Trust Guideline for Safeguarding Children

Document Control:

For Use In:	All Trust departments		
	Children from birth to their 18th birthday		
Search Keywords	Safeguarding Children, Child Protection		
Document Author:	Dr C Thomas, Named Doctor for Safeguarding Children Angela Johnson, Named Nurse for Safeguarding Children Abby Harrison, Safeguarding Midwife		
Document Owner:	Dr Priya Muthukumar, Chief of Service for Paediatrics Tina Chuma, Lead Professional for Safeguarding Barbara Jackson, Named Midwife for Safeguarding		
Approved By:	Rachael Cocker Interim Chief Nurse Kim Goodby Director for Complex Health, Safeguarding and Professional Standards Safeguarding Assurance Committee		
Ratified By:	Hospital Management Board		
Approval Date:	16th October 2024	**Date to be reviewed by:** This document remains current after this date but will be under review	16th October 2027
Implementation Date:	October 2024		
Reference Number:	ID 1179 Version 11		

Version History:

Version	Date	Author	Reason/Change
V10	May 2021	Dr R Reading Tina Chuma	Addition of new safeguarding subject matters, addition of appendices.
V11	October 2024	Dr C Thomas, Angela Johnson, Abby Harrison	Addition of new safeguarding subject matters, addition of appendices.

Previous Titles for this Document:

Previous Title/Amalgamated Titles	Date Revised
None	Not applicable

Distribution Control

Printed copies of this document should be considered out of date. The most up to date version is available from the Trust Intranet.

Distribution list / dissemination method

All areas Trust wide

Maternity Unit.

Consultant Paediatricians.

Emergency Department.

Practice Development and Education Department.

The-Beat – Safeguarding Children page.

Consultation

The following were consulted during the development of this document:

Dr Catherine Thomas, Angela Johnson, Abby Harrison

The authors listed above, on behalf of the department, have agreed the final content after drafting the guideline. During its development it has been circulated for comment to: Paediatric A&E Consultants, Women and Children's Governance, and members of the Safeguarding Assurance Committee.

Monitoring and Review of Procedural Document

The document owner is responsible for monitoring and reviewing the effectiveness of this Procedural Document. This review is continuous however as a minimum will be achieved at the point this procedural document requires a review e.g. changes in legislation, findings from incidents or document expiry.

Relationship of this document to other procedural documents

This document is a policy applicable to individual Trust please refer to local Trust's procedural documents for further guidance, as noted in Section 5.

Contents Page

Quick reference

1. 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.norfolklscb.org/about/policies-procedures/3-13-medical-examinations/ . Please also refer to NICE guidance CG89 2017 Guidance on when to suspect child maltreatment http://guidance.nice.org.uk/CG89. This guidance provides details of the five categories of abuse; physical, emotional, sexual, neglect and contextual. 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.norfolklscb.org/people-working-with-children/. Additional resources can also be found on the Safeguarding children's page on the Beat via the following link Safeguarding children - The Beat (nnuh.nhs.uk)

If concerns are identified, then:

- Get advice from your line manager, senior practitioner, or a member of the safeguarding 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 09:00-17:00 Mon-Fri, or by contacting the Emergency Duty Team (EDT) 0344 800 8020 out of hours.
- For all safeguarding referrals to CADS or the EDT an ICE referral must be completed. Please note, a referral on ICE should be completed only after the telephone referral has been made to CADS or EDT. Instructions on how to complete this easily and rapidly are available on the Safeguarding Children page on the Beat. See appendix 5
- It is the responsibility of the professional identifying the concern to ensure that a referral to Children's Social Services is made, if appropriate. The professional should access any help they may require either in making the referral, for support following the referral being submitted, or support to agree next steps if criteria for a referral is not met.
- 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 anticipates that by disclosing that 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~~ Beat page and email to SafeguardingChildren@nnuh.nhs.uk There are separate paediatric and maternity forms and these should be fully completed with details of what the concerns 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/practitioner.

2. Safeguarding Children Reporting Flow Chart

Referral **No referral needed**

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

1. Introduction

2.1. 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 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.
- 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 instigate an enquiry into the reasons why correct processes were not followed.

