# TRUST POLICY FOR SAFEGUARDING CHILDREN

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## Reference Number

- **Version / Amendment History**
- **Version**
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<td>Trust named contact</td>
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<td>Oct 2008</td>
<td>Joanne Clark/ Mary Hobin</td>
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<td>Following merger</td>
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**Intended Recipients:** All nursing, clinical and medical staff. Associate Directors, Service Managers, Divisional Nurse Directors, Operational Managers and Senior Matrons/Senior Midwives, Facilities Managers and Therapy staff.

**Training and Dissemination:**
Safeguarding mandatory training
Dissemination will be via the intranet

**To be read in conjunction with:** Derby and Derbyshire Safeguarding Children Procedures, Staffordshire Safeguarding Children Procedures, Trust Policy and Procedures

**In consultation with and Date:**
TSORG and Trust
Safeguarding Committee Nov 2018

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<td><strong>Executive Lead Signature</strong></td>
<td>Executive Chief Nurse and Director of Patient Experience</td>
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<td><strong>Approving Executive Signature</strong></td>
<td>Cathy Winfield Executive Chief Nurse and Director of Patient Experience</td>
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TRUST POLICY FOR SAFEGUARDING CHILDREN

1 Introduction

Section 11 of the Children’s Act (2004) places a duty on key people in University Hospitals Derby and Burton NHS Foundation Trust to have arrangements in place to ensure that organisational functions are discharged with regard to the need to safeguard and promote the welfare of children in accordance with The Children Act (1989) and Working Together to Safeguard Children (DfES 2015)

2 Purpose and Outcomes

The overall purpose of the Policy is to make clear the duties, responsibilities and arrangements in place to safeguard and promote the welfare of children and young people in the Trust, to manage the risks and reduce the incidence of harm to children.

The Policy will ensure that:

• All staff employed by the Trust will understand their responsibility for safeguarding and promoting the welfare and safety of children.
• Staff will be aware of social care thresholds and of the processes from Early Help Assessment through to referrals to Children Social Care.
• Staff will also be aware where appropriate of the pre-birth assessment.
• Staff will be aware of the SCB escalation policy and seek support to utilise the policy when necessary.
• The organisation has approved documentation which describes the local arrangements for the process for managing the risks associated with safeguarding children.
• There is a staff training plan developed from the Training Needs Analysis.
• There is a process for supporting staff involved in safeguarding children.
• There is a process for monitoring compliance with this policy.

3 Definitions Used

Safeguarding Concerns:
Safeguarding is a continuum of responses that seek to prevent or respond to abuse and neglect. It is an umbrella term for both 'promoting welfare' and 'protecting from harm.'

Child Protection Concerns:
Concerns that a child is at risk of, or has experienced, significant harm, neglect or abuse (s47 Children Act 1989) All definitions of the categories of abuse can be found at Appendix 1

Children or Young People:
The Children Acts (1989 and 2004) apply to anyone who has not yet reached their 18th
Birthday or 21yrs if disabled or in Local Authority Care (LAC). However where there are safeguarding concerns identified with persons aged 18 and over referrals must be made through adult safeguarding procedures.

Issues of neglect can apply to the unborn baby in so far as it is defined in Working Together 2015.

**Significant harm:**
Is that attributed to lack of adequate parental care or control whether intentional or not. Significant Harm is the threshold that justifies compulsory intervention in family life in the best interests of children. Physical Abuse, Sexual Abuse, Emotional Abuse, witnessing of Domestic Abuse and Neglect may constitute significant harm.

Harm is defined as the ill treatment or impairment of health and development. There are no absolute criteria on which to rely when judging what constitutes significant harm. Sometimes a single violent episode may constitute significant harm but more often it is an accumulation of significant events, both acute and longstanding, which interrupt damage or change the child's development.

**Child in Need:** Section 17 of the Children Act 1989 defines a child as being in need in law if:

- He or she is unlikely to achieve, or maintain, or to have the opportunity to achieve, or maintain a reasonable standard of health, or development without provision of services from the Local Authority (LA);
- His or her health or development is likely to be significantly impaired, or further impaired, without the provision of services from the LA;
- He or she has a disability.

Development can mean physical, intellectual, emotional, social or behavioral development. Health can be physical or mental health

**CSC:** Children’s Social Care

**Early Help:** Professionals working with families, children, young people or adults who are parents and carers identifying emerging problems and potential unmet needs for individual children / families and work together to provide early coordinated help to families to prevent deterioration in circumstances.

**Private Fostering:** Is any arrangement made privately for the care of a child under the age of 16 (or 18 if a disabled child) by someone other than a parent or close relative for a period of 28 days or more and will encompass e.g. children sent from abroad to stay with another family; asylum seeking / refugee children / teenagers having moved in to live with other families voluntary; students living with “host” families.
4 **Key Responsibilities/Duties**

4.1 **Safeguarding Children’s Boards**
Safeguarding Children’s Boards (SCB) are required to lead children’s safeguarding arrangements across their locality, monitor and coordinate the effectiveness of the safeguarding work of its member and partner agencies. The Trust is required, as a partner agency, to attend the Boards and their sub-groups; participate in the work of the Boards to achieve their aims and submit the findings of s11 (Children Act 2004) audits to the SCB. The SCBs provide policies and procedures specific for safeguarding process and practice in their area.

4.2 **Clinical Commissioning Groups (CCG)**
The CCGs (Southern Derbyshire CCG and NHS South East Staffordshire & Seisdon Peninsula CCG) monitor Trust performance in safeguarding in regular meetings with the Trust and the Designated professionals for Safeguarding children, attend the Trust Safeguarding Committee and provide supervision to Named professionals in provider organisations.

4.3 **Chief Executive**
The Chief Executive is ultimately responsible for ensuring that the Health contribution to safeguard and promote the welfare of children is discharged effectively and that there is a process in place to ensure that staff are aware of and follow the policy.

4.4 **Executive Chief Nurse**
The Executive Lead accountable to the Trust Board for ensuring compliance with this policy in all parts of the Trust. The Executive Lead, or their nominated deputy, is also a member of the Safeguarding Children Board.

4.5 **Trust Safeguarding Committee (TSC)**
The Trust Safeguarding Committee has delegated authority for monitoring and assuring safeguarding activity across the Trust in relation to safeguarding children and young people and provides assurance that legal requirements, national guidance and learning from Serious Case Reviews (SCRs) and Domestic Homicide Reviews (DHRs) are incorporated into trust processes.

The Trust Safeguarding Committee has delegated authority to oversee and monitor all activities related to safeguarding to ensure safe high quality care is delivered; ensuring that risks are identified and managed to an acceptable level, and that the Trust is actively working in partnership with relevant strategic multi-agency partnerships for the purpose of safeguarding and promoting the welfare of children and young people at risk.
4.6 Trust Safeguarding Operational Reference Group (TSORG)
The TSORG has responsibility for identifying, assessing and communicating risks or barriers at the frontline to effective implementation of the Trusts safeguarding duties and obligations, and to provide consultation feedback, providing perspective on policy and practice development at the frontline.

4.7 Trust Safeguarding Lead & Trust Named Professionals
The Trust Safeguarding Lead, Named Nurses, Named Midwives, and Named Doctors are responsible for the promotion of good professional practice, delivery of the Training Plan, providing advice, supporting and supervising staff, conducting the Trust Internal Management Reviews (IMR) where they have not had significant involvement in the case), and for ensuring that the resulting Serious Case Review and Action Plans are implemented, monitored and followed up where necessary.

4.8 All Staff
All staff and those in services contracted by the Trust must attend compulsory safeguarding children training appropriate to their involvement with children, young people and families to ensure they are competent and alert to potential indicators of abuse or neglect in children and that they know how to act on their concerns to fulfil their responsibilities in line with national and local guidance in safeguarding children. (See Appendix -Training Plan and Matrix )

All staff must:
• Be aware of thresholds for social care involvement and what to do when there are concern regarding emerging need.
• Be aware of the risk factors for child abuse – this includes situations where adults may pose a risk to children or young people.
• Know how to recognise the different forms of abuse.
• Know how to act if a child or young person’s welfare or safety may be at risk.
• Be aware of local procedures for Safeguarding
• Know the name and contact details of named professionals or where to find them.
• Ensure that they have adequate Safeguarding training, in accordance with the requirements of Working Together to Safeguard Children 2018, The Intercollegiate documents (2018), relevant to fulfil the responsibilities of their post.

