Witness Name: Pippa Nightingale

Statement No.: WITN4572017

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**EXHIBIT WITN4572018**

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# Safeguarding Children and Young People (including unborns) Policy

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| **COMMITTEE APPROVAL:** | **NAME OF COMMITTEE**<br>Children's Safeguarding Committee | | **NAME OF CHAIR OF APPROVING COMMITTEE**<br>Vanessa Sloane, Director of Nursing |
| | **DATE APPROVED:**<br>**5th August 2019** | | |
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| **AUTHOR / FURTHER INFORMATION:** | Dr Paul Hargreaves (CW) and Dr Anne Davies (WMUH) – Named Doctors for Child Safeguarding<br>Daisy Dholoo – Named Nurses for Child Safeguarding<br>Dr Charlotte Cohen – Safeguarding Lead for HIV/GUM Directorate<br>Sarah Green, Consultant Midwife Public Health | | |
| **STAKEHOLDERS INVOLVED:** | Senior nursing team<br>Safeguarding professionals | | |
| **FRONT LINE STAFF APPROVAL (NAME AND DESIGNATION)** | | | |
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## APPENDICES

## 1. INTRODUCTION

Section 11 of the Children Act 2004 places a statutory duty on organisations and individuals to safeguard and promote the welfare of children. This Policy sets out the operational arrangements for safeguarding and promoting the welfare of children across all departments and areas within the Chelsea and Westminster Hospital NHS Foundation Trust.

This policy supports and is in line with the Pan London Child Protection Procedures 5th Edition 2017 and the guidance produced by the National Institute for Clinical Excellence (NICE) 'When to suspect Child Maltreatment' July 2017. It has been updated in line with Safeguarding Children and Young People – Roles and Competencies for NHS Staff Intercollegiate Document 2006, 2010, updated 2019.

## 2. PURPOSE OF THE POLICY

The purpose of this policy is to ensure that all staff employed by the Trust are aware of:

- Their individual responsibilities in relation to the safeguarding of the unborn baby, children and young person.
- The process to follow when concern about child maltreatment arises in any unborn baby, child or young person attending the Trust.

Safeguarding and child protection is everybody's business and as an acute Trust are at the forefront of safeguarding children. Every staff member has the responsibility to be vigilant, to act promptly if they have concerns about a child's wellbeing, and follow this policy.

## 3. DEFINITIONS IN SAFEGUARDING CHILDREN AND YOUNG PEOPLE

### 3.1. Definitions of a Child & Young Person

A child/young person is defined as any person who has not reached their Eighteenth birthday. Young people aged 16 -17 may be cared for in an adult environment, but any safeguarding concerns must be managed under this policy. This Policy also includes unborns and assessing the potential for significant harm regarding an unborn baby (e.g. domestic violence, parental substance misuse or mental ill health).

### 3.2. Definition of Safeguarding and Promoting the Welfare of Children and Young People

Safeguarding and promoting the welfare of children is defined as the process of:

i. Protecting children from maltreatment;
ii. Preventing impairment of children's health or development;
iii. Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care;
iv. Undertaking that role to enable those children to have optimum life chances and to enter adulthood successfully.

### 3.3. Definition of Child Maltreatment

Child maltreatment includes physical, emotional, sexual abuse, neglect and fabricated or induced illness.

### 3.4. Definition of Child Protection

The process of protecting individual children identified as either suffering, or at risk of suffering, significant harm because of abuse or neglect.

### 3.5. Definition of Significant Harm

The Children Act 1989 introduced the concept of 'significant harm' as the threshold that justifies compulsory intervention in family life in the best interests of children. 'Harm' is defined as the ill treatment or impairment of health and development. This definition was clarified in section 120 of the adoption and Children Act 2002, implemented on 31st January 2005 so that it may include, for example, impairment suffered from seeing or hearing the ill treatment of another.

### 3.6. Definition of a Child in Need

Under Section 17 [10] of the Children Act 1989, a child is a Child in Need if:

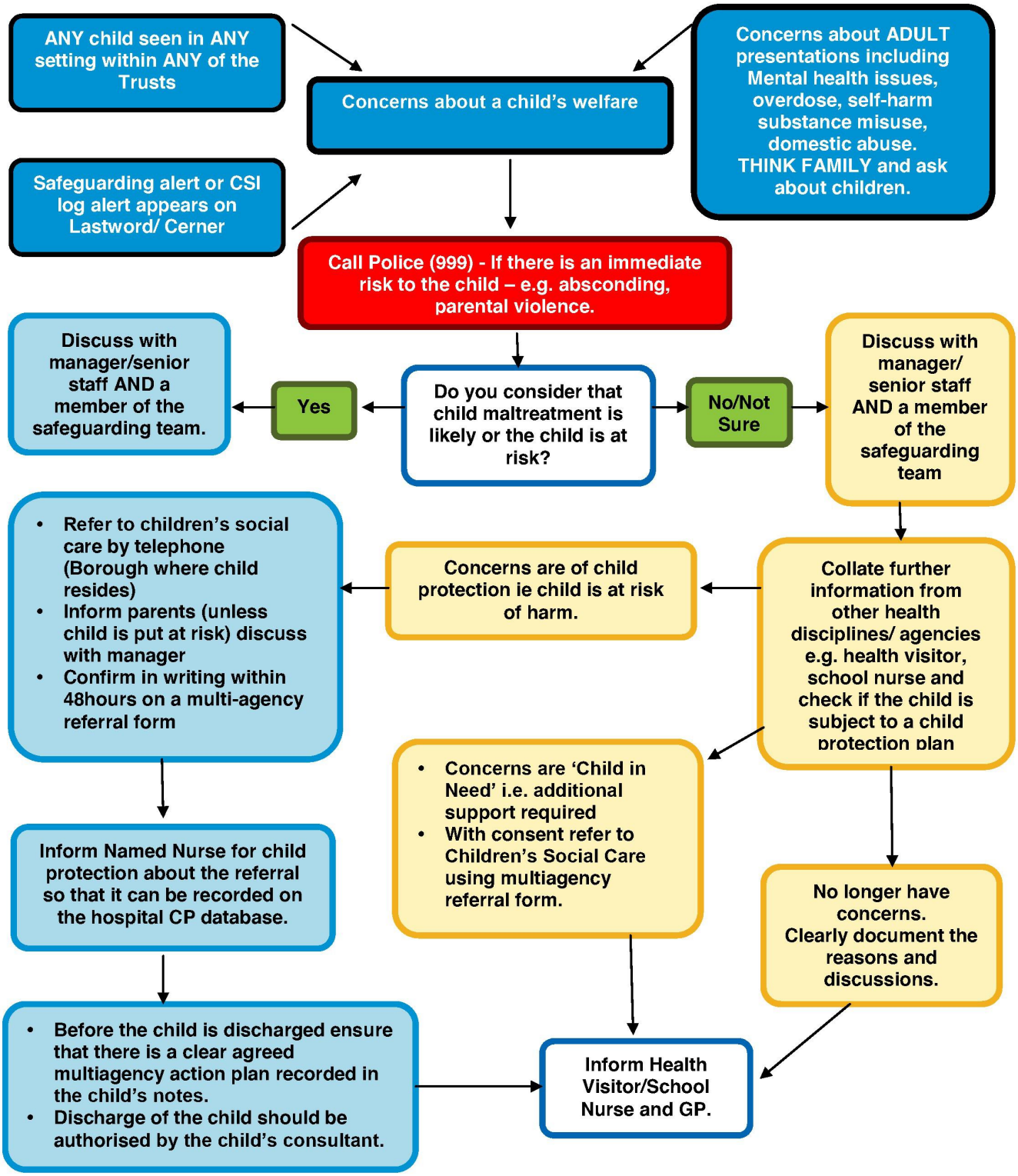
- He/she is unlikely to achieve or maintain, or have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him/her of services by a local authority;
- His/her health or development is likely to be significantly impaired, or further impaired, without the provision for him/her of such services; or
- He/she is a disabled child.

### 3.7. Definition of a Child Subject to a Child Protection Plan

Children found to be at risk of significant harm, after a multi-agency investigation led by Children's Social Care (previously known as Social Services), are subject to a child protection plan (**previously known as being on the child protection register**). This indicates that a clear plan of action has been developed by the identified key worker so that professionals and family can work to keep the child safe and reduce/remove any risks.

## MANAGEMENT OF CHILD/YOUNG PERSON SAFEGUARDING CONCERNS

## ALL STAFF HAVE A DUTY TO PROTECT CHILDREN (0-18) FROM HARM



## 4. ROLES AND RESPONSIBILITIES

### 4.1. Local Authorities

Local authorities have overall responsibility for safeguarding and child protection within each borough and as such oversee the work of the Local Safeguarding Children's Board. Where children from other boroughs or outside London are seen within the Trust & concerns raised these will be addressed with the appropriate local authority.

### 4.2 Local Safeguarding Children's Board

The Children Act 2004 required of each Children's Service Authority in England to establish a Local Safeguarding Children Board. Local Safeguarding Children's Boards (LSCB) are the key statutory mechanism for agreeing how organisations working with and providing services for children in each local area will co-operate to safeguard and promote the welfare of children, and to ensure the effectiveness of the work done for that purpose. Senior Trust representatives attend each of our locality LSCB's.

### 4.3 The Trust Board

The Trust Board is responsible for the overall safeguarding of children in the organisation. The Board is responsible for reviewing and maintaining an effective system of internal control, including systems and resources for managing all types of risk associated with safeguarding children.

### 4.4 Chief Executive

The Chief Executive has overall responsibility for the delivery of the Trust's policy and procedures including those related to safeguarding and child protection.

### 4.5 Director of Nursing

The Director of Nursing is the Executive lead with responsibility for Safeguarding, with Chief Nurse providing Board level representation

### 4.6 Designated Doctor and Designated Nurse for Safeguarding Children

The Designated Doctor and Nurse take a strategic and professional lead on all aspects of the health service's contribution to safeguarding children across both sites. Designated professionals provide advice and support to the named professionals in each provider trust. In Serious Case Reviews, designated professionals should review and evaluate the practice and learning from all health professionals and providers who are involved within the Clinical Care Commissioning Group (CQC). These designated individuals are external to the Trust.

### 4.7 Named Doctor, Nurse and Midwife and Liaison Health Visitor

The focus of the Named professional's role is to safeguard children within the Trust. Named professionals should support the Trust in its clinical governance role by ensuring that audits on safeguarding are undertaken. Named professionals also have a key role in ensuring that a safeguarding training strategy is in place and is delivered within the Trust.

### 4.8 Safeguarding Children's Board

The Safeguarding Children's Board provides leadership and coordination in promoting the wellbeing, interests and health of children within the Trust, in partnership with other health, social care and educational agencies.

### 4.9 The Paediatric Clinical Effectiveness Committee

The Paediatric Clinical Effectiveness Committee or Children's & Young Persons Committee identifies and monitors safeguarding or child protection risks through consideration of incident reports. It further identifies where safeguarding or child protection risks need to be escalated through the Trust's Risk Management Committee. The Committee reviews all risk assessments relating to Safeguarding or Child Protection, to validate risk and confirm appropriate measures are in place.

## 5. TRAINING AND SUPERVISION

### 5.1 Safeguarding Children and Young People Training

The safeguarding competencies required for NHS staff are set out in the Safeguarding Children and Young People – Roles and Competencies for NHS Staff Intercollegiate Document updated 2019. Effective training ensures that all staff are competent to carry out their duty to safeguard children. Training is mandatory (refreshed every 3 years) as follows:

**Level 1: All staff** working in health care settings
**Level 2:** All non-clinical and clinical staff **that have any contact** with children, young people and/or parents/carers
**Level 3:** All clinical staff

- Working with children, young people &/ or their parents/ carers &/ or any adult who could pose a risk to children.
- Who could potentially contribute to assessing, planning, intervening &/ or evaluating the needs of a child or young person &/ or parenting capacity (regardless of whether there have been previously identified child safeguarding concerns or not)

**Level 4:** Safeguarding Specialist Roles (named professionals)

**Provision of Training –** There is in-house e-learning provision of training at Levels 1 & 2 and face to face access at level 3 both internally and externally. Level 4 is provided externally due to small numbers.

An annual written update is also disseminated to all staff to inform about current documents/guidelines and changes to practice. The Learning Resource Centre or Safeguarding Professionals can advise staff on how to access relevant training. The Trust's Safeguarding Children & Young People Training Strategy provides more comprehensive information about the training and frequency of updates that are required. The safeguarding professional's meeting evaluate training delivered, review the training strategy, and update training material. A monthly training report is produced by QlikView (OLM) this highlights the percentage of staff trained at level 2 & 3. Attendance at training is recorded centrally. Overall uptake of training is monitored by the Safeguarding Children's Board.

### 5.2 Supervision and Support for Staff

Safeguarding supervision helps to ensure that healthcare professionals are clear about their roles and responsibilities in relation to safeguarding children. It also serves to help in an individual's professional development and is a primary source of support for staff.

The Trust recognises that safeguarding children and young people can be very complex, stressful, difficult and emotive. Key safeguarding staff has regular safeguarding supervision provided by the designated professionals. All Trust staff has open access to the named professionals for supervision as and when required.

Please refer to the Safeguarding Supervision Policy for more information:

Please refer to the Safeguarding allegations made against staff policy for information about the process to follow should you have concerns about the actions of a staff member:

## 6. IDENTIFYING AND ASSESSING SAFEGUARDING RISK

Safeguarding issues need to be considered as part of any routine assessment of an unborn, child or young person. This includes all new follow up contacts and covers all wards/departments including outpatients, day care, emergency department and inpatients. The following should always be considered as part of any assessment:

- Potential drug and alcohol abuse: in parents/guardians and in children and young people
- Potential domestic abuse: within the family and in relationships
- Mental health problems in the parent/carers of children and young people
- Children or young person subject to a child protection plan
- When there are difficulties in communicating fully with parents and children it is important, particularly when there are safeguarding concerns that the interpreting services are used.

