University Hospitals Coventry and Warwickshire NHS Trust

Child Protection Policy	
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Title of Relevant Director:	Chief Nursing Officer
Target audience:	All UHCW employees and contracted staff

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This Trust-wide CBR has been developed / reviewed in accordance with the Trust approved ***'Development & Management of Trust-wide Corporate Business Records Procedure (Clinical and Non-clinical strategies, policies and procedures)'***	Version **10.0**

Summary of Trust-wide CBR:	This policy identifies the organisational arrangements in place to meet UHCW safeguarding responsibilities and identifies the responsibility of staff that has concerns regarding the welfare or safety of a minor, aged 0 – 18 years or an unborn baby.
Purpose of Trust-wide CBR:	To support staff to identify and take appropriate action when a child protection or child welfare issue/ concern is identified and outline relevant trust processes
Trust-wide CBR to be read in conjunction with:	• Coventry safeguarding children board inter-agency procedures • Warwickshire safeguarding children board inter-agency procedures • UHCW NHS Trust child protection training strategy • UHCW NHS Trust child protection supervision strategy • UHCW NHS Trust Notification under Section 85 of children act policy
Relevance:	Governance
Superseded Trust-wide CBRs (if applicable):	Child Protection Policy 2010 (version 4.0)

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Department/Specialty:	Trust wide

Version	Title of Trust Committee/Forum/Body/Group consulted during the development stages of this Trust-wide CBR	Date
5.0	Safeguarding Vulnerable Adults & Children Committee	January 2015
5.0	Coventry LSCB Health sub committee	January 2015
5.0	Corporate Business Records Committee	14th January 2015

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1.0 SCOPE

1.1 This policy applies to all employees of the Trust, including staff seconded to this Trust, agency, locum, contract and voluntary staff.

1.2 All levels of management must understand and implement the policy.

1.3 The provisions of this policy and associated procedures are applicable to children who have not reached their 18th birthday.

2.0 INTRODUCTION

2.1 *Working Together to Safeguard Children (2013)* places a responsibility on Local Safeguarding Children Boards (LSCB) to ensure that organisations providing services to children and their families in a given locality are familiar with the processes to safeguard and promote the wellbeing of children and young people.

2.2 Health staff who come into contact with children, young people, parents and carers in the course of their work need to be aware of their safeguarding responsibilities. (*Working Together to Safeguard Children 2013)*

2.3 UHCW is accountable to Coventry LSCB for delivery of, and compliance with, local safeguarding requirements. In order to facilitate this requirement UHCW employs both a Named Doctor and Named Nurse for Child Protection to ensure that the Trust is compliant with the Statutory, National and Local requirements for safeguarding children

2.4 This policy outlines how the organisation will fulfil its statutory duties under Section 11 of the Children Act 2004 to safeguard and promote the welfare of children and young people and detect and manage concerns around child abuse.

2.5 Practitioners and managers engaged in safeguarding children must understand

their role and be able to work effectively with others both within their own agency and across organisational boundaries to achieve positive outcomes for children.

2.6 This document **must** be read in conjunction with the **Coventry** and **Warwickshire (2014) online Inter-Agency Child Protection Procedures and Appendix 12.** These are separate documents and are available in full via links from the child protection intranet page.

3.0 STATEMENT OF INTENT

3.1 The welfare of the child is paramount *(Children Act 1989)*. UHCW has a duty to initiate the sharing of information when a concern has been identified and/or to co-operate and share information as required with agencies engaged in work to safeguard children and young people. Children's Social Care is the lead agency with responsibility for investigating child protection issues.

Refer to relevant ***Inter Agency Child Protection Policies*** and ***Information Sharing Protocols*** as required.

4.0 DEFINITIONS

4.1 Child abuse - A child/young person is considered to have been abused if s/he is treated by an adult in a way that is unacceptable at a given time in a given culture.

4.2 Child - For the purpose of this policy, the age group includes pre-birth to 18 years of age; the reference culture is the UK.

4.3 This policy aims to ensure that all employees of UHCW are aware of their responsibilities and procedures in place to identify children and young people in need of support and those at risk of harm.

5.0 DUTIES / RESPONSIBILITIES

5.1 The Trust

- UHCW is responsible for identifying children and families who would benefit from early help.
- UHCW is responsible for ensuring its employees are confident and competent in carrying out their responsibilities to safeguard children and young people by ensuring that employees are aware of how to recognise and respond to welfare and safeguarding concerns.
- UHCW will be represented on the LSCB by an Executive with Safeguarding responsibilities to ensure effective collaboration with LSCB and partner organisations.
- The Safeguarding Vulnerable Adults & Children Committee (Strategic) meets monthly and is chaired by the Executive Director with Safeguarding Responsibility.
- Child Protection Link Group (Operational) meets quarterly and is chaired by Named Nurse Child Protection.
- There will be representation on the LSCB and its subcommittees by appropriate UHCW staff.

The Chief Executive as the Accountable Officer has the overall responsibility for meeting all statutory requirements including, ensuring the implementation of effective child protection policies and procedures, clinical governance processes are in place and training is provided and appropriately recorded.

5.2 Chief Nursing Officer

Has the delegated responsibility from the chief executive in relation to safeguarding children

5.3 Divisional nurse for safeguarding vulnerable adults and children

Leads both Children's and Adult's Safeguarding services ensuring there are mechanisms to monitor the quality of services. Provides leadership for the Safeguarding agenda, ensuring all legislative and quality indicators are met and works closely with all partners to ensure that interagency Safeguarding Services are optimised.

5.4 Named Child Protection Professionals

It is a requirement of Working Together to safeguard children (2013) that the trust employs a named nurse and named doctor and where maternity services are provided that a named midwife is in post. The named Nurse/Midwife and Named Doctor have specific expertise in children's health and development, child maltreatment and local arrangements for safeguarding and promoting the welfare of children and young people.

They provide advice and support to staff, managers & Trust Board on safeguarding children matters; provide training and updates for staff; carry out case reviews and monitor child protection activity and quality of practice within the Trust.

They represent UHCW on the LSCB subcommittees & attend Local Safeguarding Children Board meetings as delegated by the Executive member.

