Great Ormond Street Hospital for Children NHS Trust

GREAT ORMOND STREET HOSPITAL

CHILD PROTECTION POLICY

PROCEDURES & GUIDANCE

AUGUST 2012

VERSION 3.5

Document Control Information

Lead Author	Child Protection Management Group	**Author Position**	Various
Additional Contributor (s)			

Approved By	Management Board	**Approver Position**	Management Board
Read By			

Document Owner	Liz Morgan	**Document Owner Position**	Chief Nurse/Director of Education

Document Version	Child Protection Policy version 3.5	**Replaces Version**	Child Protection Policy Version 3.4

First Introduced	November 2007	**Review Schedule**	2 yearly
Date approved	July 2012	**Next Review**	November 2014

Policy Overview

The aim of the policy is to ensure that staff are aware of the procedures for dealing with suspicions or actual concerns about a child's welfare or safety.

Who should know about this policy?

All staff

CONTENTS

1 INTRODUCTION

1.1 LAYOUT & USE OF DOCUMENT

1.1.1 This document is constructed as follows:

- **Section 1:**information about legal and professional safeguarding and protection responsibilities, the purpose and status of the document and its layout and application
- **Section 2 : Operational procedures** of relevance to the immediate responses and early management of suspicions or concerns – these must be followed by all GOSH staff - and amplify processes and decision making illustrated in the flow chart on page 10 & 21.
- **Section 3 : On going child protection**
- **Supplements 4 – 24: specific procedures** arranged in alphabetical order indicating required practice in specified circumstances or sites, or additional information. Cross references to them are included throughout the policy
- **References & useful websites** (indicated by number throughout the text)
- **Appendix:**
- **An alphabetical subject index**

1.1.2 Hypertext links have been provided so that by clicking on cross-references, the reader will be taken to the relevant link.

1.2 SAFEGUARDING & PROTECTION RESPONSIBILITIES

DEFINITIONS

1.2.1 **Safeguarding and promoting the welfare of children** is defined in ch.1.18 of *Working Together to Safeguard Children* 2006 [ref.11] as agencies and professionals:

- Protecting children from maltreatment
- Preventing impairment of children's health or development
- Ensuring that children are growing in circumstances consistent with the provision of safe and effective care and
- Undertaking their role so as to enable those children to have optimum life chances and to enter adulthood successfully

1.2.2 All NHS Trusts and Foundation Trusts have a responsibility under s.11 Children Act 2004 [ref.14] and *Working Together to Safeguard Children* 2006 [ref.11] to ensure that their functions are 'discharged with regard to the need to safeguard and promote the welfare of children'.

1.2.3 **Child protection** refers to the activity undertaken to protect children who are suffering or are likely to suffer significant harm and is an essential element of safeguarding and promoting the welfare of children.

1.2.4 Ch 1.20 – 21 of *Working Together to Safeguard Children* 2006 [ref.11] indicates that all agencies and individuals should aim to safeguard and promote children's welfare proactively so that the need to protect individual children is reduced.

1.2.5 **A child**, in legislation relevant to child protection (Children Act 1989 [ref.11] and Children Act 2004 [ref.14]) is defined as a person aged less than 18 years. For purposes of professional practice, actions may also be required to protect the future safety of an unborn child.

1.2.6 **Harm** means 'ill-treatment or impairment of health or development including, for example impairment suffered from seeing or hearing the ill-treatment of another' [s.31 (9) Children Act 1989 as amended by the Adoption and Children Act 2002] [ref.13].

1.2.7 Where the question of whether harm suffered by a child is 'significant' her/his health or development is to be compared with that which could reasonably be expected of a similar child [s.31(10) Children Act 1989] [ref.12].

1.2.8 To understand and establish harm, it is necessary to consider the:

- Nature of the harm, in terms of maltreatment or failure to provide adequate care
- Impact on the child's health or development
- Child's development within the context of her/his family and wider environment
- Possibility of any special needs such as medical condition, communication impairment or disability that may affect the child's development and care within the family
- Child's reactions, her/his perceptions and wishes and feelings according to age and understanding
- Capacity of parents to meet adequately the child's needs and
- Wider and environmental family context

1.2.9 Safeguarding and promoting children's welfare and in particular protecting them from significant harm, depends upon effective joint working between agencies and professionals with different roles and expertise.

1.2.10 Individual children, especially some of the most vulnerable and those at greatest risk of social exclusion, need co-ordinated help from health, education and Children's Social Work Service.

1.2.11

Children and Young People with Disabilities (Including Learning disabilities)

All GOSH staff should be aware of the increased vulnerability of children and young people with disabilities which include learning disabilities. A significant proportion of patients at GOSH fall within this group. These children and young people are at an increased risk of abuse than non disabled children due to factors such as their lack of contact with others outside the home environment, having their personal care administered by adult carers, and low self esteem. They are also more likely to be bullied and may be hindered from seeking help or explaining their abuse because of communication barriers resulting from their disability.

1.2.12 For those children who are suffering or likely to suffer significant harm, and where necessary in order to bring perpetrators of crimes against children to justice, all agencies and professionals should:

- Be alert to potential indicators of abuse or neglect
- Be alert to the risks which individual abusers, or potential abusers, may pose to children
- Share and analyse information so that an assessment can be made of the child's needs and circumstances
- Contribute to whatever actions are needed to safeguard and promote the child's welfare
- Take part in regularly reviewing outcomes for the child against specific plans and
- Work in partnership with parents unless this is inconsistent with ensuring her/his safety [ch.1.16 *Working Together to Safeguard Children* 2006 HMG [ref.11]

1.3 GLOSSARY

Abuse and neglect	Forms of maltreatment of a child.
Care order	A court order under s.31 of the Children Act 1989 placing a child in local authority care to protect the child from harm they are suffering or may suffer, whilst under the care of his/her parent (and/or being beyond a parent's control).
Child	Children 0-17, adolescents up to their 18th birthday (+ young people with special needs cared for by GOSH up to 19 years).
Child in need	Section 17 (10) of the Children Act 1989 defines a child in need as a child who, without the provision of local authority services: • Is unlikely to achieve or maintain a reasonable

	standard of health or development; • Whose health or development if likely to be significantly impaired; • Or a child who is disabled.
Child protection	The process of protecting individual children identified as either suffering, or at risk of suffering, significant harm as a result of abuse or neglect.
Child protection enquiry	Section 47 of the Children Act 1989 gives local authority children's social work a duty to make enquiries to decide whether they should take action to safeguard or promote the welfare of a child who is suffering, or likely to suffer, significant harm.
Common Assessment Framework	The CAF is a standardised approach to conducting an assessment of a child's additional needs and deciding how those needs should be met. It can be used by practitioners across children's services in England. The CAF is intended to provide a simple process for a holistic assessment of a child's needs and strengths, taking account of the role of parents, carers and environmental factors on their development. All local authority areas are expected to implement CAF between April 2006 and the end of 2008.
e-CAF	An IT system to enable common assessment to be shared securely with other agencies London-wide.
Emergency duty team	Local Authority children's Social Work Service which receives and responds to all child concern referrals – outside office hours.
Emergency protection order	A court order under s44 of the Children Act 1989 giving local authority children's social work and the police the power to protect a child from harm, by removing the child to suitable accommodation or preventing a child from being removed (e.g. from hospital).
Framework for the Assessment of Children in Need and their Families	The assessment Framework is a systematic way for professionals to assess a child's needs and whether s/he is suffering or likely to suffer significant harm, what actions must be taken and which services would best meet the needs of the child and family. All professionals should be competent to contribute to as assessment, which is usually led by local authority children's social work under the Children Act 1989.
Gillick competence	The competency test resided by Lord Fraser, 1985 (known as Gillick Competence), which laid down criteria for establishing whether a child, irrespective of age, had the capacity to provide valid consent to treatment in specified circumstances.
Great Ormond Street Hospital	In this guidance this refers to Great Ormond Street

(GOSH)	Hospitals NHS Trust as a whole organisation, not a geographical location.
Hospital children's Social Work Service	Social workers employed by the local authority who are based at the hospital. Previously known as Social Work Department/Team.
Impairment of health and development	Where professionals are seeking to judge whether a child's health and development have been significantly harmed, the Children Act 1989 (s31(10)) directs them to make a comparison with the health and development which could reasonably be expected of a similar child.
Individual who may pose a risk to children	Description of an adult or child who has been identified (by probation services/Youth Offending Teams, police or health services, individually or via the Multi-Agency Public Protection Arrangements) as posing an ongoing risk to a child (replaces the term Schedule 1 Offender).
Interim care order	A court order under s38 of the Children Act 1989 where, during the proceedings of a care order, the court adjourns, and [usually] the court directs an investigation into the child's circumstances.
Lead Consultant	All children attending or admitted to GOSH will have a named Lead Consultant, who will take overall responsibility for the child's care. The Lead Consultant should be named on PiMS respectively.
Local authorities	In this guidance this generally means local authorities that are child's services authorities – effectively a council responsible for social services and education.
Parent	Parent or carer.
Powers of police protection	Section 46 o f the Children Act 1989 giving the police powers to protect a child from harm by removing the child to suitable accommodation or preventing a child from being removed (e.g. from hospital).
Safeguarding and promoting the welfare of children	The process of: • Protecting children from maltreatment; • Preventing impairment of children's health or development; • Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care; • Undertaking that role so as to enable those children to have optimum life chances and to enter adulthood successfully.
Significant harm	There are no absolute criteria on which to rely when

	judging what constitutes significant harm. Consideration of the severity of ill-treatment may include the degree and the extent of physical harm, the duration and frequency of abuse and neglect, the extent of premeditation, and the presence or degree of threat, coercion, sadism, and bizarre or unusual elements. Each of these elements has been associated with more severe effects on the child, and / or relatively greater difficulty in helping the child overcome the adverse impact of the maltreatment. Sometimes, a single traumatic event may constitute significant harm (e.g. a violent assault, suffocation or poisoning). More often, significant harm is a compilation of significant events, both acute and longstanding, which interrupt, change or damage the child's physical and psychological development. Some children live in family and social circumstances where their health and development are neglected. For them, it is the corrosiveness of long-term emotional, physical or sexual abuse that causes impairment to the extent of constituting significant harm. In each case, it is necessary to consider any maltreatment alongside the family's strengths and supports.
Staff/staff member	Any individual/s working in a voluntary, employed, professional or unqualified capacity.
Well-being	The achievement of the best outcomes for children. That is, for every child to: • Be healthy; • Stay safe; • Enjoy and achieve; • Make a positive contribution; • Achieve economic well-being; • Not cause harm to others.

1.4 PURPOSE & STATUS OF POLICY, PROCEDURES & GUIDANCE

PURPOSE

1.4.1 The contents of this document set out how GOSH staff should work together to safeguard and promote the welfare of children:

1.4.2 This document is being distributed throughout the Trust and:

- **Summarises agreed policies** i.e. organisational beliefs and intentions

- **Makes explicit what must be done**
- **Applies to all children** who have contact with GOSH without regard to service provided, location or private / NHS or visitor status
- **Is** to be used by all staff

1.4.3 **All** GOSH staff should have knowledge of these and any additional LSCB procedures - in particular, how to contact the hospital children's Social Work Service at their site and the 'named professionals' for advice and support.

STATUS

1.4.4 Policies and procedures incorporate or accurately reflect relevant sections of the following key documents/guidance:

- Children Act 1989 [ref.12] and other legislation e.g. Adoption and Children Act 2002 [ref.13] of operational relevance to child protection
- Children Act 2004 [ref.14]
- Working Together to Safeguard Children (HMG 2006) [ref.11]
- What To Do If You're Worried A Child Is Being Abused (DH 2006) [ref.4]
- National Service Framework (NSF) for Children & Maternity Services [ref.6]
- Safeguarding Children: The Second Joint Chief Inspector's Report on Arrangements to Safeguard Children [ref.2]
- Lord Laming's Report [ref.8]

1.4.5 The document is also compatible with the principles and/or requirements of:

- The UN Convention on the Rights of the Child
- Relevant parts of The European Convention on Human Rights (introduced in the UK via the Human Rights Act 1998) [ref.17]
- The London Child Protection Procedures (3rd ed. 2007) [ref.19]
- Healthcare Commission Standards
- Joint Area Review (JAR) Assessments
- Framework for the Assessment of Children in Need & Their Families (DfES 2003) [ref.5]
- Guidance related to the Common Assessment Framework 2006/07 http://www.everychildmatters.gov.uk/deliveringservices/caf/

1.4.6 Commissioning authorities require child protection to be included in the contracts agreed with the Trust and satisfy themselves that monitoring arrangements are in place, e.g. every patient who is the 'subject of a child protection plan' [for GOSH, Camden's LSCB] has an appropriate alert on the Trust's electronic patient record [PiMS respectively].

1.4.7 Whilst it is the responsibility of a referring Trust to inform GOSH if there are child protection concerns that may impact on the child's care, GOSH staff have a reciprocal duty to ask the appropriate questions on admission/attendance.

1.5 KEY POINTS

CONTEXT

1.5.1 In any child protection situation, the child's home local authority Children's Social Work Service is responsible for investigating concerns about a child's welfare or safety, working in collaboration with GOSH professionals.

1.5.2 The **lead** local authority GOSH Children's Social Work Service is **GOSH** –provided by London Borough of Camden. Works in liaison with the child's home authority.

1.5.3 GOSH have a 'named doctor' and a 'named nurse' to take a professional lead within the service for child protection matters, supported by the Child Protection Co ordinating Manager [Supplement 22: Roles]. They have expertise in hospital settings, inter agency working. and the nature of child maltreatment

1.5.4 Named professionals have a professional accountability to their employing Trust [ref.11] and Nursing Midwifery Council / General Medical Council. They should work closely with the designated professionals.

1.5.5 Designated professionals and the Child Protection Co ordinating manager provide advice and support to the named professional's in the provider Trust. Designated professionals are located Camden Primary Care Trusts.

BELIEFS & POLICY COMMITMENTS

1.5.6 Professionals should keep an open mind throughout any enquiries, making no lasting assumptions that abuse must have taken place or that it never could.

1.5.7 The primary concern at all times is to promote the welfare and safety of the child/ren. In keeping with the Children Act 1989 [ref.12] and 2004 [ref.14], it is good practice to work in partnership with parents, unless this is felt not to be in the best interests of the child. Where there is a conflict of interest between the child/ren and parents or carers, the interests of the child/ren are paramount.

1.5.8 Children should be listened to and their views taken seriously. In some cases a mature child will be able to give informed consent, without referral to their parents or carers if they are judged to be 'Gillick competent'.

1.5.9 Whilst any enquiries are being made into possible abuse or neglect, discussion within the professional network has priority over that with parents and carers until it is clear there is no conflict between the interests of the child and those of the parents / carers.

1.5.10 Effective communication both internally and externally is required.

1.5.11 No culture sanctions harm to a child. Working within diversity frameworks demands recognition of the additional vulnerability of some children and the extra barriers they face because of their race, gender, age, religion or disability, sexual orientation and social background.

1.5.12 A balanced assessment must incorporate a cultural perspective but guard against being over sensitive to cultural issues at the expense of promoting the welfare and safety of the child.

1.5.13 Commitment to equality in meeting the diversity needs of all children and their families is vital for understanding the effects of harassment, discrimination or disadvantage to which they may have been exposed.

1.5.14 All enquiries should be carried out as speedily as possible in keeping with the Children Act 1989 [ref.12] and the Framework for the Assessment of Children in Need and their Families [ref.5].

1.5.15 Within any Assessment Framework there should be a focus on joint assessments and decisions making between key agencies for example; health, Children's Social Work Service, education and Police, as appropriate. This holistic approach will ensure an understanding of the child within the context of the child's family, educational setting, community and culture in which s/he is growing up. The analysis of the child's situation will inform planning and action in order to secure the best outcomes for the child.

1.5.16 GOSH should demonstrate a commitment to underpinning these procedures with a Trust-wide training, audit and evaluation strategy [Supplement 23: Training and Audit Strategy].

UPDATING PROCEDURES

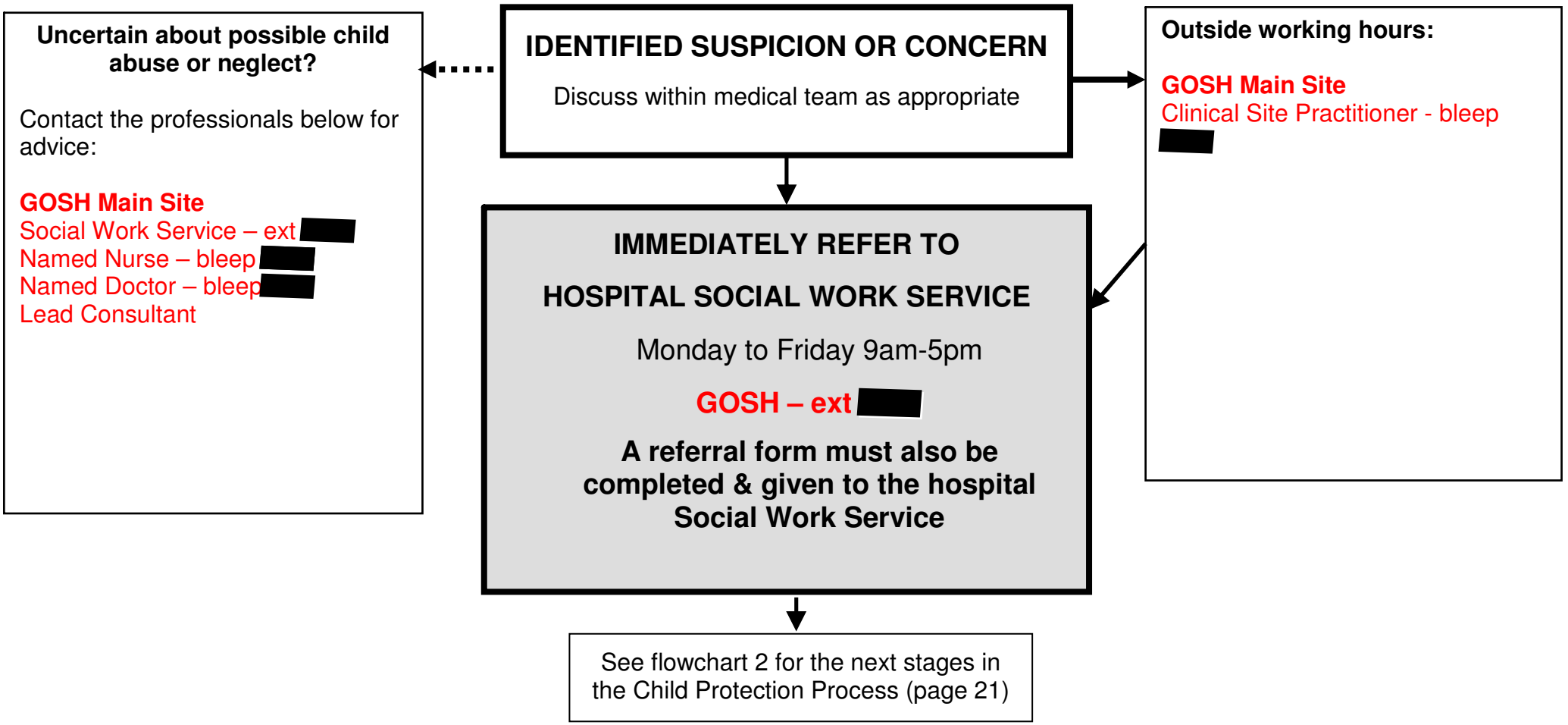
1.5.17 The footnote of each module confirms the month and year of issue, including its proposed review date.

1.5.18 The document in its entirety is scheduled to be reviewed every 2 years.

2 IMMEDIATE RESPONSES TO SUSPICIONS & CONCERNS

IMMEDIATE RESPONSE TO SUSPICION OR CONCERN

(Flowchart 1)



2.1 IDENTIFIED SUSPICION OR CONCERN

PRINCIPLES

2.1.1 Whenever concerns are raised, support and guidance should be sought from a hospital social worker, named doctor or named nurse [Supplement 22: Roles] remaining objective at all times remembering:

- Never delay emergency action to protect a child from harm
- Make an immediate referral to the Children's Social Work Service [see referral process in 2.2]
- Always record in writing in the child's medical records concerns about a child's welfare, including whether or not further action is taken
- Always record in writing any discussions about a child's welfare, including any decisions reached [2.1.8]
- At the close of a discussion, always reach a clear and explicit recorded agreement in the child's medical records, about who will be taking what action, or that no further action will be taken including how this decision was made.

2.1.2 In most cases no clear disclosure or allegation will be made by a child, but hospital staff may have concerns about a child's welfare or suspect that abuse or neglect has occurred.

2.1.3 Some children or parents may disclose, make specific allegations of abuse or raise concerns about a child's welfare or safety. Any disclosure or allegation made by a child or parent must be taken seriously and treated with sensitivity. The child or parent should feel that the person in whom s/he confided will take her/his allegation seriously and will arrange for it to be looked into, by referring to the Children's Social Work Service [Supplement 7: Communicating Directly with Parents and Children].

2.1.4 When a concern about a child's safety or welfare has been identified Social Work practitioners may undertake an assessment using the Assessment Framework [ref.5]. This will look at parenting capacity/child developmental needs and family environmental needs in order to identify how the family will be best supported.

2.1.5 In general, staff should seek to discuss concerns with the child, as appropriate to her/his age and understanding, and with parents, seeking their agreement to making a referral to Children's Social Work Service unless considered such a discussion would place the child at risk of significant harm. Any reason for **not** seeking parental agreement must be fully documented in the child's

medical records [Supplement 7: Communicating Directly with Parents and Children].

2.1.6 If the parents refuse permission, staff should discuss concerns with a social worker / named doctor / named nurse and having taken full account of the parents' wishes, if concerns remain, a referral should be made to the Children's Social Work Service including details of the parents' lack of agreement to the referral. Any communication with the parents, or action taken must be noted in the appropriate section of the child's medical notes [i.e. CP section at GOSH main site] including where there is a disagreement between parents and hospital staff.

2.1.7 Staff cannot keep any disclosure, allegation or suspicion of abuse confidential, and have a duty and responsibility to pass on any such concerns to Children's Social Work Service or the Police. The Royal College of Paediatrics and Child Health [RCPCH], General Medical Council [GMC], Nursing and Midwifery Council [NMC] and the Health Professionals Council have issued guidance detailing the circumstances in which information may be disclosed without the consent of either child or parent [Supplement 7: Communicating Directly with Parents and Children].

2.1.8 As soon as any member of staff becomes concerned about the welfare, safety or vulnerability of a child [Supplement 13: Identification of Abuse], s/he should discuss those concerns with a senior colleague/manager, documenting any discussion and agreed actions in the relevant part of the child's medical notes [i.e. CP section at GOSH main site]. The Children's Social Work Service, named nurse or named doctor should be consulted in cases where clinicians are uncertain about possible child abuse or neglect.

2.1.9 Unless a senior medical colleague can give and document an explicit opinion that signs noted indicate a medical condition, the professional noting concern should:

- Verbally report the concern to the unit or duty social worker during normal working hours (if concerns arise out of working hours, see 2.2.9)
- All verbal referrals must be confirmed in writing immediately using the site specific referral form [Supplement 8: Documentation]
- Inform other relevant members of the medical and nursing team, including Named Nurse about the referral; and

2.1.10 If the child has suffered injuries, an appropriate member of the medical team should take a history and carry out a full medical examination of the child, documenting all injuries including the use of a body map / photographs [Supplement 17: Photography] where

relevant together with any explanation offered by the child and her/his parents / carers of how the injuries occurred.

2.1.11 Guidance in relation to medical assessment where there may be concerns about a child's injuries is detailed in Supplement 15: Medical Examination. All information from the assessment should be documented in the medical records. At GOSH, a cross reference to this information should be noted in the child protection section of the child's medical notes [Supplement 8: Documentation].

2.1.12 If there is any possibility, concern or suspicion that an injury has occurred during attendance or admission to GOSH, the Lead Consultant may require a more specialist medical opinion. A referral should be made to Children's Social Work Service and if necessary advice can be sought from a hospital social worker / named doctor / named nurse about the requirement for further medical examination and arrangements for ongoing care. In certain circumstances an external medical review may be sought following advice from the named doctor for child protection.

2.1.13 Where there are concerns about unexplained or discrepant reports or observations about a child's condition, which could be linked to fabricated or induced illness (FII) [Supplement 10: Fabricated or Induced Illness] discussion will be undertaken with the named doctor for child protection. Documentation of such concerns and action plans will be termed 'unexplained medical condition – further observations and investigations needed'. A referral to the hospital Children's Social Work Service will be made if there are definite concerns about FII, at which point a child protection section will also be inserted into the notes.

2.1.14 A hospital social worker, named doctor or named nurse should be consulted in cases where clinicians are uncertain about a child's welfare or safety or have suspicions of child abuse or neglect. All professionals have a duty of care to safeguard and promote a child's welfare and can be held professionally accountable for their actions. Where professionals are unsure or reluctant to make a referral then support and guidance will be offered by a hospital social worker, named doctor or named nurse ensuring that appropriate referrals are made and the needs of the child remain paramount.

2.2 REFERRAL TO HOSPITAL SOCIAL WORKER

2.2.1 Health professionals must make a referral to the relevant Children's Social Work Service about a child under the age of 18 years or an unborn baby, when there are any concerns about her/his welfare or safety [1.4.1 / 2].

MONDAY TO FRIDAY 9AM-5PM

2.2.2 At GOSH, where the majority of the children are not resident in Camden, lead responsibility for ensuring a proper investigation of suspected abuse of a child lies with the child's home authority in liaison with the GOSH Social Work Service and hospital staff. Social workers will act as liaison unless it is a Camden child where GOSH social work will undertake the investigation.

2.2.3 Referrals at GOSH must be directed to the Ward social worker or in her/his absence, the duty social worker via social work reception on extension [redacted]. This should happen immediately if there are concerns about a child's welfare or safety. The referrer should confirm verbal and telephone referrals in writing to the relevant social worker immediately, using the referral form [Supplement 8: Documentation]. The social worker should contact the local authority Children's Social Work Service on the basis of the concerns or suspicions identified.

2.2.4 If it is known that the child is subject to a child protection plan, the GOSH social worker should be contacted to verify this information with the child's local Children's Social Work Service and ensure that a PiMS patient alert is added to the child's electronic record [3.2]

2.2.5 Where concerns regarding a child's welfare or safety are identified when the child is present in the Outpatient Department, concerns should be forwarded to the GOSH Children's Social Work Service as stated in 2.2.3.

2.2.6 When a concern arises about a child who has left the hospital following an appointment or has been discharged, it is the responsibility of the professional who has concerns about a child's welfare or safety to refer those concerns to the child's local Children's Social Work service and to ensure the original health service referrer is informed of the Social Work referral in the discharge summary/letter. The hospital social worker / named doctor / named nurse at GOSH are available for support, advice and guidance in carrying out the responsibility.

2.2.7 Once the referral has been received by the hospital Children's Social Work Service, the child protection concern will be managed through the process outlined in 2.3 -2.8 (also see flowchart on page 21).

OUT OF HOURS

2.2.8 Policies and procedures in this document are applicable at all times. However, if a child protection situation arises 'outside normal working hours' i.e. weekends and Public holidays, and Monday to

Friday 5pm to 9am, the Clinical Site Practitioners (CSPs) will contact the relevant local authority Emergency Duty Team (EDT).

2.2.9 Nursing or medical staff must inform the CSPs (bleep [redacted]) when there is a concern or suspicion that abuse has or may have taken place to any child or concern about a child's welfare or safety.

2.2.10 The member of staff reporting the concern should complete a written referral form to be given to the CSPs who will ensure it is delivered to the hospital Children's Social Work Service on the next 'working day'. If the CSPs take action to safeguard the child they will initiate the CP paperwork and insert a CP divider.

2.2.11 All information related to child protection should be recorded in the child protection section of the child's medical notes [Supplement 8: Documentation].

2.2.12 Any junior medical staff must inform the consultant under whom the child is admitted. The child may need a full medical examination.

2.2.13 The parents should be informed that a concern has been raised, the reasons why, and that it will be referred to Children's Social Work Service. If the safety of the child is put at risk by informing the parents, a referral must be made without their knowledge and the reason/s recorded. As far as possible, staff should try to work in partnership with parents but at all times the welfare and safety of the child is paramount [Supplement 7: Communication with Parents].

2.2.14 The CSPs will inform the relevant local authority, giving as much detail as possible to assist them in completing routine checks of the family. Details of siblings, if known, will also be requested.

- If concern relates to an incident that has occurred on the hospital premises, the CSPs should inform Camden's Emergency Duty Team (EDT) who are responsible for Camden and will advise on any necessary action.
- If the child arrives at the hospital with an existing concern or has been affected or injured by an incident that occurred elsewhere, the CSPs should inform the local authority EDT in the area that the child lives. A list of phone numbers for the 'out of hours' local authority teams is available in the CSPs office.

2.2.15 The social worker to whom the referral is made and the CSP will agree a plan for the safety of the child in GOSH and the social worker will inform of any instructions relating to parent/s visiting / supervision. The name of the social worker to whom the referral was made, the time of the conversation and the outcome and plans for the child should be recorded in the child protection section of the child's medical notes. If concerned about the immediate safety

of a child, refer to the Police Child Abuse Investigation Team 24 hour number held in the CSP office.

2.2.16 If there are problems with aggressive or angry family members causing potential risk to other patients and staff GOSH, Security should be contacted by the CSPs or the ward. Holborn Police should be called to attend if necessary and an action plan agreed [Supplement 5: Behaviour Management of Parents].

CHILD PROTECTION PROCESS - OUTPATIENTS

2.2.17 IF CONCERNS ARISE WHILST THE CHILD IS ATTENDING AN OUTPATIENT APPOINTMENT

Examples:

- Child being seen in clinic and doctor has found bruising that is not consistent with the child/parents explanation.
- Consultant notices deterioration in the child as the parent refuses to follow medical advice regarding the treatment of the child.

Process

Following a concern; (copied from the current procedures)

- The doctor should obtain an explanation from the child, parent or carer;
- The concern and explanation must be documented;
- If the explanation is **consistent** with the observed signs and does not indicate any cause for concern relating to a possible non-accidental injury, the doctor involved need take no further action other than reviewing at the next contact with the child;
- If the explanation is **not consistent** with the signs or indicates the possibility of non-accidental injury, the doctor should contact and make a referral to the specialty attached social worker or duty social worker to plan assessment and management of the situation, .

The child's safety is paramount and consideration should be given to whether a child can return home.The social worker will liaise with the local social work team, and in conjunction with them, assess the safety issues for the child and make the appropriate arrangements.

Concerns should be shared with the parents unless this would place the child at risk of harm. In some cases, the severity of the mark or injury may warrant admission of the child to GOSH.

Documentation:

Referral Form - Should be completed by the person who observed or has the concerns. This can be written using the duplicate Referral to social work forms or completed electronically.

Written referral forms - If you fill in a written referral form you must take it to the social work department or give it to the duty or ward allocated social worker within 24 hours of the concern being raised with the social work department.

After consultation with the social work manager the social worker will advise you if the referral is to be progressed as a child protection case (in this case an orange divider and accompanying orange paperwork, usually the conclusion to CP actions, will be put into the child's medical notes by the social worker). The white (top copy) of the referral form will be inserted in to the notes and the social worker will retain the blue copy.

Electronic referral forms - If you choose to complete an electronic form you can download a form by going to GOSH WEB and right clicking on "social work referral form". You can then save the form, complete the form electronically, and email it to [redacted]

The same procedure will be followed by the social worker as above.

Divider - The divider will be inserted by the social worker once they are informed by the person observing the concern and if they deem the concern to be child protection.

The Key contacts form - The social worker will complete this form but the clinician involved may add to it if they have relevant contact details. The lead consultant should complete their details.

Multi-disciplinary chronological record - All professionals can contribute to this documentation. All information relating to the child protection concern should be documented on these sheets by all staff involved.