### 6.1 Identifying Alerting Features of Child Maltreatment

- All staff working at Chelsea and Westminster Hospital have an important role and a duty outlined in law, to ensure that they safeguard and promote the welfare of children and young people. In order to carry out their responsibility they need to be able to recognise alerting features of child maltreatment.
- All clinical staff as part of any assessment of a patient should routinely ask about dependents such as children, or about any caring responsibilities.
- All staff also need to be aware of what to do if they are concerned that a child is being maltreated.

Key alerting features of child maltreatment have been included in **Appendix B**. This information has been extracted from the National Institute of Clinical Excellence – 'When to Suspect Child Maltreatment' July 2012. For further information, the quick reference guide is available in all departments or can be downloaded from www.nice.org.uk/CG89.

#### 6.1.1 Referral to Children's Social Care

- Any member of staff who has concerns about the welfare of a child/young person has a responsibility to escalate their concerns to a member of the Trust Safeguarding Team/social services who will decide on the most appropriate action. It is the responsibility of each individual to raise the concern & ensure it is followed through.
- If staff suspect that a child is or might be maltreated, then a telephone referral should be made to Children's Social Care in the Borough where the child resides. Concerns MUST be followed up with 48hrs with a written multi-agency referral sent via email to both the local authority and the safeguarding team. Once a referral to social care has been made details of who made the referral, who it was sent to and what the concerns were must be documented appropriately. If staff agree that the child is a 'child in need' and requires additional support from Children's Social Care a written referral should be made to the Children's Social Care in the borough where the child resides using a multi-agency referral form.
- The trust standard referral can be found on the intranet under children's safeguarding with the list of most London boroughs contact details including email addresses. (if the local authority you require is not on the list please contact the safeguarding team, look on the boroughs website or contact them directly via telephone)
- It is the responsibility of the person sending the referral to ensure that the referral has been received by Children's Social Care. The Named Nurse for Safeguarding Children/Safeguarding Midwife should be informed via email or telephone of the referral so that it can be recorded on the Trust's Child Protection referral database.

#### 6.1.2 Escalation Process

If there are concerns or disagreements about the management of safeguarding cases, interagency referrals or outcome, then these concerns must be escalated. The member of staff should direct their concerns

initially with the relevant managers and if unresolved, there should be discussion with the Trust Safeguarding Team/ social services and the named consultant for the child. Contacts in appendix A

If the outcome of a case is unsatisfactory escalate in writing to Designated Professionals to escalate to Local Safeguarding Board.

### 6.1.3 Children who spend more than 3 months in Hospital

In line with the Children Act 2004 - all staff who work with children who spend more than 3 months in hospital should notify Children's Social Care about these children to trigger an assessment, under the Framework for the Assessment of Children in Need and their families, and a follow up of their welfare needs. (See **Appendix E** for referral form). A copy of the referral should be sent to the named nurse for child protection so that it can be recorded on the referral database. (The London Child Protection Procedures state that it is the responsibility of the Hospital to notify the child's local authority) The Named Nurse is responsible for making sure that timely notifications are made.

### 6.2. Identifying Drug and Alcohol Misuse

- All children, young people and families/carers should be assessed for drug and alcohol misuse.
- Parental misuse of drugs and/or alcohol can affect the unborn and/or child's health and welfare directly and indirectly.
- Drug and/or alcohol misuse in a child or young person may be an alerting feature of past or present abuse and neglect.

Where there are significant concerns about drug and alcohol misuse for any child or young person attending the hospital a joint assessment by CAMHS and Children's Social Care should be carried out before discharge. A referral to the alcohol liaison nurse should also be made

All clinical staff in contact with parents/carers in whom there is drug and alcohol misuse - directly or reported – need to follow the flowchart- 'Management of Child Safeguarding Concerns'. For professionals working within the Emergency Departments there is specialised guidance. Please see **Appendix G**.
All children under 18yr who present with concerns regarding drugs and or alcohol who are not admitted still require a safeguarding referral.

### 6.3 Identifying Domestic Abuse in Families and Relationships

- Staff may have contact with families where there are concerns about domestic abuse and young people in whom there is concern about relationship abuse. Domestic abuse is a factor involved in the families of more than 70% of children presenting with child abuse. All clinical staff dealing with families and/or young people in relationships needs to be able to identify alerting features of domestic abuse. Where staff have concerns about domestic or relationship violence in relation to a child or young person they should follow the 'Management of Child Safeguarding Concerns' included in . For professionals working within the Emergency Departments a referral to the Independent Domestic Violence Advisor (IDVA) should also be made, there is specialised guidance (please see **Appendix G and H**). Within maternity all women should routinely be asked at some point in their pregnancy whether they are subject to abuse or violence in the home. Additionally, if women present with risk indicators for DV, they should be asked directly and responded to accordingly. Referral to the maternity IDVA should be offered. If the woman declines a referral to the IDVA and is deemed to be high risk of domestic abuse a referral to MARAC should be made.

Also refer to the Trust Domestic Abuse Policy

**All children witnessing or involved in domestic violence incident must have a social services referral and the Safeguarding Team informed.**

**Domestic Abuse in Maternity**

Pregnancy is widely acknowledged as a significant risk factor for Domestic Violence (DV), with almost a third of cases beginning in pregnancy. For women already experiencing abuse, pregnancy is a time when there is often escalation of violence. DV can impact significantly on the physical and mental health of women, and may result in her being killed. Living within an abusive relationship may also affect women's ability to effectively and safely parent their children. DV is associated with increased rates of miscarriage, premature birth, foetal injury and foetal death. It significantly affects the safety, physical health and emotional/mental health of children. In pregnancy, women may be prevented from seeking or receiving antenatal or postnatal care. DV may be linked with other risk factors such as parental substance misuse and mental health concerns.

Assess the woman's immediate safety – if she wishes to go to a place of safety, Women's Aid can be contacted 24hrs a day on 0808 2000 247.

- Offer her referral to the Maternity Independent Domestic Violence Advisor (IDVA)
- Make a referral to Children's Social Care if the woman has experienced abuse in her pregnancy or with her current partner
- Make a referral to the Caseload Midwives Team at CW and WMH if the client is antenatal and resident within the Chelsea and Westminster NHS Foundation Trust catchment area, if outside catchment refer to Poppy Team CW & caseload Midwife team WM.
- Inform the GP & Health Visitor
- Document any concerns, disclosures, plans and actions taken in the appropriate section of the hospital/case/Cerner notes**. Information about DV must NEVER be recorded in the woman's hand-held maternity record or any part of her records that may be sent as correspondence to her address or given to her.**
- Inform the Safeguarding Lead for Maternity

**6.4 Identifying Mental Health Problems in Parents/Carers**

Parents/carers with psychiatric disorders may abuse and neglect their children. All clinical staff involved in the care of parents/carers in whom there are mental health concerns need to consider the safety of the children and follow the 'management of child/young person safeguarding concerns' flowchart . For professionals working within the Emergency Departments there is specialised guidance (please see **Appendix G**).

**Mental Health concerns in pregnancy**

While many cases of parental mental illness may not impact upon a child's wellbeing or development, enduring or more severe illnesses are associated with increased risk of or actual significant harm to children. (London CP Procedures 2017) Pregnancy and the postnatal periods are a time of great psychological, emotional and physical change and can be a time where existing mental health conditions deteriorate, or when women may show first signs of illness. Women with a history of mental ill-health are at an increased risk of relapse in the postnatal period, even if they are stable antenatally.

- Women presenting at any stage during pregnancy, birth or post-natal period should be referred to social care if presenting with worsening and significant Mental Health- to allow a robust MDT

assessment to assess any potential risk to the unborn any other children as well as the risks of the father of the baby and / or other family. Practitioners in maternity should ask all women about past and present mental health during their pregnancy and in the postnatal period. Where severe mental health concerns are identified, practitioners will need to: Consider the impact that any parental mental ill-health may have on their ability to parent their baby. They will also need to consider whether the woman or another family member has a severe mental illness that may put a baby at risk of abuse, neglect or even death.

- If a mother has significant mental health concerns refer to the Perinatal Mental Health Team. See Perinatal Mental Health Policy for further referrals required & for a list of professionals to be informed. Ensure the safeguarding midwife is informed.

### 6.5 Parents with a Learning disability

Parental learning disabilities do not necessarily have an adverse impact on a child's developmental needs, but it is essential to always assess the implications for each child in the family. Parents with a learning disability may need support to develop the understanding, resources, skills and experience to meet the needs of their children. Where a parent has enduring and / or severe learning disabilities, children in the household are more likely to suffer significant harm through emotional abuse, and / or neglect, but also through physical and / or sexual abuse. London CP procedures 2018

The London CP Procedures 2017 state that the Local Authorities vulnerable adult's services should ensure eligibility criteria for service provision is such that parents with learning disabilities who need help in order to be able to care for their children can benefit from support provided under the NHS and Community Care Act 1990.Ensure parents have Accessible information; refer to Advocacy services if necessary; liaise and obtain support from the Trust Learning Disability Nurse, multi-agency & multi-disciplinary assessments with close liaison between all children's & adults services. Inform all professionals involved of any in or outpatient antenatal attendance or attendance for a child.

### 6.6 Identifying Unborns, Children or Young People with a Current Child Protection Plan

There is a safeguarding responsibility for all health professionals to ensure that any unborn, child /young person who attend the hospital and is subject to a child protection plan the allocated social worker is notified This should also be mentioned in discharge summaries.

Each child is routinely checked to see if they are 'Subject to a Child Protection Plan' or Child in Need plan by a IT flagging system which was implemented in May 2018, (CP-IS) this is in place for all children under the age of eighteen years that present to the ED and Maternity department. It does so by connecting local authorities' child protection social care IT systems with those used by staff in NHS unscheduled care settings. The information sharing focuses on three specific categories:

Those with a child protection plan
Those with Looked after status
Pregnant women whose unborn child has a pre-birth child protection plan.

**Refer to Checking the Child Protection Information System (CP-IS)**
**Quick Reference Guide on the hospital intranet.**

### 6.7 Identifying additional vulnerabilities in children, young people and/or carers

**Child Sexual Exploitation (CSE)**

- Sexual exploitation of children and young people **under 18** involves exploitative situations, contexts and relationships where the young person (or third person/s) receive 'something' (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) because of them performing, and/or another or others performing on them, sexual activities.
- Child Sexual Exploitation can occur through the use of technology without the child's immediate recognition; for example, being persuaded to post sexual images on the internet/mobile phones without immediate payment or gain.

Violence, coercion and intimidation are common. Involvement in exploitative relationships is characterised by the child's or young person's limited availability of choice resulting from their social, economic or emotional vulnerability. (Pan London CSE operating protocol 2015).
Children and young People who are subject to Child Sexual Exploitation may be identified through acute and outpatient services throughout the trust. It is important that staff is aware of the possible indicators and how to access help and support for these children. Follow guidance in the flowchart at the beginning of the policy, where safeguarding concerns are identified and seek advice from safeguarding leads if unsure. Further information is available in **Appendix I**.

http://www.londoncp.co.uk/chapters/sg_sex_exploit_ch.html

Statutory guidance outlining how organisations and individuals should work together to protect young people from sexual exploitation:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/278849/Safeguarding_Children_and_Young_People_from_Sexual_Exploitation.pdf

National document - Step-by-step advice outlining actions to be taken if staff suspect that a child they are in contact with is being sexually exploited.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/279511/step_by_step_guide.pdf

**Trafficking/ Modern Slavery**

Trafficking in people includes the exploitation of children through force, coercion, threat and the use of deception and human rights abuses. Exploitation occurs through prostitution and other types of sexual exploitation, and through labour exploitation. It includes the movement of people across borders and also the movement and exploitation within borders. The UK is a destination country for trafficked children and young people. Such children enter the UK through various means. Some enter as unaccompanied asylum seekers, or students or as visitors. Children are also brought in by adults who state that they are their dependents, or are met at the airport by an adult who claims to be a relative. If it is suspected that a child is the victim of trafficking, the police or children's social care should be informed and if a pregnant women is suspected to be trafficked

**Female Genital Mutilation (FGM)**

FGM is considered child abuse in the UK and a grave violation of the human rights of girls and women. In all circumstances where FGM is practised on a child it is a violation of the child's right to life, their right to their

bodily integrity, as well as their right to health. The UK Government has signed a number of international human rights laws against FGM, including the UN Convention on the Rights of the Child. (London FGM Resource Pack 2009).

The World Health Organisation (WHO 2008) defines female genital mutilation as: "all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons"

The trust has a duty to protect the rights of children whilst keeping their safety paramount. As a form of abuse staff should follow the flow chart in Appendix A and need also to use the Trust FGM Policy and safeguarding leads for guidance. Mandatory Reporting - since October 2015 registered professionals have a statutory duty to report to the police any girl under the age of 18 who discloses FGM or they identify who has undergone FGM.
Please see the FGM policy for further information.

**Pregnant Women Found to Have Had, or Disclosing FGM**

- Maternity services have implemented practice where pregnant women who attend for their antenatal booking appointment will be asked routinely if they have had FGM.
- If they disclose that they have had FGM, then they must be referred to the FGM specialist midwifery clinic and the CWFT FGM in Pregnancy Guideline should be followed.
- Pregnant women should not be automatically referred to children's social care unless there is a concern or identified risk to their daughters, or any unborn children or other young females within their sphere of influence. A referral to social care should be based on a risk assessment and the CWFT FGM guideline should be followed. If there are any concerns the Safeguarding Team should be contacted and case discussed.
- The pregnant woman's GP and Health Visitor must be informed in writing that they have suffered FGM and normal female genitalia should be documented in the child's notes if a female child is born. If a woman who has a history of FGM gives birth to a daughter the labour ward midwife is responsible for completing the FGM IS notification on the NHS spine which alerts that a female has been born into a family with a history of FGM. Please see Appendix 2

- Since 31st October 2015, all Registered Professionals now have a mandatory duty to report any identified cases of FGM in any females under 18 year olds directly to the Police. If the woman is under 18 and FGM is found or disclosed, please immediately contact the Safeguarding Team for advice and support on meeting this requirement. If this is out of hours, please immediately contact the on-call Consultant Paediatrician at Chelsea and Westminster via switchboard for advice. Please be aware that a pregnant woman may also be under 18 years old and therefore if found to have/ disclosed FGM also needs to be reported due to the fact that she is legally still a child.