5.5 Managers

Training and development in child protection is relevant to operational managers and those with strategic responsibility for services. Understanding their role in child protection, supporting their staff in child protection matters and ability to access advice & support from child protection specialists as required.

5.6 Employees

All professionals are accountable for their practice and responsible for maintaining their current knowledge base. Child protection training is mandatory and staff must ensure they attend this training as part of their professional development plan (*see UHCW Training Needs Analysis booklet – available from Training & Development Department).*

Staff who have a concern about the welfare or safety of a child or young person are obliged to follow the procedure described in Appendix 1 adapted from ***'What to do if you are worried a child is being abused'***

6.0 DETAILS OF THE POLICY

6.1 Communication

6.11 Effective communication is a key requirement to the protection of children and young people from harm. Staff need to be able to access information on who to contact in relation to safeguarding or child protection concerns. Details of contacts within health and social care in both routine and urgent cases will be maintained on the Trust intranet site by the named professionals and safeguarding children clerk. This information will be reinforced through child protection training. Specialist contact details will be included.

6.12 An information sharing agreement is in place within Warwickshire and Coventry and UHCW is a key partner within this agreement. This specifies that information should be shared with relevant agencies and practitioners in the best interests of the child. This is key to effective child protection. Managers should support staff with sharing information and the named professionals for child protection, and legal departments, will support staff in decision making around sharing information. This will ensure that robust processes for sharing information relating to child protection are in place. Information governance is a key issue for the organisation and staff may experience conflict and concern around information sharing.

6.2 Managing Allegations Of Abuse By Staff Or Volunteers / Persons Working With Children (Or Vulnerable Adults)

6.21 Staff who have cause for concern or receive notification of allegations against staff working with children or vulnerable adults, regarding the treatment/abuse of a child or young person, by a colleague / other worker within the Trust must contact the associate director of nursing for safeguarding, or chief nurse, or medical director. This person should inform the associate director of human resources. Management of allegations should be in line with the Interagency procedure for Allegations of Abuse against staff (Coventry or Warwickshire safeguarding board procedures accessible on trust intranet via internet) and UHCW Disciplinary policy. One of the named professionals for child protection should be informed.
Regardless of whether employed by UHCW NHS Trust or a contracted service the above procedure applies and the associate director of HR should be informed.

Implementation of the Interagency procedures should be considered if the allegation indicates a member of staff has:

- Behaved in a way that has harmed a child, or may have harmed a child
- Possibly committed a criminal offence against or related to a child
- Behaved towards a child or children in a way that indicates s/he is unsuitable to work with children in connection with his/her employment (either UHCW or other employment), or voluntary activity
- Concerns arise about the person's behaviour with regard to his/her own children

If the allegation is not patently false, the manager receiving the allegation should report the matter to the associate director of nursing for safeguarding vulnerable adults and children who will contact the Local Authority Designated Officer (LADO). The LADO will establish if the allegation is within the scope of the Child Protection Procedures.

Any disciplinary investigation should be conducted alongside the child protection procedures or any police investigation. Consideration should be given to contacting the police early in the process to ensure any evidence which would aid a conviction for child abuse crimes is not destroyed.

6.3 Thresholds For Referral

Decisions regarding whether a referral to social care is required, a single agency referral or a Common assessment framework should be supported by the "Thresholds and Practice Standards" guidance from Coventry social care (accessed via intranet site or via Coventry safeguarding children board website). This is a level 2 competency for child protection training and managers should ensure that their staff are competent to make appropriate referrals.

6.4 Common Assessment Framework (CAF)

All staff working with children should have access to staff within UHCW who have the skills, knowledge and training to complete a CAF as the method of assessment for children whose needs do not meet the threshold for social care. These staff will be working within specific areas of the organisation (maternity, paediatrics and neonates). This single assessment provides a planning and review pathway for all

children and young people, ensuring that needs are identified earlier and addressed on a multi-agency basis.

A CAF can be undertaken by any practitioner. Training is required for those staff that form part of the team around the family. It is important to establish whether a CAF has already been undertaken by another professional to avoid duplication. Contact details for CAF coordinators are available from the trust intranet**.** For further information refer to the ***Coventry Inter Agency Procedures*** or ***Warwickshire Inter Agency Procedures.***

If any practitioner requires further guidance on the CAF process, contact a CAF Advisor within social care, maternity matrons, paediatric lead nurse or named nurse for child protection.

6.5 Confidentiality & Information Sharing

Working Together to Safeguard Children (2013) guidance encourages the sharing of information between agencies to safeguard a child ***even without consent***. The professional must be justified in acting in the best interests of the child, with the information they have at that time.

Service Users should be made aware, when appropriate, of the limitations of, and exceptions to, confidentiality in relation to child protection. When there is a conflict of interest between the needs of the adult and those of a child, the welfare of the child is paramount *(Children Act, 1989).*

All children & young people attending departments in UHCW will have information passed to their GP, Health Visitor or School Nurse about each attendance. Notification of this information sharing process is displayed within each department in a range of languages.

If a child is hospital for 3 months the manager of the clinical area is required to make notification as per UHCW NHS Trust policy "Notification of Children in Hospital for 3 Months to the Local Authority Children's Services Procedure. (Section 85 of Children Act 1989).

Professionals should seek, in general *(see exceptions below)*, to discuss concerns with the family and, where possible, seek the family's agreement to making a referral

to social care. This should only be done where the discussion and agreement will ***not place the child at risk.***

When a parent objects to the referral and where a child is believed to be at risk of significant harm this overrides the need to gain consent from the parent, carer or child / young person.

If permission to contact or refer to Social Care is refused in cases where the threshold for significant harm is not met, a decision must be made regarding the nature of the concern and risk to the child, in discussion with a Senior Manager or Named Professional for Child Protection.

There are two other exceptions to discussing contact with social care with the parent or carer, in cases of suspected or disclosed sexual abuse and cases of suspected fabricated or induced illness. Always discuss with consultant paediatrician before discussing referral with the parent or carer.

Sharing information – consider what needs to be shared, with whom and for what purpose *(Data Protection Act).* If in doubt, consult a senior on duty and refer to the ***Information Sharing Protocol.***

If there are suspicions or allegations are about relatives, friends or colleagues, professional or otherwise, the concerns ***must not*** be discussed with them before making the referral. Contact the Chief Nurse, medical director, associate director of nursing for safeguarding vulnerable adults and children or Named Professionals for Child Protection for allegations involving members of staff or volunteers.