Child Protection Conclusion to Actions - The social worker should complete an action plan, alert the doctor to sign and should then insert into the child's medical file. This will usually take the form of a "Conclusion to Action" sheet because of the timescale of children attending outpatient

appointments and their subsequent discharge. If the child attends a subsequent appointment and the divider is in the notes a re referral should be made to the social work department. This will allow the social work team to update the status of the concern and the CP actions if appropriate.

2.2.18 CONCERNS ARISE ONCE THE CHILD HAS LEFT OUTPATIENT APPOINTMENT

Examples:

- Child being seen in clinic, doctor acknowledges that child's' appearance is poor and unkempt. It is not until the family have left the hospital that they consider that there may be concerns of neglect
- Child attends outpatient appointment for an x-ray. Upon review of the x-ray, rib fractures of varying ages are noted indicating possible non-accidental injury.

- It is the responsibility of the staff member who observed the behaviour or injury, and who knows the family circumstances, to refer the concerns to the local social services department so that all the information is first hand.

- The social work department, named nurse and named doctor are available to advise and support staff in carrying out their responsibility.

Process:

a) The person who observed the behaviour or injury should refer the concerns to the duty social work team in the child's local social services department. The contact details of the local Social Services Department can be obtained from the GOSH Social Work department.
b) The following information should be given to the duty team in the child's local social services department:
    - Child and family details
    - Detail the cause for concern including details of incident or allegation, source of concern, timing and location.
    - Child's current location and emotional and physical condition
    - An appropriate assessment of risk to the child.
    - Information regarding parental knowledge of, and agreement to, the referral.

c) The local social services department may be able to share information with you regarding the child and notify you of the next course of action.
d) The details of the conversation should be documented on the multidisciplinary chronological record in the child protection section of the child's medical notes.

Documentation:

Referral Form - A written referral should be completed by the person who observed the concerns. The referral Should be made to the child's local authority, however, the GOSH social work department should also be made aware of this referral so that they can ensure that if appropriate a cp divider and accompanying orange paperwork is inserted in o the child's file

Divider - the GOSH social worker will insert the divider if appropriate.

Key Contacts - the GOSH social worker will insert the key contacts as part of the orange paper work if appropriate. The person corresponding with the Local Authority can complete the key contacts sheet.

Multi-disciplinary chronological record - All professionals who are involved with the child can contribute to this documentation. All information relating to the child protection concern should be documented on these sheets by all staff involved.

Child Protection Conclusion to Actions - The social worker should complete a "Conclusion to Action" sheet because of the timescale of children attending outpatient appointments and their subsequent discharge. If the child attends a subsequent appointment and the divider is in the notes a re - referral should be made to the social work department. This will allow the social work team to update the status of the concern and the cp actions if appropriate.

The doctor should sign the form and then the form should be inserted into the child's medical file by the GOSH social worker or the involved professional. This should happen whether or not the child is likely to attend GOSH in the future.

2.2.19 STAFF ARE INFORMED THAT THERE ARE CHILD PROTECTION CONCERNS BUT NO CONCERNS ARE OBSERVED

Examples:

A. If the concern is one of notification e.g. the Dr is notified by the attending parent/or carer that the child is known to be subject to a child protection plan or has a child protection social worker locally in the community
B. Referral letter or history specifies that the child is subject to a plan or there is or has been local child protection social work involvement

Make a written or electronic referral to the GOSH social work Department who will decide if:

The Child Protection Divider and accompanying orange paperwork should be inserted in the child's notes along with the accompanying orange paperwork (which will normally consist of a Conclusion to CP actions only.)

If you have concerns about anything else in relation to the visit e.g. who is accompanying the child, if social work is involved and you need advice of any sort regarding the nature of the involvement.

Or

If you need some advice. Remember, you can contact the duty social worker if you are unsure of any safeguarding concern in respect to an outpatient attendee.

Process (for A and B)

- Clinician should contact the GOSH social work service.
- GOSH social work service will contact the child's local social services department to verify if the child is on the list of children subject to a plan and get a copy or details of the plan.
- The social worker will record on an action plan (Conclusion to Action Plan) any relevant information and file it in the child protection section of the child's medical notes.
- The social worker will inform the child protection administrator if the child is subject to a plan and / or if the child has been removed from the list so that PIMS can be updated.
- The Conclusion to Action Plan will be completed once the child has attended their appointment or immediately if the appointment is not within the week.

If there is current CP paperwork in the medical file, a referral should be made to the GOSH social work department who will record an updated assessment on the CP paperwork..

Documentation:

Referral Form - A written referral should be completed by the person who observed the concerns. The referral should be made to the child's local authority, however, the GOSH social work service should also be made aware of this referral so that they can ensure that if appropriate a CP divider and accompanying orange paperwork is inserted in the child's file.

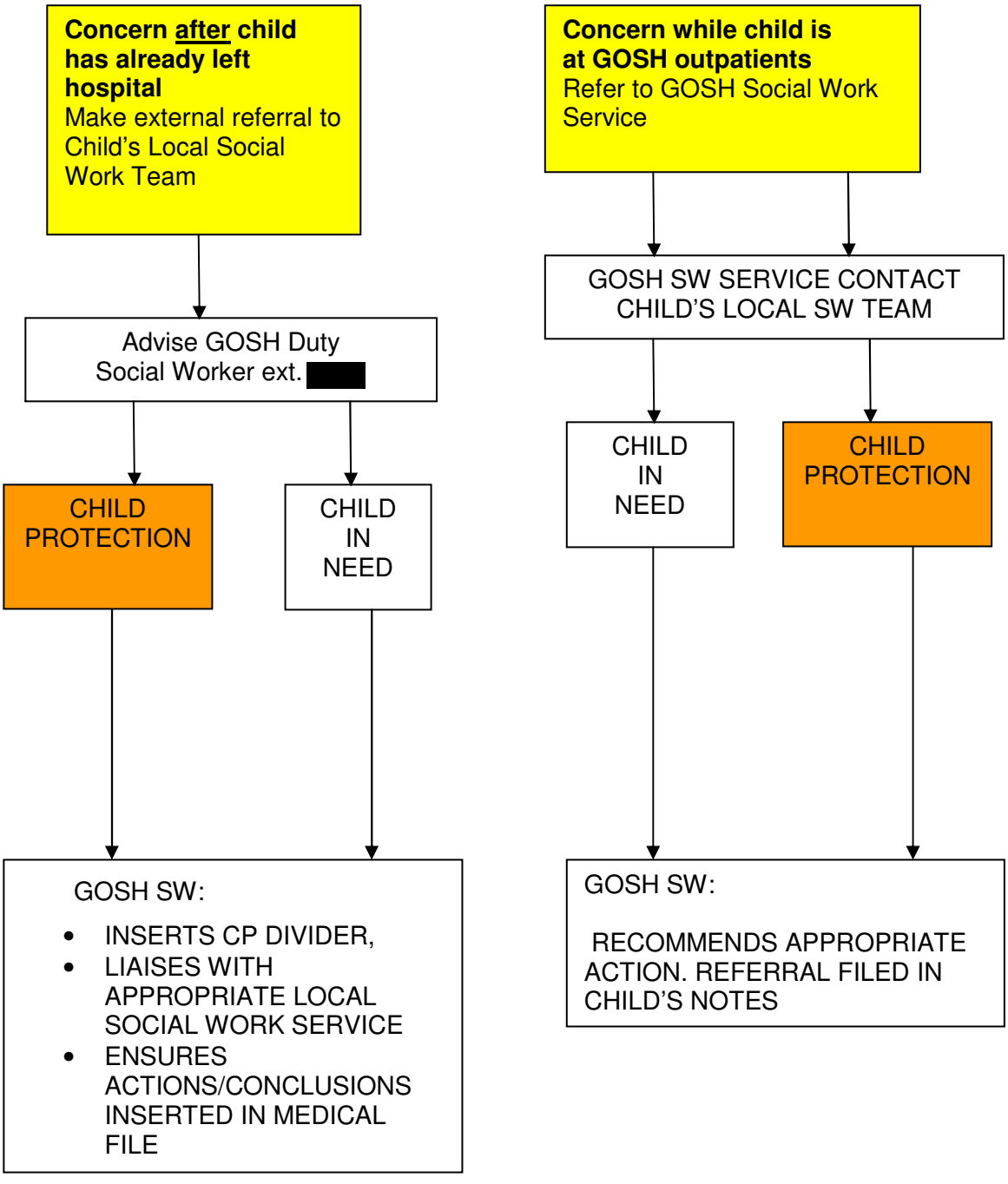
Divider - the GOSH social worker will insert the divider if appropriate.

Key Contacts - the GOSH social worker will insert the key contacts as part of the orange paper work if appropriate. The person corresponding with the Local Authority can complete the key contacts sheet.

Multi-disciplinary chronological record - All professionals who are involved with the child can contribute to this documentation. All information relating to the child protection concern should be documented on these sheets by all staff involved.

Child Protection Conclusion to Actions - The social worker should complete an Actions/conclusion form, with updated child protection information. This is to be signed by the appropriate consultant, and placed in the child's medical file.

IMMEDIATE RESPONSES TO SUSPICIONS & CONCERNS (OUTPATIENTS)



DIPLOMATIC IMMUNITY

2.2.20 Children of diplomatic agents are immune from proceedings under the *Children Act* 1989 [ref.12] unless they are citizens of the United Kingdom.

2.2.21 If abuse of such children is suspected it may be possible to ask the Foreign Office to intervene.

2.2.22 Legal advice must be taken if this situation arises. For consultation on a childcare matter, contact the Social Work Department. For other legal advice contact:

- Assistant Director Clinical Governance and Safety , ext: [redacted] or
- Legal advisors, ext: [redacted]

DOCUMENTATION

2.2.23 The hospital uses its own paperwork and processes to record child protection concerns in the child's medical notes. The specific guidance should be followed [Supplement 8: Documentation]. However, the general principles outlined below are shared throughout GOSH.

2.2.24 Demographic details about the child, parents and siblings should be documented on first contact.

2.2.25 The referrer should keep a written record in the appropriate section of the child's medical notes [i.e. CP section]:

- Discussions with the child
- Discussions with parent or carer
- Any explanations offered by child or parent / carer
- Any discussion about the concern/referral e.g. managers, hospital social worker, named doctor, named nurse and other specialist teams
- Information offered to child or parent / carer
- Information provided to the social worker
- Decisions taken [clearly timed – using 24 hour clock, dated and signed]
- All liaison with the home authority

2.2.26 A copy of the referral form should be placed in the child's medical record.

2.2.27 It is vital in all cases of concern, suspected or actual child abuse and neglect that the following information is documented by all relevant staff in the appropriate section of the child's medical notes using the appropriate forms:

- All conversations between professionals both internally and externally
- All conversations between professionals and the family
- All conversations with the child
- Any concerns that are observed
- Recommendations or investigations, interventions and treatment including timescales
- Discussions undertaken on ward rounds and psychosocial meetings, the resolution of differences of opinions e.g. cause of bruising
- Actions taken and by whom

2.2.28 Records should: [Supplement 21: Record Keeping]

- Be contemporaneous, signed, name printed (with contact details e.g. bleep number), dated and timed (using the 24 hr clock), following Trust and professional guidance
- Include accurate and factual description of the child's behaviour and physical marks or signs illustrated by drawing, noting location, size, shape, and colour on the appropriate body diagram [appendix 2: body diagrams]; photographs [Supplement 17: Photography] where relevant, including any explanation offered by the child, parent or carer
- Be legible and retrievable – medical records may be used at a later date in court

2.2.29 If there is a dispute over the nature of a child protection concern, a social work manager at GOSH should be contacted for further discussion, support and guidance. It is important such disputes are resolved by common agreement and the reasons for this are recorded [ref.8].

COMMUNICATION BETWEEN PROFESSONALS

2.2.30 Any concerns about a child should take into account issues associated with diversity whilst promoting her/his well-being and safeguarding the child from significant harm. This depends crucially

upon effective information sharing, collaboration and understanding between agencies [ref.11].

2.2.31 Whilst any enquiries are being made into concerns about a child's welfare or safety and, in particular, during any attendance or admission of the child to hospital, information must be frequently and regularly shared between all professionals concerned, including for example the hospital school where relevant. Staff should keep an open and objective view at all stages, including documenting the source of all relevant information available. Appropriate advice and support at each stage can be obtained from a hospital social worker / named doctor / named nurse [Supplement 22: Roles].

2.2.32 If professionals from external agencies contact the ward directly about concerns about a child's welfare or safety, information should not be shared until their identify has been verified i.e. telephoning them back (see Information Sharing Protocol). Contact should be fully recorded and relevant people informed of the contact. In addition It is essential that ward and medical staff inform the allocated or duty social worker of any such contact, identifying any relevant information shared, and confirming actions taken in the relevant section of the child's medical records [i.e. CP section in GOSH medical notes].

2.2.33 Members of the ward staff will be supported throughout the process, by the appropriate professionals who may include a ward based or duty social worker, named nurse, named doctor or the lead/admitting consultant [Supplement 22: Roles].

2.2.34 When there are child protection concerns, a Consultant responsible for the child protection aspects of the child's care should be identified. This may be the admitting consultant, Lead Consultant, or another individual who agrees to accept the role. The responsible Consultant should be named in the child's medical notes. If there are difficulties in identifying which Consultant will be responsible for the child protection aspects, the Named Doctor should be contacted for advice.

2.2.35 The identified consultant will be responsible for the child protection aspects of the case and they will coordinate liaison with other disciplines involved, following the child protection policy and any inter disciplinary or multi agency plan agreed. In circumstances where there may be a difference in opinion in relation to individual case management a social worker / named doctor / named nurse should be consulted and the original plan should continue until negotiated amendments are agreed and in place, including discussion and agreement by the local authority Children's Social Work Service responsible for the child.

2.2.36 In complex medical cases, which may require lengthy admission, there are likely to be several internal discussions between members of the hospital staff, including the local authority Children's Social Work Service and other agencies. In all cases involving concerns about a child's welfare or safety a Lead Consultant should be identified to facilitate effective communication, particularly when the child is under the care of more than one consultant [Supplement 22: Roles].

2.2.37 The Lead Consultant should ensure clear lines of communication among all ward staff. This may also include further attendance at internal meetings / psychosocial meetings. Members of the hospital Children's Social Work Service/ named doctor / named nurse will actively facilitate and promote effective communication.

2.2.38 Relevant child protection communication with the child / parents will be undertaken by the Lead Consultant and allocated social worker following internal discussion or strategy meetings [Supplement 7: Communicating Directly with Parents and Children].

2.2.39 Where parents or carers express concerns about any service they are receiving from a GOSH service, including management of concerns about a child's welfare or safety they may wish to involve Pals to advise and support them. In such cases staff should be aware and understand the role of Pals [Supplement 22: Roles].

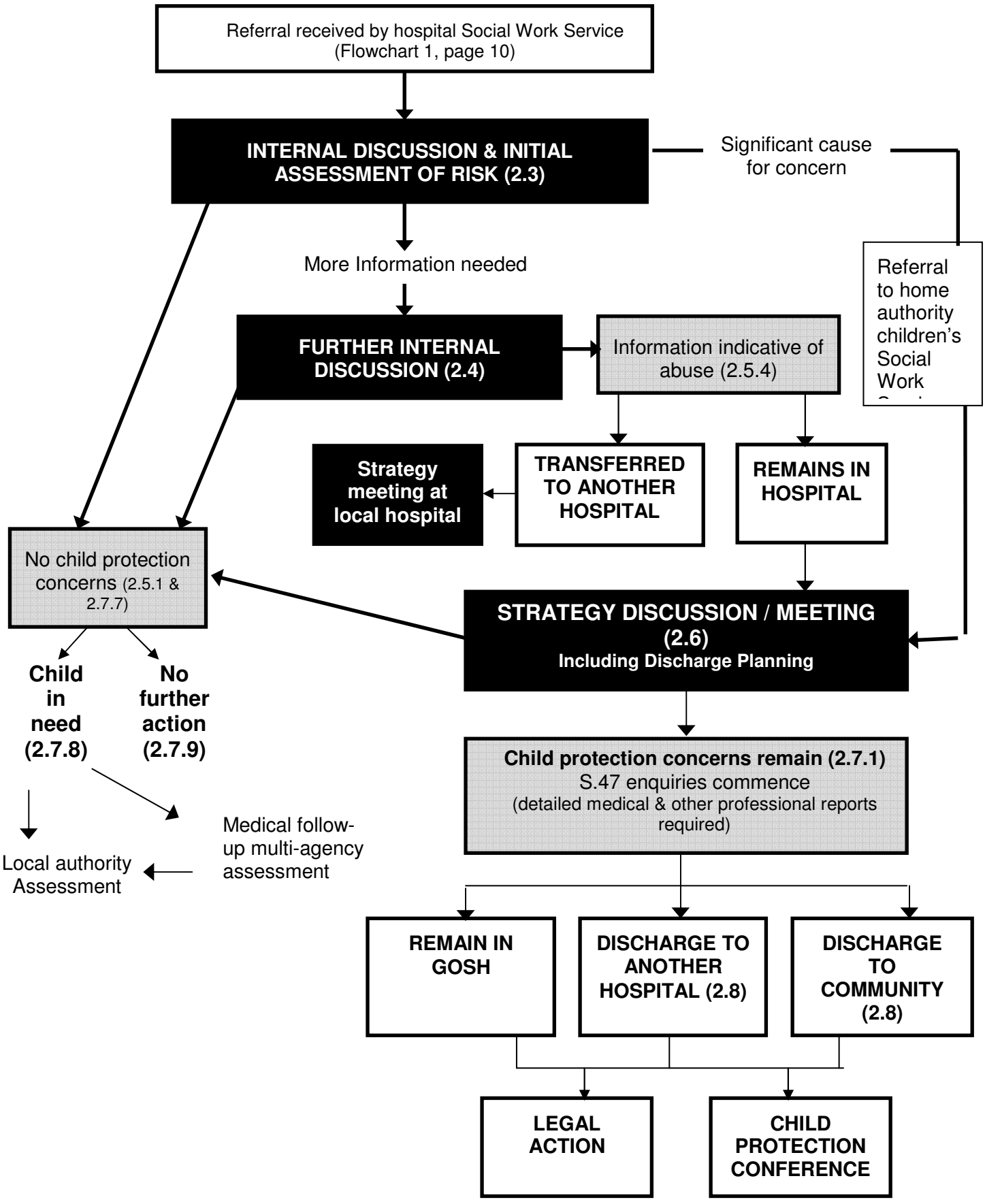
COMMUNICATION & INFORMATION

2.2.40 GOSH have a responsibility to ensure staff, children and their parents or carers have all the information they require to help them understand the processes that will be followed when there are concerns about a child's welfare or safety. Information should be clear and accessible and available in the family's preferred language. In each case a lead professional will be identified to support the family accessing relevant information.

2.2.41 If the child and / or family member has a specific communication needs, either of language or disability, it may be necessary to use the services of a specially trained independent interpreter or play worker [at a level identified by the court's to undertake child protection work], or to make use of other aids to facilitate communication.

MANAGEMENT OF SUSPICION OR CONCERNS

(Flowchart 2)



2.3 INTERNAL DISCUSSION & INITIAL ASSESSMENT OF RISK

2.3.1 'Internal discussion' is sharing of information between professionals and may take the following forms:

- A series of time limited telephone calls
- An informal face-to-face discussion between professionals; or
- A formal internal meeting which is chaired by a Social Work Service manager and minuted by an administrator
- Contact with members of the Primary Health Care Team as appropriate

Where child protection concerns are identified a formal strategy meeting should be convened [2.6].

2.3.2 The child's Lead Consultant should be informed that an internal discussion/ meeting is being convened.

2.3.3 Relevant Information to be shared includes:

- Full names, date of birth and gender of child/ren including siblings
- Family address and [where relevant] school / nursery attended
- Identity of those with parental responsibility
- Names, age and date of birth of all household members
- Ethnicity, first language and religion of children and parents/carers
- Any special needs of the child/ren particularly around communication issues
- Any significant / important recent or historical events / incidents in the child's or family's life
- Causes for concern including details of any allegations, their sources, timing and location
- Whether concerns are about possible fabricated or induced illness
- Reason for attendance / admission / appointment including medical plan
- Any observations or information about family interactions and behaviour, including responses to hospital staff
- Child's current location, behaviour, emotional and physical condition including any signs giving rise to concerns or suspicion
- Whether the child needs immediate protection

- Details of alleged perpetrator, if known
- Details of any agencies / professionals already known to be involved and if there are any existing or previous child protection concerns.
- Current whereabouts of the parents and what information has been shared with them and by whom [ref.8]

DECISIONS & CONSIDERATIONS

2.3.4 The discussion / internal meeting must:

- Share all information known to the hospital team
- Assess the information known to date
- Decide what further information is required at this stage and from whom
- Establish whether concerns are validated or not
- Identify an action plan, including allocation of tasks
- Decide what, when and who to inform the parents about the concerns
- Decide what, when and how to inform the child about the concerns
- Identify support needs of child, family and staff
- Confirm who the Lead Consultant is so they can take responsibility for the child protection case, if concerns persist
- Set a date for further meetings if relevant (within 7 days max)
- Assess whether there is a need for a press briefing.

2.3.5 When an allegation or suspicion is serious, or information is indicative of abuse, a strategy meeting [2.6] may take place on the same day.

2.3.6 The Lead Consultant will:

- Provide details of the current medical situation
- Review all previous admissions to hospital and contact with medical professions (this may include information about admissions under a different speciality when there should be discussion between the previous clinicians and the current team)
- Maintain an overview of the child protection section in the child's medical notes, ensuring information has been referred to the appropriate professionals and
- Ensure further information obtained from GP / other relevant doctors

2.3.7 The above action may clarify:

- A continuing uncertainty about the cause of the child's condition
- The child is not responding to treatment or
- There are unusual observations [Supplement 13: Identification of Abuse]

2.3.8 This process will help bring together fragmented events and facilitate:

- Identification of any medical investigations which may be required to clarify the situation e.g. full skeletal survey
- Organisation of photographs of injuries including obtaining photographic consent [Supplement 17: Photography]
- Compliance with the 'head injury protocol' for relevant under 2 year olds [Supplement 11: Head Injury Protocol] and
- The request for a specialist paediatric examination, in consultation with the social worker, when there is suspicion of sexual abuse or the Lead Consultant is uncertain about injuries such as bruises and feels a 2nd opinion would be beneficial [Supplement 15: Medical Examination]

2.3.9 If the child requires an examination by a specialist paediatrician, specific consent will be required from a person with parental responsibility or the child if they are 'Gillick competent'. The reason for the 2nd examination should be discussed with the child and parent, unless it is felt that doing so would expose the child to further risk of harm, for example in cases of fabricated or induced illness.

2.3.10 Timing of any 2nd examination should be agreed by the specialist consultant, Lead Consultant and social worker.

2.3.11 The social worker should check for salient information with the child, parent and relevant agencies, obtaining the child's if 'Gillick competent' or parent's permission for checks to be made unless

this is contrary to the child's welfare, in which case reasons for this must be recorded.

2.3.12 In cases of discrepancies between reports and observations / findings in the child or where the medical condition is unexplained, fabricated or induced illness may be a possibility, and the named doctor for child protection should be informed. Consideration should be given to involving a consultant general paediatrician with expertise in fabricated or induced Illness for support and guidance [Supplement 10: Fabricated or Induced Illness].

2.4 FURTHER INTERNAL DISCUSSION

2.4.1 Any further internal discussions should follow the format as outlined above in 2.3 and if suspicions are confirmed as a result of further observation, information or adverse events, a referral should be made to the local authority with statutory responsibility for the child.

2.4.2 It is important that internal discussions are not used in-place of strategy meetings, and that following a second internal discussion if concerns have not been resolved, unless the case is particularly complex, for example FII, then a strategy meeting should be convened.

2.4.3 If the local authority do not move to convene a strategy meeting and the concerns raised indicate there are safeguarding concerns that warrant a section 47 investigation then the GOSH social work management should go up the line in the local authority to ensure they convene a strategy meeting.

2.5 OUTCOMES

NO CHILD PROTECTION CONCERNS

2.5.1 If, after the initial enquiries and checks, child protection concerns are not identified:

- Full details should be documented within the appropriate section of the child's medical notes that the concern has been investigated and there are no child protection concerns [Supplement 8: Documentation]
- Appropriate medical intervention will continue
- The local Children's Social Work Service should be kept informed of any further developments as appropriate by the lead professional
- Where relevant, a core assessment carried out by the local Children's Social Work Service may be agreed [2.7.8 for further information]
- Decisions should be made about how and by whom to inform the child / parents about the concerns which are felt unfounded

2.5.2 Information about child protection concerns must not be removed from the child's medical notes even if it is decided following a meeting that the child protection concerns were not substantiated.

2.5.3 **At GOSH,** a child protection section will have been inserted into the child's medical notes; this **must not** be removed even if the concern has been resolved.

INFORMATION INDICATIVE OF ABUSE

2.5.4 If Information indicates concerns about a child's welfare or safety, s/he should remain on hospital premises until a referral has been made to the relevant Children's Social Work Service and an action plan agreed. Ideally a strategy discussion will take place the same day and should involve the police. If the child leaves the hospital prior to an agreed action plan being in place further discussion should take place immediately with the relevant Children's Social Work Service.

2.6 STRATEGY DISCUSSIONS / MEETINGS

2.6.1 It is the responsibility of the child's home local authority to lead a strategy discussion/meeting. This is by nature a multi-agency meeting, involving the police, social work and health, to plan the child protection investigation. This may take place as follows:

- Discussion by phone may occur where the matter is of such urgency there is no time to convene a meeting or there is no need for a meeting to be held in the hospital as one has been organised in the community
- Communications must be documented by all parties to the discussion and will include any information shared, decisions reached, and the basis for those decisions
- A formal meeting, for which a dedicated minute taker is essential

- There may be a need for a series of strategy meetings before this stage is completed, especially in complex cases such fabricated or induced illness

PURPOSE OF DISCUSSIONS / MEETINGS

2.6.2 Aims, in addition to the information gathered via internal discussions are to:

- Decide whether there are child protection concerns which warrant a Core Assessment to inform enquiries under s. 47 of the Children Act 1989 [ref.12]
- Ensure that there are plans in place to protect the child
- Decide what and how information will be shared with the parents and the child
- Allocate tasks and set time scales
- Determine if legal action is required and by whom and
- Agree co-ordination of any criminal investigation

PROFESSIONAL ATTENDANCE

2.6.3 Attendance should be kept to minimum but key representatives from the hospital, police, children's social work, and possibly education should be present.

2.6.4 The chair of the meeting (child's home local authority) will decide attendance of key professionals, including legal representation and the Police, following discussion with the hospital Social Work Service.

2.6.5 Where a specialist consultant's opinion has been sought and is crucial to the decision making process, s/he should be invited, as should the named nurse and named doctor, especially in complex cases i.e. FII concerns.

2.6.6 The local Children's Social Work Service for the area in which the child normally resides should attend and is responsible for:

- Chairing the strategy meeting (this should be clarified beforehand);
- Inviting all relevant local and hospital professionals involved in the care of the child, including Lead Consultant. The Named Nurse and Named Doctor should be invited but will only attend if their professionals support or expertise is required.
- Taking and producing minutes, in keeping with London Child Protection Procedures [ref.19]

PARENTAL / CHILD ATTENDANCE

2.6.7 Parents or mature children are not usually invited to attend strategy meetings although they may be told they are taking place subject to the decision of the local authority Children's Social Work Service.

2.6.8 In complex cases, e.g. fabricated or induced illness [Supplement 10: Fabricated or Induced Illness], the parents should not be informed about the meeting if this is felt not to be in the child's best interests. Any such decisions should be recorded on the hospital Children's Social Work Service file.

2.7 OUTCOME OF STRATEGY MEETING

CHILD PROTECTION CONCERNS REMAIN

2.7.1 If the strategy meeting concludes that the child is at risk of actual or likely significant harm, the local authority Children's Social Work Service has a duty to make enquiries under s.47 of the Children Act 1989 [ref.12].

2.7.2 Following any strategy meeting, an action plan should be identified and implemented, and a copy placed in the child's medical notes, including:

- How the terms of any relevant legal order will be applied
- Scope and plan for s.47 enquiries
- Plan for management if child is to remain in hospital, including contact with parents
- A contingency plan for non co-operation or removal of child from hospital against advice by child / parents, including legal options
- Strategy meeting decisions to be shared with child / parents by the home local authority Social Work Service.

2.7.3 In cases of fabricated or induced illness, any action plan should follow the guidance detailed in Supplement 10: Fabricated or Induced Illness including any expert opinion given.

2.7.4 Throughout enquiries, all professionals must remain objective. Hospital staff, regardless of whether the child remains in hospital, is discharged or medical follow up takes place at the hospital, have a duty to comply with any requests for support and assistance within a multi agency plan, so long as consistent with the child's safety and welfare [ref. 11].

2.7.5 No significant changes should be made to the plan, unless a further strategy meeting has been convened, chaired by the local

authority Children's Social Work Service and any agreed changes confirmed. Any concerns in relation to the management of the child protection plan should be immediately referred to a hospital social worker. In the case of concerns arising out of hours the GOSH child protection protocol should be followed [2.2.9].

2.7.6 Continuing care and contact should be carried out in such a way as to minimise distress to the child and to ensure that families are treated sensitively and with respect within a multi agency framework.

NO CHILD PROTECTION CONCERNS

2.7.7 Information gathered and discussion in the strategy meeting may decide that no further child protection intervention is necessary in which case procedures in routine discharge arrangements should be followed [see 2.8].

CHILD CONSIDERED IN NEED

2.7.8 Following initial assessment, discussion or a strategy meeting the child may be considered as a child in need as defined by s.17 Children Act 1989 [ref.12]. A Common Assessment Framework (CAF) or core assessment (Assessment Framework) may be initiated to enable the local authority Children's Social Work Service to make the appropriate provision.

NO FURTHER ACTION CONSIDERED NECESSARY

2.7.9 No further action (NFA) may be indicated as the result of an internal or strategy meeting. This should be clearly documented in the CP section of the child's medical notes [CP section at GOSH main site]

2.7.10 Where parents or a mature child were unaware of the protection concerns and enquires, there must be a professional discussion to agree what information is to be conveyed to the parents or child and who will do this.

DISPUTE

2.7.11 Any dispute about the outcome of the strategy meeting should immediately be referred to senior management within the child's home authority and GOSH senior management.

2.8 DISCHARGE

2.8.1 It may be confirmed in the Strategy meeting that there are child protection concerns, and that the child is medically able to be discharged i.e.

- Transferred to another hospital
- Discharge to community (i.e. return home to parents/relatives or a fostering arrangement)

2.8.2 Before the child is discharged, the strategy meeting should agree a plan to ensure that the child will be adequately protected following discharge. It may be decided that a separate meeting is convened to discuss discharge. This planning should involve all key multi agency professionals. Any such plan will be documented in the appropriate section in the child's medical notes by the Lead Consultant and social worker. An assessment using the Common Assessment Framework (CAF) may be used to inform the action plan.

2.8.3 If the child is being transferred to another hospital, the Lead Consultant should provide the receiving hospital with clear written information (Discharge Notification) including:

- Diagnosis and treatment
- Explicit child protection summary of concerns and action taken
- What information has been shared with the parents
- Nature of follow-up at GOSH
- Key professionals involved at GOSH
- Details of any relevant discussion / strategy action plan

2.8.4 If it is agreed that the child should be discharged to the community, the Lead Consultant should ensure the child has a GP identified. The Lead Consultant should provide the GP with clear written information (Discharge Notification) as outlined in 2.8.3. If a GP can not be arranged before discharge, the reasons and action plan need to be carefully documented in the child's Health Record.

2.8.5 Where there are ongoing concerns but a plan has been agreed to ensure that it is safe to discharge the child to the community, the health service referrer should be informed of the concerns in writing before discharge.

2.8.6 In addition, a discharge summary should be prepared within 3 weeks of discharge which should state the likelihood of abuse or neglect and all child protection concerns including actions taken.