All pregnant women of any age who present/ disclose with FGM must be documented on the FGM log as well as being referred to the FGM midwives for further review and so appropriate risk a

**FGM Information Sharing System (FGM-IS)**

FGM-IS is a national IT system that supports the early intervention and ongoing safeguarding of girls under the age of 18, who have a family history of Female Genital Mutilation (FGM). It allows healthcare professionals and administrative staff to record that a girl has a family history of FGM.

The FGM-IS is part of the NHS Spine. Healthcare professionals and administrative staff can view and add, an FGM indicator, accessed via the Summary Care Record Application (SCRa). Access is controlled via NHS smartcards and the appropriate Role Based Access Codes (RBAC).

FGM-IS contains:

- an indicator that a girl has a family history of FGM
- the date that the FGM indicator was added on to the system

FGM-IS shares FGM information with authorised healthcare professionals and administrative staff, who come into contact with girls with a family history of FGM as they grow up. The FGM-IS indicator stay on the girl's record until she reaches 18 years old.

Midwives delivering a female baby of a mother with FGM history, must complete FGM-IS in addition to the current safeguarding referral made.

Midwives discharging such a woman postnatally, and the midwives performing the baby's EON (examination of newborn) must double-check the FGM-IS indicator has been set before the woman is discharged from care.

FGM-IS QRG.DOCX

**Suspected sexual abuse or acute sexual assault**

Children or young people may present to A&E unexpectedly (or less frequently outpatients) following a sexual assault, or present with features suspicious of chronic abuse.

If the nurse at triage recognises that sexual assault may have taken place, he or she will contact the specialist registrar or consultant directly. The triage history should cease once an allegation has been made or suspicion aroused, and no direct questioning regarding sexual assault should occur. However, it is appropriate for the nurse to establish if there are any acute medical complications following the assault that might need urgent treatment e.g. vaginal bleeding.

If on the other hand at triage, no suspicion or allegation of sexual assault occurs, but subsequently, the SHO recognises the possibility, then the SHO should refer directly upwards. The medical assessment is essentially divided into one of two categories, depending on whether the alleged sexual assault is acute (within 72 hours) or non-acute.

Once an allegation is made that an acute sexual assault has occurred, the Middle Grade Doctor **must immediately** discuss with the on-call consultant. All cases are now referred to the local Haven based at St Marys Hospital (on 0203 312 1101, 9-5pm), (0203 312 6666, out of hours) (fax: 0203 312 1850). The Middle Grade Doctor should not directly question the child or carer regarding details of the assault. **Please inform the Safeguarding Team and Social Services as soon as possible.**

The Haven will see all children (and adults) referred to them for a forensic medical if the assault has occurred within a certain timeframe. They will see girls and boys under the age of 13 if the assault occurred within 72 hrs. For young people 13-17 they will see girls if within 7 days of assault and boys within 3 days.

NB Below 13 years of age is statutory rape and the police must be contacted.

## 7.0 Information Sharing

"There is nothing within the Caldecott report, the Data Protection Act 1998 or the Human Rights Act 1998, which should prevent the justifiable and lawful exchange of information for the protection of children." (Carlisle Review, 2002)

Guidance from Working Together 2018 states;

Effective sharing of information between practitioners and local organisations and agencies is essential for early identification of need, assessment and service provision to keep children safe. Serious case reviews (SCRs13) have highlighted that missed opportunities to record, understand the significance of and share information in a timely manner can have severe consequences for the safety and welfare of children

Practitioners should be proactive in sharing information as early as possible to help identify, assess and respond to risks or concerns about the safety and welfare of children, whether this is when problems are first emerging, or where a child is already known to local authority children's social care (e.g. they are being supported as a child in need or have a child protection plan). Practitioners should be alert to sharing important information about any adults with whom that child has contact, which may impact the child's safety or welfare.

Fears about sharing information must not be allowed to stand in the way of the need to promote the welfare, and protect the safety, of children, which must always be the paramount concern.

**Practitioners should not assume that someone else will pass on information that they think may be critical to keeping a child safe. If a practitioner has concerns about a child's welfare and considers that they may be a child in need or that the child has suffered or is likely to suffer significant harm, then they should share the information with local authority children's social care and/or the police**

Practitioners should aim to gain consent to share information, but should be mindful of situations where to do so would place a child at increased risk of harm. Information may be shared without consent if a practitioner has reason to believe that there is good reason to do so, and that the sharing of information will enhance the safeguarding of a child in a timely manner. When decisions are made to share or withhold information, practitioners should record who has been given the information and why

**Where there is information to indicate that a baby/child is at risk of significant harm a referral to Children's Social Care must be made by the practitioner identifying the concerns.** Safeguarding leads in children's services or maternity will support with this process if needed. A copy of the referral should be placed in the child / baby's records & in the maternal record if an antenatal referral.

Emergency Duty Teams within Children's Social Care can be contacted by telephone if out of hours support is needed in making a decision about whether to refer a case. Contact information for each borough is available on the Intranet.

Parents should be informed of referrals, unless there is a risk to the child/ baby, but parental consent to refer is not required.

**See Appendix L for information sharing myth busters**

## 8.0 Maternity care - identifying safeguarding concerns

### Maternity Specific Considerations in Safeguarding

Newborn babies are particularly vulnerable as they are totally dependent for all their care needs. A study undertaken of serious case reviews of child abuse where children had died or were seriously injured highlighted that 41% were under one year old and half of these under 3 months. Of the 31 cases of Sudden infant death, 81% of these had social care involvement due to high levels of substance misuse and parental mental health concerns. The risks increased significantly if parental mental illness co-existed with domestic violence and substance misuse. https://seriouscasereviews.rip.org.uk/health/

### 8.1 Recognising a Baby/Child in Need or at Risk of Significant Harm in Maternity Situations

**Risk Assessment in Maternity Situations**

Recognition of a baby at risk constitutes an imperative part of maternity care at CWFT. There are many factors that could indicate a baby is at risk or at potential risk of harm. Offering early intervention to parents may help to prevent more serious problems later. In the majority of cases, safeguarding concerns will be identified through social history and factors presented during the antenatal period. Practitioners are therefore often ideally placed to offer early intervention where appropriate, or to initiate safeguarding procedures. Practitioners also need to remain alert to risk factors in the intrapartum or postnatal periods. Any inconsistent, unclear or possibly false information given by a woman should be clarified.

At booking an assessment of the woman's individual needs including a social history is obtained to ensure she receives appropriate care. Partner details must be obtained. Risk assess at all contacts, should concerns arise appropriate referrals should be made.

Practitioners must ensure that all women are given the opportunity to discuss any issues in private i.e. with no other family member or friend present.

All women should be offered a woman only appointment/ part appointment at either the Booking or 16 week appointment where she can be seen on her own with no other family members or friends present.

Where women/parents have limited understanding or use of English, a professional interpreter (booked through the Trust Interpreting Service (either via phone or face to face) must be used.

**Children or family members should never be used to interpret. –** Sufficient time must be given for interpretation and flexibility should be offered in both the number and length of the antenatal appointment.

The key issues outlined below can constitute significant safeguarding risk factors to a baby/unborn baby and practitioners should act to ensure prompt and appropriate care, which ensures the safety of the baby (and any other children) and support for the family. This should often involve a multi-agency team.

- Alcohol or substance misuse (could be affecting the health of the unborn baby and may significantly impair parenting skills)-Inform the Maternity Safeguarding Team to discuss referral to the appropriate Substance Misuse Service
- Domestic Violence

- Serious mental health concerns
- Substance Misuse
- Current/Historical Involvement With Children's Social Care
- Identifying Alerting Features of Child Maltreatment in Community or Home Settings
- Women or Children Identified as Having FGM.
- Young maternal age.
- Learning disabilities
- Unaccompanied asylum seekers
- Potential Victims of Modern Day Slavery/ Trafficked Women
- A history of non-cooperation with agencies in families for whom there are concerns, especially where there is a new partner.
- Persistent non-attendees for ante-natal care.

**Roles and Responsibilities**

All maternity staff coming into contact with parents with any of the above concerns must act to ensure effective, appropriate and safe support for the family.

- Make a referral to Children's Social Care if there are immediate safeguarding concerns using the Interagency Referral Form which can be found on the Trust Intranet **Maternity Safeguarding/ P2/ Interagency Referral Form**.
- Make a referral to the in Caseload Teams at CW and WMH if the client is antenatal and resident within the Chelsea and Westminster NHS Foundation Trust catchment area. Please mark for the attention of the socially complex leads so the case can be appropriately allocated.
- Make a referral to the Poppy Team at CW and Caseload Team at WM if the woman lives outside of the catchment area.
- Inform the GP & Health visitor.
- Document any concerns, disclosures, plans and actions taken in the appropriate section of the maternal records
- Inform the Safeguarding Lead for maternity

### 8.2 Caring for Under 18s in Maternity

Staff must remain mindful that if the young mother is under the age of 18 herself, she is legally classed as a child. Generally, the younger in age, the greater the level of concern, however this will need to be considered in the context of each young woman's circumstances and age should not be used in isolation when assessing risk.

**Sexual intercourse below the age of 13 is classed as statutory rape/ sexual assault by Penetration, regardless of whether the young woman feels she consented or not.** If a young woman is under 13 at booking, referrals to Children's Social Care and the Police must be made as soon as possible. This should be sensitively discussed with the young woman and her family, UNLESS it is felt that this discussion might put her in any danger. The Safeguarding Leads (midwifery and nursing/ paediatrics) must be informed and will provide support with this process. Out of hours, the On-Call Paediatric Consultant should be contacted for advice, via the Trust Switchboard.

Where young women under the age of 16 at booking are receiving care, consideration should be given to the involvement of Paediatric services. This will be more likely, the younger the woman is.

**Paediatric involvement is required for any young woman under the age of 13 at booking. A Consultant Paediatrician should be informed and involved in care planning, including inpatient episodes**. In addition the Trust Named Nurse/ Doctor for Safeguarding must also be informed. For any inpatient episodes, the Senior Paediatric Nurse should also be made aware of the admission so that they can provide Paediatric nursing input and advice as needed.

**Process**

• The Chelsea and Westminster NHS FT Interagency referral form for Children's Social Care can be found on the Safeguarding Children and Young People page on the Intranet **Maternity Safeguarding/ P2/ Interagency Referral Form.** This form enables practitioners to clarify how the concerns could affect the safety and wellbeing of the baby, when born

• Record the decision to refer any concerns, plans and actions taken must be documented in the appropriate section of the hospital/case notes. At CW record in the Confidential Social Information (CSI) Log on Last Word/ safeguarding concerns section on Cerner and at WM the Safeguarding Birth Plan on the U drive. **Newton Clinical/ Midwifery/ Safeguarding Newton Clinical / Midwifery/Safeguarding WMUH Maternity/ Care Plans.**

Please be mindful of the information that is documented in the woman's hand held notes –especially in the case of domestic abuse where the perpetrator may have access to them. Instead please put an alert on the notes to alert practitioners to refer to hospital records.

• Send a copy of the referral to the Maternity Safeguarding team email

**8.3 Young Maternal Age**

While many young women who are pregnant are well supported and happy to be having a baby, staff must remain aware that young women under the age of 19 may also be vulnerable in their own right. Circumstances surrounding the pregnancy should be sensitively explored at booking, with vigilance for possible child sexual abuse or child sexual exploitation (CSE) maintained. For all young parents, practitioners should;

- Sensitively explore her social circumstances, including who is the father of the baby, the circumstances in which she has become pregnant, who she is currently living with, who her support network is and whether she has any current or previous social care involvement.
- Consider the need for sexual health services, including counselling and screening tests over and above routine maternity screening tests.

- Make a referral to Children's Social Care if there are any significant/immediate safeguarding concerns.
- Make a referral to the Caseload Team at CW if within CWFT catchment area and Poppy Team if out of area. At WM refer to YMAG Team if in or out of area.
- Inform the GP & Health visitor.
- Refer to the Family Nurse Practitioner (FNP) service in the local area. If the young woman declines or disengages from this service, liaison with a Health Visitor should take place instead.
- Inform the Safeguarding Lead for Maternity.
- Any concerns, plans and actions taken must be documented in the appropriate section of the hospital/case notes. At CW –the Confidential Social Information (CSI) Log on Last Word/ Cerner safeguarding record and at WM the Safeguarding Birth Plan on the U drive. **Newton Clinical/ Midwifery/ Safeguarding Newton Clinical / Midwifery/Safeguarding WMUH Maternity/ Care Plans.**

## 8.4 Multi-Agency Working within maternity

**Rationale, Roles and Responsibilities**

Midwifery input is essential when multi-agency care planning is required in the perinatal periods.

For cases within the CWFT catchment area, the Midwife most involved in the care of the woman will be expected to attend any internal or external multi-agency meetings concerning cases where risk factors have been identified. If necessary, the Midwife should inform a Midwifery Manager at the earliest opportunity to arrange cover for clinical duties.

For cases outside the CWFT catchment area the Midwife most involved in the care of the woman must produce a written report and ensure this has been handed over to the Safeguarding Leads who will try and attend the out of area meetings if the midwife is not able to do.

The Safeguarding Leads will be informed by the midwife of any invitations received to attend multi-agency care planning meetings.

If unable to attend any inter-agency meeting, the Midwife must submit a written report and arrange for a suitable colleague or the Maternity Safeguarding Leads to attend. This representative should be fully briefed so that she can contribute to the meeting in an informed manner.

If Midwifery attendance is not possible, the Safeguarding Lead for Maternity must be informed at the earliest opportunity. **A report must always be submitted and a copy sent to the Safeguarding Team via the Maternity Safeguarding Inboxes-email addresses as below.**

A Midwife attending any meeting should report any new information; decisions and plans to the relevant member of the Safeguarding Team.

Senior team members or a member of the Safeguarding Team should accompany new or inexperienced members of staff to such meetings to ensure support for Midwives and effective care planning.