There must be clear justification for ***NOT*** informing the parent/ carer, which must be documented, and Social Care must be told that the parent/carer is not aware of the check or referral.

6.6 Staff Working With Adults

Staff that work with adults should be mindful that adults can be parents or carers of children and young people. Staff have a duty of care and protection to children and young people. Any concern about the adult's ability to safely care for children should be considered. Any circumstances in which an adult has been declared medically fit

to be discharged, but staff considers there may be implications for their ability to provide adequate and safe child care, must be discussed with a senior member of staff on duty, a member of the child protection team or the on-call Paediatric Specialist Registrar.

Children and young people do suffer abuse and neglect from their parents and carers.

Staff should always ascertain if the adult is a parent or carer, and if a child presents with the adult, ascertain who the child is and what relation they are to the adult. Document this in the adult's records. It is particularly important to identify children who are "looked after" and are the shared responsibility of the local authority as these children have specific needs and should be notified to the looked after children's nurses (See intranet for contact details).

If you have any concerns about the adult's ability to care for a child, or that the child or young person may be at risk of harm, this must be discussed with a senior manager on duty, a member of the child protection team or the on-call Paediatric Specialist Registrar. Also consider contacting a child and family duty social worker to discuss your concern if you are not at work. Contact numbers are on the child protection intranet site.

6.7 Child Protection Referral To Children's Social Care & Information Check

When a concern is identified regarding a child's welfare or safety it may be appropriate to acquire information from other professionals who may be involved with the child and/or family, or make a child protection referral to Children's Social Care.

Sources of information: children's social care, health visitor for children under the age of 5, (or pre school, whichever happens first), school nurse for children over the age of 5, (or who have started school before the age of five) GP who is the core holder of health information about the family, community midwife for pregnant women or newborn babies, looked after children's nurses for children who are in the care of the local authority or have foster parents. These children may be in the care of family but still being categorised as 'looked after'.

School nursing and health visiting directories are available on the child protection

intranet site.

6.8 Duty to Refer

Everybody who works with children, young people and their parents / carers or other adults in contact with children should be able to recognise, and act upon, indicators that a child's welfare or safety may be at risk. Staff ***must*** make a referral to Children's Social Care if there is a ***suspicion or an allegation*** that a child, young person or an unborn is suffering or is likely to suffer significant harm; Or where the behaviour of the parent or carer is likely to adversely impact on the child or unborn; e.g. substance misuse, mental health issues and domestic violence and abuse. Referrals during pregnancy must be made as early as possible to facilitate timely assessments to be undertaken and family support services to be provided.

6. 9 Criteria for Initiating Information Check

- Late booking for antenatal care
- Lack of engagement / non compliance in antenatal care
- Arrival on Labour ward without personal held obstetric record & no / scant antenatal care
- A child is under 2 years of age with a head injury
- 3 or more attendances at Children's Emergency Department (CED) in the past year if there are concerns at that attendance
- Previous notes are not available and there are concerns
- An alert on the child's record raises concern, or states that the case is open to Social Care
- History of the injury is inconsistent with the mechanism of injury
- Changes to the history of the injury
- Inadequate explanation for injury
- Delay in seeking treatment and there is a concern
- Where a developmentally inappropriate injury has occurred
- Self harm incidents.
- Concerns about a child as a result of the parent/ carer attending with drug, alcohol, mental health issues, or self harm.
- Concerns about a child as a result of the parent/ carer attending with domestic violence/ abuse including adolescents who may be victims of abuse by their partner who may be of same sex and also adolescent .Suspicion of

domestic violence that is not disclosed should also trigger referral to social care.

In many cases these criteria should lead to a referral to Children's Social Care and not simply an information check. It is important **not** to use a "not known" response to the information check to reassure one that the child is **not at risk of,** or has **not been the victim of,** abuse.

6.10 Criteria for Pre Birth Referral

- Late booking for antenatal care
- Lack of engagement / non compliance in antenatal care
- Arrival on Labour ward without personal held obstetric record & no / scant antenatal care
- Where the pregnancy has been concealed and there is immediate need to protect the expected child or newborn
- Where concerns exist about either parents ability to protect.
- There has been a previous unexplained death of a child whilst in the care of either parent
- A parent or other adult in the household or other regular visitor is known to pose a risk to children
- A sibling in the household is subject to a Child Protection Plan
- A sibling has previously been removed from the household either temporarily or by court order
- One of both parents are care leavers or have been known to children's social care as children in need or in need of protection or are looked after children.
- Domestic violence is known to have occurred within the family / significant relationships
- The degree of parental substance misuse is likely to significantly impact on the baby's safety or development
- The degree of parental mental illness / impairment is likely to significantly impact on the baby's safety or development
- There are concerns about parental ability to self care and/or to care for the child e.g. unsupported young or learning disabled mother
- Any other concern exists that the baby may be at risk of significant harm, including a parent previously suspected of fabricating or inducing illness in a

child or harming a child

- Where the expectant parent(s) are very young and a dual assessment of their own needs as well as their ability to meet the baby's needs is required.
- A child aged under 13 is found to be pregnant under the Sexual Offences Act (2003)
- One of both parents have a history of violence or have committed crimes which suggest they may present a risk to children
- Children born into families where there is a history of sexual offences

6.11 Criteria for Child Protection Referral

- A disclosure of abuse
- Domestic violence where the child has been injured, used as a shield or contacted emergency services on behalf of the parent
- Alleged or suspected serious physical injury
- Concerns about a child as a result of the parent/ carer attending with drug, alcohol, mental health issues, domestic violence or self harm.
- Where children are the subject of parental delusions, or are targets for parental aggression, rejection or neglect for pathological reasons, self harm of a parent which impacts on child care provision.

The following should raise suspicions about abuse and lead to discussion with the on call Paediatric or ED consultant or Specialist registrar.

All staff working with children should use '*National institute for Health and Clinical Excellence – When to suspect child maltreatment guideline*' (Appendix 12) as a basis for decision making and discussion with senior colleagues.

