1 Introduction

1.1 The Children Act (1989, s.27 and s.47) and (2004, s.11), places a duty on all agencies to work together to safeguard and promote the welfare of children. The statutory guidance, Working Together to Safeguard Children (DOH 2010), describes how agencies should achieve this aim. There have been further recommendations from Lord Laming following the death of Baby Peter in 2008 with the aim to ensure that “services are as effective as possible at working together to achieve positive outcomes for children”.

1.2 All children and young people who have yet to reach their 18th birthday are legally subject to Child Protection arrangements and includes those young people who may be living independently, who may be parents themselves or who may be in the armed services.

1.3 Standards for Better Health (2004) along with NICE guidance (2009) and The National Service Framework (NSF) for Children, Young People and Maternity Services, Standard 5 (2004), have set out in more detail the standards that should be achieved to ensure that children are safeguarded and their welfare is promoted. Every Child Matters (2005) sets out five outcomes that the Government expects all children to be able to achieve. These are:

- Be Healthy
- Stay safe
- Enjoy and achieve
- Make a positive contribution and
- Achieve economic well being

1.4 The Newcastle upon Tyne Hospitals NHS Foundation Trust (NUTH) are required to demonstrate that they are achieving the standards set out in Outcome 7, Care Quality Commission (DOH 2010), and are regularly inspected by this independent regulatory body to ensure compliance.

2 Scope

2.1 Everybody who works with or has contact with children, parents and other adults who care for children, should be able to recognise, and know how to act upon, evidence that a child’s health, welfare or development is or may be
being impaired especially when they are suffering, or likely to suffer, significant harm.

2.2 NUTH Child Protection policies give clear information on the action to be taken when a member of staff has concerns about a child or family. The Guidelines and supportive documents should help staff explore and document their concerns.

2.3 These policies will cover the roles and responsibilities of all staff working with children, young people and their families and carers who are, or may be assessed as being in need (vulnerable) or in need of protection.

2.4 Careful consideration should be given to children and young people in the following categories:

a) Pregnant Mothers:
   Young women may be seen in areas such as midwifery or gynaecology, the Emergency Department (ED) and in the community. These women, and their babies, may be at risk from e.g. domestic violence, drug and alcohol abuse or may be victims of sexual abuse. The appropriate Safeguarding Team should be contacted to share any concerns.

b) Overdose/Self Harm:
   Any child or young person seen in Emergency Department (ED) or admitted to a ward who has either taken a drug overdose or has deliberately self-harmed or is misusing alcohol or drugs may be vulnerable. An enquiry should be made to check if a child is subject to a Child Protection Plan, this should be undertaken by a doctor or senior nurse on duty and a referral made to the appropriate person/service including Child and Adolescent Mental Health Services.

c) Young People involved in Sexual Activity:
   Many young people are sexually active; however some young people may be particularly vulnerable because of their young age, risk of exploitation or abuse.

d) Children/ young people with Disabilities:
   The Children Act (2004) identifies children with disabilities as being in need and their individual vulnerabilities will need careful assessment.

3 Aims

3.1 These policies and procedures are designed to ensure all Trust staff understand their responsibilities when they have concerns about the safety or welfare of a child/ young person and the actions that need to be taken. It also provides guidance to support staff in undertaking their role in specific areas of child protection and safeguarding children.
3.2 This document should not deter staff from seeking further advice from the Safeguarding Teams if they have concerns about any aspect of child protection/ safeguarding children.

4 Duties (Roles and responsibilities)

4.1 The Trust Board and Directors have responsibility and overall accountability for ensuring that the health contribution to safeguarding and promoting the welfare of children is discharged effectively. This covers not only Trust staff, but also all other health services provided throughout the local area, with whom the Trust has commissioning arrangements.

4.2 The Director of Nursing and Patient Services has delegated responsibility for ensuring that the health contribution to safeguarding and promoting the welfare of children is discharged effectively. The Director of Nursing and Patient Services performance manages the Designated Nurse for Safeguarding Children in Newcastle upon Tyne.

4.3 The Designated Nurse has a specific role and responsibility for safeguarding children and providing a professional lead on all aspects of the health service contribution to safeguarding children. This responsibility covers NUTH and also all other health providers in the city. The Designated Nurse provides advice and support to the Named professionals in each provider Trust in Newcastle.

4.4 The Named Professionals for Child Protection employed by NUTH; one Named Doctor and two Named Nurses (Community and Hospital) and a Named Midwife, on Designated Nurse for Looked After Children. There is also a Named GP who is not employed by the Trust, but works closely with the Named Nurse for Safeguarding Children (Community). The named professionals provide advice and expertise to fellow professionals and have a key role in promoting good professional practice through a variety of activities e.g. facilitating training and supervision, contributing to decisions made at child protection meetings and audit of quality measures.

4.5 The Safeguarding Children Nursing Teams (Community & Hospital) are staffed by Safeguarding Nurse Advisors, who are senior nurses who have specialist knowledge and training in safeguarding children and are available for advice, support and supervision.

4.6 All medical staff, registered nurses, midwives and health visitors are professionally accountable for the standard of care they provide to clients/patients via the General Medical Council & Nursing and Midwifery Council, (GMC 2012, NMC, 2008) and for care delegated and subsequently provided by non registered staff.

4.7 All staff, employed by the Trust have a responsibility to safeguard and protect the welfare of children/young people that they provide care for or come into contact with. All staff are expected to take appropriate and timely action to safeguard and protect the welfare of children/young people who are suffering,
or are likely to suffer, significant harm and to inform the Safeguarding Team of their concerns and actions.

Providing communication support; for example provision of interpreters and advocates where needed, is key to ensuring the quality of safeguarding.

4.8 The list above is not exhaustive and there may be occasions where it will be applicable to additional stakeholders/ specialist personnel with a specific role and/or responsibility.

5 Definitions

A comprehensive glossary and definition of terms used in this document can be found in Appendix 1.

6 Safeguarding Children and Child Protection

These policies, procedures and guidelines are broken into 4 subsections:

6.1 Medical staff
6.2 Hospital staff
6.3 Community staff
6.4 Areas which relate to all staff members

Staff should refer to the appropriate section for their role and clinical area.

6.1 Medical staff

6.1.1 Children and young people who may have been abused will present with different symptomatology to a wide number of different departments within the Trust. It needs to be recognised that some children and young people may present to departments with signs and symptoms of possible abuse which are discovered by chance and do not relate to the initial reason for referral (e.g.: a young infant is noted to have facial bruising when they attend a routine out patient appointment, or the child who is in the waiting room where it is observed that they are reprimanded and physically hit by their carer). Staff within all directorates need to know what action they need to take in any situation where there are concerns about a child’s safety.

6.1.2 Managing Suspected Child Abuse

The Continuity Consultant Paediatrician for general paediatrics must be informed immediately of any child or young person presenting during working hours where there are child protection concerns. A child or young person presenting after 1700hrs, or at weekends must be discussed with the Consultant Paediatrician on call. The child’s consultant needs to be clearly identified and documented. A full history and examination needs to be carried out and recorded using the document entitled “Safeguarding Children- Medical Record” (Blue Book). Whilst the Paediatric Registrar may carry out the initial
assessments, every case must be discussed with the Consultant Paediatrician.

6.1.3 When abuse is suspected:

a) An enquiry should be made to check if a child is subject to a Child Protection Plan. Within working hours Monday to Friday contact the Children’s Safeguarding Team on 21950 who will check on your behalf. Out of Hours contact the Out of Hours Social Care on 0191 2328520, or relevant Children’s Social Care area, contact numbers can be located on the Trust Safeguarding Children’s website.

b) The General Practitioner, Health Visitor and/or School Health Advisor should be consulted if possible.

c) Emergency Department records should be checked via E Record for previous attendances.

d) The issue of abuse should not be raised with the parents or carers without discussion with the Consultant.

e) Junior medical staff who feel unhappy about a child’s injuries or the history should indicate this to the parent or carer. It is often difficult. Language used should not be confrontational or challenging and parents need to be offered as much positive comment as possible, e.g. “Your baby seems to be growing well but....” or “I can see how worried you are about these marks...” Express concern e.g.: “I am a little puzzled about these marks and would like to get some advice” or if no history offered, “Because we don’t know what happened, we need to see if any bones are broken”. Make sure you offer care to the family e.g.: “are there children to be picked up from school?” “Have they had a drink or eaten?” “Do you need to make phone calls?”

f) At all times it is helpful to remember that the parent who has possibly injured a child has nevertheless brought that child for attention because of concern for the child. It needs to be remembered that the parent in front of you may have no knowledge of how a possibly imposed injury happened. Most physical abuse of children occurs in situations of high stress; the parent who is either hostile or sullen is reflecting much of that same stress, sadness and fear. Respect for these feelings should underpin all engagement with the family.

g) The Consultant Paediatrician may wish to explore with the parents their opinion about the likely source of injuries seen. Junior medical staff are strongly advised to stick to the facts and document the history and findings meticulously and in a non-committal manner.

h) There are very few situations where urgent confrontation is required. Expert medical assessment may be sought later. The
most important issue for the Paediatrician is maintaining the child’s safety and treatment of the presenting problem, however if parents try to remove the child then advise should be sought from Social Services or Police.

i) When the situation is uncertain or there is a difference of opinion; advice should be sought from the Named Doctor for the Trust.

6.1.4 Following an assessment, where concerns are identified, contact should be made with;

a) The Duty Social Worker, Initial Response Service, Cruddas Park Tel no. 01912772500
   or
b) The Out of Hours Social Care Service Tel no. 0191 2328520

c) The police and security should be contacted immediately if a child or staff member is perceived to be in immediate danger from an abusive or violent parent /carer.

6.1.5 Investigations:

a) Blood Tests - Coagulation should be checked where there are concerns about bruising. Further advice may be sought from the Consultant Haematologist in individual cases if there are concerns about the possibility of a clotting disorders.

b) Medical Photography - should be facilitated as follows: To arrange photography for any mark where there concerns about possible inflicted injury the request form attached to the Blue Book should be completed and the Medical Photography Department contacted.

c) X Rays - Discuss the need for X Rays directly with the Consultant Radiologist. (See NAI/SUDI/SIDS Skeletal Survey Guidelines).

d) Skeletal surveys - should be performed in all children under the age of 18 months where physical abuse is suspected and should also include a CT Head Scan because of the increased incidence of severe head injury in this age group.

e) It may be helpful to have discussions with the Consultant Radiologist and the Named or Designated Dr about imaging of older children.

f) Follow up X-rays should be carried out 11-14 days after the initial skeletal survey. These will include CXR with oblique rib views as well as any suspicious areas seen on the initial X-rays. Consideration of repeating the full skeletal survey will need to be discussed with the Radiology Department.
MRI - In suspected non accidental head injury an MRI scan should be performed if any abnormality is seen on the initial CT scan and timings of subsequent scans should be discussed with the Neuroradiology Consultant.

Further imaging will be guided by the clinical presentation but there should be a low threshold for considering intra abdominal injury.

Ophthalmology Examination - Should be requested for children where there are concerns about possible shaking injury to look for the appearance of retinal haemorrhages. Retinal haemorrhages are very rare after the age of 2 years. The on call ophthalmology registrar can be contacted via switchboard who will liaise with the Consultant Ophthalmologist.

All skeletal surveys and follow up imaging are second reported by the Consultant Paediatric Radiologist at Sheffield Children’s Hospital. The Consultant Paediatrician is responsible for sending images electronically via the Radiology Department along with a copy of the Child Protection Report for the attention of the Consultant Paediatric Radiologist at Sheffield Children’s Hospital (Contact Paediatric Radiographer via Radiology Department at RVI to arrange).

Referral to Paediatric Dentist for any bite mark must be considered. Fresh bites should be reviewed and repeat photographs considered. Specific advice about bites may be obtained from the Named Doctor.

Burns/scalds are usually assessed and treated on the Burns Unit. Suspicious burn injuries should be discussed with the on call Consultant Paediatrician.

Genital examination of children should only be carried out by a skilled Registrar or Consultant following the Blue Book documentation. Repeated examinations should be avoided where possible and should only be undertaken if presenting symptoms demand this for immediate clinical care.

If recent sexual abuse is suspected or if a child requires urgent treatment for an acute ano-genital injury a forensically trained Doctor (accessed through the Children and Young People’s Clinic or out of hours via Switch Board) can be called upon to discuss the case and further management.

6.1.6 Fabricated or Induced Illness (FII)
There are specific guidelines available from the Department of Health 2008 as well as from the Royal College of Paediatrics and Child Health. These are discussed in more detail in Associated Documentation 1.
6.1.7 Report Writing
It is the responsibility of the Consultant Paediatrician to ensure that there is a written report for any child where there are concerns about possible non accidental injury. If the report is written by a Paediatric Registrar the report should be discussed with and agreed by the Consultant before the report is sent out.

6.1.8 Unsolicited Statements made by Children
In any location e.g. outpatients, the Emergency Department or inpatient department, where a child makes a spontaneous statement suggesting abuse, the following approach would be suggested:-

a) Allow the child to complete the statement naturally.

b) Be non-committal, but accepting. For example, repeat the statement back to the child verbatim and say, “I understand”. Do not press for more detail or ask questions.

c) Do not pledge secrecy.

d) Tell the child that you know what to do to help keep him or her safe.

e) Make a note of what has been said using the child’s words.

f) Tell the child what you intend to do e.g.; “I am going to write all this down and talk to someone who knows lots of children who have had trouble like you. I know it will help if you tell that person what you’ve just told me and anything else you may remember”.

g) Report the allegation to the Consultant on call whose duty it is to report to Social services.

h) You should not under any circumstances confront the alleged perpetrating parent/ carer with the statement.

i) The police should be asked to attend immediately if the situation escalates e.g. the parent/ carer begins to remove the child.

6.2 Hospital staff

6.2.1 General Principles
a) Prompt action must be taken to ensure the immediate safety of a child in hospital. Consideration must be given to the safety of other children at the home address, or who are part of the family.

b) The nurse in charge of the ward or department must be informed as it will be their responsibility to contact the Named Nurse for advice, or their deputy.
c) Ensure your line manager is aware of the child protection concern as soon as possible, but by the next working day at the latest.

d) Ensure accurate contemporaneous records are kept.

e) Maintain clear communication between the hospital and community services this should be by the next working day at the latest.

6.2.2 Child Protection Alerts

a) For children who reside in Newcastle and are subject to a Child Protection Plan a non clinical risk alert will be flagged on E-record and the Clinicians will be able to access what this risk is i.e. the alert which will state the fact that the child has a Child Protection Plan, the category of the concern and the date that the plan commenced. In addition the non clinical risk flag will appear on the paper record of the clinic list. It is the clinician’s responsibility to access E-record to determine further details and cause of action to be taken to safeguard the child or young person.

6.2.3 Action

a) Inform the Named Nurse for Child Protection (RVI Dect phone: 29150) or out of hours the Consultant Paediatrician on call and the Directorate bleep holder on duty (RVI Dect phone: 29261). The Patient Services Coordinator/ Night Sisters are available via the switchboard for further advice and support, if necessary.

b) Complete a ‘Cause for Concern’ form and fax a copy to the Named Nurse for Child Protection based at the RVI on (28) 26183.

c) Place a copy of the Cause for Concern form in a red plastic wallet and file behind the front sheet in the child’s health record.

d) If there is no action, document clearly why no action was taken and who the case was discussed with.

e) Medical staff must be informed when there are concerns for a child’s safety or welfare.

6.2.4 Process

a) What do I tell the family? - Inform the parent/carer/child (if appropriate) you have concerns and what you aim to do unless:

- to do so would place a child, someone else or yourself at risk
- fabricated or induced illness is suspected, you must first seek advice from a named or designated professional
- you may be jeopardising a police investigation
- Refer to Information sharing: Practitioners’ Guide HM Government 2006
b) Document that you have obtained verbal consent to share information, what information was shared and with whom. If you have not obtained consent, document clearly why this is the case.

c) An enquiry should be made to check if a child is subject to a Child Protection Plan. Within working hours Monday to Friday contact the Children's Safeguarding Team on 21950 who will check on your behalf. Out of Hours contact the Out of Hours Social Care on 0191 2328520, or relevant Children’s Social Care area, contact numbers can be located on the Trust Safeguarding Children’s website.

j) Please note children who are subject to a Child Protection Plan in Newcastle will have a non clinical risk alert on E-record.

6.2.5 Referral
a) If a referral to Children’s Social Care is necessary, the Medical staff, Named Nurse for Child Protection or the Nurse in Charge of the ward/department will initially telephone and ensure a written referral is sent within 48hrs.

b) If you have made a referral to Children’s Services and have not heard what action they are taking within 3 working days, contact them to ensure concerns have been acted upon.

c) If a parent/carer attempts to remove a child for whom there is a child protection/ safeguarding concern from a ward/ department, the police and Children’s Social Care should be notified immediately.

d) Explain to the parent/ carer that it is in their child’s best interests to remain but do not attempt to physically restrain them or place yourself in any danger. The Named Nurse for Child protection should also been informed on Dect 29150.

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

b) Discharge from hospital - No child should be discharged from hospital without the permission of the paediatrician in charge of the child’s care or a doctor above the grade of Senior House Officer and a clearly documented plan for future care and follow-up arrangements.

c) Case notes and record keeping – All case notes and records should be clearly written and contemporaneous. All face to face and telephone discussions and agreed actions plans should be
documented. All records and minutes from child protection meetings should be stored together in the child’s records.

d) Nursing staff should commence extended nursing records. These are kept separately from the nursing notes, and should not be accessible to the child or parent(s).

e) A written report may be requested by the Named Nurse for Child Protection or her deputy, and must be available within forty eight hours of the concern being raised.

f) Principles specific to the Hospital Management of cases.

- In the case of a child seen in hospital where there a possible child protection concern, the child should never be sent away from a clinic or department until the Nurse in Charge has ensured that the Consultant/Medical Staff and Named Nurse have been consulted. Out of hours the Directorate Bleep Holder should be contacted. Team consultation will determine further action to be taken

- If the parents refuse to agree to the medical consultation or the child’s admission, or if they seek to remove the child too soon, serious consideration must be given to contacting Social Services or the Police to ensure the child’s safety

- If the child is admitted to hospital, the nursing staff should be aware that suspected child abuse is the reason for admission. Visiting by parent(s) may need to be supervised. Clarification of this must be agreed by contacting Social Services or the Police and this must be documented

g) Strategy Meeting (multi agency) will be held to agree child protection arrangements to ensure the safety of the child in hospital and any other children within the family. Written reports are not required for Strategy Meetings, unless specifically requested. Outcome of the meeting must be documented in the child’s notes. The professional attending may find it beneficial to seek a supervisory discussion prior to these meetings with the Named Nurse/Midwife Child Protection or other designated professional.

h) Child Protection Case Conference
Where an invitation to a child protection conference is received, it is that staff member’s responsibility to discuss the case with the Named Nurse/Midwife or other designated professional prior to the conference. All those invited should prepare a written report, which must be shared with the parents prior to the meeting, if this is not possible, the Named Nurse/Midwife or other designated professional must be made aware of the reasons why the report has not been shared. Staff members are expected to make a
recommendation regarding Child Protection Plan based on their professional opinion within their conference report. If this is difficult, there should be a discussion with the Named Nurse/Midwife Child Protection or other designated professional before submitting the report. Following the case conference, the staff member should discuss the outcome and subsequent plan with the Named Nurse/Midwife or other designated professional.

i) Court attendance
If a practitioner is required to give evidence in court, they must inform the Named Nurse/Midwife or other designated professional immediately who will liaise with the Trust’s Legal Services Department. This will ensure the practitioner is provided with an appropriate level of advice and support in completing the statement and during any subsequent court appearance.

6.2.7 Child Missing from Hospital procedure
The Newcastle upon Tyne Hospitals NHS Foundation Trust has a duty of care to ensure the safety of patients in its care and takes all possible steps to do so. On occasions when this has not been possible and patients have left an area and cannot be located, the Trust will ensure a prompt and systematic response in order to minimise the risk to the individual.
(see Associate Documentation 2)

6.2.8 Child not registered with a GP procedure

a) All parents/carers will be encouraged to register their child/ren with a local GP

b) A Cause for Concern Form will be completed and faxed to the Safeguarding Team who will liaise with the Health Visitor Liaison Nurse to share this information and they will follow this up

6.2.9 Child Non Attendance at Hospital Outpatients Policy
This policy provides guidance to healthcare staff working with Children and Young People to help staff determine the correct course of action when a child and their parents fail to attend a pre-arranged appointment. (DNA = Did Not Attend)

6.2.10 Guidelines when there is Suspicion of Fabricated or Induced Illness (FII)
It is important that professionals working with children and their carers are aware of the different ways in which fabricated or induced illnesses can present. It is also vitally important for professionals to distinguish between those carers who are very anxious and who may be responding in a reasonable way to a sick child and those who exhibit abnormal behaviour. (see Associated Documentation 1)
6.2.11 Guidelines for Children Attending the Emergency Department
These guidelines are aimed at staff working with children in general. Refer to departmental guidelines for treatment of specific conditions. As with any guidelines initiative should be used where appropriate. Safeguarding guidelines and interagency child protection guidance is available on the Safeguarding website, accessible through the trust intranet site. (see Associated Documentation 3)

6.2.12 Guidelines on writing Nursing Reports for Child Protection Case Conference
(see Associated Documentation 4)

6.2.13 Women’s Services Safeguarding Guidelines
These guidelines are specific to Women’s Services. All staff within Women’s Services Directorate have a statutory duty to ensure the welfare and safety of children and unborn children.

