries are undertaken. Specific examples include:

- Infants under age 1 yr and non-mobile children with any injury (including bruises).
- Any child requiring an urgent place of safety where this cannot be guaranteed in the community.
- Children requiring urgent inpatient investigation.
- Children admitted under other non-paediatric specialties such as orthopaedics.
- Children with significant genital injuries (see trust guideline on Children Presenting with genital or perineal injury (Trust docs CA5139)).

Community Paediatrics

Children presenting with problems, which require assessment and investigation but not admission, will normally be referred to the community paediatrician on call. These cases are often referred by Children's services or the police but may come through primary care. Specific examples include:

- Mobile children over one year with injuries not requiring treatment
- Children where there are concerns about sexual abuse.
- Neglect or emotional abuse.

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If such cases present out of hours to the acute service the on call consultant should decide whether the child should be seen there and then, or whether it is appropriate to defer assessment until a community paediatrician is available during regular working hours.

These distinctions are not absolute and there will be grey cases where the ideal referral pathway is not clear. **Responsibility for these cases must be clarified at the time of presentation by direct discussion between the acute and community paediatrician.**

Second opinions and peer review

It is good practice to discuss the management of cases involving safeguarding children with a colleague. The community paediatrician on call for child protection and/or the Named Doctor for Safeguarding Children is usually available within normal working hours. Discussing management in this way does not imply the need to transfer responsibility. It is not always necessary for the second consultant to talk to the parents or examine the child. Complex clinical cases can usefully be reviewed on the grand round with input from radiology colleagues. It is also good practice for conference reports and police statements to be peer reviewed prior to submission.

Paediatric medical team

Most GP calls will be passed to the consultant via the consultant held DECT phone (ext 6580) on Children's Assessment Unit (CAU) or Children's Emergency Dept (CHED).

1. The middle grade paediatrician on-call (SpR)

The middle grade paediatrician will lead the assessment of most child protection cases who present acutely to the hospital. The role of the middle grade is to accept appropriate referrals, to plan and execute an assessment of the case and to consult regularly with the consultant paediatrician on-call.

- (a) Accept referrals - The consultant or middle grade paediatrician will accept referrals from Norfolk Children's Services, the NNUH Emergency Department, general practitioners and other medical or surgical teams seeking advice about safeguarding children procedures.
- (b) Attend telephone strategy meeting – in cases where children's services have received a referral and are seeking a paediatric assessment, they are advised to hold an initial strategy meeting to which a paediatrician should be invited. These are important meetings in planning out a safeguarding investigation and ensuring children's safety. They should be attended by either the consultant paediatrician on call or the middle grade paediatrician with consultant support and advice.
- (b) The middle grade paediatrician should plan an appropriate assessment. Usually children referred with child protection concerns have their initial clerking and assessment carried out by the middle grade on-call. There may be circumstances where this task can be delegated to a more junior trainee with appropriate oversight and supervision. The assessment will

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consist of a carefully constructed history, examination and, if necessary, investigations. Guidance on these procedures is included in the safeguarding children assessment paperwork which is available from most of the ward areas. **It is important this assessment form is completed fully and accurately.** Once the initial assessment is complete the paediatric middle grade doctor on-call will discuss the case with the consultant paediatrician on-call. This discussion may arrive at one of three conclusions.

- The assessment confirms that the child is at risk and a referral will be made to children's social care services if they are not already involved.
- The assessment may produce convincing evidence that the injuries to the child were accidental, the child is not at risk and no further action need be taken.
- The assessment may conclude that there is insufficient evidence at the present time. In that case children's social care services should be contacted to share concerns and discuss the appropriate way forward.

Important reminders

- This whole process is designed to ensure children are kept safe. **If there is evidence that the child is at risk they should remain in hospital as a place of safety until the assessment is complete and the child's safety assured.**
- If the assessment has concluded that the child is at risk remember that siblings may also be at risk.
- The police are involved through their membership of the Multi-Agency Safeguarding Hub (MASH) team. A direct referral from the NNUH is not required. The police may be involved in the early stages if parents or carers are threatening or abusive, or if they want to remove the child against medical advice. In some cases it is important to involve the police early for example, so that forensic evidence at the scene of an assault on a child can be collected before it deteriorates.
- In summary, the paediatric middle grade will assess, consult and refer. Always remember the aim is to keep the child safe.

2. The On-Call Consultant Acute Paediatrician

The consultant paediatrician on-call for the ward must be informed of all in-patients where child abuse is considered in the differential diagnosis irrespective of the admitting speciality.

If the child is referred to the Emergency Department this guidance may apply to the consultant in the A&E Department if urgent action is required. However liaison with the consultant paediatrician on call will still be necessary.