- Any injury, however minor, to a non mobile baby or child
- History of the injury is inconsistent with the mechanism of injury
- Changes to the history of the injury
- Inadequate explanation for injury
- Where a developmentally inappropriate injury has occurred
- Delay in seeking treatment and there is a concern
- Self harm incidents where there is a concern.
- Suspected domestic violence or abuse which is not disclosed by the victim where

there are children in the household.

6. 12 Referral Pathway

Follow the referral pathway here or on the child protection intranet page in conjunction with Appendix 5 & ***follow guidance section on confidentiality above.***

- **Complete the multi agency referral form**
- **telephone contact with the Duty Social Worker to discuss concern**
- **fax AND post the referral form within 24 hours**
- **copy of referral in child's/ mother's obstetric record or attached securely to the A&E record**
- **Send a copy of the referral to the Named Nurse Child Protection (follow guidance on intranet – social care referrals**

The timing of such referrals must reflect the level of perceived risk and must be made as soon as possible when any such concern becomes known. Access and follow the prescribed referral pathway on the hospital Child Protection Intranet site, select the appropriate section for either Coventry or Warwickshire depending on where the child is resident.

- If a child informs you about a concern or makes an allegation, listen and seek clarification but do not make a judgement or make any enquiries yourself *(see Talking to the Child).*
- Never delay emergency action to protect a child
- Keep a ***record*** of all discussions about a child's welfare. At the close of the discussion, always reach a clear and explicit recorded agreement about who will be taking what action, or that no further action will be taken and a clear reason why.

If the child can understand the significance and consequences of making a referral to Children's Social Care, s/he should be asked her/his view. Whilst the child's view should be considered, it remains the responsibility of the professional to take whatever action is required to ensure the safety of that child and any other children.

Professionals making referrals cannot choose to remain anonymous, though members of the public may, if they wish to.

6.13 Children's Social Care Referral Feedback

The Social Worker taking the referral should contact the referrer with the outcome decision within 1 day (WTSC, 2013) of receipt of the referral unless there are clear reasons to proceed immediately to safeguard the child.

Referrals to Social Care are collected by the safeguarding clerk and recorded on a database to provide data on the types of and frequency of referral. It remains the responsibility of the individual to ensure that the referral is of good quality, in cases where social care report that the referral is inadequate to enable them to proceed with the case, the named nurse for child protection will be informed by social care and will approach the individuals or their clinical lead.

Information regarding the outcome of the referral will be recorded in the records. Outcomes received by post or fax will be matched with the referral and information passed to the Named Nurse Child Protection for recording purposes.

It is the responsibility of the referrer to ensure that feedback is received unless delegated to another professional.

6.14 Talking to the Child

If a child makes an allegation or discloses information which raises concern about significant harm, this should be listened to. The child should be reassured and informed that the information will be passed to the Children's Social Care Services. A record of all conversations and actions must be kept. No enquiries or investigations may be initiated without the authority of the Children's Social Care Services or Police.

Where abuse is alleged, the initial response should be limited to listening carefully to what the child says so as to:

- Clarify the concerns
- Offer re-assurance about how s/he will be kept safe and
- Explain what action will be taken

The child must not be pressed for information, led or cross-examined or given false assurances of absolute confidentiality. Such well intentioned actions could prejudice

police investigations, especially in cases of ***sexual abuse***. In circumstances where questions ***have*** been asked, document these questions and the answers given accurately.

When the first language of the child is not English, a professional interpreter must be engaged to communicate with the child in their preferred language at least once, where the child is of an age where medical staff would expect to communicate directly with a child of that age group.

6.15 Child Protection Enquiry (Section 47)

Following receipt of a referral, Children's Social Care and the Police Child Abuse Investigation Team (CAIT) will have a Strategy discussion or Strategy meeting. Strategy meetings include information from Police, Health & Social Care (WTSC 2013)

Outcomes may include:

- No further action
- Referral to other professional/agency – CAF may be recommended
- Child & Family Assessment via Social Care
- Section 47 enquiry (Child Protection investigation)

UHCW staff have a duty to co-operate with information sharing, provision of written reports and attendance / representation at all related child protection meetings, as required by Working Together to Safeguard Children 2013.

6.16 Medical Assessments

Where a referral originates from hospital it is likely that the child has been medically examined prior to the referral. The outcome and medical reports obtained will be shared with the Social Worker in order to reach a conclusion of further action.

In cases referred via other routes, a Strategy Discussion or meeting will consider whether a medical assessment is required. A medical assessment will be conducted after the interview of the child unless there are exceptional circumstances.

Where medical assessments are required for ***physical injury or serious neglect***,

the responsibility for arranging the medical will rest with Children's Social Care Services.

Where medical assessments are required because ***sexual abuse*** is suspected, the Police will discuss and arrange the medical through the Police Surgeon and the Community Paediatrician. A medical assessment in cases of ***sexual abuse*** should only take place after an interview has taken place unless there is a clear case where a forensic assessment is needed and/or medical treatment is needed urgently.

During normal working hours medical assessments should take place at City of Coventry Health Centre, Stoney Stanton Road, or at the Sexual Assault Referral Centre, George Eliot Hospital, Nuneaton.

Unless the Strategy Meeting has decided otherwise, the Social Worker undertaking the Section 47 Enquiry (Child Protection Enquiry) and the enquiry Police Officer will jointly attend the medical assessment. Their roles in helping, supporting and managing the child and their families through this process should have been agreed in the Strategy Discussion.

For further information & guidance consult the ***West Midlands Joint Protocol: Child Protection Enquiries and Related Criminal Investigations version 2 Feb 2011.***

6.16.1 Attendance at Emergency Department or other urgent care setting

All children 0 – 18 yrs attending any of the Emergency Areas across the Trust must have previous attendances checked ***(Laming Recommendation 73)*** and note made of any Child Protection Alert on the record at the time of the attendance by the treating clinician/ senior nurse.

This includes all urgent care settings including Gynae short stay, eye departments, Rugby St Cross A&E minor injuries centre for children, children's emergency department, and the emergency department for 16-18 year olds.