6.2.14 Working with Sexually Active Young People Guidelines
This Protocol applies to all professionals who work with young people under 18 seeking advice or treatment for sexual health issues. It is based on the core principle that the welfare of the young person is paramount. It emphasises the need for professionals to work together to accurately assess risk when a young person is engaged in sexual activity and describes the action to take when risk is identified, to assist all professionals who provide sexual health advice or treatment to young people under 18.

6.2.15 NAI / SUDI / SIDS Forensic skeletal survey guidelines
Skeletal surveys are performed for investigation of Non-Accidental Injury (NAI), as well as for Sudden Unexpected Death in Infants (SUDI) and (formerly called Sudden Infant Death Syndrome (SIDS). For patients with suspected NAI, the skeletal survey provides important information to inform clinical decision-making, particularly with respect to identification of unsuspected fractures and underlying skeletal disorders. These surveys also provide forensic evidence that may be used in a court of law.

For SUDI cases, findings may also be helpful during the investigation of the circumstances of the death.

6.3 Community staff
Staff working in the community who have a concern regarding the safety or welfare of a child/children should refer to guidance below.

6.3.1 Policy & procedure for responding to concerns about child abuse or neglect
Any member of staff who has knowledge of, or suspicion that, a child is suffering or is likely to suffer from significant harm, will refer their concerns to Children’s Social Care immediately.

a) Research evidence indicates a strong link between domestic abuse and all types of significant harm to children and therefore all health assessments should include questions that would promote early identification of domestic abuse. Practitioners should always refer to Children’s Social Care if they have concerns or suspicions that domestic abuse is occurring, to ensure that both the child and the non-abusing parent are safeguarded. All staff should ensure that they refer/ re-refer to Children’s Social Care or take advice from a member of the Safeguarding Advice & Support Team (SAST), if they know or have suspicion that a perpetrator of domestic abuse has resumed or commenced contact with a parent or child. Where appropriate to role, clinical staff will receive training on identifying and responding to concerns regarding domestic abuse.

6.3.2 Procedure for Referral regarding concerns about any type of abuse or neglect:

a) Staff will inform parents/carers of their concerns and request their permission to refer the child to Childrens Social care. If the parents refuse to give their permission, staff will then explain to the parents that they are required by legislation and under Trust policies and procedures to make the referral, even without their consent.

b) In the following circumstances staff will not seek consent or inform the parents/carer’s of their intention to make a referral to Children’s Social Care:

- When seeking consent may increase the risk of harm to the child e.g. when fabricated or induced illness is suspected. If fabricated or induced illness is suspected, the member of staff will contact the SAST to discuss and decide upon action to be taken. Clinical staff will receive some level of training with regard to Fabricated or Induced Illness as appropriate to their role.

- When seeking consent may prejudice a police investigation e.g. if sexual abuse is disclosed or suspected; Staff will seek advice from a Safeguarding Nurse.

- Informing the parents/carers at that particular time is deemed to put the member of staff at risk. If a staff member has concerns about their own safety they should contact their line manager and the SAST (see Associated Documentation 12 for contact details), to discuss and agree other options that would allow them to inform the parents in a way that would ensure both the child’s and their own safety. If the concern is identified outside of normal working hours, then the member of staff should contact Children’s Social Care and discuss their concerns immediately – a referral
concerning a child at possible risk of harm should not be delayed until the SAST is on duty/available.

c) The member of staff will make the referral by contacting Childrens Social Care and initially make a verbal referral to the duty Social Worker at the Initial Response Service (see Associated Documentation 12 for contact details),

d) The duty Social Worker will be informed of the concerns and whether or not the parents/carers are aware of the referral (and if not the reasons why the parents have not been informed).

e) The referral will be followed up with written confirmation which should be received by Children’s Social Care within 48 hours of the verbal referral using the appropriate referral form (Associated Documentation 14). The member of staff should ensure that a copy of the referral form is kept in the child’s Continuous Child Health Record (CCHR) or confidential file and a copy is sent to the SAST within 48 hours of the referral being made attached to a CP3 Cause for Concern Form (Supporting Documentation15.1) or Multi-Purpose Safeguarding Children Form (Supporting Documentation 15.5). If the member of staff making the referral is not the holder of the CCHR a copy should be forwarded to the appropriate key professional (Health Visitor/ Public Health School Nurse (HV/PHSN)) involved.

f) The Common Assessment Framework (CAF) form should not be used for referrals regarding concerns about abuse or neglect.

g) Following the referral, staff will document in the child’s records the following information:

- The date and time that the referral was made.
- The name of the Social Worker who took the referral.
- Details of the information that was given to the Social Worker, (reference can be made to the written referral).
- What action is to be taken and by whom

h) If any member of staff is in any doubt about whether to make a referral to Children’s Social Care for any reason, including another member of staff/colleague having a different view, rather than not make the referral, the member of staff will obtain advice from the SAST.

i) In cases of emotional abuse or more complex situations (that do not involve immediate physical risk), staff should speak to a member of the SAST to discuss the issues prior to the referral being made.

j) Staff need to be aware of the legal framework relating to the disclosure of information. It is acknowledged, however, this is a
complex area of work and therefore if staff are at all unsure about their right to disclose information, or their duty to share information, they should contact a member of the SAST or the Caldicott Guardian for the Trust (prior to sharing the information), to discuss the matter further.

k) When there is suspicion that a child has been physically abused or neglected, a referral may need to be made to a paediatrician ‘on call’ for child protection for a medical opinion and written report. In these circumstances a medical opinion should not be sought from a General Practitioner. It is the Social Worker’s responsibility to make the referral to the paediatrician following the referral from the member of staff, if it is believed that a medical opinion is necessary.

l) If a member of staff has concerns that a medical opinion is not being sought and they believe it should be, the member of staff should inform the Social Worker of their views and reasons why and also the Senior Social Worker / Team Manager. The member of staff should also contact a member of the SAST to inform them of their concerns and to discuss any further action that may be required.

6.3.3 Procedure for referring to Children’s Services for child/ family support
a) Support: All members of staff will refer to Children’s Social Care or other supportive services, when they believe that a child is in need of further support and services to promote their welfare.

b) Procedure: When a member of staff becomes concerned that a child or family has a number of unmet needs or the parents are struggling to provide the child with appropriate care, they will discuss their concerns with the parent/s (and/or child if appropriate) and request permission to undertake an assessment using the Common Assessment Framework (CAF – Form can be accessed via the intranet). If a staff member has concerns about their own safety they should contact their line manager and a member of the SAST to discuss and agree other options that would allow them to inform the parents in a way that would ensure their own safety.

c) If the member of staff has not undertaken training on the use of the CAF assessment tool, they will (with the child or family’s permission), refer on to another member of staff who has completed the training, or seek advice from a member of the SAST.

d) If the parents refuse to give their permission for a CAF assessment or a referral to Children’s Services or other support and services, the member of staff will need to carefully consider whether or not without these services, the child would be left at risk of significant harm. A member of the SAST should be contacted for advice if the member of staff is unsure. Parental refusal for a CAF should be logged with the CAF Co-ordinator in the same way as a CAF.
e) The CAF assessment or any other referrals that are undertaken on a ‘Child in Need’ basis cannot be undertaken without the parents’ or child’s permission /consent.

f) Once the CAF assessment has been completed, a copy should be kept in the Continuous Child Health Record and a copy sent to the Information Sharing and Assessment team. (see Associated Documentation 13 for contact details).

g) Undertaking a CAF does not necessarily mean that a referral to Children’s Social Care will not be required; it may be that the assessment identifies that a referral to other agencies or services would be inappropriate.

h) The CAF form should not to be used when making referrals to Children’s Services because of concerns about child abuse or neglect.

6.3.4 Procedure for writing reports for Child Protection Meetings

a) All members of staff will write reports that give an accurate account of their involvement with a child or family and include their professional judgement of the parent’s/ carer’s ability to safeguard and promote the child’s welfare, using the “Framework for Assessment” (DFES 2000).

b) The report will include both historical and current information regarding the involvement of their service and the child’s health and development. Reports should be submitted for the following meetings:
   - Initial Child Protection Conferences
   - Child Protection Reviews
   - Looked After Reviews
   - Meetings that are formally reviewed by an Independent Reviewing Officer.
   - Statements for Court

c) Written reports are not required for Strategy meetings, Core Group meetings or Care Team meetings, unless specifically requested by the SAST or the member of staff believes that it is necessary given the amount or complexity of the information to be shared.

d) It is the organisation’s policy that all reports for meetings will be typed on computers that are owned by the Trust or GP Practice and that reports will not be typed using personal computers that are owned by staff. This is to ensure the security of the information.

e) Procedure: All members of staff will submit reports which are factual and distinguish between fact, observation, allegation and opinion.
f) All members of staff will write reports following the organisational ‘Proforma and Guidance for Writing Reports’ (see Associated Documentation 5)

g) Staff will provide a copy of their report to the parents/ carers at least two working days in advance of the meeting, if the parent has an identified learning disability the report should be shared at least seven days prior to the meeting and include a short synopsis of the report, written in simple English.

h) The parents will be given the option to discuss the report with the health professional in advance of the meeting and the member of staff will need to ensure sufficient time is allowed taking account to the parents / carers communication needs. If a staff member has concerns about their own safety they should contact their line manager and a member of the SAST to discuss and agree other options that will allow them to share their report with the parents and ensure their own safety.

i) Staff who are requested to provide a statement for Court, will seek advice and support from a member of the SAST.

6.3.5 Procedure for attendance of Community staff at Child Protection and Child in Need meetings (Community)

a) Staff members will be fully prepared for attendance at all Child Protection and Child in Need meetings. They will give high priority to ensuring they attend Child Protection and Child in Need meetings (and submit reports as appropriate). This applies to:

- Strategy Meetings
- Initial Child Protection Conferences
- Child Protection Reviews
- Looked After Reviews
- Meetings that are formally reviewed by an Independent Reviewing Officer
- Core Group and Care Team meetings

b) Procedure: Reports will be written following the policy and procedure for Writing Reports for Child Protection meetings (see Associated Documentation 5)

c) At Initial Conferences and Child Protection Review meetings, staff members will make a recommendation regarding whether or not they believe the child requires a Child Protection Plan and state which category of abuse they believe is most appropriate. The test should be that either:

- The child has suffered ill-treatment or impairment of health or development as a result of abuse or neglect by their parent(s) /
carers and that professional judgement is that the child continues to be at risk of significant harm;

or

- on the basis of research evidence and/or the findings of an enquiry regarding the individual case, the child (or unborn baby) is likely to suffer ill treatment or impairment of health or development as a result of abuse or neglect by their parent(s) / carers.

d) Staff will give attendance at meetings the highest priority, but will inform a member of the SAST immediately they become aware that they will not be able to attend, and that they have been unable to arrange representation from a colleague. In this event, staff will also submit apologies to the Social Worker and the Independent Reviewing Officer who is to Chair the meeting.

e) When a member of the SAST is unable to attend a Strategy meeting, the staff member who attends will complete the ‘Child Protection Strategy Meeting Record form CP4 or Multi Purpose Safeguarding Children Form (Supporting Documentation 15.2/15.5) and forward a copy to the SAST within 2 working days of the meeting. This does not apply to any other meetings.

f) When a member of staff is unable to attend a Strategy meeting a member of the SAST will advise them of the outcome by telephone and/or in writing within 48 hours / 2 working days, via the Child Protection Strategy Meeting Record form CP4 or Multi Purpose Safeguarding Children Form (Supporting Documentation 15.2/15.5).

g) When there has been a Child Protection or Child in Need meeting, the staff member will open a separate pink confidential file (or equivalent) in which all minutes of meetings and reports will be stored in chronological order and securely tied together. A Chronology/ Significant Events sheet is to be maintained on all children who have a Confidential File (or equivalent) and is to be updated following each event.

h) The newer style Continuous Child Health Record does not require a separate confidential file as it is integral to the record. A separate confidential file may be required if the amount of information to be stored makes to records unwieldy. The records should be marked to state that a separate confidential file exists.

i) It is the staff member’s responsibility to ensure the confidential file is maintained and contains all minutes/ notes of Child Protection/ Child in Need meetings.

j) When there are changes in any of the family member’s names or addresses, or changes in the health professional involved, the
member of staff involved with the family prior to the change(s), will complete the notification form titled 'Change of Circumstances / CP6 (Supporting Documentation 15.4) and forward this to the SAST.

6.3.6 Procedure for reporting 'missing' children (Community)

a) When there are concerns about a child’s welfare or safety and they appear to be ‘missing’, the key health worker will inform relevant staff immediately so that further action can be taken in an attempt to secure the child’s safety. This applies to any child who is the subject of a Child Protection Plan and any child for whom there are concerns about their welfare and safety, but who may not be involved with Children's Services.

b) Procedure: The member of staff will inform the SAST immediately they become aware of, or have suspicions that a child is ‘missing’ and further advice will be given following discussion.

c) If the child has a named Social Worker, the member of staff will inform the named Social Worker (key worker) immediately they become aware of, or have suspicions that a child is ‘missing’. If the Social Worker is not available, staff will inform a duty Social Worker.

d) A member of the SAST will inform the Safeguarding Nursing Team in other areas as appropriate.

e) Once the child has been located, other procedures may need to be followed, e.g. ‘Transfer of Records / Change of Circumstance Notification.

f) The staff member should document all actions in the in the CCHR.

g) The staff member will complete a CP3 or Multi-Purpose Safeguarding Children Form (Supporting Documentation 15.2 or 15.5). Copies will be filed in the CCHR and sent to SAST, any other HV’s/PHSN’s involved with the family and the family GP

h) In cases where the family are not known to Children’s Services and are not part of any formal review or are within the ‘Looked After’ system, staff will contact the SAST to discuss and agree any further action that may be required.

6.3.7 Procedure for Health Visitors (HV) and Public Health School Nurses (PHSNs), regarding non–attendance for health appointments. This applies to any child, including those subject to a Child Protection Plan.

a) When a child who is the subject of a Child Protection Plan does not attend for an appointment with their HV/PHSN, the member of staff will inform the named Social Worker (SW) for the child and family, so that further action can be taken, in an attempt to ensure the child’s safety.
b) If the child is not involved with Children’s Social Care, the staff member will inform the SAST within one working day following the third missed appointment.

c) The staff member will complete a CP3 or Multi-Purpose Safeguarding Children Form (Supporting Documentation 15.2 or 15.5). Copies will be filed in the CCHR and sent to SAST, any other HV’s/PHSN’s involved with the family and the family GP.

d) Procedure for children for whom there are concerns or who are the subjects of a child protection plan.

**Following 1st No Access visit:**

- Following the first ‘no access’ visit / contact, the member of staff will leave a contact card or a letter with a new appointment within 2 – 5 working days of the previous appointment. The contact card / letter will advise the parent/ child, to contact the member of staff if the new appointment is inconvenient so that it can be re-arranged.

- The member of staff will also try to contact the family via telephone to ascertain the reason for their non-attendance and to enquire about the child’s welfare.

- The member of staff will inform the named SW for the family, within one working day of the date of the appointment. If the named SW is not available, the member of staff will inform a duty SW.

- If there is not a SW involved, the member of staff will consider whether a referral to Childrens Social Care is necessary and if unsure they should discuss their concerns with a member of the SAST. If a referral to Children’s Social Care is to be made, the member of staff will follow the procedure for making a referral set out in section 2.

**Following 2nd No Access visit:**

- Following the 2nd ‘no access’ visit / contact, the member of staff will leave a contact card / letter with a new appointment within 2 – 5 working days of the previous appointment.

- The contact card / letter will advise the parent / child, to contact the member of staff if the new appointment is inconvenient so that it can be re-arranged.

- The member of staff will also try to contact the family via telephone to ascertain the reason for their non-attendance and to enquire about the child’s welfare.
• The member of staff will inform the named SW for the family, within one working day of the date of the appointment. If the named SW is not available, the member of staff will inform a duty SW.

• If there is not a SW involved, the member of staff will consider whether a referral to Childrens Social Care is necessary and if unsure they should discuss their concerns with a member of the SAST.

**Following the 3rd No Access Visit:**

• Following the 3rd ‘no access’ visit/ contact, a letter will be posted or left, requesting the family to make contact to arrange an appointment as a matter of urgency.

• The member of staff will also try to contact the family via telephone to ascertain the reason for their non-attendance and to enquire about the child’s welfare.

• The member of staff will inform the named SW for the family, within one working day of the date of the appointment. If the named SW is not available, the member of staff will inform a duty SW.

• If there is not a SW involved, the member of staff will consider whether a referral to Childrens Social Care is needed and if they are unsure, discuss their concerns with a member of the SAST.

• The member of staff will inform any other professionals involved of the fact that the child/ parent is not engaging with them and has missed 3 appointments.

e) Procedure for children for whom there are no known safeguarding concerns.

**Following the 1st No Access visit:**

• Following the first ‘no access’ visit / contact, the member of staff will leave a contact card or a letter with a new appointment within two weeks of the previous appointment. The contact card/ letter will advise the parent/ child, to contact the member of staff if the new appointment is inconvenient so that it can be re-arranged.

**Following the 2nd No Access Visit:**

• Following the 2nd ‘no access’ visit / contact, the member of staff will leave a contact card / letter with a new appointment within two weeks of the previous appointment.
• The contact card/ letter will advise the parent/ child, to contact the member of staff if the new appointment is inconvenient so that it can be re-arranged.

• The member of staff will also try to contact the family via telephone to ascertain the reason for their non-attendance and to enquire about the child’s welfare.

Following the 3rd No Access Visit:

• Following the 3rd ‘no access’ visit, a letter will be posted or left, requesting the family to make contact to arrange an appointment as a matter of urgency.

• The member of staff will also try to contact the family via telephone to ascertain the reason for their non-attendance and to enquire about the child’s welfare.

• The member of staff will seek advice from a member of the SAST for those children for whom there are no known child protection concerns after the 3rd ‘no access’ visit and the staff member will also inform the GP.

Sample letters can be found in Associated Documentation 6

6.3.8 Procedure for a staff member who suspects a child is ‘home alone’

a) The safety of any child/children suspected of being “home alone” will be paramount and staff will notify the police via a 999 call from their mobile phone whilst at the home, when such concerns arise.

b) Procedure: see ‘Home Alone’ flow chart in Associated Documentation 7

c) If a member of staff has concerns that a child is ‘home alone’ due to a child being heard or seen in the home but there is no response from the parent/ carer, the member of staff will use all reasonable and safe resources to gain the attention of the parent/ carer e.g. telephone parent/ carer using mobile, ring house number, knock loudly, call loudly through the letter box, stating that you will have to call the police if you do not receive a response. If it is a communal front door to a building which holds a number of properties, the member of staff will try to obtain entry to the building by asking a neighbour to open the communal front door but without disclosing any confidential information.

d) If there is no response, the member of staff will remain at the address and contact the police for assistance by dialling 999 using their mobile phone and give details of concerns.

e) The member of staff will then contact a member of the SAST and remain at the address until the police arrive.
f) A referral to Children’s Social Care will be made if there is concern that a child has been at risk of significant harm. The incident should be documented in the child’s health records.

g) The staff member will complete a CP3 or Multi-Purpose Safeguarding Children Form (Supporting Documentation 15.2 or 15.5). Copies will be filed in the CCHR and sent to SAST, any other HV’s/PHSN’s involved with the family and the family GP.

6.3.9 Procedure for the transfer of Continuous Child Health Records both within and outside of Newcastle upon Tyne where there are or have been child Protection/ Safeguarding concerns.

a) Staff will ensure that records are transferred within 7 working days of notification of family’s change of G.P. practice/ area. This applies to any child for whom there are concerns regarding their safety and welfare.

b) Procedure for movement within Newcastle
- As soon as staff are aware of the need to transfer records they will ensure the record is updated and complete; including any centile charts and confidential file, and that all documentation is secure within the Continuous Child Health Records.
  
- The member of staff will inform the SAST of the details by completion of a Change of Circumstance form CP6 (Supporting Documentation 15.4).

- If the change is due to temporary homeless accommodation or a foster placement this should be discussed with a member of the SAST so that the most appropriate plan of action can be decided.

- The member of staff will inform the SW (key worker), for the family, the GP and any other relevant professionals involved with the family.

- The member of staff will contact the relevant health professional who will be taking over health responsibility for the family and arrange a time to handover the records and discuss the case.

- The staff member will inform the Child Health Records Department.

- When a child commences school, the Continuous Child Health Record and the Confidential file will be handed over to the PHSN unless there is a younger sibling who is also the subject of a Child Protection or Child in Need plan. In this case a summary of the past history will be given in addition to a copy of
the minutes of the last meeting held and the Child Protection/Child in Need Plan.

- When there are changes in the child or family’s name, address or health professional involved, the member of staff involved with the family prior to the change(s), will complete the Change of Circumstances form CP6 (Supporting Documentation 15.4), send this to the SAST and inform the Child Health Records Department.

- If a child is placed in a pre-adoptive placement the member of staff must continue to use the child’s original name and Continuous Child Health Record until a formal Adoption Order has been granted by the Court. Once the staff member is aware that the formal adoption process has been completed they should seek advice from a member of the SAST to ensure that consideration is given to the legal framework, i.e. that only appropriate and necessary information is transferred to the child’s new record. Advice will be given on management of the record and confidential file.

c) Procedure for movement outside of Newcastle

- As soon as a staff member is aware of the need to transfer records they will ensure the records are updated and complete, including any centile charts, Continuous Child Health Record, Confidential file and that all information is secure within the record.

