University Hospitals of Derby and Burton NHS Foundation Trust

TRUST POLICY FOR SAFEGUARDING CHILDREN

Reference Number POL-CL/ 1886/2006 Old Ref: CL-CH PROT 2010 031	**Version: 2.13**		**Status:** FINAL	**Author:** Jane O'Daly -Miller **Job Title**: Head of Safeguarding & Vulnerable People
Version / Amendment History	Version	Date	Author	Reason
	1	Jan 2006	Trust named contact	Original Policy
	2	Oct 2008	Joanne Clark/ Mary Hobin	Review
	2.1	Oct 2008	Pam Twine	To meet NHSLA standards
	2.2	Nov 2008	Pam Twine/ Lynne Fryatt	Further amendments
	2.3	Sept 2010	Jane O'Daly	Following CQC inspection and Working Together 2010
	2.4	March 2014	Jane O'Daly	Following revised statutory guidance WT 13
	2.5	Nov 2015	Sarah Fitzgerald / Jane O'Daly-MIller	Review in accordance with revised Statutory guidance WT 2015 and The Care Act 2014 & statutory guidance Apr 2015
	2.6	June 2015	Jane O'Daly-Miller	Incorporation of guidelines re management of NAI
	2.7	Aug 2017	Jane O'Daly-Miller	Addition of Modern Slavery information
	2.8	Dec 2017	Jane O'Daly-Miller	Addition of further information on Parental Responsibility & Missing Family process
	2.9	Dec 2018	Jane O'Daly-Miller	Following merger
	2.10	Jan2020	Jane O'Daly-Miller	Incorporating learning issues from SI
	2.11	August 2020	Jane O'Daly-Miller	Incorporating recommendations from External Review
	2.12	June 2022	Jane O'Daly-Miller	Amending review dates required by RoAPT and addition of guidance re apprentices

	2.13	Jan 2023	Jane O'Daly-Miller	Amendments following DDSCP guidance re Keeping Babies Safe
	2.14	April 2024	Jane O'Daly-Miller	Amendment to TNA matrix in Appendix 4a

Intended Recipients: All staff	
Training and Dissemination: Safeguarding mandatory training and dissemination will be via the internet	
To be read in conjunction with: Derby and Derbyshire Safeguarding Children Procedures, Staffordshire Safeguarding Children Procedures, Trust Policy and Procedures including Was Not Brought Policy, Safeguarding Supervision Policy, Managing Allegations Policy, FGM Policy	
In consultation with and Date: Trust Safeguarding & Vulnerable People Committee (TSVPC) February 2023	
EIRA stage One Completed Yes stage Two Completed Yes	
Approving Body and Date Approved	Trust Delivery Group - March 2023
Date of Issue	January 2023
Review Date and Frequency	January 2026 (then every 3 years)
Contact for Review	Head of Safeguarding & Vulnerable People
Executive Lead Signature	 Executive Chief Nurse

Contents

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 & 2004), Working Together to Safeguard Children (DFE 2018) and Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework (2019).

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 and to manage the risks and reduce the incidence of harm to children.

The Policy outlines the following:

- Staff responsibilities for safeguarding and promoting the welfare and safety of children.
- Children's social care thresholds for action and the processes from Early Help Assessment through to referrals to Children's Social Care.
- Pre-birth assessment process and action to take where there are concerns regarding unborn babies
- Required response to bruising in babies and children and the management of concerns with regard to non-accidental injuries
- The process of escalation of concerns from front line staff, to the Trust Safeguarding Children Specialists / Named Midwives and with Children's Social Care in accordance with local Safeguarding Children Partnership policies and procedures.
- The level of safeguarding children training staff are required to undertake.
- Training and support for staff involved in safeguarding children cases.
- The monitoring undertaken to ensure compliancewith this policy.

3. Definitions Used

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
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).
CSC	Children's Social Care

Early Help	A process by which professionals working with families, children, young people, or adults who are parents and carers, identify 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.
LA	Local Authority
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 or students living with "host" families
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'.
Significant harm	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.

4. Key responsibilities/ Duties

Safeguarding Children's Partnerships	Safeguarding Children's Partnerships (SCP) 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 key meetings of the Derby and Derbyshire SCP, their sub-groups and undertakes a s11 (Children Act 2004) process led by the DDSCP and CCG Designated Professionals. The SCPs provide policies and procedures specific for safeguarding process and practice in their area
Integrated Care Board (ICB	Derby and Derbyshire ICB and Staffordshire and toke on Trent ICB monitor Trust performance in safeguarding in regular meetings with the Trust. The ICB employee Designated Nurses and Doctors who attend the Trust Safeguarding Committee and provide supervision to Trust Named Nurses and Doctors.
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.

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 Derby and Derbyshire Safeguarding Children Partnership.
Trust Safeguarding & Vulnerable People Committee (TSVPC)	The Trust Safeguarding & Vulnerable People 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 are met, that performance is compliant with national and local guidance and that learning from Child Safeguarding Practice Reviews (SPRs) and Domestic Homicide Reviews (DHRs) are incorporated into Trust processes. The TSVPC 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.
Head of Safeguarding & Vulnerable People and Trust Named Professionals	The Head of Safeguarding and Vulnerable People, Named Nurses / Specialist Safeguarding professionals, 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 action plans are implemented, monitored and followed up where necessary
All Staff	All staff and those in services contracted by the Trust must attend mandatory safeguarding 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 3) All staff must: • Recognise indicators of abuse • Be aware of the vulnerability and risk factors for child abuse –including situations where adults may pose a risk to children or young people and be aware of thresholds for social care involvement and what to do when there are concern regarding emerging need. • Take the appropriate action if a child or young person's welfare or safety may be at risk. • Know how to contact the Safeguarding Team. • Ensure that they access safeguarding training.
Apprentices	Many young people coming into the Trust are likely to be new the workplace, with some facing unfamiliar risks from the job they will

	be doing. The Trust recognises these risks and will ensure that young workers will receive sufficient training in their role to safeguard them, minimising any unnecessary risks to themselves or others. Safeguarding determines the actions we take to keep apprentices safe and protect them from harm in all aspects of their work placement For further information see Appendix 7

5. Thresholds for response to concerns about children

5.1 Referral thresholds and methods

Referrals to services regarding concerns about a child typically fall into four levels:

I. **Low level needs**: where need is relatively low and where individual / universal services may be able to address the child's needs without the involvement of other services.