6.16.2 Admission of a Child to Hospital with a suspicion of abuse or neglect

Laming Recommendation 64

When a child is admitted to hospital and deliberate harm is suspected the nursing

care plan must take account of this diagnosis. The Child Welfare Care Pathway is available on the child protection intranet site and should be completed and filed within the child's hospital records *(Appendix 1)*

Laming Recommendation 73

When a child is admitted to hospital and deliberate harm is suspected, the doctor or nurse admitting the child must enquire about previous admissions to hospital, particularly those outside Coventry.

Laming Recommendation 74

Any child admitted to hospital about whom there are concerns about deliberate harm must receive a full and fully-documented physical examination within 24 hours of admission.

Laming Recommendation 75

In cases of possible deliberate harm to a child in hospital, when permission is required from the child's carer for the investigation of such possible deliberate harm, or for the treatment of a child's injuries, the permission must be sought by a doctor above the grade of Senior House Officer (SHO).

Laming Recommendation 76

When a child is admitted to hospital with concerns about deliberate harm, a clear decision must be taken as to which consultant is to be responsible for the child protection aspects of the child's care. The identity of that consultant must be clearly marked in the child's notes so that all involved in the child's care are in no doubt as to who is responsible for the case.

6.17 Attendance at Child Protection Meetings - Strategy Meeting

The meeting should be chaired by a Social Care Manager, within **7 working days** of the referral and involve all agencies with relevant information. In pre birth circumstances, the expected date of delivery will determine the urgency for the meeting.

All staff in attendance at the meeting should have a written record of the outcome and actions of meeting to store in the medical records. Minutes of the meeting will be the responsibility of Social Care to complete and send out, the minutes will then be

filed within the medical / obstetric records.

The parents should be informed as soon as possible of the concerns and the need for assessment, except on the rare occasions when medical guidance/ advice suggests this may be harmful to the health of the unborn baby and/or mother.

All health professionals, when invited, must prioritise attendance at Child Protection Meetings. They should be fully prepared to share relevant information and to be clear about their role and professional involvement.

Health staff must notify their manager who, if training around child protection conferences, core groups, strategy meeting is required will inform the Named Nurse or Doctor for Child Protection. The member of staff who will attend must confirm their attendance with the Safeguarding Children Service.

In most circumstances professionals will be expected to attend alone as professionally accountable individuals, following pre-meeting preparation/supervision.

In certain circumstances the health professional may be accompanied by another health professional or Named Child Protection professional e.g. in a complex case, or mentoring situation. A professional observer can only attend with the prior consent of the Chair and the family and must not take part in discussions or decision-making.

When the contributor is unable to attend, reports may be presented by proxy, or with the agreement of the chair, a written report alone may be acceptable. Where another professional is attending on behalf of the named worker, the named worker must provide the report to the attending professional at least 24 hours prior to the meeting, having discussed the report with the manager/supervisor/named child protection professional first and made any adjustments as required. Ideally a verbal handover should occur between named worker and conference representative prior to the meeting. Managers should report situations where staff are unable to meet their obligation to attend any part of the child protection process, including strategy meeting, case conference, core group, child in need meeting, CAF meeting, team around the family meeting to the named professionals who will assist in reviewing the significance of non attendance. If service limitations are causing non attendance this should be reviewed through the safeguarding vulnerable adult and children

committee.

The health professional should be clear about the appropriateness of their role and the extent to which they have authority to make decisions on behalf of their organisation during the meeting / conference. This should be discussed with their manager/supervisor prior to the meeting, particularly where post natal or paediatric length of stay may be an issue, or there are overt security issues.

The health professional should make known any disagreements or concerns they have about any statements or decisions that are made at the meeting / conference and check that these are recorded in the minutes.

Where involvement of a professional has ceased prior to the Conference a verbal and written summary of involvement must be provided to the Key worker at the time of contact ending which will be submitted to the Conference in the absence of the professional. A midwife providing post natal care may be required to attend a case conference up to 1 month post delivery, to ensure accuracy of relevant information and understanding.

In exceptional circumstances a professional who has ceased to be involved with the child/family may attend a Conference where there is requirement for specific information by the Chair. Attendance must be discussed with a manager/Named professional for child protection.

A written record must be made either directly in the medical records or on a child protection meeting proforma when attending any child protection meeting. All templates for recording and reporting to child protection meetings can be found on the child protection intranet site *(Appendix 2).* The formal meeting minutes should be received within the timescale identified within the local authority procedures. If not received this should be escalated by the professional to the agency involved and then to the named nurse/ midwife for child protection. The formal record of the meeting should be entered in the child's records. Child protection alerts can be added to CRRS when a risk of harm has been identified and the professional can arrange this by contacting the named nurse or safeguarding clerk.

Laming Recommendation 77

All doctors involved in the care of a child about whom there are concerns about possible deliberate harm must provide Social Services with a written statement of the nature and extent of their concerns.

A written or typed, legible and signed report must be prepared for all Initial and Review Child Protection Conferences and available to the conference chair, where possible, **2 working days** in advance of the conference. The report should be discussed at the supervisory session prior to the meeting, and submitted to the Conference Chair, with the exception of the meeting being called with less than 36 hours notice.

Information in the report must be factually correct, pertinent to the concerns being discussed and any opinions must be based on professional judgement or evidence from research. The reports must make it clear which child/ren are the subject of the conference, but address any known circumstances of all children in the household. Include details of the agency's involvement with the child and family, and information concerning their knowledge of the child's developmental needs, and the capacity of the parents to meet the needs of their child within their family and environmental context *(see Guidance for completion of Case Conference Reports and template – available on Child Protection Intranet page & Appendix 3).*

It is good practice for the content or the actual report to be shared with the family prior to the conference. (In some cases with multiple injuries the Police may ask that the report is not shared with the family until carers have been questioned. This should be discussed with the Chair of the Conference before it takes place). Ensuring that information is communicated / translated in the most appropriate way, taking account of the language and any sensory or learning difficulties of the child or parents. The reports will be attached to, or subsumed within the minutes of the conference, for circulation. Reports made to Case Conference should be used in court proceedings with the addition of any current information.