- The member of staff will inform the SAST of the details by completion of a Change of Circumstance form CP6 (Supporting Documentation 15.4) which must include a summary of current and historic health and social concerns and any action required from the new health professional. The member of staff will contact the new health professional who will be taking over health responsibility for the family by telephone and give a verbal handover of the case and document this in the records.

- If there has been input from the current member of staff within the previous three months, the records should be forwarded to the SAST for onward transfer via the relevant Safeguarding Nurses Team in the new area.

- If there has been no input from the current member of staff for over three months, the Continuous Child Health Record and Confidential file should be forwarded to the Child Health Record Department for onward transfer via the normal procedure for any child without a Confidential file. A copy of the Change of Circumstances form CP6 (Supporting Documentation 15.4) should be sent to the SAST.
• The member of staff will inform the SW (key worker), for the family, the G.P. and any other relevant professionals involved with the family, of the change.

• The member of Staff will inform the Child Health Department.

• If a child is to be placed in a pre-adoptive placement outside of Newcastle the member of staff must seek advice from a member of the SAST to ensure that consideration is given to the legal framework.

6.3.10 Procedure for a child not registered with a GP

a) All parents/ carers will be encouraged to register their child/ ren with a local GP.

b) Procedure: Health Visitors must contact the SAST to discuss any baby reaching 6 weeks of age who is not registered with a GP, so that a plan of action can be agreed. The HV must document the plan in the Continuous Child Health Record.

c) Health Visitors must discuss with the SAST any child/ ren they become aware of who is not registered with a GP so that a plan of action can be agreed. The member of staff must document the agreed plan in the Continuous Child Health Record.

d) Parents/ carers must always be advised of local resources and encouraged/ supported to register their child/ ren with a GP.

e) If the SAST are contacted by another Trust about a pre-school child who has moved into the area and who is not registered with a local GP, a member of the SAST will contact Locality Co-ordinator and request that the member of staff visits the family to advise of local resources and encourage GP registration.

f) If the SAST are contacted by another Trust about a school aged child who has moved into the area, who has no pre-school siblings and who is not registered with a local GP, a member of the SAST will contact the PHSN for the child’s nearest school, and request that the member of staff visits the family to advise of local resources and encourage GP registration and school enrolment if not already enrolled.

g) A HV/ PHSN requested to undertake a geographical visit by a member of the SAST will do so within the timescale advised by the member of the SAST and feedback to SAST following visit.

6.4 Generic for all staff

6.4.1 Guidelines for the Management following the Death of a Child

(Associated documentation 8)
6.4.2 Child Protection/ Safeguarding Supervision
Effective Clinical Supervision with regard to Child Protection and Safeguarding Children is essential to promote and ensure standards of practice which are consistently high and support staff to make safe decisions. To access the Newcastle Upon Tyne Hospitals NHS Foundation Trust Policy please see link below:-
Clinical Supervision in Safeguarding Children, Young People for Nurses, Midwives and Allied Professions

6.4.3 Procedure for response by staff to requests for court statements, attendance at court, Police statements / interviews (Associated documentation 9)

6.4.4 Domestic Abuse is any incident of threatening behaviour, violence or abuse (psychological, physical sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality. (Home Office 2005). This can include forced marriage and so-called 'honour crimes'. To Access Domestic Violence and Abuse Newcastle Upon Tyne Hospitals NHS Foundation Trust Policy please see link below:-
Domestic Violence and Abuse Policy

6.4.5 Employees who are victims of Domestic Violence
The Newcastle Upon Tyne Hospitals NHS Foundation Trust has a responsibility for the welfare of all its employees, and believes that Domestic Violence is not acceptable.
To access the Newcastle Upon Tyne Hospitals NHS Foundation Trust Policy please see link below:-
Employees who are Victims of Domestic Violence

6.4.6 Exclusion from treatment of violent or abusive patients
The Newcastle Upon Tyne Hospitals NHS Foundation Trust has a duty to provide safe and secure environment for patients, staff and visitors. To access the Newcastle Upon Tyne Hospitals NHS Foundation Trust for Exclusion from Treatment of Violent or Abusive Patients Policy please see link below:-
Exclusion from Treatment of Violent or Abusive Patients

6.4.7 Consent and Confidentiality (Associated Documentation 10)

6.4.8 Forced Marriage and Honour Based Violence (Associated Documentation 11)

6.4.9 Looked After Children (Associated Documentation 12)

6.4.10 Managing Allegations Against Staff
This policy sets out the action to take in respect of allegations against staff concerning child protection/safeguarding matters. It also raises
awareness of the risk of abuse and clarifies the process to be followed if an allegation of child abuse is made involving an employee.

6.4.11 Contacts List
(Associated Documentation 13)

6.4.12 Children’s Social Care Referral Form
(Associated Documentation 14)

6.4.13 Request to visit Trust premises from VIP/Celebrity and Non VIP/Celebrity
These guidelines apply to all staff to advise on the process to be followed when a VIP/Celebrity or non VIP/Celebrity request to visit Trust premises and consent to take photographs.
(Associated Documentation 15)

7 Training

The Newcastle upon Tyne Hospitals NHS Foundation Trust Safeguarding Children Training Policy sets out the mandatory training requirements for all staff with regard to safeguarding children and can be accessed via the Newcastle upon Tyne Hospitals NHS Foundation Trust Intranet. Trust Safeguarding Children Training Intranet page Mandatory Training Policy

8 Equality and diversity

The Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds. This document has been appropriately assessed.

9 Monitoring compliance

<table>
<thead>
<tr>
<th>Standard / process / issue</th>
<th>Monitoring and audit Method</th>
<th>By</th>
<th>Committee</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical notes audit will be undertaken on an annual basis by the Named Doctor &amp; Nurses for Child Protection to ensure compliance of policy. The audit will be an agenda item to be received by the Trust Safeguarding Group.</td>
<td>A sample of thirty cases are selected on a yearly basis from the Safeguarding Children Hospital data base where identified the child or young person has met the threshold for multi-agency strategy intervention</td>
<td>Named Nurse Child Protection (hospital)</td>
<td>Safeguarding Operational Management Group</td>
<td>Annually</td>
</tr>
<tr>
<td>Activity</td>
<td>Responsible Party</td>
<td>Frequency</td>
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<tr>
<td>Community Safeguarding Children review two sets of continuous child health records at each individual supervision session to ensure compliance with the Child Protection Policies and Procedures. Records transferred out of Newcastle are also reviewed.</td>
<td>Named Nurse Child Protection (community)</td>
<td>Annually</td>
<td></td>
<td></td>
</tr>
<tr>
<td>To ensure child protection report writing meets the required standards outlined in the Child Protection Policies and Procedures.</td>
<td>Report writing audit is being undertaken annually by the Community Safeguarding Team</td>
<td>Annually</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical &amp; Nursing staff training will incorporate these policies and procedures.</td>
<td>Attendance to mandatory children’s safeguarding training is monitored and data collection of evaluations undertaken</td>
<td>Annually</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dashboards produced to identify safeguarding activity</td>
<td>Data collection for number of Cause for Concerns raised and actions taken including safeguarding activity and outcomes is measured on a monthly basis</td>
<td>Quarterly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child Missing from Hospital Policy will be reviewed as indicated or updated as required.</td>
<td>A report will be generated within the timescale of this policy by the to ensure compliance of the policy.</td>
<td>Three yearly</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

10 **Consultation and review**

The consultation and review of this policy will be carried out by the Safeguarding Operational Management Group.

11 **Implementation (including raising awareness)**

Staff will be informed of the new combined Safeguarding Child Policies and Procedures through staff briefings, the Safeguarding Newsletter, Safeguarding Training, and Trust Intranet.
References

- Nursing and Midwifery Council (NMC). The code: Standards of conduct, performance and ethics for nurses and midwives. NMC. 2008
- British Association for Adoption and Fostering: Private Fostering Ten Top Tips for Health Professionals
- Royal College of Paediatrics and Child Health (RCPCH), Safeguarding Children and Young People: Roles and Competencies for Health Care Staff, Intercollegiate Document. RCPCH. 2010
The Newcastle upon Tyne Hospitals NHS Foundation Trust
Guidelines when there is Suspicion of Fabricated or Induced Illness (FII)

1. Introduction

It is important that professionals working with children and their carers are aware of the different ways in which fabricated or induced illnesses can present. It is also vitally important for professionals to distinguish between those carers who are very anxious and who may be responding in a reasonable way to a sick child and those who exhibit abnormal behaviour.

Children who have been subjected to fabricated or induced illness are at risk of significant harm. Research suggests that 10% of children die as a result of FII and 50% suffer long term morbidity. Psychologically there are long term effects on the child of being brought up in the sick role and also concerns about the abnormal relationship with the carer who has been fabricating or inducing symptoms as well as disturbed family relationships.

Children with suspected fabricated or induced illness may present to the full range of medical specialists and for staff involved, dealing with these cases can prove stressful.

Concerns may be raised when it is considered that the health or development of a child is significantly impaired or further impaired by a parent or caregiver who has fabricated or induced illness. These concerns may arise when:

- Reported symptoms and signs found on examination are not explained by any medical condition from which the child may be suffering
- Physical examination and results of medical investigations do not explain reported symptoms and signs
- There is an inexplicably poor response to prescribed medication and other treatment
- New symptoms are reported on resolution of previous ones
- Reported symptoms and found signs are not seen to begin in the absence of the carer
- Over time the child is repeatedly presented with a range of signs and symptoms
- The child’s normal, daily life activities are being curtailed for example school attendance beyond that which might be expected for any medical disorder from which the child is known to suffer
- Consideration always needs to be given to obtaining toxicology samples from children and young people who present with unexplained symptoms atology especially history of collapse and altered consciousness.

There are three main ways of fabricating or inducing illness in a child. These are not mutually exclusive and include:
Fabrication of signs and symptoms. This may include fabrication of past medical history
Fabrication of signs and symptoms and falsification of hospital charts and records and specimens of bodily fluids. This may also include falsification of letters and documents
Induction of illness by a variety of means including administering medications or other substances, by means of intentional transient airways obstruction or by interfering with the child’s body so as to cause physical signs.

“Safeguarding children in whom illness is fabricated or induced: 2008” is a Department of Health publication which outlines the framework within which agencies work when there are concerns about possible FII.

2. General Principles

This is a form of child abuse which can place a child in danger, even whilst in hospital
In hospital it is usual for carers to be involved in the child’s care. In cases of suspected FII the carer has the opportunity to continue this behaviour e.g.: interfering with treatments and tests. Carers are often very involved and never leave the ward. They may be very involved with other families on the ward and with hospital staff. Carers may be unusually unconcerned about results of investigations which may indicate possible serious physical illness in the child and their interactions with the child may be unusual.

The child is generally unaware of deceptions in the history giving or contamination of samples (e.g. urine specimens contaminated by parental blood).

3. Expressing Concerns

When any staff member has concerns about a child’s condition which raises suspicion of fabricated or induced illness, he/she must:

Discuss concerns with the ward sister/charge nurse/consultant. The Named Nurse/Doctor for Child Protection can be contacted for further advice or management

Concerns should not be shared with the parent or carer at this stage.

It is advisable for health professionals involved with the child and family to meet to share their concerns. The Named Nurse for Child Protection should be contacted and further advice should be sought from the Named or Designated Doctor. It is helpful to produce a detailed chronology of events to outline the child’s full medical and developmental history. If FII is suspected then the next steps is to request a multiagency strategy meeting with professionals involved with the child and family lead by Children’s Social Care. For children who are inpatients this referral is direct to Children’s Social Care in Newcastle even though the child may not reside in Newcastle. It is then the responsibility of Newcastle Social Care to liaise with the child’s local services.
4. **Process**

Carers should **not** be told about the strategy meeting in advance. Failure to ensure this could prevent adequate protection for the child and might have serious consequences.

Staff will be guided and supported by the Named Nurse/Doctor for Child Protection, Matron for Children’s Services. It may be that only one or two nurses on the ward will be aware of the investigation. Nurses should seek the support of the Named Nurse for Child Protection, and Matron for Children’s Services and not discuss with other staff.

It will be the responsibility of the Named Nurse/Doctor for Child Protection/Matron for Children’s Services to approach Senior Management for funding of extra resources. These resources may be nursing, clerical or administrative.

Procedures for the confiscation and collection of forensic evidence will be discussed with the Police, e.g. you may be asked to seize soiled linen or waste disposed of in the cubicle, or possibly bathroom areas. Labels / bags, etc., are available from the Children and Young People’s Clinic.
1. Introduction

The Newcastle upon Tyne Hospitals NHS Foundation Trust has a duty of care to ensure the safety of patients in its care and takes all possible steps to do so. On occasions when this has not been possible and patients have left an area and cannot be located, the Trust will ensure a prompt and systematic response in order to minimise the risk to the individual. The purpose of this policy is to ensure an effective and co-ordinated response in the event of a child going missing from a clinical area within the Newcastle upon Tyne Hospitals NHS Foundation Trust.

Definitions
Where this protocol refers to a ‘child or ‘children’, these terms include young people under the age of 18 years.

2. Detaining patients against their will

Unless subject to a section of the Mental Health Act 1983, no patient, child or parent with child can be kept in hospital against his/her will. Should a patient wish to discharge her/himself against medical advice or their child the identified procedure should be followed, (Hospital Discharge Policy Section 6). If a child discharges her/himself or the parent/carer self-discharge their child without completing the necessary paperwork the child should not be regarded as a ‘missing patient’ but must be followed up by contacting relatives and relevant professionals e.g. CPN, GP, in order to ensure the child’s personal safety.

3. Immediate role of the Clinical Team

3.1 Any member of staff suspecting that a child is missing from the ward should convey this information immediately to the Nurse in Charge/Head of Department.

(i) The Nurse in Charge/Head of Department will: establish whether a child is missing from the ward or department and will ask staff on duty if they are aware whether the child has left the ward.

Other patients on the ward should be asked if they are aware whether the missing child or parent/carer had indicated where they may be going.

At the same time, the Nurse in Charge will initiate a search of all rooms and spaces including, for example, linen rooms, store cupboards, within the ward/departmental area. The occupant of each bed space should be identified and accounted for.
(ii) If the child has not been found the Nurse in Charge will then undertake the following action:

In hours:
- Contact the Matron Children’s Services, Dect phone: 29720, Named Nurse for Child Protection, Dect phone: 29150, and Patient Service Co-ordinator Dect phone: 24300, who will conduct an initial assessment and provide immediate support to the clinical area.
- Make an entry to this effect in the child’s records and ensure an incident report is completed.
- Compile a detailed description of the child, including any special needs, e.g. in relation to communication or distinguishing features. Any special circumstances should also be noted.

Out of hours:
- Contact would be directly with Directorate bleep holder, Dect phone: 29261 and Patient Services Co-ordinator.

Contacting the Police:
- Following Risk Assessment if deemed inappropriate to wait until after site search.
- In the case of a child who is subject of a Police Protection Order, the police must be contacted immediately.

4. Immediate Role of the Matron

The Matron will take the following action:

(i) Confirm a local search of the ward and immediate vicinity has been undertaken by the nurse in charge.

(ii) Contact the PSC who will assume the role of Search co-ordinator and undertaken the following actions.

(iii) Confirm whether the child has gone missing previously, where the child went to, and whether she/he subsequently returned to the ward unaided. If it is decided that a search is necessary this information is vital and must be conveyed to all the search teams.

(iv) Contact the child’s consultant (or in the out of hours period, the consultant on the relevant on-call team). In conjunction with the senior nurse on the ward and the consultant, assess the risk to the missing patient, ensuring the details are recorded in the child’s clinical record.

(v) Ensure the patients relatives are informed and a record if the conversation is made in the child’s records.

(vi) Contact the Directorate Management Team and keep them informed of progress.
5. **Search Co-ordinator and Search Team Roles**

5.1 The intensity and duration of the search will depend upon the result of the risk assessment. Children, or their parents, may be considered to be at risk because of their mental or physical condition. This will include:

- A child on their own.
- Detained under the provisions of the Mental Health Act.
- Suffering from debilitating illness of physical frailty.
- At risk of self-harm.
- Considered to be at risk of harming other people.
- Liable to suffer a deterioration in health.
- Subject of a Child Protection Investigation and/or Legal Order.
- Learning disability.

Other information to be considered should include whether the child has gone missing previously, where the child went to, and whether she/he subsequently returned to the ward unaided. If it is decided that a search is necessary this latter information is vital and must be conveyed to all the search teams.

5.2 Advise security of the missing child, giving details of the ward of origin, a description of the patient and any essential information.

5.3 Request the neighbouring wards to send one nurse each to liaise with the search co-ordinator. These nurses will join search teams, each of which will consist of two members of staff. This will enable help to be summoned promptly whilst also maintaining patient safety in the event that the patient requires medical assistance.

5.4 A local search of the ward and immediate vicinity should be initiated immediately by the nurse in charge.

5.5 Other patients or parents on the ward should be asked if they are aware whether the missing child had indicated where he/she may be going.

5.6 A systematic search of the hospital will be undertaken by the search teams concentrating initially on all unlocked wards, departments, corridors, rooms on the same level and other most likely locations e.g. smoking/dining areas, public telephones etc., subsequently broadening out the search to other areas if necessary. Where necessary laminated site plans and walkie-talkies are available from the security control room.

5.7 All search items must document which named personnel have looked where and at what time. This report must be filed with the Clinical Incident Report From. The search teams will contact the search co-ordinator at regular intervals of no more than 30 minutes to report on progress.

5.8 Unless already aware, if there is no trace of the child in the hospital or the grounds, the next of kin should be advised. A record of this conversation should be entered in the child’s records.
5.9 Once the initial search has been conducted, if the child has not been located, the relevant Head of Nurse (out of hours PSC) should be advised of the incident by the Search Co-ordinator.

5.10 Following discussion a decision on whether to notify the police will be taken. It is the responsibility of the Manager on call to advise when to contact the police. Ward staff should not contact the police directly. This decision will be made by either the Matron Children's Services, Patient Services Co-ordinator or following discussion with the Directorate Manager. The exception to this is in 3.3

6. General Guidance to Searchers

6.1 Various search tactics may be employed which include an immediate search of all likely places where the missing child may be found. The tactics should be directed by the search co-ordinator.

6.2 The following should be remembered:

- A child can hide in a very small space.
- Examine all locked and unlocked areas – keys will be available from domestic services.
- Thoroughly check all recesses.
- Check closed and empty wards and departments.
- Check all toilets and corridors.
- Check all landings and stairways.
- Check under stair storage space, storerooms and linen/waste collection points.
- Whilst searching observe for evidence that the patient may have been in the vicinity (May have discarded clothing or drooped the patient identification armband).
- CCTV footage may provide initial evidence.
- On completion of the search of the designated area search teams should contact the search co-ordinator for further instructions.
- The details of all searched must be documented as described.

7. Media Attention

7.1 All enquiries from the media should be referred via the Patient Services Co-ordinator and, if necessary, to the On Call Manager who will agreed a press statement with a Trust Executive. The police press office is available for assistance if it is considered necessary.

7.2 Under no circumstances should any other member of staff give information to the media without the express permission of the On Call Manager.
8. **Action following the incident**

8.1 A full and comprehensive untoward incident report should be completed and forwarded immediately to the Clinical Governance and Risk Department. Statements from ward staff and the Patient Services Co-ordinator should be attached. Documentation must be submitted within 24 hours.

8.2 If the Matron/Directorate Manager was not on duty at the time of the incident (e.g. Out of hours) the Nurse in Charge of the ward is responsible for informing them at the earliest possible opportunity, and no later than the following working day.

9. **Monitoring**

On an annual basis a report will be provided by Clinical Governance and Risk Department to identify the number of occasions the policy has been applied and reviewed to ensure satisfied outcome.
Supplementary Procedures for Staff in Emergency Department
Guidelines for Children Attending the Emergency Department

The following guidelines are aimed at staff working with children in general. Refer to departmental guidelines for treatment of specific conditions. As with any guidelines, initiative should be used where appropriate. Safeguarding guidelines and interagency child protection guidance is available on the Safeguarding website, accessible through the trust intranet site.

1. Triage
   Nursing staff assessing children should have 6 months+ Emergency Department experience.
   **Suspect N.A.I. until shown otherwise**

2. Triage Category
   When allocating triage category to a child use Manchester triage, but take other circumstances into account, how distressed child and carer are, the need for analgesia or temperature control. Time of day may be relevant as other children may need picking up from school, late at night the scene in Emergency Department may be distressing for a child.

3. Subjective Triage Data
   Briefly describe the child or carers account of the incident, include mechanism of injury where relevant, record circumstances surrounding incident i.e. was it witnessed, was the child supervised, were other children involved etc. If injury was caused by another party state weather accidental or deliberate and what, if anything, has been done to prevent a further occurrences i.e. have Police or School been informed of assaults, if injury was caused by an animal was it a pet or stray, has anyone been informed. Use common sense, accidents do happen and children cannot be supervised 24hrs per day. Give accident prevention advice where appropriate.

4. Objective Triage Data
   Describe child’s injuries and general condition i.e. distressed, drowsy, alert, subdued etc. Observe and record child’s interaction with carer. Record relevant observations. Look for other injuries and record explanations. Think about mechanism in relation to child’s age and development i.e. falls in non-mobile children. Ask if any medication has been given prior to attendance and give name dose and time given.