II. **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. E.g.,

- 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.
- Low level parental mental health, physical health/illness, learning disability, substance misuse issues.
- Standard risk domestic abuse
- 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 through the relevant local authority EHA process always sending a copy to the Safeguarding team uhdb.safeguarding@nhs.net. A copy should be attached or uploaded to the child's health record / electronic record.

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 CSC may be necessary. Staff can discuss such cases with the safeguarding professionals via the phone or in supervision sessions

III. **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:

- Children/young people with significant mental health concerns, disability/learning difficulty, alcohol and/or substance misuse.

- Children and young people who indicate a medium risk of being sexually exploited, or trafficked.
- If a child is identified as seeking asylum.
- Young carers who are not coping.
- Parents with significant mental health, learning disabilities, chronic debilitating illness or alcohol/substance misuse problems.
- Medium / high risk domestic abuse
- Children identified as in a private fostering arrangement.
- Children who exhibit sexually harmful behaviour.

IV. 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 undertake 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 injuries / injuries inconsistent with explanation or injuries where it appears there has been neglect.
- 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 (HBV), 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

Where concerns arise in relation to attendance indicating concern relating to neglect or the potential for abuse, an enquiry must be made to CSC to help build a picture of any concerns, aiding the development of a differential diagnosis.

This can be done by telephone in most circumstances, or, re Staffordshire LA, an online enquiry form is also available although this will not be responded to out of hours. (Contact numbers and links to LAs proximate to the hospitals and MIUs are on Trust intranet safeguarding pages).

Referrals must be made first by telephone and then followed up in writing using the following methods:

- Via the whiteboard on inpatient areas of RDH site

- Via the online referral forms of the relevant LA.

(Whenever an online referral is completed, the referrer is requested to enter an email address. The email address to be entered **MUST** be uhdb.safeguarding@nhs.net. This will ensure that the safeguarding team receive a copy of the referral, can escalate concerns if there are disagreements regarding thresholds or take to discussion in 1:1 supervision)

6. Child Protection Information System (CPIS)

When a child is a Looked After Child or on a Child Protection Plan, basic information relating to that plan (e.g., the local authority CSC) is uploaded to the national spine by CSC and this can then be seen on attendance to an urgent or emergency care setting. Bearing in mind that it is a rare occurrence for children to be subject to a plan, this is valuable information that can be vital in forming a differential diagnosis and assessing risk to children. All children attending urgent or emergency care settings in the Trust must be checked on the system for a CPIS alert and contact made with the relevant LA CSC to find out more details of the concerns and reasons for the CP plan. They must not be discharged without this information being understood and considered.

7. Management of Child Protection processes; Responding to Bruising in Babies, Non-mobile Children 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

7.1 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

7.2 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.

7.3 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.

7.3.1 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.

7.3.2 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 i.e., 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.

7.3.3 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.

7.3.4 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

7.4 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 and if under 2 or if not mobile the child should not be discharged. **The threshold for referral should be lower in a younger child, even if the child is mobile.** 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.

7.5 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. Parental responsibility can be problematic to identify at times and if there is doubt staff should refer to appendix 2.

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.

7.6 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 Trust Named Doctor. **Out of hours** the police surgeon or the community consultant paediatrician on the rota 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.

7.6.1 Investigations Required

The RCR/RCPCH Guidance "Standards for radiological investigations of suspected non-accidental injury" states that the following investigations are required:

7.6.1.1 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.

7.6.1.2 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 haemorrhagicretinopathy.
- 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

7.6.1.3 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.

7.6.1.4 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 longerthan 10 minutes),
- menorrhagia,
- prolonged bleeding post-operatively (e.g. dental extraction),
- poor wound healing (e.g. Ehlers-Danlossyndrome)
- 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:

- APTR 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.

7.7 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.

8. Confidentiality & Information Sharing

- 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 (eg 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.

9. Safeguarding in Specific circumstances

9.1 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.

With regard to consent; 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, the age difference between a 15 year old and a 20 year-old.

Where there is a clear 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, nurse, doctor, 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 safeguarding team must be contacted. If the person is a Trust employee, the Managing Allegations policy must be followed. Allegations relating to persons in a position of trust employed or otherwise must trigger following of relevant SCP policies.

At an early stage where there are concerns that a child or young person has been involved in sexual activity, or they show behaviours of concern, and further information is needed to clarify risk, a referral must be made to the relevant LA CSC.

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. 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.

9.2 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 s e x u a l 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.

9.3 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 to the police

on Tel 101 in these circumstances (Serious Crime Act 2015) and are required to make a safeguarding children referral

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. All pregnant women who have undergone FGM must be notified to the Named Midwives of the Trust on uhdb.safeguarding@nhs.net.

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.

9.4 Children at Risk of Exploitation (CRE)

Child exploitation is where a child can be exploited for sexual purposes or drawn into criminal acts. Child sexual abuse 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 CRE Checklist should be completed (See safeguarding intranet pages)

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 CRE 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 CRE Checklist should be sent to uhdb.safeguarding@nhs.net.

If the CRE 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 CRE information sharing form (safeguarding intranet pages) should be completed and emailed to the safeguarding team.

If the CRE 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.

9.5 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.

9.6 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).

9.7 Children attending with Self harm / emotional and mental health concerns
Self-harm can take a number of forms including;

- Overdose of legal or illegal substances including alcohol or medication
- Cutting
- Attempted hanging / ligature use
- Burning
- Jumping in front of trains / out of vehicles

It is most common in children of 11 years or older but can occur from as young as 5 yrs

It can be seen as a coping response to

- Bullying / online bullying & discrimination
- Relationship difficulties within the family or peers
- Abuse / neglect
- Depression and anxiety

Self-harming behavior must be taken seriously and treated with concern, care and sensitivity for the young person to avoid any sense of stigmatization.