The Midwife attending the meeting is responsible for the documentation of outcomes and plans in the hospital case notes/ Electronic Records. They must also send an update to the Safeguarding Leads following the meeting so they can add this information to their records.

**Copies of Child Protection Plans must be:**

Filed in the front of the hospital/case notes to both mothers and babies (when born)

And an electronic copy sent to the Specialist Midwife/Safeguarding Lead for Maternity for further dissemination and upload on to the Electronic Records.

**Please also ensure that in addition to any MDT planning for the baby a clear plan is also made for the mother who is also very likely to need support.**

### 8.5 Specific Forums That May Require a Maternity Representative

**Pre-Birth Strategy Meeting**

This is a forum convened and chaired by Children's Social Care, usually after a referral is made to them. The meeting will be a forum for information sharing and care planning. A decision to escalate a case to Case Conference may be made in light of information shared (LSCB, 2015).

**Child Protection Case Conference**

This is a formal meeting, chaired by Children's Social Care and attended by all agencies concerned with the welfare of the unborn/baby and family to share information and assess the level of risk. A decision will be made as to whether the unborn/baby (and any other children) should be made subject to a Child Protection Plan (formerly known as being on the Child Protection Register).

The Midwife attending will produce a balanced and factual report, covering any positive and negative information regarding concerns, the woman's engagement, needs, support and relevant health information regarding the woman and her unborn baby. It is good practice to share this information with the woman prior to the conference.

A template for report writing can be found on the Intranet Safeguarding Section.

A copy of the written case conference report must be forwarded to the Safeguarding Leads at the respective sites within AT LEAST 48 hrs. of normal office hours prior to the date of the conference using the emails **maternity.safeguardingwestmidd@nhs.net** for West Middlesex Cases and **maternity.safeguardingchelwest@nhs.net** for Chelsea and Westminster cases

Practitioners should notify the Safeguarding Leads of any CP Conferences, strategy or professional meetings they are requested to attend. They should ensure that they feedback to the Safeguarding Lead following the conference regarding the outcome. The Safeguarding Leads are available for support or supervision both pre and post conference if required.

**Core Group Meeting**

The 'Core Group', led by the Key Worker, will be identified at Case Conference and will include the parents of the unborn baby/child, and professionals involved with the unborn baby/child. The Core Group are responsible for the development and implementation of the Child Protection Plan

**Discharge Planning Meeting**

In most instances the pre-birth core group meetings or pre-birth planning meeting will have detailed the immediate post natal care plan and plans for discharge from hospital. The recorded plan will have been placed in the maternal hospital health records and on the Electronic Safeguarding Plan on the U Drive at WM and CSI Log/ Cerner safeguarding at CW.

A copy will be held by the Safeguarding Leads for Maternity.

In complex or unanticipated cases a multidisciplinary discharge planning meeting will be required. This is a meeting chaired by Children's Social Care, after the birth of a baby and prior to discharge. This meeting should ensure all appropriate plans are in place to maintain the safety of the baby following discharge from hospital care. The midwife most involved in the postnatal care of the mother and baby will be expected to attend and this Midwife is responsible for informing the Community Midwives, Health Visitor and GP in writing (if not present at the meeting) of the discharge plans. This should be done by completing the Postnatal Safeguarding Discharge Summary Form.

**8.6 Postnatal Care of Babies on a Child Protection Plan**

Where a Pre-Birth Case Conference has been held and the decision made to place the baby on a Child Protection Plan, staff must ensure they follow the necessary parts of the plan to ensure the safety of the baby when they are born and to effectively support the mother.

An unborn baby has no legal status, so although an unborn baby may be the subject of a Child Protection Plan, no legal orders can be applied for until the baby is born. A legal order will not always be necessary, but in cases where Children's Social Care are going to apply for an order, Children's Social Care must be informed promptly of the baby's birth.

When a baby on a Child Protection Plan is born, staff must act promptly to ensure that plans are carried out effectively. Copies of plans should have been placed by the midwife caring for the mother antenatally in the front of the hospital case notes/and a copy in the Electronic Records. Plans will be individual for each baby, but may well include points such as:

Informing the allocated or duty Social Worker of maternal presentation in labour and of the baby's birth. Telephone numbers will be given in the plan.

Whether there are any restrictions on visitors over and above maternal wishes/normal visiting policies.

Whether separation of mother and baby is necessary (if not voluntary by the mother, this will require a legal order to be obtained by Children's Social Care).

**Whether supervision of mother and baby is necessary.**

Whether there are any restrictions on the mother and baby leaving hospital. (It is not possible to physically prevent a mother and baby leaving hospital unless there is a legal order in place. It may be necessary to contact the Police on 999 to use their powers of protection if a mother (or any family member/friend) does

attempt to leave with her baby. This should be stated in the Child Protection Plan and if necessary can be advised by a Social Worker).

Whether there are any contra-indications to breastfeeding.

Consideration may also need to be given to observing a baby for signs of drug withdrawal. This may be due to maternal substance misuse, or to prescribed medications e.g. anti-depressants. Plans for observation and infant feeding should be developed in conjunction with the Neonatal Team and with support from the Medicines Information Department as needed. Social care and the Safeguarding Team should be updated on a regular basis.

**Babies On A Child Protection Plan Remaining With Their Mother In Hospital**

Where a baby remains with his/her mother (as will usually be the case), consideration must be given to the potential risks to the baby. Liaison with the Social Worker should include assessing the needs of the mother in relation to support and supervision. **If it is agreed that a mother would need constant supervision and/or is at risk of absconding from the ward with her baby, Children's Social Care should be requested to provide a dedicated member of staff to support and supervise the mother until fit for discharge. If this is not possible, it must be made clear to the Social Worker that constant supervision, over and above normal medical and midwifery care cannot be guaranteed in hospital.** It is important that Senior Midwives, and, if necessary Midwifery Managers and the Safeguarding Team are involved if there is any risk to the baby.

**Babies Separated From Their Mother for Safeguarding Reasons**

If a baby needs to be separated from his/her mother for safeguarding reasons dedicated care must be given by hospital staff to ensure the baby's safety and that all their needs are being met until the baby can be discharged. Contact with the parent(s) should be facilitated in agreement with the Social Worker. Please note that unless the mother has agreed for the separation under a Section 20 agreement- if a mother and baby are to be separated post birth a legal order from social care or police protection has to be in place.

**Babies Separated From Their Mothers for Non-Safeguarding Reasons**

A baby may need to be separated from his/her mother for non-safeguarding reasons, for example where a mother is transferred to ITU for medical care.

Babies must have dedicated care from hospital staff to ensure their safety and that all their needs are met. Family members should be supported to care for and bond with the baby, but should not be expected to provide full, unassisted care.

If it is unlikely that a mother and baby would be reunited within 48 hours, discharge arrangements should be explored with the next-of-kin/father of the baby.

If the mother is unable to give consent for the baby to be discharged, and the father does not hold parental responsibility the Safeguarding Team must be informed.

## Discharge of a Baby on a Child Protection Plan or social care involvement

All baby's born subject to a CPP will remain in hospital until a Discharge Planning Meeting has been convened.

The attending Social worker will chair the meeting, and the midwife caring for the woman on the post-natal ward will attend to ensure information is shared and an action plan is formulated for discharge. The safeguarding team must be informed of the discharge who will then in addition also inform the safeguarding midwife in the area the mother and baby are being discharged to.

The Postnatal Safeguarding discharge summary sheet should be completed by the ward staff and sent to Community midwives, GP and H/V. **Please note the safeguarding summary should not be sent home with the mother. Please also ensure that a verbal message is also left for the community midwives of the hospital where the mother and baby are being discharged out to. If it is not possible to speak to the community midwives then the labour ward of the hospital being discharged to should be informed and a name obtained of the midwife who the information was handed to.**

Preparations should be made to discharge mother and baby as soon as they are fit. Staff must ensure on going respectful support for mother and baby, taking into account any additional needs in supporting the mother to feed and care for her baby.

It is not appropriate to keep a healthy mother and baby in hospital any longer than the time required for necessary medical or midwifery care.

If a longer stay is requested by Children's Social Care for social reasons, this should only be agreed by a Senior Midwife and Midwifery Manager, with involvement from the Safeguarding Team as appropriate. Consideration as to the source of funding such use of a hospital bed should be given. Wherever possible this should be avoided by robust planning in the antenatal period based on the likely length of stay in hospital for clinical needs. **A Birth Plan should be in place by 32 weeks gestation. This should be written in conjunction with the social worker and the midwife caring for the mother with the Safeguarding Team for support and oversight.**

The Community Midwives, Health Visitor(s) and GP must be informed immediately in writing (and by telephone if appropriate) of the discharge arrangements. Copies of this correspondence must be filed in the hospital case notes.

Confidentiality and sensitivity must be implemented with regard to the written discharge information a woman takes with her. For example, the mother should NOT be given address/contact details of a foster placement. Foster carers do not need details of maternal medical and obstetric history etc.

**There should NEVER be any information regarding Domestic Violence in any discharge information the woman takes with her.**

## Principles When a Baby is discharged to Foster Care

The allocated Social Worker **MUST** be present for the discharge.

A clear discharge plan must be placed in both the Mothers and Baby records.

Please ensure that there is a clear plan of care for the baby and the mother. Mothers who have had their babies removed from their care are often very vulnerable and it is important that there is a plan of handover and necessary follow up by the relevant professionals

A copy of any relevant care order, or the signed agreement in case of mother giving voluntary consent, **must** be placed in the baby's records.

The identity and contact details of the foster carer must be confirmed and documented in the baby's records.

The discharge address and arrangements, including Social Worker's contact details must be given to the local Community Midwives and Health Visitors.

**Security**

In cases where a risk is posed to the new-born of abduction or of violence towards the staff from either the mother, partner or family member a security meeting **must be** held in the antenatal period involving the managers, Safeguarding Team, social care and members of the security team. If necessary obtain police advice re planning with a police reference number on the Birth Plan

## 8.7 Identification of Alerting Features of Child Maltreatment in Community Settings

### Rationale

Maternity Staff constantly come into contact with babies and children, in a wide variety of settings including homes and community settings such as Children's Centres. Staff should remain alert not only to risk factors for child maltreatment, but also to signs of actual child maltreatment, in both the babies they are caring for and any other children, for example the siblings of the baby.

### Roles and Responsibilities

Appendix B contains a list from the guidance commissioned by the National Institute for Clinical Excellence (NICE) this guidance relates to identifying alerting features of child maltreatment. This list is non-exhaustive and a practitioner identifying ANY features that alert them to the possibility of child maltreatment must act immediately to ensure safety and appropriate medical review of that child.

- In community settings, the aim will be to achieve assessment of the child by a paediatrician, preferably with the co-operation of the parents. This will normally be via referral to the family's local A&E department.
- The practitioner should immediately inform the department to which she/he has referred of the concerns and reason for referral.
- If the parents are not co-operative, the practitioner should leave the premises for her/his personal safety then either seek advice from the Safeguarding Team, and/or, in serious cases, call the Police on 999.

- A referral to Children's Social Care should be made as appropriate.
- The Health Visitor should be informed.
- The GP should be informed.
- The Safeguarding Team should be informed.
- Any concerns, plans and actions taken must be documented in the appropriate section of the hospital case notes/ Electronic Records.

**Liaison with Other Professionals**

**GP**

The GP is a key person in the ongoing care of both mother and baby/ child and will often hold key information about a woman and family It is essential that GPs are kept fully informed of concerns, risk factors and plans throughout the antenatal and immediate postnatal period.

**Process**

A letter can be written at any point with information and updates.

Copies should be filed in the Correspondence section of the hospital notes/ note made in Electronic records.

Any telephone correspondence should also be documented in the hospital/case notes and on Electronic Records as appropriate.

**Health Visitor**

The Health Visitor is a key person in providing on-going care for a baby when they are born. It is essential that Health Visitors are kept fully aware of concerns, risk factors and plans throughout the antenatal and immediate postnatal period. For young women under 19, they may have a Family Nurse Practitioner (FNP) instead of a Health Visitor, however engagement with FNP is voluntary and if the woman declines or disengages, the H/V **must** be informed so that normal liaison with the Health Visitor would continue.

**Other Referrals**

Other referrals may include the Safeguarding Team, Caseload/ Team Midwives, Socially Complex Lead Midwives, Specialist Midwives and Specialist Clinics/Doctors.

Contact details for the Safeguarding Team are kept updated on the Intranet.

Otherwise local/departmental referral procedures will apply. Any referral should be recorded appropriately in the hospital case notes/Electronic Records. Confirmation of receipt of referral should also be recorded. Within maternity staff MUST remember to ensure they liaise with the allocated Consultant Obstetrician for any women with safeguarding concerns to ensure they are involved in care planning.

### 9.0. Children who Do Not Attend / Not Brought to Outpatient Appointments:

Non-attendance at appointments may be an alerting feature of neglect. In extreme situations, where children have died or suffered serious injury because of abuse or neglect, poor uptake is a feature in a third of cases.

Consultants, Specialist nurses and therapists who run their own clinics are responsible for reviewing the medical record of all children who fail to attend a hospital outpatient appointment, either clinic or ward-based appointment. This review should include:

- Previous history of concerns about child maltreatment.
- Parental factors such as domestic abuse, drug misuse and parental mental health problems.

When review of the notes identifies previous safeguarding concerns then staff should follow the 'Management of Child Safeguarding Concerns' flowchart

**For all children and young people who are not brought to appointment or do not attend appointments, the following process must apply.**

All children that fail to attend their appointment, the Consultant will review the medical records and establish whether the child is known to children's social services and proceed to step 1 and or step 2.

**Step 1: All children and young people who do not attend / are not brought to an appointment.**

- Consultant / Specialist Nurse / Other Practitioner led clinic staff review notes of all "DNA's" at the end of clinic/ward session and determine whether a further appointment is to be offered.
- Ensure the Named Consultant for the child is aware of the action taken.
- A letter of non-attendance is sent to the GP.
- A copy of the GP letter is sent to the parents.