5. Last Tetanus
   Enter immunisation status, if routine immunisation programme has not been followed record this on the Emergency Department card and advise carer to contact GP/HV to commence full course of immunisations. Giving tetanoid toxin in the Emergency Department removes the perceived need for immunisations so may reduce likelihood of carers commencing full immunisation programme. This does not apply if Tetanus Immunoglobulin is indicated.
6. **Previous Attendances**  
Look at previous attendances for all children as patterns of attendance can be significant i.e. lots of preventable minor injuries. If any concerns ask receptionist to pull any previous A/E cards. The last 5 attendances will be recorded on the front of the A/E documentation.

7. **Person Present**  
Fill in the details of the person present on the Emergency Department card. If the next of kin is not present give details of person present i.e. childminder, neighbour, elder sibling. State if Next of kin is aware of attendance. Some older children will attend unaccompanied (Trust Safeguarding Procedures). Whenever possible inform the next of kin of attendance. This is best practice but may not always be possible or essential. If the circumstances surrounding incident are reasonable then older children may consent to treatment and be discharged without their next of kin being informed. (See Gillick competence)

8. **Further Information** (Document on the Emergency Department card)  
A note should be made of any relevant information i.e. that the child is in the care of social services or whether any information needs to be passed on to the Health Visitor or School Health Advisor. Record any contact made regarding the child and the outcome.

If the card is for the attention of the Health Visitor or School Health Advisor, document the reason for this and be aware that it is for the purpose of information sharing only and any immediate action needed must be initiated in the department or discussed in person with Health Visitor or School Health Advisor. Certain circumstances may indicate the need to involve other agencies, the contacts list can be found in Related Documents.

9. **Treatment**  
Children should, whenever possible have their treatment carried out in the children’s area. Obviously very ill children, children who have suffered significant trauma or any alteration of conscious level should be seen in resus, If in doubt use resus as it’s easier to move a well child out of resus than to move a sick one in.

10. **Explanations**  
By far the best way of reducing stress and anxiety in children and their carers is to give full explanations of what is going to happen and what is expected of them. Be truthful e.g. children are often told they are going to have their picture taken when going to X-Ray, X-Ray equipment bears no resemblance to the cameras used for family snapshots, so the child may feel you lied and not believe other things you tell them, i.e. that sterri strips don’t hurt. Tell children when things are going to hurt and suggest ways of helping them cope with the pain i.e. counting out loud.

11. **Observations**  
All unwell children need a minimum set of observations comprised of respiratory rate Oxygen saturation SpO2, heart rate, temperature and capillary refill time. In addition capillary blood glucose measurements should be performed on any child with loss of consciousness, and/or seizures, or any children requiring resus. A base line blood pressure should also be obtained (ensure that the correct size cuff is used).
12. **Pain Control**
Paracetamol is an effective analgesia and should be used where appropriate, Ibuprofen should also be considered. Ensure any drugs given are checked and signed for by 2 qualified nurses. If stronger analgesia is required involve a doctor from triage. Use pain scores and reassess at appropriate intervals. If intravenous analgesia is required or intravenous access is thought necessary apply a topical anaesthetic cream such as Ametop at the earliest opportunity. Topical anaesthetic cream can be working in the time taken to inform medical personnel and gather appropriate equipment and drugs.

13. **Temperature Control**
Paracetamol should be given from triage if the child is pyrexial, if given prior to attendance then consider ibuprofen. However be aware of the need to ensure the child is well hydrated and has passed urine before prescribing ibuprofen. Children who have a fever should not be discharged or transferred to the children’s ward until the fever is addressed. Be alert to signs of meningococcal disease in febrile children.

14. **Consent to Treatment**
Children who are capable of understanding diagnosis, treatment and the implications of the treatment they receive are able to give consent to treatment (see supporting Documents 2 Consent and Confidentiality). It is rare that this will be applied in children younger than 13 years of age. In some circumstances the child’s next of kin may give the responsibility to consent to others acting in “loco parentis” i.e. childminders, teachers and organisers of trips, the child’s next of kin should be contacted whenever possible. In the event of an emergency the duty is to act in the child’s best interests.

15. **Child Protection Awareness**
While completing treatment look for further signs of neglect and/or abuse. Do not rely solely on the assessment by the Triage nurse. Any circumstances which require highlighting to Health visitor or school health advisor should be documented on the Emergency Department card and acted on where appropriate.

16. **Discharge**

16.1 **General Advice**
Read the Triage data; ensure all explanations are consistent and that the final diagnosis fits with the mechanism of injury and developmental stage of child. Ensure that child and carer:

- Are aware of the diagnosis
- Know how long to keep dressing/bandage in place
- Are aware of any follow up needed
- Know how to get help or advice if necessary
- Have been told of expected outcome i.e. how long healing will take, the likelihood of scarring.
- Have been given advice on when to take medication, how long to take it for and how to store it.
- Students and HCAs should have treatments checked.
Give bravery certificates and stickers where appropriate, they can reduce fear for further visits by giving child something pleasant to associate with visit to the department.

Discharge information should be recorded for all vulnerable and/or unaccompanied children.

16.2 Transport Home
Ask the child or carer how they are getting home, if they have problems provide transport either PTS or taxi where appropriate. Unaccompanied children should usually be provided with transport home, use common sense!

17. Children requiring special consideration
Non-accidental injury (NAI)
Many of the accidents that occur in children could be classed as non accidental, i.e. the young child that falls down stairs where no stair gate is fitted, is this neglect?

For the purpose of these guidelines NAI refers to deliberately inflicted injuries or harm. When NAI is suspected Children’s Services should be contacted to see if child is known to them. Inform the nurse in charge and Paediatric Consultant on call of any concerns and arrange for either the Emergency Department middle grade or Consultant to see the child.

After immediate treatment the child will be referred to the paediatric department and admitted. If there is any disagreement about the cause of injuries and you are still concerned, then involve Children’s Services and refer to the Paediatric Consultant. A cause for concern form should be completed and Faxed to the Named Nurse for Child Protection Eileen Wardhaugh. The children’s safeguarding team will follow the case up and make sure appropriate action has been taken.

17.1 Children Known To Have Been Abused
Occasionally Police or Children’s Services bring children who are known to have been abused into department for assessment if possible these cases should be seen on ward 6 at the RVI. These children should be referred to the on call paediatric middle grade or consultant unless the presenting complaint is unrelated to abuse. In the latter case the attendance should be fully documented on the Emergency Department card and a cause for concern form completed and faxed to Named Nurse for Child Protection to inform her of the attendance.

17.2 Poor Parenting Skills
This can manifest itself in many ways; the most obvious presentation in the Emergency Department is numerous attendances for easily preventable accidents. Other incidents include basic lack of childcare skills i.e. being unable to communicate appropriately with the child or attend to the child’s needs while in department, under nourished or developmentally delayed children. Judgement and commonsense should be used when assessing parenting skills, everyone’s standards differ, and it is the risk to the child that we are assessing. When parenting skills are not “good enough”, and this is thought to be the reason for attendance this should be discussed, in person, with the child’s health visitor. and a cause for concern form completed.
17.3 Psychiatric Problems
Children attending with psychiatric problems require follow up, especially when they
don’t require admission. Intentional over doses, deliberate self-harm or psychotic states
will require admission. Others need careful assessment i.e. eating disorders,
purposeful delinquency and suicidal intent. Referrals to Child Psychiatry can be made
either through the paediatrician on call if urgent or via the child’s GP. A cause for
concern for should be completed. (Up to 18 yrs)

17.4 Accidental Ingestion
Many children attend after ingesting various household items or medications left in
reach, treat as appropriate for the substance ingested but ensure a cause for concern
form is completed for all attendances even very trivial ones.

17.5 Drug and Alcohol Use
Parents/carers should be contacted if any child attends as a result of intoxication by
drugs or alcohol. Referral to paediatric services should be made if the parent/carer
cannot be contacted. In most cases there is no need for admission to hospital if the
child can be discharged into the care of a responsible adult. Capillary blood glucose
should be checked prior to discharge. The health visitor or school health advisor
should be informed and a Cause for Concern completed. (Up to 18 yrs)

17.6 Children in Looked After System
A note should be made on the Emergency Department card and form completed for the
Designated Nurse of all children in the care of the local authority and a care worker
informed of the attendance.

17.7 Inappropriate Attendance
Carers often bring children to the department with complaints which are more
appropriately dealt with by child’s GP, this should be discussed with the carer and
advice given on what is appropriate for the Emergency Department and what require
involvement of the family doctor.

17.8 Missing From Home
Up to date records of all children who are “missing from home” locally and nationally
are maintained by the police. If you suspect a child is living rough or with various
friends’ i.e. inconsistent stories about address or next of kin, or a different address to
previous attendances, contact the Police to see if the child is known to them.

18. Recognition of Sick Child
18.1 Breathing
Respiratory rate - < 1 30 – 40
1-2 25 – 35
2-5 25 – 30
5-12 20 – 25
>12 15 – 20

This is the most important observation in children and is often not recorded.
These are rates at rest if child distressed attempt to settle child before recording
respiratory rate.
Recession – Intercostal, subcostal or sternal recession shows increased effort of breathing. Most easily seen in younger children as they have more compliant chest wall. Presence in children over 6 or 7 years suggests severe respiratory problems.

Noises – Inspiratory noises (Stridor) is a sign of laryngeal or tracheal obstruction. Wheezing indicates lower airway narrowing and is more pronounced on expiration. Grunting – Produced by exhalation against a partially closed glottis. This is sign of severe respiratory distress.

Accessory muscle use – as in adults, in small children may cause head to bob up and down with each breath.

Flaring of the alae nasi (Nostrils) – seen in infants with respiratory distress. In the infant or child who has had severe respiratory problems for some time, fatigue may occur and the signs of increased effort will decrease – Exhaustion is a pre-terminal sign.

SaO2 – in air gives good indication of efficacy of breathing but supplemented oxygen will mask this information unless hypoxia is severe.

Children with any of above signs should be in resus

18.2 Circulation

Heart rate - < 1 110 - 160
1-2 100 - 150
2-5 95 - 140
5-12 80 – 120
13
>12 60 – 100

Heart rate initially increases in shock, as compensation for decreased stroke volume rate may be extremely high up to 220. Bradycardia is a pre-terminal sign.

Capillary refill – Pressure on digit or centrally on sternum for 5 secs refill should occur in less than 2 secs. Useful sign in early septic shock when child seems otherwise well. Use with caution in trauma patients who are cold.

Blood pressure – Hypotension is a late and pre-terminal sign of circulatory failure. Once a child’s blood pressure has dropped cardiac arrest is imminent.

Expected systolic blood pressure can be estimated by formula – Blood pressure = 80 + (age in years times 2)

18.3 Neurological Function

Conscious level. – Rapid assessment
A Alert
V Responds to voice
P Responds to pain
U Unresponsive

18.4 Temperature

Recorded alone temperature is a very poor indicator of how unwell a child is.

19. Definition of Gillick Competence

Where a child needs medical treatment, any examination or assessment without consent may be held in law to be an assault. For consent to be valid, the person giving consent must be aware of what he or she is consenting to, and the possible consequences, and the consent must be given freely. A child of 16 is presumed in law
to be capable of giving or withholding consent unless there is mental incapacity to consent. Depending on their age and understanding, younger children may also be regarded by a doctor as capable of giving consent to examination or assessment. The doctor must decide whether the child is Gillick competent, i.e. does the child have sufficient understanding and intelligence to understand fully what is proposed. Gillick competence must be assessed in respect of each individual child and each proposed treatment. For younger children who are not regarded by a doctor as capable of giving consent, consent would normally have to be obtained by the parents. A local authority may be able to give the necessary consent if it holds parental responsibility for the child under an emergency protection order or care order. Where there is dispute over medical treatment for a child, legal advice should be sought.

20. **Cause for Concern Forms**

It is recommended that staff complete a Cause for Concern form in any situation where they feel that additional information sharing may help to safeguard a child.

20.1 **Examples of when to complete a form when a child presents in the department**
- ANY injury to a non-mobile baby, explained or not
- ANY child / young person who has taken an intentional overdose or self harmed
- ANY child / young person who attends with alcohol intoxication / substance misuse
- ANY burns or scalds where it is not consistent with the mechanism given
- ANY accidental ingestions of medication or other harmful substances
- ANY genital injuries where it is not consistent with the mechanism given
- ANY sexual assault under 16 years, NB if the child is under 13 years then a referral to Children’s Services also needs to be made
- ANY child who has been assaulted
- Where there are signs of neglect, e.g. poor hygiene, severe nappy rash, undernourished
- Any unusual reaction by a parent/carer or child, e.g. is the child very withdrawn, over compliant
- Any unusual or worrying interaction between parent/carer and child

20.2 **Examples of when to complete a form when an adult presents in the department**
- Any adult who has been assaulted, regardless of perpetrator, and they have children at home, but particularly when it is a domestic violence assault
- Any adult who has taken an overdose or who is intoxicated, and they have children at home
- Any adult who has self harmed, and they have children at home
- Any adult who has acute mental health issues, and they have children at home
- Any adults in police custody, who have children at home

**In these circumstances always ask:- Who is looking after the children now?**

20.3 This is by no means an exhaustive list, and there will be other situations not mentioned above when a form will need to be completed. Please note that completing a Cause for Concern form is not the same as a referral to Children’s Services. It is simply a more robust way of sharing information, initially with the Named Nurse for Safeguarding Children (Eileen Wardhaugh Dect 28 29150 ext. 20589)
If you have concerns about a child’s immediate safety then police and/or Children’s Services should be informed.
To make a referral to Children’s Services in Newcastle telephone the Initial Response Team on 0191 2772500 based at Cruddas Park or out of hours please contact the Out of Hours Social Care Service on 0191 2328520
Child Protection Conference Report Protocol for Hospital Based Staff
The Newcastle upon Tyne Hospitals NHS Foundation Trust
Guidelines on Writing Reports for Case conferences

1. Introduction

Staff should remember that the reason a report is required for Initial Child Protection Conference is to determine if the child is at risk of significant harm. Written reports prepared for case conferences form an important part of the decisions made regarding the child’s future care. Wherever possible the report should be written by a member of the nursing team who knows the child and family. Please read the following guidelines before writing the report. There is a template which has been designed to assist you in writing your report. (See report protocol Appendix 1 within the Guidelines for Writing Reports for Case Conferences for Hospital Staff). Also refer to the Framework for Assessment of children in need and their families (2000) (see report protocol Appendix 2 within the Guidelines for Writing Reports for Case Conferences for Hospital Staff).

Reports should be clearly and concisely written (preferably typed) in black ink. Ensure all information is factual and that positive as well as negative incidents/observations are reported. Present objective and measurable evidence of the child’s health and development. Where subjective views are given, they should reflect balanced professional judgement e.g. ‘she’s a happy child’- write why you think this. Abbreviations should not be used. Please make every effort to ensure the basic information (including spellings of names) is as accurate as possible.

Reports must be discussed and shared with the Named Nurse Child Protection prior to submission. Support and guidance is available for nurses writing reports and attending conferences. In addition parents should be aware of the reports contents and time should be allocated for discussion between the nurses and parents and where appropriate the child, prior to attendance at the case conferences. Nothing should be included in the report that you do not feel able to say directly to the parents and which you have not already discussed with them. There is a section at the end of the report template for the parent and or child to add their personal comments.

If you need to describe a specific incident i.e. inappropriate behaviour or language, it is most appropriate to use direct quotes in parenthesis. Concerns raised by other people should also be noted indicating who the informant was but do not include names of other parents or visitors.

When preparing a written report on a child, all professionals should keep in mind that the written report may be used in subsequent court appearances; therefore confine the report to the facts. Also remember the more comprehensive and comprehensible the report, the less likely it is you will be called to give verbal evidence in court.

Reports must be submitted to the named social worker at least 48 hours prior to attendance at the case conference. There may be occasions when you wish to share information with the social worker or chairperson prior to the case conference. This may be information which the child and or parent is unaware of or you feel you
cannot share in an open forum. The Chairperson or Social worker must be contacted at least 24 hours in advance.

2. **Content of Report.**

**Sec 1. Reason for admission:** Give a brief summary of why the child was admitted to hospital on this occasion and summarize any previous admissions to the trust including dates. Please state if there has been any history of child not attending appointments.

**Sec 2. Nurse involvement with the child and family** in the circumstances leading to the initial Child Protection Conference: Give a brief resume of the child’s treatment and care given during admission. Do not interpret results of investigations e.g. X rays.

**Sec 3. General Appearance:** Include the child’s appearance on admission, clothes, cleanliness etc. Also include any physical injuries e.g. bruises.

**Sec 4. Nursing observations:** State the child’s most recent weight, height and head circumference and the measurements taken on admission (if known). Please also plot these on a centile chart and attach to report.

**Sec 5. Growth, feeding and eating patterns** observed by nursing staff during admission.

**Sec 6. Developmental milestones.** Is the child reaching their developmental milestones including speech, language, play. Include observations about the child’s behaviour/ emotional state.

**Sec 7. Visiting arrangements during visiting.** Comment on who has visited the child during the admission. State who required supervised access. State where the child was nursed i.e. cubicle or main ward. Comment on telephone calls received from family members or friends. Attach copy of visiting observation chart if used.

**Sec 8. Observation of family.** Include your observation of the child’s interaction between family members and staff during the admission. Are there extended family support/involvement? Also comment on the parents interaction with staff including general behaviour and response to advice.

**Sec 9. Details of your knowledge of the parent’s ability to safeguard the child and promote his/her health and development, including both positive and negative factors and area of need:** (i.e. their basic care needs, ensure the child’s safety, provide emotional warmth, ensure the child has appropriate stimulation and opportunities, provide appropriate guidance and boundaries, provide stability and consistency).

**Sec 10. Your assessment of the child’s needs and any risks to the child.** It is imperative for staff to analyse their information concerning the child, family and environment and to make a professional judgment as to whether the child is at continuing risk of significant harm or not.
Report Protocol Appendix 1

Report for Initial Child Protection

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Author of report: 

Designation: 

Workplace: 

Child’s name: 

Date of birth: 

Child’s address: 
(exclude if protected)

Details of family members and significant others:

<table>
<thead>
<tr>
<th>Names</th>
<th>Relationship to child</th>
<th>Date of Birth</th>
<th>Ethnicity</th>
<th>Nursery/School</th>
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Date of admission to Newcastle upon Tyne Hospitals: 

1. Reason for admission:

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2. Details of involvement with the child and family in the circumstances leading to the Initial Child Protection Conference including treatment and care given:

3. General appearance on admission:

4. Nursing observations:

<table>
<thead>
<tr>
<th>Admission height:</th>
<th>Weight:</th>
<th>Head Circumference:</th>
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</thead>
<tbody>
<tr>
<td>Present height:</td>
<td>Weight:</td>
<td>Head Circumference:</td>
</tr>
</tbody>
</table>

5. Comment on growth, feeding and eating patterns.

6. Developmental milestone inc speech, language, play and social interaction with family and staff. Include emotional state and behaviour, any known disabilities, is English the child's first language.

7. Visiting arrangements during admission:
8. Observation of family including child’s interaction between family and staff members. Parents interactions with staff including general behaviour and response to advice.

9. Details of your knowledge of the parent’s ability to safeguard the children and promote his/her health and development, including both positive and negative factors and area of need: (i.e. their basic care needs, ensure the child’s safety, provide emotional warmth, ensure the child has appropriate stimulation and opportunities, provide appropriate guidance and boundaries, provide stability and consistency)

10. Your assessment of the child’s needs and any risks to the child:

Has this report been discussed with the parent/carer/young person? Yes □ No □

Do the parents and or child wish to add any comments:

Signature: ........................................... Date:.........................................
Printed: ................................................
Child Protection Conference Report Protocol for Community Based Staff

CONFIDENTIAL REPORT

THE INFORMATION IN THIS REPORT SHOULD NOT BE COPIED, REPLICATED OR DIVULGED WITHOUT THE PERMISSION OF THE AUTHOR OR THE ORGANISATION

REPORT FOR INITIAL / REVIEW CHILD PROTECTION CONFERENCE TO BE HELD AT CRUDDAS PARK / WALKER / SHERRIFF LEAS SOCIAL CARE OFFICE ON DATE AT TIME

SECTION A

Name:
Role:
Base: (consider protected in some cases)

SECTION B

Subject: (name and dob) (only child / children you are responsible for)
Address: (don’t make reference to foster carer’s address / consider protected address in cases of DV)

Mother: (name and dob)
Address: (if not with dad and kids and if safe to disclose)

Father: (name and dob)
Address: (if not with mum and kids and if safe to disclose)

siblings (record if full or half): (name and dob)
Address: (if not with one or both parents and if safe to disclose)

Carer / Foster Carer: (name and dob(not foster carer) and address if safe to disclose (not foster carer)

Significant Others: (info known and relationship)
SECTION C

State professional involvement, for how long, including any current / previous CSC involvement.

Chronology of Contacts
Detail contacts – home visits (by appointment or ad hoc) / attendances at baby clinic / no access visits / non attendance at baby clinic / DNA GP, hospital and other appts. If extensive contacts consider summary of contacts and highlight (detail) significant contacts. Consult with Safeguarding Team if required.

SECTION D

CHILD’S DEVELOPMENTAL NEEDS

Health
Make reference to birth / where / gestation and birth weight kgs (lbs oz).