The method chosen for self-harm can mistakenly lead people / professionals to assume that there was minimal suicidal intent (e.g., low numbers of tablets taken in an overdose.) However, intent can be a subtle issue and many people who go on to take their own life often deny suicidal intent prior to an act that ends their life. The child or young person must be assessed by CAMHs trained professionals to determine intent and level of risk.

A pathway flowchart can be seen at Appendix 8.

9.8 Children attending with substance misuse / alcohol misuse issues.
This can be an indicator of exploitation or self-harm or reflect the culture within a peer group or family for example - On attendance at UHDB services, discussion with the child or young person should take place including obtaining their consent for referral to specialist substance misuse services.

Burton: Contact T3 service – 07500770604 / 07974727475
Derby: Contact Breakout – 01332 641661

9.9 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 hasdiabetes
- 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.

9.10 Concerns regarding unborn babies

Full enquiries into 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:

- 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 of delayed presentation to antenatal services (defined as 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 (defined as when the pregnant woman does not present until in labour), a referral should be made to CSC and a discharge planning meeting undertaken prior to discharge.

9.11 Keeping Babies Safe

Infants are intrinsically vulnerable, particularly with regard to death or serious injury from shaking or unsafe sleep practices of parents / carers e.g., co-sleeping (having the infant in bed with the carer / parent) Guidance and required action to promote infant safety can be seen at Appendix 9.

- With regard to **risks of injury / death through shaking babies or unsafe sleeping**;
  All postnatal women and their partners wherever possible should be shown the "Don't Shake the Baby" video prior to discharge from the hospital. Where a home birth takes place or discharge occurs before video is accessed this must be addressed and shown the video in the first post-natal visit or given the link to the video. Access to the video must be recorded in the health record
- All practitioners who have contact with families should consider the potential vulnerability of the baby within the family. The identification and assessment of the vulnerability of families who have a baby to care for is essential to ensure that babies remain safe
  Staff are required to Think 3 S's:
  - Safer sleep: where the baby sleeps day and night?
  - Safe space: Is it a safe home environment?
  - Safe Handling: Discuss the management of crying with family / carers?

Any UHDB professional visiting the family home should use the opportunity to gain information a great deal of information by observing the home environment and to consider what it is like to be a baby within that home.

Some considerations:

- Is the home acceptably clean and without clutter?
- Where does the baby sleep day and night?
- Is the baby equipment in good order and safe to use?
- Are there appropriate baby toys?
- Is the baby at the centre of the family?
- Does the parent or care giver handle the baby appropriately?
- Does the parent or care giver respond to the baby's cues, crying or needs appropriately?
- Are there any safety risks (including pets, fire hazards etc.)?

The guidance at Appendix 9 highlights helpful conversations that can be had with families in this regard and should be used by staff to facilitate discussion and ensure there is appropriate recording of thoughts and findings. Where concerns arise these should be discussed with their safeguarding supervisor or the UHDB Safeguarding 0-18yrs service.

9.12 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 (e.g., 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.

9.13 Private Fostering

Where a child is thought to be in a private fostering situation (i.e., 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.

9.14 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.

9.15 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 3 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 stepparents and where the child is in Local Authority care. Please see Appendix 2 for clarification of who has Parental Responsibility (PR) in these circumstances.

9.16 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.

9.17 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.

10. 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).

11. Safety planning and discharge arrangements

11.1 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.

11.2 Where there are emerging needs or safeguarding concerns and there is no current plan in place sufficient to address the concerns, (e.g., 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 (e.g., 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

11.3 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.

11.4 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.**

11.5 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 firsthand 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.

12. 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).

13. Untoward/ Incident Report

Any allegation of abuse or neglect occurring in a hospital service should be taken forward as an SI. Where a member of staff has abused their position of power and trust then the Trust Managing Allegations policy should be followed. Safeguarding issues that are felt to have not been dealt with adequately should be recorded on DATIX and investigated accordingly and, if it has led to abuse or harm then an SI should be undertaken. It is expected in these circumstances that the Named Doctor and Named Nurse should be closely involved, if not the lead investigators, with these investigations.

14. Safeguarding Children Practice 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 CPR, the Trust individual Management Review will be developed by the Trust Named Professionals and agreed by the Head of Safeguarding and Vulnerable People. 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 Operational Reference Group and Trust Safeguarding Committee.

When subjects of the IMR are identified, all paper records in the Trust relating to them must be

acquired by the Safeguarding Team, immediately photocopied and the original record returned to records.

15. Monitoring Compliance and Effectiveness

Criterion	Lead	Monitoring method	Frequency	Committee/ Group
Child protection process and record keeping	Named Nurse & Named Doctor for Safeguarding	Case file audit	Yearly	Trust Safeguarding Committee
Compliance with S85 CA	Named Nurse & Named Doctor for Safeguarding	Case file audit	6 monthly	Trust Safeguarding Committee

16. References

- The Children Act (1989 and 2004).
- Working Together to Safeguard Children (DfES 2010, 2013, 2015,2018) Derby and Derbyshire Safeguarding Children Procedures,
- 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 sometime 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 thethigh
- 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 temperoutbursts
- flinching when approached or touched
- reluctance to get changed, for example in hotweather
- 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 theirbehaviour
- 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 oranorexia
- self-harm or mutilation, sometimes leading to suicide attempts
- saying they have secrets they cannot tell anyoneabout
- substance or drug abuse
- suddenly having unexplained sources ofmoney
- 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 anotherperson.
- 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

4.1 Civil Parents

- Same-sex partners will both have parental responsibility if they were civil partners at the time of the treatment, e.g., donor insemination or fertilitytreatment.

4.2 Non-civil parents

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 thedoctor(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. <u>What happens when those with parental responsibility disagree?</u>

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, stepparents 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.

Appendix 3 - Overview of Lawful Authority for Examination, Care or Treatment - 16yrs plus

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?

Y

Documents 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.

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.

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.

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.

N

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

Y

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.*

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.

Proceed with care, examination or treatment.

N

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.*

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 care given and any associated observations or anomalies.

Appendix 4 - 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.

