Clinical Guideline

CHILD PROTECTION IN CLINICAL PRACTICE

SETTING       UHBristol
FOR STAFF     All staff
PATIENTS      All patients up to the age of 18 yrs

This document outlines different scenarios and clarifies the involvement and responsibility of the different teams when facing children with possible non-accidental injury or other safeguarding concerns.

- Any professional employed by the Trust has some training in consideration and recognition of child safeguarding issues
- Anyone trained in paediatrics has additional ability to recognise and act upon child protection concerns/suspicions
- Consultant community paediatricians have additional specialist experience and their posts provide the locality with 24/7 rota on call for advice and expertise when complex safeguarding concerns are raised.
- Hospital and community consultants will often have to work together to achieve the best management for these children.
- Communication between teams and individuals is vital and if necessary should be ‘overdone/repeated’ in order to ensure all aspects of care are addressed

Safeguarding the care of children in UHB is the responsibility of ALL professionals and senior leadership is essential in ensuring good patient management.

The descriptive scenarios that follow are:

1. **Outpatients/existing inpatients in whom safeguarding concerns are identified**
2. **Emergency department attendees/ED ward or ‘short stay’ patients**
3. **In-patients admitted where safeguarding is the prime reason for admission**
4. **Planned child protection medical examination required semi-urgently**
5. **The importance of the Did Not Attend Out patients policy for Children**
6. **Identification of FGM and those in family potentially at risk of FGM**
7. **Update re injuries in non-mobile baby guidance**
8. **Recognition of risk factors for Child Sexual Exploitation (Signs of Safety)**

**Appendix**  Radiological Imaging in cases of Non-Accidental Injury, Sharing information with Police, Unexpected Child Death
1. **Outpatients/existing inpatients in whom safeguarding concerns are identified**

Clinician (nurse/doctor /AHP) asks their senior for advice. If required safeguarding team (x21696) available for advice (in hours). Record concerns and actions taken. If a non-paediatric consultant is responsible for the child and additional advice and help is needed, (falling short of the ‘more complex’ case, Table 1) this should initially be sought through the **general paediatric** team within the hospital. If more specialist advice is required, the consultant community paediatrician is also available. Both of these resources are available 24/7.

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**Child protection concerns are considered/suspected or presentation generates a safeguarding enquiry**

- **Safeguarding team (CP supervisors) (x 21696)** for advice on how to proceed, to discuss case and provide general information on whom to contact.
- **Consultant general paediatrician** for advice/initial assessment to be arranged – especially if further action required to ascertain if this case is of concern or not.
- **5. Consultant paediatrician** on how to especially if complex (see Table 1).

*These actions are not mutually exclusive

**Different cases and different professionals and consultants will require different levels of support from teams/experts**

*Remember to use the green safeguarding paperwork to record concerns and actions in notes.*

If safeguarding concerns reach a threshold where a strategy discussion/meeting* is required, the community paediatrician is the normal ‘health’ member of a triumvirate of decision makers of health, police and social care. Where information from the hospital needs to be shared (ie any child in the above group), a hospital representative MUST also contribute. **A conversation between community paediatrician and hospital teams at consultant level should occur with the aim of clarifying safeguarding issues, attendance and ongoing responsibilities.**

*Strategy Meetings: expected practice*

- To be held at the hospital at which the patient/child is an inpatient – if not possible (regional cases in particular) use a speaker phone or telephone conference facility.
- No consultant = no strategy (unless exceptional circumstances eg experienced other staff available and liaison with community consultant by telephone is possible).
- **Hand written clinical notes documenting outcome and actions** from the strategy must be made promptly available to those providing on-going care and management of the child; typed Children’s Social Care report of strategy will take longer to arrive at hospital. Social workers should be encouraged to write in or check what medical professionals write in the hospital record.

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**Table 1**

**Examples of ‘more complex’ cases where clinical assessment by a specialist community paediatrician might be appropriate:**

- Babies (not independently mobile) with unexplained/inconsistent injuries
- PICU attendances
- Serious cases (suspected shaken baby; methadone ingestion; deliberately inflicted harm etc)
- Concern about factitious and induced illness
- Thresholds around neglect
- Interpretation of patterns of injury
- Possibility of child sexual abuse/FGM risk/Child Sexual Exploitation
2. **Emergency Department Attendees/Observation ward patients under CED care**

At times the consultant in the paediatric emergency department will be the one assessing the need to involve consultant community paediatrician or not: in non-admitted cases or those admitted only to the observation ward.