Speech and Language – detail

Feeding – breastfeeding / formula (volume and frequency) / solids / diet / routines

Weight and height – current (include centile chart) / growth and nutrition service

Medical conditions – detail

Disability- detail

Medication – generic name (trade name) / dose and frequency / compliance / concordance

Gross motor function – detail

Fine motor skills – details

Sleep – pattern / routine

Hearing screening

Eye screening

Registered with dentist – does child attend

Immunisation status

Developmental assessments

Sexual health

Substance misuse – include cigarettes

Education

Cognitive development

Engage with Surestart / baby social / playgroup / nursery / school

Emotional and Behavioural Development

Refer to emotional wellbeing of child / children. What observed – refer to infant mental health observation (if appropriate). What child reports. Comment on behaviour as appropriate.

Signs of stress or not – is it appropriate

Risk / Resilience

DV – impact on mental health of baby / child. Refer to brain development of child – ‘flight or fight’ and effect on limbic system.

Reciprocity / containment – with the parent
Identity
Race / religion / place within the family
Child / children self worth

Family and Social Relationships
Child / children demonstrate empathy
Bonding (< 12 months) / Attachment (> 12 months) to primary carer
Bonds with other family members / other significant adults or children
Bonds with peer group

Social Presentation
Clean / dirty / well and appropriate clothing or not / smell / head lice
Follow cultural beliefs

Selfcare Skills
Ability to feed self / toilet self / wash and dress self – if appropriate
Clean teeth
Does older child have to look after younger sibs – inappropriate to age
Toilet training – detail

PARENTING CAPACITY

Basic Care
Make reference to parent’s / carer’s ability to meet basic care tasks of child / children especially in relation to any learning disability / difficulty / medical condition.
Ability to maintain home to an acceptable standard.
Parents’ ability to keep appointment for child.

Ensuring Safety

Refer to home / road safety as appropriate. Comment on ‘stranger danger’ as appropriate.
Refer to current or previous Children Social Care involvement either in respect of current or previous children or in respect of parents when they were children i.e. LAC.
Comment on parents’ mental health / any drug or alcohol issues – comment if any services involved and/or medication.
Comment on any Police or Probation involvement (this does not need to be detailed as if current this will be shared by respective agency).
Any learning disability / difficulty.
Domestic Violence

Emotional Warmth

Comment on interaction demonstrated by parents to child and vice versa. Comment on attachment – refer to Solihull assessment / observation. Comment on positive / negative attitude to child / children.
Reciprocity / containment from the parent / carer
Stimulation

Is there sufficient and appropriate stimulation. What observed - toys, games, physical play.
Physical and cognitive stimulation.
Reciprocity

Guidance and Boundaries

Are there any boundaries – sleeping, feeding, road safety, behaviour. Comment whether positive / negative / consistent. What methods used – any support from professionals / agencies.
Behaviour strategies – do parents have capacity to implement / tailor to the child.
Do parents demonstrate emotional containment.

Stability

Secure home environment or mobile family. Parents in secure stable relationship or hx DV. Do parents have insight re: effects upon child / children.

FAMILY AND ENVIROMENT

Family History and Functioning

Stability of parents / carers relationship

Wider Family
Who – what contact.
Are they supportive to family / type of contact

Housing
Local authority / private let / owner occupier
Rent arrears
Rehouse
Type
Is it sufficient for needs of family
Condition of property.
Stability of home

Employment
Employed – part / full time – in what capacity
Unemployed.

Income
Benefits
Any financial problems / debts / ‘loan sharks’
Family’s Social Integration
From area / new to area
Ability to utilise services

Community Resources
Surestart / groups for children or parents

SECTION E

Professionals / Agencies Involved
Name and title/role

SECTION F

Analysis and Recommendations

Refer to strengths / positives / negatives – how this impacts on child / children physically and emotionally. Refer to protective factors / protective adults
Refer to Solihull Approach / Infant Mental Health
Recommendation – why
Cite research if appropriate

SECTION G

Report shared – has this been done – if not why not. If because parent / carer has not kept your appointment to share report - state this.
NB: parents with learning disability need to have a copy of report 7 days in advance of conference – they should also have brief synopsis of report in language that they can read / understand (this does not have to be long (couple of short paragraphs / bullet points).
Routine reports should be shared 2 days in advance of conference.
Share report at home only if safe to do so – invite to clinic / surgery / school if necessary.

Signature:

Date:
Dear Parent

I have recently visited your home on 3 occasions and unfortunately have missed you each time.

If you would like a further home visit please telephone me on the above number to arrange a convenient date and time, or you may prefer to attend the baby clinic held at

………………………………. On………………………………

between…………………… hours.

Your child’s next routine contact would be due in …………………

If there are any issues you wish to discuss please do not hesitate to contact me.

Yours sincerely

Health Visitor

cc GP
cc file
Dear Parent

I have recently visited your home on 3 occasions and unfortunately have missed you each time.

It is important that you make contact with me within one week, by………………………… otherwise I have a duty to inform your GP and Social Services.

Yours sincerely

Health Visitor

cc file
Dear Parent

I wrote to you on ....................., but as yet have had no contact with you.

I am now writing to let you know that I have a duty to inform your GP and Social Services that you, and your family, are not being visited by a Health Visitor.

The offer of Health Visiting services remains open to you should you change your mind. If you do wish to discuss this please telephone me on the above number.

Yours sincerely

Health Visitor

cc file
GUIDANCE IN SUSPECTING A CHILD IS ‘HOME ALONE’

HOME VISIT

CONCERNS CHILD ‘HOME ALONE’

CHILD HEARD WITHIN HOME

MOVEMENT HEARD WITHIN HOME

MOVEMENT SEEN WITHIN HOME

USE ALL RESOURCES TO GAIN ATTENTION FROM WITHIN PROPERTY

MOBILE PHONE (CONTACT BARPUP SURGERY FOR CONTACT DETAILS IF NECESSARY)

KNOCK LOUDLY

CALL THROUGH LETTER BOX

REQUEST ASSISTANCE FROM NEIGHBOUR IF IN COMMUNAL PROPERTY

ALERT PARENT/CARER THAT IF NO RESPONSE OTHER AGENCIES WILL BE NOTIFIED

IF NO RESPONSE PHONE 999/LOCAL POLICE NUMBER AND GIVE DETAILS/CONCERNS

CONTACT SAFEGUARDING ADVICE & SUPPORT TEAM (SAST)

REMAIN AT ADDRESS UNTIL POLICE ARRIVE

INFORM SAST AND COMPLETE CP3 or Multi-Purpose Safeguarding Children Form (Supporting Documentation 15.2 or 16.5)

REFERRAL TO SOCIAL SERVICES

DOCUMENT IN CHILD/REN RECORDS
Chapter 7 Working Together to Safeguard Children 2010 outlines the Statutory duty of agencies to respond to any death of a child or young person under the age of 18 years.

There are two inter related processes for reviewing child deaths.

1. A rapid response by a group of key professionals who come together for the purpose of enquiring into and evaluating each unexpected death of a child on an individual level.
2. An overview of all child deaths (under 18yrs) by the Child Death Overview Panel for that area. For children resident in Newcastle upon Tyne, North Tyneside and Northumberland this is the North of Tyne Child Death Overview Panel. However some of the children who die in Newcastle may be resident of other areas necessitating liaison with other Child Death Overview Panels. The key principles remain the same.

**The criteria for implementing a rapid response to a Child Death**

The rapid response process was established to investigate “unexpected deaths”. By definition these were deaths which were not anticipated as a significant possibility for example 24 hours before the death or where there was a similarly unexpected collapse or incident leading to or precipitating the events which led to the death.

The nature of the Rapid Response is set out in Working Together (2010). It states that the joint responsibilities of the professionals involved in the Rapid Response are:

1. Making immediate enquiries into and evaluating the reasons for and circumstances of the death, in agreement with the Coroner.
2. Undertaking the types of enquiries/investigations that relate to the current responsibilities of their respective organisations when a child dies unexpectedly. This includes liaising with those who have ongoing responsibilities for other family members.
3. Collecting information in a standard manner.
4. Following the death through and maintaining contact at regular intervals with family members and other professionals who have ongoing responsibilities for other family members, to ensure they are informed and kept up-to-date with information about the child’s death.

However, only responsibilities 1 and 2 are unique to unexpected deaths: the other two apply equally to deaths that are expected.

The purpose of the rapid response is to satisfy the competent agencies (principally the police and children’s social care) as to:
• Whether there is any need for a forensic investigation in relation to possible criminal actions
• Whether there are any pre-existing, or newly ascertained, safeguarding issues.

Once it is clear that no such issues pertain, the focus is on ensuring that the family is handled in an appropriate, supportive and sensitive manner, that parents are kept informed of the child death review processes and procedures, and that the outcomes of the child death review processes, including post mortem examinations and inquests, are properly recorded – just the same as for any other child death.

In Working Together (2010) the need for a Rapid Response was predicated on the death satisfying the criteria for being 'unexpected', which is defined as “the death of an infant or child (less than 18 years) which:

• was not anticipated as a significant possibility for example, 24 hours before the death, or
• where there was a similarly unexpected collapse or incident leading to or precipitating the event which led to the death.”

The difficulties inherent in this definition were tacitly acknowledged, as the paragraph continues:

“The designated paediatrician responsible for unexpected deaths in childhood should be consulted where professionals are uncertain about whether the death is unexpected. If in doubt, these procedures should be followed until the available evidence enables a different decision to be made.”

Because of the ambiguities inherent in the above definition, it seems reasonable to help those in the front line by spelling out the likely circumstances in which a death requires a Rapid Response, and to specify which deaths are unlikely to need a rapid response.

**Child deaths for which a Rapid Response is likely or certain to be appropriate:**

• Sudden Unexpected Deaths in Infancy (SUDI, up to 2 years old)
• Cardio-respiratory collapse of a previously healthy child
• Where self-harm seems likely
• The death from any lethal injury such as falls, drowning, fire, etc.
• Death that appears to be from a disease that is rarely lethal, such as diabetes or asthma
• Deaths occurring in hospital (for instance, in intensive care) that follow any of the above.

**Child deaths for which a Rapid Response is very unlikely to be appropriate:**

• Deaths of babies occurring in hospital either shortly after delivery, or in infants so seriously unwell that they have never left hospital since birth
• Infants and children dying in hospital of a disease, even when the onset is very rapid
• Children dying while in receipt of an organised palliative care programme, either through a hospice, Macmillan nurses, or some other clinical team
Most deaths in children with degenerative, neurological, metabolic or other severely life-limiting illnesses, regardless of the place of death (NB in making a decision not to undertake a rapid response, it must be borne in mind that occasionally children with such conditions are subjected to abuse or even killed).

The reporting of a child death to the Coroner is **NOT** by itself a reason to activate the rapid response, since the requirements for medical reporting to the Coroner include many instances of deaths occurring in hospital that have no implications for a Rapid Response, or for police involvement (for example, death during or following an operation or other procedure). In some areas, the Coroner has requested that every single child death is reported to them with no exceptions.

In practice, a key event in the Rapid Response is the involvement of the police to examine the scene of death, and to interview the parents. Except in situations such as SUDI, or where there is prima facie suspicion of abuse, the determination as to whether to proceed with Rapid Response activities should be made in discussion with the relevant paediatrician (the duty paediatrician, the designated doctor for child deaths, or one of the paediatricians with named or designated responsibilities for safeguarding), and with an appropriate officer of children's social care.

Finally, remember that the Rapid Response is not a single uniform entity, but a generic concept that should be tailored to the circumstances.
The Principles of the Rapid Response Process

The death of a child is always a tragedy and the family need to feel supported throughout the process. There should be a sensitive balance between the requirements for forensic and medical information and the need to provide support for the family. The family should be informed that there is a process which needs to be followed to help understand why their child died and that information about their child will be shared with the different statutory agencies. Plans should be made for maintaining contact with the family throughout the process.

If there are any concerns that the death of a child may have been as a result of abuse or neglect then Children’s Social Care should be informed if there are other children in the family. Following such discussions with Social Services there would be a multi-agency strategy meeting.
Process Following the Unexpected Death of a Child

1. Consultant Paediatrician on call / continuity informed of the child’s presentation. (Young people aged 16-17 years may be managed by Consultant Emergency Department staff) Consultant will most likely be involved in resuscitation attempt and decision to stop active resuscitation if resuscitation unsuccessful.

2. Death confirmed

3. Parents seen by Consultant and the process explained including the need to inform the coroner. Full background history taken in discussion with parents and Green Workbook completed. Contact details of bereavement officer given to parents and contact number for Consultant Paediatrician.

4. Coroner informed

5. Full surface examination of the child carried out by Consultant Paediatrician and samples taken as per Green Workbook. If there are any suspicions of possible non-accidental injury or neglect discuss with the coroner/coroner’s officer prior to taking samples to ensure forensic chain of evidence.

6. In such cases where there are any suspicions of abuse or self harm there needs to be a prompt multi-agency discussion/ information sharing with Police and Children’s Social Care. This should ideally be a face to face meeting but if this is not possible because of time constraints a telephone discussion between relevant personnel may suffice.

7. Consultant to organise staff “debrief” following resuscitation attempt to provide support for staff. This should be carried out as soon as possible after the event. If there are any specific practice issues identified these should be discussed with the relevant heads of department with a view to seeing staff members individually.

8. Inform the proposed contact list detailed in the Green Book of the Child’s death on the next working day if out of hours including the GP/Health Visitor, Named Nurse for child protection and the Designated Dr for Child Deaths. Inform the Child Death Administrator. If the child resides out of area then the local Child Death Administrator will be able to provide relevant contact details

Child Death Review Meeting

1. The Consultant liaises with the Designated Dr for Child Deaths to organise a Child Death review meeting. This meeting is usually chaired by the Designated Doctor for Child Deaths and should be attended by as many of the professionals who had dealings with the family and child. This meeting should be held when information from the post mortem is available.

The purpose of the meeting is to:
- Share information to identify the cause of death and contributory factors
- To plan future support for the family
To complete the overview report form and case analysis for the Child Death Overview Panel
  - To inform the inquest
  - To identify any lessons which can be learnt

2. Prior to the Child Death review meeting the Child Death Administrator will forward the report proforma (Form B) to all relevant professionals who should complete the document detailing their involvement so that this information is available at the Child Death Review meeting.

3. The information provided in the Form B’s is completed by professionals and the outcome of the case discussion is summarised by the Chair of the meeting in the Document Summary Form B.

4. Following the analysis of the Form B’s the Chair completes Form C in discussion with the representatives present. Form C focuses on identifying contributory factors and lessons to be learnt.

5. Completed Forms B and C are forwarded to the relevant Child Death Overview Coordinator by the Chair. These forms are then anonymised prior to discussion at the Child Death Overview Panel

Child Death Overview Panel

1. The purpose of the overview panel is to review the information on all child deaths in a specific area in order to inform local strategic planning on how to best safeguard and promote the welfare of children. The panel includes representatives from Health, Police and Children’s Services and it examines anonymised information including the outcomes of the Child Death review meeting.

2. Information about individual deaths are fed back to the relevant LSCB. It is the responsibility of each LSCB to ensure that lessons are learnt and that relevant organisations act on any recommendations to improve policy, professional practice and interagency working to safeguard and promote the welfare of children.

Dr Martin Ward-Platt
Designated Dr Child Deaths

Dr Caroline Grayson
Named Dr Child Protection
The Newcastle upon Tyne Hospitals NHS Foundation Trust
Procedure for response by staff to requests for Court statements, attendance
at court, Police statements/ interviews

a) All members of staff will be supported, given guidance and be prepared when
writing reports for court or when attending court, by a member of the relevant
Safeguarding Children Team (hospital or community).

b) Procedure: Staff will inform the appropriate Safeguarding Children Team and their
line Manager within 48hrs / 2 working days of being notified that a statement for
Court or attendance at Court is required.

c) An appointment will then be made for the member of staff to meet with a member
of the Safeguarding Children Team to discuss the case and obtain advice on
writing statements for Court / court skills.

d) The statement for Court will be written following the Policy and Procedure for
writing reports.

e) Staff will inform the Safeguarding Children Team if they are requested to meet
with a Guardian ad Litem / Children and Family Court Advisor, within 48hrs / 2
working days of the request being received. The case will then be discussed prior
to the meeting and a member of the Safeguarding Children Team will be available
to attend the meeting with them.

f) When a member of staff is required to appear in court, they will be accompanied
by a member of the Safeguarding Children Team.

g) If a member of staff is approached by a solicitor to provide information for private
law proceedings, for example, residence or contact orders, staff should first
discuss this with the Safeguarding Children Team.

h) When a staff member receives a request for information from the Police or
Coroner, they will contact a member of the Safeguarding Children Team, the
Clinical Governance Team or the Caldicott Guardian for advice and support.

i) If a member of staff is asked to attend a meeting with the Police or Coroner’s
officer, they will be accompanied by a member of staff from the Safeguarding
Children Team or another manager.

j) If the Police request copies of community or hospital health records, the member
of staff should contact a member of the Safeguarding Children Team, the
Caldicott Guardian or the Clinical Governance Team for advice. Normally copies
of health records should not be given to the Police without a Court Order or the
written consent of the person to whom the information relates, or their parent if the
child is unable to consent.

k) If any other person/s request copies of hospital health records they should be
signposted to contact Medical Records to assist in this request.
1. The Common Law Duty of Confidentiality

Respecting patient confidentiality is an essential part of good care. Guidance on the issue of consent and confidentiality is laid down in GMC Guidance Good Medical Care and also in 0-18 years Guidance for Doctors GMC:2007.

Personal information about children and families held by professionals and agencies is subject to a legal duty of confidence and should not normally be disclosed without the consent of the subject or a person having legal authority (usually a parent). Disclosure should be justified in each case, and advice from the Trust's Legal Advisor should be sought in cases of doubt.

2. Confidentiality

If it is deemed necessary to share information about a child or young person then this should be discussed with the individual and their consent obtained to share information. However if consent is not given to share information there are still circumstances in which information should be disclosed. The law permits disclosure of confidential information necessary to safeguard a child or children in the public interest that is the public interest in child protection may override the public interest in maintaining confidentiality. There may be a situation in which it is judged that disclosure is in the best interest of a child or young person who does not have the maturity or understanding to make a decision about disclosure, it may be that disclosure is required by law.

If a child or young person refuses consent or it is not practical to ask for consent then information should be disclosed that is necessary to protect the child or young person from risk of serious harm or death. e.g.: the child at risk of neglect or physical abuse, sexual abuse or emotional abuse; The child or young person is involved in behaviour that might put them or others at risk of harm; or there is information which would help in the prevention or detection or prosecution of a serious crime.

If you judge the disclosure is justified then it is important that information is disclosed appropriately. This will usually be in the form of a referral to social services but may involve a direct referral to the police. Any discussions should be recorded. If it is judged that disclosure is not justified then the reason behind this decision should also be recorded.

Confidentiality is important and information sharing should be proportionate to the risk of harm. If in any doubt further advice should be sought from the Named or Designated Professionals. Advice is also available from individual Professional Bodies or Defence Organisations. It is good practice when dealing with young people to state when confidentiality must be broken. Young people who disclose abuse are often at the point when they accept they need help in protecting themselves and others.
3. **Consent (Fraser Guidelines / Gillick)**

Medical treatment can be provided to a child or young person with their consent if they are competent or with the consent of a parent or the Court. Emergency treatment can be provided without consent to save a life or prevent serious deterioration in the health of a child or young person. Young people over the age of 16 can consent and young people under the age of 16 may be deemed capable of giving consent in certain circumstances. In the case of Gillick v West Norfolk and Wisbech Area Health Authority in 1986, the House of Lords reviewed the issue of consent with regard to young people under 16 and ruled that to give valid consent to medical treatment a young person had to satisfy a number of criteria:

- The young person must be able to understand the nature, purpose and possible consequences of any investigations or treatments proposed
- The young person needs to be able to understand, retain and use the information and be able to communicate their decision

Lord Scarman identified the principle that parental rights yield to the young person’s right to make their own decision when they reach a sufficient understanding and intelligence to be capable of making their own minds on such matters. Therefore parents cannot override the competent consent of a young person to treatment that is considered to be in the young person’s best interest.

4. **Refusal of Treatment**

The Fraser principle does not apply to the young person’s unreasonable refusal of consent to receive treatment deemed to be in their best interest (e.g.: in the case of cardiac transplant). In such situations it would be important to seek further legal advice and consider applying to Court for an Order.

5. **The Data Protection Act**

The Data Protection Act (1998) requires that personal information is obtained and processed fairly and lawfully: only disclosed in appropriate circumstances; is accurate, relevant and not held longer than necessary and is kept securely. The Data Protection Act is not a barrier to information sharing but aims to strike a balance between the many benefits of public organisations sharing information, and maintaining and strengthening safeguards and privacy of the individual. The Act allows for disclosure without the consent of the subject in certain conditions, including for the purposes of the prevention or detection of crime, or the apprehension or prosecution of offenders, and where failure to disclose would be likely to prejudice those objectives in a particular case. Further advice is available in HM Government’s “Information Sharing Guidance” (2008)

6. **The Human Rights Act**

There must be an awareness of the ways in which the Act which came into force in October 2000 may affect basic rights e.g. the right not to be subjected to inhuman or degrading treatment, the right to privacy and the right to family life.
7. **Parental Responsibility**

Clarification is needed to ascertain who can give consent on behalf of a child. Only someone who has “parental responsibility” as defined by the Children Act 1989, can give consent e.g. the mother will have parental responsibility as will married fathers. Unmarried fathers who are named on the Birth Certificate if the child was born after 1\textsuperscript{st} December 2003 will also have parental responsibility. For those children of unmarried parents who were born before 1\textsuperscript{st} December 2003, the father even if named on the birth certificate would not have automatic parental responsibility unless there is a specific Court Order. The Local Authority may share parental responsibility for a child if the child is subject to a Care Order.