↓

Is it apparent that the patient can:

1. Understand all of the information you give them? AND
2. Retain the information for long enough to make a decision? AND
3. Weigh up the risks/ benefits of having/not having the care, examination or treatment or the various alternatives? AND
4. Communicate the outcome of their decision-making by any means?

i.e. is the patient Gillick / Fraser competent in relation to this decision?

N

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.)

N

Consider alternative lawful authority e.g., use of Mental Health Act or a court order.

Y

Determine who has 'parental responsibility' (PR) and obtain documentary evidence of this.

↓

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).

↓

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.

↓

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.

Y

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

Y

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. There is no obligation to inform the parents, although all young people should be encouraged to involve significant family members *NB: For consent to be valid it must also not be given under duress. If you have concerns about this consider safeguarding*

↓

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.

N

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.

↓

The consent of someone with parental authority CANNOT be relied on. Ultimately refusal must be respected (unless certain provisions of the Mental Health Act apply or a court order is obtained)

↓

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 care given and any associated observations or anomalies.

Appendix 4a - Safeguarding Training: Target Audience and Training Delivery

Level of training	**Level 1 Safeguarding adults and children**	**Level 2 Safeguarding adults and children**	**Level 3 Safeguarding adults and children**	**Level 4**	**Basic Prevent Awareness**	**WRAP**
Delivery model	video	video	e-Learning package / Face to Face option also provided (2 sessions a month; 1 QHB 1 RDH)	Specialist safeguarding professionals courses External providers	e-learning	e-learning
Refresher / update requirement	Every 3 yrs	Every 3 years	3 Yearly	3 yearly	3 yearly	3 yearly
Safeguarding Team Named Professionals				•		•
All clinical **and** patient facing staff			•		•	All clinical staff **in urgent and emergency**
Clinical **non-patient facing** staff		•			•	
Chaplaincy, volunteers, security , facilities and All other non-clinical staff	•				•	

Trust Board	• + Board level training refreshed 3 yrly					

Appendix 5 - Missing child / Family / Pregnant Woman Notification

University Hospitals of Derby and Burton NHS Foundation Trust

Missing child / Family / Pregnant Woman Notification Missing Patient Details

Missing patient details

Name **DoB**

NHS Number

Last Known Address

Date Last Seen:

Relevant others:

Parents / Carers

Name **DoB**

Name **DoB**

Siblings

Name **DoB**

Name **DoB**

Name **DoB**

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:

Appendix 6 - Child Protection Medical Guidance - Burton site

Refer to Trust Children's safeguarding policy.

1. Monday to Friday 9-5pm- Referrals should be redirected to Community Paediatric team through social care.

2. Referrals from other in-house speciality / CSC /Police/GP- over weekends and out of hours should be taken by Middle grade doctor or Consultant on call. Where the child is referred from in-house speciality, middle grade doctors should discuss with consultant about the referral and the child should be admitted under joint care and discussed with consultant. Confirm that they have already reported to social care on the basis of their clinical concern/suspicion.

3. Once the decision is made to do CP medical examination, a detailed history and head to toe examination should be documented in the CP proforma

4. Investigations:
   - Full blood count, blood film and coagulation screen, if there is evidence of bruising or intra cranial bleed. Where necessary, please arrange extended screening to eliminate a blood disorder. Please liaise with Birmingham Children's Hospital haematology team before taking the samples to ensure that samples are transported and processed promptly. This should include the following (in addition to FBC and coagulation profile).

     Von Willebrand factor assay (VWB antigen and VWB activity)
     Factor XIII assay
     Factor VIIIc assay
     Platelet glycoprotein
     Fibrinogen levels
     Thrombin time

   - Bone biochemistry (as well as Vitamin D and parathormone levels) if there is an unexplained fracture.
   - Investigations into other suspected abuse (e.g. faltering growth)
   - Skeletal survey should be performed in children under the age of 2 where physical abuse is suspected. If it is decided not to perform skeletal survey, the reasons for this should be detailed in the patient's notes. Consent should be taken from person having parental responsibility for imaging.
   - If a decision has been made to perform skeletal survey, please discuss this first with Dr Crookdake at RDH (01332 785540). Once agreed, inform radiology department at QHB and order on V6. Ask radiology department at QHB to send all the images (skeletal survey as well as CT head-if performed) via IEP to Dr Crookdake for reporting. Repeat skeletal survey will be required in 11-14 days to complete the radiological investigations. In absence of Dr Crookdake, Paediatric Consultant should speak to Radiologists in Leicester on 0116 2587524.RDH radiographers will perform the study and inform Leicester Radiologist. Leicester radiologist will report the study. Paediatric secretary is Amanda Cassidy on 0116 2586898(amandcassidy2@nhs.net)
   - In children over the age of 2 years, the decision to perform a skeletal survey will be guided by

clinical/social history and physical findings.

- When serious injury is identified in a child with suspected physical abuse:
    a) Any multiple birth sibling(s) of an index case less than two years should have the same recommended imaging as the index case.
    b) Age-appropriate imaging should be considered in all siblings and children less than two years old living in the same household or in the household of the alleged or suspected perpetrator(s) on a case –by- case basis.
- A repeat of the full skeletal survey may be required in cases on ongoing clinical concern; or where follow up imaging is not completed with 28 days of the original examination, as advised by the supervising radiologist.
- CT brain should be part of the skeletal survey for children under the age of 1 year. A clinical decision to perform CT head should be made on children over 1 year of age depending on history and the clinical findings.
  Subsequent neuro-imaging should be discussed with Paediatric Radiologist.
- If the initial cranial CT is abnormal or if the child has neurological abnormalities in the presence of an apparently normal or equivocal CT, cranial MRI should be performed.
- Photography should be undertaken by a police photographer or by medical photography.

5. Subsequent Management/Strategy meeting

Police and social care will carry out their own investigations and a strategy meeting to discuss and weigh up findings and risks should take place between all health care professionals, social care and the police before the child is discharged from the ward.