All templates for recording and reporting to child protection meetings can be found on the child protection intranet site. *(Appendix 4)*

6.18 Differences of medical / professional opinion in Child Protection

Laming Recommendation 67

Where there are disagreements between health professionals it is important that full discussion takes place between those with differing views, and is recorded in the child's medical record. Where deliberate harm has been raised as a possible diagnosis, it must not be rejected without proper consideration and, if necessary, a second opinion should be sought.

UHCW staff, has a duty to co-operate with the multi agency child protection plan. Difficulties in implementing the protection plan which impacts on the safety of the child must be discussed with the Key Worker in the first instance. If difficulties continue or concerns escalate, staff must contact their manager and/ or Named Child Protection professionals as soon as possible.

Where there is disagreement between staff about a child protection plan or issue, the manager and/ or Child Protection professional must discuss the issue with the relevant Social Care manager as soon as possible, depending on the nature of the risk or concern involved. Early resolution is imperative. – The resolution of disagreements in work relating to the safety of children's procedures (Coventry LSCB procedures) should be instigated if required after discussion with manager and named professionals for child protection.

NB. Significant changes to the Child Protection Plan cannot be made without going back to a Review Conference.

6.19 Discharge Planning for Child Protection Cases

Laming Recommendation 70

No child about whom there are child protection concerns is discharged from hospital without the permission of either the Consultant in charge of the child's care or of a Paediatrician above the grade of Senior House Officer (SHO).

Laming Recommendation 71

No child about whom there are child protection concerns is discharged from hospital without a documented plan for the future care of the child.

Laming Recommendation 72

No child about whom there are concerns about deliberate harm should be discharged

from hospital back into the community without an identified GP.

When a child is subject to a child protection plan, it is the duty of the named social worker to organise and chair the discharge planning meeting. For new born babies subject to a child protection plan, the midwife should ensure that the named social worker is informed of the birth of the baby as soon as possible to facilitate early discharge planning. Social Care should provide minutes of the meeting to be filed within the child's hospital records.

Where there are social concerns raised during the stay of a child in hospital but the child is not subject to a child protection plan, then the ward staff should organise the discharge planning meeting, inviting all relevant professionals involved with the child including a representative from Children's Social Care. Hospital staff will chair the meeting. The outcome of the meeting should be recorded in the child's medical record.

6.20 Child Protection Record Keeping

Trust guidelines for general record keeping standards should be followed.

Records are an essential source of evidence for investigations and inquiries, and may also be required to be disclosed in court proceedings. Cases where s47 enquires do not result in the substantiation of referral concerns should be retained in accordance with health record retention policies.

Laming Recommendations 68, 69, 78 & 80

To serve these purposes all recording of activity in suspected child protection cases will be within one set of records, namely the child's medical/ mother's obstetric record for cases involving unborn. Entries should be contemporaneous, comprehensive, concise, accurate in fact, and differentiating between opinion and professional judgement. A record must be kept of all discussions about the child, including all face-to-face discussions, telephone conversations, and of all decisions made/ actions agreed during conversations. If doctors are unable to make their own notes, they must be clear about what they wish to have recorded on their behalf.

Laming Recommendation 64

When a child is admitted to hospital and deliberate harm is suspected the nursing

care plan (Child Welfare Care Pathway) must take account of this diagnosis. *E-library*

Various documents are available to support the presentation, collection and collation of information in child protection cases. In maternity cases, information is recorded on the 'orange child protection information sheet' which is updated regularly and is available inside the front cover of the obstetric record.

6.21 Child Protection Alert System

A Child Protection Alert system is in operation in this Trust covering children 0 to 18 years of age. The system creates an alert on the front sheet of the record generated by contact with any of the Emergency Departments across the Trust.

The system is to assist staff to recognise where there is further information about a child about whom there may have been previous concerns, or where children are currently known to other health services or Children's Social Care.

Staff, have a duty to look up this information and make a professional judgement whether information on the system influences the management of the current presenting issue with the child.

The child protection alert system is managed by members of the child protection team and identified others.

6.22 Reporting a Child Death or Serious Injury to a Child

When staff are involved with a child death or serious injury to a child the flow chart in Appendix 8 of this policy should be followed.

Where the incident may attract press attention the Chief Nurse, Directorate Clinical Lead and Trust Communications Manager should be informed immediately.

The Designated Professionals for Child Protection for the area where the child would normally be resident must be informed of the incident or death as soon as possible.

Any contact from the press should be referred to the Trust Communications Manager who will liaise with the Safeguarding Children Board for a joint agency managed response.

As soon as practicable, and usually within 24 hours of being informed of the death or serious injury, the Safeguarding Children Service will convene a strategy meeting to include police and doctors involved in the investigation of the death or serious injury. This meeting will examine what is known about the circumstances of the incident, plan further investigation, support to the family and consider the safety of other children in the family.

The Named Professionals for Child Protection are available to support the practitioners involved, where necessary will accompany them to the strategy meeting or be present for any police interviews if required. The child's records should be forwarded to the Child Protection Team for safekeeping.

When a professional is involved when a child has died, whether expected or unexpected, the appropriate form should be completed to inform the manager for the local Child Death Panel of the death of the child. The form is available on the Child Protection and Children's Emergency Department Intranet sites.

6.23 Missing Pregnant Women / Children

Women who default from antenatal care once booked, or for no access visits refer to the ***Maternity policy for Missed appointments in the antenatal period***

There is a facility to notify maternity units nationally of any pregnant woman who goes missing where there are identified concerns. Complete notification of missing persons form from intranet site or contact named nurse/midwife child protection. A copy should be held within the patient medical records.

When children abscond from hospital premises and they are in patients Trust security and the police must be informed.

When children fail to attend an appointment with a service provided by UHCW, staff should follow the procedure for children who DNA. Full guidance available in UHCW Patient Access Policy.

Information regarding a missing child or family is received by the Named Nurse Child Protection via various channels. It is the responsibility of the Named Nurse Child

Protection to disseminate this information to relevant staff / departments. This information must be retained for 3 months then destroyed. With unborn babies the information should available on the maternity child protection meeting minutes for 4 weeks after the expected date of delivery.

When a missing child or family is identified, the practitioner must contact the Key Worker on the notification and the Duty Social Worker at the Children's Social Care office local to the child / family's address.