2.9 SERIOUS CASE REVIEWS

2.9.1 A serious case review is a review of a serious case when a child dies, and abuse or neglect is known or suspected to be a factor in the death. The review is undertaken by Local Safeguarding Children's Boards (LSCB) in the Local Authority where the child usually lives. The case must meet the criteria set out in Chapter 8 of *Working Together to safeguard children*. (as above) . In addition, The LSCB must also consider:

- Child sustains a potentially life-threatening injury or serious and permanent impairment of health and development through abuse or neglect; or
- A child has been subjected to particularly serious sexual abuse; or
- A parent has been murdered and a homicide review is being initiated; or
- A child has been killed by a parent with a mental illness; or
- The case gives rise to concerns about inter-agency working to protect children from harm.

2.9.2 At GOSH due to the tertiary nature of referrals to our hospital we may be requested by any Local Authority nationally to contribute to a Serious Case Review where it is known that we have had involvement with a child or young person. The correct procedure for responding to a request is outlined in the pathway at Appendix 3.

3 ONGOING CHILD PROTECTION

3.1 CHILD SUBJECT TO A CHILD PROTECTION PLAN

GENERAL

3.1.1 An electronic record is maintained by each local authority Children's Social Work Service of all children resident in its area for whom there is a child protection plan.

3.1.2 The purpose of the above record is to make agencies and professionals aware of those children who are judged to be at continued risk of significant harm and ensure effective multi-agency working in order to safeguard those children.

3.1.3 All hospital staff should ensure that professionals involved with the care and safety of these children whilst they are in hospital are aware of and can ensure the protection plan is maintained.

3.1.4 The procedural requirements for GOSH are described in 3.2

3.2 PIMS ALERTS

3.2.1 If a member of staff is given information relating to a child being subject to a child protection plan, s/he must immediately inform the hospital Children's Social Work Service, who will be able to verify the information and clarify the plan.

3.2.2 GOSH Children's Social Work Service has responsibility for verifying whether a child is subject to a child protection plan (when informed by hospital staff or other agencies that one exists). A PiMS Patient Alert will be added to the child's record, by the Child Protection Administrator. This should be removed when informed s/he is no longer subject to a CP plan.

3.2.3 If a member of staff is given information relating to a child subject of a child protection plan, s/he must immediately inform the hospital Children's Social Work Service, who will be able to verify the information and clarify the plan.

Access to 'PiMS' Alert

3.2.4 To ensure confidentiality it has been agreed that the following staff groups will have access to this information:

- Doctors
- Nursing staff
- Social workers
- Allied health professionals
- Ward administrators and clinicians' assistants

3.2.5 When a child is known to be subject to a child protection plan, a child protection divider must be inserted into her/his medical notes. A child protection actions form (orange paperwork) must be completed by the GOSH social worker and signed by the social work manager, GOSH social worker and the lead Consultant. The actions form is to be updated, in line with the guidance on the form, if any changes occur. A child protection conclusion form must be completed and signed as for the actions form, either when the professional network has agreed there are no ongoing concerns or when CP concerns may be ongoing, but discharge to another hospital has been agreed and the CP episode at GOSH has been completed.

4 ALLEGATIONS OF CHILD ABUSE MADE AGAINST A MEMBER OF STAFF

4.1.1 Despite all efforts to recruit safely there will be occasions when allegations of abuse against children are raised. Staff are expected to follow high standards of conduct in their private as well as their working life. Professionals who work with children must be aware that safe practice also involves using judgement and integrity about behaviours in places other than the work setting. Staff should also understand that when allegations arise regarding their behaviour and actions in relation to such allegations this may raise questions about their suitability to work with children

4.1.2 These procedures should be applied when there is an allegation or concern that any person who works with children, in connection with their employment or voluntary activity, has:

- Behaved in a way that has harmed a child, or may have harmed a child;
- Possibly committed a criminal offence against or related to a child;
- Behaved towards a child or children in a way that indicates they are unsuitable to work with children.

4.1.3 These behaviours should be considered within the context of the four categories of abuse (i.e. physical, sexual and emotional abuse and neglect). These include concerns relating to inappropriate relationships between members of staff and children or young people, for example:

- Having a sexual relationship with a child under 18 if in a position of trust in respect of that child, even if consensual (see sections 16-19 of the Sexual Offences Act 2003 [ref.18]);
- 'Grooming' i.e. meeting a child under 16 with intent to commit a relevant offence (see section 15 of the Sexual Offences Act 2003 [ref.18]);
- Other 'grooming' behaviour giving rise to concerns of a broader child protection nature (e.g. inappropriate text/e-mail messages or images, gifts, socializing etc);
- Possession of indecent photographs/ pseudo-photographs of children.

4.1.4 All references in this document to 'members of staff' should be interpreted as meaning all staff, whether they are in a paid or unpaid capacity (including volunteers).

ROLES AND RESPONSIBILITIES

4.1.5 The Chief Nurse/Director of Education (contacted via GOSH switchboard) is the identified senior officer with overall responsibility for:

- Ensuring that GOSH deals with allegations in accordance with the following procedures;
- Resolving any inter-agency issues and ensuring liaison with the relevant LSCB

4.1.6 The senior manager to whom allegations or concerns are reported for GOSH is:

- The manager on call (contacted via GOSH switchboard)
- In the absence of the manager on call or where that person is the subject of the allegation or concern the GOSH Director on call (contacted via GOSH switchboard) will be designated as the senior manager.

4.1.7 Local authorities designate an officer/s to:

- Be involved in the management and oversight of individual cases;
- Provide advice and guidance to employers and voluntary organisations;
- Liaise with the police and other agencies;
- Monitor the progress of cases to ensure that they are dealt with as quickly as possible consistent with a thorough and fair process.

4.1.8 The police detective inspector on each child abuse investigation team will:

- Have strategic oversight of the local police arrangements for managing allegations against staff and volunteers;
- Liaise with the LSCB on the issue;
- Ensure compliance.

4.1.9 The police designate a detective sergeant/s to:

- Liaise with the local authority designated officer (LADO);
- Take part in strategy meetings/ discussions;
- Review the progress of cases in which there is a police investigation;
- Share information as appropriate, on completion of an investigation or related prosecution.

4.1.10 The Children's Hospital School should also refer to chapter 5 of Safeguarding Children and Safer Recruitment in Education [ref.3] which covers issues relating to allegations of abuse made against teachers and other education staff.

INITIAL RESPONSE TO AN ALLEGATION OR CONCERN

4.1.11 Allegations against a member of staff may arise from a number of sources (e.g. a report from a child, a concern raised by another adult in the organisation, or a complaint by a parent).

Initial action by person receiving or identifying an allegation or concern

4.1.12 The person to whom an allegation or concern is first reported should treat the matter seriously and keep an open mind.

4.1.13 They should not:

- Investigate or ask leading questions if seeking clarification;
- Make assumptions or offer alternative explanations;
- Promise confidentiality, but give assurance that the information will only be shared on a 'need to know' basis.

4.1.14 They should:

- Make a written record of the information on a Trust Incident Form where available (where possible in the child/adult's own words), including the time, date and place of incident/s, persons present and what was said;
- Sign and date the written record;
- Immediately report the matter to the manager/director on call, or the manager on call where the manager/director on call is the subject of the allegation.

4.1.15 Where a Trust Incident Form was not available at the time of making written record, an incident form should be completed retrospectively.

Initial action by the manager/director on call

4.1.16 When informed of a concern or allegation, the manager/director on call should not investigate the matter or interview the member of staff, child concerned or potential witnesses. They should:

- Obtain written details of the concern/allegation, signed and dated by the person receiving (not the child/ adult making the allegation);
- Countersign and date the written details;
- Record any information about times, dates and location of incident/s and names of any potential witnesses;
- Record discussions about the child and/or member of staff, any decisions made, and the reasons for those decisions.

4.1.17 The manager/director on call should inform the Chief Nurse/Director of Education and the hospital duty social work manager as soon as possible. Dependent on the situation the Press Office [Supplement 19: Press Involvement] may also need to be informed in case of possible reports to the media).

4.1.18 The Manager/ Chief Nurse/Director of Education on call will agree who will be the Lead Senior Manager for the case. This person will lead this case and fulfil the responsibilities below. This will need to be someone who is able to make decisions on behalf of the Trust.

4.1.19 If the allegation meets the criteria in 4.1.2, the Lead Senior Manager should report the allegation or concern to the relevant LADO within 1 working day. Referrals should not be delayed in order to gather information and a failure to report an allegation or concern in accordance with procedures is a potential disciplinary matter.

4.1.20 If an allegation requires immediate attention, but is received outside normal hours the Lead Senior Manager should consult the local authority children's social work emergency duty team or local police and inform the LADO as soon as possible.

4.1.21 If an allegation is made directly to the hospital children's social work service, they should immediately report it to the manager/director on call.

Initial consideration by the Lead Senior Manager and the LADO

4.1.22 There are up to three strands in the consideration of an allegation;

- A police investigation of a possible criminal offence;
- Social work enquiries and/or assessment about whether a child is in need of protection or services;
- Consideration by an employer of disciplinary action.

4.1.23 The LADO and Lead Senior Manager should consider first whether details are needed and whether there is evidence or information that established that the allegation is false or unfounded. Care should be taken to ensure that the child is not confused as to dates, times, locations or identity of the member of staff.

4.1.24 If the allegation is not demonstrably false and there is cause to suspect that a child is suffering or is likely to suffer significant harm, the LADO should refer to duty manager of the hospital children's Social Work Service and ask them to convene an immediate strategy meeting / discussion.

4.1.25 The police must be consulted about any case in which a criminal offence may have been committed. If the threshold for significant harm is not reached, but a police investigation might be needed, the LADO should immediately inform the police and convene an initial evaluation (similar to strategy meeting/discussion), to include the police, employer and other agencies involved with the child.

4.1.26 References in this document to 'Strategy meetings/discussions' should read to include 'initial evaluations' where appropriate.

STRATEGY MEETING/ DISCUSSION

4.1.27 Wherever possible, a strategy meeting/discussion should take the form of a meeting. However, on occasions a telephone discussion may be justified. The following is a list of possible participants:

- LADO;
- Social Work Service Manager to chair (if strategy meeting);
- Relevant social worker;
- Lead Senior Manager;
- Human resources representative;
- Senior manager of the staff members profession or area of work;
- The person to whom the concern/allegation was first reported;
- Child's Medical Lead Consultant;
- Legal adviser where appropriate;
- Senior representative of the employment agency or voluntary organisation if applicable;
- Where applicable: those responsible for regulation and inspection (e.g. CQC or Ofsted);
- Where a child is placed or resident in the area of another authority, representative/s of relevant agencies in that area;
- Complaints officer if the concern has arisen from a complaint;
- Detective sergeant.

4.1.28 The strategy meeting/discussion should:

- Decide whether there should be a S.47 enquiry and/or police investigation and consider the implications;
- Consider whether any parallel disciplinary process can take place and agree protocols for sharing information;
- Consider the current allegation in the context of any previous allegations or concerns;
- Where appropriate, take account of any entitlement by staff to use reasonable force to control or restrain children (e.g. section 550a Education Act 1996 in respect of teachers and authorised staff) [ref.15];
- Consider whether a complex abuse investigation is applicable;
- Plan enquiries if needed, allocate tasks and set timescales;
- Decide what information can be shared, with whom and when.

4.1.29 The strategy meeting/discussion should also:

- Ensure that arrangements are made to protect the child/ren involved and any other child/ren affected, including taking emergency action where needed;
- Consider what support should be provided to all children who may be affected;
- Consider what support should be provided to the member of staff and others who may be affected;
- Ensure that investigations are sufficiently independent;
- Make recommendations where appropriate regarding suspension, or alternatives to suspension;
- Identify a lead contact manager within each agency;
- Agree protocols for reviewing investigations and monitoring progress by the LADO, having regard to the target timescales;
- Consider issues for the attention of senior management (e.g. media interest, resource implications)
- Consider reports for consideration of barring;
- Consider risk assessments to inform the employer's safeguarding arrangements;
- Agree dates for future strategy meetings/discussions.

4.1.30 A final strategy meeting/discussion should be held to ensure that all tasks have been completed and, where appropriate, agree an action plan for future practice based on lessons learnt.

ALLEGATIONS AGAINST STAFF IN THEIR PERSONAL LIVES

4.1.31 If an allegation or concern arises about a member of staff, outside of their work with children, and this may present a risk of harm to child/ren for whom the member of staff is responsible, the general principles outlined in these procedures still apply.

4.1.32 If the member of staff lives in a different authority area to that which covers the workplace, liaison should take place between the relevant agencies in both areas and a joint strategy meeting/discussion convened.

4.1.33 In some cases, an allegation of abuse against someone closely associated with a member of staff (i.e. partner, member of the family or other household member) may present a risk of harm to child/ren for whom the member of staff is responsible. In these circumstances, a strategy meeting/discussion should be convened to consider:

- The ability and/or willingness of the member of staff to adequately protect the child/ren;
- Whether measures need to be put in place to ensure their protection;
- Whether the role of the member of staff is compromised.

PERSONS TO BE NOTIFIED

4.1.34 The LADO will advise GOSH whether or not informing the parents of the child/ren involved will impede the disciplinary or investigative processes. Acting on this advice, if it is agreed that the information can be fully or partially shared, an agreed person should inform the parent/s. In some circumstances, however, the parent/s may need to be told straight away (e.g. if a child is injured and requires medical treatment).

4.1.35 The parent/s and the child, if sufficiently mature, should be helped to understand the processes involved and be kept informed about the progress of the case and of the outcome where there is no criminal prosecution. This will include the outcome of any disciplinary process, but not the deliberations of, or the information used in, a hearing.

4.1.36 GOSH, together with the children's social work and/or police should consider the impact on the child concerned and provide support as appropriate. Liaison between the agencies should take place in order to ensure that the child's needs are addressed.

4.1.37 GOSH should seek advice from the LADO, the police and/or local authority children's social work about how much information should be disclosed to the accused person.

4.1.38 Subject to restrictions on the information that can be shared, the line manager and GOSH HR representative should, as soon as possible, inform the accused person about the nature of the allegation, how enquiries will be conducted and the possible outcome (e.g. disciplinary action, and dismissal or referral to the barring lists or regulatory body). They should also be advised to contact their union or professional association where applicable.

4.1.39 The accused member of staff should:

- Be treated fairly and honestly and helped to understand the concerns expressed and processes involved;
- Be kept informed of the progress and outcome of any investigation and the implications for any disciplinary or related process;
- If suspended, be kept up to date above events in the workplace.

CONFIDENTIALITY

4.1.40 Every effort should be made to maintain confidentiality and guard against publicity while an allegation is being investigated or considered. Apart from keeping the child, parents and accused person (where this would not place the child at further risk) up to date with progress if the case, information should be restricted to those who have a need to know in order to protect children, facilitate enquiries, manage related disciplinary or suitability processes.

SUSPENSION

4.1.41 Suspension is a neutral act and it should not be automatic. It should be considered in any case where:

- There is cause to suspect a child is at risk of significant harm; or
- The allegation warrants investigation by the police; or
- The allegation is so serious that it might be grounds for dismissal.

4.1.42 The possible risk of harm to children should be evaluated and managed in respect of the child/ren involved and any other children in the accused members of staff's home, work or community life.

4.1.43 If a strategy meeting/discussion is held or if local authority children's social work service or the police are to make enquiries, the LADO should canvass their views on suspension and inform the employer. Only the employer, however, has the power to suspend an accused employee and they cannot be required to do so by a local authority or police.

4.1.44 If a suspended person is to return to work, GOSH should consider what help and support might be appropriate (e.g. a phased return to work and/or provision of a mentor), and also how best to manage the

member of staff's contact with the child concerned, if still in the workplace.

RESIGNATIONS AND 'COMPROMISE AGREEMENTS'

4.1.45 Every effort should be made to reach a conclusion in all cases even if:

- The individual refuses to cooperate, having been give a full opportunity to answer the allegation and make representations;
- It may not be possible to apply any disciplinary sanctions if a person's period of notice expires before the process is complete.

4.1.46 'Compromise agreements' must not be used (i.e. where a member of staff agrees to resign provided that disciplinary action is not taken and that a future reference is agreed).

ORGANISED AND HISTORICAL ABUSE

4.1.47 Investigators should be alert to signs of organised or historical abuse and/or the involvement of other perpetrators or institutions. They should consider whether the matter should be dealt with in accordance with complex abuse procedures which, if applicable, will take priority.

4.1.48 Historical allegations should be responded to in the same way as contemporary concerns. It will be important to ascertain if the person is currently working with children and if that is the case, to consider whether the current employer should be informed.

RECORD KEEPING AND MONITORING

4.1.49 GOSH will keep a clear and comprehensive summary of the case record on a person's confidential personnel file and give a copy to the individual if he/she returns to work. The record should include details of how the allegation was followed up and resolved, the decisions reached and the action taken. It should be kept at least until the person reaches normal retirement age or for 10 years if longer.

4.1.50 Consideration should be given to whether any information relating to the child should be recorded in the child's medical notes, and whether a Child Protection section (divider) should be inserted.. Information relating to the accused person should not be recorded in the child's medical notes.

4.1.51 The LADO should monitor and record the progress of each case, either fortnightly or monthly depending on its complexity. This could be by way of review strategy meetings/discussions or direct liaison with police, children's social work, or employer, as appropriate. Where target timescales cannot be met, the LADO should record the reasons.

4.1.52 The LADO should keep comprehensive records in order to ensure that each case is being dealt with expeditiously and that there are no undue delays.

4.1.53 If a police investigation is to be conducted, the police should set a review date for reviewing its progress and consulting the Crown Prosecution Service (CPS) about continuing or closing the investigation or charging the individual. Wherever possible, this should be no later than 4 weeks after the strategy meeting/discussion. Dates for further reviews should also be agreed, either fortnightly or monthly depending on the complexity of the investigation.

UNSUBSTANTIATED AND FALSE ALLEGATIONS

4.1.54 Where it is concluded that there is insufficient evidence to substantiate an allegation, the Chair of the strategy meeting/discussion or initial evaluation should prepare a separate report of the enquiry and forward this to the Lead Senior Manager to enable then to consider what further action, if any, should be taken.

4.1.55 False allegations are rare and may be a strong indicator of abuse elsewhere which requires further exploration. If an allegation is demonstrably false, GOSH, in consultation with the LADO, should refer the matter to children's social work to determine whether the child is in need of services, or might have been abused by someone else.

4.1.56 If it is established that an allegation has been deliberately invented the police should be asked to consider what action may be appropriate.

DISCIPLINARY PROCESS

4.1.57 The Trust Disciplinary Procedure should also be referred to when considering disciplinary action.

4.1.58 The LADO and the Lead Senior Manager should discuss whether disciplinary action is appropriate in all cases where:

- It is clear at the outset or decided by a strategy meeting /discussion that a police investigation or children's social work enquiry is not necessary; or
- GOSH or the LADO is informed by the police or the Crown Prosecution Service that a criminal investigation and any subsequent trial is complete, or that an investigation is to be closed without charge, or a prosecution discontinued.

4.1.59 The discussion should consider any potential misconduct or gross misconduct on the part of the member of staff, and take into account:

- Information provided by the police and/or local authority children's social work service;
- The result of any investigation or trial;
- The different standard of proof in disciplinary and criminal proceedings.

4.1.60 In case of agency, contract and volunteer workers, normal disciplinary procedures may not apply. In these circumstances, the LADO and GOSH should act jointly with the providing agency, if any, in deciding whether to continue to use the person's services, or provide future work with children, and if not, whether to make a report for consideration of barring or other action.

4.1.61 If formal disciplinary action is not required GOSH should institute appropriate action within three working days. If a disciplinary hearing is required, and further investigation is not required, it should be held within 15 working days.

4.1.62 If further investigation is needed to decide upon disciplinary action, GOSH and the LADO should discuss whether GOSH has appropriate resources or whether GOSH should commission an independent investigation because of the nature and/or complexity of the case and in order to ensure objectivity. The investigation should not be conducted by a relative or friend of the member of staff.

4.1.63 The aim of an investigation is to obtain, as far as possible, a fair, balanced and accurate record in order to consider the appropriateness of disciplinary action and/or the individual's suitability to work with children. Its purpose is not to prove or disprove the allegation.

4.1.64 If, at any stage, new information emerges that requires a child protection referral, the investigation should be held in abeyance and only resumed if agreed with local authority children's social work and the police. Consideration should be given as to whether suspension is appropriate in light of the new information.

4.1.65 The investigating officer should aim to provide a report within ten working days.

4.1.66 On receipt of the report, GOSH should decide, within two working days, whether a disciplinary hearing is needed. If a hearing is required, it should be held within 15 working days.

4.1.67 Wherever possible, police and local authority children's social work should, during the course of their investigations and enquiries, obtain consent to provide the employer and/or regulatory body with statements and evidence for disciplinary purposes.

4.1.68 If the police or CPS decide not to charge, or decide to administer a caution, or the person is acquitted, the police should pass all relevant information to the employer without delay.

4.1.69 If the person is convicted, the police should inform the employer straight away so that appropriate action can be taken.

REFERRAL TO LIST 99, POCA LIST OR REGULATORY BODY

4.1.70 If the allegation is substantiated and the person is dismissed or GOSH ceases to use the person's services, or the person resigns or otherwise ceases to provide their services, the LADO should discuss with GOSH whether a referral should be made to the DCSF List 99 or Protection of Children Act and/or regulatory body. Consideration will be given as to whether the individual should be barred from, or have conditions imposed in respect of, working with children.

4.1.71 If a referral is to be made, it should be submitted within 1 month of the allegation being substantiated.

5 BEHAVIOUR MANAGEMENT OF PARENTS

RESOLVING CONFLICT BETWEEN PARENTS AND STAFF

5.1.1 When a child protection concern has been raised with parents, their behaviour towards staff or other families may be considered inappropriate.

5.1.2 A Trust policy has been developed to manage these situations – Resolving Conflict Between Parents And Staff.

WITHDRAWAL OF TRUST ACCOMMODATION

5.1.3 It is important that GOSH has a consistent approach when dealing with parents who are subject of criminal investigations, which indicate that they may constitute a risk to children. These are difficult issues and it is a shared responsibility across the Trust. We will need to ensure that our practice in these situations is in keeping with the guidance on working with parents who have a dying child, and are considered suspects [Supplement 18: Police Involvement]

5.1.4 When:

- A parent/carer is considered a suspect.
- Criminal investigations are in process.
- Local social work services do not have arrangements for supervised contact.
- No legal order in place.

5.1.5 Social Worker should assess whether the criminal investigation taking place indicates there may be a risk to children.

5.1.6 The Social Worker should contact the Local Authority Social Work Service without delay, and ask them to undertake a risk assessment (together with their Child Abuse Investigation Team) to form the basis of a decision whether it is safe for the parent/carer to be resident, or to visit the hospital. (This assessment should include consideration of the risk posed to not only the patient/ carers own child but any children cared for within GOSH).

5.1.7 Prior to receiving this risk assessment, policy dictates a meeting chaired by Clinical Governance and Safety Team member to be convened. This will take a conservative view of the risk, and may refuse accommodation of the child's parents. In addition the hospital Social Work Service will ensure that decisions are taken which protect the child /children. If this occurs out of working hours, the CSP's should contact the child's local authority Emergency Duty Team for further information. The CSP's will take a conservative view of the risk and

may refuse accommodation. When the risk assessment from the Local Authority Social Work Service is received in writing, hospital Social Work Service will consider this together with any other information available and in consultation with the medical team and Patient Staff Safety (who may need to coordinate a meeting in line with Trust policy) to form a final assessment of risk to the child / children. The Social Worker will make a recommendation regarding the contact (and/or supervision) that the parent/carer should have while their child is at GOSH. This recommendation should be discussed with a manager and forwarded to Clinical Governance and Safety Team for ratification.

5.1.8 The Local Authority Social Work Service should be asked to advise the parents/carers of the restricted and/or supervised contact, unless GOSH has made a decision different from the Local Authority recommendation. If the GOSH decision differs, Clinical Governance and Safety Team will inform the parents/carers of the restrictions to be applied whilst their child remains in GOSH.

5.1.9 While undertaking this assessment, we will continue to keep the needs of the child/children paramount, and work with parents/carers in a compassionate way.

6 CHILDREN'S ACUTE TRANSPORT SERVICE (CATS)

RETRIEVAL OF CHILD WHERE THERE ARE CONCERNS

6.1.1 If the Children's Acute Transport Service (CATS) arrives at the referring hospital to retrieve a child where retaining clothes or nappies for forensic evidence is felt necessary, the items should be retained under forensic conditions by the referring hospital rather than being sent with the child.

REFERRALS

6.1.2 If the CATS is informed by a referring hospital of child protection concerns, it will:

- Advise the referring hospital to contact the child's local Children's Social Work Service
- Inform the CATS consultant and
- Inform the receiving paediatric or neonatal intensive care unit

6.1.3 CATS should record clearly the following information on the CATS referral form which will be filed in the child's medical notes at GOSH:

- If there are child protection concerns
- The reasons for these initial concerns
- Name of consultant / paediatrician at the referring hospital who has been informed and asked to contact Children's Social Work Service (including date and time of conversation/s)
- Name of CATS consultant who has been informed (including date and time of conversation)

CONCERNS

6.1.4 If a member of the CATS team is concerned about child protection issues, they should inform the receiving hospital and refer the concern to the child's home local authority immediately.

7 COMMUNICATING DIRECTLY WITH PARENTS & CHILDREN

7.1.1 Partnership does **not** mean always agreeing with parents / carers, or always seeking a way forward which is acceptable to them. The aim of child protection processes is to ensure the safety and welfare of the child, and the child's best interests should always be paramount. Professionals should be honest and explicit with children and families about professional roles, responsibilities, powers and expectations, and about what is and is not negotiable.

7.1.2 When dealing with child protection issues, the immediate sharing of information in relation to concerns may not always be in the best interests of the child.

7.1.3 Where there are concerns about fabricated or induced illness, parents are to be told that the cause of the child's condition is not yet fully understood and that staff need to make their own observations about the child. Suspicions of fabricated or induced illness should not be mentioned at this point [Supplement 10: Fabricated and Induced Illness].

7.1.4 When, and how to share information with parents and carers needs to be carefully planned as part of the child protection process.

7.1.5 Consideration should be given to whether an interpreter is required when discussing concerns with parents [21.1.11].

7.1.6 Medical, nursing and all staff should avoid any attempt to obtain an admission of guilt or responsibility.

7.1.7 Initially staff should focus on the needs of the child, explain the child's symptoms and the necessary medical investigations in accordance with their professional responsibilities.

7.1.8 Any explanation offered by the parents or the carers or the child should be carefully documented.

7.1.9 The stage at which the issue of abuse is introduced as a differential diagnosis is a matter of judgement. It can only be determined after background information is obtained and internal discussion and or strategy meetings have taken place with social work colleagues.

7.1.10 The strategy or internal meeting will decide the most appropriate professionals to talk to the parents and what information will be shared. The child's welfare, rather than that of the parents' or family is paramount.

7.1.11 The reactions of parents / carers when concerns are raised are difficult to predict, e.g. denial, shock, anger, relief. Parents and carers should

be dealt with sympathetically, but it should be made clear that abusive or aggressive behaviour will not be tolerated.

7.1.12 The hospital has a right to refuse entry to anyone who is seriously disruptive or to call the police to eject them if necessary [Supplement 5: Behaviour Management of Parents] & Trust Resolving Conflict between Parents and Staff.

7.1.13 Families may feel better supported if it is clear that interventions in their lives, while firmly focused on the safety and welfare of the child, are also concerned with the wider needs of the child and family.

7.1.14 When appropriate the child also needs to be given information in a sensitive and caring way by the most appropriate staff. Because of the disruption that the child protection issues may cause to the family the child will need ongoing care and reassurance.

7.1.15 Listening to children is important to win their trust and promote a sense of safety.

7.1.16 When deliberate harm of a child is identified as a possibility, the examining doctor should consider whether taking a history directly from the child is in her/his best interests. If so, this history should be taken even when consent of the carer has not been obtained and the reasons for dispensing with consent recorded by doctor.

7.1.17 If parents themselves raise the question of medical staff suspecting abuse, it is essential the doctor explain that there may be a variety of possible causes, of which abuse may only be one. Certain investigations e.g. skeletal surveys, photographs, detailed genital examinations are likely to make parents fear abuse is suspected.

7.1.18 The multi agency strategy meeting may decide that it is not in the best interests of the child to discuss concerns of child abuse with parents until more information is gathered e.g. in cases of suspected fabricated or induced illness or in cases of suspected sexual abuse.

7.1.19 In cases of fabricated or induced illness staff may be asked to:

- Participate in constant observation of the child
- Observe parent-child interaction, or
- Indicate to parents that the cause of a child's condition is not yet fully clear and that further observations and investigations are required

7.1.20 In cases of sexual abuse:

- When parents raise concerns that sexual abuse has occurred, this should be appropriately investigated. Staff should explain to the parents that further specialist examination is required to aid diagnosis
- When professionals suspect that sexual abuse has occurred, but this hasn't been raised by parents, suspicions must not be shared with

parents until immediately before the planned interview / examination of the child because of the very great risk of them silencing the child

- If the investigation is then undertaken whilst the child is still an inpatient, the strategy meeting will decide on who interviews him/her and a social worker and manager from the child's local Children's Social Work Service have to be present to talk to parent/s and progress a child protection investigation. If the parents are implicated as alleged perpetrators of abuse and the child remains an inpatient, GOSH medical and social work staff will need to liaise with the Clinical Governance and Safety team to progress the 'Individuals who may pose a risk to children policy'.

7.1.21 Children and families may be supported through involvement in the child protection process by advice and advocacy services, and they should be advised of these by the GOSH social work service or by PALS.

DISCLOSURE OF INFORMATION BY CHILD OR CARER

7.1.22 Children and /or their carers may disclose information to hospital staff that relates to possible child abuse concerns.

7.1.23 Staff should listen carefully to the child / adult:

- Offer comfort and be sympathetic
- Not make the child tell anyone else (they may have to be formally interviewed later)
- Not promise to keep information confidential - this will need to be explained to the child
- Explain with whom this information will be shared in order to provide help and support
- Initially and pending discussion with the social worker respect a child's requests that parents are not told
- Document exactly what was said and their response
- Refer to GOSH social worker or, if out of hours, to the CSPs.

7.1.24 The child will be informed before any subsequent action is taken in a way appropriate to their age and understanding.

8 DOCUMENTATION

8.1.1 A dedicated section for child protection should be placed into the patient's medical notes when a CP concern is confirmed (child protection concerns prior to this will be located within the main body of the child's medical notes).

8.1.2 Filing all child protection information in one place in the child's medical notes supports effective information sharing, assists staff to maintain an overview of the welfare of the child and to refer as appropriate. It ensures that both a coherent account of the situation and the plans to protect the child are easily visible and available to staff.

8.1.3 The child protection divider should be inserted in the notes after the social worker has confirmed in writing (via the referral to Social Work form and CP Actions form) that the concerns identified are being pursued as child protection, and in all cases of a head injury to a child under 2, in line with the head injury protocol. [Supplement 11: Head Injury Protocol].

8.1.4 It is the duty of the Lead Consultant, named on PiMS to overview the child's medical records, including the child protection section, ensuring that all information has been referred to appropriate professionals.

8.1.5 If, following a clinical or social assessment, no child protection concerns are substantiated, this should be clearly recorded by the Lead Consultant and agreed by the social worker involved. The child protection section must be retained in the notes.

8.1.6 If the referral is based on mistaken information, the Child Protection Management Group will decide whether the child protection section should be removed from the child's notes. In order for an informed decision to be made, the social worker should provide the Child Protection Management Group with a report detailing the reasons for removal of the section.