(DNA letter to be sent see **Appendix F** for Template)

**Step 2: All children and young people who do not attend / are not brought to an appointment and have known Safeguarding concerns or are subject to a Child Protection Plan.**

The family should be phoned immediately after clinic or the next working day by the consultant/registrar to ascertain:

- That they received an appointment.
- If so, why they did not attend, and a further appointment must be given.
- This discussion with a clear plan must be recorded in the medical notes.
- The family should be discussed with the GP and/or Health Visitor/School Nurse and Social Worker (if applicable). (complete an external service referral)
- If the family are not known to social services, follow flowchart if necessary.
- For **all** DNA's of a child or young person with safeguarding concerns the Named Nurse for Child Protection must be notified.

## 10.0 . DOCUMENTATION OF INFORMATION

All safeguarding concerns must be documented both clearly and concisely in the appropriate section of the hospital notes/ electronic records. At Chelsea & Westminster Hospital information is recorded on the CSI log in Lastword/ in the safeguarding section of Cerner, at West Middlesex document in the patient record. For maternity at West Middlesex safeguarding plans are placed on the safeguarding drive (U drive).

In maternity a 'please refer to hospital notes' instruction should be recorded in the handheld notes. Hospital notes should always be accessed whenever the woman attends hospital along with any electronic records.

Contacts for any Multi Agency Team members, a clear summary of concerns & action plans should be recorded on a safeguarding care plan in the notes.
The safeguarding leads will add any additional background information & any plans onto the electronic records.
Following birth if there are safeguarding concerns midwives must document this on both the infants written & electronic records, & ensure mothers information is added to the notes.

On any occasion that a child is seen in the Trust, the following information should be recorded and checked to see if previous details are still correct:

- The name of the child/young person.
- Address
- CPIS (child protection information system)
- Whether the child/young person is subject to a child protection plan
- GP.
- Health visitor (for children under 5yrs).
- School (for children over 5yrs).
- Social worker (if applicable).
- The adult accompanying the child.

The adult's relationship to the child and if they have parental responsibility. If it is a private fostering arrangement Children's Social Care in the borough the child is resident should be informed (see **Appendix J** for more detail).

**Safeguarding Alerts and Child Protection Information System(CPIS)**

The CP-IS service will deliver the capability to share key information as to whether a child/unborn child is subject to a Child Protection Plan (CPP), or is a Looked after Child (LAC).

When records are updated locally by Children's Social Care teams, those updates will trigger the automatic upload of the CP-IS service within 24hrs, providing NHS healthcare workers with appropriate permission, access to the latest Child protection / Looked After Children status for a child. The information provided by the Children's Social Care team, will either provide new information for a child/unborn child or update any existing CPP/ LAC information already held within CP-IS, by replacing what was previously recorded.

When the information held within CP-IS is accessed, the system will send an alert to the allocated Local Authority who will be able to see where children, young people or pregnant mothers have attended for unscheduled care. Health professionals will be able to see information regarding social care plans and contact details for the local authority social worker in addition to a list of other unscheduled care settings that have been attended.

CP-IS QRG.docx

Documentation for all children is expected to contain the following:

- Presenting complaint and history of presenting complaint. Simple social history of child i.e. genogram or information regarding family household. It must also be documented if the child has a social worker or not.
- Findings on examination.

- Outcome of consultation and documentation of any or no child protection means.

Recognition of the abused or neglected child depends on numerous factors and is rarely based on an isolated finding e.g. you should evaluate patterns of presentation (check previous attendances, CSI logs, recurrent attendances, the presence of inconsistencies in the history etc.)

Adequate history taking is crucial e.g. with regards to injuries - the exact mechanism of injury, the timings of events and the action the parents took in response to the injuries are vital pieces of information. Suspicion may arise if the history does not match the pattern of injury, e.g. a fractured limb in a non-mobile child, or there are unexplained injuries or delay in presentation.

## 11.0. SAFE DISCHARGE OF CHILDREN AND YOUNG PEOPLE

Where there is a safeguarding concern there must be a clear agreed multi-agency action plan recorded in the child's notes before the child is discharged.

- When there are concerns about child maltreatment the consultant responsible for the child's care must agree to the discharge and discharge plan and this should be clearly documented in the medical records.

- If any child/young person does not have a General Practitioner (GP) the Liaison Health Visitor or Named Nurse for Safeguarding should be contacted to help identify an appropriate and details on how to register at a GP given to the parents.

  Locum junior doctors do not have the authority to discharge children with safeguarding concerns or safeguarding flags without clearly documented discussion with the consultant involved in that case.
- Social care must be informed prior to discharge of all children with safeguarding concerns.

- In complex cases a discharge planning meeting should be considered to ensure the child/young person has an appropriate multiagency plan for discharge. All professionals within the child's network should be invited to attend.

## 12.0 VISITORS NOT KNOWN TO FAMILIES (TO INCLUDE VIP& CELEBRITIES)

All those visiting children's wards or departments will be supervised at all times by a member of Chelsea and Westminster Hospital NHS Foundation Trust staff. Where there is more than one visitor, they will be kept together in a group with a dedicated member of staff i.e. no individual can visit patients unaccompanied unless known to the patient and their family.
Please refer to the Chaperone and Intimate care guideline for further information.

## 13.0. PROCESS TO FOLLOW THE DEATH OF A CHILD/ Young Person up to the age of 18 years

The child death review processes are a statutory requirement from April 1st 2008 as part of the Children Act 2004 (section11) All NHS Staff must comply as part of their duty to safeguard children and protect their welfare. Government legislation requires every Local Children's Services Authority to review the circumstances of all expected and unexpected child deaths (**up to the age of 18years**). To do this the Local Child Death Overview Panel (CDOP) Single Point of Contact (SPOC) must be notified of all child deaths in the Trust within 24 hours of the child's death as per trust protocol.

Please refer to the **'Child Death Guideline'** for further information.

## 14.0. CHILD PROTECTION MEDICAL ASSESSMENTS

The majority of requests for child protection medical assessments on the Chelsea and Westminster site come via Community Paediatrics and the Social Paediatric Co-ordinator.

However, children may be referred acutely or attend the paediatric emergency department where they might be found to have signs suggestive of non-accidental injury or may be undertaken on the paediatric wards and the Burns Unit. The same process and documentation must be followed.

Please see the separate guidelines entitled (please refer to **Appendix N** 'Guideline for Child Protection (CP) medical assessments A copy of any Child Protection Medical report (**appendix O**) must be sent to the Social Paediatrics Co-ordinator in community paediatrics (please see Flowchart **Appendix P**).

The doctor will complete the report, this is then sent to the child's social worker and a copy filed in the medical notes.

## 15.0. MONITORING OF CHILD/ YOUNG PERSON SAFEGUARDING PRACTICE

The LSCBs are responsible for monitoring compliance to the standards set out in this document. The safeguarding team are responsible for submitting an annual report to the Trust Board on a yearly basis. This report will include a review of national and local child safeguarding arrangements and an analysis of how well the hospital safeguards children and young people. A programme of continuous audits has been developed within the trust to identify areas where the service can be improved.

## 16.0. SAFEGUARDING HEALTH OUTCOMES (SHOF)

CCG's are required to monitor the performance and safeguarding arrangements of acute sector NHS providers. Chelsea and Westminster Hospital Foundation Trust is required to submit performance indicators such as training figures on a quarterly basis to the designated professionals and children's board to provide assurance regarding the safeguarding activity and arrangements that are in place as in line with Working Together to Safeguard Children (HM 2018). This is a joint document with adult safeguarding

The aim of this data collection is to monitor trends around safeguarding activity and to use this information to make future recommendations for safeguarding children within our organisation.

## 17.0. E-SAFETY

E-safety covers issues relating to children and young people and their safe use of the internet, mobile phones and other electronic communications technologies. Additionally, the acceptable use of electronic communications technologies guidelines for the Trust employees' safeguards children and young people receiving care and treatment in the Trust.

E-safety includes education for staff on risks and responsibilities and is part of the 'duty of care' which applies to everyone working with children. Promotional materials regarding on-line safety are available in appropriate areas of the Trust and awareness training for staff is provided within the safeguarding training programme. Staff who has concerns regarding safeguarding risk by inappropriate use of electronic communications technologies must escalate concerns using the management of 'child safeguarding concerns' flowchart

Policies that relate directly to e-safety are:

- Acceptable use policy
- Social networking policy

## 18. REFERENCES


- The Children Act 2004
- The London Child Protection Procedures, 5th Edition 2017
- The National Institute for Clinical Excellence 'When to Suspect Child Maltreatment' July 2012
- Safeguarding Children and Young People – Roles and Competencies for NHS Staff
- Intercollegiate Document 2006, 2015, 2019
- Working Together to Safeguard Children - 2018
- The Children Act, Department for Children, Schools and Families 1989
- Emergency Department Community Notification Guidelines: Paediatric Referral Criteria and Community Liaison within the Adult Emergency Department
- Eliminating female genital mutilation: An interagency statement (WHO, 2008)
- Female Genital Mutilation Resource Pack LSCB 2009
- The London CSE Operating Protocol, 2017

**Appendix A**

****PLEASE NOTE THE SAFEGUARDING TEAM IS SITE SPECIFIC with telephone cover provided cross site****

## Safeguarding Team

**Chelsea & Westminster**

**Named Nurse**
extn GRO-C
Bleep GRO-C
Mobile GRO-C

**Safeguarding Midwife**
X GRO-C
GRO-C

**Named Midwife (cross site)**
GRO-C

**Liaison Health Visitor**
ext GRO-C
Bleep GRO-C

**Paediatric registrar bleep** GRO-C

**Named Doctor**
Via Switchboard

**Health Link Team** (Hospital Children's Social Care Team)
**0207 361 4030**
**0207 373 2227 out of hours**

**West Middlesex**

**Named Nurse**
X GRO-C
Mobile GRO-C

**Safeguarding Midwife**
x GRO-C
GRO-C

**Named Midwife (cross site)**
GRO-C

**Liaison Health Visitor**
GRO-C

**Paediatric registrar bleep** GRO-C

**Named Doctor**
Via Switchboard

**Children's Social Care Team:**
**Mon – Fri 9.00am to 5.00pm**
**0208 583 3200/6600**

**Out of Hours : 0208 583 2222**

## Referral to Children's Social Care

**Chelsea & Westminster**

- **RBKC see above**
- **Hammersmith & Fulham:** 020 8753 6600 Out of hours: 020 8748 8588
- **Westminster:** 020 7641 4000 Out of hours: 020 7641 4000/6000
- **Wandsworth**: 020 8871 6622 Out of hours: 020 8871 6000

**West Middlesex**

- **Emergency Duty Team (out of hours)**:- 0208 5832222
- **Early Help Hounslow (MASH)**:- 0208 583 6600
- **Richmond Children's Social Care**: - 0208 891 7963
- **Ealing Children's Social Care:** - 0208 825 8000

## APPENDIX B – CLINICAL ALERTS OF MALTREATMENT

**For further information refer to the nice guidelines quick reference guide – available in wards and departments or download from www.nice.org.uk/CG89**

| | |
|---|---|
| | **Physical features** |
| | Abrasions, bites (human), bruises, burns, cold injuries, cuts, eye injuries, fractures, hypothermia, intra-abdominal injuries, intracranial injuries, intrathoracic injuries, ligature marks, oral injuries, petechiae, retinal haemorrhage, scars, spinal injuries, strangulation, subdural haemorrhage, teeth marks. |
| | **Sexual abuse** |
| | Anal symptoms and signs, anogenital injuries, dysuria, foreign bodies, genital symptoms and signs, pregnancy, sexual exploitation, sexualised behaviour (also see Emotional behaviour, interpersonal and social functioning), sexually transmitted infections (STIs) vaginal discharge. |
| | **Neglect** |
| | Abandonment, bite marks (animal), clothing, dirty child, failure to thrive, faltering growth, footwear, head lice, health promotion, health reviews, home conditions, immunisation, lack of provision, lack of supervision, medication adherence, parental interaction with medical services, persistent infestations, poor hygiene, scabies, screening, smelly child, sunburn, tooth decay. |
| | **Emotional, behavioural, interpersonal and social functioning** |
| | Age-inappropriate behaviour, aggression, body rocking, change in emotional or behavioural state, cutting, dissociation drug taking, eating and feeding behaviour, encopresis, fearful, runaway behaviour, self-esteem, self-harm, sexual behaviour, smearing (faeces), wetting. |
| | **Clinical presentations** |
| | Apparent life-threatening event, attendance at medical services (see also Neglect), hypernatraemia, ingestion (see also Neglect), nasal bleeding, near drowning, poisoning, poor school attendance. |
| | **Fabricated or induced illness** |
| | Child's history, physical or psychological presentation, or findings of assessments, examinations or investigations leads to a discrepancy with a recognised clinical picture. Plus, one or more of the following; even if the child has a past or concurrent physical or psychological condition:<br>• reported symptoms and signs are only observed by, or appear in the presence of, the parent or carer<br>• an inexplicably poor response to prescribed medication or other treatment<br>• new symptoms are reported as soon as previous symptoms stop<br>• biologically unlikely history of events<br>• despite a definitive clinical opinion being reached, multiple opinions from both primary and secondary care are sought and disputed by the parent or carer and the child continues to be presented for investigation and treatment with a range of signs and symptoms<br>• child's normal daily activities (for example, school attendance) are limited, or they are using aids to daily living (for example, wheelchairs) more than expected from any medical condition that the child has. |
| | **Parent – or carer – child interactions** |
| | Domestic abuse (exposure to), emotional unavailability and unresponsiveness, expectations (age inappropriate), hostility, isolation, marital disputes (using child), rejection, scapegoating, socialisation (inappropriate), wetting (response to). |

## APPPENDIX C

### Referrals and reports

There are two types of reports that we supply to Social Services:

- Interagency Referral
- Child Protection Medical Report.

### Interagency Referral

These are the referrals which we submit to social services when we have concerns about a child/parent. The referral forms are found on the intranet. Please ask the safeguarding team for any assistance required.

### Child Protection Medical Reports

A written referral must be sent to social care on all presenting cases that require a CP medical. (This is important to prevent delay in actions being undertaken whilst the CP medical is being created).