6.24 DNA's

For women who default from antenatal care once booked, or for no access visits refer to the *Maternity policy for Missed appointments in the antenatal period.* Consideration should be given to whether this is resulting in risk of significant harm to unborn which would require referral to social care.

New patient DNA – the patient will be returned to the GP unless the Consultant deems it clinically appropriate that the patient needs to be seen.

Follow-up DNA – patients who DNA a follow up appointment whilst still on the 18 week pathway will be discharged from the Consultant's care and returned to the GP unless the Consultant deems it clinically appropriate that the patient must be seen.

Repeated DNA – If a patient DNA's a second time, access to further appointments will only be permitted in exceptional circumstances at the discretion of the Consultant responsible for the clinic.

Inpatient/ Day case DNA – In the event of a routine patient not attending on their TCI date then the patient will be discharged and returned to the care of their GP unless the Consultant deems it clinically appropriate that the patient needs to be seen.

In specific cases, known to the Consultant, where families have difficulty in attending appointments, it may be appropriate to arrange telephone contact with the family the day before the appointment is due to facilitate attendance at the scheduled appointment.

Where it is known that the family's first language is not English, and there are social

concerns, arrangements should be made to ensure that the appointment date, time and location are communicated to the family in their own language.

Information from the child protection alert system should be used to assist decision making. If the child is known to be on a child protection plan then the social worker should be informed of the non attendance in addition to relevant health professionals e.g. health visitor, looked after children's nurse. This will facilitate the child having their needs met in relation to health.

For full guidance see ***UHCW Patient Access Policy***

6.25 Child Protection Supervision

It is acknowledged that child protection work can be distressing and stressful for staff involved. Staff, therefore, need to have access to advice and support from peers, managers or named and designated professionals. Supervision should help to ensure that practice is based on local Safeguarding and organisational procedures, ensuring practitioners understand their role and responsibilities and scope of professional practice. Supervision can be useful in identifying training and developmental needs.

6.25.1Supervision is offered in a variety of ways within the Trust:

- Post traumatic event sessions e.g. child death, complex child protection case
- Individual or group child protection supervision sessions for staff involved in child protection cases or concerning safeguarding cases.
- Pre and post Child Protection Conference supervision sessions
- Individual supervision sessions by request
- Group supervision of managers by request
- Regular weekly child protection supervision element in Paediatric, Midwifery management, Neonatal Management meetings
- Open door policy for staff requiring advice and information on child protection matters

Documentation of supervision is dependent on each case. Supervision directly relating to a case will be documented within the hospital record on relevant paperwork. Formal supervision will be documented using the Child Protection

Supervision documentation. A copy should be retained by the named professionals for audit purposes and to demonstrate compliance with the **UHCW NHS Trust Child protection supervision policy.**

6.25.2 Supervision access for Senior Trust staff:

- Child Protection supervision & advice is available to the Executive team from the Named Professionals for Child Protection.
- Named Nurse/Midwife for Child Protection receives bi-monthly supervision from a Designated Nurse & participates in local / regional peer review & support arrangements,

Named Doctor Child Protection receives supervision via appraisal and informal discussion of cases with the Designated Doctors across the Arden Cluster.

6.26 Child Protection Training

Professional staff that have contact with children and their families should be able to recognise when a child may require safeguarding and should know what to do in response to concerns raised about a child's welfare. Practitioners and managers engaged in safeguarding children must be able to work effectively with others both within their own agency and across organisational boundaries. Working Together to Safeguard Children (2013) places a responsibility on Safeguarding Children Boards (SCB) to ensure that single agency and multi agency training on safeguarding children is provided. UHCW is accountable to Coventry SCB for provision of child protection training for all staff that come into contact with children, young people and adults who may be parents or carers.

The UHCW Child Protection Training Strategy (2014) provides the framework to address CSCB requirements and should be used in conjunction with the CSCB Inter Agency Training Strategy and Training Program. Child Protection Training for all staff is a requisite standard of the Care Quality Commission. CQC requires that 90% of staff have child protection awareness relevant to their role and that information regarding child protection is current. The training strategy assists in ensuring that staff achieve the competencies required at Level 2 and Level 3. Core and specialist competencies are based on the RCPCH Intercollegiate framework (2014) and the Coventry and Warwickshire health training strategy.

The UHCW Child Protection Training strategy is progressive. Courses are structured to deliver relevant information and support skill development in a logical sequence. As skills become more developed and roles more specialised, the professional responsibilities associated require a more in depth level of training.

Level 2 training is delivered on the hospital Induction Programme. Additional Level 2 training is available upon request. Attendance of staff is recorded on the electronic staff record system (ESR). Refer to the UHCW Child Protection Training Strategy (2014) and the child protection intranet site for details of which training is required for which staff.

Due to the complex nature of health care and diversity in roles, managers should determine the level of competence staff need in conjunction with the named professionals, this will be reflected by a competence level being attached to the job role on ESR. This will then provide a record to managers and to the trust of compliance with training.

The specific Inter Agency guidance (Coventry and Warwickshire interagency procedures) must be utilised to enable staff to identify abuse, manage the case providing a key resource for staff managing cases where there are concerns. In all situations discussion with senior paediatric colleagues or matrons should take place to assist with decision making (Appendix 1).

Fabricated & Induced Illness (FII)

Domestic Violence & Abuse – In addition there is specific guidance for maternity services *UHCW Maternity Services domestic violence and abuse in pregnancy and the postnatal period.*

Working with Sexually Active Teenagers - Children **under the age of 13** are not legally capable of consenting to sexual activity and must be referred to children's social care (see *Appendix 5)*

Coventry interagency specific procedures

Allegations of abuse made against a person who works with or is in contact with

children
Management of allegations against people who work with children and young people where there are cross border issues
Child abuse linked to a belief in spirit possession (including witchcraft)
Child abuse through the inappropriate use of the internet and other technology
Safeguarding children and young people affected by adult viewing child sexual abuse images on the internet
Child trafficking and exploitation
Children and female genital mutilation (FGM)
Children and forced marriage
Children in whom illness is fabricated or induce
Children involved in prostitution
Children of drug misusing parents
Children who display sexually abusive behaviour
Safeguarding children and young people with disability
Domestic violence and abuse
HIV
Honour based violence
Neglect
Safeguarding children from abroad
Safeguarding sexually active children and young people
Safe recruitment
Unborn children
Sudden unexpected deaths in infants
Working with resistant and non compliant families

7.0 DISSEMINATION AND IMPLEMENTATION

7.1 All staff informed of child protection policy at initial and update child protection training.

8.0 TRAINING

8.1 Training is delivered in line with the UHCW NHS Trust training strategy, level of competence required is dependent on job role as determined by manager and directly with staff at PDR.