The consultant paediatrician on-call takes primary responsibility for safeguarding children matters for all children who are in-patients; irrespective of the child's clinical

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need and involvement of other consultants. This is in accordance with statutory advice. Please see guidance on consultant responsibility on page 10.

The consultant paediatrician will seek to answer the questions:

- Is there evidence of child abuse?
- What are the medical problems?
- Are there any forensic concerns?
- Is the index child safe?
- Are siblings safe?

Action required must include:

- Ensuring appropriate medical care.
- Immediate discussion with social care colleagues via CADS
0344 800 8021 (8am-8pm Mon-Fri) or EDT 0344 800 8020 (Out of hours).

Always consider whether:

- A joint interview with parents and a social worker would be useful and timely
- Forensic investigations are required and hence early police involvement.

It is the responsibility of a social worker to inform the police; but this should not preclude any health professional from doing the same should the need arise.

A consultant paediatrician must assume continuing responsibility for the case to include:

- Writing reports.
- Attending case conferences.
- Preparing evidence and attending court.
- Supervising junior staff involved in such activities.

Patients where there have been child protection concerns may only be discharged on the advice of a consultant paediatrician. The discharge proforma form in the safeguarding children paperwork must be fully completed.

The consultant community paediatricians are available to provide a further opinion or examination. Usually this request would be made at a consultant to consultant level.

Consultant Community Paediatrician

The consultants in community paediatrics offer a first line service to all referrals from children's social care services, GPs and the police during working hours, Monday to Friday. They also offer a consultation service to senior paediatric colleagues. If the consultant in community paediatrics has assumed responsibility for the case they will carry out all the roles of the acute consultant in paediatrics detailed above.

General guidance for Trust Staff

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- 1. Training.** All staff should attend appropriate safeguarding children training as set out in the Intercollegiate Document. Training is available at different levels depending to what extent staff are working with children. All clinical staff are required to undertake Safeguarding Adults and Children Level 3 Training. Advice on training is available in the Trust's Safeguarding Children Training Strategy which can be found on the Intranet.
 - 2. Attitude.** All staff should be willing and able to identify children who have been or are at risk of being harmed. This ability depends on roles, experience and training. Consideration of safeguarding issues should ideally occur at every initial contact with patients and clearly documented that it has been considered and dismissed or acted upon.
 - 3. Identification / discussion / referral.** NICE guidance (CG89 2009) 'When to suspect child maltreatment' describes clinical features which should raise *suspicion* of child maltreatment or *consideration* of child maltreatment. Clinical features which indicate a suspicion of child maltreatment require referral either to the appropriate hospital team or to Children's Services. Clinical features which indicate that child maltreatment should be considered require discussion with an appropriately experienced person(s). Referrals to Children's Services or the police should be made via the CADS (0344 800 8021 8am-8pm Mon-Fri) or EDT (0344 800 8020 Out of Hours). Referral to a paediatrician may be made to the acute hospital paediatric team, for infants and anyone likely to require admission; or to the community paediatrician on call for child protection for anyone unlikely to require admission or cases of possible sexual abuse. If it is unclear where a referral should be made advice can be obtained from the Safeguarding Team or the community paediatrician on call. Discussion about cases where child maltreatment should be considered may be with the safeguarding team, the acute paediatric on call registrar or consultant, the community paediatrician on call or CADS, whichever seems most appropriate.
 - 4. Child sexual abuse.** Concerns about child sexual abuse can be referred as above. The paediatric team will refer all such cases to the consultant community paediatrician on call via switchboard. While trust staff should not attempt to perform specific examinations for sexual abuse unless trained, genital, perineal and anal examinations should be performed if clinically indicated otherwise (eg to exclude infection, injury etc).
- 1. Fabricated or induced illness (FII).** Staff should discuss their concerns regarding FII with the named or designated doctor or a member of the safeguarding team. Guidance on the management of FII is to be found In the Royal College of paediatricians document **Perplexing Presentations (PP) / Fabricated or Induced Illness (FII) in Children RCPCH guidance (March 2021)** <https://childprotection.rcpch.ac.uk/resources/perplexing-presentations-and-fii/>
 - 2. Confidentiality.** It is important to be open with parents. Parents should usually give consent for a referral to be made unless, in the staff's view, seeking such consent would increase the chances of the child coming to harm. Irrespective of consent being obtained for a safeguarding referral, parents must always be informed that a referral has been made. See GMC guidance above. Further advice and guidance can be sought from one of the Safeguarding Team.