Please refer to **Appendix P** for guidance on generating reports.

Dictations should be made and sent to the Social Paediatric Officer for typing.

When assessing children in whom you think there have been child protection concerns in relation to either physical or sexual abuse use the form on the intranet called or accessible through safeguarding icon. "Record of a medical assessment for a child who may have suffered physical/sexual abuse" This form is **not** the Child Protection Medical Report form but rather a guide to prompt and ensure adequate information gathering during the consultation.

This then needs to be typed up into the report also on intranet entitled "Child Protection Medical Report". You can either type it yourself or dictate it and ask the on-call consultants' secretary to type it for you. This needs to be done within 48 hours of attendance and signed by the attending consultant before being sent to social services.

Examining doctors should be prepared to attend Child Protection Conferences and court as required.

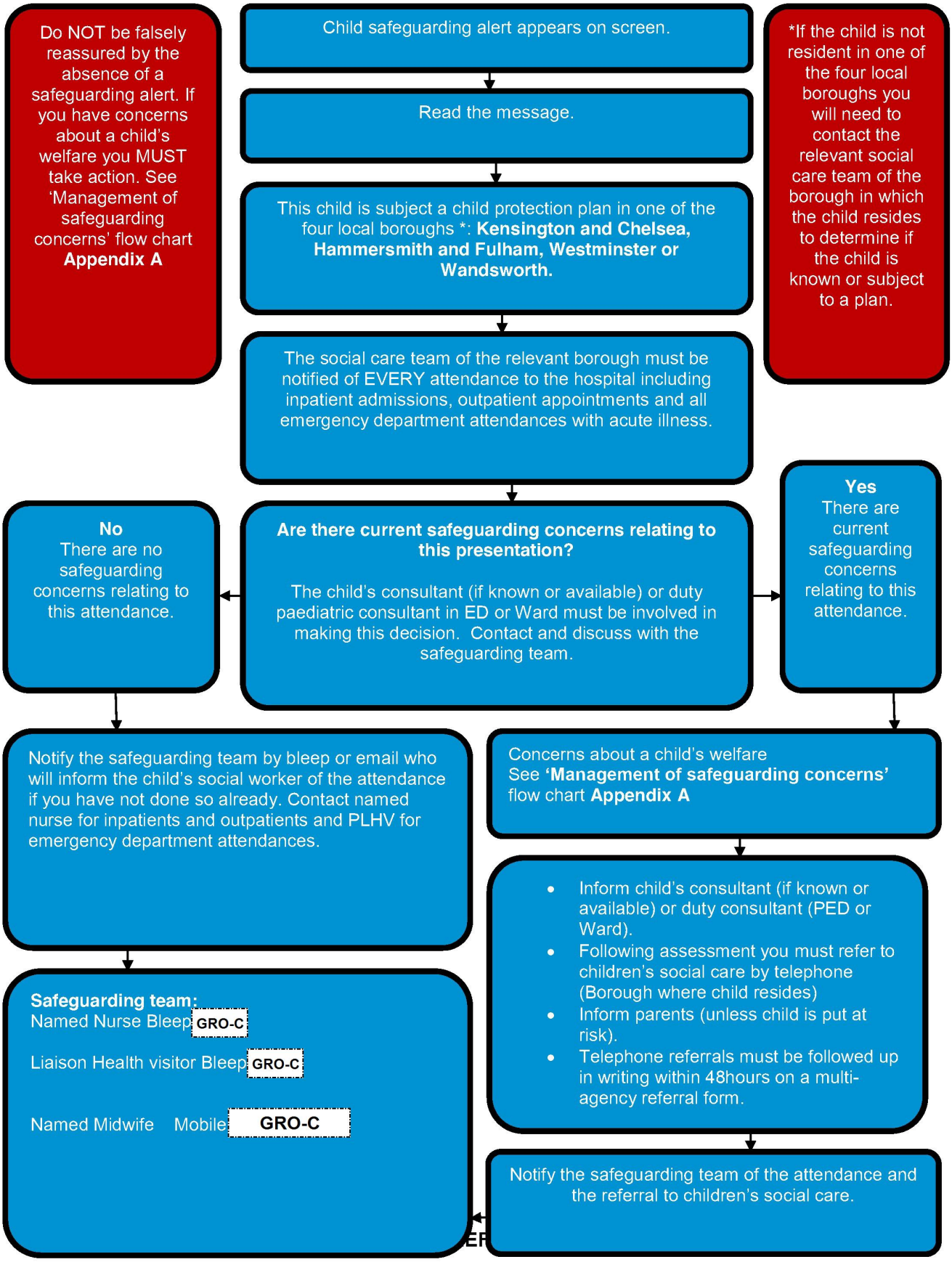
It has been agreed that the following children receive higher priority;

- Young age (especially under age of 2 years)
- Severity of injury
- Other vulnerabilities (such as disability)
- Disputed cause of injury
- Adolescents will be decided on an individual case basis

The following children receive a lower priority and a medical may be declined:

- Historical allegations / Siblings of cases being presented "just to check"
- Sibling on sibling abuse

## APPENDIX D – WHAT TO DO IF YOU SEE A SAFEGUARDING FLAG



**Appendix E**

West Middlesex University Hospital

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

## Children who spend more than 3 months in hospital

| | | |
|---|---|---|
| **Name of child** | **Date of Birth** **Gender M / F**<br><br>**Hospital No.** **Ward** | |
| **Home Address** | **Telephone:**<br>**Landline**<br><br>**Mobile** | |
| **Parental responsibility** | **Address (if different from home)** | |
| **Narne & address of GP** | **Health Visitor/Clinic/**<br><br>**School** | |
| **Children's Social Care address*** | | |
| **Date of Admission** | **Projected Date of discharge** | |
| **Reason for admission and diagnosis** | **Summary of treatment** | |
| **Services received in hospital (e.g. school and play facilities)** | **Services possibly required on discharge** | |
| **Child's adaptation to hospital life (include child's views)** | | |
| **Parents: visits, involvement in care, support** | | |
| **Name of doctor** | **Signature** | **Date** |
| **Name of nurse** | **Signature** | **Date** |

*Please send this form to Children's Social Care in the Local Authority in which the child resides, a copy in the child's records, and a copy to the Named Nurse for Child Protection*

## APPENDIX F – LETTER TO GP

West Middlesex University Hospital

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Date:

Dear Doctor:

Notification of non-attendance at outpatient appointment in Children and Young People's Services

Hospital No: NHS Number:

Name: Date of Birth:

Address:

Date of Appointment: Consultant:

I am writing to inform you that your patient did not attend their booked outpatient appointment as above, and the hospital was not contacted to either cancel or rearrange.

We are discharging the patient back to your care but please send another referral if still necessary and a further appointment can be scheduled.

Please consider that there may be extenuating circumstances that have led to the non- attendance. If you have any safeguarding concerns, please follow your local procedures.

Yours sincerely

Consultant

Cc Parents

## APPENDIX G – ADULT EMERGENCY DEPARTMENT

### Introduction

### Process of identifying potential cases needing referrals:

**Parents (of children <16yrs) or Pregnant females**

- Mental Health Issues
- FGM – See FGM Guidance
- Overdose
- Deliberate self-harm
- Substance abuse or alcohol misuse
- Victims of Domestic Abuse
- Frequent concerning presentation in parental behaviour

**16th to 18th Birthday**

- Sexual Assault
- FGM – See FGM Guidance
- Death including death of a close family member - mother/father as they may require additional support.
- Remember 16 – 18 year olds are children, any death must follow the child death process
- Overdose
- Deliberate self-harm or any other mental health presentations
- Substance abuse and alcohol misuse
- Victims of Domestic Abuse
- Suspicious injuries
- Repeat presentation
- signs of child sexual exploitation
- signs of child criminal exploitation

### Things to think about

- Why this happened
- Who is at home with the children and are they safe? (i.e. Victim of abuse may present in the hospital and the perpetrator of the abuse is the carer at home with the children)
- What impact does the situation have on them?
- Other support available to them (GP/Family/Social Worker/CAMHS/Health Visitor and School Nurse)

### Social service referrals

If it is felt that a social services referral is required please remember to discuss this with the Consultant and contact the relevant social services while the patient is still in the department by telephone and then to follow up the referral in writing.

Informing parents of referrals to social services: the best practice is to inform the parents, however there are some circumstances where this may be unwise and put the child in more danger. Both the NMC and the GMC will protect staff who share information with third parties (i.e. police and social services) in order to protect a child without consent of the parents (see London Safeguarding Children Child Protection Procedures section 3.6).

The trust has one standard referral form that can be found on the trust intranet under children's safeguarding. The details for all the London base social care teams can also be found on the intranet under children's safeguarding. If the borough you are looking for is not on the list contact the safeguarding team who can assist you, alternatively search for the borough online and contact them directly.
If there is no known address for the patient or person of concern, please refer to the Health link social services team in RBKC and complete the referral form for this team (available in the SG box and on the intranet).If the child/ young person does not have an address or the address is unknown then the referral should go to the place in which the child was found at Chelsea and Westminster this would be RBKC and Westmid Hounslow.

All referrals should be sent to the safeguarding team via email for the Liaison Health Visitor to follow up. The Liaison Health Visitor **MUST** be informed of all referrals made to Children's social services. This is to ensure appropriate follow up and so that the referral can be logged on the database.

## APPENDIX H

## Independent Domestic Abuse Advocate (IDVA) Referral

Domestic Abuse is any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. This includes:

- Gay
- Lesbian
- Bisexual
- Transgender
- Honour based violence
- FGM
- Forced marriage
- Sexual
- Financial

Domestic abuse is a frequent and serious crime:

25% of Lesbian, bisexual, transgender and woman experience domestic violence in their lifetime this is less compared with 33% of gay men. 16% of men will also experience domestic violence.

- 25% of reported violence crime is domestic
- 2 women are killed through domestic abuse each week
- On average there will be 35 assaults before a women first calls the police
- 1 in 3 women who attempt suicide do so because of domestic violence
- Transgender victims do not access help until after the 20th high incident of abuse

When there is a disclosure of Domestic Abuse as well as a referral to Social services the victim may want to receive the support of the IDVA. The IDVA cannot contact the victim unless the victim has agreed to the referral.

Referral forms are on the intranet under safeguarding and domestic violence.

**Chelsea and Westminster IDVA**
Telephone: 07583 172 928
Email: IDVA@chelwest.nhs.uk

**West Middlesex University Hospital IDVA**
Telephone 07909 932 953
Email: IDVA@nhs.net
Out of Hours: National Domestic Violence Helpline 0808 2000 247

## APPENDIX I – PRACTICAL GUIDE TO MANAGING YOUNG PEOPLE ATTENDING SEXUAL HEALTH SERVICES

This practical guide should be used alongside the Trust Safeguarding Children & Young People's policy. Although the Children's Act 2004 defines a child as anyone aged under 18, in practice adolescent sexual health services at C&W see many patients aged 18 and 19 who are equally vulnerable and their needs need to be carefully considered in a similar way.

In England and Wales it is an offence for anyone to intentionally engage in sexual touching, including sexual intercourse, with someone under the age of 16. This applies to individuals who identify themselves as heterosexual, homosexual, bisexual or transgender.

By Law, a young person under the age of 13 cannot consent to have sexual intercourse. Any sexual activity with an under 13-year-old, according to the Law, is considered to be rape. A significant number of young people under the age of 16 are already sexually active, and increasingly we are beginning to see 12 year olds who are sexually active with their class peers. The Law does not aim to prosecute young people who engage in mutually consenting sexual activity, but aims to help staff identify and protect those young people who are at risk of, or are being sexually exploited.

Each sexual health clinic in HIV/GUM directorate has nominated Young People's (YP) safeguarding leads that are available to support staff in the management of complex cases and challenging decisions. Any safeguarding concerns pertaining to a young person, must be accurately documented in the Confidential Social Information (CSI) log, and must be discussed with your local YP lead and/or the Trust Child Protection team. All three sexual health clinics have access to health advisor teams who are ideally placed to further explore concerns about a young person in greater detail.

All clinical areas should have a copy of the flowchart (Management of Child Safeguarding concerns -from the Trust Safeguarding Children & Young People's policy) clearly displayed for staff, together with an up to date Trust Child Protection Consultant on-call rota. All clinical staff within sexual health must have completed their Level 3 Trust Child Protection training and ensure it remains up to date every 3 years.

### Confidentiality

Staff must read the Trust Data Protection and Confidentiality policy in conjunction with this guidance. The duty of confidentiality owed to a person aged under 18 (and including those under 13) is that same as that owed to adults. However, this duty is not absolute. If a situation arises, where a staff member believes that the health, safety or welfare of a young person or others is at risk, the young person should be counselled to try and gain permission to share and pass on information. If the young person does not agree to disclosure, the decision to disclose will depend on the degree of current or potential harm. A degree of trust allowing this to occur may need to be built up over several visits to the clinic. Please discuss these cases with a YP lead in your clinic. Wherever possible, the young person should be informed that the disclosure will occur, with the clinician taking into account the need to provide the patient with a confidential sexual health service whilst protecting them or others from harm, abuse, or exploitation.

### Can we see under 13's in the GUM clinic?

Increasingly we are beginning to see young people aged 12 in our sexual health services. If an under 13-year-old is having sex, even if consensual, this should always be a cause for concern. Sexual activity at a very young age is a strong indicator that there are risks to the welfare of the child.

These patients must also be discussed with the Trust Child Protection team, as the young person would need to be referred to children's services (if not already known). It is usual to find that 12 year olds who attend our services do so in the company of a parent/carer/older sibling/keyworker and their details must be recorded in the notes. However, no actual assessment of the young person should take place unless they are seen with an adult that has parental responsibility for them.

## Can we see under 16's in the GUM clinic?

All young people under the age of 16 needs to be assessed for Fraser competence: this must be documented in the notes. The Fraser guidelines are:

- The patient, although under the age of 16, understands t eh healthcare worker's advice
- S/he cannot be persuaded to inform parents of responsible adult and will not allow the healthcare worker to inform them
- S/he is very likely to begin or to continue having sexual intercourse with or without contraceptive treatment (+/- STI screen)
- Her/his physical and/or mental health is likely to suffer unless s/he receives contraceptive (+/- STI) advice or treatment
- Her/his best interests require the healthcare worker to proceed without parent consent

If a young person is found not to be Fraser competent, they must be discussed with your YP lead and/or Trust's Child Protection team as appropriate.