9.0 MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT

The effectiveness of the policy in practice will be monitored by the Safeguarding Vulnerable and Children's Committee (SVACC). The Committee will be provided with monthly reports containing the performance monitoring data for safeguarding children.

- Monthly Mandatory Training figures.
- Monthly Referral Numbers.
- Risk report relating to any potential/actual serious case reviews.

9.1 Monitoring Table

Aspect of compliance or effectiveness being monitored	Monitoring method	Individual department responsible for the monitoring	Frequency of the monitoring activity	Group / committee which will receive the findings / monitoring report	Group / committee / individual responsible for ensuring that the actions are completed
Thresholds of referral are recognised	Audit of referrals from CSC feedback	Safeguarding team	3 monthly	C&W LSCB, CQC, Link groups	Safeguarding team, link group
All staff receive the required level of training / all case loading staff receive ongoing supervision	Data from ESR / OLM	Departmental mangers / safeguarding team	Monthly	Mandatory training committee, C&W LSCB, CQC, Trust executive	Safeguarding team, link group, departmental managers
Actions when children attend emergency settings / robust measures in place when	Audit of referral proformas of children determined to be at risk when	Safeguarding team	Annual Laming audit. Twice yearly case report at	LCSB CQC Trust Executive board	Safeguarding team, link group, departmental managers

children DNA appointments	attending emergency care settings and feedback forms from CSC / audit of Children's outpatient department		paediatric audit meeting Recent Audit of referral forms		
Differences of medical opinion / review of serious injuries or child death / standards of record keeping / lessons learnt and disseminated	Audit of notes of all children where a difference of opinion is considered with an issue of safeguarding	Named Doctor for child protection / named nurse / midwife for child protection	Ongoing	C&W LSCB, CQC, Trust exec, CDOP	C&W LSCB, CQC, Trust exec, CDOP

10.0 STAFF COMPLIANCE STATEMENT

All staff must comply with this Trust-wide Corporate Business Record and failure to do so may be considered a disciplinary matter leading to action being taken under the Trust-s Disciplinary Procedure. Actions which constitute breach of confidence, fraud, misuse of NHS resources or illegal activity will be treated as serious misconduct and may result in dismissal from employment and may in addition lead to other legal action against the individual/s concerned.

A copy of the Trust's Disciplinary Procedure is available from eLibrary.

11.0 EQUALITY & DIVERSITY STATEMENT

Throughout its activities, the Trust will seek to treat all people equally and fairly. This includes those seeking and using the services, employees and potential employees. No-one will receive less favourable treatment on the grounds of sex/gender (including Trans People), disability, marital status, race/colour/ethnicity/nationality, sexual orientation, age, social status, their trade union activities, religion/beliefs or caring responsibilities nor will they be disadvantaged by conditions or requirements which cannot be shown to be justifiable. All staff, whether part time, full-time, temporary, job share or volunteer; service users and partners will be treated fairly and with dignity and respect.

12.0 REFERENCES AND BIBLIOGRAPHY

The Children Act 1989 & 2004

Data Protection Act 1998

Sexual Offences Act 2003

Working Together to Safeguard Children - HMSO 2013

Coventry Safeguarding Board Interagency Procedures - online 2012

Warwickshire Safeguarding Board Interagency Procedures - online 2012

Victoria Climbie Inquiry – Laming Report 2003

NSF for Children 2004

National institute for Health and Clinical Excellence – When to suspect child maltreatment guideline (2009)

Common Core of Skills & Knowledge for the Children's Workforce 2012

UHCW Employee Support Policy

UHCW Patient Access Policy

Coventry Information Sharing Protocol 2005

Warwickshire Information Sharing Protocol 2004

What to do if You're Worried a Child is Being Abused 2007

Information Sharing: Guidance for Practitioners and Managers 2008

West Midlands Joint Protocol: Child Protection Enquiries and Related Criminal Investigations

The Protection of Children in England: A Progress Report 2009

The Protection of Children in England: action plan 2009

The Government's response to Laming 2009

Safeguarding Children: A review of the arrangements in the NHS for safeguarding children. CQC Report 2009

Understanding Serious Case Reviews and their Impact
A Biennial Analysis of Serious Case Reviews 2005-07

UHCW Training Needs Analysis 2009

Intercollegiate document 2014

13.0 UHCW ASSOCIATED RECORDS

UHCW NHS Trust Child Protection Training Strategy, Version 2 (2014)

UHCW NHS Trust Child Protection Supervision Strategy, Version 2 (2014)

Appendices and Supporting Information

Appendix 1	What to do if you are worried a child is being abused flowchart (accessible on intranet)	 What to do if your worried a child's being
Appendix 2	Child protection serious case review governance reporting arrangements	 CP serious case gov arrangements
Appendix 3	Guidance for writing conference and court reports	 Guidance for writing conference/court rep
Appendix 4	Child protection report meeting template	 Child Protection report template
Appendix 5	Urgent action to safeguard children flowchart Accessible on intranet	 Urgent Action Flowchart
Appendix 6	Audit of the management of paediatric suspected non accidental injury (Yearly Laming audit criteria)	 Yearly Laming Audit
Appendix 7	Coventry Safeguarding Network	 Coventry Safeguarding Networ
Appendix 8	Reporting an unexpected death or serious injury of a child	 Report a unexpected death or serious injur
Appendix 9	Coventry Multi Agency Referral Form	 Cov - Referral Form
Appendix 10	Warwickshire Multi Agency Referral From	 Warks - Referral Form
Appendix 11	Coventry Thresholds	 Child Development Needs Thresholds
Appendix 12	National institute for Health and Clinical Excellence – When to suspect child maltreatment guideline, 2009	 NICE - When to suspect child maltreat