5 Trust Arrangements for Reporting Concerns and Managing Safeguarding Risks to Children

5.1 Referral pathways and services
Referrals to services regarding concerns about a child typically fall into four levels:

Low level needs where need is relatively low and where individual services and universal services may be able to address the child’s needs without the involvement of other services.
Emerging needs where a range of early help services may be required, Coordinated through an early help assessment (EHA) where there are concerns for a child's well-being or a child's needs are not clear, not known or not being met. Eg:

- Child with ongoing complex medical, health or developmental needs.
- Young carers who appear to be coping Teenage parents
- Consider young people who are admitted with self-harm, substance misuse, alcohol intoxication, low level CSE risks indicators.
- Parental mental health, physical health/illness, learning disability, substance misuse.
- Standard DV
- Parents expressing concern/anxiety about coping or managing their child’s behaviour

This is not an exhaustive list

Where emerging needs have been identified, an Early Help Assessment (see Trust safeguarding intranet pages) should be discussed with child and family. It should be completed with them and any other agency/professional involved with the family and submitted to the relevant local authority EHA service. A copy should be attached to the child’s records and a copy should also be sent to the safeguarding team.

Where parents and/or the child do not consent to an early help assessment, then there should be professional judgement as to whether, without help, the needs of the child and concerns will escalate. If so, a referral into local authority CSC may be necessary.

Complex or serious needs where without intervention the child would become at risk of significant harm or the needs are such that without intervention the child's health or development would be seriously impaired. This meets the threshold for social care input. Help is provided as a "child in need" under Section 17 of the Children Act 1989 via a specialist in-depth assessment and following this at least initial co-ordination of services via a social worker. Examples of needs:

- Consider Children/young people with significant mental health concerns, disability/learning difficulty, alcohol and/or substance misuse.
- Consider children and young people who indicate a medium risk of being sexually exploited, or trafficked
- If a child is identified as asylum seeking.
- Young carers who are not coping.
- Parents with significant mental health, learning disabilities, illness or alcohol/substance misuse problems.
- Repeated and serious domestic violence
- Children identified as in a private fostering arrangement
- Children who exhibit sexually harmful behaviour.
Where there are child protection concerns (reasonable cause to suspect a child is suffering, or likely to suffer, significant harm) Staff must complete a social care referral and the local authority social care services must make enquiries and decide if any action must be taken under section 47 of the Children Act 1989.

Examples of child protection concerns:
- Non accidental injuries/unexplained, inconsistent injuries.
- Alleged abuse/disclosure
- Where a person in contact with a child or young person is identified as posing a risk to children.
- Neglect or emotional abuse which significantly impairs development.
- Serious, chaotic parental mental health, substance misuse or learning disability.
- High risk domestic abuse
- Honour Based Violence, Forced marriage, female genital mutilation (FGM)
- Children and young people at high risk of sexual exploitation.
- Children and young people who have been trafficked, or at high risk of being trafficked. Children can be victims of modern slavery. Modern Slavery and/or human trafficking are serious organised international crimes. In these cases staff must contact the police at the time of completing a social care referral
- Where a sibling is subject to a child protection plan.
- Where another child has previously been removed from the care of a parent.
- Where there are concerns about the parents ability to self-care and/or to care for the child.
- Where it becomes apparent that an under 13 year in having sexual intercourse or an expectant mother is under the age of 13, or where there is a mother aged under 16 years and there are additional concerns

6 Management of Child Protection processes; Responding to Bruising in Babies and Child Protection (CP) Medical Examinations

Bruising is the most common injury encountered when children have been physically abused, however, children will always sustain bruises as a consequence of simple accidents. There are some skin markings which can look similar to bruises and there are medical conditions which can cause bruising. This section aims to assist professionals to:
- Understand the causes of bruising in infants, children and young people
- Understand the importance of bruising in infants as an indicator of physical abuse.
- Clarify the arrangements between health and social care colleagues in relation to the investigation of bruising in children and young people

6.1 Why we are worried about bruises
- A bruise, as well as being accidental, may be an external marker that a child or young person is being abused. Information gathered as a result of an appropriate investigation may enable that child to be safeguarded
- In contrast to older children, babies and young children are more vulnerable to
injuries of equivalent force. A single assault to a baby or young child can result in death or serious and lasting harm, including brain injury. Research and Serious Case Reviews confirm that relatively minor bruising may be a warning that an adult is under stress and / or that a baby may be at serious risk: consequently a lower threshold for referral for both medical and social investigation is needed to effectively protect a baby or young child.

6.2 What is a bruise?
- A bruise occurs when blood comes out of the blood vessels into the soft tissues, producing a temporary, non-blanching discolouration of skin however faint or small with or without other skin abrasions or marks. Colouring may vary from yellow through green to brown or purple. This includes petechiae, which are tiny red or purple non-blanching spots, less than two millimeters in diameter and often in clusters;
- Bruises have been described as red marks, ecchymoses, purpura, petechiae, lesions, rashes, contusions, injuries, vasculitic lesions and have also been confused with birth marks. When there is doubt as to the nature of a mark that may be a bruise, it is important that the child is kept safe whilst a definitive conclusion is reached.

6.3 What factors are important in distinguishing accidental bruises from physical abuse
A bruise should never be interpreted in isolation and must always be assessed in the context of the child’s medical and social history, developmental stage and the explanation given.

- **Vulnerabilities**
  Look for factors that may make children more vulnerable to abuse and neglect. These may exist in the adults who care for the child (e.g. alcohol and drug use, domestic abuse, poor mental health, learning difficulties, and poverty) or in the child (e.g. premature birth, disability, and unwanted pregnancy) Contrary to popular belief, boys do not sustain more bruises than girls.

- **Presentation**
  Consider the presentation of the bruise:
  - Was the presentation delayed?
  - Was the bruise found incidentally during another contact or appointment (e.g. whilst giving immunisations)
  - Was the bruise described to a professional and is it no longer visible

Is the explanation for the bruise:
- Not available ie. Is the bruise unexplained (especially in a baby or young child or with a significant injury)
- Inadequate and unlikely (e.g. bruising on the chest from rolling onto a dummy)
- Inconsistent with the child’s development stage (e.g. sustained when rolled off bed when child not yet rolling)
- Inconsistent over time or confused
• **Age and stage of development of the child**
  Accidental bruising is strongly related to mobility. This is reflected in both national evidence and the learning from local serious case reviews.

  **A non-independently mobile child**: is a child who is not crawling, bottom shuffling, pulling to stand, cruising or walking independently. It includes all children under the age of six months and any children with a disability who are not able to move independently.
  - Once children are mobile they sustain bruises from everyday activities and accidents;
  - Bruising in a baby who is not yet crawling, and therefore has no independent mobility, is very unusual - ‘Those that don't cruise rarely bruise';
  - Only one in five infants who is starting to walk by holding on to the furniture will sustain bruises;
  - Most children who are able to walk independently have bruises;
  - Bruises usually happen when children fall over or bump into objects in their way.

**The location or pattern of bruising**
In mobile children bruising that suggests the possibility of physical child abuse includes:
  - Bruises on any non-bony part of the body or face including the face, back, abdomen, arms, hands, eyes, ears and buttocks;
  - Multiple bruises in clusters;
  - Multiple bruises of uniform shape;
  - Bruises in the shape of a hand, ligature, stick, teeth mark, grip or implement.
  - Bruises with petechiae (dots of blood under the skin) around them
  - Bruising that may be due to the misuse of equipment

### 6.4 When to refer
Bruising in children who are not independently mobile including bruises in babies should raise concern about the possibility of physical child abuse and a bruise or suspicious mark in this group, however small should be referred to CSC.
In older, more mobile children, referrals should be made based on the index of suspicion that the injury may have been caused by abuse, using the information gathered as above. The threshold for referral should be lower in a younger child, **even if the child is mobile**

### 6.5 Strategy Discussion
The social worker/team manager should then arrange a strategy discussion with police and health colleagues to discuss the need for section 47 enquiries. This should be arranged in line with the Child Protection Section 47 Enquiries procedure. If the meeting concludes the threshold for section 47 is met, then a Child Protection medical should be considered. This will usually involve arranging a medical examination. If there are issues regarding the decision to hold a medical, the obtaining of consent, communication difficulties or other factors which may make the paediatric medical examination complex then consider including a paediatrician in the initial strategy discussion.
Paediatric medical examinations for bruising require informed consent from an individual with parental responsibility or, in the absence of this, a court order directing that a paediatric medical examination takes place. If the injury is thought to have been caused by an implement where practicable this should be brought to the medical examination or images of the implement made available to the examining paediatrician.