## What do I need to do when seeing a young person in clinic?

All young people accessing our sexual health service should:

- Expect confidentiality
- Have trust and confidence in the service provided
- Be consulted and have choices
- Remain in control of the process, where possible

All young people must have a comprehensive sexual history taken which aims to assess whether they are at risk of, or are experiencing sexual abuse or exploitation. Please make it explicitly clear that sexual activity may include vaginal, oral and anal sex.

At all times questions need to be asked sensitively using familiar language without medical jargon.

There should be an assessment and documentation of the following information:

- The young person's age and social circumstances – home/school/work and involvement of any external agencies with their relevant contact details.
- **It is imperative to record if the young person is a looked after child (LAC) or have a Child Protection Plan (CPP) by asking the patient directly as a routine check.** Staff **CANNOT** solely rely on looking up the patient as patients may provide a false name or date of birth. Chelsea and Westminster only records CPPs from the Tri-borough and Wandsworth areas, but our patients can self-refer from other boroughs. All such disclosures must be recorded If the young person is under a CPP, they should be informed that it is good practice to inform their social worker of their attendance but not the reason why, unless there are further safeguarding concerns that arise during the consultation that need to be shared. It is important to explain to the young person what you will say to their allocated social worker on a need-to-know basis only. It is also an opportunity to gain further information from the social worker to include on the CSI log which may help a clinician support the young person further.
- It is essential that staff record the nature of the sexual relationship including if it is consensual, the age of the sexual partner/s and whether barrier protection was used. An age imbalance of >5 years and/or a partner in a position of Trust/authority would cause concern.
- It is important to include information regarding the use of alcohol/other drugs that have been taken or offered as a transaction for sexual activity or as a disinhibitor, and ask how these drugs have been obtained.
- Unusually high levels of secrecy, or the young person trying to minimise your concerns should be explored further.
- At the end of your consultation it is important to establish if you as the clinician feel there are any signs of:
    - Coercion
    - Over aggression
    - Suspicion of sexual exploitation / grooming
    - Sexual abuse

- Power imbalance
- Other vulnerabilities

At all times questions need to be asked sensitively using familiar language without medical jargon.
Any such issues should be discussed with the young person. It is important to consider the importance of working within an extended on-site team, sharing your concerns. Any significant risks must be escalated to your YP lead and/or the Trust Child Protection team as appropriate. If your local YP lead is unavailable, please discuss with a Consultant.

**New referrals to children's services must involve discussion with the Trust Safeguarding team, and be made initially via telephone followed up with a written multiagency referral form within 48 hours in accordance with the Trust's Child Safeguarding Policy from an nhs.net secure email**. Do follow up your referral to ensure it has been received by the borough services. The completed forms should be scanned on to Lilie so they are available to view on the electronic patient record, and then retain the e-copy on the H drive within the Multiagency referrals folder. This folder will have restricted access YP leads only. **All these forms can be found on the Trust Intranet under the Child safeguarding tab**.

## What do I do if I need to refer a young person under a CPP to the main hospital for a review or possible admission?

If you see a young person who is under a CPP, and they need to be referred into the main hospital for review by an on-call team, you must:

- Inform the team you refer to that the young person is under a CPP
- Alert the Trust Child Protection Team that there is a young person under plan expected
- Inform the allocated social worker for that young person of the possible admission
- Inform Named Nurse of admission or attendance

## Additional useful references can be found at

BASHH guidelines (http://www.bashh.org)

GMC guidance 2012 (http://www.gmc-uk.org/Child_protection_guidance.pdf_52579216.pdf)

BMA children and young people toolkit 2011 (http://bma.org.uk)

## APPENDIX J– PARENTAL RESPONSIBILITY: WHO HAS IT?

The Children Act 1989 (as amended) sets out who may have parental responsibility. These include:

- **Mothers automatically** – either birth or gestational when through a surrogacy arrangement. If she is under 16 she can only give consent if she is deemed competent;
- Married fathers **automatically if married at time of birth;**
- The **child's father, if married** to mother at the time of conception or birth, or who subsequently marry one another;
- The child's mother, but not the father if they were not so married unless the father has acquired parental responsibility via a court order or a parental responsibility agreement, or (**with effect from 1st December 2003**), the mother and father have jointly registered the child's birth;
- The child's **legally appointed guardian** if they have a guardianship order in their favour;
- A person in whose favour the court has made a **resident's order** concerning the child;
- A **local authority** designated in a care order in respect of the child (Looked After Children);
- A local authority or other authorised person who holds an **Emergency Protection Order** in respect of the child (usually the local authority); and
- Under S2 Legitimacy Act, as long as he can prove he is the father of the child, the father acquires parental responsibility if he subsequently marries the mother of the child
- *Consent given by one person with parental responsibility is valid even if another person with parental responsibility withholds consent.*

### Unmarried Fathers of Children born before 1st December 2003

Unmarried fathers of children born prior to 1st December 2003 only have PR if they have applied through the courts.

### Unmarried Fathers of Children born after 1st December 2003

Unmarried fathers of children born past 1st December 2003 can obtain responsibility if father goes with mother to register the birth of the child and his name is on the birth certificate.

Unmarried fathers can obtain PR by:

- Marrying the mother
- Being named on the birth certificate (on or after 01/12/2003)
- By agreement or court order
- As a result of residence order

Copies of court orders and residence orders must be in the child's records.

### Children 'Looked After' or 'In Care'

If cared for under a Section 20 of the Children Act 1989 (this is voluntary care) consent has to be obtained from the mother.

If a child is 'looked after' under s30 or s31 of the Children Act 1989 consent must be obtained from the local authority who are acting as corporate parents. There must be a letter in the child's records from the Director or a senior manager in Children's Social Care, giving consent. Ideally parental consent is always sought too, that can be discussed with the Social Worker.

A copy of a court order must be in the child's records – a s30 is an interim order with an expiry date; a s31 order does not have an expiry date.

### Who can give consent?

Aged 16 – 17 years

- Can consent to any procedure

- Cannot refuse procedure

Aged under 16 years

- May be competent to consent
- Even if competent cannot refuse

Any person with Parental Responsibility

## APPENDIX K – ORDERS USED IN THE CHILD PROTECTION PROCESS

**The Order is a legal document – and piece of paper that protects the child, signed by the Court and persons applying for the order.**

**For the purposes of the Hospital it protects the child and supports the staff to care for the child safely.**

**When an order is in place, the child cannot be removed from the Hospital unless there is permission from the local authority.**

When a child is admitted to Hospital and there is a likelihood of significant non-accidental harm, if there is any possibility that the child may be unlawfully removed, or the injuries are considered to be extremely significant, the police will be called. The police have to see the child, and they seek information from the staff and liaise with the social work department where the child lives.

They have the power to put the child on a **Police Protection Power (PPP)**, without going to Court. This used to be called a 'place of safety' order. It lasts for **72 hours**, allowing time for plans to be made and the injured child treated. The child **cannot** be removed from the 'place of safety' and there must be a copy of the documentation in the medical notes.

An **Emergency Protection Order (EPO)** can be sought by the police or social worker, but must be applied for through the Court. This will last for 8 days and can be extended for a further 7

An **Interim Care Order (ICO)** lasts from 1 week to 3 months and usually follows an EPO. But, when seriously injured children are admitted and there is clear indication that this is a non- accidental injury an EPO or ICO can be obtained immediately.

### When Orders are in place

a) **Parents share PR with the local authority.** The parents will be aware (mostly, unless there is an increased risk to the child at a time when an order must be made), but will be encouraged to share partnership responsibilities i.e. there must be a joint consent for investigation and treatment and consent must be obtained in the same way as at any other time, with full explanation, pros and cons. Of course, if the parents refuse and it is live saving, or the evidence for it is overwhelming then their wishes may be over-ridden.

b) **There must be a copy of the Order** in the medical notes.

c) **The social worker** needs to keep in mind the date of expiry – a further order requires planning and applying to Court in time.

**APPENDIX L**

## Myth-busting guide to information sharing (Working Together 2018)

Sharing information enables practitioners and agencies to identify and provide appropriate services that safeguard and promote the welfare of children. Below are common myths that may hinder effective information sharing.

### Data protection legislation is a barrier to sharing information

No – the Data Protection Act 2018 and GDPR do not prohibit the collection and sharing of personal information, but rather provide a framework to ensure that personal information is shared appropriately. In particular, the Data Protection Act 2018 balances the rights of the information subject (the individual whom the information is about) and the possible need to share information about them.

### Consent is always needed to share personal information

No – you do not necessarily need consent to share personal information. Wherever possible, you should seek consent and be open and honest with the individual from the outset as to why, what, how and with whom, their information will be shared. You should seek consent where an individual may not expect their information to be passed on. When you gain consent to share information, it must be explicit, and freely given. There may be some circumstances where it is not appropriate to seek consent, because the individual cannot give consent, or it is not reasonable to obtain consent, or because to gain consent would put a child's or young person's safety at risk.

### Personal information collected by one organisation/agency cannot be disclosed to another

No – this is not the case, unless the information is to be used for a purpose incompatible with the purpose for which it was originally collected. In the case of children in need, or children at risk of significant harm, it is difficult to foresee circumstances where information law would be a barrier to sharing personal information with other practitioners14.

### The common law duty of confidence and the Human Rights Act 1998 prevent the sharing of personal information

No – this is not the case. In addition to the Data Protection Act 2018 and GDPR, practitioners need to balance the common law duty of confidence and the Human Rights Act 1998 against the effect on individuals or others of not sharing the information.

### IT Systems are often a barrier to effective information sharing

No – IT systems, such as the Child Protection Information Sharing project (CP-IS), can be useful for information sharing. IT systems are most valuable when practitioners use the shared data to make more informed decisions about how to support and safeguard a child.

APPENDIX M

**Multidisciplinary meetings are held in different wards and departments to support staff with complex cases and also identify children who may be vulnerable (see table below).**

| Department | Site | Focus | Schedule | Key Attendees |
|---|---|---|---|---|
| Paediatric Emergency<br><br>Adult ED | Both sites | Safety-net meeting | Weekly | Paediatric consultant, social worker, named nurse for safeguarding and child protection, liaison health visitor, PED nurse and the independent domestic violence advisor (site specific attendance) |
| Paediatrics | CW | Gastroenterology Psychosocial Meeting | Weekly | Clinical psychologist, specialist nurse, social worker, play specialist, ward nurse, named nurse for safeguarding and child protection |
| Paediatric Diabetes Team | WMH | Diabetes Psychosocial Meeting | Monthly | Psychologist, diabetes specialist consultants & nurse, named nurse for safeguarding |
| Burns Unit | CW | Psychosocial Meeting | Weekly | Ward nurses, social worker, consultants, psychotherapist, play specialist and named nurse for safeguarding and child protection |
| Sexual Health and HIV | CW | Safety Net Meeting | Monthly | Named nurse for safeguarding, sexual health consultants, medical/nursing staff, and health advisors |
| Supervisors of Midwives | CW | Current Safeguarding Issues | Weekly | Midwifery managers, named midwife |
| Maternity | Both sites | Ante-natal Substance Misuse Liaison & Vulnerable Pregnant Women's Forum | Monthly | Midwives, social workers, drug treatment centre liaison nurse, NICU liaison nurse, named nurse and midwife for safeguarding and child protection. |
| School | CW | Vulnerable Children in Hospital | Weekly | Teaching staff, named nurse for safeguarding and child protection (within ward safety net) |
| Paediatric Wards | | Ward Safety Net | Weekly | Attending consultant, named nurse for child safeguarding and child protection, social worker, paediatric bleep holder |
| Safeguarding Professional's Meeting | | Discuss the Safeguarding Work Plan | Monthly | Designated doctor and named doctor, designated nurses and nurse/midwife for safeguarding and child protection, liaison health visitor |
| Neonatal Unit | | Family Matters Non-clinical Discussion on All In-Patients | Weekly | Nursing staff, doctors, social worker, psychologist, chaplain and named nurse for safeguarding and child protection. |

## APPENDIX N– GUIDELINE FOR CHILD PROTECTION (CP) MEDICAL ASSESSMENTS AT C&W TRUST (both sites)

- Concerns about child abuse and neglect can come from several professionals e.g. school, GP, HV, school nurse, another doctor.

- All CP concerns should be discussed with the CP lead in that agency and a decision made as to whether a referral to Children's Social Care is necessary.

- All referrals to Social Care are made initially via telephone and then must be followed up in writing (via referral form) within 48 hours.

- Upon receipt of a referral the Social Worker (SW) should:
  - Take referral ensuring as much information as possible, check whether family is known, is CP Plan in Place?
  - Consult with manager as to whether a section 17 (child in need), section 47 (child in need of protection) is required, or signpost to another agency (which may require a CAF to be completed).
  - Consult with other agencies that have information about the family.
  - Assess if there is evidence that a crime has been committed. If so, urgent liaison with the Police Child Abuse Investigation Team (CAIT) is necessary via strategy discussion or meeting.
    - Police will then lead on any criminal investigation
  - Assess if there is a legal action necessary to safeguard child (e.g. children at significant risk of immediate harm).
  - Speak to non-abusing carer, explain process of investigation, seek permission and consent from parent with parental responsibility to interview child and undergo medical examination (unless child is old enough to give consent).
  - Interview the child (may be jointly with Police – Achieving Best Evidence (ABE) video).

- To make a referral for a medical assessment to the Trust, the SW needs to gather vital information to help the paediatric team to prioritise. This information includes:
  - Name of child
  - DOB
  - Address (so that we can identify whether the child lives in our catchment area)
  - School / nursery
  - Name and address of GP & HV
  - Who has parental responsibility (PR) for the child?
  - Has a parent with PR given consent for the medical to take place?
  - Who will be attending the medical with the child? It is good practice for a parent with PR to attend with the child unless the child has specifically requested not to do so (see below).
  - Details of alleged incident
  - Other questions which may be relevant:
    - When did the referrer receive the referral and from whom?
    - Who made the allegation and when?
    - Date and possible time when alleged assault took place
    - Has a strategy meeting or discussion taken place and if so, what was the outcome?
    - Has the child been interviewed either by SQ or jointly with police (ABE interview)?