6. Discharge
    - Discharge should not take place before all results are available and a strategy meeting / discussion between health (including relevant community health professionals), social care and police has been held. If a child protection medical is done out of hours it should be discussed with OC consultant before discharging the child. In general a child who has been admitted for a CP medical should not be discharged out of hours.
    - A child with a finding of NAI being likely or more than likely or cannot be ruled out should **not** be discharged unless there has been a strategy discussion with police and social care. The CP medical report should be sent without delay to the LA. The CP medical should be entered into the child's record and a copy sent to the relevant Designated Doctor and the Named Doctor.
    - Complete the ward discharge slip on V6 and send copy to GP noting full details of concerns leading to the CP medical, the findings and the outcome of the strategy meeting. Discuss appropriate follow up arrangements with the consultant in-charge.

7. Confidentiality
    - The doctor's primary duty is to act in the child's best interest. It is important to cooperate with police and social care at all times and share information with them.
    - Be open and honest with parents always keep them well informed except when there is sufficient reason to believe that informing them may potentially harm the child (e.g. in cases of child sexual abuse where the perpetrator potentially has access to the children, where parents are in the possible timeline of abuse having occurred or in cases of fabricated or induced illness).

8. Reference

    - The radiological investigation of suspected physical abuse in children. Society and College of Radiographers and The Royal College of radiologists. Revised first edition. November 2018
    - RACPCH- Child protection evidence- Systematic review on fractures .April 2018
    - Working together to safeguard children-A guide to inter agency working to safeguard and promote the welfare of children. July 2018

Written: February 2005 Dr C Goel, Consultant Paediatrician
Updated: August 2019
Review: August 2022

Appendix 7 - Apprentices and safeguarding

Safeguarding determines the actions we take to keep apprentice learners safe and protect them from harm in all aspects of their work placement. As a Hospital Trust we are committed to safeguarding and the safety of all learners. UHDB seeks to provide a safe and supportive learning environment where learner views are valued, they feel listened to and are encouraged to confidently report any concerns. Safeguarding is everyone's responsibility and does not rest solely with the Head of Safeguarding and their deputies. This policy should be used in conjunction with the following Trust policies:

- Safeguarding vulnerable adults, children and young people; practice guidance and operational policies
- Managing Allegations Policy
- Prevent Policy

Within the Trust, anybody can contact the designated Safeguarding lead if they have concerns about a young person or vulnerable learner. They are contactable via 01332 787547 or uhdb.safeguarding@nhs.net

Organisations employing young workers in the UK should comply with all appropriate legislation and guidelines applicable to their activities relating to the safeguarding of children, young people or vulnerable adults including, where appropriate, relevant Regulations of the Children Act 1989 and 2004, Regulations and National Minimum Standards of the Care Standards Act 2000, Working Together to Safeguard Children 2018, the aims and aspirations of the Human Rights Act 1998, the Prevent strategy, the use of the Disclosure and Barring Service or similar UK legislation pertaining to regulated activity in this context.

Safeguarding Training

All staff within the Trust, including students and apprentices are required to complete mandatory training for Safeguarding and PREVENT (Basic Prevent Awareness (e-lfh)). Staff associated with teaching learners, as well as the learners themselves, are expected to know the procedure for reporting Safeguarding concerns.

Many young people coming into the Trust are likely to be new the workplace, with some facing unfamiliar risks from the job they will be doing. The Trust recognises these risks and will ensure that young workers will receive sufficient training in their role to safeguard them, minimising any unnecessary risks to themselves or others.

Young people in the workplace will always be supervised. This will ensure that their progress is monitored, and any reasonable adjustments can be implemented, as per individual risk assessment at the time of employment, as required. When completing the risk assessment in partnership with the training provider and apprentice please ensure the risk assessment of all learners considers their psychological or physical immaturity, inexperience and lack of awareness of risks and introduce control measures to eliminate or minimise the risks, so far as is reasonably practicable.

The manager (or a delegated person) should assess competency and confidence in carrying out all the tasks required. Once the employee is assessed as competent and confident, they may begin to work out of sight of experienced colleagues within delegated boundaries.

Managers must ensure that appropriate support is offered to them; this could be in the form of coaching, peer support, buddying or mentoring.

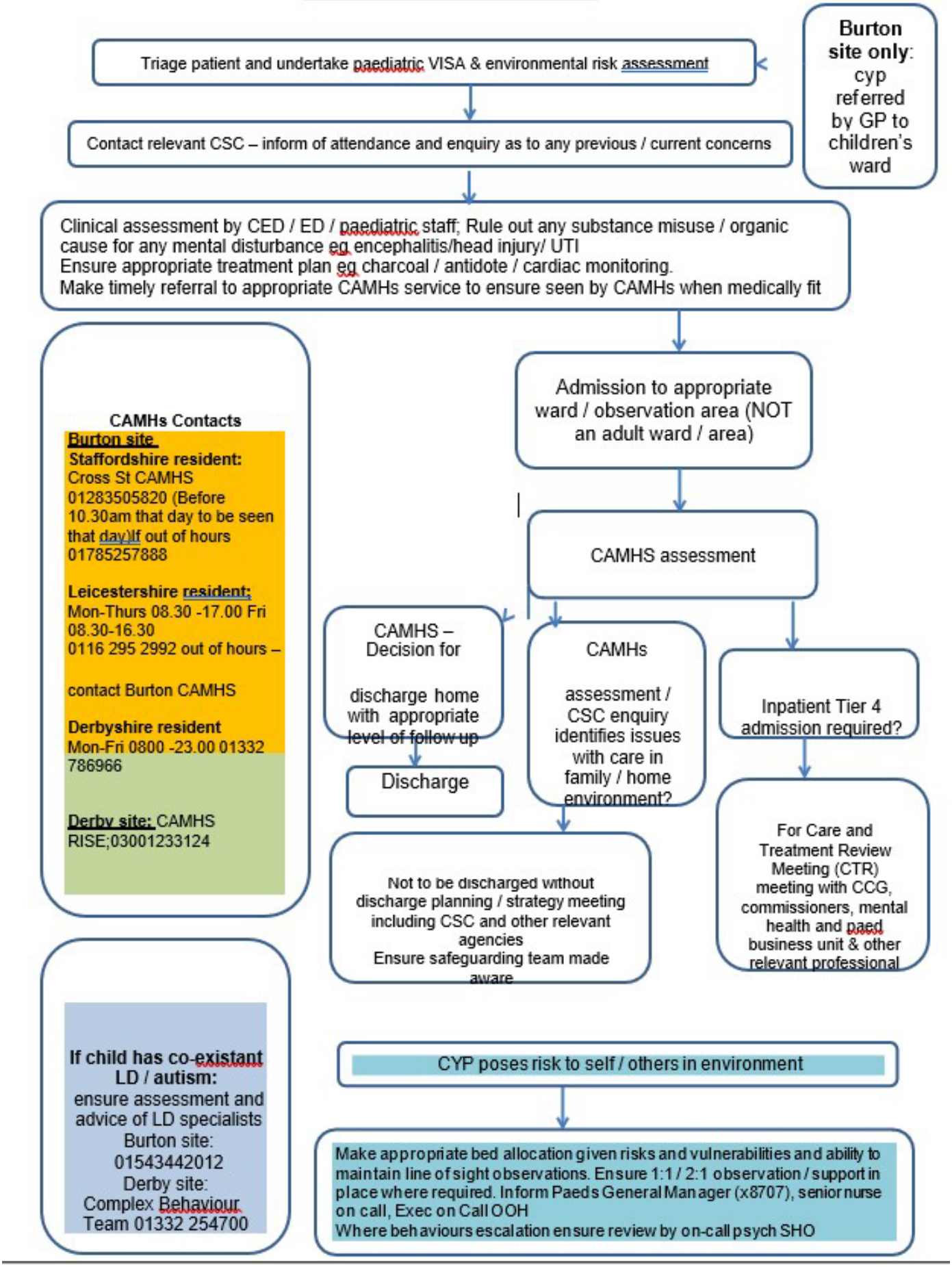
The Trust is a member of the Derby and Derbyshire Safeguarding Children Partnership and all Partnership policies and guidance is available via the safeguarding pages on Neti.