IDENTIFIED SUSPICION OR CONCERN

8.1.7 The criterion for initiating the child protection section is if one, or more, of the following leads to a referral to the hospital Children's Social Work Service, and is confirmed by them as a child protection concern:

- A member of staff has suspicion or concerns of child abuse/ neglect
- A child is admitted with accompanying information from a parent/carer or other professional that s/he is subject to a child protection plan or has a PiMS alert for that reason
- A child under the age of 2 is admitted with a head injury [Supplement 11: Head Injury Protocol]

- Where CATS (in a retrieval) has reported and documented concerns from the referring hospital, or has itself expressed and documented suspicions about the nature and cause of a child's condition

8.1.8 Following the written referral to the hospital Children's Social Work Service (or clinical site practitioners out of hours) on the Referral to Social Work form:

- The ward allocated social worker, or duty social worker, should consult with the social work manager, and confirm whether the referral will be followed up as a CP concern.
- If so, the social worker will provide a child protection divider for the child's medical notes, with a completed CP Actions form (to be updated as appropriate) and a key contacts form.

8.1.9 All staff members must record any ongoing child protection or welfare issues in the child protection multi-disciplinary record, or cross reference to a recording elsewhere in the medical notes.

See summary of documentation/materials [p.59] for detailed guidance.

SUSPECTED FABRICATED OR INDUCED ILLNESS (FII)

8.1.10 The process of clarifying a possibility of FII involves careful observation, and possibly further investigations, in order to identify or exclude a medical cause for the child's reported symptoms or observed signs [Supplement 10: Fabricated or Induced Illness]. Because, at this stage, it is not clear whether the concerns are caused by FII, all that should be noted in the child's medical record is 'explanation for child's difficulties and diagnosis are unclear and require further observations and investigations'. The child protection section **must not** be initiated until there is a clear possibility of FII.

8.1.11 The child protection divider should only be inserted into the medical notes once a child protection issue has been established and the parent(s) have been informed. The decision to make a child protection referral and therefore initiate the child protection section will be made in an internal professionals meeting.

Summary of Documentation / Materials

Document	Guidance	Lead professional	Storage
Divider	Should be placed in child's medical notes as the 2nd divider, behind "Problem List & Growth Charts". For medical notes that have been split, ensure the divider is in most recent file in a visible place	Social worker	Wards and other documentation stations
Referral form	Person who has the concern should complete: Both the white and blue copies of the form and pass it to the GOSH social worker.	Person who has identified the concern	Wards and other documentation stations (when returned and signed by the social work manager)
Key Contacts	Should be placed in the child protection section when the child protection divider is inserted • The social worker should complete his/her details and the details of the community social worker. If details change, the form should be clearly updated. • The Lead Consultant should complete his/her details. If the Lead Consultant changes, the new Lead Consultant must update the form.	Person who has identified the concern	Wards and other documentation stations
Multi Disciplinary Record	All staff involved in the child's care, who have information about child protection concern, must record their involvement and concerns, ensuring a chronological, complete and integrated review is possible This record must include all key points - may also be cross-referenced to more complete entries in child's medical notes or locally held files	All staff	Wards and other documentation stations

Child Protection Actions	The social worker will record actions and key information. The first actions form should be completed by the end of the day on receipt of the referral. Subsequent action forms should be completed as new or updated information is known. This will document any key issues relating to the concern and any action that is to be taken. The Lead Consultant should be informed of the actions by the social worker. There may be several numbered action forms for a particular child so it is important to review all forms, not just the most recent.	Social worker	Hospital Children's Social Work Service
Conclusion to Child Protection Episode at GOSH	For every referral , a CP conclusions form must be completed when either: **CHILD IS DISCHARGED FROM GOSH** No child about whom there are child protection concerns may be discharged from hospital without a documented plan for her/his future, including follow up arrangements. Satisfaction with this plan should be documented on this form by the social worker and Lead Consultant, and should be filed in the child's medical notes. **CONCERNS NO LONGER REMAIN** Where a decision is made that there are no child protection concerns and there is no need to undertake a formal investigation, this fact and the justification for the decision should be recorded on this form by the social worker and Lead Consultant, and should be filed in the child's medical notes.	Social worker and Lead Consultant	Hospital Children's Social Work Service

8.1.12 Child protection documentation / materials can be ordered from the Child Protection Administrator on ext [redacted].

CHILD PROTECTION DOCUMENTATION - PROCESS FOR CHILD AND ADOLESCENT MENTAL HEALTH SERVICE (CAMHS) DEPARTMENT

8.1.13 All children referred to the CAMHS department have a hospital file and departmental held file. The locally held departmental file usually holds the majority of information on the child* and the child protection divider should therefore be inserted into the locally held file. The team administrator will ensure that a Child Protection divider is also inserted in the hospital file with a clear instruction directing other GOSH clinicians to the locally held CAMHS file.

* In exceptional circumstances the hospital file may be the main record for the child.

8.1.14 If a child is subsequently seen in a department outside of CAMHS, and a child protection suspicion or concern arises, it is not appropriate to continue documenting the child protection information in the locally held CAMHS file. The clinician outside of CAMHS will notify the CAMHS team administrator who will transfer all the information filed in the child protection section of the locally held file into the hospital file. The administrator will also insert a note in the locally held CAMHS file of the transfer and the need to stop all further documentation in the CAMHS file.

INPATIENT

8.1.15 If child protection suspicions or concerns are identified on the Mildred Creak Unit, or a child is admitted with child protection concerns, the concerns should be referred to the GOSH Social Work Service who will if appropriate insert a child protection divider into the child's multi-disciplinary file. If appropriate the team administrator will then be instructed by GOSH social work service to place a divider in the hospital file alerting all clinicians to the locally held file. An exception is in the case of possible Fabricated or Induced Illness (FII). The child protection divider must not be inserted into the file until a Child Protection issue has been established (See section 8.1.7 . in the GOSH Child Protection Policy).

8.1.16 The process for referring and inserting the child protection section into the child's notes should be followed (see section 8 in GOSH Child Protection policy & Procedures).

8.1.17 An alert in the form of a red sticker will be placed on the nursing section of the multidisciplinary notes to alert staff that a child protection divider has been placed in the file.

OUTPATIENT

8.1.18 If a child is referred to the Parenting and Child Service (CAMHS) or the Parent Interaction with Child team within CAMHS for child protection concerns only, a child protection section should not be inserted into the locally held file as the whole file contains child protection information.

8.1.19 If a child is referred to other CAMHS Outpatient teams, and during the course of their treatment, a child protection suspicion or concern is identified at GOSH or a third party informs the team that there are child protection issues, then the child protection divider should be inserted into the locally held file by the GOSH social worker.

8.1.20 Where possible an appropriately qualified and experienced team member should:

- Make the referral to the child's local social services department.
- Download an electronic social work referral form by going to the GOSH Web and right clicking on "social work referral form". You can then save the form, complete the form electronically, and email it to [redacted]. Alternatively you can complete a duplicate paper version and take both sections to the GOSH Duty Social Worker.
- The GOSH social worker will then insert the child protection divider into the CAMHS file.
- Ensure that the relevant team administrator in CAMHS liaises with GOSH Social Worker in order to place a divider in the hospital file with a note directing other clinicians to the locally held file.

8.1.21 If assistance is required and the child is still on GOSH premises, the GOSH social work service should be contacted.

8.1.22 If a child from Camden does not have an allocated Camden social worker, the child should be referred to the GOSH social work service.

Please note for extra copies of Social Work referral forms, contact the Duty Social Worker on ext [redacted] Electronic referrals can also be made by accessing the GOSH Web and downloading the electronic version of the SW referral form, completing it and emailing it to [redacted]

9 EDUCATION & CARE FACILITIES

GOSH SCHOOL

9.1.1 The Children's Hospital School at Great Ormond Street is a 'Special Foundation Hospital School'. The maintaining local education authority is Camden. The school governors are the employers.

9.1.2 The Children's Hospital School operates within the Great Ormond Street Hospital NHS Trust. Staff, Governors and volunteers therefore follow and adhere at all times to the guidance, child protection policy and procedures issued by the Trust.

9.1.3 The school has a child protection policy developed in line with recommendations for schools in 'Safeguarding Children and Safer Recruitment in Education' DfES 2006 [ref.3] and 'Handbook for inspection of special schools and pupil referral units' Ofsted 2003. A copy is available from the school.

9.1.4 It is a requirement from the local authority and Ofsted that the school holds an up to date record of all children who are subject of a child protection plan.

9.1.5 To satisfy the above requirement and in addition to the PiMS alert system operating in the hospital, it has been agreed that the Child protection Administrator will advise the school designated teacher of all child protection referrals of children aged 5 years or over.

9.1.6 Teachers will follow the GOSH procedures and complete the child protection section of the medical notes if they have information related to any child protection issue.

9.1.7 Any referral to the hospital school by the ward should indicate the presence of any safeguarding /child protection concerns or supervision arrangements as set out in the Local Authority care plan and/or as arranged with the ward. This is to ensure that the school staff are fully aware of any issues which may have an impact on how the safety of the child is managed. The school will contact the hospital Children's Social Work Service as appropriate if they have any additional concerns about the safety of the child while they are in the school. Similarly, these should be shared with ward staff when the child returns to the ward.

STAFF NURSERY & HOLIDAY PLAY SCHEME (GOSH MAIN SITE ONLY)

9.1.8 GOSH offer a staff nursery for children aged 3 months to 5 years, and a play scheme for children aged 4 to 11 years of age. Both are available to parents / legal guardians directly employed by GOSH.

9.1.9 If a concern about possible or actual abuse or neglect arises about a child attending the nursery or play scheme, GOSH staff must follow the procedures outlined below.

ALLEGATIONS AGAINST NURSERY/PLAYSCHEME STAFF OR PARENTS EMPLOYED BY GOSH

9.1.10 If an allegation is made against a GOSH employee who is the parent or any member of GOSH staff, the guidance Allegations of Child Abuse Made Against A Member of Staff [Supplement 4] should be followed.

NURSERY OR PLAY SCHEME CONCERNED ABOUT CHILD ABUSE OR NEGLECT

9.1.11 If a child is physically present on GOSH premises and staff are concerned about possible or actual abuse or neglect which has occurred elsewhere, a member of nursery / play scheme staff should inform the hospital Children's Social Work Service who will contact the child's local Children's Social Work and act as liaison. If the person subject of the allegation is not a GOSH employee, the child's local Children's Social Work, in conjunction with the hospital Social Work Service, will agree on a case by case basis how the case will be managed and how the parent who is the staff member will be informed.

9.1.12 If the concern occurs outside working hours (Monday – Friday, 9am-5pm), the Clinical Site Practitioners should be contacted on bleep [redacted]

9.1.13 If a staff member is concerned about a child who is not currently present on GOSH premises i.e. child may have already left for the day or may not have arrived at the nursery, s/he should contact the child's home local authority directly. The hospital Children's Social Work Service will assist in making this call if necessary.

9.1.14 In both of these cases, if the parent who is employed by GOSH is the subject of the allegation, the guidance Allegations of Child Abuse Made Against A Member of Staff [Supplement 4] should be followed.

RECORD KEEPING

9.1.15 It is important to keep a detailed record which complies with GOSH Record Keeping policy [Supplement 21: Record Keeping]

10 FABRICATED OR INDUCED ILLNESS

GENERAL

10.1.1 There is unequivocal evidence that parents/carers can and do cause harm to children through fabricated or induced illness.

10.1.2 Terminology to describe the fabrication or induction of illness in a child has changed over time and included Munchausen's Syndrome by proxy, factitious illness by proxy and illness induction syndrome. Terminological differences risk losing the focus on the child. The key issue is not the term for this type of abuse but rather the impact of fabrication or induction of symptoms and signs on the child's health and development and consideration of how best to safeguard her/his welfare.

10.1.3 Management of suspected or actual fabricated or induced illness should follow the same processes outlined in the procedural section of this manual.

10.1.4 The mother's (or other carer's) possible actions (not mutually exclusive)

- **Fabrication (false reporting)** of signs and symptoms which may include fabrication of past medical history
- **Interference** with specimens of bodily fluids and with lines or with medical equipment whose malfunction will directly affect patient care.
- **Falsification** of hospital charts and records, and of letters and documents and
- **Direct interference** with the child (induction)

10.1.5 There is a range in nature of the presenting symptoms, the severity of the initial illness, the age at which harm starts, the length of time of falsification or illness induction continues before identification and any action takes place, whether fabrication escalates to illness induction, and whether the child is drawn into collusion and self perpetuating illness [Supplement 14: Identification of Abuse]

The child

10.1.6 Existing diagnosed illness in a child does not exclude the possibility of induced illness.

10.1.7 The age range of children in whom illness is fabricated or induced extends throughout childhood, although it is most commonly identified in younger children.

10.1.8 Effects on the child

- The child suffers repeated investigations, procedures and treatments
- Her/his health and life is threatened if illness is induced
- S/he is deprived of a full education
- The child becomes socially isolated
- The child may experience anxiety about her/his own state of health
- The child may be confused about her/his true state of health
- The child may develop a false self view of being sick and vulnerable
- The child may collude with illness behaviour
- The child may become silently trapped in falsification of illness

The mother (or other carer)

10.1.9 Fabricated or induced illness is usually perpetrated by the child's mother, and occasionally father or grandmother. The latter adult would have a significant responsibility for providing much of the child's daily care.

10.1.10 At times, more than one carer may be involved in perpetuating the belief that the child is seriously ill. Thus it is not always appropriate to consider the father to be a mere bystander of the process of fabrication or illness induction.

10.1.11 The underlying dynamic is the (usually) mother's need (for a variety of reasons) for the child to be recognised and treated as ill when s/he is actually well, or as more ill than the child actually is.

10.1.12 The presence of an existing illness in the child can act as a stimulus to mother's behaviour and also provide the carer with opportunities for inducing signs. The close relationship with health professionals may both fulfil the needs of the mother and reduce suspicion by the professionals.

10.1.13 Alerting signs

- Reported symptoms, and signs found on examination are not explained by any medical condition from which the child may be suffering
- Investigations do not explain reported symptoms
- The signs are reported or symptoms observed only by a parent or when a parent is present
- There is an inexplicably poor response to prescribed medication and other treatment. New symptoms are reported on resolution of previous ones
- There are repeated presentations, particularly to a variety of doctors and with a variety of problems

- The child's normal daily activities are being curtailed beyond that which might be expected for any medical disorder from which the child is know to suffer
- The parent disputes negative findings and requests further investigations

If one alerting sign is present, look for others.

10.1.14 A focus on 'typical scenarios' risks missing cases of fabricated or induced illness, or failing to identify genuine disorders.

Clinicians' involvement, response and responsibilities

10.1.15 By definition, FII can only exist with the involvement of clinical professionals

10.1.16 Fabricated or induced illness is unique in that health professionals have an integral role in the evolution of the problem and a key involvement from the early stages of emerging concerns through to the completion of inquiries and investigations because:

- Many children subject to fabricated or induced illness also suffer from a genuine medical condition
- The medical professions are responsible for investigations and treatment which they initiate in response to fabricated history and symptoms or illness induction by the parent
- The effect on the child's health brought about by the illness induction is serious and may be life threatening

10.1.17 The initial role of clinicians is to ascertain whether a child's symptoms and signs have an unequivocal explanation as a verified illness. If there are discrepancies between reported symptoms, and independent observations, or signs remain unexplained, the possibility of fabricated or induced illness must be considered as part of the range of possibilities.

10.1.18 Once the possibility of fabricated or induced illness appears likely, a failure to alert Children's Social Work Service will lead to more suffering by the child and hamper the chances of successfully concluding the enquiry.

10.1.19 The Royal College of Paediatrics and Child Health '*Fabricated or Induced Illness by Carers*' 2002 [ref.20] and the Department of Health '*Safeguarding Children in Whom Illness is Fabricated or Induced'* 2002 [ref.7] are useful documents.

MANAGEMENT IN GOSH

10.1.20 The process of clarifying suspicions of FII involves careful observation and possibly further investigations in order to identify or exclude a medical cause for the child's reported symptoms or observed signs.

10.1.21 Because at this stage, it is unclear whether FII is the problem, it is not appropriate that information relating to these concerns is named as FII in the child's medical notes. Thus, at GOSH main site, the child protection section **must not** be initiated at this point. The wording to be used in the medical notes should be that 'the child's diagnosis is currently unclear and requires further observations and investigation'.

10.1.22 The person who is concerned about possible Fabricated or Induced Illness should contact the child's Lead Consultant, as named on PIMS/PAS.

10.1.23 The Lead Consultant should convene an internal professionals meeting inviting all other consultants and relevant other professionals at GOSH with responsibility for the child's care to discuss the concerns and agree the management of the concern. Support is available from the Named Doctor Child Protection [Supplement 22: Roles].

10.1.24 In cases of suspected fabricated or induced illness, where there are discrepancies between the child's presentation and results of investigation or the child's condition remains undiagnosed, the named doctor for child protection should be informed and consideration given to involving a consultant general paediatrician with relevant expertise.

10.1.25 Under these conditions, a plan needs to be constructed for systematic independent observation of the child. This will often require a planned admission, which will specify the nature of observations during this admission. The psychosocial team needs to be involved.

10.1.26 The essence of this process is constant, careful observation of the child and accurate recording:

- All observations must be attributed to the reporter or observer e.g. 'mother said', 'nurse saw'. Discrepancies between different observers need to be noted
- It is important to record whether and which parent/s were present during any recorded observations
- Observations of the mother and other carers with the child whilst preparing feeds or feeding, bathing, changing, playing or having tests must be recorded
- Staff should record routine observations about the child's condition and obtain all samples from the child – all observations should be recorded in detail and clearly signed, noting how samples have been obtained and collected

10.1.27 Progress data must be recorded and plotted on appropriate charts e.g. blood pH, glucose.

10.1.28 Parents are to be told that the cause of the child's condition is not yet fully understood and that staff need to make their own observations about the child. Suspicions of fabricated or induced illness should not be mentioned at this point.

10.1.29 Staff require explanations and support during this difficult phase on a 'need to know' basis.

10.1.30 A chronology should be constructed by the lead consultant, covering detailed medical and family history.

10.1.31 Following the collation of these observations, an internal meeting should be convened to decide whether there are child protection concerns.

10.1.32 The need for action to protect the child is established when

- There are persistent discrepancies between parental reports and independent observations
- The parent(s) does not accept the validity of independent observations
- There is evidence of fabrication
- There is evidence of induction

10.1.33 The parent/s should be informed of the concerns and need to protect the child, and the child protection divider inserted into the child's medical notes [Supplement 8: Documentation].

Response to Requests for information

Our FII procedures are based on national guidance and stipulate what actions staff should take when they encounter alerting features or see medically perplexing cases.

If a colleague from outside the Trust wishes to discuss concerns about FII or safeguarding relating to a child who is currently a patient of the Trust this should be dealt with in the same way as the investigation of any CP concerns. Details of phone and written conversations should be entered in the child' notes and shared with the appropriate agency in the normal way.

Our procedures do not cover or provide advice for members of staff where they are contacted for advice or information by colleagues who are involved in the management of FII (or other CP concerns) in a child who is no longer being seen here and is no longer registered as a patient .

In this case members of staff who receive such requests should record details of such requests in the case notes in the usual way

They should contact the appropriate named professional who would then provide advice and support and ensure that details were logged with the Child Protection Team and that appropriate legal advice was sought. The named professional, under the terms of the Trust's supervision policy would continue to offer the staff member advice and support so that they and the protection of the child were both safeguarded.

11 HEAD INJURY PROTOCOL

11.1.1 This protocol applies to all children with serious head injury and not only those admitted to ICU [1]

11.1.2 A child might first be presented to their local accident and emergency department but may be transferred to GOSH and the following expectations consequently apply to GOSH staff in the management of head injuries.

MANAGEMENT STANDARDS

11.1.3 The following text describes the required standards for management, of specified children who have a serious head injury

11.1.4 This protocol is intended to help clinical teams provide care in an agreed, consistent and expert manner; and to communicate effectively with those who have responsibility for child protection and the child's continuing medical care.

11.1.5 Standards apply to the management of children who fulfil the following criteria:

- S/he has a suspected or proven traumatic brain injury (which can include any of the following: subdural haemorrhage, extradural haemorrhage, cerebral contusion, skull fracture and retinal haemorrhage, with or without cerebral oedema)
- The child has not yet reached her/his 2nd birthday and/or a child above this age with a serious head injury requires additional enquiry and investigation if the injury is not consistent with the story given and/or it is suspected that injury has occurred which may be consistent with non accidental injury.

11.1.6 The standards do not apply to children with a head injury as a result of a Road Traffic Accident (RTA) or other publicly witnessed accidents. However if there are possible CP concerns, the Children's Social Work Service will refer to the responsible Local Authority Social Work Service and work in partnership with them.

11.1.7 If conclusive evidence is found of a medical cause for the child's injuries, then the lead consultant for the child can decide not to continue with the protocol after consultation with colleagues in the other specialities involved in the child's care including the allocated ward social worker and/or manager of the GOSH Social Work Service. The

[1] some are directly admitted to Neurosurgery and Neurology ward

reasons for the decisions must be clearly documented in the child/young person's medical notes

GOSH INTENSIVE CARE UNIT

11.1.8 The Paediatric or Neonatal Intensive Care Unit (PICU or NICU) consultant will remain as Lead Consultant as long as the child is on PICU or NICU.

11.1.9 When the child is transferred to another ward, the attending consultant neurologist will take over as Lead Consultant.

NEUROLOGY

11.1.10 The attending / on-call consultant neurologist:

- Will be informed about every child who meets the criteria set out in 1.1.4 at the time of admission (to PICU, NICU, Neurosurgery Ward, Neurology Ward or elsewhere in GOSH).
- Will see the child as soon as possible after admission and by no later than the beginning of the next working day.
- The attending consultant will be the Lead Consultant for that child's admission after the child leaves PICU until the child is discharged from GOSH.
- The attending neurology consultant will prepare a medical report summarising the key clinical findings and provide an opinion as to causation prior to the child's discharge from hospital.
- The attending consultant will liaise with the local paediatric services to ensure they are aware of the conclusions about this case and a local follow-up plan is in place.

GOSH CHILDREN'S SOCIAL WORK SERVICE & NAMED NURSE / NAMED DOCTOR

11.1.11 GOSH Children's Social Work Service and Named Nurse / Named Doctor for Child Protection must be informed by the senior nursing staff on the ward about every child who meets the criteria for the protocol.

11.1.12 The social work referral form should be completed and the child protection section inserted into the child's medical notes [Supplement 9: Documentation].

11.1.13 If out of hours, nursing / medical staff should:

- Inform the clinical site practitioners who will contact the child's local authority Emergency Duty Teams and insert the child protection divider into the child's medical notes [2.2.10]
- Give the social work and child protection administrator's copies of the referral form to the clinical site practitioners who will ensure they are given to the hospital Children's Social Work Service the next working day
- Inform hospital Children's Social Work Service and the named nurse as early as possible on the next working day (responsibility of senior nurse)
- Hospital Social Work Service will make contact with home authority at the earliest opportunity

OPHTHALMOLOGY

11.1.14 The child should be examined by an ophthalmologist within 48 hours of admission to hospital and s/he should be asked to identify any abnormality and comment on its significance.

11.1.15 If the child is initially examined by an ophthalmology registrar and an abnormality is identified, a consultant ophthalmologist should be asked to comment on the significance of the abnormality.

11.1.16 Consideration should be given to imaging any abnormal findings. At GOSH photography should always be attempted. If a decision is made not to proceed with photography then this should be clearly recorded with reasons why.

NEURORADIOLOGY

11.1.17 If it has not already been carried out, a cranial CT should be undertaken as soon as the child is stabilised following admission.

11.1.18 The CT scan should be examined soon after completion by a neuroradiologist (either a consultant or an on-call registrar if it is done out of hours).

11.1.19 A finalised report authorised by a consultant neuroradiologist should be issued by the end of the working day on which CT scan completed.

11.1.20 If the initial CT brain scan is abnormal or if the child has neurological symptoms in the presence of a normal or equivocal first CT scan, an MRI examination should be performed by the end of day 4.

11.1.21 The MRI scan should include images of the cervical spine.

11.1.22 If MRI scan is normal, no further neuroradiological examination is required.

11.1.23 The need for and timing of further MR and/or CT scans will be decided in consultation with a consultant neuroradiologist.

RADIOLOGY

11.1.24 Skeletal survey (including skull films) should be completed within 48 hours of the admission to hospital, provided that the child's clinical condition allows. If this is impossible the reasons should be clearly recorded in the medical notes and clear plans indicated as to how and when this may proceed and the decision factored into any discharge planning. However, if an underlying medical diagnosis is found prior to this by the Consultant the need for a skeletal survey may be dispensed with. This decision should be discussed with the multi disciplinary team and reasons for dispensing with this investigation should be clearly recorded in the child/young person's medical notes and on social work database.

11.1.25 A finalised report, authorised by a consultant radiologist should be issued by the end of the working day on which the skeletal survey has been completed (or Monday morning if the child was admitted on a Friday afternoon / evening).

HAEMATOLOGY INVESTIGATIONS

11.1.26 All children with haemorrhage (subdural, intracerebral and scalp) should have as soon as possible after admission:

- Blood count
- Platelet count
- Clotting screen
- Send citrated blood to be stored for factor assays, von Willebrand screen, factor XIII assay and alpha-2-antiplasmin. Please put 'possible or ? NAI' on the form which will alert the lab to follow their protocol. This should ideally be sent in normal working hours.
- PFA – 100 in vitro bleeding time – a member of the haematology/ haemophilia team should take the sample. This should be sent within normal working hours.

11.1.27 Any abnormalities in results and the need for additional more specialised platelet investigations should be discussed with a Consultant Haematologist.

OTHER MEDICAL INVESTIGATIONS

11.1.28 If a CSF sample is available this should be examined microscopically, cultured for bacteria and viruses and assayed for viral titres and Herpes Simplex PCR

11.1.29 In all infants with encephalopathy and in any other infant with suspected infection the following microbiological investigations should be carried out:

- Blood cultures
- Viral titres in blood
- Viral cultures

11.1.30 The following metabolic investigations should be carried out:

- Urine for organic acids (for glutaric aciduria)
- Blood and urine carnitine and acylcarnitines (for glutaric aciduria)
- Blood copper and ceruloplasmin
- Calcium, phosphate, alkaline phosphatase, PTH and Vitamin D

CHILDREN WHO DIE

11.1.31 The Trust procedures for children who die must be followed [When a Child Dies Policy & End of Life Care Pathway].

11.1.32 If not already carried out, a skeletal survey should take place, as soon possible after death, in the Radiology Department.

11.1.33 In some circumstances, brain imaging after death is of assistance in diagnosis. This should be discussed with the consultant neuroradiologist and decision recorded.

MEDICAL REPORTS

11.1.34 A medical report, which summarises key clinical findings and possible causes, is essential for child protection and for the local medical team.

11.1.35 The consultant neurologist who is the Lead Consultant during the child's admission should prepare a report, which will be available before the child leaves GOSH and should be included in the discharge summary [see 2.8].

11.1.36 Other medical and nursing staff (from Intensive Care, Ophthalmology, Radiology) may also be asked to prepare reports. Senior staff should prepare those reports that include an expert opinion. If required, assistance is available from the Named Doctor or the Named Nurse.

11.1.37 A child whose care is following this protocol must not be discharged from GOSH until all the investigations outlined above are completed and the reports have been prepared and authorised. Until this occurs the child should be nursed on the acute neurology ward. Any request to discharge the child before this time by any agency must be reviewed by the multidisciplinary team (clinical and social work) and any decision made must ensure the safety of the child.

LOCAL MEDICAL TEAM

11.1.38 Each child must have a named consultant paediatrician from the local referring hospital (even if the child was admitted from a local A&E). The named consultant must identify a named consultant locally who will be assuming the care of the child. The local consultant paediatrician will be kept informed of developments in the child's condition, by the clinical team caring for the child on the ward.

DISCHARGE

11.1.39 If there are CP concerns discharge cannot take place until GOSH professionals are satisfied that the child is safeguarded. The GOSH Social Worker will discuss discharge plans with the responsible Local Authority Social Worker to ensure clear safeguarding plans are in place. Following discharge, the Local Authority Social Work Service will have lead responsibility for ongoing CP work.

11.1.40 The local consultant paediatrician (or a colleague) will be expected to take the prime role in the longer-term management of the child following discharge from GOSH.

11.1.41 The role of the GOSH medical teams is to assist the local medical team, but not to assume prime responsibility for child protection investigation after the child has left GOSH.

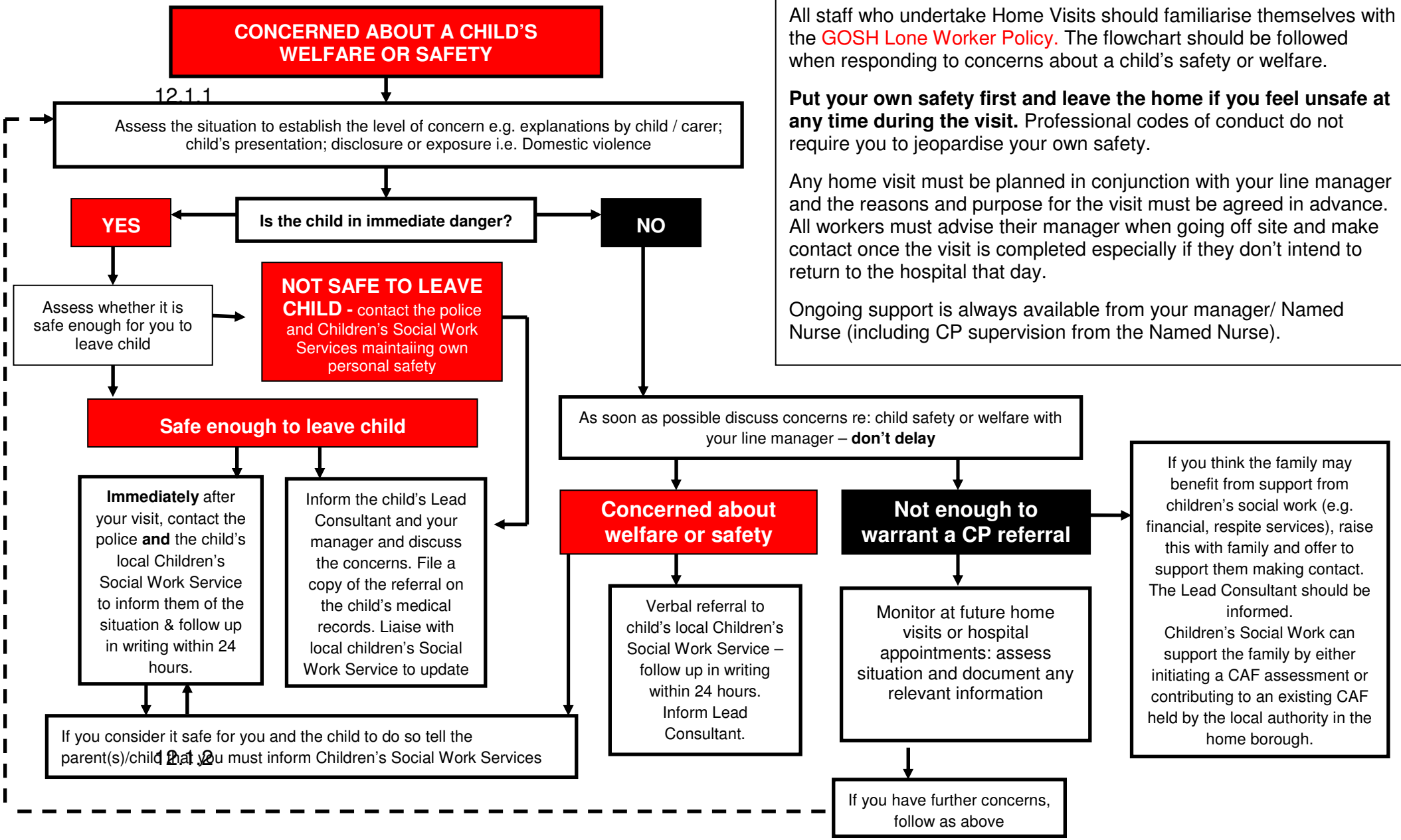
12 HOME VISITS: GUIDANCE FOR STAFF

All staff who undertake Home Visits should familiarise themselves with the GOSH Lone Worker Policy. The flowchart should be followed when responding to concerns about a child's safety or welfare.