- Medical assessments will be considered in the following circumstances:
  - When a child has alleged that s/he has been recently physically assaulted (alleged non-accidental injury – NAI).
  - Where there are concerns that a child is suffering from chronic neglect which may impact on their health or development (alleged chronic neglect).
  - Where there are concerns that a child may have been recently sexually assaulted (alleged child sexual assault – CSA).
  - All these will be prioritised differently depending on the nature of the concerns and they all require a different type of medical assessment.

- If the concerns are of a minor physical assault or chronic medical condition, then the GP may be approached by Social Services to ask if they would see the child and offer an opinion. Many GPs will not offer to see children if they are required give an opinion on the causation of any injuries – and this is appropriate unless they have experience in this area. GPs should NOT be approached to give an opinion in cases of alleged sexual abuse (either acute or chronic) and if concerns of this nature are raised to them then they must refer to Social Services (as well as discuss with the Named or Designated Doctor).

- For CP medicals conducted at Chelsea & Westminster Trust:

    - It has been agreed that the following children receive higher priority:
        - Young age (especially under age of 2yrs)
        - Severity of injury
        - Other vulnerabilities (such as disability)
        - Disputed cause of injury
    - The following children receive a lower priority and a medical may be declined:
        - Historical allegations
        - Adolescent age group
        - Siblings of case being presented "just to check"
        - Sibling on sibling abuse
        - Perpetrator or other non-perpetrating adult admitting assault occurred, so non-accidental causation is known

- If the child does not live within our catchment area, then the social worker will be directed to the appropriate hospital to arrange a medical assessment.

- **For CP medicals conducted at Chelsea & Westminster Hospital Site:**

- To make a referral for a CP medical, the SW should call GRO-C and speak to the Social Paediatric Co-ordinator (SPC) who will take down further details during working hours

- At C&W Hospital we have two separate rotas for CP medical assessment:

    - Non-accidental injury (NAI): operates morning OR afternoon weekdays and children are assessed by middle-grade Paediatric doctor.

    - Child sexual abuse (CSA) rota: operates 9-5 all weekends and children are assessed by a Consultant Community Paediatrician and Consultant in Genito-urinary Medicine (GUM) This is for Non-acute CSAs (>72 hours post alleged assault)
    - For acute CSAs please contact Haven sexual assault referral centre at St Mary's Hospital on 020 7886 1101 (Mon – Fri 9-5) or 020 7886 6666 (other times)

- **For CP medicals conducted at the West Middlesex University Hospital Site**

    - Shared rota with community paediatricians at 92 Bath Road Hounslow arranged by calling 0208 321 6495 and asking for the attending consultant on-call

    - For acute CSAs please contact Haven sexual assault referral centre at St Marys Hospital on 0207 8861101 (Mon–Fri 9-5) 0207 886 6666 (other times)

- It is vital therefore that the SPC is aware as to whether the alleged assault is of a potentially sexual nature so she can advise appropriately.

- The SPC will page the doctor on the appropriate rota and arrange a time when the child can be seen.

- If it is not possible to organise a medical on the day of referral and it is thought necessary to do so, the SW should discuss the concern with the doctor on call (either on the NAI or CSA rota). The doctor should then directly speak to the SW making the referral.

- If is thought that the child's injuries are deemed by the SW and doctor to be serious but there are no CP medical slots available, then the SW will be encouraged to bring the child to the Paediatric Emergency Department (PED) for assessment as soon as practically possible. In this case the SPC will inform the PED staff of the expected attendance and the child will be seen by a PED or General Paediatric middle-grade doctor as soon as possible. It may be that other children in PED are given a higher priority because of their presentation therefore a prolonged wait in PED may be unavoidable.

- If it is thought the child's injuries are not sufficiently severe then the child may be offered the next available slot for a medical which will hopefully be the next available working day. The SW and Police should identify any immediate safeguarding concerns in the interim and ensure that the child is safeguarded (i.e. is an order or temporary foster arrangement required?)

- If it is thought that the concerns of a chronic neglectful nature with no recent physical injury or significant risk of acute harm, then the SPC or the doctor may recommend that the child is seen in the next available afternoon Community clinic. She will then arrange for this to happen but it is likely not to be the week the referral is made.

- Before a child is seen for a CP medical it is vital that the paediatric team are satisfied that there is enough information about the alleged assault to proceed, and that consent has been gained by a parent who has PR for the child. It is NOT necessary for a strategy discussion / meeting or ABE interview to have taken place but it is essential that the SW has spoken to the referrer, child and parent to explain the process.

- The following caregivers have PR:
  - Birth mother (unless child is adopted)
  - Father
    - If married at time of child's birth or marries subsequently (and is biological father)
    - If named as father on birth certificate (baby born AFTER 01/12/2003)
    - If a parental responsibility agreement is in place
  - Other may have or share PR e.g. guarding ad litem

- The SW should discuss with the parent and child what will take place in the CP medical and what its purpose is, namely:
  - To assess the child's health and development
  - To enquire about the alleged assault (may not be necessary if ABE interview has been carried out already)
  - To look for any physical signs of abuse or neglect
  - To take photographs of any concerning marks if necessary (with consent)
  - To establish whether any marks are likely to be accidental or inflicted
  - To establish whether any medical psychological follow-up is required

- If a child or young person is Gillick competent then they may attend without a parent for a medical – but the SW must be happy that the child is able to make that decision (this may be helped by speaking to the child's school to assess this). It is always good practice to inform a parent with PR that the child is attending for a medical and they should be encouraged to attend (unless the child refuses). Please see GMC guidelines at http://www.gmc-uk.org/guidance/archive/GMC_0-18.pdf for further advice on consent and young people.

- In cases where parents have been arrested and are therefore not available to attend the medical, then the SW must have obtained consent and documented this.

- In other rare cases where the parents cannot attend the medical, the examining doctor may request to speak to them on the telephone to gain their verbal consent. This must be documented in the notes.

- If a parent with PR refuses to give consent to the medical, and the child is not Fraser competent and thus cannot give consent themselves, then the SW needs to apply for a court order (e.g. Emergency Protection Order EPO) to enable the doctor to proceed with the medical. Note Power of Police Protection (PPP) only enables the child to be placed in a protected environment for 72 hours and does NOT give consent to proceed with a CP medical.

- In cases where the child's injuries are so severe and the risk to the child is very high, then it may be possible to proceed to a CP medical without consent from the parents. GMC guidelines prevent doctors from examining or treating children without consent (or an appropriate order in place) unless the child has life-threatening or very severe injuries (e.g. head injury, burns, multiple fractures etc). In such cases the child will need to be admitted for medical treatment and to safeguard against further abuse. Parents will then be urgently contacted and notified of any investigations or treatment carried out.

- If it is anticipated that the parent or child may become verbally or physically aggressive during the medical, the SW must inform the SPC so that security and the Police can be contacted in order to de-escalate any potentially disruptive scenario.
- The SW MUST attend the CP medical with the child so that the doctor can give verbal feedback at the time.

- The examining doctor will endeavour to send a CP medical report out within 7 days – copies are normally sent to the GP, HV (or school nurse), parents, SW, Police and a copy is kept in the hospital notes. If a report is required sooner it is essential that the SW asks for this at the time of the medical.

**APPENDIX O**

Typed:
Ref:

369 Fulham Road
London SW10 9NH
Tel: 0203 315 8000

Confidential

# Child Protection Medical Report

| | | | |
|---|---|---|---|
| Name: | | Hosp no. | |
| DOB: | | Age: | |
| Address: | | | |
| Home Phone: | | | |
| School: | | | |
| GP:<br><br>Phone No: | | | |
| Social Worker:<br><br><br>Telephone: | | | |
| Police Officer:<br><br><br>Telephone: | | | |
| Name of Examining Doctor:<br><br><br>Also present: | | | |
| Where child seen: | | | |
| Consent given by: specify written or verbal | | | |
| Date & Time examination commenced: | | | |

**Background:**

**History of Incident Given To Examining Doctor and by who:**

**Past Medical History:**

**Perinatal History:**

**Immunisations:**

**Early Development:**

**School:**

**Social and Family History:**

**Current Medication:**

**Physical Examination:**

**Medical Opinion**

**Action Plan:**

**Further Follow Up:**

***Dr Smith***
***Specialist Registrar***

***Supervising Consultant:***
***Dr Jones***
***Consultant Paediatrician***

Cc: (*please tick to whom copies must be sent)*

□ Hospital Notes

□ Social Worker

□ GP

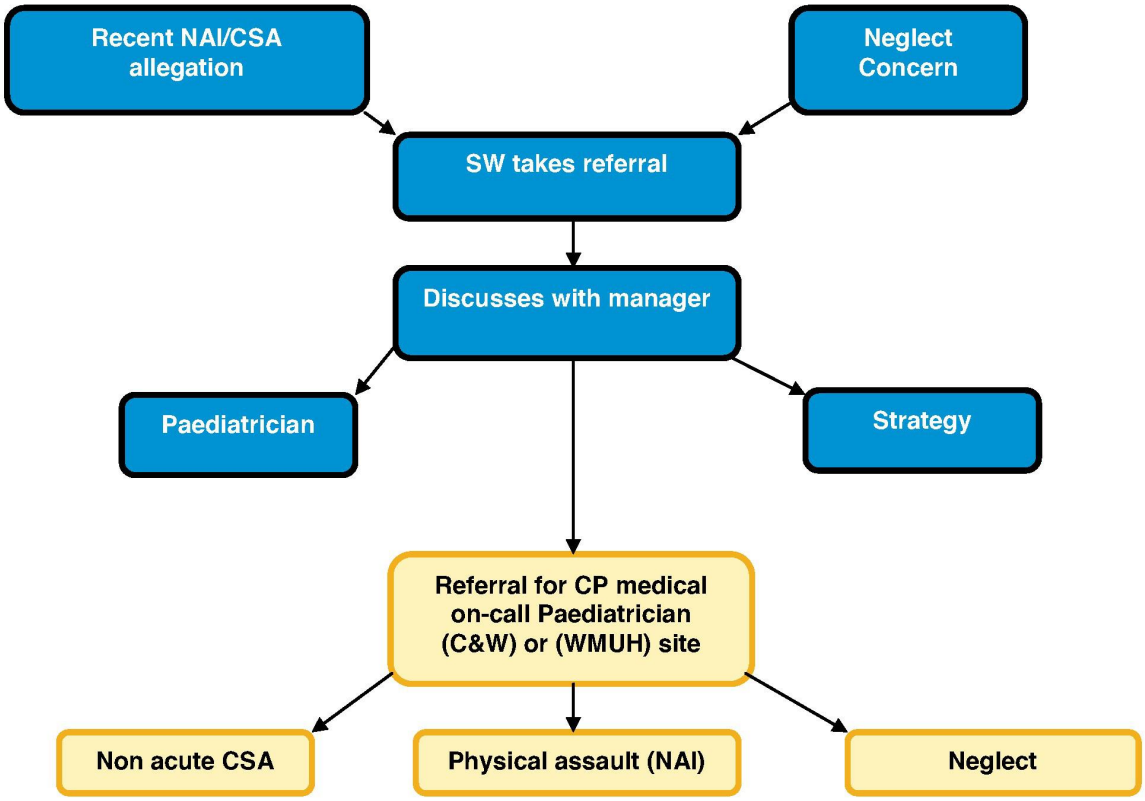
□ School Nurse

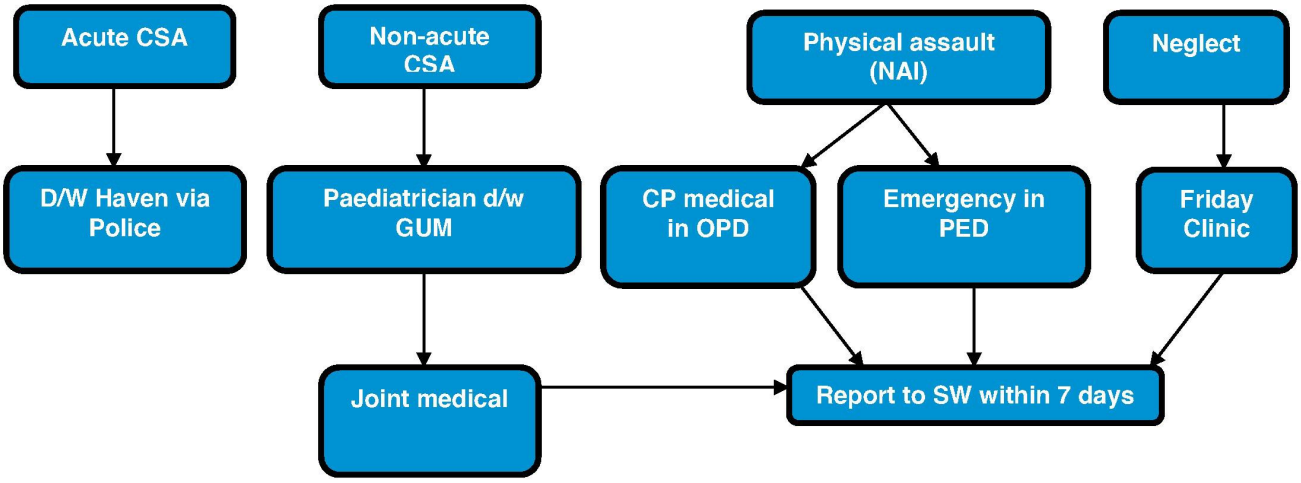
□ Parent

□ Other (*please specify)* _____

**** Delete as Appropriate***

## APPENDIX P – CP REFERRAL FLOW CHART




Referral for CP medical on call
Phone: GRO-C
WMUH

Referral for CP medical on call
Phone: GRO-C
(C&W)