8. **Training**

Training for staff will incorporate this guidance.
Forced marriage is defined as a marriage conducted without the full consent of both parties and where duress is a factor. There is a clear distinction between forced marriage and an arranged marriage. In a forced marriage one or both spouses do not consent to marriage.

Honour based violence are crimes involving violence usually against women. Such crimes can include assault, imprisonment and murder. The victim is punished by their family or community because their behaviour is perceived to have brought shame or “dishonour” on their family.

Forced marriage and honour based violence both abuse human rights and fall within the definition of domestic abuse. It is important for any professional who has concerns about possible honour based violence or forced marriage to take appropriate action. In the case of suspected honour based violence this will involve following the procedures as set out in the domestic abuse policy with special reference to the fact that information should not be shared with families or friends as this may place the young person at greater risk (see Domestic Violence Policy).

When forced marriage is suspected it is imperative that action is taken swiftly to prevent the young person being married against their consent. Suspicions may be raised by a professional seeing a young person where there are concerns about the perceived restrictions placed on the young person. There may also be concerns about any plans for spending an extended time abroad especially when this is seen to disrupt a young person’s education. A young person in this situation may exhibit symptoms of depression or self harming behaviour.

There may only be one opportunity for the professional to speak to the young person and therefore it is imperative that as much information is gathered as possible. This will include ensuring that the individual’s name, date of birth and contact details are recorded. The young person must be seen on their own in private where any conversations cannot be overheard. Suspicions must be reported to Children’s Social Care. The Named Nurse can be contacted for further advice but action should not be delayed if the situation arises out of hours as any delay may result in a young person being forced to marry against their will. Where there are sufficient grounds to suspect that a young person is at risk a forced marriage order can be applied for. There is a specific Government Department, the Forced Marriage Unit which provides support both for victims as well as professionals involved in possible forced marriage cases. There is further detailed statutory guidance available in: “The Right to Choose: Multi-agency statutory Guidance for dealing with Forced Marriage” and in “Multi-agency practice guidelines: Handling Cases of Forced Marriage” published in 2009.
The Newcastle upon Tyne Hospitals NHS Foundation Trust
Looked After Children and Young People

- Children and young people who are looked after are some of the most socially excluded groups in England. A series of Government reports have highlighted the health neglect, unhealthy life-style and the mental health needs that characterise children and young people living in care.

- Looked after Children and young people share many of the same health risks and problems as their peers, but often to a greater degree. They often enter care with a worse level of health part due to the impact of poverty, abuse and neglect. (Statutory Guidance on promoting the health and well being of Looked after Children 2009)

- Looked after children are the epitome of the inverse care law – their health may not only be jeopardised by abusive and neglectful parenting, but care itself may fail to repair and protect their health. And for some it may exacerbate damage and abuse.

- 71% of looked after children are placed with foster carer, with 1 in 6 of these placed with family or friends. N.B. It must be remembered that although foster carers may have the 24 hour care of looked after children, they do not, at any time, have parental responsibility. This rests with birth parent(s) and, when children are subject to a care order, is shared with Social Services. So foster carers are not in a position to give consent for medical treatment / procedures which should be obtained from either the birth parent or the child’s social worker.

- Emergency treatment may be offered and a decision made that it is in the child’s best interests, but under normal circumstances consent must always be sought as above. Signed consent from someone with parental responsibility is always obtained by the child’s social worker when a child first becomes looked after, this covers access to ‘routine’ health care / procedures and includes dental care, opticians appointments, immunisations, GP appointments and the giving of prescribed medication, and attending hospital outpatients appointments etc.

- When children and young people become looked after there is a statutory requirement for them to have an Initial health Assessment (IHA) carried out by a ‘registered medical practitioner’ in time to inform Social Services 28 date post placement review.

- Following the initial health assessment the children and young people have regular Review Health Assessments (RHA). These are carried out 6 monthly for children under the age of 5 years and annually for children and young people aged 5 to 18 years.

- These reviews are designed to be carried out by either a suitably qualified nurse or a doctor and in Newcastle they are usually carried out by the child’s Health Visitor or School Health Advisor.

- Young people who are no longer attending school who are hard to reach or reside in a residential home and are out of education or for any other complex reason will have their RHA completed by the Designated Nurse or Specialist Nurse for LAC.
## Safeguarding Contacts

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<tr>
<th>Designated Doctor</th>
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<tr>
<td>Dr Alison Steele</td>
<td>Margaret Tench</td>
<td>Newcastle upon Tyne Hospitals</td>
</tr>
<tr>
<td>Newcastle upon Tyne Hospitals</td>
<td>Tel: 0191 2824753 (ext 24753)</td>
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<tr>
<th>Named Doctor</th>
<th>Named Nurse</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Caroline Grayson</td>
<td>Margaret Tench</td>
<td>Newcastle upon Tyne Hospitals</td>
</tr>
<tr>
<td>Tel: 0191 2823363 (ext 23363)</td>
<td>Newcastle upon Tyne Hospitals</td>
<td>Tel: 2821069 (ext 21069)</td>
</tr>
<tr>
<td>or via air call</td>
<td>or Dect 2829581 (29581)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospital based</th>
<th>Community based</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Named Nurse: Eileen Wardhaugh</td>
<td>Named Nurse: Vanessa Powell</td>
<td>Newcastle upon Tyne Hospitals</td>
</tr>
<tr>
<td>Newcastle upon Tyne Hospitals</td>
<td>Safeguarding Advice &amp; Support Team</td>
<td>Arthurs Hill Clinic</td>
</tr>
<tr>
<td>Tel: 2829150</td>
<td>Tel: 0191 2195205</td>
<td>Tel: 0191 2195654</td>
</tr>
<tr>
<td>Out of hours Dect: 29261</td>
<td>Fax: 0191 2195654</td>
<td>E-mail: <a href="mailto:ncs-pct.sast@nhs.net">ncs-pct.sast@nhs.net</a></td>
</tr>
<tr>
<td>Fax no: 0191 2826183 (ext26183)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E-mail: <a href="mailto:tnu-tr.safeguardingchildren@nhs.net">tnu-tr.safeguardingchildren@nhs.net</a></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Paediatric Forensic Network</th>
<th>Lead Midwife</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Newcastle upon Tyne Hospitals</td>
<td>Caroline Ruddick</td>
<td>Newcastle Children’s Social Care:</td>
</tr>
<tr>
<td>Switchboard on 0191 2336161</td>
<td>Contact Newcastle Hospitals</td>
<td></td>
</tr>
<tr>
<td>Ext 24753 in working hours</td>
<td>Switchboard on 0191 2336161</td>
<td></td>
</tr>
<tr>
<td>Out of hours via hospital switchboard</td>
<td>Dect: 29759 or ext 25666</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Or out of hours: senior midwife on duty</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Designated Nurse Looked After Children (LAC)</th>
<th>Newcastle Information Sharing and Assessment Team / Contact Point</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mandy Winthrop</td>
<td>Grainne Feigan</td>
<td></td>
</tr>
<tr>
<td>Newcastle upon Tyne Hospitals</td>
<td>Tel: 0191 211 5805</td>
<td></td>
</tr>
<tr>
<td>Tel: 0191 28223008 (ext 23008)</td>
<td><a href="mailto:grainne.feigan@newcastle.gov.uk">grainne.feigan@newcastle.gov.uk</a></td>
<td></td>
</tr>
<tr>
<td>Dect: 0191 28223910 (ext 23910)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Newcastle Children’s Social Care:</th>
<th>Northumbria Police:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Response Team</td>
<td>Vulnerable Person Unit</td>
<td></td>
</tr>
<tr>
<td>Tel: 0191 2772500</td>
<td>North Tyneside Area Command HQ</td>
<td></td>
</tr>
<tr>
<td>Out of Hours Team</td>
<td>Middle Engine Lane</td>
<td></td>
</tr>
<tr>
<td>Tel: 0191 2328520</td>
<td>Wallsend</td>
<td></td>
</tr>
<tr>
<td>West Team</td>
<td>Tyne &amp; Wear</td>
<td></td>
</tr>
<tr>
<td>Tel: 0191 2772111</td>
<td>NE28 9NT</td>
<td></td>
</tr>
<tr>
<td>East Team</td>
<td>Tel: 03456 043043 ext 45175</td>
<td></td>
</tr>
<tr>
<td>Tel: 0191 2788500</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# REFERRAL AND INITIAL INFORMATION RECORD

(To be used by agencies when making a referral to Social Services – A written referral must be made within 48 hours of a verbal referral)

<table>
<thead>
<tr>
<th>SSD Case Numbers</th>
<th>Is the parent/carer aware of the referral?</th>
<th>Yes</th>
<th>No</th>
<th>Re-referral</th>
</tr>
</thead>
</table>

## Child/Young Person’s name, address and responsible Local Authority

<table>
<thead>
<tr>
<th>Family name</th>
<th>Forenames</th>
<th>DoB</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>Tel:</th>
<th>Postcode</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Current address if different from above</th>
<th>Postcode</th>
<th>Tel:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Previous address</th>
<th>Postcode</th>
<th>Tel:</th>
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<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>SSD Team</th>
<th>Responsible Local Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Child/Young Person’s Principal Carers

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship to child/young person</th>
<th>Parental Responsibility</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Referred by

<table>
<thead>
<tr>
<th>Agency/rel. to child/young person</th>
<th>Address</th>
<th>Postcode</th>
<th>Tel:</th>
<th>Date of Referral:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

## Child/young person’s religion

<table>
<thead>
<tr>
<th>Caribbean</th>
<th>Indian</th>
<th>White British</th>
<th>White &amp; Black Caribbean</th>
<th>Chinese</th>
</tr>
</thead>
<tbody>
<tr>
<td>African</td>
<td>Pakistani</td>
<td>White Irish</td>
<td>White &amp; Black African</td>
<td>Any other ethnic</td>
</tr>
<tr>
<td>Any other</td>
<td>Black background</td>
<td>Any other White Background</td>
<td>White and Asian</td>
<td>Not given</td>
</tr>
<tr>
<td>Any other</td>
<td>Asian background</td>
<td>Any other Mixed background</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If other, please specify</td>
<td>Child’s first language</td>
<td>Parent(s)’s first language</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Child/young person’s ethnicity

<table>
<thead>
<tr>
<th>Is an interpreter or signer required?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has this been arranged?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>
### Other household members (including non-family members)

<table>
<thead>
<tr>
<th>Surname</th>
<th>Forename</th>
<th>DoB</th>
<th>Nursery/School</th>
<th>Relationship to child</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

### Significant family members who are not members of child’s household

<table>
<thead>
<tr>
<th>Name</th>
<th>Name</th>
<th>Relationship</th>
<th>Relationship</th>
<th>Address</th>
<th>Address</th>
<th>Tel:</th>
<th>Tel:</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

### Child/young person or other child(ren)/young person(s) in family is/has been on a disability register

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please give details

<table>
<thead>
<tr>
<th>Name</th>
<th>Date(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Child/young person or other child(ren)/young person(s) in family is/has been on a child protection register

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

Please give details

<table>
<thead>
<tr>
<th>Name</th>
<th>Date(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

### Child/young person or other family member(s) has/have been looked after by a local authority

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please give details

<table>
<thead>
<tr>
<th>Name</th>
<th>Date(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

### Key agencies (please tick if currently working with the family)

<table>
<thead>
<tr>
<th>GP</th>
<th>Tel:</th>
<th>H.V.</th>
<th>Tel:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Nursery</th>
<th>Tel:</th>
<th>E.W.O.</th>
<th>Tel:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>School</th>
<th>Tel:</th>
<th>Police</th>
<th>Tel:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Y.O.T.</th>
<th>Tel:</th>
<th>Other SSD</th>
<th>Tel:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Community Mental Health</th>
<th>Tel:</th>
<th>Community Paediatrician</th>
<th>Tel:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>School Nurse</th>
<th>Tel:</th>
<th>Other</th>
<th>Tel:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Other</th>
<th>Tel:</th>
<th>Other</th>
<th>Tel:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>
What supports are currently in place.
**Reason for referral/request for services:**
Identify strengths as well as needs
Considering: Parenting capacity, child development, family and environmental factors

You must state the nature of concern or perceived risk in as much details as possible

Name of worker (completing this referral)
Signature:

**For Social Services use only**

**Further Action:**
- Provision of information and advice
- Initial assessment (to be completed within 7 working days)
- Core assessment (to be completed within 35 working days)
- Referral to other agencies (please state which)
- No further action

**Practice note:** ensure this referral is collated with previous referrals or files

Name of Social Worker:
Signature

Name of Team Manager
Signature:

Allocation Date
Or
NFA Date
Request to Visit Trust from VIP / Celebrity

Visitors must be supervised at all times

**IN HOURS**

The member of staff who receives the call will collate the information e.g. purpose of visit, date, time and who will visit.

Information is passed on to the Matron who will contact the Assistant to Chief Executive and Chairman (Mrs Bessford Ext 26055).

**OUT OF HOURS**

Media / VIP call to ward who contact Patient Services Co-ordinator (PSC) Dect number 24300 (RV1) or 26623 (Freeman hospital). PSC collects details on the proforma. (purpose date, time and who would like to visit)

PSC contacts hospital manager on call via switchboard. The manager on call will make the decision to contact the director on call if necessary.

**Approved**

PSC or supervisor to fill in proforma and ensure written consent is given for photographs and person supervised at all time. The completed proforma is returned to CGARD and a copy to Directorate Managers Office for retention on the next working day.

Media asked to call back in working hours Assistant to Chief Executive and Chairman (Mrs Bessford Ext 26055)

**Not Approved**

Matron to Inform, PSC, Security, area to be visited. Supervisor identified.

Proforma to be completed when visitor/s arrive. Supervisor sends completed sheet to CGARD and a copy to Directorate Managers Office for retention.

NB – In cases where filming or photography involvement there must be written consent signed and stored in the patient’s medical records

Final version 1.7.14
Request to Visit Trust by None VIP / Celebrity
Visitors must be supervised at all times

IN HOURS

The member of staff who receives the call will collate the information e.g. purpose of visit, date, time and who will visit.

Information is passed on to the Matron.

Matron to inform, Security if felt necessary and area to be visited. Supervisor identified.

Proforma to be completed when visitor/s arrive. Supervisor sends completed sheet to CGARD and a copy to Directorate Managers Office for retention.

OUT OF HOURS

Visitor calls ward/department who contact Patient Services Co-ordinator (PSC) with details of visit - Dect number 24300 (RVI) or 26623 (Freeman Hospital).

PSC sanctions or declines visit and identifies supervisor.

Approved

Not Approved

Supervisor to fill in proforma and ensure written consent is given for photographs and person supervised at all time. The completed proforma is returned to CGARD and a copy to Directorate Managers Office for retention on the next working day.

Discuss with relevant Matron in hours

NB – In cases where filming or photography involvement there must be written consent signed and stored in the patient’s medical records

Final version 1.7.14
<table>
<thead>
<tr>
<th>Date</th>
<th>Area visited</th>
<th>Name of ‘visitor’</th>
<th>Media Name/Type, i.e Tyne Tees reporter / Chronicle photographer</th>
<th>Name of Media personnel and contact number</th>
<th>Signature of Media personnel</th>
<th>Name and Title of Trust Staff in attendance responsible for supervision</th>
<th>Authorised by:</th>
<th>Consent for filming given?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>PSC Matron</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>DMT Hospital Manager</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Asst to Chief Exec</td>
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<td>PSC Matron</td>
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<td>DMT Hospital Manager</td>
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<td>DMT Hospital Manager</td>
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<td>DMT Hospital Manager</td>
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<td></td>
<td>Asst to Chief Exec</td>
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</tr>
</tbody>
</table>

Please forward completed forms to Matron for Patient Services / Matron for Children’s Services and a copy to CGARD for retention.
Filming / Photography / Quote
Parental Consent Form

Name of person(s) in filming / photography / providing a quote:

________________________________________________________________________

Date taken:

________________________________________________________________________

Photographer / Interviewer name and details:

________________________________________________________________________

I give my consent for filming / photography and / or quotes given by:

Myself: ___________________________ Signature and date: ______________________

My child: ___________________________ Name of child: ___________________________

Relationship to child: ___________________________ Signature and date: ______________________

to be used by the Newcastle upon Tyne Hospitals NHS Foundation Trust and/or its employees for training and/or publicity in all media (newspapers, leaflets, website, social media etc).

I also give my consent that any photography or filming undertaken by third parties, ie. BBC, Tyne Tees, NCJ Media may also be used by the Trust on its website.

I hereby waive any right that I may have to inspect and approve the finished product or copy that may have been used in connection with any image(s) that the cameraman / photographer has taken of me or the use to which my images or quote may be applied.

Contact address:

________________________________________________________________________

________________________________________________________________________

Contact telephone:

________________________________________________________________________

This form will be retained in the medical notes.
14. Supporting Documentation Relating to Hospital Staff

14.1 The Child Protection List

The Newcastle upon Tyne Child Protection List is accessed through Children’s Safeguarding Standards unit on 0191 2116745 between 9-5pm.

The Out of House Social Care Service can be contacted on 0191 232 8520.

Please have the following information to hand:

- Child/Family Name(s)
- DOB
- Address
- Siblings names and DOB
- Reason for Checking

The list can be accessed by the following:

- Named Nurse Child Protection/Deputy Dect phone: 29150
- Directorate Bleep Holder, NGH & RVI Dect phone: 29261
- Named Midwife
- or Senior Midwife on Duty
- Medical Staff
- Accident /Emergency Staff

Checking the list fulfils several functions including:

a) Informing a concerned professional whether a child is the subject of a current inter-agency Child Protection Plan or was previously subject to a plan.

b) Highlighting an expression of concern about a child. A second enquiry will trigger consideration of that child as being a child in need of assessment/protection and a referral will be made to the appropriate team.

Please note:

Professionals are asked not to request a child protection plan check after 12.00 midnight; unless the circumstances suggest that the check cannot wait until office hours.

A check made during office hours will lead to increased information being available to the person making the enquiry.

Where there appear to be grounds to initiate a child protection investigation, (Section 47 of Children Act) Out of hours Social Care Service will take whatever immediate necessary protective action is indicated.

Please complete a Cause For Concern Form and fax to the Named Nurse for Child Protection.
# 14.2 Cause for Concern Form (hospital)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Report for Named Nurse Child Protection where there is a Cause for Concern / Information Sharing about a child/young person under the age of 18 years or a pregnant woman.

**THIS FORM DOES NOT CONSTITUTE A SOCIAL SERVICES REFERRAL**

<table>
<thead>
<tr>
<th>Child’s Name(s)</th>
<th>DOB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Family Names</td>
<td>GP</td>
</tr>
<tr>
<td>Patients address</td>
<td></td>
</tr>
<tr>
<td>HV/School Nurse</td>
<td></td>
</tr>
<tr>
<td>School</td>
<td></td>
</tr>
<tr>
<td>Siblings Names &amp; DOB</td>
<td></td>
</tr>
</tbody>
</table>

**Reason for Attendance:**

**Concern:**

---

Action taken:

---

Is the child/carer aware of referral? Yes/No

If not, given reason:

---

**Child:** Admitted Wd: Discharged Home: Other:

Have you checked if this child is subject to a Child Protection Plan Yes No

(formerly known as register check)

Are they known to Social Services Yes No

Has a referral form been faxed to Social Services? Yes No

Name/Signature Date Ward

Print Name

---

Please File original in notes then fax a copy of this form to a Named Nurse.

You can also telephone to seek advice, discuss your concerns and action taken in respect of this child. Eileen Wardhaugh or Irene Davidson; contactable on DECT phone 29150 or 0191 2820589

Please Fax Cause for concern Form to 26183 or 0191 282 6183.

Comments by Named Nurse, Child Protection

---

Signature Date

Continue overleaf
### PROFORMA FOR SEXUALLY ACTIVE UNDER 16S

<table>
<thead>
<tr>
<th>NAME:</th>
<th>DOB:</th>
<th>AGE:</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCHOOL:</td>
<td>GP:</td>
<td>PATIENT NUMBER:</td>
</tr>
</tbody>
</table>

| Limits of confidentiality explained | ☐ |

Who is the young person accompanied by?

<table>
<thead>
<tr>
<th>Reason for attendance?</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Living arrangements</th>
<th>(How is your home life / Who lives with you?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□Home</td>
<td>□Relative</td>
</tr>
<tr>
<td>□Friend</td>
<td>□Partner</td>
</tr>
<tr>
<td>□Foster care</td>
<td>□Social service</td>
</tr>
<tr>
<td>□Homeless</td>
<td>□Other</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sexual history</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age of partner</td>
</tr>
<tr>
<td>Unconsensual sex?</td>
</tr>
<tr>
<td>Gifts/bribery</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age at first sexual intercourse</th>
<th>Number of sexual partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any previous unconsensual sex?</td>
<td>Yes ☐</td>
</tr>
</tbody>
</table>

Consider discussing sexual orientation

<table>
<thead>
<tr>
<th>Parental/Carer* knowledge:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has your parent/carer come with you today?</td>
</tr>
<tr>
<td>Does your parent/carer know you have come here today?</td>
</tr>
<tr>
<td>Does your parent/carer know you are having sex?</td>
</tr>
<tr>
<td>Will you tell your parent/carer?</td>
</tr>
</tbody>
</table>

*A carer can only consent for a Young Person if they have parental responsibility

**Fraser guidelines for provision of contraceptive advice/treatment**

It is good practice to follow these criteria when providing sexual health advice to under 16s.