2.2. Objective

To ensure that doctors, nurses, midwives, allied health professionals, administrative and 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.

- **The Children Act (1989)** introduced the framework of significant harm which requires the compulsory intervention into family life 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)** places a duty on each Local Authority (LA), health provider, and partner agency to make arrangements to promote co-operation between the authorities. Section 11 (Children`s Act 2004) sets out 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, Integrated Care Boards (ICBs), and the Local Authority to make arrangements to work together, alongside other partners locally to safeguard and promote the welfare of all children in their area.

- **Working Together to Safeguard Children (2023)** is a statutory guidance on inter-agency working to safeguard and promote the welfare of children.
- **The NHS England Accountability and Assurance Framework (~~2022~~2024)** sets out clearly the safeguarding roles and responsibilities of all individuals working in providers of NHS funded care settings and NHS commissioning organisations.
- **The Domestic Abuse Act (2021)- Section 3** states that children who see, hear or experience the effects of domestic abuse (DA) and are related to the victim or the perpetrator of DA , the children are also regarded as a victim.
- **The Serious Violence Duty (2023)-** places a legal duty on organisations to work together to prevent and reduce serious violence.

2.3. Scope

This guideline applies to all staff within NNUH and children up to 18 years of age. This also applies to children of patients and staff where there are safeguarding concerns.

2.4. Glossary

The following terms and abbreviations have been used within this document:

Term	Definition
CADS	Childrens Advice and Duty Service
EDT	Emergency Duty Team
SW	Social Worker
LAC	Looked After Child
LA	Local Authority
NNUH	Norfolk and Norwich University Hospital
CAU	Childrens Assessment Unit
ED	Emergency Department
NMC	Nursing and Midwifery Council
GMC	General Medical Council
HCPC	Health and Care Professionals Council
CHED	Childrens Emergency Department
MASH	Multi Agency Safeguarding Hub
PP	Perplexing presentations
FII	Fabricated or induced illnesses
NICE	National Institute for health and care excellence
NSCP	Norfolk Safeguarding Children Partnership
AHP	Allied Health Professional
CP Plan	Child protection plan
CP-IS	Child Protection Information Sharing service
DA	Domestic Abuse
C4C	Cause for Concern
PBRA	Pre-birth Risk Assessment
NGCP	Norfolk Graded Care Profile
CAMHS	Community Adolescent Mental Health Service
ICB	Integrated Care Board

3. Roles and Responsibilities

3.1. Chief Nurse

The Chief Nurse has Trust Board responsibility for all aspects of safeguarding children and has delegated responsibility for ensuring that the Board are fully informed of risk or serious incidents related to child safeguarding.

3.2. NNUH Safeguarding Team

The Director of Complex Health, Safeguarding and Professional Standards, the Safeguarding Lead, Named Nurse/Midwife and Named Doctors for Safeguarding Children and Adults 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.

3.3. All staff

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 understand 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 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 docs ID 8754.

All 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 Beat.

Remember! Safeguarding is everybody`s responsibility!

3.4. Community and acute paediatric teams

The different roles of the community and acute paediatric teams in performing safeguarding medical assessments are outlined in the chart below.

4. Policy Principles/ Service to be delivered/Processes to be followed

4.1. Guidance for specific staff groups

4.1.1. Adult medical or surgical teams

Child abuse or neglect needs to be considered with any injury or unexplained recurrent problem (including Mental Health presentations) presenting to adult medical or surgical teams. For 16- and 17-year-old patients on adult wards, for whom there are concerns around abuse or neglect, advice and assessment can be requested by the patient's Consultant from the Children's Assessment Unit (CAU) Consultant via the numbers below. Clinicians from many specialties (especially orthopaedics, Gynaecology, and plastic surgery) need to consider child abuse when they are seeing children.