6.6 CP medical
The Child Protection Medical can only be carried out during a section 47 investigation and the police and CSC are the lead agency. A child protection medical examination should be completed by a paediatrician trained in child protection and above the level of ST2 (i.e. on the middle grade rota or above) in a child friendly, private and confidential space.

The history, examination and conclusions should be documented using the Trust proforma. The checklist should be completed on the proforma to ensure that all aspects of the medical have been completed thoroughly.

A second opinion should be sought before any child or young person is discharged from hospital. In the vast majority of cases this will be the registrar discussing the case with the paediatric consultant. If a consultant sees the child for the medical then they may discuss the case in hours with the named doctor; Out of hours the police surgeon or the community consultant paediatrician on the rota for child sexual abuse are available as the second opinion. The purpose of this discussion is to agree on the medical opinion of the findings and the management plan for the child.

It is important not to hypothesize with the parents / carers regarding likely causes of the injury as the parent or carer may then adopt the same as their subsequent explanation for the injury.

Investigations Required
The RCR/RCPCH Guidance “Standards for radiological investigations of suspected non-accidental injury” states that the following investigations are required: Skeletal survey
- In children under the age of 2 where physical abuse is suspected, a full skeletal survey should always be performed. If it is decided not to perform a skeletal survey, the reasons for this should be detailed in the patient’s notes.
- In children over the age of 2, the decision to perform a skeletal survey will be guided by clinical and social history and physical findings.
- Follow-up radiographs may be of significant value in cases of NAI providing in some cases confirmatory evidence and in others contributing to the exclusion of the diagnosis. It is recommended that they are obtained 11 to 14 days after the original skeletal survey to achieve optimum detection of healing.
**Neuroimaging**

Neuroimaging should be obtained for:
- any child under the age of one where there is evidence of physical abuse;
- any child with evidence of physical abuse with encephalopathic features or focal neurological signs or haemorrhagic retinopathy.
- Schedule of neuroimaging depends on clinical presentation:
  - Day 1 post injury - cranial CT
  - Day 3 -5 post injury - if initial CT scan abnormal or child continues to have neurological signs despite normal CT scan then arrange Cranial MRI scan including DWI. Strongly consider imaging spine at this stage.
  - if MRI abnormal arrange for follow-up scan in 3-6 months to aid prognosis

**Ophthalmology**

The same indications for neuroimaging apply to obtaining a formal ophthalmological opinion, looking specifically for retinal haemorrhages and congenital abnormalities. A consultant ophthalmologist with a particular interest in paediatrics will perform the examination as soon as practically possible from the onset of the concerns. The pupils will need to be dilated for this examination.

**Coagulation tests for bruises**

Coagulopathies are not common and NAI can co-exist with disorders of coagulation. When a child or young person presents with bruising suspicious of NAI, a bleeding history should be documented:
- bleeding from gums,
- significant epistaxis (more than 5 episodes or lasting longer than 10 minutes),
- menorrhagia,
- prolonged bleeding post-operatively (e.g. dental extraction),
- poor wound healing (e.g. Ehlers-Danlos syndrome)
- use of NSAIDs (may cause platelet dysfunction).

When a coagulopathy needs ruling in or out the RCPCH “Child protection companion, 2006” suggests performing the following screening tests:
- APTT INR
- Fibrinogen level Thrombin time
- FBC (to look at platelet count)

Coagulopathy screening is advised in all cases where NAI is the most likely diagnosis for the cause of the bruising or if the diagnosis of the bruising is uncertain. If the decision is made not to perform the screening tests then the reasons should be clearly documented.
6.7 Report writing and communication
After a child protection medical examination, the allocated social worker should be informed of the findings away from the family to ensure that a clear uninhibited conversation has taken place.
The conversation between social care and the medical professional needs to be documented and include:
- whether the findings indicate NAI is more likely than accidental injury; **this should be clearly articulated**
- whether in the absence of any significant findings, the history alone is significant to warrant further child protection investigations due to the level of risk to the child/young person,
- the need to examine siblings or other children in the care of the family,
- the immediate safeguarding of the child and other siblings

The child and family should then be informed of the findings and the plan. This responsibility is shared between the health professional and social care.

The formal report should be dictated that day and be sent to social care within 5 working days from the examination.

**The opinion of the consultant in charge of the case should be the opinion offered to CSC to avoid confusion.** If there is a difference of opinion as to mechanism of injury, then agreement should be established within the health team before contradiction is expressed to other agencies (e.g. CSC or Police) as this can hinder the investigation. Peer review is a useful opportunity to seek opinions from others within the health team.

For children and young people admitted to hospital here there are concerns regarding child protection or there are complex safeguarding concerns, there should be a strategy meeting prior to discharge.

7. **Confidentiality, Information Sharing and Referral process**

- Parents and carers should be informed of the nature of concern and role of hospital staff in relation to information sharing **unless** concerns are in relation to sexual abuse or fabricated or induced illness or the child is at risk of harm as a result of the disclosure of concern to the parents
- Where there are emerging concerns or concerns relating to child in need, information may not be shared outside of the health community (e.g. GP, school nursing service, health visiting service etc) without the parent’s consent to this.
- Where concerns relate to significant harm and child protection issues enquiry and case discussion with CSC can be undertaken without consent of the parents.

To make a CSC referral staff **must** make a telephone call to the relevant Local Authority CSC department and are required to follow up the call in writing using the Trust referral form (see the white board in Derby / safeguarding intranet page for Burton).
On completion of the referral form a copy must be sent to the safeguarding team. The safeguarding team will forward to the relevant CSC department within 72 hours, obtain the outcome of the referral and escalate in line with SCB escalation policies. The safeguarding team will also share the referral with relevant health partners and place an alert on emergency department systems and e-records as to fact of concern and referral.

8. Safeguarding in Specific circumstances

8.1 Working with sexually active young people
In working with young people, it must always be made clear to them, from the outset, that absolute confidentiality cannot be guaranteed, and that there may be some circumstances where the needs of the young person can only be safeguarded by sharing information with others.

Consent issues
No child under the age of 13 is able to consent to any sexual activity (Sexual Offences Act 2003) and sexual activity with a child under 13 must be reported to the police and CSC.

All young people, regardless of gender, or sexual orientation who are believed to be and/or have been engaged in, or planning to be engaged in, sexual activity must have their needs for health, education, support and/or protection assessed by the agency involved. This must include an assessment of their ability to give informed consent.

A child or young person’s ability to consent is impaired if they do not have the freedom, capacity or choice to act, e.g. if they are given alcohol, drugs or if there are learning needs which mean they cannot truly consent.

In assessing the nature of any particular behaviour, it is essential to look at the facts of the relationship, and an assessment must also include the partner. Sexual abuse and sexual exploitation of a child or young person involves an imbalance of power or control and/or coercion. Power imbalances are very important and can occur through differences in size, age and development (including cognitive development) and where gender, sexuality, race and levels of sexual knowledge are used to exert such power. Of these, age may be a key indicator, for example a 15 year old and a 20 year-old.

There is also an imbalance of power if the young person's sexual contact/partner is in a position of trust in relation to them, for example: a teacher, youth worker, carer etc. It is an offence for an adult in a position of trust or authority to engage in sexual activity with a young person (Sexual Offences Act, 2003). If it has been identified that a young person is at risk from an adult in position of trust or authority, the Allegations against Staff, Carers and Volunteers Procedure of the relevant LSCB should be initiated.

At an early stage where there are concerns that a child or young person has been involved in sexual activity or they show associated behaviours and further information is needed to clarify risk, relevant checks must be undertaken with other professionals, including Police, CSC and Health to assist with the risk assessment. While a Referral to CSC may prevent a young person from engaging or making a further disclosure it is important to safeguard the child or young person from further Significant Harm.
All decisions made should be carefully documented including where a decision is made not to share information or make a Referral, this should include a clear rationale for decisions made.