Inform young person of legal position.
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the young person (YP) understand the advice given</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is it likely that the YP will continue to have sex without using contraception or has already had sex in case of emergency contraception?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Is the YP’s physical/mental health likely to suffer if they are not supplied with contraception?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Can the YP be persuaded to inform their parents that he/she is seeking contraceptive advice?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Does their best interest require us to give contraceptive advice, treatment or both without parental consent?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**Statement of competence:**
In my opinion this patient is sufficiently mature to give consent to examination and treatment and to understand advice given to them  

Signed: ................................................................. Name: .................................................................

Designation: ............................................................. Date: .................................................................

Signed: ................................................................. Name: .................................................................

Designation: ............................................................. Date: .................................................................

**Services offered by the clinic discussed (tick which discussed):**
- Confidentiality/information sharing
- Sexual Health Advice
- Free condoms provision
- Full STI screen & HIV testing
- Reimbursement of travel expenses
- Pregnancy testing
- Young peoples services/condom access
- Safer sex
- Counselling Services
- Contraceptive Advice
- Emergency contraception
- Letter for school/college/work offered

**Contact details for young person:**

**Outcome:**
- Discussed with lead for child protection (individual identified in Box 1 of flow chart)
- Referral to Social Services
- No concerns identified
- Cause for Concern Form completed
- Review appointment arranged (if appropriate) – Date: .................................................

Signed: ................................................................. Name: .................................................................

Designation: ............................................................. Date: .................................................................
<table>
<thead>
<tr>
<th>Name of Child:</th>
<th>MRN:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dob:</td>
<td>NHS No:</td>
</tr>
<tr>
<td>Home Address:</td>
<td>Gender:</td>
</tr>
<tr>
<td>(or affix label)</td>
<td>Ward:</td>
</tr>
<tr>
<td></td>
<td>Siblings:</td>
</tr>
<tr>
<td>GP:</td>
<td>School (if applicable):</td>
</tr>
<tr>
<td>H.V.:</td>
<td></td>
</tr>
<tr>
<td>Who has parental responsibility?</td>
<td></td>
</tr>
<tr>
<td>Who is the main carer?</td>
<td></td>
</tr>
<tr>
<td>Legal Order in Place? (specify):</td>
<td></td>
</tr>
<tr>
<td>Reason for Admission:</td>
<td></td>
</tr>
<tr>
<td>Date of Admission:</td>
<td></td>
</tr>
<tr>
<td>Ward Discharged From:</td>
<td>Date:</td>
</tr>
<tr>
<td>Medical Status &amp; Drugs on Discharge:</td>
<td></td>
</tr>
<tr>
<td>Brief Summary of Safeguarding Issues:</td>
<td></td>
</tr>
<tr>
<td>Social Worker:</td>
<td>Contact Details:</td>
</tr>
<tr>
<td>Police Officer:</td>
<td></td>
</tr>
<tr>
<td>Current Safeguarding Plan:</td>
<td></td>
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<tr>
<td>---------------------------</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Any follow up arrangements from this Trust (specify):</th>
<th>Accompanying Documentation list:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Transfer Arrangements:</th>
<th>Date of Transfer:</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>Discharging Consultant:</th>
<th>Discussed with Receiving Consultant (name):</th>
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<tbody>
<tr>
<td></td>
<td>Date Discussed:</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Receiving Ward/Trust:</th>
<th>Discussed with Receiving Ward Staff (name &amp; designation):</th>
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<tbody>
<tr>
<td></td>
<td>Date Discussed:</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Named Nurse (Child Protection - NUTH):</th>
<th>Discussed with Named Nurse, Receiving Hospital (name):</th>
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<tbody>
<tr>
<td></td>
<td>Date Discussed:</td>
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<table>
<thead>
<tr>
<th>Other Comments:</th>
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<table>
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<tr>
<th>Completed by:</th>
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</thead>
<tbody>
<tr>
<td>Name:</td>
</tr>
<tr>
<td>Designation:</td>
</tr>
<tr>
<td>Date:</td>
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</tbody>
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PLEASE NOTE: To be faxed directly from discharging Appendices
### 14.5 Visiting Chart

**The Newcastle upon Tyne Hospitals NHS Foundation Trust**

**VISITING CHARTS**

<table>
<thead>
<tr>
<th>TIME</th>
<th>(a) VISITORS</th>
<th>INPUT Oral</th>
<th>INPUT Other</th>
<th>V</th>
<th>BO</th>
<th>PU</th>
<th>02Sats</th>
<th>GENERAL COMMENTS</th>
<th>SIGNATURE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>F</td>
<td>PGM</td>
<td>PGF</td>
<td>MGM</td>
<td>MGF</td>
<td>Other</td>
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</tbody>
</table>

**Key:**
- M = Mother
- F = Father
- PGM = Paternal Grand Mother
- PGF = Paternal Grand Father
- MGM = Maternal Grand Mother
- MGF = Maternal Grand Father
- V = Vomiting
- BO = Bowels Operation
- PU = Passed Urine

**NAME……………………………………………….       D.O.B………………………………      DATE…………………………………**
<table>
<thead>
<tr>
<th>TIME</th>
<th>(a) VISITORS</th>
<th>INPUT</th>
<th>INPUT</th>
<th>V</th>
<th>BO</th>
<th>PU</th>
<th>02Sats</th>
<th>GENERAL COMMENTS</th>
<th>SIGNATURE</th>
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<td>M  F  PGM  PGF  MGM  MGF  Other</td>
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<td>Other</td>
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</tr>
</tbody>
</table>

Key:  
M = Mother  
F = Father  
PGM = Paternal Grand Mother  
PGF = Paternal Grand Father  
MGM = Maternal Grand Mother  
MGF = Maternal Grand Father  

V = Vomiting  
BO = Bowels Operation  
PU = Passed Urine
**15. Supporting Documentation specific to Community staff**

**15.1 Community CP3 – Information Sharing Form**

**CHILD PROTECTION CONCERN**

Please complete and forward to Safeguarding Advice and Support Team, CLO2/ ncs-pct.sast@nhs.net even if a verbal report has been made.

<table>
<thead>
<tr>
<th>GP</th>
<th>HV</th>
<th>SHA</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Parent /Care’s / Mother</th>
<th>DOB</th>
<th>Parent /Care’s / Father</th>
<th>DOB</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS No</td>
<td></td>
<td>NHS No</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Parent /Care’s / Mother’s Address</th>
<th>Parent /Care’s / Father’s Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Children’s address (if different from mother)**

<table>
<thead>
<tr>
<th>Children (full names)</th>
<th>M / F</th>
<th>NHS No</th>
<th>DOB</th>
<th>School</th>
<th>Status:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>C-Concern CPP- Child Protection Plan CIN – Child in Need D-Discontinued plan LAC – looked after Child</td>
</tr>
<tr>
<td>1.</td>
<td></td>
<td></td>
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<tr>
<td>2.</td>
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<td>3.</td>
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<td>4.</td>
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<td>5.</td>
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<tr>
<td>6.</td>
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<td>7.</td>
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</tr>
</tbody>
</table>
CONCERNS IDENTIFIED: Please detail concerns (eg substance misuse, mental health, domestic violence, allegations etc)

| ACTION TAKEN (eg: referrals to other agencies / information shared) |

<table>
<thead>
<tr>
<th>Signed</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Telephone</td>
</tr>
</tbody>
</table>

CP3
# Community CP4 Strategy Meeting Record Form

## CHILD PROTECTION STRATEGY MEETING – RECORD FORM

**Date of Meeting:**  
**Subject/s:**

**Address:**

<table>
<thead>
<tr>
<th>Family Details:</th>
<th>Name:</th>
<th>Date Birth: of</th>
<th>Childcare/School:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Father:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Other relevant family members / carers:**

**Professionals Involved (In bold if attended mtg):**

<table>
<thead>
<tr>
<th>Professionals</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Visitor:</td>
<td></td>
</tr>
<tr>
<td>PHN/School Health Advisor</td>
<td></td>
</tr>
<tr>
<td>Midwife:</td>
<td></td>
</tr>
<tr>
<td>GP:</td>
<td></td>
</tr>
<tr>
<td>Social Worker:</td>
<td></td>
</tr>
<tr>
<td>Team Leader:</td>
<td></td>
</tr>
<tr>
<td>Education:</td>
<td></td>
</tr>
<tr>
<td>Childcare:</td>
<td></td>
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<tr>
<td>Police:</td>
<td></td>
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<tr>
<td>Legal:</td>
<td></td>
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<tr>
<td>SAST:</td>
<td></td>
</tr>
</tbody>
</table>
15.3 Community CP5 Record of Multi Agency Meeting

Please complete and forward to Safeguarding Advice and Support Team, CLO2/ncs-pct.sast@nhs.net

even if a verbal report has been made.

Report Following Attendance at a Multi-Agency Meeting

Please complete and forward to Safeguarding Advice and Support Team/ncs-pct.sast@nhs.net

Held at CSC Cruddas Park / Walker / Sheriff Lees Children’s Social Care

<table>
<thead>
<tr>
<th>Start Time</th>
<th>End Time</th>
<th>Date</th>
</tr>
</thead>
</table>

GP | HV | SHA |

<table>
<thead>
<tr>
<th>Mother</th>
<th>DOB</th>
<th>Father</th>
<th>DOB</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS No</td>
<td>NHS No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother’s Address</td>
<td>Father’s Address</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Children’s address (if different from mother)

<table>
<thead>
<tr>
<th>Children (full names)</th>
<th>M / F</th>
<th>NHS No</th>
<th>DOB</th>
<th>School</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
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<td>2.</td>
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<td>6.</td>
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</tbody>
</table>

Reason

Meeting Type (tick)

Core Team Meeting
Care Team Meeting
Professionals Meeting
Planning Meeting
Initial / Review CPC

Status:
C-Concern
CPP- Child Protection Plan
CIN – Child in Need
D-Discontinued plan
Decisions – (include input provided/ required from Health Professionals and any other significant information eg. Changes to the Plan, Parental issues which impact on their ability to safeguard their children etc. There is no need to re-document the whole Plan after each meeting.)

For GP practices only: enter appropriate computer coding below using information from ‘Status’ and ‘Category’ above Note: For all conferences enter code 3875 (social services case conference)

<table>
<thead>
<tr>
<th>STATUS</th>
<th>Read code</th>
<th>Code term (add freetext where indicated)</th>
<th>CATEGORY</th>
<th>Read code</th>
<th>Code term</th>
</tr>
</thead>
<tbody>
<tr>
<td>R</td>
<td>13IM</td>
<td>Child on protection register + freetext ‘Placed on register’</td>
<td>P</td>
<td>13ZT</td>
<td>At risk of physical abuse</td>
</tr>
<tr>
<td>M</td>
<td>13IM</td>
<td>Child on protection register + freetext ‘Maintained’</td>
<td>S</td>
<td>13ZW</td>
<td>At risk of sexual abuse</td>
</tr>
<tr>
<td>N</td>
<td>64c</td>
<td>Child protection procedure + freetext ‘Not registered’</td>
<td>E</td>
<td>13ZR</td>
<td>At risk of emotional abuse</td>
</tr>
<tr>
<td>D</td>
<td>13IO</td>
<td>Child removed from register</td>
<td>N</td>
<td>13ZV</td>
<td>At risk of neglect</td>
</tr>
<tr>
<td>Def</td>
<td>64c</td>
<td>Child protection procedure + freetext ‘Registration decision deferred’</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Key Worker
Care Team

Signed     Telephone 219 5202     Date

CP5
### Community CP6 Change of Circumstance Form

**Internal & External Transfer of Child Protection/Child In Need/ Looked After/Cause for Concern Records**  
(Delete as appropriate)

This form is to be used by the health professional when transferring families within and out of Newcastle upon Tyne and must be completed at all times.

It is the responsibility of the professional transferring case responsibility to notify all interested parties of the changes i.e. Safeguarding Team and health professional newly appointed to the family. Please complete and attach to records for transfer out of area. If internal transfer, please complete and send to the Safeguarding Team, but send the records directly to the receiving health professional.

<table>
<thead>
<tr>
<th>Family Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Children:</strong></td>
</tr>
<tr>
<td>Name:</td>
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<td>Name:</td>
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<td>Name:</td>
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<td>Name:</td>
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<table>
<thead>
<tr>
<th>Parent(s)/Carer(s):</th>
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<tbody>
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</table>

<table>
<thead>
<tr>
<th>Previous Details:</th>
<th>New Details:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>Address:</td>
</tr>
<tr>
<td>Health Visitor / Public Health Nurse: (Name / Address / Contact No.)</td>
<td>Health Visitor / Public Health Nurse: (Name / Address / Contact No.)</td>
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<tr>
<td>School:</td>
<td>School:</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Other Known Professionals:</th>
</tr>
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<tbody>
<tr>
<td>S/W</td>
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<tr>
<td>S/W</td>
</tr>
<tr>
<td>Summary of family history, Children's Services involvement &amp; any orders in place (CP/CIN/LAC/CFC):</td>
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<tr>
<td>-------------------------------------------------------------------------------------------------------------------------------</td>
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<thead>
<tr>
<th>Summary of current concerns and input to date:</th>
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<tbody>
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<thead>
<tr>
<th>Action required by receiving health professionals:</th>
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<tbody>
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<table>
<thead>
<tr>
<th>Any risk / safety issues for staff?  Yes ☐  ☐  p ☐</th>
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<th>Signed:</th>
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<th>Date:</th>
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<tr>
<th>Print Name:</th>
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<tr>
<th>Telephone contact no:</th>
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</table>

CP6
15.5 Community Multi use Safeguarding Form

Forward to the Safeguarding Advice and Support Team, ncs-pct.sast@nhs.net even if a verbal report has been made.

**Multi-Purpose Safeguarding Children Form (Community)**

A. Cause for Concern (Parts 1 & 2 to be completed following identification of all concerns) ☐ (Please tick which applies)

B. Information feedback from meetings etc. (Parts 1 & 2) ☐

C. Supervision (Parts 1 & 3) ☐

<table>
<thead>
<tr>
<th>Professional</th>
<th>Name</th>
<th>Base</th>
<th>Is this a change from previous notification?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Visitor</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>PHSN</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Worker</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Child/ren (full names)</th>
<th>M / F</th>
<th>Dob</th>
<th>NHS No</th>
<th>Address (if different from mother)</th>
<th>School</th>
<th>Status*: See key below</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<table>
<thead>
<tr>
<th>STATUS</th>
<th>Computer coding for General Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>C</td>
<td>Concern 13If (XaMzr)</td>
</tr>
<tr>
<td>CPP</td>
<td>Child Protection Plan 13IV (XaOnx)</td>
</tr>
<tr>
<td>CIN</td>
<td>Child in Need 13IS (XaEFq)</td>
</tr>
<tr>
<td>D</td>
<td>Discontinued plan 13 IW (XaOtl)</td>
</tr>
<tr>
<td>LAC</td>
<td>Looked After Child 13 IB (13IB)</td>
</tr>
</tbody>
</table>

Is this a Private Fostering Arrangement? Yes ☐ No ☐

<table>
<thead>
<tr>
<th>Relationship to Child/ren</th>
<th>Name</th>
<th>Date of Birth</th>
<th>NHS No</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Biological Father</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother’s Partner (if different from father of child)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Significant others (specify)</td>
<td></td>
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</tbody>
</table>
PART 2 (Use R.O.P.E)

CONCERNS IDENTIFIED: Please detail concerns (eg substance misuse, mental health, domestic violence, neglect, physical, emotional, sexual, non-engagement, learning disabilities, 3rd party allegations, exploitation, FGM, Honour Based Violence etc)

If this is information feedback following a multi-agency meeting please identify type and specify date and venue

<table>
<thead>
<tr>
<th>Strategy Meeting</th>
<th>☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conference (state type)</td>
<td>☐</td>
</tr>
<tr>
<td>Professionals Meeting</td>
<td>☐</td>
</tr>
<tr>
<td>Other (state type)</td>
<td>☐</td>
</tr>
</tbody>
</table>

R

O

ACTIONs TAKEN (eg: referrals to other agencies / information shared)

Has a Referral to Children's Social Care been made as a result of this information Yes/ No (if yes attach a copy and forward to SAST)

P

E

<table>
<thead>
<tr>
<th>Signed</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name and Role</td>
<td>Telephone</td>
</tr>
</tbody>
</table>

CC (please tick all that apply)
Confidential File ☐ GP ☐ School Health Advisor ☐ Health Visitor ☐
PART 3
For Supervision Use (Part 1 to be completed prior to supervision)

Section 1 (summary of involvement/ significant events/ concerns/ risks/ protective factors since last supervision)

Section 2
   a. Agreed Actions by practitioner and timescale:

   b. Agreed Actions by supervisor and timescale:

Signature of Supervisor  Date

Signature of Practitioner  Date

Is there good practice in this case that could be shared through the Appreciative Inquiry Panel of the NSCB  Y/N

Cc Child/ family confidential file
Cc Practitioner’s supervision file
15.6 Community Intelligence Form

Police / Community Intelligence and Information sharing form.

Date Time

Person completing form:

Name: Tel. No:
Address:

Source of Information: (if different from person completing form):

Is the source of the information willing to speak to the Police? Yes No

Name: Tel. No:
Address:

Information/concerns – (see guidelines):

Please continue on a separate sheet of paper if necessary

Details of adults &/or child/ren/ young people if known

<table>
<thead>
<tr>
<th>Name</th>
<th>DOB</th>
<th>AGE</th>
<th>Address &amp; Tel. No.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

Fax or email to: Named Nurse, Child Protection on 0191 219 5654 or ncs-pct.sast@nhs.net

RESTRICTED
For Intelligence Notification Purposes Only
Guidance notes for completion of the Police/ Community Intelligence and Information Sharing Form

1. Background

It was identified that staff working with young people, in particular, may become aware of an emerging picture of concerns, recurrent and similar information about people, places or activities or just snippets of information which left staff feeling uneasy, and there was nowhere to record or share this inconclusive or vague information.

Following discussions between the Named Nurse for Child Protection, senior Sexual Health Nurses and the Police Intelligence Unit (PIU), this form was devised so that information and concerns could be recorded and shared, allowing the Police to build a better picture and target Community Police resources more appropriately, especially where children and young people may be at risk of exploitation or abuse.

2. Process

The information provided by professionals should be forwarded to the Safeguarding Advice and Support Team (SAST) in the same way as a CP3 (Cause for Concern form) is currently and the Named Nurse will ensure that it is forwarded to the PIU, based at Etal Lane Police Station.

The Sergeant in the PIU will log all the information by recording it on their Confidential Source Database and will disseminate it daily to the local Beat Managers for the appropriate area that the information relates to. The names of professionals and the source of any information will be kept secure and will not be disclosed.

3. Types of useful information to be included on the form

a) General Intelligence

- Information about specific/ general areas i.e. Parks, Streets, houses etc
- Information about people involved i.e. males/ females, ages, ethnic origins
- Information about activities i.e. drugs/ alcohol, sexual activity, parties etc
- Information about the frequency of concerns i.e. one off, daily, weekly etc.

b) Potential Criminal Activity

- Who is involved
- Where is it taking place
- What is the activity
- Any known or suspected associates
- Any vehicles which may be used
- Areas that may be targeted i.e. children’s homes, schools, youth groups etc.
- How the activity is carried out i.e. in a car, with a weapon, via mobile/ internet communication etc
- How any stolen goods/ drugs/ etc. may be disposed of and where
• Any known or suspected motives i.e. drugs, money, sexual activity etc.

c) Sexual Offences (Sexual Assault, anonymous referral form may be attached if appropriate)

• Is the victim (or disclosee) willing to speak to the Police?
• What are the circumstances of the offence?
• Is/ was the offender known to the victim and or the Police?
• Where was the location of the offence? – the more precise the better as CCTV may be available
• Was this a one-off event or has it happened previously/ repeatedly?
• Does the victim know of any other victims?

d) Provenance

• How the professional knows this information i.e. seen it, overheard it, been told it
• If the information is second hand, who told the professional and would they be willing for their name to be shared with the police?
• Did the information come from a victim, an associate or was it rumour?

e) General comments

• The professional’s thoughts on the information, i.e. is it likely to be true?
• Does the information, if second hand, come from someone who is thought to be reliable or have they been known to fabricate stories, do they have mental health, substance misuse problems?
• Has similar information been heard before or from a different source?
• Does this information link with other information known?

f) Description checklist

A - Age
B - Build
C - Clothing
D - Distinguishing marks – tattoos, scars, acne etc
E - Elevation/ height
F - Features – skin colour, ethnicity, beard, glasses etc
G - Gait – limp, way of walking
H - Hair – colour, style, length, condition
Appendix 1

Definitions and Glossary of Terms:

1. Definitions:

1.2 LSCB: The Children Act 2004 requires each local authority to establish a Local Safeguarding Children's Board (LSCB). This is a Board of senior managers from different services and agencies in a local area. The core functions of the LSCB are in relation to safeguarding and promoting the welfare of children:

- Development and implementation of policies and procedures in relation to safeguarding and promoting the welfare of children in the area of authority
- Communicating and raising awareness
- Monitoring and evaluation
- Participating in planning and commissioning
- Reviewing the deaths of children
- Serious case reviews
- Ensuring all agencies, including voluntary and private sector agencies that provide services to children and families, work together to ensure appropriate systems and services are in place to safeguard and promote the welfare of children.
- Ensuring that employees have the appropriate training and supervision to enable them to carry out their duties in respect of this.