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- 3. Safety.** Staff are reminded of the importance of keeping safe and avoiding conflict, parents or carers should not be confronted and no attempt should be made to physically restrain families who are acting against advice and seeking to leave. If families leave under these circumstances police and children's social care services should be involved as a matter of urgency. If families or carers become threatening or abusive call security.
- 4. Medical records.** Staff should keep clear and comprehensive notes of all discussions with the family and other agencies on the designated Safeguarding Children paperwork. Staff must not photocopy notes for other agencies without the appropriate request being submitted to NNUH Legal Department.
- 5. Supervision.** Staff should report their involvement in child protection cases to the relevant lead professional and/or a member of the Safeguarding Children team. Staff should be ready to provide reports or attend conferences. Nursing, midwifery and allied health professional (AHP) staff may request guidance or support from their lead professional or a member of the Safeguarding Children team in these circumstances. Formal Safeguarding Children supervision is available for staff – see Health Care Professionals participating in Safeguarding Supervision Policy on Trust Docs for how to access this. Medical staff can also request guidance, advice and supervision from the Named Doctor for Safeguarding Children.
- 6. Differences of opinion between staff.** There may be occasions when staff have different opinions about the appropriate management of a child protection case. Usually these differences will be resolved by discussion but in the event of an impasse further opinions will be sought – in the first instance from either the Named Nurse or Named Doctor for Safeguarding Children. There may be instances where it is helpful for Children's Services to be aware that there are differences in medical opinion. These differences must be presented professionally in an agreed fashion as there is no place for medical dispute at a case conference or other multiagency meetings.
- 7. Differences of opinion between agencies.** If staff feel that their concerns about a child are not being taken seriously or are not being managed by Children's Services appropriately there is a clear escalation process to follow. This can be found on the Safeguarding Children dept page under Referrals to Children's Services.
- 8. Professional Boundaries.** Maintaining professional boundaries is essential to providing safe and quality care for patients. It ensures personal and organisational reputation is maintained, professional standards are upheld and statutory requirements are met. Staff should be aware that this responsibility extends to conduct on the internet and in the use of communication devices such as mobile phones and tablets.

Nurses, Midwives and Therapists

Nurses, midwives and therapists are often in the front line when it comes to safeguarding children as they build close relationships with children and families who then feel that they can confide in them. Because of this, nurses, midwives and

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therapists should ensure that they have had sufficient training to enable them to be alert to the risk factors, signs and symptoms associated with child abuse and that they can recognise situations that are potentially harmful to the child.

See the Safeguarding Children Training Strategy on the intranet for details of training and how to access this as well as the Norfolk Safeguarding Children Partnership web page for specific training opportunities.

If a child chooses to approach staff and disclose abuse they should listen and always take such allegations seriously. They should also ensure that they keep an accurate record of the conversation and their subsequent actions. The same procedure should be followed if they suspect that a child is at risk but the child has not disclosed this.

Multi agency pre birth protocol

Very young babies are extremely vulnerable and work carried out in the antenatal period to assess risk and to plan intervention will help to minimise harm. The antenatal assessment is a valuable opportunity to develop a proactive multi-agency approach to families where there is an identified risk of harm.

This protocol supports practice that is located within documents such as The Munro Review of Child Protection, Maternity Matters, the Antenatal and Postnatal NICE Guidance and The Child Health Promotion Programme as well as Working Together to Safeguard Children 2018 and **should be used by all professionals when assessing pregnant women** and not just in those cases that have already been identified with child protection issues.

Although the legal status of an unborn child is limited, the duty to safeguarding remains a priority. If there is reasonable cause to suspect a child is at risk of harm before birth or following birth it is appropriate to take action to identify and address the risks.

Where an unborn baby is likely to be in need of support from Children's Services when born, it is the responsibility of all professionals to make such a referral to either Early Help or Children's Services dependant on the gestation of the unborn and the level of concerns and parental consent.

Wherever possible, the referrer should share their concerns with the prospective parent(s) and seek to obtain agreement to refer to either Early Help or Children's Advice and Duty Service (CADS), unless this action may place the unborn child at risk, for example, the parent(s) possibly making their whereabouts unknown.

These circumstances include (but are not limited to):

- Where concerns exist regarding the mother's ability to protect.
- Where alcohol or substance abuse is thought to be affecting the health of the unborn baby.
- Where expectant parents are themselves deemed as children/ young people (under age 18yrs) and there are a number of concerns/complicating factors evident that would need to be considered to ensure the safety of parent/s and unborn. Where expectant parents are under the age of thirteen a referral regarding expectant parent/s and unborn baby must be submitted.