In order to determine whether the relationship presents a risk to the young person, the following risk factors should be considered. This list is not exhaustive and other factors may be needed to be taken into account. This is not an exclusive list. A combination of risk factors should heighten concerns:

- Where there has been a disclosure of sexual activity, particularly if non-consensual;
- Whether there is any sexual harassment;
- Whether the young person is being isolated from family and friends;
- Whether there is a misuse of substances including alcohol which places them in a position where they are unable to make informed choice about sexual activity;
- The nature of the relationship, particularly if there are age or power imbalances or the partner is in a position of trust and/or authority;
- If the following vulnerability factors are also present the risk is increased;
  - history of previous abuse,
  - underlying medical conditions,
  - mental health issues,
  - a learning disability which impairs a person’s ability to consent,
  - communication difficulties,
  - low self esteem
- Whether coercion, manipulation or bribery is involved
- Whether overt aggression, such as threats of, or sexual acts used as punishment or retribution;
- Whether there is any genital injury to self or other;
- Whether the young person is displaying sexually aggressive/exploitive behaviour;
- Sexual degradation / humiliation of self or others;
- Any attempts to secure secrecy by the sexual contact/partner beyond what would be considered usual in a teenage relationship;
- Distributing naked or sexually provocative images of self and others;
- Arranging to meet with an on-line acquaintance in secret;
- If accompanied by an adult, does that relationship give any cause for concern? Is the adult inhibiting / encouraging / colluding / encouraging secrecy or grooming the young person?
- Reports of domestic abuse or violence within the sexual contact/relationship;
- Use of drugs to prolong and/or enhance sexual activity i.e. "CHEM" sex;
- Whether or not the young person is attempting to or exposing their body and/or genitals. Being forced to expose themselves to others including masturbating in public and/or on social media / webcam; Accessing and/or being shown pornography; Taking and sending naked or sexually provocative images of self or others and sexting;
- Seeking adult social networking sites and accessing web based relationships;
- The presence of a sexually transmitted infection (STI) and/or repeated STI or requests for repeat pregnancy tests and/or a confirmed pregnancy;
- The history of the young person, frequency of contact with services and any factors that may make them vulnerable.
If any factors above are identified in the history then a CSC referral should be made

8.2 **Female Genital Mutilation (FGM)**

Any information that a girl or young woman under the age of 18 is at risk of, or has undergone, FGM must result in a referral to CSC and to the police; staff have a mandatory duty to report in these circumstances (Serious Crime Act 2015)

The unborn baby of a woman who has been subject to FGM at some point in her history must be referred to CSC and re-referred if a female baby is born

Staff should not attempt to investigate cases themselves however they must fully record all information/ observations/ disclosures made; this information may be used as criminal evidence and used in court in the future.

8.3 **Management of ano-genital injuries / concerns about sexual abuse**

A history of genital symptoms or injuries must be treated with care. Concerns regarding sexual abuse should not be discussed with the parent / carer before discussion with police and / or CSC.

Where clinical concern or suspicion of sexual abuse exists (e.g. a disclosure of abuse), there should be immediate referral to CSC and a strategy discussion held with social care and the police. The on-call paediatric hospital consultant must be made aware of the case.

Where sexual abuse is clearly suspected it is important that health professionals do not inadvertently destroy or alter evidence that the forensic team would require; e.g. washing the perineum during nappy changes, asking for a urine sample, MSU etc. The child should not be examined before a strategy discussion with CSC and the police.

All sexual abuse medicals now take place at a Sexual Assault Referral Centre (SARC) and are arranged by CSC / police with the appropriate SARC for the area

8.4 **Child Sexual Exploitation (CSE)**

Child sexual exploitation is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology.

Both boys and girls may be victims of CSE

If a child under the age of 18 years attends or is admitted via either Children’s Emergency Department / Adult Emergency Department or Minor Injuries Unit to any area / department and has apparent vulnerabilities, then a CSE Checklist should be completed (See safeguarding intranet pages Derby / Burton)
Vulnerabilities include;
• those who attend with Deliberate Self Harm including Overdose, Alcohol Intoxication
• Drug Use (Legal or Illegal),
• young people in the care of the Local Authority (Foster Care/Children’s Homes)
• A history of going missing for periods of time.

This is not an exhaustive list and CSE should be considered in other cases. With all of these children there should be a CSC check to see if they are known and if they are, then who are they known to and why?

Copies of the completed CSE Checklist should be sent to the Safeguarding Team.

If the CSE Checklist identifies a Medium Risk then further discussion with multi-agency partners needs to be undertaken prior to discharge and the Safeguarding Team to be informed of the case. A CSE information sharing form (safeguarding intranet pages) should be completed and emailed to the safeguarding team.

If the CSE Checklist identifies a High Risk then a referral to CSC is required under Section 47 Significant Harm and a Strategy Meeting must be held prior to discharge. CSC is responsible for arranging this meeting

8.5 Trafficking
Prompt decisions are needed when the concerns relate to a child who may be trafficked to avoid the risk of the child being moved again. Children who have been trafficked are likely to have complex or serious needs and there will often be child protection concerns. Anyone who has a concern regarding the possible trafficking of a child must immediately contact the Child Trafficking Advice Centre 0808 800 5000 – this is managed by the NSPCC who is classed as a “first responder” in child trafficking cases and liaise with the Trust Safeguarding Team

Staff should not do anything which would heighten the risk of harm or abduction to the child, such as consulting with or informing those suspected of trafficking that a referral is being made.

8.6 Forced marriage
Forced marriage is an abuse of human rights and a form of domestic abuse. Where it affects children and young people it is child abuse. It can never be justified on religious or cultural grounds.

A forced marriage is a marriage conducted without the full and valid consent of both parties and where duress sufficient to force a child or young person to comply with the marriage is a factor. The duress that a child experiences and the forced marriage, if it goes ahead, may indicate a reasonable likelihood that the child may have been or will be subjected to one or more forms of emotional, physical and sexual abuse. Where staff identify concerns in relation to forced marriage referrals should be made to the responsible CSC department or the Forced Marriage Unit 020 7008 0151 Monday to Friday, 9am to 5pm or Out of hours: 020 7008 1500 (ask for the Global Response Centre)
8.7 **Fabricated induced illness (FII)**

Fabricated or induced illness (FII) is a rare form of child abuse. The incidence of FII is difficult to estimate how widespread FII is because many cases may go unreported or undetected. One study published in 2000 estimated 89 cases of FII in a population of 100,000 over a two-year period. However, it is likely that this figure underestimates the actual number of cases of FII.

FII occurs when a parent or carer, usually the child’s biological mother (but not always; there have been cases where the father, foster parent, grandparent, guardian, or a healthcare or childcare professional was responsible), exaggerates or deliberately causes symptoms of illness in the child. FII covers a wide range of symptoms and behaviours involving parents seeking healthcare for a child. This ranges from extreme neglect (failing to seek medical care) to induced illness.

Behaviours in FII include a mother or other carer who:
- persuades healthcare professionals that their child is ill when they’re perfectly healthy
- exaggerates or lies about their child’s symptoms
- manipulates test results to suggest the presence of illness – for example, by putting glucose in urine samples to suggest the child has diabetes
- deliberately induces symptoms of illness – for example, by poisoning her child with unnecessary medication or other substances

FII can involve children of all ages, but the most severe cases are usually associated with children under five.

Concerns about FII should be discussed with the Paediatrician responsible for the child’s care. If there is no Paediatrician involved with the child, the situation should be discussed with the Named Doctor and Named Nurse to advise on the way forward and a health chronology should be developed, as soon as there is a concern. This should include all involved health professionals / providers. The case should also be discussed with the Designated Doctor from the CCG which covers where the child is normally resident.

Any concerns are not usually discussed with the family at an early stage as there is a risk that the behaviour may escalate and increase harm to the child or could impact on the evidence gathering. The reasons for not disclosing to parents/carers should be recorded.

Following discussion with the Designated Doctor and confirmation of concern about FII, a referral must be made to the relevant CSC department and a strategy discussion undertaken to determine the plan going forward.