Put your own safety first and leave the home if you feel unsafe at any time during the visit. Professional codes of conduct do not require you to jeopardise your own safety.

Any home visit must be planned in conjunction with your line manager and the reasons and purpose for the visit must be agreed in advance. All workers must advise their manager when going off site and make contact once the visit is completed especially if they don't intend to return to the hospital that day.

Ongoing support is always available from your manager/ Named Nurse (including CP supervision from the Named Nurse).



13 IDENTIFICATION OF ABUSE

HOSPITAL CONTEXT

13.1.1 For all staff who are used to working with parents for the benefit of children, suspicions of abuse may strain the therapeutic partnership.

13.1.2 Child protection issues may arise in the hospitals in the following ways:

- A child is admitted with signs and symptoms indicative of abuse or neglect
- Child protection concerns are first raised while child under care of GOSH A child is already known to social work and/or is subject to a child protection plan in the borough of residence, but medical treatment is required perhaps for a separate problem.
- A child attends the outpatient appointment and suspicions of child maltreatment arise.

INITIAL CONCERNS

13.1.3 It is important that all members of staff are alert to signs of possible abuse or neglect at all times and all initial concerns should be documented in detail e.g. on body charts or 'babygrams'.

13.1.4 Abuse may be identified or suspected because of a single sign or symptom e.g. a particular physical injury.

13.1.5 It is common for children who have been abused or neglected to show a range or cluster of symptoms or signs which may indicate abuse. It is essential that when suspicions are aroused by a specific presentation, the child's general physical health, and emotional and behavioural state be assessed. This should include a full medical history.

13.1.6 It is important to attempt to define the degree of suspicion regarding the possibility of abuse by reference to evidence based sources material e.g. RCPCH Child Protection companion and Welsh systematic review (www.core-info.cf.ac.uk) and NICE guidelines. Some signs are more strongly suggestive e.g. subdural haematoma in a young baby, whilst others may arouse high, medium or low levels of suspicion.

13.1.7 In the following sections some guidance is given on how these levels may be defined by certain presentations. However, the following presentations are neither exhaustive nor exclusive and other factors may need to be considered. In cases of doubt the guidance of a more experienced professional **must** be sought.

13.1.8 The evidence base for signs or symptoms of abuse may be imprecise. Summary of evidence from meta analyses can be found on the Core Info website www.core-info.cf.ac.uk

13.1.9 Concerns may arise as a result of:

- Child's appearance and physical signs observed on him/her
- Emotional and behavioural signs observed in the child or in the parent or carer
- Allegation of abuse by child or parent
- Other alerting factors

APPEARANCE & PHYSICAL SIGNS OBSERVED ON THE CHILD

Child's general appearance

13.1.10 Some aspects of a child's general appearance may raise concerns about neglect and be linked with other types of abuse, including:

- Child seen to be inappropriately dressed for weather conditions
- Neglect of child's personal hygiene, unwashed
- Poor oral hygiene or severe caries
- Evidence of poor skin care (untreated sore nappy area, dirt and soreness in skin folds, soreness around mouth)
- Poor hair hygiene e.g. evidence of untreated head lice
- Child looks thin and weight and height not age appropriate
- Evidence of weight loss without organic explanation
- Unexplained evidence of poor development

13.1.11 Concern should be raised if there are:

- Injuries of different ages
- Particular patterns in injuries

13.1.12 Level of suspicion should be increased if:

- Explanation for injury/ies is inadequate
- Explanation of injury/ies does not fit with observed characteristics or developmental capacities of child
- Explanation does not fit with distribution of injuries
- There was a delay in presentation

Bruises and bites

13.1.13 The Welsh Child Protection Systematic Review Group have conducted a review of bruises and bites. Information can be found on the Core Info website www.core-info.cf.ac.uk . Be aware that bruises cannot reliably be aged, but swelling and acute pain should be recorded.

13.1.14 Accidental bruises may be seen on any part of the body but must have a clear, appropriate and credible explanation.

13.1.15 In active children accidental bruising tends to occur over bony parts of the body. Bruising at other sites e.g. head, neck, trunk, upper limbs and abdomen may raise suspicions of abuse.

13.1.16 Serious internal injury may occur without external bruising.

13.1.17 The following should always be carefully investigated:

- Any bruises in non-mobile infants, especially in the sites mentioned;
- Bruising on the head (including ears) may indicate more significant internal injury
- 'Fingertip' bruises including those produced by pinching (small, round or oval marks in typical configuration produced by gripping)
- Linear imprints consistent with slaps
- Knuckle bruises consistent with punching (note any impact by rings)
- Marks left by objects e.g. sticks, belts, cords – the shape of the object are etched on the skin
- Evidence of multiple bruising of different ages (note size, colour and location carefully)
- Injuries to the mouth and teeth, including a torn frenum (a bridge of tissue which joins the middle of the inside top lip to the gum).
- Bilateral black eyes
- Bruising from human bite marks either in the form of `love` bites or true bites in the shape of two crescents. If the diameter of the circular mark produced exceeds 3cm it is likely that they were produced by an adult or older child
- Multiple minor, but unexplained bruises
- Bruises, scratches and bite marks to the breasts, buttocks, lower abdomen and genital and rectal area which may be suggestive of sexual abuse [14.1.34]

Burns, scalds and scars

13.1.18 Review of thermal injuries can also be found on www.core-info.cf.ac.uk Burns are found in 10% of physically abused and 5% of sexually abused children.

13.1.19 Accidental scalds tend to occur on the lower face and chest and have splash marks. Skin allergies, birthmarks and infections e.g. impetigo may resemble burns.

13.1.20 The following patterns are suspicious of abuse:

- Deliberate burns are likely to have a regular shape with a clearer outline than accidental burns

- Splash marks occur if hot water is thrown at a child
- Immersion scalds
- Contact burns on the back of hands
- Cigarette burns are circular, 0.6 - 2cms in diameter and lack the `tail marks` of accidental `brushing` burns. They are usually full thickness
- Radiant burns can be produced by neglect e.g. standing too close to a heat source

Fractures (other than skull)

13.1.21 The Welsh Child Protection Systematic Review Group have conducted a review of fractures. Information can be found on the Core Info website www.core-info.cf.ac.uk

13.1.22 In the 1st year of life, any fracture should arouse immediate concern (immobile babies rarely break their bones accidentally).

13.1.23 Some of the fractures which are specific for physical abuse are not apparent on clinical examination (metaphyseal and periosteal shearing injuries).

13.1.24 General presenting features are:

- Abnormal posture of limb
- Unwillingness to move affected limb
- Swelling
- Indication of pain - child cries and becomes distressed when moved or when the area is palpated or handled

13.1.25 Specific features that may help identify fractures caused by physical abuse are:

- **Rib fractures** - common in infants who have been abused and their presence strongly suggests abuse usually as a result of squeezing
- **Spiral fractures** - caused by a twisting force, being swung by the arms or legs; most accidental fractures in school-age children are spiral but are highly suggestive of abuse in immobile children
- **Long bone fractures** which can be caused by violent pulling and may not produce any external signs; long bone fracture and periosteal new bone formation can occur as a result of gripping and twisting injuries
- **Periosteal new bone formation** - the long bones in the arms and legs are protected by a thin layer called the periosteum; when this is damaged from shearing forces, periosteal new bone is seen some 7-10 days later
- **Metaphyseal** injuries where fragments of the bone become separated from the ends of long bones either as a chip or as a whole plate and may cause a ‘bucket-handle’ appearance - such injuries are usually caused by applied gripping and twisting movements but

may be caused by shaking a child; the forces of pulling and twisting disrupt a fine layer of new bone close to the junction with the cartilage, usual sites are the knees

- **Multiple fractures of different ages**
- **Unusual fractures** e.g. acromion of scapula
- **Greenstick fractures** - cracks in bones which do not result in a complete break; the bone cracks half way across and splits some way up its length; the cortex of the bone buckles; these may occur from accidental causes

Injuries to the skull, brain or eyes

13.1.26 In many young children, particularly under 2, a serious head injury is not accidental and may be due to deliberate injury.

13.1.27 Injury to the head and brain is a common cause of death in childhood. Violent shaking of a small child can cause haemorrhage around the brain and eyes.

13.1.28 General presenting features include:

- External evidence of head injury – swelling, laceration
- Extreme irritability
- Drowsiness
- Vomiting
- Fits
- Headache
- Severe pain
- Photophobia

13.1.29 Skull fractures in the absence of clear accidental cause are suggestive of physical abuse:

- Skull fracture with intra-cranial injury
- Wide, multiple or complex (fissured) skull fractures at unusual sites

Dental injuries

13.1.30 Children may be brought to the dental department or elsewhere with oral injuries which arouse suspicion of abuse and for which there may be no adequate explanation such as:

- Broken / damaged teeth
- Injuries to lips or facial bruising accompanying dental injuries
- Torn frenum in the absence of appropriate explanation is suspicious but not diagnostic of abuse.

Poisoning

13.1.31 Poisoning may occur by neglect when a child is not adequately supervised and/or the child's immediate environment is not kept safe

13.1.32 Drugs or poisons may be administered to produce physical signs of illness as part of the spectrum of fabricated or induced illness [Supplement 10: Fabricated & Induced Illness]

13.1.33 The following signs should arouse suspicion:

- Burns to mouth and oesophagus as a result of ingesting corrosive substances e.g. bleach
- Symptoms of acute poisoning e.g. diarrhoea, vomiting, coma, fits, hyperventilation
- Symptoms which do not seem to correlate with the child's observed illness

SIGNS SPECIFICALLY RELATED TO SEXUAL ABUSE

13.1.34 Child sexual abuse may present in a variety of ways, some of which clearly indicate the probability of abuse while others lead only to its suspicion. Symptoms and signs are age related, for example the preschool child may present with sexualised play and the young person with promiscuity. An allegation by the child is an important pointer to a diagnosis of sexual abuse; false allegation is rare.

13.1.35 Diagnosis should rarely be made on the physical signs alone as many sexually abused children have no abnormalities on examination; remember absence of physical signs does not imply absence of abuse. The presence of signs varies according to the type of abuse-oral, digital, anal and vaginal, and how long it has been since the most recent episode. As a general rule, be familiar with genital anatomy and always refer to a senior colleague.

13.1.36 Physical signs that are diagnostic of sexual abuse are not commonly elicitable unless genitalia and anus are examined in detail. Suspicions of sexual abuse may be aroused by the finding of otherwise unexplained injuries e.g. bruises, abrasions etc in the external anogenital area, including the inner thighs.

13.1.37 Inspection of the external genitalia and anus is part of the paediatric examination, and any signs need to be documented and explained e.g. RAD, vulvovaginitis, bleeding. Examination of the genitalia and anus with a colposcope should be carried out when there is an allegation of suspicion of sexual abuse. Consent as for all examinations must be obtained. For many children and their parents it will be reassuring to know that there is no physical damage to the genitalia and anus. Detailed examination is not usually acceptable and should not be carried out without good reason and unless specific consent has been obtained [Supplement 15: Medical Examination]

13.1.38 There are a few diagnostic signs but consider nonetheless the different levels of suspicion outlined below. Behavioural changes may co-exist, occur alone or be the presenting problem. Interpret all signs and symptoms in the context of the child's social and other related circumstances. Exclude medical causes and in particular accidental trauma. Timing of the alleged assault is important as to whether or not there will be signs.

Diagnostic signs:

- Semen in vagina, anus or on external genitalia
- Pregnant by alleged perpetrator
- Transaction of the hymen

Suspicious signs:

- Laceration or scars in the hymen, which may extend to the posterior vaginal wall
- No posterior hymen tissue
- Some sexually transmitted infections (STIs) outside the relevant incubation period for vertical transmission
- Laceration or healed scar extending beyond the anal mucosa on to the perianal skin
- Bruises, scratches or other acute injuries to the genital or anal areas

Consider when there is:

- Teenage pregnancy, with unknown or concealed identity of the father
- Repeated and frequent sexualised behaviour
- Some STIs e.g. warts
- Child hinting that there are secrets about which they cannot talk
- Psychiatric disturbances, mutism, anorexia, deliberate self-harm
- Concern about inappropriate behaviour with other children or adults
- Allegation by another person

More detailed guidance on physical signs and their interpretation are to be found in The Physical Signs of Child Sexual Abuse: An evidence based review and guidance for best practice (2008) published by RCPCH. (Ref.21)

EMOTIONAL & BEHAVIOURAL SIGNS IN THE CHILD

13.1.39 Many of the patients of GOSH (and some in all hospitals) will have experienced serious illness with accompanying intrusive procedures, likely separations from family members and disruption of ordinary life.

13.1.40 These factors may in themselves lead to a child demonstrating emotional and behavioural signs which are similar to those presented by some children who have been abused.

13.1.41 In assessing any child where abuse is suspected it is essential to take into account the child's medical history and assess whether the behaviour may be attributable to factors other than abuse.

13.1.42 There are no behavioural or emotional indicators specific to child abuse and neglect.

13.1.43 Sudden onset of changed behaviour may suggest recently commencing abuse, such as sexual abuse.

13.1.44 Chronic behavioural difficulties are more likely, but not exclusively, to be associated with emotional abuse and neglect. Ongoing sexual abuse may also lead to emotional or behavioural difficulties.

13.1.45 The following are important and an explanation needs to be sought.

Behaviour

- Inappropriate sexualised behaviour or preoccupation
- Excessive or indiscriminate attention seeking
- Frozen watchfulness / hyper vigilance
- Socially withdrawn and unresponsive presentation
- Oppositional / aggressive behaviour
- Over compliant behaviour
- Unusual response to separation (indifference or excessive anxiety)
- Food scavenging
- Very disturbed sleep
- Onset of bedwetting over the age of 5
- Encopresis without constipation

Emotional state

- Unhappiness / depressed
- Self soothing / rocking
- Frightened / distressed
- Very anxious

Peer relationships

- Isolated

- Aggressive

Developmental / educational progress

- Developmental or educational underachievement
- School non-attendance or persistent lateness
- Age-inappropriate responsibility for younger children or for parent – child over-mature for age
- Unusually dependent or immature behaviour

EMOTIONAL & BEHAVIOURAL SIGNS IN PARENT / CARER

13.1.46 The following indicators of parent / carer - child interaction may suggest abuse:

- Emotional unavailability, unresponsiveness and neglect
- Hostility, harsh punishment, denigration and rejection of a child
- Developmentally inappropriate or inconsistent interactions with child including over protection and unrealistic expectations
- Exposure to confusing or traumatic events and interactions, especially domestic violence
- Using the child for the fulfilment of the parent's psychological or other needs
- Inability to distinguish between the child's reality and the parent's belief and wishes
- Failing to promote the child's social adaptation (including isolating and corrupting)
- Psychological neglect by failure to provide or ensure adequate stimulation and education
- Failure to attend necessary health care appointments

SUSPICION OF FEMALE GENITAL MUTILATION (FGM)

13.1.47 FGM has been a criminal offence in the UK since the Prohibition of Female Circumcision Act 1985 was passed. The Female Genital Mutilation Act 2003 [ref. 16] replaced the 1985 Act and made it an offence for the first time for UK nationals or permanent UK residents to carry out FGM abroad, or to aid, abet, counsel or procure the practice abroad, even in countries where FGM is legal.

13.1.48 If there are any suspicions that a child has been or might be subject of FGM, e.g. the presence of uro-genital symptoms in a child from an area where such practice is common, a decision needs to be made as to whether the child should be examined by an appropriately experienced paediatrician. A referral must be made **immediately** to the hospital Children's Social Work Service so that these issues can be discussed and plans to safeguard the child can be made.

FABRICATED OR INDUCED ILLNESS

13.1.49 This condition is rare in the community but is likely to be more common in large tertiary referral units such as GOSH. It is important that if alerting factors are present they are discussed with a person with appropriate expertise, and that the Trust's guidance on the management of perplexing presentations at GOSH is followed.

13.1.50 Alerting signs:

- Reported symptoms, and signs found on examination are not explained by any medical condition from which the child may be suffering
- Investigations do not explain reported symptoms
- The signs are reported or symptoms observed only by a parent or when a parent is present
- There is an inexplicably poor response to prescribed medication and other treatment New symptoms are reported on resolution of previous ones
- There are repeated presentations, particularly to a variety of doctors and with a variety of problems
- The child's normal daily activities are being curtailed beyond that which might be expected for any medical disorder from which the chills is know to suffer
- The parent disputes negative findings and requests further investigations

If one alerting sign is present, look for others

13.1.51 **Parental behaviour:** The following observations of parental behaviour may also be noted but are not exclusive to fabricated or induced illness:

- Parent observed to be tampering with specimens or equipment
- Parent shows unusually detailed knowledge and interest in child's condition
- Parent predicts when further episode of illness will occur
- Parent not easily reassured or questions negative findings
- Parent unusually involved in details of child's treatment
- Parent constantly by in-patient child's side
- Parent not distressed or unusually calm in face of a seriously ill child

13.1.52 See also guidance on Fabricated & Induced Illness [Supplement 10]

TESTS IN SPECIFIC CIRCUMSTANCES

Coma, drowsiness & seizures

13.1.53 If a BM glucose estimation stick suggests hypoglycaemia, take a true blood sugar (fluoride oxalate) and 2ml of blood (in lithium heparin or serum) for C peptide and insulin.

13.1.54 If insulin is present/high and levels of C peptide low, the implication is that exogenous insulin has been given. It is important to separate these samples as soon as possible. Look also for evidence of oral hypoglycaemics.

13.1.55 Hyperglycaemia may be due to 'stress' or rebound after hypoglycaemia.

Drugs / hormones

13.1.56 It is unhelpful to collect samples and send off for 'toxicology screen'.

13.1.57 Untargeted analysis for unknown administered compounds is not possible – the chemistry is too diverse even within one class, e.g. drugs and the methodologies very different.

13.1.58 The preferred sample will vary, e.g. whole blood (EDTA) for some heavy metals, urine for drugs of abuse, serum for hormones and common medications.

13.1.59 Sample volume is likely to dictate extent of investigations, so get as much as possible.

13.1.60 Collect urine specimens in the 6 hours after a 'collapse' or suspected poisoning in a plain bottle and freeze them until they can be analysed. Ensure that the child's name, and date and time of collection is clearly documented.

13.1.61 Ensure that the time and amount of any medication the child has been given by nursing staff is clearly documented.

13.1.62 In suspected poisoning collect specimens of vomit, stool, serum as well as urine – all clearly labelled. Discuss the case with the clinical biochemist or toxicologist and ensure they are taken to the lab where they are appropriately stored initially and then analysed.

13.1.63 Make sure that relevant samples are able to be stored securely in the lab freezer. Wrongly labelled or lost samples may crucially delay an investigation.

13.1.64 Consider administration of prescribed or OTC medication or available compounds (e.g. health care worker) and depending on presentation.

13.1.65 Collect serum (preferred) or plasma (Li Hep anticoagulant) and a random urine ensuring timing of samples is noted on the request form and sample container. Further urines may be recommended.

Drugs

13.1.66 Most labs measure classes of drugs of abuse by immunoassay so it is important that both clinicians and biochemist know what has been looked for or reliably excluded.

13.1.67 Thin layer chromatography screening may identify a range of compounds but again it is necessary to know the limitations of what can and can not be detected.

Other substances

13.1.68 For e.g. lead, mercury and some other heavy metals – whole blood is required (EDTA/Li Hep) although urine may also be useful.

13.1.69 A difficulty arises where administered compounds occur naturally (e.g. catecholamines, steroids).

13.1.70 It may be appropriate to look at metabolite profiles in urine by GC/mass spectrometry.

Salt administration

13.1.71 Biochemical estimations should be made at least of sodium and chloride, potassium creatinine and acid base balance on blood and urine. Check urine osmolality.

13.1.72 Fluid balance details including weight must be accurately measured and recorded. A raised serum sodium may be the alerting factor as this result is soon available.

13.1.73 Sodium output in a timed urine sample is the gold standard. The sodium / creatinine ratio in urine should be measured: a ratio over 100 indicates salt poisoning.

13.1.74 The fractional sodium excretion may also help.

13.1.75 Gastric aspirate may be difficult to analyse locally for sodium as the extreme pH can interfere with the electrodes, but any relevant material including feeds should be collected and stored appropriately.

Seizures

13.1.76 Prolactin rises immediately after a tonic clonic seizure, and if blood is taken in the first hour, this may help distinguish between pseudo and true seizures – however this is usually not possible as often the presentation is a history of seizures and so repeated

13.1.77 EEGs and prolonged EEGs with video monitoring may be required.

Apparent bleeding disorders

13.1.78 Full blood count and coagulation studies. Evidence of trauma. If blood is present in samples, e.g. urine, ask haematology if they can group the blood in the specimen and compare it to the child's blood group and if the same group, check the DNA profile.

13.1.79 A forensic laboratory may be necessary.

Legal implications for tests

13.1.80 Chain of custody packs for sample collection are available to purchase.

13.1.81 The less legal alternative is to ensure traceability of the sample from collection to production of a result of storage of the samples by informing the laboratory what is happening or delivering samples by hand so that further handling can be accurately documented.

DISCLOSURE OF ABUSE

13.1.82 Disclosure can be made in a number of ways, including:

- By a parent concerned that a relative / other known person is abusing the child
- By a parent concerned that a relative / other known person is abusing a sibling of the child
- The child may disclose experience of abuse to themselves
- The child may disclose abuse to a sibling
- Parent or child may disclose abuse by a member of staff
- A member of staff may disclose that another staff member is abusing a child
- A child may disclose another patient is abusing them

OTHER ALERTING FACTORS

13.1.83 Staff should be alert to risk factors. Information may come to light during the admission process which raises questions and concerns.

Sudden unexpected death in infancy

13.1.84 These cases are always carefully investigated by post mortem examination. A history of sudden infant death in the family of a child presenting with unexplained injuries should be noted and a very careful history taken [see Trust SUDI Protocol].

Death of a sibling

13.1.85 Where a child is admitted to GOSH with an unclear diagnosis and a sibling has died without a satisfactory explanation as to cause, a thorough investigation must be done with as much information as

possible being gained from all agencies involved both now and in the past.

Parental risk factors

13.1.86 Sources of stress within families may have a negative impact on a child's health, development and well being, either directly or indirectly or because they affect the capacity of parents to respond to their child's needs.

13.1.87 This is particularly the case when there is no other significant adult who is able to respond to the child's needs.

13.1.88 Research has shown that such sources of stress include:

- Domestic violence [5.11 in LCPP]
- Parental mental illness [5.29 in LCPP]
- Parental drug or alcohol misuse [5.31 in LCPP]
- Social exclusion
- Learning disability [5.30 in LCPP]
- Poverty
- Poor housing
- Forced marriage [5.15 in LCPP]
- Female genitalia mutilation [5.13 in LCPP]

The references above refer to sections in the London Child Protection Procedures (LCPP) [ref 19] which provides additional information. For a full list of the specific circumstances that are covered in the London Child Protection Procedures see page 123.

14 INDIVIDUALS WHO MAY POSE A RISK TO CHILDREN

INTRODUCTION

14.1.1 This section provides practice guidance and information about a range of mechanisms that are available when managing adults and children who have been identified as presenting a risk or potential risk of harm to children.

Use of the term 'Schedule One Offender'

14.1.2 [2]The term 'Schedule One offender' is no longer used and has been replaced with 'Risk to Children'. This is intended to indicate that the person has been identified as presenting a risk or potential risk of harm to children. It is important to note that children and young people may also pose a significant risk of harm to other children /young people and are therefore included within this group.

Recognition

14.1.3 Indicators of people (including children) who may pose a risk to children include:

- Those found guilty of an offence under schedule 1 of the Children and Young Persons Act 1933
- Individuals known to have been cautioned / warned / reprimanded in relation to an offence against children
- Individuals against whom there is a previous finding in court proceedings e.g. Sex Offender Order or care proceedings
- Those about whom there has been a previous s.47 enquiry which came to the conclusion that there had been abuse
- An individual who has admitted past abuse of a child
- Others whose past or present behaviour gives rise to a reason to suspect that a child may be at risk of significant harm e.g. a history of domestic violence and other serious assaults

---

1.1.1 [2] The term 'Schedule One offender' and 'Schedule One offence' has previously been used for anyone convicted of an offence against a child listed in Schedule One of the Children and Young Person's Act 1933.

- Offenders against adults who are notified to the local authority, because the prison or probation services are concerned about the possible risk to children

- Offenders who come to the attention of the Multi-Agency Public Protection Arrangements (MAPPA) [see London Child Protection Procedures ref.19]

- A child/young person, who is the patient, who is known to have committed an offence or be suspected of behaviours that may pose a risk

- A child/young person visiting who is known to have committed an offence or be suspected of behaviours that may pose a risk

All staff working with children are subject to POCAL (Protection of Children ACT list) and Criminal Record Bureau enhanced clearance [GOSH Recruitment and Selection Policy].

MANAGEMENT OF AN INDIVIDUAL (ADULT OR CHILD) WHO MAY POSE A RISK TO CHILDREN AT GOSH

Advance Notice of Visit

14.1.4 If a person who may pose a risk to children is due to escort, visit or stay with a child/young person at GOSH, or is the patient, it is important that their visit is planned to ensure the safety of all children in the hospital.

14.1.5 Wherever possible this planning should happen in advance of the visit to ensure that a plan can be agreed with the person, the hospital Social Work Service and other relevant people.

14.1.6 If it becomes known to any GOSH staff member that a person who may pose a risk to children may attend a future appointment or admittance they must:

- Inform the hospital children's Social Work Service and named nurse when the appointment/attendance is booked, or as soon as it is realised
- A hospital social worker will obtain information about the offender and the offence, and discuss the case with a social work manager
- The hospital social work manager will assess the information which has been collected in order to establish the facts as they are currently known
- The hospital social work manager will liaise directly with a senior manager in the Clinical Governance and Safety Team (CGST).

14.1.7 The Head of Clinical Governance and Safety or their nominated deputy will chair a meeting at least 2 working days before the planned visit involving at least a social work manager, a named nurse and named consultant (or delegated clinical professional).
The chair's responsibility is to facilitate the discussion and decisions. They will also ensure that a copy of the decision letter is placed in the

medical file (in the Correspondence Section) and cross-referenced in the body of the medical notes.

Unplanned Visit

14.1.8 If it becomes known to any GOSH staff member that a person who may pose a risk to children is escorting, visiting or staying with a child/young person at GOSH, or is the patient, they must immediately:

- Contact the hospital Social Work Service and named nurse
- The hospital social worker will on that day obtain information about the offender and the offence, and discuss the case with a social work manager
- The hospital social work manager will assess the information which has been collected in order to establish the facts as they are currently known
- The hospital social work manager will liaise directly with the Head of Clinical Governance and Safety or their nominated deputy.

14.1.9 The Clinical Governance and Safety Team manager will chair an emergency meeting involving at least a social work manager, a senior involved nurse and lead consultant (or delegated clinical professional). This meeting should occur before the arrival of the individual who may pose a risk and be recorded on the medical file by Clinical Governance and Safety Team manager.

14.1.10 In some occasions the person may already be on Trust premises, or it may not be possible to gather information or convene the meeting prior to their arrival. In that case there will be immediate contact (in person or by phone) between the meeting attendees, to decide whether the individual should be barred / escorted from Trust premises, until an emergency meeting has been convened. The meeting should then occur within one working day. Attendees' responsibilities are outlined in 15.1.12.

PLANNING MEETING - (RESPONSE IN HOURS)

14.1.11 Roles & Responsibilities at the meeting:

- The Trust's overriding responsibility is a duty of care to all children within the hospital, and not just the individual patient in question. This responsibility must be taken into consideration by all participants at the meeting. For clarity this meeting is a Trust meeting
- The meeting is chaired by the CGST manager on behalf of the Trust in view of the overall patient safety implications which are likely to extend beyond the protection of the individual patient. The chair is responsible for ensuring that minutes of the meeting are taken (by an appropriate administrator from CGS) and that all information and views are taken into consideration, and an action plan is agreed, implemented and communicated quickly and appropriately after the

meeting. The chair is also responsible for ensuring that a copy of any decisions put in writing to the parents are also placed in the correspondence section of the child/Young person's medical notes.

- The social work manager and named nurse are responsible for providing expert advice and assessment based on their expertise in child protection matters, liaising with the local Social Work Service, and providing support to clinical staff in accordance with their normal role.
- Social work will ensure that CG and Safety are given the relevant contact details of social work professionals and/or negotiate attendance of external social work staff if they are already in communication with them
- The clinical professional is responsible for providing current information about the individual patient's needs and plans, and liaising with the rest of the multidisciplinary team as appropriate after the meeting. This person will also be responsible for communicating the meeting's decision to the individual concerned, and must therefore have the appropriate seniority (i.e. consultant, senior registrar, senior nurse or ward sister).

14.1.12 The purpose of the meeting is to agree a plan for that individual's visit and contact with the child, which should take into account the circumstances and consider;

- Nature of and reason for visit and attendance e.g. outpatient, inpatient, request to be resident and any issue regarding the child's condition.
- Reason for offence;
- Is the individual a risk to his/her own child only, other children in the hospital?; and
- Is it necessary to supervise the person while in the hospital? In view of the central responsibility for all patients' welfare, the Trust will require convincing objective evidence that the individual does NOT require supervision, before this decision can be made.

14.1.13 Recommendations and plans agreed by the CGST Chair should be checked for consistency against any child protection plan. The agreed plans will be recorded and circulated by the Chair directly to all relevant parties i.e. the individual, their family, hospital children's Social Work Service, nursing team, medical team, security and legal departments (where appropriate).

14.1.14 It is reasonable to expect those normally supervising contact in the community would continue to do so, in circumstances where the local Children's Social Work Services is providing this.

14.1.15 The hospital will have responsibility while the individual is on hospital premises to protect other patients. How this will happen will be decided at the above meeting.

14.1.16 Liaison should also take place with necessary staff as agreed in the meeting, including Consultant and nursing staff on a need to know basis.

14.1.17 It is best practice in most circumstances to draw up a written agreement, giving copies to the individual and the ward if appropriate.

14.1.18 A process to review the situation and update the plan as necessary must be agreed by the Chair.

14.1.19 Security must be informed, the amount of information given being on a need to know basis.

14.1.20 The clinical professional (or person identified by the CGST Chair) is responsible for informing the individual or the person/s with parental responsibility for the child or young person of any restrictions of access (which should be dependent on the agreed plan). A senior nurse or social work manager should also be present (where appropriate).

14.1.21 The clinical professional should be fully briefed by the ward manager or other relevant clinical member of staff who has attended the planning meeting. If the clinical professional has not attended the meeting and/or had previous involvement the ward manager can brief the family together with the Consultant so that any questions which parent/carers may have can be answered confidently.

14.1.22 If the agreed course of action needs to change and/or be reviewed the senior nurse is responsible for monitoring the situation and liaising with a social work manager if guidance is needed. Social Work where involved in the care share this responsibility and would request to convene an Individuals Who May Pose A Risk meeting if necessary.

RESPONSE OUT OF HOURS

14.1.23 A “person” arriving out of hours /weekends and /or a time when information is not accessible should not be allowed onto the ward. Ward staff are not to make any decisions to allow entry. The Clinical Site Practitioner’s (CSP’s) should be contacted out of hours and in hours this decision should be escalated to the Chief Nurse/Director of Education.

14.1.24 If the nursing view and the CSP view is in conflict the matter should <u>always</u> be escalated to the Duty Manager for a decision. If any incident occurs as a result of a decision made regarding admission, an incident form should be completed by the ward staff as per usual procedure.

SECURITY

14.1.25 Security staff should be contacted so that they can be available at all times when the family /person is being informed of any restriction/plan. This applies to out of hours situations also.