Referrals for further investigation or management should come to the CAU Consultant on **extension 6580** 09:30-22:00 Mon-Thu, 09:30-21:30 Fri, 14:00-21:00 Weekends or via the CAU Registrar on Alertive at all other times, or for inpatients by discussion with the on call paediatric team for the ward via the Buxton Registrar on Alertive or the on call Paediatric Consultant via switchboard, and documenting the referral/discussion outcome in the medical records.

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 responsible. If the child is being assessed in the Emergency Department, Consultant responsibility is with the Emergency Department (ED) Consultant in charge of the Children's Emergency Department.

Once a child attends CAU for assessment, but is 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.

4.1.2. 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 considered 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 12 months 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 with safeguarding concerns requiring urgent inpatient investigation or treatment.
- Children with safeguarding concerns admitted under other non-paediatric specialties such as orthopaedics will be under shared care with the paediatric team.
- Children with significant genital injuries (see trust guideline on Children Presenting with genital or perineal injury (Trust docs 10014).

4.1.3. 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.
- Neglect or emotional abuse.

If such cases present out of hours to the acute service the CAU Consultant, on call Consultant or night Paediatric Registrar 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 paediatricians.**

4.2. Second opinions and peer review

It is good practice to discuss the management of cases involving safeguarding children with a colleague. The Named Doctor for Safeguarding Children is usually available within normal working hours. If they are not available, due to leave or sickness, cases should be discussed with any Consultant colleague and any Consultant can peer review another's safeguarding report. 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.

4.3. 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).

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 virtual strategy meetings – 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 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.

4.4. 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.

4.5. 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.

The Consultant paediatrician on-call takes primary responsibility for safeguarding children matters for all children who are inpatients; irrespective of the child's clinical need and involvement of other Consultants. This is in accordance with statutory advice.
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 (09:00-17:00 Mon-Fri) or EDT 0344 800 8020 (Out of hours).

Consideration to more complex safeguarding presentations is needed. Types of abuse you may wish to consider are:

1. **Child sexual abuse.**
   Concerns about child sexual abuse in children of any age must be referred directly to CADS. These children will have assessment arranged via CADS with Mountain Healthcare Appendix 2

2. **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/

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.

The police will be involved in any cases reported to CADS for whom a strategy meeting is convened. However, this should not preclude any health professional from calling the police urgently, should the need arise.

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

- Writing reports.
- Attending strategy meetings and 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.

5. General guidance for Trust Staff

1. **Training.** All staff should attend appropriate safeguarding training as set out in the Intercollegiate Document. Training is available at different levels. All clinical staff are required to undertake Safeguarding Adults and Children Level 3 Training. Advice on training is available in the Trust's Safeguarding Training Strategy (Trust docs 4980).

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 role, 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 2017) '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 09:00-17:00 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 CAU registrar or Consultant or on call Consultant community paediatrician on call or CADS, whichever seems most appropriate.

4. **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.

5. **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. All safeguarding assessments are done with a chaperone present and this can be considered in all interactions with a child in whom safeguarding is a concern.

6. **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.

7. **Supervision.** Staff should report their involvement in child protection cases to the relevant lead professional and/or a member of the Safeguarding team. Staff should be ready to provide reports or attend strategy meetings and case conferences. Nursing, midwifery, and allied health professional (AHP) staff may request guidance or support from their lead professional or a member of the Safeguarding Team in these circumstances. Formal safeguarding supervision is available for staff – see Health Care Professionals participating in Safeguarding Supervision Policy (ID 8754) on Trust Docs for how to access this. Medical staff can also request guidance, advice and supervision from the Named Doctor for Safeguarding Children.

8. **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.

9. **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 on the NSCP website via the following link Resolving Professional Disagreements Policy | NSCP (norfolklscp.org.uk)

10. **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.

6. Nurses, Midwives and Other Health Professionals.

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 other health professionals 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 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. It is the responsibility of the person who holds the concern to make sure that this is documented in the patient's notes, call CADS and attend strategy meetings to explain their concerns if they are invited.

7. 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 guideline supports practice that is located within documents such as The Munro Review of Child Protection and The Child Health Promotion Programme as well as Working Together to Safeguard Children 2023 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 need support from Children's Services when born, it is the responsibility of all professionals to make such a referral to 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 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 parents' 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.
- 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 due to exposure 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.