8.8 **Concerns regarding unborn babies**

Full details of partners / fathers name, date of birth, care of other children or blocks to his access to other children must be made in the booking appointment.

Enquiry must also be made with regard to the father of the unborn and any mental health issues as well as maternal mental health issues and a routine enquiry regard domestic abuse must be made.
Local research identifies that it is very uncommon for mother's not to give details of father to the unborn and failure to provide a name, date of birth and address should be taken as a potential risk indicator.

Where it has been identified that the parent/s may need additional support to meet the needs of their unborn child, an early help assessment should be considered as the means to clearly identify needs/strengths and the support required; In some cases pregnant women and their families may only require additional advice and support from the agency or agencies currently involved.

- families who may need early support and help include:
- parent/s who are asking for help and support.
- young parents under 18 or with limited support from family/friends.
- care leavers.
- families whose dynamics result in levels of instability.
- parent/s struggling to maintain standards of hygiene/repair with the family home.
- families in poverty or where food, warmth and other basics may not always be available.
- families where the advent of a new baby may exacerbate existing difficulties.
- families with housing issues which places them at risk of homelessness or are currently homeless.

Where there are serious concerns about the parent's capacity to meet the needs of the baby when it is born, or if the baby may be at risk of significant harm, a referral to CSC should be made at the earliest opportunity to allow sufficient time for a full and informed assessment, enable appropriate interventions and support, and time to make plans for the baby's protection.

In the following circumstances unborn babies should be referred to CSC as soon as possible after 12 weeks of pregnancy:
- a parent, or other adult in the household, or the person a parent is in an on-going relationship with, is a person who poses a risk to children.
- a sibling or child in the household is subject to a child protection plan.
- another child has previously been removed from the care of either parent, either temporarily or by a court order (this may include where the child has been placed with a family member).
- there is evidence of one or more parental risk factors:
- high risk domestic abuse, or
- female genital mutilation (FGM), or
- problematic and chaotic substance misuse, or
- severe and enduring mental illness.
- there are concerns about the parental ability to self-care and /or to care for the child, e.g. where the parent is learning disabled.
- the expectant mother is under the age of 13 years or where the mother is under 16 years and there are additional concerns.
- any other concerns exist that the baby may be at risk of significant harm.
Lastly in the case delayed presentation to antenatal services (beyond 18 weeks of pregnancy) it should be borne in mind that concealment or delayed presentation to antenatal services may, in some cases be because the woman is unaware that she is pregnant BUT it may also be a deliberate act or act of denial due to sexual abuse or exploitation or due to domestic abuse. An antenatal home visit is mandatory if a woman books after 18 weeks of pregnancy and the reasons for the delay in booking explored. Where a pregnancy is concealed (ie the woman does not present until in labour), a referral should be made to CSC and a discharge planning meeting undertaken.

8.9 **Children in Hospital for 3 consecutive months or more**

The Children Act 1989 s85 requires NHS Foundation Trusts to notify the ‘Responsible Authority’ (i.e. the Local Authority CSC Department) for the area where the child is ordinarily resident, when a child has been, or will be, accommodated by the UHDB (or another hospital )for a consecutive period of three months or more. This is so that CSC can assess the child’s needs and decide whether services are required under the Children Act 1989.

The purpose of the notification is to ensure the Local Authority:

(a) take such steps as are reasonably practicable to enable them to determine whether the child’s welfare is adequately safeguarded and promoted while he is accommodated by the accommodating authority;

and

(b) consider the extent to which (if at all) they should exercise any of their

Consultants having care of infants, children or young people who have had a consecutive in-patient stay of 3 months (taking into account any time spent in another hospital prior to admission in UHDB) should make a referral to CSC to notify them of the child to fulfil the duty under s85 of the Act as above and with the express request for an initial assessment of need as required under s85 of The Children Act 1989. An early help assessment should be offered to the family.

A running total of days as a hospital in-patient should be identified and maintained in both the nursing record and the medical record. Where children have been in any hospital (s) for a consecutive period of 3 months or more it is expected that, following the notification to CSC, a discharge planning meeting will be held inviting representatives from CSC and all other relevant parties (eg Health visitor, KITE team) unless there are very clear reasons for not doing so. In this meeting the early help assessment will be completed by all present.

8.10 **Private Fostering**

Where a child is thought to be in a private fostering situation (ie not living with a close relative and the situation is continuing longer than 28 days) a referral must be made to the relevant CSC for assessment under The Children (Private Arrangements for Fostering) Regulations 2005.
8.11 **Young Carers and Children with Disabilities**
The Care Act 2014 Sections 58 – 64 Care Act 2014 contain provisions relating to disabled children, young carers and transition services for disabled children. The Local Authority has an obligation to assess needs not only of the child in all of the circumstances noted above but also the parent or carer during transition of the young person between children’s and adult services and a referral for assessment should be made to CSC.

8.12 **Lawful Authority for Consent to care and treatment in young people**;
The Mental Capacity Act (MCA) 2005 applies to children and young people 16 years and above. The MCA outlines processes to be followed in certain circumstances. Please see Appendix 2 for an outline of the process and the inter-relationship with Frazer competency guidelines. Consent issues also arise in situations where there are new “blended families” and in relation to parents and step parents and where the child is in Local Authority care. Please see Appendix 2 for clarification of who has Parental Responsibility (PR) in these circumstances.

8.13 **Allegations Made Implicating Trust Staff**
Allegations can arise in professional or private life. All allegations indicating behavior demonstrating unsuitability to work with children or young people made against staff should be managed according to Trust Policy Managing Allegations and LSCB Local Authority Designated Officer (LADO) procedures.

8.14 **Missing Families**
It should be recognized that for some families, leaving their usual home and moving without notification to GPs or other services may be an attempt at closure and to avoid input / assessment by services who are seeking to protect children from harm or neglectful care. This is a particular issue for professionals working in the community.

Where a family or pregnant woman are not contactable and appear to have left the family home the professional must attempt a home visit leaving a letter which notes the concern that they have not been seen and requesting contact from them within 1 week. Note in this letter that if there is no response a missing family / person process will be initiated which will involve contacting other agencies.

Make contact with the GP to ascertain when last seen or heard from

Make contact with CSC to enquire if they are known to services or their whereabouts known. If there is no contact – staff must contact the safeguarding team using the form at Appendix 5.

9. **Documentation in Health Records**
At the point when safeguarding issues are identified, the safeguarding file divider must be inserted into any paper health record or an alert put on the e-record and appropriate entries made detailing the safeguarding concerns. Care plans must indicate there are safeguarding concerns.
There is an expectation that all safeguarding occasions, concerns, events, discussions, child protection medicals & peer review or incidents will be appropriately recorded in the record whether the paper or electronic records. When a strategy discussion or meeting is held there must be a contemporaneous record made in the health record.

Where a professional or agency has concerns regarding fabricated or induced illness in a child, accurate record keeping is vital for identifying issues in the care of the child. Specific record keeping requirements in these circumstances are identified in the DCSF Guidance Safeguarding Children in Whom Illness is Fabricated or Induced (Mar 2008) (Available on the Trust Safeguarding intranet web)

10. **Safety planning and discharge arrangements**

10.1 Following recent local serious case review no child must be discharged overnight without clear consideration of safeguarding / child protection concerns and discussion with the responsible consultant. **Where there are emerging needs or safeguarding concerns and there is no current plan in place sufficient to address the concerns, (eg EHA, Child in Need or Child Protection Plan)** no child or young person may be discharged without a discharge planning meeting. This is a hospital responsibility to organise and hold. All relevant professionals and agencies should be requested to attend (eg HV, School Nurse, school representative, voluntary agency, Community Midwife Multi-Agency Team professionals) and a plan sufficient to meet the needs of the child or young person agreed. Where low level/emerging needs are identified EHA can be completed at the discharge planning meeting.

10.2 **Where there are child protection concerns.**

Whenever there is reasonable cause to suspect that a child is suffering, or is likely to suffer significant harm there must be a strategy discussion or meeting in the hospital prior to discharge. This must be chaired by CSC Team Manager or above.

The purpose of the strategy discussion / meeting is to determine the child's welfare and plan rapid future action if there is reasonable cause to suspect the child is suffering, or is likely to suffer, Significant Harm. This should be held in the hospital and all relevant agencies / professionals including the police should attend. This meeting is the responsibility of social care to organise and chair but it is a matter of good practice for health professionals to ensure that all relevant health professionals are informed and invited to attend.