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- Where a previous child in the family has been removed because they have suffered harm or been at risk of significant harm.
- Where the expectant parents are currently active to Social Care and / or they have children who are currently active to Social Care.
- Where a previous child / children have experienced neglect, emotional, physical or sexual abuse and these concerns continue to be evident and would impact on the unborn baby in pregnancy and once born by virtue of the child being dependant on their caregiver.
- Where a person who has been convicted of an offence against a child, or is believed by child protection professionals to have abused a child, has joined the family.
- Where there are acute professional concerns regarding parenting capacity, particularly where the parents have either severe mental health problems or learning disabilities.
- Where the child is believed to be at risk of significant harm due to domestic abuse.
- Where there are any of the above concerns parents of unborn babies should be offered intervention and support at the earliest opportunity. This will assist parents by offering them support services at a much earlier stage and will support in future care planning and assessments.

Early help involvement can be offered as soon as the pregnancy is known with a lead professional being identified to co-ordinate the support and intervention to ensure their needs are met and positive outcomes are achieved.

An early response to expectant parents:

- Avoids initial approaches to parents in the latter stages of pregnancy, as this is already an emotionally charged time.
- Enables parents to have more time to contribute their own ideas and solutions to concerns and increases the likelihood of a positive outcome.
- There is an expectation that professionals will discuss with parents the value of early help intervention and support and will ensure consent is obtained.

If consent is refused practitioners throughout their involvement should continue to advocate the benefits of this. However if a refusal to give consent continues and practitioners believe that the threshold for statutory services is met a referral should be made to Children's Services between 16 and no later than 20 weeks of gestation.

The full protocol can be found on Trust Docs and also the Norfolk Safeguarding Children Partnership website. A summary flowchart is shown in Appendix 7. The Trust has agreed and committed to work within the guidance of this protocol.

Safety

Give thought to your own safety and that of other staff, particularly community colleagues who may be visiting a household alone. Do not confront parents. Do not try to restrain them if they attempt to leave with the child. If persuasion fails call security and the police.

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Maternity staff should be aware that if a woman attends for delivery without her hand held records and without any other means of identification to verify who she is, then she should not be discharged with a baby until we have satisfactory evidence of her identity. This should only involve a partner/relative going home to collect the hand held notes. If any adverse reaction or refusal to get the records (prior to discharge) ensues, then it can reasonably be assumed that this is a suspect case and further investigations should be undertaken with the Safeguarding Children Team and / or CADS.

Confidentiality

Personal information about children and families held by professionals and agencies is subject to a legal duty of confidence and should not normally be disclosed without the consent of the subject. However, the law permits the disclosure of confidential information necessary to safeguard a child or children in the public interest. The public interest in child protection takes priority over the public interest in maintaining confidentiality. Disclosure should be justifiable in each case, according to the particular facts of the case. Legal advice from the Trust Legal Dept may be sought in cases of doubt (Working Together to Safeguard Children 2018).

PAS alerts

Safeguarding Children alerts for children on a Child Protection plan are placed against a child's record on PAS if the child:

- Is a Norfolk child, and
- Has a hospital number
- An alert on the mother's notes if they are pregnant and the unborn baby is open to Children's Services.

The alert will say either 'Safeguarding concerns – CP Plan', 'Safeguarding concerns – CP Plan ended (date)' or in the case of an unborn baby the mother's alert will state 'Safeguarding concerns – see obstetric notes'. The alerts are on the system as additional information only and should not replace professional judgement in any situation; they should not be regarded as either reassuring or not reassuring.

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Appendix 1: Definitions of Child Abuse and Web Link Guides

| | |
|---|---|
| <p>Neglect -The ongoing failure to meet a child`s basic needs. For adolescents this could also be missing education; lack of attention; no stability; no supervision or clear boundaries thus placing them at risk of other forms of abuse, becoming a carer due to parental mental health or substance misuse.</p> <p>https://www.nspcc.org.uk/what-is-child-abuse/types-of-abuse/neglect/#what-is</p> | <p>Child sexual abuse - A form of abuse in which an adult or older adolescent uses a child for sexual stimulation.</p> <p>https://www.nspcc.org.uk/what-is-child-abuse/types-of-abuse/child-sexual-abuse/</p> <p>Harmful sexual behaviour - child on child abuse</p> <p>https://www.nspcc.org.uk/keeping-children-safe/sex-relationships/sexual-behaviour-children/</p> |
| <p>Emotional abuse - the type of abuse that involves the continual emotional mistreatment of a child.</p> <p>https://www.nspcc.org.uk/what-is-child-abuse/types-of-abuse/emotional-abuse/#what-is</p> | <p>Physical abuse - When someone physically harms a child.</p> <p>https://www.nspcc.org.uk/what-is-child-abuse/types-of-abuse/physical-abuse/</p> |
| <p>Child sexual exploitation - when a child or young person is given things like gifts, money, status or drugs, in exchange for performing sexual activities.</p> <p>https://www.nspcc.org.uk/what-is-child-abuse/types-of-abuse/child-sexual-exploitation/</p> | <p>County Lines - illegal distribution and dealing of drugs from one city/county to another.</p> <p>https://www.nationalcrimeagency.gov.uk/what-we-do/crime-threats/drug-trafficking/county-lines</p> |
| <p>Trafficking and modern day slavery - movement of children and young people with the aim of exploiting them.</p> <p>https://www.nspcc.org.uk/what-is-child-abuse/types-of-abuse/child-trafficking/</p> | <p>Contextual Safeguarding - it is an approach to safeguarding that responds to young people`s experiences of harm outside of the home, eg, with peers, in schools or neighbourhoods.</p> <p>https://learning.nspcc.org.uk/news/2019/october/what-is-contextual-safeguarding</p> |
| <p>Online abuse - any type of abuse that happens on the internet.</p> <p>https://www.nspcc.org.uk/what-is-child-abuse/types-of-abuse/online-abuse/</p> | <p>Grooming - when someone builds a relationship, trust and emotional connection with a child or young person so they can manipulate, exploit and abuse them.</p> <p>https://www.nspcc.org.uk/what-is-child-abuse/types-of-abuse/grooming/#what-is</p> |