Children's services 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.

- Where pregnancy or birth has been concealed, please refer to Trust Docs ID: 16848 Clinical Guideline for the Management of Concealed or Undiagnosed Pregnancies.

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 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 preferably 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 ID: 1178 and also the Norfolk Safeguarding Children Partnership website. Summary flowcharts are shown in Appendix 6 & 7. The Trust has agreed and committed to work within the guidance of this protocol.

8. Safety

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

Maternity staff should be aware that if a patient attends for delivery without handheld records and without any other ways to verify identity, discharge with baby should not be completed until satisfactory evidence is provided. This should only involve a partner/relative going home to collect the handheld 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.

9. 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 2023).

10. PAS alerts

Safeguarding Children alerts for children on a Child Protection plan (CP 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. Information may also be available on the Shared Care Record, or could be found via CP-IS (Child Protection Information Sharing system), accessed via Summary Care Record on Spine portal accessible via The Beat.
Child Protection - Information Sharing (CP-IS) service - NHS England Digital

11. Useful Contacts

Norfolk and Norwich University Hospitals (NNUH) Safeguarding Team

- Named Doctor for Safeguarding Children- via switchboard **01603 286286**
- Named Doctor for Safeguarding Adults – via switchboard **01603 286286**
- Director for Complex Health, Safeguarding and Professional Standards - internal ext **5601**, external **01603 289601**
- Lead Professional for Safeguarding Children and Vulnerable Adults – internal **2914**, external **01603 286914**
- Named Nurse for Safeguarding Children – internal ext **3873**, external **01603 287873**
- Named Midwife for Safeguarding- internal ext **2833**, external **01603 286833**
- Safeguarding Midwife – internal ext **3056**, external **01603 287056**
- Named Professional for Safeguarding Adults and MCA Lead – internal ext **7479**, external **01603 647479**
- 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**
- Generic email- Safeguardingchildren@nnuh.nhs.uk.

Other useful contacts

- Norfolk Children`s Advice and Duty Service (CADS) - **0344 800 8021** 09:00-17:00 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.norfolklscb.org/.
- Norfolk Designated Safeguarding Children`s Team (Norfolk & Waveney Integrated Care Board (ICB)) - **01603 257164**.
    - NSPCC National Helpline - **0808 800 5000**.
    - ChildLine - **0800 1111**.
    - Child Exploitation and Online Protection (CEOP) - **0870 000 3344**.
    - Just One Norfolk – www.justonenorfolk.nhs.uk – **0300 300 0123**

Guidance from Regulatory Bodies – GMC, NMC and HCPC

The safety of the child is paramount and overrides the usual duties of confidentiality. Guidance states that: “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.

You should always ask for consent to share information before you do so. If you do need to share information without consent you should tell the child and their family you are doing this, unless in doing so you put the child at greater risk. Your decisions around sharing information should be carefully documented.

If a child or young person with capacity to make a decision, or a parent refuses to give consent to share information, you should consider their reasons for refusing, and 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- updated 2018) Protecting children and young people: The responsibilities of all doctors - professional standards - GMC (gmc-uk.org)

12. Training & Competencies

All clinical patient facing staff complete Level 3 Safeguarding Training.
Non patient facing staff complete Level 1 Safeguarding Training.

13. References

Children Act 2004 Children Act 2004 (legislation.gov.uk)

Intercollegiate document Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff | Royal College of Nursing (rcn.org.uk)

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

NICE guidance CG87 2017 http://guidance.nice.org.uk/CG89.