All staff employed by the Trust have DBS checks on recruitment. Where necessary teaching staff will have enhanced DBS checks performed. If formal teaching is undertaken by someone without an enhanced DBS check, a person with enhanced DBS will be present as necessary.

All safeguarding matters relating to learner/child protection are to be treated as confidential and only shared in accordance with Data Protection and Trust Safeguarding policy. We have a statutory duty of care with regards to child protection concerns and this will be actioned through the Trust Safeguarding team. Information will be shared with individuals within the Trust who 'need to know' and staff and learners are aware that they cannot promise to keep a disclosure confidential.

Reporting and referral of Safeguarding issues
If staff are concerned that there is a learner safeguarding risk, they should raise a concern in the first instance with the Trust Safeguarding Team.

Appendix 8 - CYP attends CED / ED with Mental Health Problem



Every Baby Matters: Identifying Vulnerability Observations and Conversations Supportive Guidance




Derby and Derbyshire

December 2022

Introduction

The Derby and Derbyshire Safeguarding Childrens Partnership have commissioned Child Practice Reviews to consider the learning from cases where significant harm has occurred to babies. The recurring theme is that infants are intrinsically vulnerable and that practitioners need to identify the vulnerabilities of babies and their families at a much earlier stage to ensure that the needs of babies are being met and that all babies in Derby and Derbyshire remain safe and well cared for.

This guidance is to support practitioners who come into contact or work with families who have infants under a year old. The tool will give practitioners guidance on what to consider when having contact or visiting families with infants and some ideas of what to look for and how to gather information which may alert a practitioner to concerns or aid a further assessment of the family.

This tool and guidance will not replace any other assessment tool or processes however it may help to enhance those assessments with a particular focus on the baby. The tool can be used universally as an aid to gain an understanding of the lived experience of a baby within a family and can be used to support other assessment processes such as the Early Help Assessment.

The pack of resources include:

- Guidance Document
- Resource poster on the five key messages for Every Baby Matters – Identifying Vulnerability.
- The Every Baby Matters Vulnerability Tool to aid quality conversations and observations to enhance further assessment and support for families.

Every Baby Matters Identifying Vulnerability - Resource Poster

All practitioners who have contact with families should consider the potential vulnerability of the baby within the family.

The identification and assessment of the vulnerability of families who have a baby to care for is essential to ensure that babies remain safe in Derby and Derbyshire.

Every Baby Matters - Five Key Messages

> It matters that all babies are safe
>
> It matters that their needs are met immediately
>
> It matters that families feel supported
>
> It matters that we understand the relationship between babies, their parents/carers
>
> It matters that we understand any vulnerabilities or risks that affect a baby's care and development

Please consider:

- What is it like to be a baby within the family?
- Are there any vulnerability factors?
- What support can be offered?

This resource poster can be used by anyone who has contact with families who have a baby to care for. This is a first step to:

- Raise the awareness of the vulnerability of babies
- Have a basic understanding of what it is like to be a baby in the family
- Identify any immediate concerns and signpost practitioners on who to contact to support the family

The Derby and Derbyshire Safeguarding Childrens Partnership expect this resource to be used widely across all partners in practice either individual as part of an assessment process, or as an aid memoir when having contact with families to remind the work force of the priority of Keeping Babies Safe in Derby and Derbyshire.

Every Baby Matters: observations and conversations

Refer to the Every Baby Matters Vulnerability Guidance Document

Bonding and Attachment:

- Describe what it is like caring and looking after your baby.
- Explain how you cope when your baby cries a lot or is difficult to settle.
- Tell me about your relationship with your baby. If your baby could speak, what might they say?

Health and Wellbeing:

- Tell me what you are enjoying about being parents. Is there anything that is worrying you?
- How are you feeling?
- Looking after yourself is important. How do you look after yourself?

Knowledge and Expectations:

- Is there someone in your life that you can trust to offer you support and advice?
- Do you find the views/advice from other people (including social media) helpful?
- Where do you get your information from about being a parent/carer?

What is it like to be a baby within the family?

Are there any vulnerability factors?

What support can be offered?

Community Strengths and Stressors:

- Tell me about how you feel about where you live and your local community.
- Do you feel able to access local groups and support from your community?
- Would you like to talk about financial pressures? Do you know where to get advice on benefits?