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For Domestic Abuse see [Trustdocs Id: 1106](#).

For Female Genital Mutilation (FGM) see [Trustdocs Id: 11407](#).

For Radicalisation / Extremism / PREVENT see [Trustdocs Id: 10320](#).

Appendix 2: References / source documents

Norfolk Safeguarding Children Partnership Policy and Procedure Manual Chapter 3.13: Child Protection Medical Examinations including injuries to non-mobile children
<https://www.norfolkscb.org/about/policies-procedures/3-13-medical-examinations/>

Norfolk Safeguarding Children's Partnership: <https://www.norfolkscb.org/>

NSPCC: <https://www.nspcc.org.uk/>

Pregnancy and complex social factors: A model for service provision for pregnant women with complex social factors (NICE guideline CG110 2010)
<http://publications.nice.org.uk/pregnancy-and-complex-social-factors-cg110>

Protecting Children and Young People: The responsibilities of all doctors (2012)
http://www.gmc-uk.org/guidance/ethical_guidance/13257.asp

Safeguarding Children and Young People: Roles and Competencies for Health Care Staff (2019) <https://www.rcn.org.uk/professional-development/publications/pub-007366>

The Children Act 1989/2004 - The Children Act 1989/2004

The Children and Social Work Act (2017)
[Children and Social Work Act 2017 - Legislation.gov.uk](#)

The NHS England Accountability and Assurance Framework (2019): Safeguarding Children, Young People and Adults at risk in the NHS

The Victoria Climbié Inquiry: report of an inquiry by Lord Laming (2003) London: The Stationery Office. www.victoria-climbié-inquiry.org.uk

When to suspect child maltreatment (NICE guideline CG90 2009)
<http://publications.nice.org.uk/when-to-suspect-child-maltreatment-cg90/introduction>

Working Together to Safeguard Children. A guide to inter-agency working to safeguard and promote the welfare of children (DfE 2018)
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942454/Working_together_to_safeguard_children_inter_agency_guidance.pdf

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Appendix 3: The Trust Safeguarding Children Team

Chief Nurse – The Chief Nurse has trust board responsibility for all aspect of safeguarding children and has delegated responsibility for ensuring that the board are fully informed of risk or serious incidents related to child safeguarding.

Safeguarding Lead, Named / Deputy Named Nurses / Midwives and Named Doctors – The Trust's Lead, named nurses/midwives and named doctors for safeguarding children are responsible for the co-ordination, management, development and implementation of safeguarding practice within the organisation. This includes providing specialist advice, training and supervision to support staff in the discharge of their safeguarding children responsibilities. It also includes partner agency liaison to ensure compliance with Section 11 duties.

Contact details for the team are on the Trust intranet within the Safeguarding Children departmental page http://intranet/depart/Safeguarding_Children/index.htm

All Norfolk and Norwich University Foundation Hospitals NHS Trust staff irrespective of grade, discipline or role, whether substantive, temporary, contracted or honorary have a duty to ensure that children are safeguarded from harm and are aware of and understand their responsibilities.

All staff will undertake mandatory Level 1 safeguarding training and should be able to recognise concerns and have an understanding of how to report concerns and seek additional guidance and support. All staff should be aware that the needs of the child are paramount and the child's needs should always be prioritised.

All clinical staff - All clinical staff must ensure they have undertaken the appropriate level of mandatory training appropriate to their role. In this Trust all clinical staff are required to complete the level 3 Safeguarding Adults and Children Training Staff should be aware of their local procedures for reporting concerns about children and how to seek additional support and guidance from their named professionals.

Staff should utilise clinical supervision to discuss children's safeguarding cases and reflect on actions, complexity and any other factors. Refer to specific policy on safeguarding supervision found on the Trust's intranet pages.