It is the responsibility of the Chair of the strategy discussion / meeting to ensure that the decisions and agreed actions are fully recorded using an appropriate form / record and circulated at the conclusion of the meeting.

10.3 **Where Children Are Not Registered with a GP**

Where there are safeguarding issues relating to a child or young person, discharge planning must include the checking and allocation of a GP prior to discharge. **No child about whom there are child protection concerns should be discharged before a GP is identified.**
10.4 **Attendance at multi agency meetings and conferences**

Community Practitioners and acute staff as appropriate are required to attend discharge planning meetings, strategy meetings, child protection conferences and early help or “team around the family” meetings for children. It is essential that first hand information is provided in multi-agency forums. A written report of the child’s progress or chronology of involvement must be submitted as required. In the event of annual leave or sickness, a report must be provided in the absence of the practitioner and apologies provided. Where possible another qualified colleague may attend on their behalf. Employees are expected to prioritise work associated with Safeguarding children.

11. **Support for Staff involved in Safeguarding Children and Young People**

Working to ensure children and young people are protected from harm requires sound professional judgements to be made. It is demanding work that can be distressing and stressful. All of those involved have access to advice and support from their peers, Managers or Named Professionals. Ongoing supervision of cases where there are complex issues can be provided for staff members following discussion with the Safeguarding team. See the Trust Safeguarding Supervision policy

Staff may also refer to the Trust Policy and Procedures for Supporting Staff Involved in Traumatic Situations and Incidents.

12. **Untoward/Incident Report**

Any local Safeguarding issues that are felt to have not been dealt with adequately should be recorded on DATIX and investigated accordingly.

13. **Serious Case Reviews**

National and Regional Serious Case reports and recommendations should be discussed by the Trust Safeguarding Committee, Trust Named Professionals and used to check the robustness of the Trust processes. Any recommendations or changes to practice will be fed back to the divisions for implementation by the business units. Trust Named Professionals will advise and support where required.

Where the Trust is required to take part in a Serious Case Review, the Trust individual Management Review will be developed by the Trust Named Professionals and agreed by the Lead Executive for Safeguarding. Recommendations and actions will be implemented by the responsible business units or others identified as responsible and implementation must be monitored by the relevant Divisional Management Board who report exceptions to implementation to the Trust Safeguarding Committee and Trust Named professionals.

When subjects of the IMR are identified, all records in the Trust relating to them must be acquired by the Safeguarding Team, immediately photocopied and the original record returned to records.
14. **Monitoring Compliance and Effectiveness**

Monitoring Requirement:
Process for ensuring that policy is acted upon throughout the organisation

Monitoring Method:
Random audit of referrals to CSC Random audit of case files in child protection cases
LMS database compliance reports
MARAC research

Reports prepared by Trust Named Nurse Safeguarding Children
Report presented to Trust Safeguarding Committee
Division of Integrated Care Governance Board
Frequency of Report Annually

15. **References**

Framework for the Assessment of Children in Need and Their Families (DoH 2000).
Derby and Derbyshire Safeguarding Children Procedures, Trust Intranet NHSLA (April 2008),
Staffordshire Safeguarding Children Procedures
Risk Management Standards for Acute Trusts.
Intercollegiate Document (2014) Safeguarding children and young people: roles and competences for health care staff
The Care Act 2014
The Care and Support Statutory Guidance April 2015
Appendix 1

Safeguarding Children: Definitions and Potential Indicators of Abuse

Abuse and neglect are forms of maltreatment of a child. Somebody may abuse or neglect a child either directly by inflicting harm, or indirectly, by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting; by those known to them; or, more rarely, by a stranger. They may be abused by an adult or adults, or another child or children. The definitions below are taken from Working Together to Safeguard Children 2015

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

Potential Indicators
Injuries should always be interpreted in light of the child’s medical and social history, developmental stage and the explanation given. Most accidental bruises are seen over bony parts of the body, e.g. elbows, knees, shins, and are often on the front of the body. Some children, however, will have bruising that is more than likely inflicted rather than accidental. Important indicators of physical abuse are bruises or injuries that are either unexplained or inconsistent with the explanation given, or visible on the ‘soft’ parts of the body where accidental injuries are unlikely, e.g., cheeks, abdomen, back and buttocks. A delay in seeking medical treatment when it is obviously necessary is also a cause for concern, although this can be more complicated with burns, as these are often delayed in presentation due to blistering taking place some time later.

The physical signs of abuse may include:
- unexplained bruising,
- marks or injuries on any part of the body
- multiple bruises- in clusters, often on the upper arm, outside of the thigh
- cigarette burns
- human bite marks
- broken bones
- scalds, with upward splash marks
- multiple burns with a clearly demarcated edge

Changes in behaviour that can also indicate physical abuse:
- fear of parents being approached for an explanation
- aggressive behaviour or severe temper outbursts
- flinching when approached or touched
- reluctance to get changed, for example in hot weather
- depression
- withdrawn behaviour
- running away from home.
Emotional Abuse

Emotional abuse is the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child’s emotional development. It may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may feature age- or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond the child’s developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction. It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.

Potential Indicators
Emotional abuse can be difficult to measure, as there are often no outward physical signs. There may be a developmental delay due to a failure to thrive and grow, although this will usually only be evident if the child puts on weight in other circumstances, for example when hospitalised or away from their parents’ care. Even so, children who appear well-cared for may nevertheless be emotionally abused by being taunted, put down or belittled. They may receive little or no love, affection or attention from their parents or carers. Emotional abuse can also take the form of children not being allowed to mix or play with other children.

Changes in behaviour which can indicate emotional abuse include:

- neurotic behaviour e.g. sulking, hair twisting, rocking
- being unable to play
- fear of making mistakes
- sudden speech disorders
- self-harm
- fear of parent being approached regarding their behaviour
- developmental delay in terms of emotional progress
- eating disorders and self harm

Sexual Abuse
Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, including prostitution, whether or not the child is aware of what is happening. The activities may involve physical contact including both penetrative or non-penetrative acts such as kissing, touching or fondling the child's genitals or breasts, vaginal or anal intercourse or oral sex. They may include non-contact activities, such as involving children in looking at, or in the production of, pornographic material or watching sexual activities, or encouraging children to behave in sexually inappropriate ways.
Potential indicators

Usually, in cases of sexual abuse it is the child’s behaviour that may cause you to become concerned, although physical signs can also be present. The physical signs of sexual abuse may include:

- pain or itching in the genital area
- bruising or bleeding near genital area
- sexually transmitted disease
- vaginal discharge or infection
- stomach pains
- discomfort when walking or sitting down
- pregnancy

Changes in behaviour which can also indicate sexual abuse include:

- sudden or unexplained changes in behaviour e.g. becoming aggressive or withdrawn
- fear of being left with a specific person or group of people
- having nightmares
- running away from home
- sexual knowledge which is beyond their age, or developmental level
- sexual drawings or language
- bedwetting
- eating problems such as overeating or anorexia
- self-harm or mutilation, sometimes leading to suicide attempts
- saying they have secrets they cannot tell anyone about
- substance or drug abuse
- suddenly having unexplained sources of money
- not allowed to have friends (particularly in adolescence)
- acting in a sexually explicit way towards adults

Neglect

Neglect is the persistent failure to meet a child’s basic physical and/or psychological needs, likely to result in the serious impairment of the child’s health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to provide adequate food and clothing; shelter, including exclusion from home or abandonment; failing to protect a child from physical and emotional harm or danger; failure to ensure adequate supervision including the use of inadequate caretakers; or the failure to ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, a child’s basic emotional needs.