Who is in your baby's life:

- Does anyone else help you look after your baby?
- If your baby could speak, who would they say is important to them. Who makes them smile or laugh?
- Relationships can often change after a baby has been born. Have you noticed any changes in your close relationships?

Your baby's development:

- Babies born early can sometimes be more vulnerable. Have you got any concerns about your baby's health and development?
- Babies change/develop quickly, what changes have you noticed? Do you feel ready for the next stage of development?
- Tell me about an average day for you and your baby.

Keeping Babies Safe for Practitioners - Think 3 S's ***Safer Sleep:*** See where the baby sleeps day & night.

Safe Space: Is it a safe home environment.

Safe Handling: Discuss the management of crying.

Scan here for more information

Derby and Derbyshire Safeguarding Children Partnership

December 2022

Every Baby Matters: Identifying Vulnerability Observations and Conversations Tool

This tool is to enhance and support the early conversations with families about their relationship and parenting of their baby. It is designed to give practitioners information on how to increase their awareness of the parent/carer relationship and to identify any vulnerabilities by using skills of observation and open-ended questioning that will produce quality conversations and enhance contacts/visits and assessments.

There is no expectation to ask all of the questions or for the tool to be used at one contact or visit. It is not designed to be used as a check list merely to support practitioners to explore and consider the lived experience of the baby and identify any areas where a family would benefit from additional support.

Observations

Practitioners who visit a family home where there is a baby can gain a great deal of information by observing the home environment and to consider what it is like to be a baby within that home. Some considerations:

- Is the home acceptably clean and without clutter?
- Where does the baby sleep day and night?
- Is the baby equipment in good order and safe to use?
- Are there appropriate baby toys?
- Is the baby at the centre of the family?
- Does the parent or care giver handle the baby appropriately?
- Does the parent or care giver respond to the baby's cues, crying or needs appropriately?
- Are there any safety risks (including pets, fire hazards etc.)?

Quality Conversations

It is important to try and use open ended questions to support an open and honest conversation. By actively encouraging discussion, rather than closed questions (and yes/no answers), a practitioner can get a better indication of parental understanding.

Practitioners maybe concerned about asking personal questions which they feel may cause offence or be embarrassing to ask. This can lead to questions being asked in a way that can make people more likely to feel uncomfortable. For example, by saying "this question is quite invasive" or "you might feel uncomfortable about answering this question" or "I hope you won't take offence at being asked this question", it suggests to them how they might feel. However, if questions are asked in a clear, respectful, and compassionate way, most people appreciate the opportunity to have a conversation about their personal circumstances, particularly if this leads to an offer of support. It is important to actively listen to what the parents/carers are saying. Focus on the interaction, make eye contact, nod, and "match" their body language to encourage parents/carers to be honest and open-up. Reflect what has been heard and ask for clarity if unsure to ensure understanding. This will also help to ensure that parents/carers understand the questions that they are being asked.

A learning disability can reduce a parent/carer's ability to understand new or complex information. Parents/carers with a learning disability may need; more time during contacts, the opportunity for information to be repeated, information to be presented in a way that they will understand it (e.g., pictural or simple words on a page), information to be broken down into simpler parts or involvement of other family members/friends/advocate to support them. Information may be taken literally and therefore the tone may be misunderstood; it is important to avoid jargon. For families where English is not their first language, please remember the importance of the use of an interpreter and resources that are translated into their own language. It is also important to discuss any cultural differences in parenting and how this can be supported.

Pregnancy and becoming a parent are key opportunities to have a conversation/s with parents/ carers about the needs of their baby, to identify potential vulnerabilities and assess if additional support is required.

When talking to families who have a baby please consider:

- What is it like to be a baby within this family?
- The interactions and relationship between the baby and their parents or other care givers.
- Are there any vulnerabilities for the baby or family that may indicate the need for additional support?

Examples of when the tool can be used

The Every Baby Matters tool can be used as a resource for any practitioner and can also be used as a pre assessment tool to enhance other more in depth assessments such as:

- Early Help Assessment
- Single Assessment
- Pre- Birth Assessment
- To support the completion of the Graded Care Profile

This tool has been based on the parameters of the Assessment Triangle which is a researched based tool and the basis for other assessments completed with vulnerable families.

The tool can be used creatively for example within a family meeting and as part of the assessment before and after the birth of the baby.

The Every Baby Matters tool includes a number of questions which can form part of the quality conversations with families. This is a selection of questions that cover six key areas. These are not prescriptive and are a starting point for further exploration if required. A practitioner's own level of knowledge skills and experience will lead them on how they manage the quality conversations with families. A Practitioner may only chose one or two of the 6 areas to explore depending on the needs within the family.

Six Key Areas for Consideration

Bonding & Attachment:

- Describe what it is like caring and looking after your baby.
- Explain how you cope when your baby cries a lot or is difficult to settle.
- Tell me about your relationship with your baby. If your baby could speak, what might they say?

Consider the relationship and interactions between parents/carers and their baby. Parents/carers who are struggling with their attachment to their baby or are suffering with emotional or mental health difficulties may struggle if a baby cries a lot or struggles to feed.

Research tells us that when babies are shaken this is usually by men (not always the father of the baby) and often is a result of excessive crying or extreme feeding difficulties and crying. Parents/carers who struggle with parenting or attachment need help and support please contact the Health Visitor. If there are concerns about a baby's safety, please make an immediate referral to Children's Social Care.

Your baby's development:

- Babies born early can sometimes be more vulnerable. Have you got any concerns about your baby's health and development?
- Babies change and develop quickly, what changes have you noticed? Do you feel ready for the next stage of development?
- Tell me about an average day for you and your baby.

If a baby is born early (preterm) the baby is more likely to have additional difficulties and maybe more challenging to care for.

Babies develop quickly and are extremely vulnerable and reliant on care givers for all of their needs. If there are any concerns about a baby's care or safety, support needs to be offered quickly.

Health & Wellbeing:

- Tell me what you are enjoying about being parents. Is there anything that is worrying you?
- How are you feeling?
- Looking after yourself is important. How do you look after yourself?