Norfolk Safeguarding Children`s Partnership: https://www.norfolklscb.org/ http://www.norfolklscb.org/people-working-with-children/

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

NSCP resolving professional disagreements. Resolving Professional Disagreements Policy | NSCP (norfolklscp.org.uk)

Perplexing presentations/ Fabricated or induced illness in children https://childprotection.rcpch.ac.uk/resources/perplexing-presentations-and-fii/

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, updated 2018) 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 Munro review of child protection The Munro Review of Child Protection

The NHS England Accountability and Assurance Framework ~~(~~2024): Safeguarding Children, Young People and Adults at risk in the NHS
NHS England » Safeguarding children, young people and adults at risk in the NHS

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

When to suspect child maltreatment (NICE guideline CG90 2017 ~~2009~~)
http://publications.nice.org.uk/when-to-suspect-child-maltreatment-cg89/introduction

Working Together to Safeguard Children. A guide to inter-agency working to safeguard and promote the welfare of children (DfE 2023)
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942454/Working_together_to_safeguard_children_inter_agency_guidance.pdf

14. Monitoring Compliance/Audit of the process/policy principles/service to be delivered

Compliance is monitored by each individual department and taken to their relevant governance meetings as appropriate.

.

15. Appendices

Appendix 1: Definitions of Child Abuse and Web Link Guides

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. https://www.nspcc.org.uk/what-is-child-abuse/types-of-abuse/neglect/#what-is	**Child sexual abuse** - A form of abuse in which an adult or older adolescent uses a child for sexual stimulation. https://www.nspcc.org.uk/what-is-child-abuse/types-of-abuse/child-sexual-abuse/ **Harmful sexual behaviour** - child on child abuse https://www.nspcc.org.uk/keeping-children-safe/sex-relationships/sexual-behaviour-children/
Emotional abuse - the type of abuse that involves the continual emotional mistreatment of a child. https://www.nspcc.org.uk/what-is-child-abuse/types-of-abuse/emotional-abuse/#what-is	**Physical abuse** - When someone physically harms a child. https://www.nspcc.org.uk/what-is-child-abuse/types-of-abuse/physical-abuse/
Fabricated or induced illness (FII) – Occurs when a parent or carer exaggerates or deliberately causes symptoms of illness in a child, and can cause significant harm both physically and emotionally. https://childprotection.rcpch.ac.uk/resources/perplexing-presentations-and-fii/	**Domestic abuse of children** - A child under 18yrs who sees, hears or experiences the effect of domestic abuse and is related to the victim/suspect, is also regarded as a victim. **See Section 3, Domestic Abuse Act 2021** protecting children from domestic abuse | NSPCC Learning