Potential Indicators

Neglect can be a difficult form of abuse to recognise, yet have some of the most lasting and damaging effects on children. The physical signs of neglect may include:

- constant hunger
- sometimes stealing food from other children
- constantly dirty or ‘smelly’
• loss of weight, or being constantly underweight
• inappropriate clothing for the conditions
• Changes in behaviour which can also indicate neglect may include:
  • complaining of being tired all the time
  • not requesting medical assistance and/or failing to attend appointments
  • having few friends
  • mentioning being left alone or unsupervised
Appendix 2

Guidance re Lawful authority for undertaking examination, care or treatment for children

Children under 16 are generally assumed to be unable to make complex decisions regarding examination, care or treatment. However, dependent on the complexity of the decision and the stage of development and maturity of the child, the child may have the capacity to make the decision for themselves. This is called Gillick or Fraser competence and relates to a specific decision (i.e. we would say that a child is Gillick competent to make X decision at the time of assessment). This ability would be assessed by determining whether the child can:

- Understand the decision they need to make, why they need to make it and the information about the different options available?
- Retain the information long enough to make a decision or choice?
- Weigh up the consequences, benefits, risks and impact of choosing different options (or of not making a decision at all)?
- Communicate the outcome of their decision by any means (i.e. speech, sign language)?

Where children do have capacity to give or with-hold consent their valid, informed consent provides sufficient lawful authority to provide examination, care or treatment and in such cases their refusal must be respected. Parental wishes for the examination, care or treatment to go ahead must not be relied upon as sufficient lawful authority. If in any doubt seek legal advice or submit an application to the Family Court.

Where children do not have the ability to give or with-hold consent someone with Parental Responsibility is able to give consent on their behalf. However, not all parents have Parental Responsibility for their children (for example, biological fathers not married to the biological mother do not automatically have such responsibility, although they can acquire it).

Consent to Medical Treatment for Children Looked After and Parental Responsibility

1. **Births registered in England and Wales**
   - If the parents of a child are married when the child is born, or if they’ve jointly adopted a child, both have parental responsibility.
   - They both keep parental responsibility if they later divorce.

2. **Unmarried parents**
   An unmarried father can get parental responsibility for his child in 1 of 3 ways:
   - jointly registering the birth of the child with the mother (from 1 December 2003)
   - getting a parental responsibility agreement with the mother
     (A Parental Responsibility Agreement under the Children Act 1989 is an agreement to which all other people with Parental Responsibility consent. This is a formal document which needs to be signed by all the parties and then registered at court).
   - getting a parental responsibility order from a court
     (A Parental Responsibility Order is an order under the Children Act 1989, which unmarried fathers can apply for when the mother refuses to allow the father to be registered or re-registered on the birth certificate, or refuses to sign a Parental Responsibility Agreement with him).
You must ask for evidence of any of the above in the event that an unmarried father attends with the child on his own.

3. **Step-Parents**
   A step-parent can only acquire parental responsibility for a child in very specific circumstances including:
   - When the court makes a Child Arrangements Order that the child lives with the step-parent either on their own or with another person.
   - When the step-parent adopts a child which puts him/her in the same position as a birth parent.
   - Through the signing of a Parental Responsibility Agreement to which all other people with Parental Responsibility consent. This is a formal document which needs to be signed by all the parties and then registered at court.
   - When the court has made a Parental Responsibility Order following an application by the step-parent.

On acquiring parental responsibility, a step-parent has the same duties and responsibilities as a natural parent.

In all cases you should ask for evidence of any of the above in the event a step-father attends with a child and consent to treatment is required.

4. **Same-sex parents**
   - **Civil partners**
     - Same-sex partners will both have parental responsibility if they were civil partners at the time of the treatment, e.g. donor insemination or fertility treatment.
   - **Non-civil partners**
     For same-sex partners who aren’t civil partners, the second parent can get parental responsibility in the following circumstances:
     - if a parental agreement was made. (This would be with the mother’s agreement and evidenced in the form of an Order from the Court.)
     - becoming a civil partner of the other parent and making a parental responsibility agreement or jointly registering the birth.

5. **Legal Order Guidance**
   Private Fostering is an arrangement whereby a child under the age of 16 (or 18 if the child has a disability) is placed for 28 days or more in the care of someone who is not the child’s parent(s) or a ‘connected person’ (someone who has a pre-existing relationship with the child, for example, a teacher who knows the child in a professional capacity). Those caring for a child(ren) under these arrangements will not have parental responsibility for the child(ren), therefore consent from the PR holder is required.
Section 20 The Local Authority (LA) does NOT have parental responsibility for that child.

**Interim Care Order** (s38 Children Act 1989) This is an interim order prior to the final Care Order being made and gives the LA parental responsibility for a child (the LA MUST consult with and inform other PR holders about important decisions they make for the child).

**Care Order** (s31 Children Act 1989) A Care Order gives the LA parental responsibility for a child (the LA MUST consult with and inform other PR holders about important decisions they make for the child i.e. medical treatment).

**Emergency Protection Order** gives parental responsibility for the child while at the same time does not remove it from anyone else who has PR in respect of the child. 

**Supervision Order** (s35 Children Act 1989) Does not give the LA parental responsibility for a child, PR remains with the parent(s).

**Child Arrangement Order** (s8 Children Act 1989) If a child arrangements order states that the child will live with a person, that person will have parental responsibility for that child until the order ceases. The parent(s) also retain PR as stated above under PR guidance.

**Special Guardianship Order** (Adoption & Children Act 2002) This order discharges any existing care order and grants PR to the Special Guardian(s). Although parents do not lose their right to PR, the Special Guardians will have a higher level of Parental Responsibility than the birth parent(s) should conflict arise.

**Placement Order** (Adoption & Children Act 2002) Prospective adopters will acquire Parental Responsibility for the child as soon as the child is placed with them, to be shared with the birth parents and the adoption agency making the placement (i.e. this could be the LA).

**Adoption Order** (Adoption and Children Act 2002) When a child is adopted, the parental responsibility of their biological (birth) parents as well as any other person who holds parental responsibility will end. Parental responsibility will be held solely by the adopter/s.

6. **When consent can be overruled**

   If a young person refuses treatment which may lead to their death or a severe permanent injury, their decision can be overruled by the Court of Protection. This is the legal body that oversees the operation of the Mental Capacity Act (2005). You must therefore refer to the flow chart in the appendices of the Trust Safeguarding Children Policy for further guidance.

   The parents of a young person who has refused treatment may consent for them, but it’s usually thought best to go through the courts in this situation and if this situation arises, the Trust Legal Team needs to be contacted.
7. **Looked After Children**
When children and young people become accommodated by the Local Authority, parents are asked to sign a Placement Plan which also has Consent to Medical Treatment section (note this does not give authority to anaesthetics). Social Workers should contact parent(s) when children and young people are required to undergo routine examination or treatment. They should involve the parent(s) in discussion regarding the examination or treatment prior to consent being given.

Where a child is in need of surgery, a general anaesthetic or other specific medical treatment, the child’s Social Worker should actively seek to involve the parent(s) with parental responsibility.
- Consent should be given in writing by the parent and the local authority delegated person as above (but is equally valid if given verbally, provided it was informed and freely given).
- Children’s wishes and feelings where possible should be obtained, considered and accounted for.
- If a Looked After child under 16, who is subject to a Care or Interim Care Order, the Team Manager should give consent if the parent(s) are unable or unwilling to do so.
- If a Looked After child requires serious medical treatment, this should be brought to the attention of the Local Authority senior management, who can then give consent and delegate a Social Worker or Team Manager to attend the hospital, discuss the surgery, anaesthetic and risks with the doctor(s).
- In a ‘life or limb’ situation, a Doctor must act in the child’s best interest and may proceed without consent.
- Children receiving medical treatment who are Looked After by another Local Authority should follow the same process as Looked After children locally.

8. **What happens when those with parental responsibility disagree?**
Disputes between parents can be difficult for everybody involved in the child’s care. Health professionals must take care to concern themselves only with the welfare of the child and to avoid being drawn into extraneous matters such as marital disputes.

Generally, the law only requires doctors to have consent from one person in order lawfully to provide treatment. However, doctors may feel reluctant to override the dissenting parent’s strongly held views, particularly where the benefits and burdens of the treatment are finely balanced and it is not clear what is best for the child. If the dispute is over a controversial and elective procedure (for example: male infant circumcision for religious purposes), doctors must not proceed without the authority of a court judgement in the case.

In other cases, discussion aimed at reaching consensus should be attempted. If this fails, a decision must be made by the clinician in charge whether to go ahead despite the disagreement. The onus is then on the dissenting parent to take steps to reverse the doctor’s decision.