How a parent/carer feels will have a direct impact on the baby they are caring for. There are normal stresses and strains when caring for children however some parents/ carers may feel depressed, they may be the victim of domestic abuse or feel out of control themselves. It is important that parents/carers who express these concerns get additional support quickly.

Knowledge & Expectations: • Is there someone in your life that you can trust to offer you support and advice? • Do you find the views/advice from other people (including social media) helpful? • Where do you get your information from about being a parent/carer?	It is important to understand what influences parents/carers so that we can understand where they are getting help and guidance from. Social media is a particular area of influence for younger parents/ carers.
Community Strengths & Stressors: • Tell me about how you feel about where you live and your local community. • Do you feel able to access local groups and support from your community? • Would you like to talk about financial pressures? Do you know where to get advice on benefits?	It is important to recognise how parents/ carers feel about where they live. Have they got a social network, are they isolated and away from their support systems? Are there cultural challenges or language barriers. Do parents/carers feel threatened or unsafe where they live? Research tells us that those families in poverty are more likely to struggle with parenting and may need additional support.
Who is in your baby's life: • Does anyone else help you look after your baby? • If your baby could speak, who would they say is important to them. Who makes them smile or laugh? • Relationships can often change after a baby has been born. Have you noticed any changes in your close relationships?	It is important to have a 'Think Family' approach when working with families. Often there is an assumption that parents are the main care givers for babies, this sometimes is not the case. It is important we understand who cares for the baby and that they also have access to appropriate support and advice

Adapting the tool for use in pregnancy

The tool can be easily adapted to be used in the antenatal period and will support other assessments. The tool can be used to support assessments before and after birth to evidence improvement in parenting or identify where additional support is needed. Some of the circles will remain the same:

- Knowledge and Expectations
- Community Strengths and Stressors
- Who's in Your Baby's Life

Some of the circles will support practitioners to consider these questions from the perspective of pregnancy:

- Health and Wellbeing - the tool will lend itself to considering how parents are feeling about having a baby and will be useful to consider any emotional health difficulties in the antenatal period
- Bonding and Attachment – the tool will support practitioners to consider how parents have bonded with their baby and consider what their expectations are of being parents. This is an opportunity to consider the management of crying and what their support network looks like
- Your Baby's Development – This will need to be related to the developing baby in utero, how is the pregnancy going, what is positive and what may they be worried about. It is a good opportunity to explore parent's expectations and planning for bringing a new baby into their home and family

What next - things to think about

Following your quality conversations with parents/carers, think about what it is like to be a baby within the family. Remember that babies develop and change quickly, they don't have a clear voice and often support for a family with a baby is needed straight away.

Please consider these three questions when planning next steps

- What is it like to be a baby within the family?
- Are there any vulnerability factors?
- What support can be offered?

What support can be offered

Local single agency support – consider which agency may be best to support the family. Who has already got a good working relationship with the family to encourage engagement? Consider Midwife, Health Visitor, Nursery, Early Help Practitioner or a specific agency if there is a specific need identified for example Housing.

Early Help Assessment – the identification of the need and delivery of early help is the responsibility of all agencies who work with children. Using an EHA can make sure that decisions are made at the earliest opportunity to improve the situation for the child and their family. Agencies will work together to support a family. For families with babies the Health Visitor is the Lead Practitioner for an EHA.

If there is an immediate concern about the safety of a baby always consider safeguarding or child protection thresholds and if required make a referral to Childrens Social Care.

There is additional guidance on the Derby & Derbyshire Safeguarding Children Partnership procedures and in the Keeping Babies Safe Section in the Documents Library.

Scan here for more information

Useful contacts for support

Derbyshire 0-19 Service
(Health Visiting& School Nursing)
01246 515100 (Mon-Fri 9am-4.30pm)

Derby City 0-19 Service
(Health Visiting & School Nursing)
0300 1234586 Option 3

Derbyshire Consultation & Advice Service for Professionals
01629 535 353 (Mon-Fri 10am-4pm)

Derby City Professional Consultation Line
07812 300 329 (Mon-Fri 10am-4pm)

If you are worried a child is suffering abuse or neglect please contact:

Derbyshire
01629 533190 (9am-5pm)
01629 532600 (out of hours)
All requests for support should be made to using online Starting Point referral form.

Derby City
01332 641 172 (9am-5pm)
01332 956606 (out of hours)
Note: all telephone referrals to be followed up within 48 hours via Derby Children's Social Care Online Referral System.

Supervision and Training

It is hoped this tool will be helpful when supporting families however the tool can also be used to support assessment and analysis of case work and could be utilised within practitioners supervision. The tool can support reflection of a case to focus on the needs of the baby, their voice and lived experience within the family unit.

The tool can also be utilised in training and the additional support given to newly qualified practitioners, particularly if there is limited experience of working with families who have care of a baby.

References

Derby and Derbyshire Safeguarding Childrens Partnership Procedures
Department of Health, Department for Education and Employment, and Home Office (2000) Framework for the Assessment of Children in Need and their Families. London: The Stationery Office.
Dr C Day (2012) Postnatal Promotional Guide South London and Maudsley NHS Trust
Dr C Day (2012) Postnatal Topic Guide South London and Maudsley NHS Trust
Helen Vincent (2020) Bringing up baby – the health, Context
John Oats (2020) Promoting Infant Health through focusing on social support for mothers through lockdown, Institute of Health Visiting
Keeping Babies Safe – The three steps for baby safety partnership strategy (link)
Little Minds Matter – Infant Mental Health, Bradford District Care NHS Trust
Little Minds Matter 5 Point Action Card LMM-5-Point-Action-Card-for-Practitioners.pdf
Mathew Price (2020) Taking action to keep the infant in mind Price & Ellis, IJBPE, vol 8, issue 1
MENCAP (2011). Inclusive support for parents with a learning disability
Parents with learning disabilities | Best Beginnings
MORS website: www.morscales.org
Mothers Object Relations Scales (MORS) | Perinatal mental health screening (morscales.org)
The Best Start for Life (2021) A vision for the 1,001 Critical Days HM GOV