All clinical staff are also required to complete mandatory PREVENT training available via face to face training or e-learning.

Concerns about the welfare of children can present itself in variations and the categories in Appendix 1 are by no means an exhaustive list. If in doubt contact the Safeguarding Team via switchboard or numbers available on the intranet.

Remember! Safeguarding is everybody's responsibility!

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Appendix 4: Wider safeguarding issues

It is recognised that there is a correlation between animal abuse and child abuse. It is important to consider that if an animal is being abused, a child or partner in the household may also be being abused. If you identify such circumstances where an animal is being abused please discuss with the safeguarding team as there may be vulnerable children at risk from harm.

It is also identified that an individual may suffer more than one type of abuse and there is overlap between different types of abuse.

All of the above may involve children as well as adults. Please refer to the Adult Safeguarding Policy on the Trust's intranet pages for further guidance.

In all cases, those exploiting the child have power over them by virtue of their age, gender, intellect, physical strength and/or economic/other resources. Violence, coercion and intimidation are common, involvement in exploitative relationships being characterised by the child's limited availability of choice resulting from their social/economic and/or emotional vulnerability.

Disabled children – whilst safeguards for disabled children are essentially the same as for children who are non-disabled, it is important to recognise that they are three to four times more likely to be abused and neglected than non-disabled children. It is crucial to ensure high standards of practice and provide services that are inclusive of children with additional needs and that they are safeguarded and their voices are paramount.

The impact of parental mental health needs - the impact on children must always be taken into account where children are living with a parent with a severe or enduring mental illness. Whilst mental illness can be compatible with good parenting, some parents with a severe mental illness are at risk of harming their children. **“Think family”**- this approach is essential in order to ensure that services and professionals can identify problems and intervene earlier to meet the needs of children and their parents.

Adverse Childhood Experiences (ACEs) - these are traumatic events occurring before age 18. ACEs include all types of abuse and neglect as well as parental mental illness, substance use, divorce, incarceration, and domestic violence. A study found a significant relationship between the number of ACEs a person experienced and a variety of negative outcomes in adulthood, including poor physical and mental health, substance abuse, and risky behaviours.

The more ACEs experienced, the greater the risk for these outcomes. When children experience trauma, understanding the impact of ACEs can lead to more trauma-informed interventions that help to mitigate negative outcomes. This could be in the form of identifying risks early, and referring to services early, such as Mental Health, Early Help, Reducing Substance Misuse or Children's Services.

Always keep an open mind, be professionally curious and employ respectful uncertainty and be able to “think the unthinkable”!

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Appendix 5: Some safeguarding explanations

The concept of significant harm - some children are in need because they are suffering, or likely to suffer, significant harm. The Children Act 1989 introduced the concept of significant harm as the threshold that justifies compulsory intervention in family life in the best interests of children. It gives local authorities a duty to make enquiries to decide whether they should take action to safeguard or promote the welfare of a child who is suffering, or likely to suffer, significant harm.

Section 47 (Children's Act 1989) - Under section 47 of the Children Act 1989, where a local authority has reasonable cause to suspect that a child (who lives or is found in their area) is suffering or is likely to suffer significant harm, has a duty to make such enquiries, with the support of other agencies, as it considers necessary to decide whether to take any action to safeguard or promote the child's welfare. Consent- not required but parents should be informed unless it is unsafe or not appropriate to do so.

Child in Need / Section 17 (Children's Act 1989) - Under the Children Act 1989, local authorities are required to provide services for children in need for the purposes of safeguarding and promoting their welfare. A child in need is defined under the Children Act 1989 as a child who is unlikely to achieve or maintain a reasonable level of health or development, or whose health and development is likely to be significantly or further impaired, without the provision of services; or a child who is disabled. Children in need may be assessed under section 17 of the Children Act 1989 by a social worker and parental consent is required.

Corporate Parent - some children as a result of their experiences of, for example; abuse or neglect will be removed from the family home and will become 'Looked after children. In these instances the Local Authority has a duty under Section 22 (3) (a) of the Children's Act (1989) to safeguard and promote the welfare of the children they look after. This translates to the Local Authority becoming the "Corporate Parent" for the child or young person. Looked after children include:

- Unaccompanied asylum seekers
- Children who are accommodated under a voluntary agreement
- Children subject to a care order
- Children subject to emergency orders for their protection
- Children who are compulsorily accommodated

It is widely recognised that looked after children and young people frequently have significant health, mental health and psychological needs, many of these children will access our services. Please remember to understand the status of the individual, who is involved in care and treatment and any particular arrangements and special considerations and responsibilities in regards to the Corporate Parenting role.