REVIEW OF DECISION

14.1.26 1.1.27In situations where parents disagree with decisions of the meeting **and** there is factual evidence which may alter the original decision the case will be reviewed by at least **two** suitably qualified managers or senior practitioners with child protection qualifications and experience e.g. Head of Psychosocial and Family Services, Manager or Senior Practitioner (Social Work), or Child Protection Co-ordinating Manager, who have had no previous involvement with the decision, in a timely way. The request for review of decision should go to the Clinical Governance and Safety chair of the meeting (who would be responsible for identifying two people to review the decision). The decision should be fed back to parents by relevant ward staff as soon as possible.

15 MEDICAL EXAMINATION: ACTUAL / SUSPECTED ABUSE

CONSIDERATIONS

15.1.1 Medical examination findings are important, but not the sole indicators in determining whether abuse has occurred. Findings are part of the 'jigsaw' of assessment.

15.1.2 All medical practitioners of whatever grade or level of competency must be able to make a detailed accurate recording of the history that they have taken and their examination findings.

15.1.3 The limitations of medical examination should be recognised, and in particular any limitations with respect to competence of the examiner.

15.1.4 If a member of staff is suspected of causing harm to a child, the medical examination should be undertaken by an external medical examiner.

BASIC EXAMINATIONS

15.1.5 A basic medical examination should be carried out on all children by GOSH medical staff as it would normally be expected to form part of the assessment of all children seen at GOSH. A medical examination forms part of the comprehensive multi-disciplinary assessment in cases of actual or suspected child abuse. The same general principles apply to such examinations as they do to any other with respect to the keeping of detailed contemporaneous notes of findings and the conclusions that may be drawn from them.

15.1.6 The child's general appearance should be noted, including any signs of neglect. Height and weight (and head circumference for infants) should be recorded and plotted on a centile chart, together with any earlier available recordings not previously plotted. The 'child's health care record' book held by the parents may have relevant information.

15.1.7 There should be a further examination of those:

- Presenting with an unusual physical sign of an injury/ies for which there is an inadequate, inconsistent or absent explanation
- Presenting with an abnormal appearance of the ano-genital area observed while the child is under anaesthesia - this needs to be documented and revisited when the child is fully conscious
- Presenting with unexplained uro-genital and/or ano-genital symptoms and
- About whom there are known child protection concerns
- About whom there is a family history of such concerns

15.1.8 This further examination should include inspection of the inner thighs, buttocks, separation of the buttocks so as to visualise the external anus, inspection of the inside of the mouth and nose. Any bruising, swelling or obvious injury should be recorded including:

- Size and description of lesions (measure do not estimate)
- Site of lesions (use body map and/or record distances from the nearest bony landmark) and
- Consideration of the use of photographs were relevant [Supplement 17: Photography]

15.1.9 The results of the above may be:

- No findings – and no further action (NFA)
- Findings of uncertain provenance or suspicion of abuse or neglect – refer for specialist consultant examination or opinion;
- Definite signs requiring initiation of child protection procedures – record findings and take photographs [Supplement 17: Photography].

15.1.10 Advice is possible from specialist consultant(s).

SPECIALIST EXAMINATION

Timing

15.1.11 This should be the subject of internal/ inter-professional discussion [see 2.3]. It is governed by the:

- Necessity for immediate investigation or treatment in order to protect the child or prevent further harm
- Need to obtain forensic evidence and
- Likelihood of alteration of findings over time

15.1.12 Allegations or suspicions of child sexual abuse or of fabricated or induced illness by a carer require especially detailed discussions, which may include strategy meetings.

Involvement of Specialist Consultants

15.1.13 The Lead Consultant or consultant responsible for the immediate care of the child may seek a specialist medical opinion from another colleague within GOSH, including those with specialist child protection expertise. When the route of specialist referral is unclear the Trust's named doctors or child protection consultants should be asked for advice.

15.1.14 In addition to consultants working regularly with individual hospital sites, there are consultants with specific expertise in diagnosis of child abuse [Appendix 1: Key Personnel and Contacts].Their role is to give advice and where necessary carry out specialist examinations in circumstances when it is necessary to clarify diagnosis.

15.1.15 The function of the specialist assessment is to aid in the assessment of suspicions of physical or sexual abuse or neglect, and thereby assist in the process of protecting the child. It may not be possible to make an unequivocal diagnosis of abuse.

Consent

15.1.16 The child's consent should normally be sought unless technically impossible to do so e.g. in pre-verbal children or those with severe cognitive impairment, or those under sedation. A child's refusal to be examined should initially be respected. If simple explanation fails to provide reassurance and assent, there will need to be a professionals' discussion about how to proceed.

15.1.17 Consent of parents or carers should also be obtained for specialist examination, unless the child is assessed as 'Gillick competent' or involving parents is not felt to be in the best interests of the child.

Best Practice

15.1.18 The specialist consultant must be fully informed in advance about the nature of the concerns, the extent of the suspicions and the findings thus far. This must take place before specialist examination.

15.1.19 Child and family should be informed of involvement of any other consultant unless it is not in the best interests of the child to do so. This will usually involve demonstration of reasonable grounds to believe the risk of significant harm to the child will be increased if disclosure occurs.

15.1.20 Whenever possible, any specialist examination should take place in the present of the clinical team who know the child and in the presence of a trusted adult to support her/him.

15.1.21 The hospital social worker should be informed.

15.1.22 The detailed examination findings and/or views / opinions of the specialist consultant are recorded in writing in the child's medical notes, and a summary or cross reference made in the child protection section

where applicable, and conveyed as rapidly as possible to the Lead Consultant/responsible consultant and social worker. If the specialist consultant cannot, for any reason, make a record at the time, her/his comments should be accurately recorded, giving the reasons as to why contemporaneous records are not possible.

15.1.23 Any further recommended actions / specialist investigations should be discussed, documented and appropriately carried out. It will normally be the responsibility of the consultant who is responsible for the child's clinical care to ensure this happens, unless there is clear written agreement otherwise.

15.1.24 The specialist consultant should discuss her/his findings and recommendations with the requesting consultant and social worker. They should provide a clear, comprehensive written report and attend appropriate professional and strategy meetings. A report for court proceedings may be necessary.

Specialist Examinations in the Case of Actual or Suspect Sexual Abuse

15.1.25 The examination of children in whom abuse or assault is suspected or disclosed is a procedure that requires specific expertise and defined core competencies. Appropriate course of action should be defined by a strategy discussion, involving appropriate agencies (see 2.6). In general at GOSH the procedures outlined in the *Amethyst Project Protocol: referral pathway for children and young people with suspicion or allegation of sexual abuse* produced by Camden and Islington PCT should be followed. (Appendix 4)

15.1.26 If there is a clear history of an acute episode of abuse/assault (less than 72 hours in girls under 13 and 7 days in over 13 year old girls; 72 hours for boys of all ages) referral should be made to the appropriate Haven Centre, which specifically deals with forensic examination for sexual assault. Local follow up will still be necessary.

15.1.27 When the allegation of sexual assault /abuse is non-acute as defined above a strategy discussion should be held in accordance with 2.6 in the blue section. The purpose of this meeting will be to determine the timing of any examination, where it should take place and the personnel who will undertake it.

16 OBSERVATION & SUPERVISION

16.1.1 Observation and supervision are carried out for different reasons. However, the principle that the child is constantly observed while under inpatient care pertains to both.

OBSERVATION

16.1.2 The purpose of observation is to gain a complete and detailed picture of the child's state of health and an understanding about the child's reported symptoms and signs.

16.1.3 Observation is a separate task from the nursing care which a child may be receiving.

16.1.4 As a result of an internal discussion or a strategy meeting it may be decided that more information is needed before parents / carers can be presented with, and informed about any concern.

16.1.5 To do this there will need to be constant observation, and care of the child by hospital staff.

16.1.6 There should be a decision made in the meeting as to how, what and by whom parents will be told.

16.1.7 Parents can informed that there is no clear diagnosis and to help clarify the diagnosis it is important that clinical staff are able to observe more closely their child's reaction to exercise, treatment, feeds etc, and staff will therefore need to be with their child all the time.

16.1.8 It is important staff identified to carry out this role are clear what:

- Information has been given to parents
- Observations and care they are expected to carry out and where they should document information from them
- The expected outcomes are e.g. child displays none of the signs and symptoms when clinical staff carrying out care and treatment
- Support is available from the Named Nurse/Named Doctor when carrying out this difficult role. (they must be clear that they are acting in the best interest of their patient – the child)

16.1.9 To obtain this information clinical staff will be asked to:

- Carry out all treatment and care
- Observe the child's response to treatment and care
- Observe the child's appearance and changes to it (including rashes and behaviour)

- Observe and record all input to (including food and medication) and all output by child (including vomit, faeces and urine)
- Always feed the child, or closely observe feeding of the child
- Record clearly amounts the child took, whether s/he vomited etc
- Document clearly how specimens are collected and by whom (specimens should be photographed if appropriate)
- document any unusual findings and report immediately to senior member of staff;
- Document clearly when parents and carers are with the child (using 24 hour clock) and observe behaviour and interaction with her/him
- Report immediately any worrying behaviour by the parents, especially if seen to interfere with treatment, investigations or insist on caring for the child and
- Document who reports any observation about the child e.g. mother says, nurse observed

WARD SUPERVISION

16.1.10 This section should be read in conjunction with section 5.21 and 5.22 of The London Child Protection Procedures 2007 regarding Hospitals and Specialist hospitals. A sick child is best supported by their parent, carer or relevant family member who is well known to them during an inpatient stay in hospital. This ensures that the child receives family centered care and that a holistic approach for patients care is used. This allows the nursing staff to focus on the medical/nursing care of the child.

16.1.11 Parents and carers who bring their children to hospital for treatment should be encouraged to participate and work with medical and nursing staff in the care of their child.

16.1.12 Many parents are resident on the ward with their children and continue to provide as much care for the children as possible.

16.1.13 In certain circumstances it may not be appropriate for parents to care for their child because:

- Medically, the child needs the specialist knowledge and skills of nursing professionals,
- Where there is unexplained or perplexing presentation of a child's signs and symptoms and where the parent /carer may require continuous surveillance
- There are child protection concerns and/or parents are implicated in an on-going joint Section 47 investigation
- There are restrictions to visiting/contacting the child laid down by court order
- There are restrictions imposed by the court on a parent/carer's access to their partner/ex partner e.g. an injunction
- Parents/Carers may have been identified as "Person who pose a risk to children"

16.1.14 The hospital setting is defined as a "Safe Place" by The Children Act 1989. It is neither reasonable nor practical for nursing staff to be expected to monitor a level of contact between parents/carers and child which exceeds what would be expected during the clinical nursing care /observation roles/responsibilities of nursing staff. Nurses are not able to be continuously present to supervise or monitor one to one social contact.

16.1.15 This is applicable to intensive care wards where one to one nursing care does take place but where supervision for the purpose of this policy should not be seen as part of the clinical care of the child. Instead this should be seen distinctly as a separate role which requires additional **external** resources.

16.1.16 The Purpose of supervision is to ensure safety while enabling the child to have contact with parents, carers and family members. For clarity, the term "supervision" is usually associated with supervised contact which is provided by the child's Responsible Local Authority where an identified risk to safety/protection has been identified and restrictions have been imposed on parental contact with the child to ensure the child's safety.

16.1.17 Hospital staff at GOSH are committed to ensuring that any child /young person who requires medical care is also provided with emotional care which parents and carers provide.

16.1.18 However, in certain circumstances where information regarding the safety of a child comes to our attention, the hospital may stipulate that access to that child may need to be supervised by an appropriate person supplied by or authorized by the Child's Local Authority.

16.1.19 Despite the absence of a legal order to enforce supervision, The Responsible Local Authority should seek to work in partnership with GOSH where a risk has been identified by the hospital and which would

place the child at risk of significant harm to provide a supervisor to carry out this task.

16.1.20 The Local Authority should be sensitive to the impact of supervision of children on the child, other patients and parent and carers.

16.1.21 Some children may be admitted to hospital with supervision arrangements out lining specified contact arrangements with their parent/carer already in place with the local authority responsible in the community setting.

16.1.22 A child may subject to an Emergency Protection Order, Interim Care Order or Care Order. A court order may stipulate that a parent/s is/are not allowed contact with their child at all, or only if the contact is supervised.

16.1.23 Parents will be fully aware of this order and it is the responsibility of the local Children's Social Work Service to organise and fund supervision.

16.1.24 A copy of the court order should be obtained from the local authority and placed on the child's medical notes and social work file.

16.1.25 If a child is subject of a child protection plan, it may state that parents are only allowed supervised contact with their child. Parents will be aware of this and have agreed to co-operate.

16.1.26 The local Children's Social Work Service may request that supervision is carried out, on its behalf, by hospital staff. In exceptional circumstances i.e. child in critical clinical condition, this should be discussed with senior ward staff, the hospital Children's Social Work Service and must be authorised by the Head of Nursing (CSPs out of hours).

16.1.27 There may be restrictions placed on parental contact with each other via an injunction. In these cases the hospital will facilitate visiting arrangements in the best interests of the child and may ask parents to sign a written agreement in order to minimize the impact of distress on the child.

16.1.28 In the cases above the Local Authority must consider with the Hospital Social Work Service if supervised contact should:

- Be implemented
- Reduced
- Suspended
- Continued
- In light of the child /young persons medical care and impact on health and well being

16.1.29 The Local Authority should discuss any changes in existing supervision arrangements with the family directly with parents/carers. Similarly, the Trust will ensure that any decision taken by the hospital regarding supervision on the ward will be discussed directly with parents and carers.

16.1.30 In exceptional circumstances, (where a child may be very ill) the ward supervision role can be undertaken on behalf of the Local Authority Children's Social Work Service by an appropriate GOSH member of staff for the specific purposes of safeguarding the child. However, this must only take place with the agreement of the appropriate unit Head of Nursing (in hours) or Clinical Site Practitioner (out of hours). This allows consideration to be given to whether there are adequate resources to support this task appropriately on the ward. There must also be an agreed short timeframe for review of supervision with a view to the Local Authority resuming this role where there are social as opposed to clinical reasons for which the child should be supervised.

16.1.31 In hours a risk meeting or telephone discussion should be convened (see 16.1.32) in an attempt to clarify and agree the parameters of supervision of the child. This should also ensure that appropriate documentation is recorded in the child's medical notes and include any supervision issues which may have an impact on the safety of the child and/or the management of the ward.

16.1.32 The ward social worker and/or duty social worker should liaise with the responsible Local Authority social worker to obtain a current risk assessment and/or information which will enable the hospital to ascertain the level of risk. If a meeting is held it should be chaired by the Head of Quality and Safety or appropriate representative and should include representatives from the following:

- Social Work
- GOSH Legal services
- Chief Nurse/Director of Education
- Security (if appropriate)
- Named Nurse and/or CP office rep

16.1.33 A hospital risk assessment should be undertaken and a clear plan should be formulated to ensure that all staff are aware of any supervision arrangements or any potential ward management issues arising from the supervision arrangement. The decisions of the meeting

should be placed in the child/young persons medical notes in the child protection section of the notes if applicable.

16.1.34 If parents arrive on the ward unsupervised during normal working hours:

- Hospital Children's Social Work Service should be contacted
- Parents should be asked to leave by the ward staff who should direct them to the Hospital Children's Social Work Service.

16.1.35 If there are concerns about the behaviour of parents, the Trust Behaviour Management Policy should be followed [Supplement 5: Behaviour Management of Parents].

16.1.36 Trust accommodation may be withdrawn from parents if their child is subject to child protection concerns [Supplement 5: Behaviour Management of Parents].

16.1.37 The hospital Children's Social Work Service should contact the child's home authority.

16.1.38 If parents arrive on the ward unsupervised out of hours, the CSPs and security should be contacted.

16.1.39 Any referral to the hospital school by the ward should indicate Supervision arrangements as set out in the local authority care plan or as arranged with the ward. The school will contact the GOSH Children's Social Work Service for further information when relevant

STRATEGY MEETING

16.1.40 The Strategy meeting [see 2.6] may decide that the way to ensure the safety of a child while in hospital is to allow parents to only have supervised contact with their child. This is different from a decision to observe the child constantly in relation to suspected fabricated or induced illness or when there is no clear medical diagnosis.

16.1.41 The strategy meeting will have to decide:

- What explanation will be given to parents
- Who will explain the decision to the parents and the consequence if they do not co-operate e.g. a legal order
- Who will supervise the contact and
- How the funding arrangements are to be met by the child's home local authority

16.1.42 Any decision to alter supervision arrangements must be made at a reconvened strategy meeting.

16.1.43 It is essential that staff record immediately any observations of parental behaviour and the nature of the parent / child interaction which give rise to concern, since such observations may be of crucial importance in the future planning for the child, and as evidence in any court proceedings.

17 PHOTOGRAPHY

INTRODUCTION

17.1.1 The information below is consistent with the GOSH protocol relevant 'Making / Using Illustrative Records of Patients' which should be adhered to, when taking or requesting the taking of images of children or young people where safeguarding concerns have been identified.

17.1.2 Images are taken when and where necessary to assist in treatment interventions, creating a permanent record to assist in any investigations, where concerns regarding a child / young person's health, welfare or safety have been raised.

CONSENT FOR PHOTOGRAPHY

17.1.3 It is usually a legal requirement and it is good practice to obtain consent from an appropriate person, in the case of a child a parent or carer with parental responsibility, where there are concerns about a child's or young person's health, welfare or safety and appropriate intervention has recommended that images should be taken.

17.1.4 Where a delay in taking photos is unacceptable, any difficulties in gaining parental consent can be discussed after the images have been taken. The Trust legal adviser is available to offer advice.

17.1.5 A mature child will be able to give informed consent, without referral to their parents or carers if they are judged to be Gillick competent. The Courts have stated that under 16's will be competent to give valid consent to a particular intervention if they have sufficient understanding and intelligence to enable a full understanding of what is proposed. In the case of medical photography this would include how and who may have access to the photographs and in what circumstances.

17.1.6 Consent should be obtained in writing, particularly regarding the sharing of information with any agencies, or information requested by the Police if investigating a serious crime.

17.1.7 In cases where there are concerns of a child protection nature, consent may not be required if this is felt to be in the best interests of the child, and the child is felt to be at risk of future significant harm.

17.1.8 Reasons for not obtaining consent should be clearly documented. In all such cases a consultant signature is required on the imaging request card for prescribed and un-consented recording, and referral to the Children's Social Work Service where relevant.

DIGITAL PHOTOGRAPHY

17.1.9 Clinical photographs should be taken by appropriately trained staff from the medical illustration department whenever possible. Photographs taken when the medical photographer is not available should be aware of the following areas of practice concerns:

17.1.10 It is recognised that whilst digitally orientated recordings are intrinsically no different to traditional recordings, they are easier to copy in electronic format and are therefore more at risk of (including allegations) of manipulation and inappropriate distribution. Care must be taken to protect the image and maintain its integrity.

17.1.11 Clinical digital photographs not taken by a medical photographer might be considered better than none at all, but if they are subsequently used in the legal process there is a risk that any of the following could cause them to be discounted:

- Lack of proper scale
- An audit trail to the original images
- General poor quality
- Allegations of manipulation

17.1.12 In emergencies when a digital camera may be the only option, the following information is relevant.

17.1.13 Digital photographs are accepted by the courts and can be shown by an expert to have been edited if this is so. If a digital camera is used, to ensure consistency of quality and avoid any of the above issues the following guidance should be followed:

- Contemporaneous notes, stating who was present when the photographs were taken
- Photographs should be identified including patient's name, registration number, plus time and date
- Cross referenced to the 'medical photography request and consent form'
- Digital storage card should be handed to the medical photographer as soon as possible
- Where possible digital photographs should be recorded in a 'RAW' format [in effect having a digital negative]
- Keep a clear record of each person who touches the images, and how they have been handled
- All originals should be kept
- The medical photographer should be asked to take new photographs, with linear scales where appropriate at the earliest opportunity
- Secure storage arrangements documented

- Staff taking photographs outside the 'Medical Photography and Illustrative Service' should receive relevant training from the Service before undertaking this task
- Clinical departments should register if they need to photograph patients, ensuring 'Medical Photography' has access to such records when requested, plus some control over quality and distribution

PROCESS FOR TAKING PHOTOGRAPHS AT GOSH

17.1.14 Patients should be referred to the 'Medical Illustration Department' (ext [redacted]). A continuous 'no appointment' service for outpatients is offered from 09.00 to 17.30 each weekday. Inpatients will have images taken either on the ward or in the department by arrangement, usually on the day of request.

17.1.15 All requests for clinical illustration should be made on the pink request form [GOS supplies No. WNU0205] supported by a 'consent for photography' form [GOS supplies No. WNU 558 (pads of 25)] signed by the requesting doctor and person with parental responsibility or child (if Gillick competent) at the appropriate consent level. The form should also clearly state nature of concern e.g. bruises felt to be non-accidental [Additional information in GOSH Policy for Making and Using Illustrative Clinical Records of Patients].

17.1.16 The Consent for Photography is a 3 part form:

- Top copy filed in the child's medical notes or within the child protection section of the medical notes if a GOSH patient
- 2nd copy given to the patient / person with parental responsibility
- 3rd copy sent to the Medical Illustration Department with Medical Request form

18 POLICE INVOLVEMENT

BACKGROUND

18.1.1 The following text provides information on contact and planning Police involvement in **serious** child assault or abuse.

18.1.2 It should be noted that Police have power of entry to investigate allegations of criminal offences committed against children (to collect evidence, speak to witnesses, take statements and arrest suspects) operating under the overarching principles that 'the welfare of the child is paramount 'and that their actions are in the public interest.

18.1.3 To ensure effective interagency working between hospital and Police Child Abuse Investigation Teams (CAIT) or a serious crime team these procedures must be followed.

18.1.4 A small number of the children physically assaulted or abused die from their injuries, and in these cases the Police investigate as serious crimes of murder or manslaughter.

INITIAL CONTACT

18.1.5 Before arriving the police should be directed to the hospital Children's Social Work Service during working hours to arrange to be escorted to the ward.

18.1.6 The social worker will inform the nurse in charge and other relevant people of the imminent arrival of the police.

18.1.7 Other people who need to be informed as soon as possible will be

- Named Nurse Child Protection in GOSH
- Clinical Site Practitioner

18.1.8 Outside working hours, the clinical site practitioners should be contacted by the police to make these arrangements.

18.1.9 If concern relates to an incident that has occurred on the hospital premises, in hours the procedure in Section 2; **Immediate responses to suspicions & concerns** should be followed.

FORENSIC EVIDENCE PROTOCOL

The CSP's are responsible for ensuring that the correct forensic guidelines are adhered to e.g in cases where suspicions have arisen due to possible harm to a child from e.g. suspected tampering with equipment. The CSP's should

follow the forensic protocol in relation to securing /storing / equipment specimens / which may be needed as “evidence”.

Both nursing and CSP’s should ensure that information from meetings or handovers regarding up to date information is handed over to the next shift and that any information/observations are recorded appropriately in the child’s medical notes.

Out of hours

The CSPs should inform Camden’s Emergency Duty Team (EDT) who are responsible for incidents which occur in Camden without delay (this includes cases where there may be a likely clinical explanation which may not have been proven). Camden’s Emergency Duty Team (EDT) will advise on any necessary action.

18.1.10 If the child arrives at the hospital with an existing concern or has been affected or injured by an incident that occurred elsewhere, the CSPs should inform the local authority EDT in the area that the child lives. A list of phone numbers for the ‘out of hours’ local authority teams is available in the CSPs office [2.2.16].

APPLICATION OF INVESTIGATIONS

18.1.11 For any head injury in a child of under 2 years of age, a separate specific protocol listing what investigations are most appropriate should be adhered to [Supplement 11: Head Injury Protocol]

18.1.12 For other children where abuse is suspected, the investigations that are needed will depend on how the child presents, and must be individually agreed with police in each case.

18.1.13 If any suspicions include the use of external medical equipment (e.g in cases where suspicions have arisen due to possible tampering with equipment) the CSP’s should follow the forensic protocol in relation to securing /storing such equipment which may be needed as “evidence”. Both nursing and CSP’s should ensure that information from the meeting and up to date information is handed over to the next shift and that any information/observations are recorded appropriately in the child’s medical notes.

MANAGEMENT OF PARENTS AS SUSPECTS IN THE CONTEXT OF IMPENDING OR ACTUAL BEREAVEMENT

18.1.14 When police arrive at GOSH, they should first report to security at the main reception desk and ask to meet with:

- Clinical Site Practitioner (CSP) bleep [redacted]

The CSP/Person in Charge will accompany the police to the ward and will arrange a private room for the police to talk to the parents.

18.1.15 Medical staff have a medical and ethical duty to obtain an explanation as to how the child came by his or her injury to provide the most appropriate care for the child. This process should not be delayed awaiting Police arrival. Medical staff are requested to make a contemporaneous note of the conversations with the parents or carers in the appropriate section of the child's medical notes (CP Section). If impractical a record should be made at the earliest opportunity.

18.1.16 An account will be obtained from the parents or carers by Police. Ideally this should be completed separately and may well be recorded by the police on audio tape (MIT's have this equipment) or alternatively a contemporaneous note made by the officer. It is requested that the Nurse in Charge identifies a suitable private room for this function.

18.1.17 If the child dies on arrival at the hospital or shortly afterwards it is essential that any potential forensic evidence is preserved. This will include any clothing and nappies that the child is wearing and any medical equipment, tubing or dressings utilised during treatment. Advice for storage of these items will be sought from the senior officer in attendance or the Senior Investigating Officer (SIO) or the Investigating Officer (IO). It is recommended that early consultation regarding forensic matters takes place between the SIO and the CSP/Person in Charge and Ward. The SIO can be contacted via the SCD reserve (tel [redacted]).

18.1.18 If a decision is made to arrest either or both parents it would be good practice and preferable for them to be taken separately to a private room and the arrest made away from other families and sick children on the PICU or ward. The decision to handcuff parents will be solely the judgement of the arresting officer who will take into account the sensitive public clinical setting in which this would occur. If a suspect becomes violent or there is a risk of such a danger, to medical staff other families, patients or Police, necessary reasonable force will be used to eliminate that risk.

18.1.19 Prior to arrest, where practical the SIO / IO will consult with the child's Medical team to establish the estimated survival period for the child. Consideration will be given to delay the arrest if the death is imminent. However, it is important to note that this is a criminal investigation and each case will be decided on the individual circumstances. This decision will be made by the **SIO or IO** and will be documented.

18.1.20 The SIO/IO will involve the hospital children's Social Work Service during working hours (or the CSPs at GOSH Main Site, or Enfield or Haringey Emergency Duty Team outside of working hours) and maintain contact and flow of information as appropriate depending on the circumstance of individual cases.

18.1.21 Once parents have been removed (upon arrest and if the child is still surviving) it will be the decision of hospital and local authority staff to allow relatives to remain. It is clear that this situation is difficult especially if there are two antagonistic sides. If this is the case Police will assist medical staff to remove relatives with minimal disruption to patients and their families. Again advice can be sought from the SIO or the IO.

18.1.22 If parents are arrested and the child is later expected to die the SIO will make the final decision as to how to facilitate a visit by the parents (separately) whenever possible. A written risk assessment will be conducted, normally by the IO in consultation with the Senior Nurse/Modern Matron during working hours (Monday – Friday 9am-5pm) or the CSP/Nurse in Charge outside of working hours. If allowed, the timing of a visit will be agreed with the Senior Nurse/Nurse in Charge. The parents will be escorted by Police Officers (normally in plain clothes).

18.1.23 The SIO or nominated deputy will contact the CSP and will be made aware of any potential medical updates that will require further welfare considerations for the parent or carer. The SIO will ultimately decide on the duration of the visit. Every consideration will be given so that the parent or carer has sufficient time to receive and understand this information. It is important to note that the parent or carer will still be in police detention and there are time constraints.

18.1.24 It is appreciated that part of the grieving process may be to hold or cuddle the deceased child. Advice must be sought from the SIO. As a compromise it may be possible to allow the parents to hold or cuddle their child, provided they wear a plastic apron. **The SIO must grant his or her authority for this.** This process must be supervised and details noted. The apron will then be retained and preserved as evidence. If a child has been in hospital a number of days or weeks before death the need for the apron will be reduced. Again advice to be sought from SIO.

18.1.25 As forensics may be an issue it is requested that a lock of hair or footprint is not obtained prior to discussion with the police. Arrangements will be made for this later by the SIO. Again there is flexibility in this area (forensics may not be an issue). Advice is to be sought from the SIO.

18.1.26 Police will provide Family Liaison Officers (FLOs). Their primary role is an investigative one. They will provide a conduit between the SIO /Investigation team and the family to ensure effective communication. The parents or carers are informed of this. The FLOs will report anything of relevance to the investigation back to the SIO, i.e. anything disclosed by parents or carers cannot be held in confidence. It is important to note that Police FLO's **DO NOT** perform the role of counsellors. However they will provide an introduction to support agencies. This is in the form of an advice folder. A copy is held at the Legal Department of GOSH.

18.1.27 GOSH have a children's Social Work Service based in the hospital which will provide liaison with the child's home local authority and ensure the family understand the child protection processes. They facilitate meetings, provide support for ward staff as for the named doctor and named nurse. In addition other psychosocial staff and Family Liaison Nurses in the Intensive Care Units can provide support for families in relation to coping with the medical condition of the child and likely outcomes. In any suspicious death none of the child's belongings should be returned to the family without consultation with the SIO. It is essential that all contact and conversations between staff and the parent / carer are recorded factually and contemporaneously in the child protection section of the child's medical record.

18.1.28 The decision to release the child's body for burial / cremation will be solely that of HM Coroner. It is expected that the Coroner's Officer will be involved in early consultation with Medical Staff and the Metropolitan Police Service.

18.1.29 If an irreconcilable dispute occurs between the SIO / IO and medical staff, the SCD5 'on call' Detective Superintendent (contactable through the SCD Reserve) in conjunction with the Trust Executive Lead for Child Protection will be the final arbitors.

MANAGEMENT OF A CHILD'S BODY FOLLOWING DEATH

18.1.30 Following death, the child's body comes under the jurisdiction of the coroner who will arrange for a post mortem. There is a strict protocol when investigating unnatural deaths.

18.1.31 If a child under the age of two dies in sudden and unexpected circumstances (excluding illness or accident) the Trust SUDI protocol should be followed. This can be found in the "When a Child Dies" box.

18.1.32 The list of items that may be needed for evidence by Police:-

- Medical devices and personal belongings as decided at the initial briefing meeting
- Additional items for evidence during the course of the child's admission

18.1.33 After death, consideration needs to be given to SUDI and Child Death procedures.

Radiology

18.1.34 Any unexplained death in a child will require a full skeletal survey to be carried out. Scans can also be requested. The correct place for these X-rays to be performed is in the X-ray department and is not appropriate on the ward or PICU, because:

- Quality of the images are better
- Radiation dose from a skeletal survey puts staff members at risk in ward / PICU areas

18.1.35 The coroner has to agree before any medical staff can carry out investigations after death. The Police team with responsibility for the investigations will accompany and remain with the child's body when it is being X-rayed.

18.1.36 Any investigations that are carried out will be necessary for the diagnosis and treatment of the child.

19 PRESS INVOLVEMENT

GENERAL

19.1.1 If there is a likelihood of any case being reported to the media, there should be liaison with the hospital press office. This should be done as part of the decision making process.

19.1.2 When there is a serious incident, briefing copies should also go to:

- The Chief Executive
- Director of Medical Services
- Chief Nurse/Director of Education
- The Director of Clinical Operations
- NHS London

OFFICE HOURS

19.1.3 During office hours the GOSH press office can be reached on 0[redacted] or extension [redacted] or [redacted]

19.1.4 If an issue arises outside office hours the CSP or manager on call is authorised to call the hospital press office (mobile numbers available via switchboard).

19.1.5 GOSH Children's Social Work Service must brief the press office of the London Borough of Camden and its Assistant Director of Children's Services.

20 ETHNICITY, DIVERSITY AND CULTURE

ETHNICITY, DIVERSITY AND CULTURE

20.1.1 No culture or mainstream religion supports a child being harmed. It is important to recognise the possible impact of ethnicity, diversity and culture when assessing the increased vulnerability of some children.