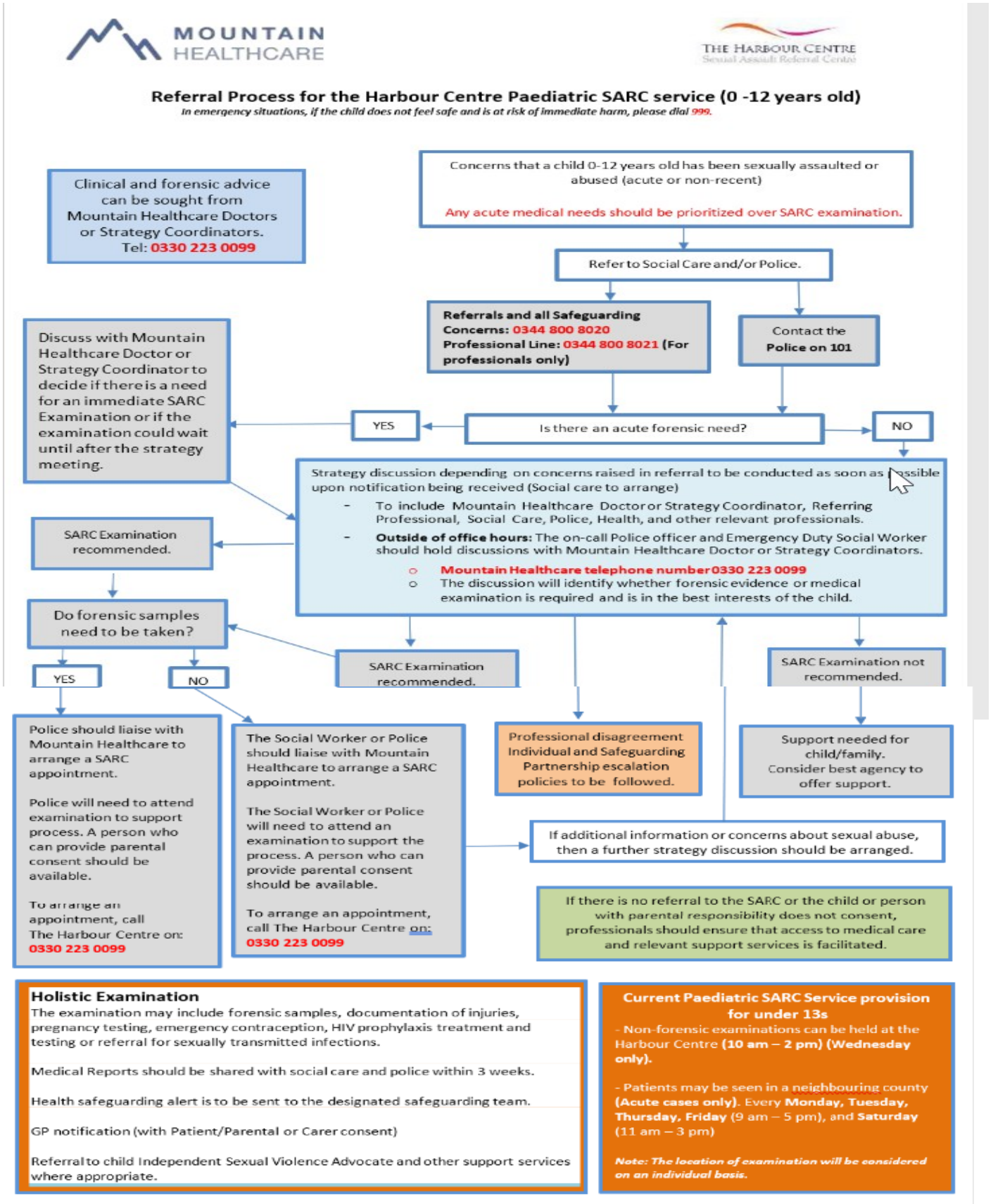
Child sexual exploitation - when a child or young person is given things like gifts, money, status or drugs, in exchange for performing sexual activities. https://www.nspcc.org.uk/what-is-child-abuse/types-of-abuse/child-sexual-exploitation/	**County Lines** - illegal distribution and dealing of drugs from one city/county to another. https://www.nationalcrimeagency.gov.uk/what-we-do/crime-threats/drug-trafficking/county-lines
Trafficking and modern day slavery - movement of children and young people with the aim of exploiting them. https://www.nspcc.org.uk/what-is-child-abuse/types-of-abuse/child-trafficking/	**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. https://learning.nspcc.org.uk/news/2019/october/what-is-contextual-safeguarding
Online abuse - any type of abuse that happens on the internet. **https://www.nspcc.org.uk/what-is-child-abuse/types-of-abuse/online-abuse/**	**Grooming** - when someone builds a relationship, trust and emotional connection with a child or young person so they can manipulate, exploit and abuse them. **https://www.nspcc.org.uk/what-is-child-abuse/types-of-abuse/grooming/#what-is**

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- Mountain healthcare



Appendix 3: Wider safeguarding issues

3.1 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 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.

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

3.3 All of the above may involve children as well as adults. Please refer to the Adult Safeguarding Policy ID 1105 on the Trust`s intranet pages for further guidance.

3.4 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.

3.5 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.

3.6 The impact of parental mental health needs - the impact on children must always be considered 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.

3.7 "**Think family**"- this approach is essential to ensure that services and professionals can identify problems and intervene earlier to meet the needs of children and their parents/carers. It refers to steps taken to identify wider family needs which extend beyond the child/individual they are supporting.

3.8 Adverse Childhood Experiences (ACEs) 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 abuse. 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.

3.9 Trauma-informed practice is an approach to health and care interventions which is grounded in the understanding that trauma exposure can impact an individual's neurological, biological, psychological and social development. It acknowledges the need to see beyond an individual's presenting behaviours and to ask, 'What does this person need?' and 'What has brought the individual/family to this situation?' rather than 'What is wrong with this person?'