Early Help Assessment- is a way of helping children, young people and families that need a bit of extra support. The process is entirely voluntary and informed consent is mandatory, so families do not have to engage and if they do they can choose the information they want to share. Where staff feel that there is an increased risk of significant harm, this should be referred to CADS. Where you are concerned about a child, but do not feel that there is a risk of significant harm, you can make contact with the Early Help Team in the child's locality.

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- Breckland - 01362 654515
- Broadland - 01603 217612
- Great Yarmouth (East) - 01493 448188
- North Norfolk - 01603 217612
- Norwich - 01603 224101
- South Norfolk - 01508 533933 - you can [complete a form to request help in South Norfolk](#)
- West Norfolk and King's Lynn - 01553 669276

For more information on early help go on the links below:

For Norfolk: <https://www.norfolk.gov.uk/children-and-families/early-help-and-family-support>

Private fostering - is when a child under the age of 16 (under 18 if disabled) is cared for by someone who is not their parent or a 'close relative'. This is a private arrangement made between a parent and a carer, for 28 days or more. Close relatives are defined as step parents, grandparents, brothers, sisters, uncles or aunts (whether of full blood, half blood or marriage/affinity). It is a requirement to report to local authority if there are known private fostering arrangements, kinship arrangements do not need to be reported.

Local Authority Designated Officer (LADO) - The Local Authority Designated Officer (LADO) has overall responsibility for the management of allegations of abuse against adults who work with children or if there are concerns regarding institutional practice. See specific policy on Managing allegations against staff on Trust intranet pages.

Child death reviews - Health Providers involved with the management of child deaths, must work in accordance with LSCP procedures for deaths in childhood. They must have arrangements in place to respond to the death of a child and the review process, including providing staff with the time and resources to fully engage in the process. For more information on the management of the Child Deaths Protocols see the link below:

<https://www.norfolkscb.org/about/policies-procedures/11-1-managing-child-deaths>

Safeguarding Practice Reviews- Formerly known as Serious Case Reviews these are undertaken when a child dies or is seriously harmed and focus on improving learning, professional practice and outcomes for children.

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Appendix 6: Reporting Safeguarding Incidents on DATIX

Referral to Local Authority (CADS) → Complete DATIX

When an initial safeguarding referral is made to CADS by phone, an incident form needs to be completed on DATIX to ensure that the safeguarding team are aware.

Ward / Dept: where the Child/ Young Person (CYP)/vulnerable person presents

Location Type / Hosp: will autofill when ward entered

Specialty: Safeguarding Team

Directorate / Division: will autofill when specialty entered

Type: Patient

Category: Safeguarding Incident

Sub category: Safeguarding referral for a child to the Local Authority

Summary: Include brief summary of reason for referral, and ongoing plan of action by CADS. Do not include patient identifiable details

Severity: No harm **Result:** No harm resulting

Who should investigate this incident: Type safeguarding into box and select most appropriate person

Safeguarding Incident occurred whilst in care of NNUH → Complete DATIX

If you feel that a safeguarding incident has occurred within the Trust that requires further investigation or is an incident that occurred whilst in our care

Ward / Dept: where the CYP / vulnerable person presents

Location Type / Hosp: will autofill when ward entered

Specialty: Specialty patient admitted under eg Paediatric medicine

Directorate / Division: will autofill when specialty entered

Type: Patient

Category: Safeguarding Incident

Sub category: Safeguarding Child or Safeguarding Adult

Summary: Do not include patient identifiable details

Severity and Result to be determined according to incident being reported. If moderate harm or above is assigned- contact ward / department manager immediately