1.3 Safeguarding and promoting the welfare or children is defined under the Children Acts 1989 and 2004 as:

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

1.4 A Child is anyone who has not yet reached their 18th birthday, therefore child refers to children and young people whatever their:

- Race, religion, first language or culture
- Gender of sexuality
- Age
- Health or disability
- Location or placement
- Involvement in any criminal behaviour
- Political or immigration status

1.5 Significant Harm is not clearly defined in the Children Act 1989 however the following guidance to aid identification is as follows: ill-treatment or the impairment of health or development, including the impairment suffered from seeing or hearing the ill-treatment of another; ‘development’ means physical, intellectual, emotional, social or behavioral development; ‘health’ means physical or mental health; and ‘ill-treatment’ includes sexual abuse and forms of ill-treatment which are not physical. The definition of ‘harm’ in the term Significant Harm was recently extended so that it is made explicit that harm may include “impairment suffered from seeing or hearing the ill treatment of another” i.e.
highlighting the impact of domestic abuse on children. (This amendment to the Children Act 1989 was made in section 120 of the Adoption and Children Act 2002, which came into effect on 30 January 2005.)

1.6 Child protection is the process of protecting individual children identified as either suffering, or at risk of suffering, significant harm as a result of abuse or neglect.

1.7 Abuse and neglect are forms of maltreatment. A person may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children and young people may be abused in a family or in an institutional or community setting; by those know to them or, more rarely, by a stranger.

1.8 Every Child Matters is a national framework and sets out 5 outcomes which are key to children and young people's well-being, they are;

- To be healthy
- To stay safe
- To enjoy and achieve
- To make a positive contribution
- To achieve economic well-being

1.9 Categories of Abuse

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

1.11 Emotional abuse is the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child’s emotional development. It may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may include not giving the child opportunities to express their views, deliberately silencing them or ‘making fun’ of what they say or how they communicate. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond the child’s developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction. It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying (including cyber-bullying), causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.

1.12 Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet). Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.
REMEMBER

A child under 13 years is not legally capable of consenting to sexual activity. Any offence under the Sexual Offences Act 2003 is very serious and should be taken to indicate a risk of significant harm to the child. Any concerns should be discussed with the Named Nurse and there should be a presumption that the case will be reported to Children’s Services.

1.13 Neglect is the persistent failure to meet a child’s basic physical and/or psychological needs, likely to result in the serious impairment of the child’s health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to:

- Provide adequate food, clothing and shelter (including exclusion from home or
- Abandonment); protect a child from physical and emotional harm or danger;
- Ensure adequate supervision (including the use of inadequate care-givers); or
- Ensure access to appropriate medical care or treatment.

It may also include neglect of, or unresponsiveness to, a child’s basic emotional needs.

1.14 Signs of abuse

Many of these signals could be associated with a child under stress. They may not necessarily indicate that a child is being abused or is at risk of abuse. However, a number of these signs together with inadequate explanations of how/why they occurred would give cause for concern.

<table>
<thead>
<tr>
<th>Physical Abuse</th>
<th>Emotional Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multiple bruising/scratching</td>
<td>Self harm</td>
</tr>
<tr>
<td>Adult bite marks</td>
<td>Developmental delay</td>
</tr>
<tr>
<td>Outline bruising e.g. belt, hand</td>
<td>Eating disorders</td>
</tr>
<tr>
<td>Bruises to eyes and ears</td>
<td>Poor self image</td>
</tr>
<tr>
<td>Finger tip bruises</td>
<td>Unwilling to join in</td>
</tr>
<tr>
<td>Burns and scalds</td>
<td>Fear of failure (lack of confidence)</td>
</tr>
<tr>
<td>Cigarette burns</td>
<td>Few friends</td>
</tr>
<tr>
<td>Difficulty in moving limbs</td>
<td>Low self esteem</td>
</tr>
<tr>
<td>Blood in white of eyes</td>
<td>May bully others</td>
</tr>
<tr>
<td>Injuries to babies not yet mobile</td>
<td>Difficulty in forming relationships</td>
</tr>
<tr>
<td>Injury to the mouth</td>
<td>Fear of new situations</td>
</tr>
<tr>
<td>Drowsiness from head injury or poisoning</td>
<td>Obsessive rocking, thumb-sucking</td>
</tr>
<tr>
<td>Aggressiveness or withdrawn</td>
<td>Attention seeking behaviour</td>
</tr>
<tr>
<td>Poor concentration</td>
<td>Witnessing domestic violence</td>
</tr>
<tr>
<td>Sexual Abuse</td>
<td>Neglect</td>
</tr>
<tr>
<td>-------------------------------------------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td>Injuries to genital/anal area</td>
<td>Delayed physical development</td>
</tr>
<tr>
<td>Sexually transmitted diseases</td>
<td>Underweight and small stature</td>
</tr>
<tr>
<td>Unwanted pregnancy</td>
<td>Overweight (or obese)</td>
</tr>
<tr>
<td>Bruises, scratches, burns or bites</td>
<td>Chronic nappy rash</td>
</tr>
<tr>
<td>Eating disorders</td>
<td>Slow growth</td>
</tr>
<tr>
<td>Self harm</td>
<td>Frequently smelly</td>
</tr>
<tr>
<td>Bleeding from vagina or anus</td>
<td>Persistently dirty</td>
</tr>
<tr>
<td>Pain in passing urine or faeces</td>
<td>Persistently hungry</td>
</tr>
<tr>
<td>Persistent discharge</td>
<td>Impairment of health</td>
</tr>
<tr>
<td>Frequent masturbation</td>
<td>Infections slow to clear up</td>
</tr>
<tr>
<td>Wetting, soiling, smearing excreta</td>
<td>Persistent head lice</td>
</tr>
<tr>
<td>Sexual awareness inappropriate to developmental stage</td>
<td>Low self esteem</td>
</tr>
<tr>
<td>Acting out sexual activity</td>
<td>Destructive tendencies</td>
</tr>
<tr>
<td>Aggression/withdrawal</td>
<td>Stealing/hiding food</td>
</tr>
</tbody>
</table>

1.15 Common Assessment Framework (CAF): this is a process of gathering and interpreting information to decide what help a child or parent/carer needs to promote the welfare of the child. The CAF is structure to help practitioners undertake and record the process and to decide, with the child and family as appropriate what support and services are needed. The aims of the CAF are:

- To provide a national, more standardised approach to assessing children’s’ needs.
- The CAF introduces a common framework that can be used by the whole of the children’s workforce.
- Promote earlier intervention.
- Improve joint working and communication and sharing of information.
- Rationalise assessments

1.16 Initial Child Protection Conference: a multi agency meeting that brings together the child (where appropriate), family members, professionals that are directly involved with the child and family and professionals whose contribution relates to their professional expertise or responsibility for relevant services. The purpose of the meeting is for the conference to decide:

- Whether or not a child is at risk of continuing significant harm, or significant harm in the future.
- If the child requires a child protection plan
- What action is needed to safeguard and promote the child’s welfare
- Development of the plan to promote and safeguard the child’s welfare

1.17 Child Protection Review Conference: a multi agency meeting that brings together the child (where appropriate), family members, professionals that are involved with the child and family and professionals whose contribution relates to their professional expertise or responsibility for relevant services. The purpose of the review is to:

- Review the safety and health and development of the child.
- Ensure that the child safe from harm
- Consider whether the child protection plan is still required or if it needs to be changed.
- Ensure that the child protection plan is being implemented.

1.18 Looked After Child Review: a multi agency meeting that brings together the child (where appropriate), family members, and foster carers, professionals that are involved with the child and family and professionals whose contribution relates to their professional expertise or responsibility for relevant services. These meetings are held when a child is in the care of the local authority rather than their parents. The purpose of the review is to:

- Review the safety
- Health and development of the child
- Ensure that the care plan is being implemented, the outcomes monitored and changes to the plan made as appropriate.

1.19 Child in Need/ Complex Child In Need meeting (that is formally reviewed): a multi agency meeting that brings together the child (where appropriate), family members, professionals that are involved with the child and family and professionals whose contribution relates to their professional expertise or responsibility for relevant services. This meeting (and any involvement with the child or family), is only carried out with child or family’s consent. This work is done with the aim of promoting the welfare of the child. In these circumstances, the child is not believed to be at risk of significant harm, but the family and child are deemed to require services to prevent the likelihood of significant impairment of the child’s health or development, or to increase the likelihood of the child achieving or maintaining a reasonable standard of health and development. The purpose of this meeting is to:

- Review the health and development of the child.
- Consider whether the child in Need plan is still required or if it needs to be changed.
- Ensure that the child in Need plan is being implemented.

1.20 Core Group meeting: a multi agency meeting that brings together the child (where appropriate), family members, and professionals who are directly involved with the child and family when working with them on a child protection or looked after basis. The purpose of this meeting is to:

- Review the safety and health and development of the child.
- Share information.
- Ensure the plan is implemented and decide on the finer detail.
- Make any necessary minor changes to the plan.
- Make decisions jointly regarding the child’s future and take these decisions to the larger more formal meetings.

1.21 Care Team meetings: a multi agency meeting that brings together the child (where appropriate), family members, and professionals who are directly involved with the child and family when working with them on a child in need basis. The purpose of this meeting is to:
- Review the health and development of the child.
- Share information.
- Ensure the plan is implemented and decide on the finer detail.
- Make any necessary changes to the plan.

1.22 Caldicott Guardian: is responsible for overseeing how staff use patient identifiable information. The Guardian will agree and monitor protocols for sharing information across organisational boundaries, safeguard the security of the information and ensure that the patient’s rights to confidentiality are respected.

1.23 Guardian ad Litem / Children and Family Court Advisor: This is an independent professional (usually from a social work background), who is appointed by the court to represent the child’s best interests when making plans for the child’s care.

1.24 Local Authority Designated Officer (LADO)
Working Together 2010 outlined significant changes made to the process of managing allegations against people working with children. The criteria for managing these cases now applies to a wider range of allegations than those previously. It also caters for cases of allegations that might indicate that the alleged perpetrator is unsuitable to continue to work with children in his or her present position, or in any capacity. The procedures should be used in all cases in which it is alleged that a person who works with children has:

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

A further significant change is that clear timescales are now laid down in respect of managing the process of investigation around the 3 elements below:-

- Criminal Investigation
- Child Protection concerns
- Disciplinary matters

Working Together also states that Local Authorities should have in place a Local Authority Designated Officer (LADO) and this person has overall responsibility for ensuring that all organisations operate procedures for dealing with allegations in accordance with the guidance in Working Together, resolving any inter-agency issues; and liaising with the Local Safeguarding Children Board. In particular the LADO is responsible for:

- Raising awareness
- Providing professional advice and guidance to organisations on all allegations relating to individuals working with children.
- Providing ongoing liaison and consultation on cases
- Monitoring and reviewing and recording progress, including timescales
- Maintaining a data set
- Attending/convening strategy discussions
1.26 Independent Safeguarding Authority (ISA)
ISA’s role is to help prevent unsuitable people from working with children and vulnerable adults. It will assess every person who wants to work or volunteer with vulnerable people. Potential employees and volunteers will need to apply to register with the ISA. Applicants will be assessed using data gathered by the Criminal Records Bureau (CRB), including relevant criminal convictions, cautions, police intelligence and other appropriate sources. Using this information ISA will decide on a case-by-case basis whether each person is suited to this work. It will securely store information about people’s ISA status for employers and voluntary organisations to use when they are recruiting. Only applicants who are judged not to pose a risk to vulnerable people can be ISA-registered. Once the scheme has been fully rolled out, employers who work with vulnerable people will only be allowed to recruit people who are ISA-registered.

1.27 The legal definition of a privately fostered child
The Children Act 1989, Children Act 2004 and the Private Fostering Arrangements 2005, defines a child to be Privately Fostered when he/she is under the age of 16 (under 18 if disabled) and is cared for, for a consecutive period of 28 days, by someone other than:

- his/her parents (includes an unmarried or putative father)
- a person who has Parental Responsibility for him/her, but is not his/her parent
- a sibling
- a close relative, for example, aunt, uncle, stepparent or grandparent (can be by full or half-blood or by affinity or step-parent but not a cousin, great aunt/uncle or a family friend).

Private Fostering Arrangements are irrespective of financial rewards. The 28 days may be broken by short breaks, but is deemed to be continuous if the care is expected to resume at the end of the short break. A child is not Privately Fostered if it is looked after by the Local Authority.

Prevalence
There are estimated to be over 10,000 children in the UK who are currently being privately fostered, many of whom are not officially identified as such. Very often circumstances can arise where a birth parent feels that it would be best for them to make an arrangement for their child to be cared for (often temporarily) by someone else ie. when a couple separate or divorce, when a single parent takes up employment away from home or abroad, or when a child comes from abroad, for instance, to study and who are cared for by others whilst their birth parents remain overseas.

Your responsibility
If you become aware, or suspect, that a child fits the criteria above, you have a responsibility to make a referral to the Local Authority Children’s Social Care. You should inform the carers and the child, if appropriate, of your intentions.

Local Authority responsibility
Children’s Social Care staff will check upon the suitability of the private foster carers and other members of their household, will also make regular visits to the child and offer advice to the foster carer/s. They will monitor the standard of care the child receives.
1.28 Inspections
The Care Quality Commission has begun formal inspections of the Local Authority and partner agencies arrangements for Privately Fostered children, in the same way as it inspects services provided to Looked After Children and general Safeguarding/ Child Protection provision.

1.29 Multi Agency Public Protection Arrangements / meetings (MAPPA):
These are statutory multi-agency meetings which are held to develop plans to reduce the risks posed to the public and or specific individuals, from sexual or violent offenders who have been assessed as posing a high risk of harm to others.

Staff have a duty to share relevant information when requested (Ministry of Justice 2009), to aid the development of safe plans that will protect those identified as being at risk from the offender and contact the SAST if further advice is required.

1.30 Multi Agency Risk Assessment Conferences (MARAC):
These are non-statutory meetings that are held to develop plans to manage the risks posed to a specific individual who has been assessed as being at ‘very high risk’ of harm from a perpetrator of domestic abuse.

The Trust has agreed that staff will share relevant information when requested to aid the development of safe plans that will protect those identified as being at ‘very high of harm’ (see ‘CAADA’ link in Appendix 2 for further guidance) and contact the SAST if further advice is required.

1.31 Child Death Overview Panel (CDOP):
In 2008 the Government, as part of their Safeguarding Children arrangements, advised all LSCBs to put in place a multi-agency process that would enable the review the deaths of all children aged 0-18yrs. The remit of the meeting is to look at whether or not there are any lessons to be learnt with regard to improving practice and improving the health and safety of children.

Those staff who have involvement with a child who dies unexpectedly, will be invited to a multi-agency meeting to discuss the life of the child, the circumstances leading to their death and what support or services the family/parents may benefit from (for further information see ‘Working Together to Safeguard Children, 2010’).
# The Newcastle upon Tyne Hospitals NHS Foundation Trust
## Equality Analysis Form A

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

**PART 1**

1. **Assessment Date:** 7th Oct 2014

2. **Name of policy / strategy / service:**
   
   Child Protection and Safeguarding Children Policies and Procedures

3. **Name and designation of Author:**
   

4. **Names & Designations of those involved in the impact analysis screening process:**
   
   Eileen Wardhaugh Named Nurse Child Protection / Lucy Hall Equality and Diversity Lead

5. **Is this a:**
   
   Policy ✗ Strategy ☐ Service ☐

   **Is this:**
   
   New ☐ Revised ✗

   **Who is affected:**
   
   Employees ☐ Service Users ☐ Wider Community ✗

6. **What are the main aims, objectives of the policy, strategy, or service and the intended outcomes?** *(These can be cut and pasted from your policy)*

   These policies and procedures are designed to ensure all Trust staff understand their responsibilities when they have concerns about the safety or welfare of a child/young person and the actions that need to be taken. It also provides guidance to support staff in undertaking their role in specific areas of child protection and safeguarding children.
7. Does this policy, strategy, or service have any equality implications? Yes

If No, state reasons and the information used to make this decision, please refer to paragraph 2.3 of the Equality Analysis Guidance before providing reasons:

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8. Summary of evidence related to protected characteristics

<table>
<thead>
<tr>
<th>Protected Characteristic</th>
<th>Evidence i.e. What evidence do you have that the Trust is meeting the needs of people in various protected Groups related to this policy/service/strategy – please refer to the Equality fact files available via the link below</th>
<th>Does evidence/engagement highlight areas of direct or indirect discrimination? If yes describe steps to be taken to address (by whom, completion date and review date)</th>
<th>Does the evidence highlight any areas to advance opportunities or foster good relations. If yes what steps will be taken? (by whom, completion date and review date)</th>
</tr>
</thead>
</table>
| Race / Ethnic origin (including gypsies and travellers) | FGM and Honour Based Violence and Forced Marriage are incorporated into the policy  
You’re Welcome assessment in children and young people’s services considers protected characteristics  
Provision of Interpreting service  
EDHR Training | Use of professional interpreters is associated with improved quality of clinical care and outcomes, use of services, patient satisfaction and reduction in communication errors. Lack of interpreting was found to produce adverse effects for patients and practitioners.  
Not meeting communication needs could cause indirect discrimination | Cultural and religious needs are considered within Safeguarding Children Training |
| Sex (male/ female)                          | Integral through the policy that the needs of men and women, boys and girls are assessed individually regardless of gender | No | No |
| Religion and Belief                         | Chaplaincy Team  
Respecting religious and cultural beliefs policy | Religious practices support families but they can become abusive. For example distressing practices such as ‘casting out of demons’ | Cultural and religious needs are considered within Safeguarding Children Training |
| Sexual orientation including lesbian,       | You’re Welcome assessment in children and young people’s services considers protected characteristics | Bullying is experienced by 30-50% of LGB young people compared to | Clarify that Safeguarding Children Training include consideration of young LGB people who may not be supported by their parents or the wider community |
| gay and bisexual people | EDHR Training  
Links with MESMAC; SHINE; West End Youth Enquiry Service and Teenage Kicks | 10-20% of young people in general  
78% of LGB under 18 experienced verbal abuse and 23% have been attacked by other pupils. | Action: EW to discuss with the new Trust Safeguarding Trainer to incorporate the above in training when she comes into post end November 14. |
| Age | Policy applies only to under 18 years.  
The policy references the issues related to different age groups within this and what staff should do. The policy talks about the need to involve young people in making a decision about their health. Issues around confidentiality covered.  
Policy identifies the need to work in partnership with parents/carers and young people  
You’re Welcome accreditation in 32 services | No | No |
| Disability – learning difficulties, physical disability, sensory impairment and mental health. Consider the needs of carers in this section | The policy identifies that disabled children are more vulnerable.  
Impact of the needs of parents and carers in relation to their ability and needs to provide safe care are considered and addressed within the policy  
You’re Welcome assessment in children and young people’s services considers protected characteristics  
EDHR Training | The policy identifies that disabled children are more vulnerable.  
Young carers are often ‘invisible’ and their needs are neglected. | Safeguarding Children Training include consideration of young carers and refers to disability pathways; learning disability pathways and passport |
| Gender Re-assignment | You’re Welcome assessment in children and young people’s services considers protected characteristics  
EDHR Training | Existing evidence suggests that trans people experience is badly affected by, transphobia, in a wide range of forms. This includes bullying and discriminatory treatment in schools, harassment and physical/sexual assault and rejection from families, work colleagues and friends. | Clarify that Safeguarding Children Training include consideration of gender identity  
Action: EW to discuss with the new Trust Safeguarding Trainer to incorporate the above in training when she comes into post end November 14. |
| Marriage and Civil Partnership | No relevant evidence | No | No |
| Maternity / Pregnancy | The policy identifies that:  
Pregnant Mothers:  
Young women may be seen in areas such as midwifery or gynaecology. | Safeguarding Children Training include consideration of Maternity and Pregnancy |
the Emergency Department (ED) and in the community. These women, and their babies, may be at risk from domestic violence, drug and alcohol abuse or may be victims of sexual abuse. The appropriate Safeguarding Team should be contacted to share any concerns. It states that their needs and the need of the unborn child should be assessed and monitored. Policy identifies the need to work in partnership with parents/carers and young people.

9. **Are there any gaps in the evidence outlined above. If ‘yes’ how will these be rectified ?**

   No

10. **Engagement has taken place with people who have protected characteristics and will continue through the Equality Delivery System and the Equality Diversity and Human Rights Group. Please note you may require further engagement in respect of any significant changes to policies, new developments and or changes to service delivery. In such circumstances please contact the Equality and Diversity Lead or the Involvement and Equalities Officer.**

   Do you require further engagement  Yes  No

11. **Could the policy, strategy or service have a negative impact on human rights? (E.g. the right to respect for private and family life, the right to a fair hearing and the right to education?)**

   No
(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified, please refer to the Policy Author identified above, together with any suggestions for action required to avoid/reduce the impact.)