**If you are in any doubt about whether the person with the child has parental responsibility for that child, you must check.** Others (such as adopted parents, step
parents or the Local Authority) may acquire parental responsibility via specific legal processes.

When babies or young children are being cared for in hospital, it will not usually seem practicable to seek a parent’s consent on every occasion for every routine intervention such as blood or urine tests or X-rays. However, you must remember that, in law, such consent is required. Where a child is admitted, you must therefore discuss with their parent(s) what routine procedures will be necessary, and ensure that you have their consent for these interventions in advance. If parents specify that they wish to be asked before particular procedures are initiated, you must do so, unless the delay involved in contacting them would put the child’s health at risk.
Overview of Lawful Authority for Examination, Care or Treatment – 16 yrs +

You must be competent regarding the principles of consent and mental capacity prior to undertaking examination, care or treatment.

Provide relevant and sufficient information about the examination, care or treatment that is proposed and any alternative options.

Consider whether any special measures can be taken to improve the provision of information e.g. interpreters, SALT.

Do you have reason to believe that the patient has not:
- Understood some or all of the information you gave them? OR
- Retained the information for long enough to make a decision? OR
- Weighed up the risks/benefits of having/not having the care, examination or treatment or the various alternatives? OR
- Been able to communicate the outcome of their decision-making by any means?

OR
- Is the patient unconscious, heavily sedated or has a low GCS score?

Document that in your opinion the patient does not have the mental capacity to make the decision regarding the particular examination, care or treatment that is proposed, as they are unable to: understand/retain/weigh-up/communicate. The extent of this documentation should be proportionate to the seriousness and potential consequences of the care, examination or treatment.

Ask the patient if they are happy to proceed with the examination, care or treatment that is proposed.

The valid, informed consent (oral, non-verbal/implied or written) that a patient provides is sufficient lawful authority for proceeding with the examination, care or treatment. NB: For consent to be valid it must also not be given under duress. If you have concerns about this consider safeguarding.

Where a patient refuses the proposed examination; care or treatment establish if there is a particular reason and consider if the objections can be overcome or the care, examination or treatment provided differently to avoid the cause of the objection. This may lead to the giving of consent.

Ultimately refusal must be respected (unless certain provisions of the Mental Health Act apply).

Document refusal, any known reasons for it and alternatives suggested. The extent of this documentation should be proportionate to the seriousness and potential consequences of not having the care, examination or treatment.

Document the process undertaken to obtain consent and that consent obtained. The extent of this documentation should be proportionate to the seriousness and potential consequences of the care, examination or treatment.

Proceed with care, examination or treatment.

Document care given and any associated observations or anomalies.

Proceed with care, examination or treatment where you believe this to be in the patient’s best interests.

If the patient resists the care, examination or treatment, consider any reasons there may be for this and whether the care, examination or treatment can be provided differently. Restrictions/restraint may be necessary but ensure that overall the care, examination or treatment remains in the patient’s best interests and the least restrictive alternative.

Ascertain if there is any evidence of a Court of Protection appointed Deputy or a Lasting Power of Attorney for Health and Welfare with the authority to consent/refuse on behalf of the patient for the care or treatment proposed. If so, they will be the decision-maker.

Ascertain if there is any evidence of a valid and applicable Advance Decision to Refuse Treatment (ADRT) which relates to the care or treatment proposed. If so, the care or treatment cannot be undertaken and alternatives should be considered.

Ensuring that you consider the checklist in the MCA, establish what you believe would be in the patient’s best interests (medically, emotionally, socially and psychologically), referring to an IMCA for an independent opinion where the patient has no appropriate family to consult and it is a residence (stay over 8 weeks) or serious medical treatment decision.

Document the process of determining best interests. The extent of this documentation should be proportionate to the seriousness and potential consequences of the care, examination or treatment.
### Overview of Lawful Authority for Examination, Care or Treatment – Under 16

You must be competent regarding the principles of consent and mental capacity prior to undertaking examination, care or treatment.

Provide relevant and sufficient information about the examination, care or treatment that is proposed and any alternative options.

Consider whether any special measures can be taken to improve the provision of information e.g. interpreters, SALT.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is it apparent that the patient can:</td>
<td></td>
<td></td>
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<tr>
<td>• Understand all of the information you give them? AND</td>
<td></td>
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<td>• Retain the information for long enough to make a decision? AND</td>
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<tr>
<td>• Weigh up the risks/ benefits of having/not having the care, examination or treatment or the various alternatives? AND</td>
<td></td>
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<tr>
<td>• Communicate the outcome of their decision-making by any means?</td>
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<tr>
<td>i.e. is the patient Gillick / Fraser competent in relation to this decision?</td>
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</table>

<table>
<thead>
<tr>
<th>Decision</th>
<th>Consider alternative lawful authority e.g. use of Mental Health Act or a court order.</th>
<th>Determine who has ‘parental responsibility’ (PR) and obtain documentary evidence of this.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the decision one that falls within the zone of parental authority? (Is the decision one that a parent would normally be expected to make? Is there confidence that the parent will act in the best interests of the child? – the less sure you are that the answers to these questions is ‘yes’ the more likely the decision is to fall outside the zone e.g. deprivation of liberty, ECT etc.)</td>
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<tr>
<td></td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Does at least one person with PR consent to the treatment? (Where disagreement priority should be given to the ‘parent’ with whom the child lives or get the court involved).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The valid, informed consent (oral, non-verbal/implied or written) of one person with parental responsibility for the child provides sufficient lawful authority for proceeding with the examination, care or treatment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The valid, informed consent (oral, non-verbal/implied or written) of one person with parental responsibility for the child provides sufficient lawful authority for proceeding with the examination, care or treatment.</td>
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<tr>
<td>Document the process undertaken to obtain consent and that consent obtained. The extent of this documentation should be proportionate to the seriousness and potential consequences of the care, examination or treatment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proceed with care, examination or treatment.</td>
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</tbody>
</table>

Document care given and any associated observations or anomalies.
# Safeguarding Adults and Children Training: Target Audience and Training Delivery

<table>
<thead>
<tr>
<th>Level of training</th>
<th>Level 1 Basic Prevent Awareness eLFH elearning package</th>
<th>Level 1 (Including Domestic Abuse Awareness and MCA Awareness)</th>
<th>Level 3 Safeguarding adults and children (This course delivers competencies at level 3, 2 &amp; 1 of the Intercollegiate Competencies for Safeguarding children AND the Intercollegiate Competencies for Safeguarding Adults.)</th>
<th>Level 3 Domestic Abuse Training</th>
<th>Prevent (WRAP3) Approved eLFH elearning package</th>
<th>Level 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delivery model</td>
<td>e-learning</td>
<td>E-learning (provided on mandatory induction programme and passport)</td>
<td>e-Learning package / Face to Face option also provided</td>
<td>e-learning</td>
<td>e-learning</td>
<td>Specialist safeguarding courses External providers</td>
</tr>
<tr>
<td>Refresher / update requirement and delivery model</td>
<td>3 yearly</td>
<td>3 yearly</td>
<td>Yearly e-Learning package / Face to Face option also provided</td>
<td>3 yearly</td>
<td>Yearly</td>
<td>3 yearly</td>
</tr>
</tbody>
</table>

## Target audience

| Safeguarding Team Named Professionals | ● | ● | ● |
| All clinical patient facing staff | ● | ● | ● |
| Non clinical and/or non-patient facing staff | ● | ● | ● |
| Chaplaincy, volunteers, security, facilities and All other non-clinical staff | ● | ● | ● |
| Trust Board | Board up-date 6 monthly |
### Missing child / Family / Pregnant Woman Notification

#### Missing Patient Details

<table>
<thead>
<tr>
<th>Name</th>
<th>DoB</th>
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<tbody>
<tr>
<td></td>
<td></td>
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<tr>
<td>NHS Number</td>
<td></td>
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<tr>
<td>Last Known Address</td>
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#### Date Last Seen

**Relevant others:**

**Parents / Carers**

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<tr>
<th>Name</th>
<th>DoB</th>
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**Siblings**

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<tr>
<th>Name</th>
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Contact made with GP? Yes No

Contact made with CSC Yes No

#### For UHDB Safeguarding Team

Contact made with Public Health Nurses Yes No

Outcome:

For distribution to Designated Professional Yes No

**Date actioned**