3.10 Professional Curiosity is a combination of looking, listening, asking direct questions, and reflecting on all the information received. It is the capacity to explore and proactively try to understand what is happening within a family or to an individual, rather than making assumptions or taking a single source of information and accepting it at face value. Professional curiosity highlights the need to fully understand a family's situation.

Always keep an open mind, be professionally curious and employ respectful uncertainty and be able to "think the unthinkable"!Appendix 4: Some safeguarding explanations

4.1 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.

4.2 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.

4.3 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.

4.4 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 with those with Parental responsibility (section 20)
- Children subject to a care order
- Children subject to emergency orders for their protection
- Children who are compulsorily accommodated

4.5 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 regard to the Corporate Parenting role.

4.6 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.

- Breckland - **01362 654567**
- Broadland - **01603 222811**
- Great Yarmouth (East) - **01493 448153**
- North Norfolk – **01692 502205**
- Norwich - **01603 222812**
- South Norfolk - **01603 222814**
- West Norfolk and King's Lynn - **01553 669673**

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

4.7 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 stepparents, 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**.**

4.8 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, Trust Docs 7992.

4.9 Child death reviews - Health Providers involved with the management of child deaths, must work in accordance with NSCP 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.norfolklscb.org/about/policies-procedures/child-death/111-managing-child-deaths

4.10 Safeguarding Practice Reviews- Formerly known as Serious Case Reviews these are undertaken when a child dies or is seriously harmed, with a focus on identifying improvements for professional practice, disseminate learning, and promote the welfare of children to prevent or reduce the risk of recurrence of similar incidents. .

4.11 Signs of Safety - Signs of Safety is an integrated framework for how to do child intervention work. The principles for practice; a range of tools for assessment and planning, decision making and engaging children and families; the disciplines for practitioners' application of the approach; and processes through which the work is undertaken with families and children, and partner agencies. Signs of Safety practice

enables child welfare intervention to be the catalyst for behaviour change by families and empowers them to make these changes.

4.12 Care Leavers - Care leavers are young people aged 16-25 years old who have been in care at some point since they were 14-years old and were in care on or after their sixteenth birthday. These young people are statutorily entitled to some ongoing help and support from the Local Authority after they leave care.

4.13 Transitional Safeguarding - Transitional safeguarding describes the need for an approach to safeguarding adolescents and young adults fluidly across developmental stages which builds on the best available evidence, learns from both children's and adult safeguarding practice and which prepares young people for their adult lives. It focuses on safeguarding young people from adolescence into adulthood, recognising this period of transition will be experienced differently by young people at different times. It also acknowledges that the needs of young people do not change or stop when they reach 18, although the laws and services supporting them often do.

Appendix 5: Reporting Safeguarding Incidents

Appendix 7 Maternity Safeguarding Pre-birth Process

14 Equality Impact Assessment (EIA)

Type of function or policy	Existing

Division	Corporate	**Department**	Complex Health Hub
Name of person completing form	Angela Johnson	**Date**	04/09/2024

Equality Area	Potential Negative Impact	Impact Positive Impact	Which groups are affected	Full Impact Assessment Required YES/NO
Race	No	No		No
Pregnancy &	No	No		No

Maternity				
Disability	No	No		No
Religion and beliefs	No	No		No
Sex	No	No		No
Gender reassignment	No	No		No
Sexual Orientation	No	No		No
Age	No	No		No
Marriage & Civil Partnership	No	No		No
EDS2 – How does this change impact the Equality and Diversity Strategic plan (contact HR or see EDS2 plan)?				

- **A full assessment will only be required if: The impact is potentially discriminatory under the general equality duty**
- **Any groups of patients/staff/visitors or communities could be potentially disadvantaged by the policy or function/service**
- **The policy or function/service is assessed to be of high significance**

IF IN DOUBT A FULL IMPACT ASSESSMENT FORM IS REQUIRED

The review of the existing policy re-affirms the rights of all groups and clarifies the individual, managerial and organisational responsibilities in line with statutory and best practice guidance.