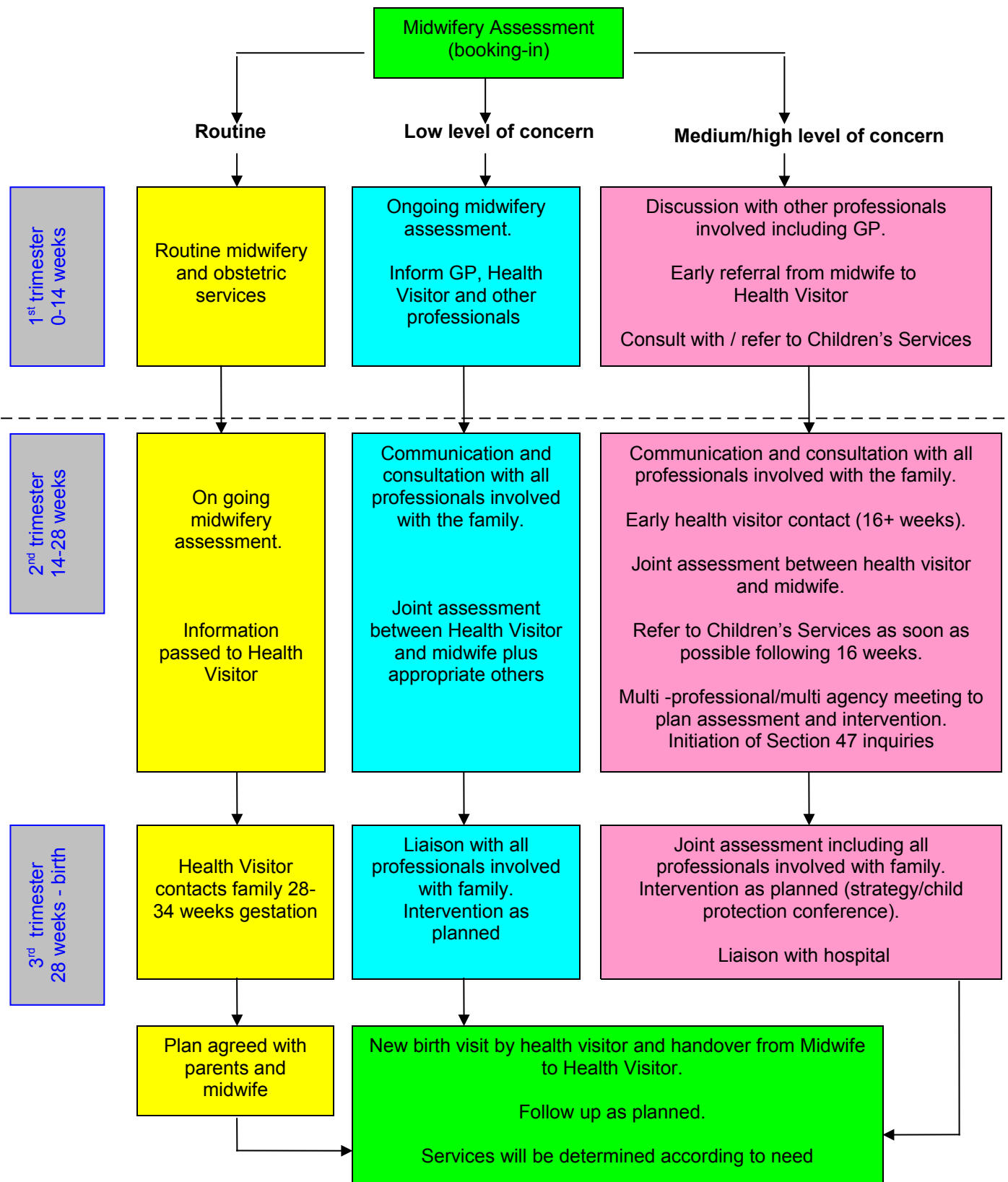
Who should investigate this incident: Ward / department manager

Is a DATIX required?

If you are just wanting to share information, but are not reporting an actual incident or documenting that you have made a referral it may be that you do not need to complete a datix- please seek clarity from the ward/department manager or Safeguarding team if you are unsure.

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Appendix 7: Multi-Agency Pre-Birth Protocol



Information gathered at any stage of the assessment may indicate a need to redefine as a higher or lower level of need / concern

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Appendix 8: Supplement for use in the Emergency Department

The safeguarding checklist on symphony must be fully completed on all under 18's

Frequent attendances - third time or more in the preceding three months?

Check reasons for previous attendances on Symphony and discuss with child / parents / carers

Meets Frequent Attender criteria and attendances are concerning
OR
Safeguarding Concerns raised this attendance i.e. neglect/physical/emotional/sexual abuse or concerns such as; mental health / social issues / in care / supervision issues etc.
Child may or may not have a pre-existing SAFE alert on PAS

Does not meet Frequent Attender criteria
OR
the previous attendances do not raise any concerns
OR
this attendance does not raise concern (clearly document you have no concerns)

No safeguarding concerns this attendance but the child has a pre-existing SAFE (safeguarding children) alert on PAS.

Discuss with middle grade or consultant. Document discussion

Check be hi proc

Report attend
Inform child
contacting socia
there are no

Conc

No current SAFE alert

Proceed as per medical need

Refer to paediatric middle grade or above if paed review / admission required. For 16-18 year olds refer to appropriate

Document in ED attendance all actions / decisions taken and details of who you have spoken to as appropriate

Inform child/parents that you are contacting the relevant service

Discharge or admit depending on medical need - ensure you hand over all relevant information

ED Safeguarding Practitioner will:

Provide advice and support regarding any safeguarding queries or concerns staff may have.

Liaise with other agencies, as required, to discuss safeguarding concerns raised during admission to ED.

Remember-The safeguarding responsibility lies with you.

Leave message in ED Safeguarding Communication book, include name, hospital number and relevant information