20.1.2 Culture is a particular way of life for a particular group based on attitudes, behaviour patterns and beliefs.

20.1.3 The concept of ethnicity and diversity is more complex, but recognises that people identify themselves with a social grouping on cultural grounds including language, lifestyle, religion, food and country of origin.

20.1.4 A balanced assessment should be carried out addressing relevant cultural perspectives. However, it is important to ensure the welfare and safety of the child remains paramount.

INTERNATIONAL PATIENTS

20.1.5 Children from all cultures and social classes can be subject to abuse and neglect. All children have a right to grow up safe from harm. While in England or Wales, children of all nationalities are entitled to protection under the Children Act 1989 [ref:12].

20.1.6 To make sensitive and informed professional judgements about a child's needs, and parents' capacity to respond to these, professionals must be sensitive to differing family patterns and lifestyles and to safe or 'good enough' child-rearing patterns that vary across different racial, ethnic and cultural groups.

20.1.7 Cultural factors neither explain nor excuse acts of omission or commission which place a child at risk of significant harm, and anxiety about being accused of discrimination, prejudice or stereotyping in practice should not prevent the necessary action being taken to safeguard a child [ref. 11].

20.1.8 A number of patients at GOSH main site come from abroad, and are not British nationals. These children are, while in the UK, protected by relevant CP legislation e.g. Children Act 1989 and procedures e.g. the London Child Protection Procedures [ref. 19]. If the family also has an address in this country (they may be staying in an Embassy flat) then the Children's Social Work for the local authority in which they reside will be contacted by hospital Social Work Service.

20.1.9 Concern about possible abuse of any child must be referred to the hospital Social Work Service or CSPs out of hours as per this policy. The GOSH Social Work Service will make an assessment and liaise with the appropriate child protection and paediatric agencies in the child's own country. A decision should be made about who will contact the Embassy, following a professionals or strategy meeting [2.6].

20.1.10 If there is immediate risk to such a child, either directly from the parents' actions, or because consent to essential treatment is withheld, an appropriate order may be applied for. In all cases legal advice should be sought. For consultation on a childcare matter, contact the hospital Social Work Service.

For other legal advice contact:

- Assistant Director patient and staff safety, ext: [redacted] or
- Legal advisors, ext: [redacted]

20.1.11 Appropriate trained interpreters should always be used when carrying out child protection investigations and when giving any explanations or information about processes. However, if this is not possible in a timely way, an advocate (who is an employee of the Trust) may be asked to carry out this role. In these circumstances, the advocate should be reminded that their first duty is to the child. It is never appropriate to use children or other family members as interpreters in child protection investigations.

21 RECORD KEEPING

STANDARDS

21.1.1 Good standards of record keeping are an integral part of professional practice and essential in child protection practice. Good standards of record keeping help protect the welfare of the child and family by promoting high standards and continuity of care.

21.1.2 The GMC and NMC have record keeping standards and publish good practice guidelines.

http://www.nmc-uk.org/

http://www.gmc-uk.org/

21.1.3 Records are a vital source of evidence for serious case reviews, internal investigations and inquiries, and may also be required to be disclosed in civil or criminal court proceedings.

21.1.4 Effective record keeping can be maintained if records are:

- Factual, concise and legible
- Clear in separating fact and observation from interpretation and explanation
- Accurately dated, timed with the 24 hour clock and signed with the name and designation printed in capital letters
- Written as soon as possible after an event has occurred (If time has lapsed it must be noted and documented that this is being written in retrospect).
- Written objectively without the use of jargon, abbreviations, separating fact from opinion and excluding subjective statements
- You must not tamper with original records in any way and records should be written clearly in such a manner that the text cannot be erased
- Consecutive

21.1.5 Telephone messages must be clearly documented.

21.1.6 E-mails about patients are disclosable therefore should be printed and filed in the appropriate section of the child's medical notes (CP Section) [Supplement 8: Documentation].

21.1.7 Faxed information should be photocopied to prevent fading.

21.1.8 Where decisions, judgments and actions are taken either individually or collectively by professionals, this should be made clear and carefully recorded in the appropriate section of the child's medical notes (CP Section) [Supplement 8: Documentation].

21.1.9 This is particularly relevant following any form of child protection meeting e.g. strategy, professionals meeting, including requests for staff to attend local/out of trust child protection meetings. Staff should:

- Agree attendance with the Named Doctor or Nurse or Social Work Manager
- Use the Trust case conference template
- Send a report using the template if not attending
- A copy of the report must be placed in the child's records
- Decisions made at the meeting should immediately be documented on the case conference template, signed by the chair of the meeting and placed in the child's records

21.1.10 It is extremely important to record whether information regarding observations have been witnessed personally or have been passed to the member of staff by parent / carer or child e.g. evidence of marks or bruises on a child's body, actually witnessed a child vomit or pass urine.

Recording basic information of accompanying adults

21.1.11 For purposes of identification all staff must record clearly the name, contact details and relationship of any visitor to a child inpatient. In addition staff should record in the medical notes the details of any parent carer or adult (including male carers) who accompany a child who is an inpatient or is attending an outpatient appointment. This information should include if they have a significant relationship with the child and/or live in the same household and is regardless of whether they hold parental responsibility of not.

DISCHARGE SUMMARIES

21.1.12 Discharge summaries should be completed within 72 hours of discharge. [See GOSH Discharge Policy]

21.1.13 Child protection concerns, however slight, need to be expressed in the discharge summary, including the estimated likelihood (i.e. possible, probable, very likely). Where a formal strategy meeting has identified a child at risk of actual harm, then a course of actions should be agreed to ensure that the child will be adequately protected following discharge.

SEPARATE RECORDS

21.1.14 Any professional keeping separate records must communicate any concerns as indicated in the procedures. (The concerns must be documented in the child's notes and communicated to the Social Work Service).

21.1.15 Hospital policy must be followed in relation to keeping of separate records

21.1.16 The hospital Children's Social Work Service are obliged to keep separate records in keeping with London Boroughs of Camden's policy and procedures. The hospital Social Work Service should also document relevant information in the child protection section of the child's hospital notes.

PARENTAL ACCESS TO RECORDS

21.1.17 In cases of suspected or unresolved child abuse and neglect including fabricated or induced Illness, care must be taken that parents do not have free unsupervised access to records, both medical and nursing.

21.1.18 If in these circumstances parents request access to their child's records, hospital policy will need to be followed. This takes into account third party information and any possible harm to the child.

22 ROLES

22.1.1 It is essential that all health professionals and their teams have access to advice and support from named and designated child safeguarding professionals and undertake regular safeguarding training and updating as detailed in Working Together to Safeguard Children [ref:11].

22.1.2 Guidance from Working Together to Safeguard Children [ref:11] states that all NHS Trusts and NHS Foundation Trusts should identify a named doctor and a named nurse for child protection. GOSH have identified relevant professionals whose name and contact details can be found in [Appendix 1: Key Personnel & Contacts].

DESIGNATED PROFESSIONALS

22.1.3 The terms 'designated' and 'named professionals' denote professionals with specific roles and responsibilities for safeguarding children. Each GOSH site has a team approach to enhance the ability to provide 24 hour advice and provide mutual support for those carrying out the named professional roles supported by the designated professionals from Camden PCT.

22.1.4 Each local PCT have a designated doctor and nurse to take a strategic, professional lead on all aspects of the health service contribution to safeguarding children across the PCT

22.1.5 Appointment as a designated professional does not, in itself, signify responsibility personally for providing a full clinical service for child protection.

22.1.6 This is done by a team of professionals with GOSH [Appendix 1: Key Personnel & Contacts].

22.1.7 Designated professionals provide advice and support to the named professionals in GOSH site. They are a vital source of professional advice on safeguarding children matters to other professionals, the PCT, Local Authority children's services departments and Camden LSCB's ,].

CHILD PROTECTION CO-ORDINATING MANAGER

22.1.8 The key responsibilities of the Child Protection Co-ordinating Manager are the co - ordination of the strategic integration of child protection within GOSH by facilitating the development and implementation of CP structures and processes, the identification of nursing roles and integrating of multi-professional training and supervision processes in child protection.

22.1.9 The Child Protection Co-ordinating Manager also demonstrates advanced communication and leadership skills, using expert safeguarding knowledge and decision-making skills including being a resource within the Trust for Named Nurses and other health and social work professionals across GOSH. In addition, the role liaises with external child protection professionals to ensure good working relationships and links are established to promote good interagency communication.

22.1.10 The Child Protection Co-ordinating Manager also provides skilled professional involvement in safeguarding processes in line with LSCB procedures, and in serious case reviews. As part of serious case reviews they review and evaluate the practice and learning from all involved health professionals within GOSH and ensures the dissemination of recommendations and learning. The post holder has a key role in ensuring the Trust's compliance with current child protection policy, procedure and policy.

22.1.11 The Child Protection Co-ordinating Manager also manages the Named Nurse for Child Protection, Practice Educator for CP and the CP administrative service.

NAMED PROFESSIONALS

22.1.12 Named professionals within GOSH have a key role in promoting good professional practice within the trust and provide advice and expertise for fellow professionals. They have specific expertise in children's health and development, child maltreatment and local arrangements for safeguarding and promoting the welfare and safety of all children using relevant site services including those for the unborn child. They work closely with the relevant hospital Children's Social Work Department.

22.1.13 The Named professionals and the Child Protection Management Group [CPMG] support the Trust in its clinical governance role by ensuring audits on safeguarding are undertaken and that safeguarding issues are part of the Trust's clinical governance system.

22.1.14 Named professionals work closely with professionals from social work , the Clinical Governance and Safety Team and the Trust Legal Team to ensure that GOSH members of staff have access to the appropriate advice and support when working with child protection matters.

22.1.15 The Named Doctor is available for advice and consultation on all child protection matters, particularly when concerns relate to fabricated or induced illness by a parent or carer. In these complex cases the named doctor should be invited to all internal professional and strategy meetings. This is especially relevant to GOSH.

22.1.16 The Named Nurse and Doctor are members of the Child Protection Management Group and the Safeguarding meeting group at GOSH. They also attend and contribute to relevant safeguarding groups / reports internally and externally as required.

22.1.17 Named Professionals sits on the Health Professional Advisory sub group of the LSCB led by the designated professionals.

22.1.18 The Named Nurse offers child protection supervision to nursing staff working with complex cases as outlined in the Trust CP Supervision protocol at GOSH.

22.1.19 The named professional will usually be responsible for conducting the Trust's internal Management reviews, coordinated by the CPMG except when they have had personal involvement in the case, when it will be more appropriate for the Child Protection Co coordinating Manager or relevant designated professional to conduct the review.

22.1.20 The named professionals and CPMG will also ensure that any relevant action plan is followed up, including the dissemination of recommendations.

22.1.21 They also have a key role in ensuring a safeguarding training strategy is in place, including external national and LSCB events, supported by the CP Co ordinating Manager and CP Training & Education Group, and is delivered and evaluated.

22.1.22 The duties of the named doctor and the core competencies required are set out in a draft job specification available on the RCPCH website.

CLINICAL SITE PRACTITIONERS (OUT OF HOURS MANAGEMENT OF CHILD PROTECTION)

22.1.23 Out of normal working hours the CSP's have a role to play in the management of child protection. [Supplement 2: Immediate responses to suspicions & concerns]

- To co-ordinate child protection processes and procedures out of hours
- To provide support and advice in relation to safeguarding children to nursing/medical staff
- To safely manage new referrals when there is identified suspicion or concern about a child's welfare
- To ensure that all relevant documentation is completed and filed correctly into the child's medical notes
- To inform and liaise with the child's local authority EDT and Camden EDT when a concern has been identified that needs intervention out of hours, agreeing a plan for the safety of the child

- To be involved in agreement of any restrictions relating to parent(s) visiting/supervision
- To inform the child's parents that a concern has been raised and the need for referral, where appropriate
- To ensure that a completed referral from to the hospital's Social Work Service is delivered at the start of the next working day, and that the duty social worker is informed of new referrals
- To inform the Duty Manager Out of Hours of any significant CP issues

HEAD OF PSYCHOSOCIAL AND FAMILY SERVICES

22.1.24 The Head of Psychosocial and Family Services is the lead manager for the Safeguarding and Social Work service which the Trust manages, as part of a legal agreement, on behalf of Camden Children Schools and Families.

22.1.25 The post holder:

- Has lead case management responsibility to ensure that the work of the Safeguarding and Social Work service operates to a high standard to fulfil it's statutory and good practice obligations
- Chairs the Child Protection Management Group and jointly with it's membership (named nurse, named doctor, social work manager, training manager, clinical workforce manager and child protection administrator) plans and oversees all child protection activity for GOSH site.
- Offers professional social work advice to the Partnership group
- Offers professional advice and support as necessary
- Links with Camden Assistant Director Social Work and Principal Officer for Child Protection & Quality Assurance to ensure all child protection requirements are met
- Liaises and promotes good working relationships with the London Police CAIC and other relevant agencies
- Offers professional advice and support to assist the Trust in dealing with complex issues

CHILDREN'S SOCIAL WORK

22.1.26 Social Work, with the cooperation of other agencies, have a duty under s47 of the Children Act 1989 to make enquires if they have reason to suspect that a child in the hospital is suffering, or likely to suffer significant harm, to enable them to decide whether they should take any action to safeguard or promote the child's welfare [ref.19].

22.1.27 Where a child is at risk of significant harm, the local authority social work professionals are responsible for coordinating an assessment of the child's needs, the parents' capacity to keep the child safe and promote their welfare.

22.1.28 At GOSH main site, the hospital Social Work Service (employed by London Borough of Camden), will act as liaison with the child's home authority, who hold the statutory duty to investigate the concerns. However, if the child is resident in Camden, the hospital Social Work Service will work jointly with Camden community social work to investigate.

22.1.29 The hospital children's Social Work Service at GOSH are available for consultation and advice if staff are uncertain.

PALS ROLE

22.1.30 PALS advises and supports families who have concerns about any service they are receiving from the hospital. Please see below re PALS role in child protection.

INVOLVEMENT IN CHILD PROTECTION

22.1.31 There are a number of ways in which the service may become involved in child protection cases, and it is important staff are aware of them, if all parties are to work together for the protection of children:

- Parents suspected of child abuse or neglect may seek advice from PALS
- The service may be working with a family suspected of child abuse or neglect and not be aware of the concerns
- It may be involved with a child who is the victim of child abuse or neglect; and
- PALS may receive information from a parent, child or third party which gives rise to concern about child abuse or neglect

22.1.32 In their dealings with families, PALS staff undertake not to disclose any information given to them without permission **unless** it is necessary to protect a child from harm or injury.

22.1.33 They are bound by the Trust's child protection policy and must follow this in reporting any information which indicates that a child may have been abused or neglected or is at risk of significant harm.

22.1.34 The hospital Children's Social Work Service should check whether PALS is involved with any family about whom there are child protection concerns and, if so the social worker involved should inform the PALS Manager/Officer.

22.1.35 Failure to do so may result in PALS misunderstanding the situation and taking inappropriate action. When sharing information in these circumstances, the information is not to be disclosed to family members.

22.1.36 If PALS staff are concerned that they may be working with a family who are in the safeguarding or child protection process, they should discuss their concern with a Social Work Service manager.

22.1.37 PALS do not advocate for parents or carers in the child protection process, but can assist by giving the family contact details of external specialist organisations that can offer advice or assistance.

LEAD CONSULTANTS: SUMMARY OF ROLE

22.1.38 All children attending or admitted to GOSH will have a named Lead Consultant, who will take overall responsibility for the child's care. The Lead Consultant should be named on PiMS respectively.

22.1.39 Any dispute over who is the Lead Consultant should be discussed with the Medical Director or the Trust Executive lead for child protection.

22.1.40 The Lead Consultant in child protection situations:

- Take appropriate action if any child protection concerns are raised with them e.g. refer to hospital Social Work Service [see 2.2] (concerns can be discussed with named doctor, named nurse or the hospital Social Work Service)
- Attend strategy meetings or arrange for a named deputy to attend and agree feedback mechanism with deputy
- Provide, within the timescales identified in the strategy meeting, a written and signed report as requested by the hospital Social Work Service or the strategy meeting chairperson
- Abide by decision taken at strategy meetings particularly in regard to communication with parents around child protection issues
- Not to discharge patient if child protection issues are outstanding or unless agreed by the hospital Social Work Service and a plan has been put in place
- Provide discharge summaries that include consideration of risk to children.
- GOSH main site only: To sign to notify that they are aware of the Action Plan and agree to discharge or Conclusion of Child Protection Episode [Supplement 8: Documentation]

22.1.41 These actions are all consistent with recommendations from the Laming Report (2009) [ref.8].

23 TRAINING AND AUDIT STRATEGY

TRAINING

23.1.1 All GOSH staff, on commencement in the Trust will receive mandatory child protection training as part of their induction.

23.1.2 A mandatory update session should also be attended by all staff every 18 months.

23.1.3 A child protection Training Strategy exists to ensure that all staff within GOSH are trained to the appropriate levels. A range of child protection teaching sessions and unit specific opportunities are available for staff to attend. (See CP training strategy).

23.1.4 All staff (including volunteers) working in clinical or non-clinical settings who have regular contact with parents, children and young people should:

- Understand what constitutes child abuse
- Know the range of physical abuse, neglect and sexual abuse
- Be able to recognise child abuse
- Know what to do and who to inform when they are concerned that a child is being abuse
- Be able to document their concerns; and,
- Understand the next steps in the child protection process

(level 2)

23.1.5 In addition, all staff work predominately with child and young people should:

- Have knowledge of the implications of key national document / reports
- Understand the assessment of risk and harm; and,
- Know how to improve child resilience and reduce risks of harm
- Understand the multi-agency framework / assessment / investigation / working
- Be able to present child protection concerns in a child protection conference
- Demonstrate ability to work with families where there are child protection concerns
- Understand forensic procedures / practice

(level 3)

CHILD PROTECTION SUPERVISION

23.1.6 High quality supervision is the cornerstone of effective safeguarding of children and young people and should be seen to operate effectively at all levels within the Trust. [See Safeguarding Supervision Policy 2009]

23.1.7 All GOSH health staff have access to clinical supervision and it is recognized that child protection issues may be considered. In all such cases if the clinical supervisor feels they are unable to deal with this issue they will refer staff to a Child Protection Supervisor or Named Nurse / CP Co ordinating Manager .

23.1.8 Supervisors / supervisees will maintain a record of the key decisions / outcomes of child protection supervision in accordance with their supervision contract. All records in relation to individual children including agreed actions will remain the property of the relevant Trust, and should be filed according to Trust standards in the child's medical records.

AUDIT

23.1.9 The child protection clinical audit annual programme is agreed by the management group at GOSH, which consists of key individuals within the Trust responsible for Safeguarding. The programme is decided in advance, usually before the end of the previous financial year. The annual programme reflects national priorities for child protection such as standards outlined by the Health Care Commission, NICE, NSF, recommendations from local safe guarding board and target local areas of clinical priority and interest.

23.1.10 For each Child Protection audit undertaken there is an identified lead responsible for ensuring data collection, dissemination of findings and agreeing local action for performance development in collaboration with the child protection management board. It is also the responsibility of the identified audit lead to engage the interest of all members of the multidisciplinary team; each audit should include as many members of the team delivering care as possible.

24 E-SAFETY

DEFINITIONS AND PURPOSE OF E-SAFETY

24.1.1 E-safety forms part of the GOSH Zero Harm policy. As a hospital providing health services for children we have a responsibility under The Children Act 2004 to safeguard and promote their welfare and provide a safe learning environment while children are patients in our hospital.

24.1.2 E-safety is a framework of policy, practice, education and technological support that ensures a safe e-learning environment in order to maximise the educational benefits of ICT whilst minimising the associated risks.

24.1.3 The e-safety strategy enables GOSH to create a safe e-learning environment that:

- protects children from harm
- Safeguards staff in their contact with children and their own use of the internet [3]
- Ensures that GOSH fulfils its duty of care to children
- Provides clear expectations for staff and children on acceptable use of the internet.

24.1.4 GOSH has clear framework /guidance and information governance around their e-safety policy and practice that ensures everyone is aware of the issues and knows what is expected of them in terms of their own acceptable use of the internet and other technologies. E-safety policies are consistent with related service policies such as GOSH Child Protection Policy and Procedure (2010)

SAFEGUARDING INCIDENTS - STAFF

24.1.5 If an allegation is made against a member of staff's inappropriate usage of the GOSH internet system which raises safeguarding concerns, the staff member/manager with the concern must report this to the ICT manager and ensure that the GOSH social work service is contacted immediately. Out of hours the Clinical Site Practitioners (CSP's) should be contacted. **The procedures in Section 4: (Allegations against members of staff) of the GOSH Child Protection Policy and procedures must be followed.**

[3] (for staff explanation please see Use of Internet Policy (2011)

24.1.6 If the breach of acceptable use of ICT calls into question the suitability of the staff member to continue to work with children, further decisions regarding appropriate disciplinary action must be taken. In addition, the person who reported the concern should also complete an incident form on line iR@G.

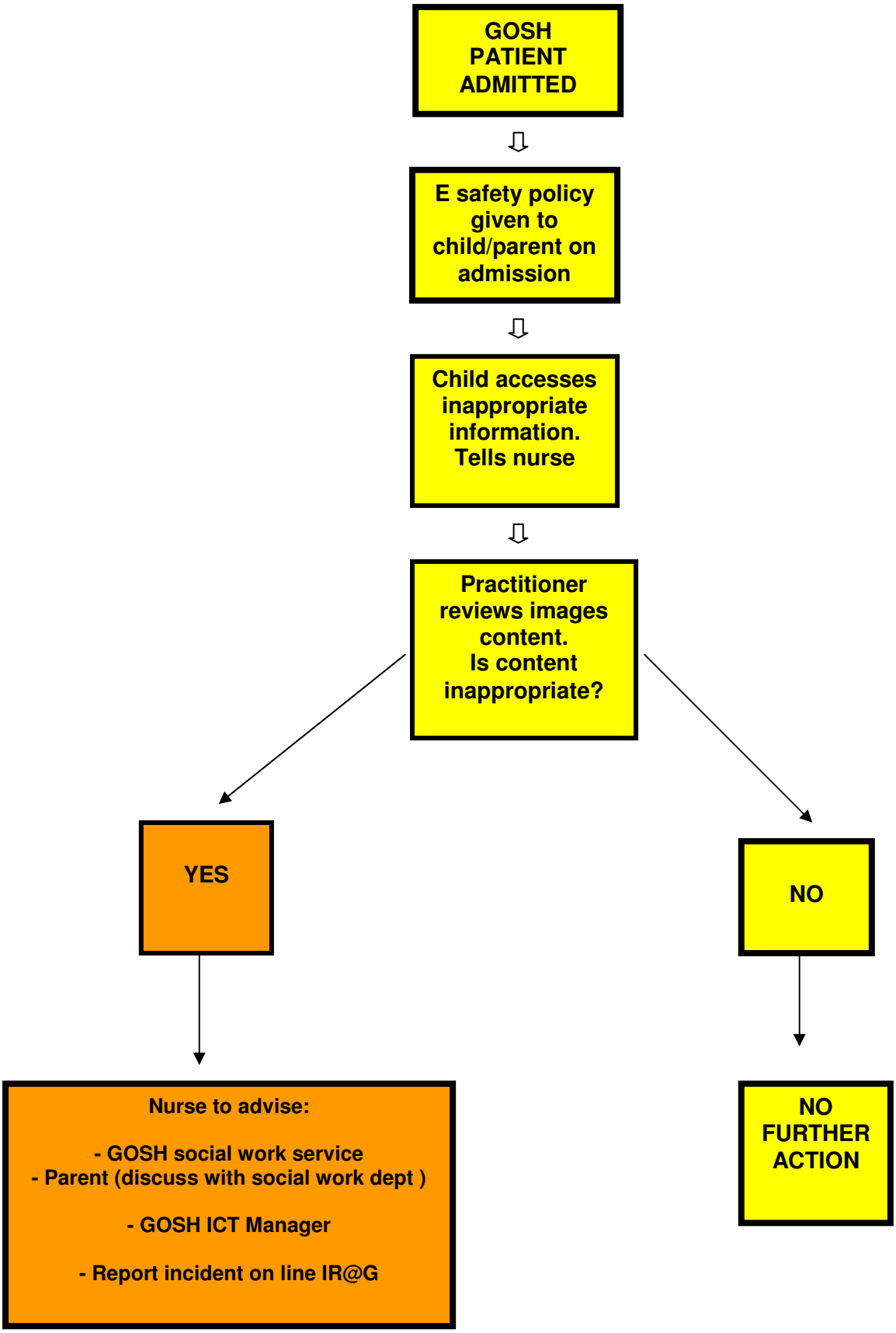
SAFEGUARDING INCIDENTS - CHILDREN/YOUNG PEOPLE

24.1.7 Where any e-safety incident has serious implications for the child's safety or well-being, the matter should be referred to the GOSH social work service who will decide whether or not a referral should be made to child's local social work team and/or the Police as appropriate. (Please see appendix 3 below).

24.1.8 This refers to all ICT or social media policies or standard operating procedures within the Trust.

Appendix: 3

Staff procedure



25 REFERENCES AND USEFUL WEBSITES

REFERENCES

1. Camden and Islington PCT (2007) *Child Sexual Abuse – General Guidance and Amethyst Protocol 2007*
2. CSCI (2005) *Safeguarding Children: The Second Joint Chief Inspector's Report on Arrangements to Safeguard Children*
3. DfES (2006) *Safeguarding Children and Safer Recruitment in Education*
4. DCSF (2006) *What to do if you're worried a child is being abused*
5. DH (2000) *Framework for the Assessment of Children in Need and Their Families*
6. DH (2004) *National Service Framework for Children & Maternity Services: Core Standards*
7. DH (2002) *Safeguarding Children in Whom Illness is Fabricated or Induced*
8. DCSF, Lord Laming (2009) *The Protection of Children in England: A Progress Report*
9. Foreign & Commonwealth Office (2007) *Dealing with cases of forced marriage: Practice guidance for health professionals*
10. Haringey LSCB (2007) *Practice Guidance on Pre-Birth Assessments*
11. HM Government (2006) *Working Together to Safeguard Children*
12. HMSO (1989) *Children Act 1989*
13. HMSO (2002) *Adoption and Children Act 2002*
14. HMSO (2004) *Children Act 2004*
15. HMSO (1996) *Education Act 1996*
16. HMSO (2003) *Female Genital Mutilation Act 2003*
17. HMSO (1998) *Human Rights Act 1998*
18. HMSO (2003) *Sexual Offences Act 2003*
19. London Safeguard Children Board (2007) *London Child Protection Procedures, 3rd Edition*
20. Royal College of Paediatrics and Child Health (2009) *Fabricated or Induced Illness by Carers (FII): A Practice Guide for Paediatricians*
21. Royal College of Paediatrics and Child Health (2008) The physical signs of child sexual abuse: An evidence based review and guidance for best practice
22. National Institute for Health and Clinical Excellence (2009) Clinical guidelines: When to suspect child maltreatment

WEBSITES

Core Info – www.core-info.cf.ac.uk

Department of Health – www.dh.gov.uk

Department for Children, Schools and Families (formerly DfES) – www.dcsf.gov.uk

Every Child Matters – www.everychildmatters.gov.uk

London Safeguarding Children Board – www.londonscb.gov.uk/

Royal College of Paediatrics and Child Health – www.rcpch.ac.uk

Teachernet – www.teachernet.gov.uk

Foreign and Commonwealth Office – www.fco.gov.uk

Nursing and Midwifery Council - www.nmc-uk.org/

General Medical Council - www.gmc-uk.org/

TRUST DOCUMENTS

This is the list of Trust documents that are referred to in this document:

- Access Policy
- Discharge of Patients Policy
- Safeguarding Supervision Policy 2012
- CP Training Strategy
- Information Sharing Protocol
- Lone worker policy
- Resolving Conflict between parents and staff
- When a Child Dies
- Incident Form
- SUDI Protocol
- Making / Using Illustrative Records of Patients Policy

LONDON CHILD PROTECTION PROCEDURES (LCPP) 2007

Additional information on the following topics can be located in the London Child Protection Procedures [ref 19] (the references below relate to the sections in the LCPP).

- Animal Abuse and Links to Abuse of Children and Vulnerable Adults [5.2]
- Begging [5.3]
- Blood-borne Viruses [5.4]

- Boarding School [5.5]
- Bullying [5.6]
- Custodial Settings for children [5.7]
- Custodial Settings (children visiting) [5.8]
- Diplomats families [5.9]
- Disabled Children [5.10]
- Domestic Violence [5.11]
- Fabricated or Induced Illness [5.12]
- Female Genital Mutilation [5.13]
- Fire Setting [5.14]
- Forced Marriage of a Child [5.15]
- Foreign Exchange Visits [5.16]
- Foster Care [5.17]
- Harming Others [5.18]
- Historical Abuse [5.19]
- Honour Based Violence [5.20]
- Hospitals [5.22]
- Hospitals (specialist) [5.23]
- ICT Based Forms of Abuse [5.23]
- Left Alone [5.24]
- Male Circumcision [5.25]
- Missing Families for Whom There are Concerns for Children or Unborn Children[5.26]
- Missing from Care and Home [5.27]
- Not Attending School [5.28]
- Parental Mental Illness [5.29]
- Parents with Learning Difficulties [5.30]
- Parents who Misuse Substances [5.31]
- Pre-Trial Therapy [5.33]
- Private Fostering [5.34]
- Psychiatric Care for Children [5.35]
- Psychiatric Wards and Facilities (children visiting) [5.36]
- Residential Care [5.37]
- Self-harming and Suicidal Behaviour [5.38]
- Sexually Active Children [5.39]
- Sexually Exploited Children [5.40]
- Spirit Possession or Witchcraft [5.41]

- Surrogacy [5.42]
- Trafficked and Exploited Children [5.43]

APPENDIX 1: KEY PERSONNEL & CONTACTS

GOSH

Child Protection

Hospital Children's Social Work Reception	[redacted]
Named Doctor Child Protection	[redacted]
Named Nurse Child Protection	[redacted]
Child Protection Co-ordinating Manager	[redacted]
Clinical Site Practitioners (out of hours)	[redacted]
Senior Child Protection Administrator	[redacted]
Child Protection Administrator	[redacted]

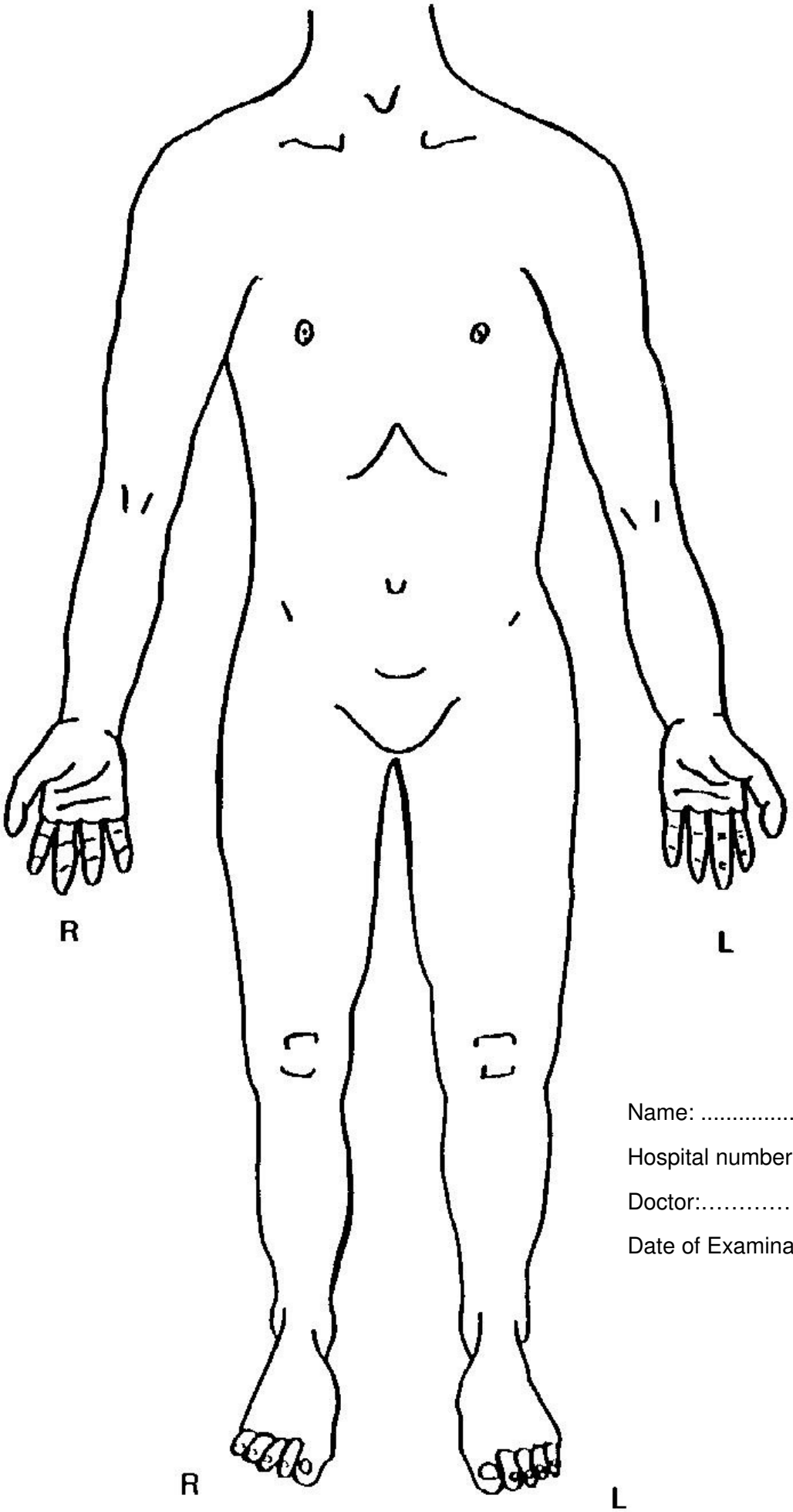
Other Useful Contact Details

Clinical Ethics Committee	[redacted]
Legal Advisor	[redacted]
Manager on call	Via GOSH switchboard
Medical Illustrations Department	[redacted]
PALS	[redacted] External line 020 7829 7862
Press Office	[redacted]
Security	[redacted]

Designated Professionals

Dr Peter Lachman, Designated Doctor Camden	[redacted]
Dr Deborah Hodes, Named Dr CP Camden	[redacted]
Jackie Dyer, Designated Nurse CP Camden	[redacted]

APPENDIX 2: BODY DIAGRAMS

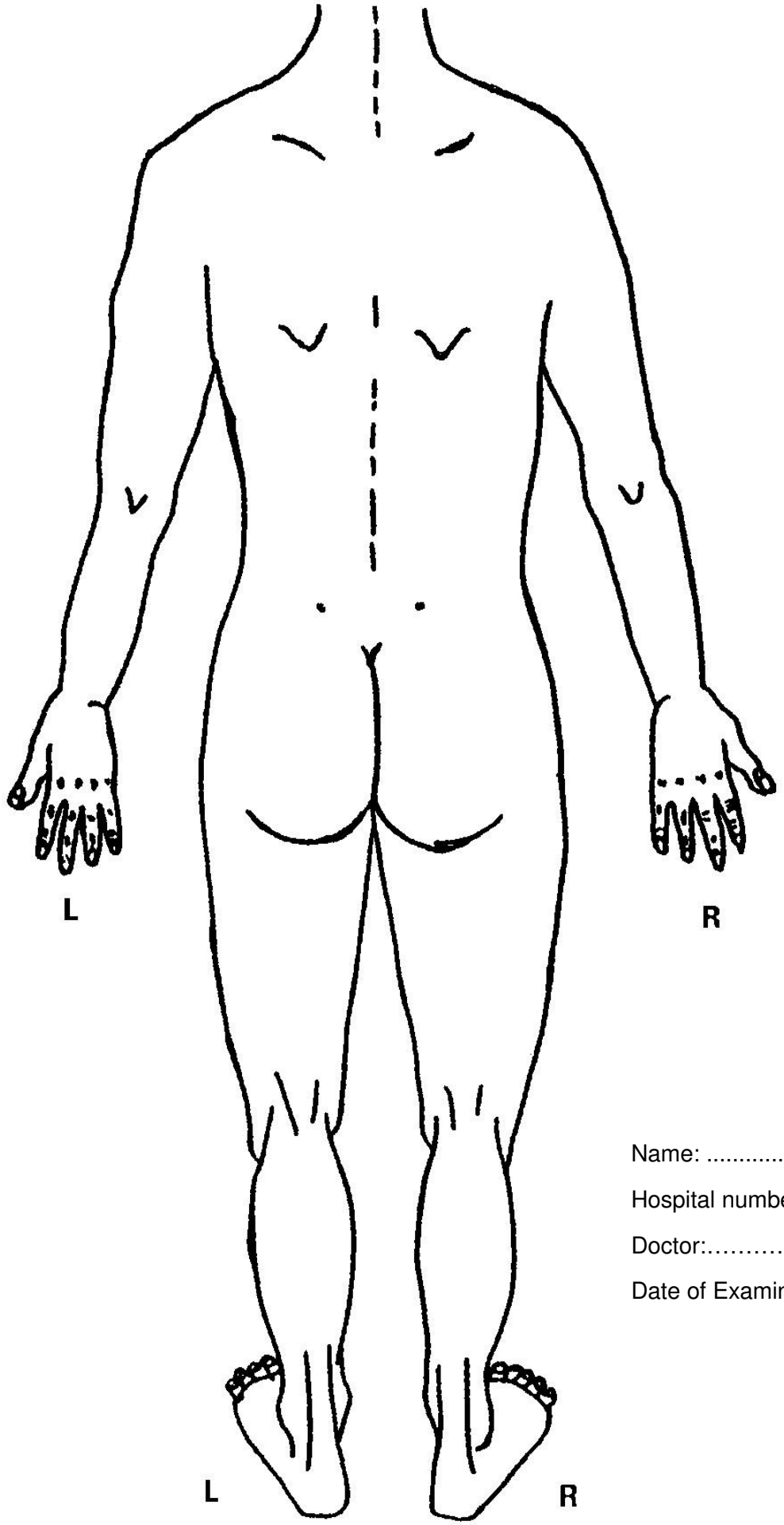


Name: .....

Hospital number: ……

Doctor:…….....

Date of Examination: …….

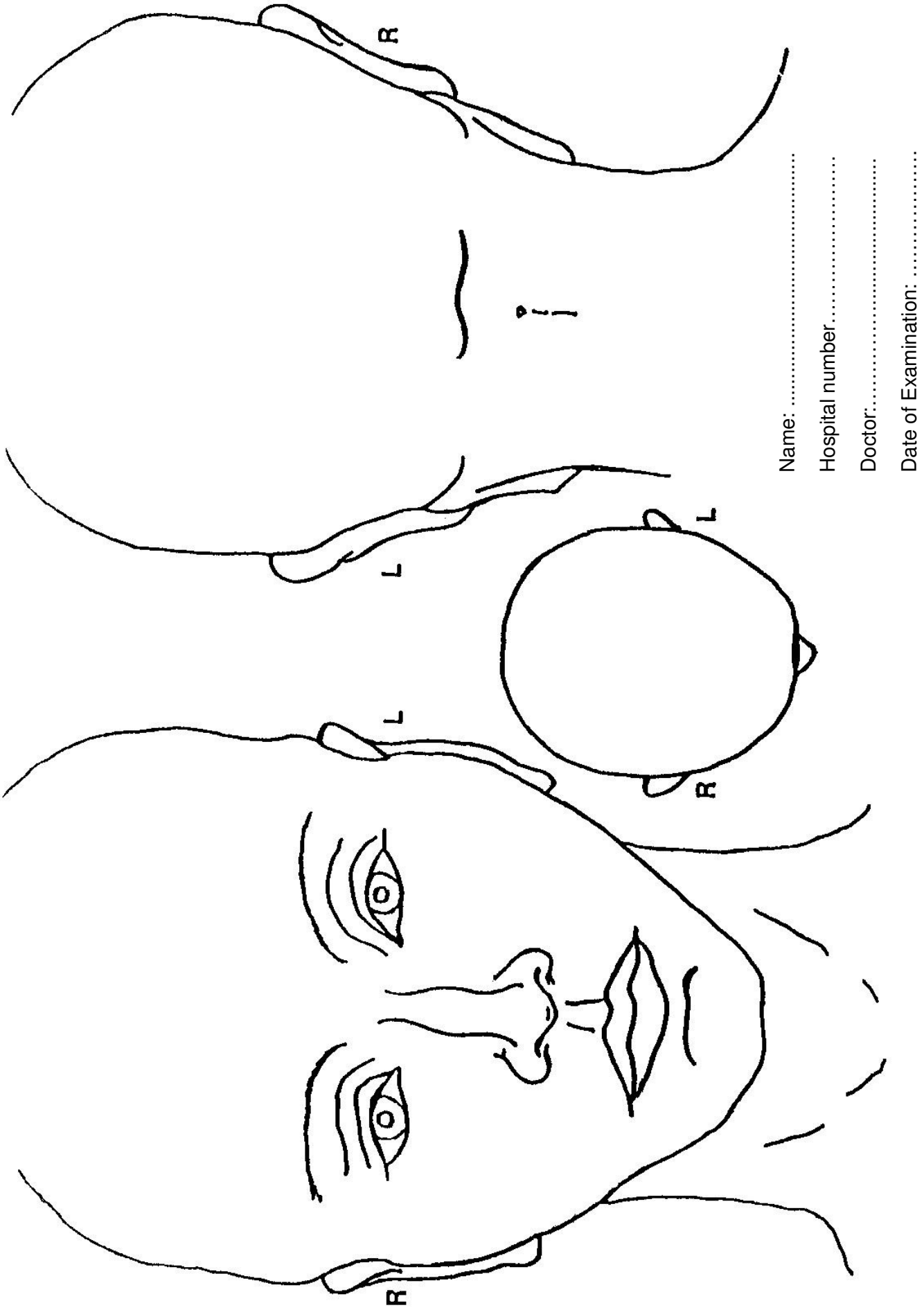


Name: .....

Hospital number…….

Doctor:…….....

Date of Examination: …….

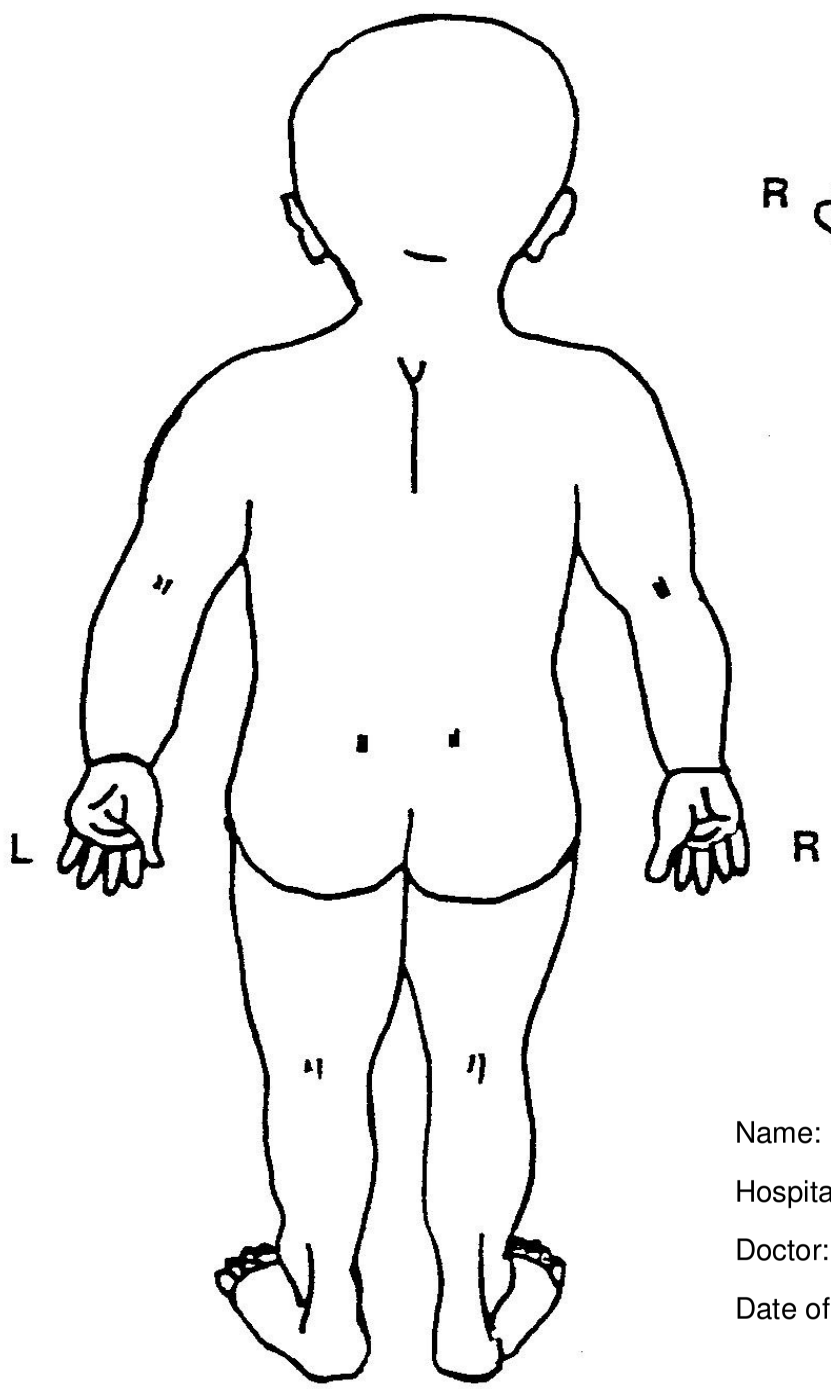


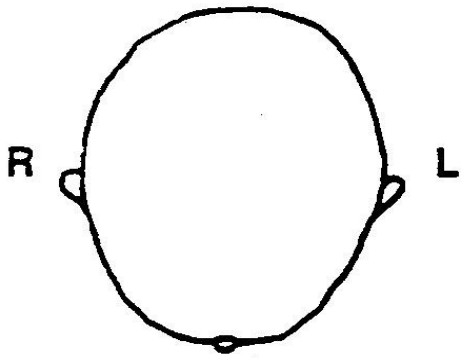
Name: .....

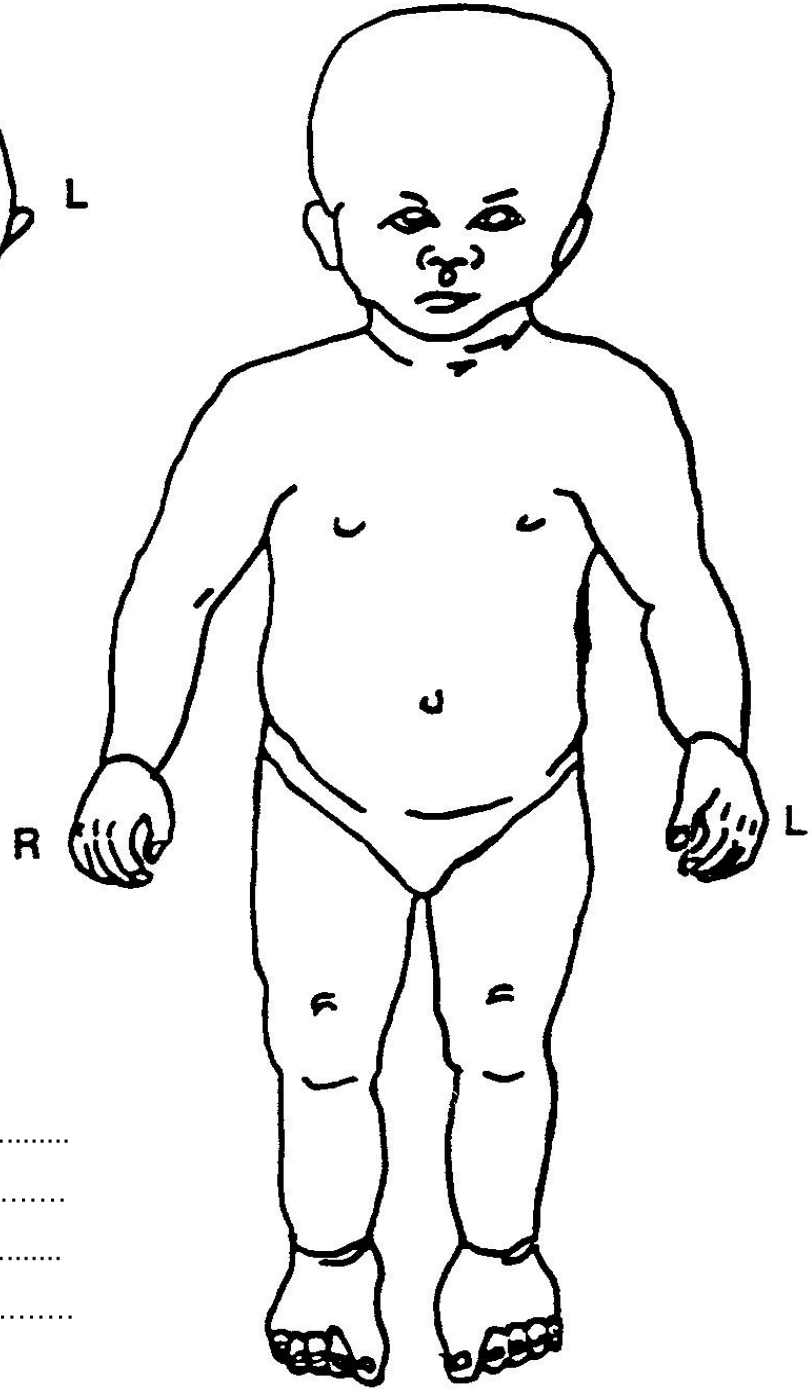
Hospital number.....

Doctor:.....

Date of Examination: .....





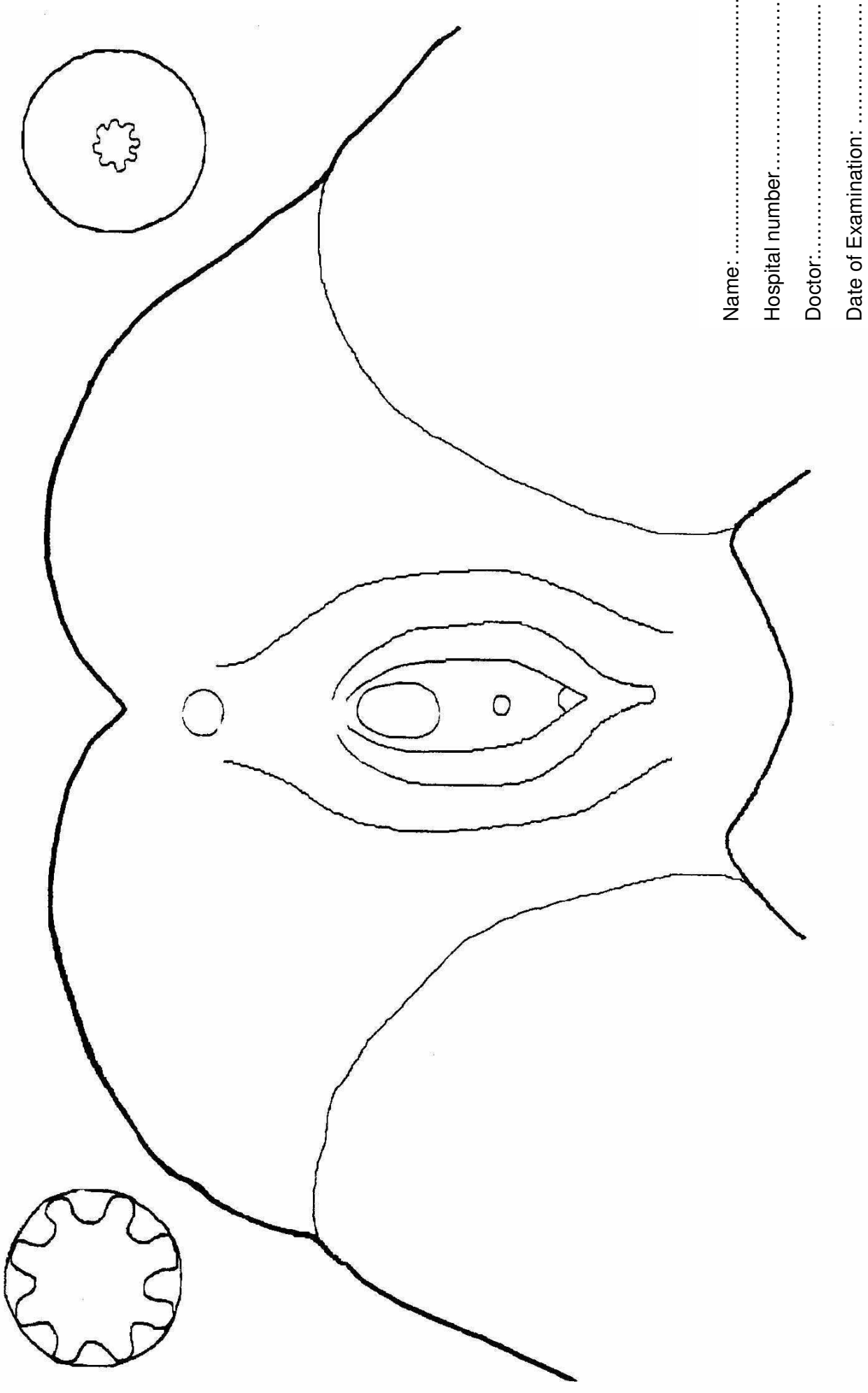


Name: .....

Hospital number……

Doctor:…….....

Date of Examination: ……



Name: .....

Hospital number.....

Doctor:.....

Date of Examination: .....

PATHWAY
Child Protection Serious Case Reviews – IMR request
GOSH

Request received by Chief Executive/Chief Nurse GOSH
From either LSCB or Commissioning PCT

↓

Senior CP Admin to identify relevant services that child/children known at GOSH and inform relevant CP personnel (below) within 24 hrs
(*if patient unknown return letter sent ASAP within 24hrs)*

↓

- Chief Nurse/Director of Education
- Child Protection Co-Ordinating Manager
- Head of Psychosocial and Family Services if GOSH main site
- Legal Department
- Named Nurse for Child Protection
- Named Doctor for Child Protection

↓

Senior CP admin to check TOR, Chronology format received
(Aim to use agreed GOSH/ OFSTED based format but any specific report format instructions noted)
To notify Clinical Governance & Safety Team (in order to report to NHS London as an SUI) if Child resident in London.
If outside London Senior CP admin to send email notification direct to NHS London safeguarding lead.

↓

Named Nurse/Named Doctor or identified persons: to complete chronology & report as identified in TOR & scoping exercise (e.g. who needs to be interviewed etc). Circulate to core staff as box 3 and Chief Nurse/Director of Education for comments and feedback. Meet/email to discuss & agree final recommendations & action plan. Senior CP admin to notify relevant Clinical Unit Chair and GM via template notification letter

↓

Finalised Report & Action plan agreed & signed off by IMR writers, GOSH Chief Nurse/Director of Education and Chief Executive
Electronic signatures required
Proposed Action Plan with timescales to be attached

↓

Final Report to be sent (both as hard copy and electronically) to:

- The commissioning PCT Designate Nurse / LSCB
- Copy to:
  - London Borough of Camden Assistant Director CSCF(Children's Social Work)
  - Commissioning PCT (Usually the Designate nurse)
  - Copy to relevant LSCB request**.**
  - **If a London IMR advise Clinical Governance and Safety Team of submission by email**

↓

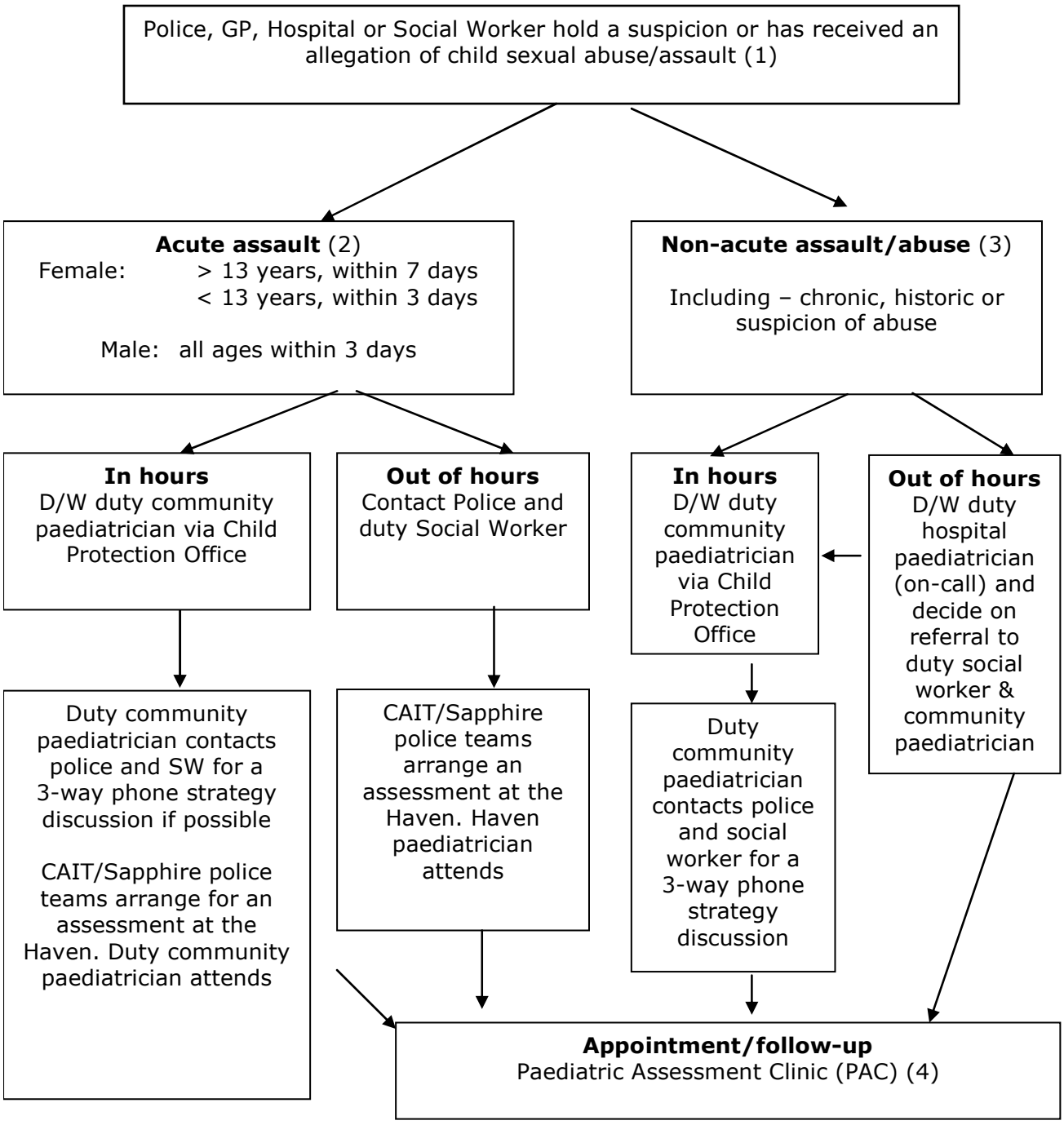
Final Report & action plan with chronology to be sent to Senior CP admin to incorporate into GOSH SCR Action Plan.

↓

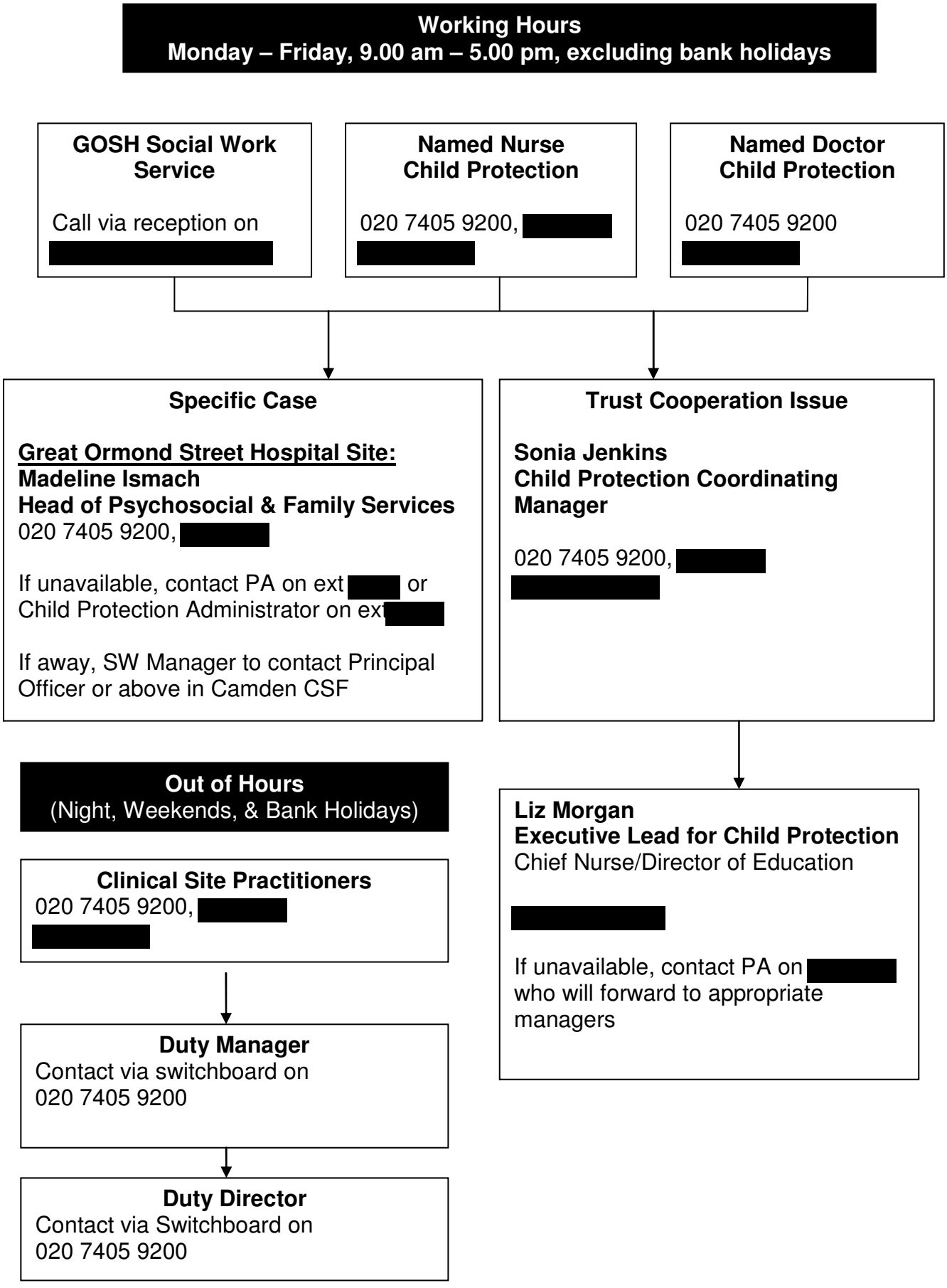
Distribution plan to be implemented

Recommendations & Action Plan to be distributed to Clinical Unit Chair /General Managers, actioned & monitored as agreed in relevant action plans. Briefings to Unit Leads and involved professionals = Trust wide Briefings lead by Chief Nurse/Director of Educaton and Named Nurse/Named Doctor.

REFERRAL PATHWAY for paediatric opinion when there is an allegation/suspicion of sexual assault/abuse



GOSH Child Protection Escalation Chart



SUBJECT INDEX