This means that a consultant should be involved with a patient prior to requesting consultant community paediatric input. The CED consultant should also be informed of any significant safeguarding concerns about any children in the department.

The Emergency Department doctors also have a certain expertise in the assessment of injuries and accidental vs possible non-accidental presentations and are a resource for an additional consult when advice is required in injury assessment: eg evolution of scalp haematomas after birth or following skull fracture; clavicular fracture and callus formation after birth injury, mechanisms of injury likely to cause fractures; accidental injuries that might go unnoticed but would represent more inaction/lack of recognition on the part of carers rather than NAI or serious neglect.

If a child is seriously injured or has other health needs they should be addressed in parallel with the management of safeguarding issues.

**Overnight attendances (eg midnight - 8am)**

Where a child attends and there are safeguarding concerns, the junior doctors should consider the following when deciding whether to contact either a consultant ED/paediatrician /community paediatrician for further advice.

3. Is the child/are their siblings safe? (going to stay in hospital/discharge with carers that seem appropriate and are co-operative etc)

4. Does the level of suspicion of NAI need immediate action and advice? Is that advice required now?

5. If restriction of parental access to the child is considered then this requires overnight discussion usually with a consultant that may include a strategy discussion

It would normally be expected that a case has been discussed with the consultant responsible for that service before a consultant community paediatrician is contacted – even if the call to community paediatrics is prompted by EDT. That phone call could occur at 8.00am, **unless more immediate advice is required.**

The next working day, follow-up any concerns with hospital child protection nursing team and, as necessary, local social work team (first response) and/or locality social care team. The social care communication from EDT to locality needs information and support from the original referring agency (us). We MUST provide a written referral (even if social care say ‘telephone is ok’ this is NOT the trust standard) (Laming recommendations).

**Children’s Social Care Notification forms in CED**

These are completed for child protection concerns, potentially life threatening events (even if accidental), deliberate self-harm episodes, child under the influence of a substance, if in private foster care, if there has been a domestic violence incident and for information to the child’s social worker if the presentation is not concerning but they are known to social care: disability, previous CPP or Child in Need etc
3. Inpatients where safeguarding concerns/injuries are reason for admission

The trust safeguarding office (child protection nursing team x21696) and named doctor for safeguarding children (Dr Lisa Goldsworthy) are advisory supports in hours.

*Remember: Different cases and different professionals and consultants will require different levels of support from teams/experts*

If a child is admitted to hospital with immediate or ongoing child protection issues, the trust’s expectation is that the consultant responsible for the overall inpatient journey is the **acute/general hospital paediatrician**, even if the injury requires orthopaedic/plastics/burns/neurosurgery consultation etc. The consultant community paediatrician is on call and should be consulted for advice about managing the child protection aspects of a case or for immediate diagnostic assistance, advice and expertise when required (‘more complex’ cases, see Table 1, where clinical assessment by a community paediatrician may also be required).

**At times this role of the ‘hospital paediatrician’ may be replaced by another consultant: if a child is under the care of another paediatric team: emergency/cardiology/respiratory/oncology/renal/endocrine etc; or when a surgical consultant with clinical responsibility is happy to include child protection within their role. Clarification of roles and responsibility is essential for nursing teams, junior doctors, social care and families.**

**Normal medical responsibilities of the in-charge consultant include:**

- Daily management of the case
- Daily clinical care including decisions jointly managed alongside social care issues
- Attendance at meetings with social services (CSC)/strategy meetings to represent ongoing information about hospital admission of child
- Co-ordination and communication with consultant community paediatrician
- Ensuring a plan for any **outstanding investigations** is completed and acted upon and communicated to other professionals
- Ensuring handover of responsibility between acute consultants occurs and is documented in hospital record and communicated to the identified community paediatrician
- Responsibility for co-ordinating the safe discharge of patient and communication of admission and actions to all relevant professionals and family. Ensure the in-patient green paperwork is complete (this will act as a prompt to ensure safe discharge of patients)

**The consultant community paediatrician will provide**

- Advice at the time of admission, (this might include coming and seeing the child, where management is not clear cut and their additional expertise is required eg in complex cases see Table 1, P2).
- Presence and leadership at strategy meetings/discussions (both community and acute team consultants should be present at a strategy meeting for a hospital patient) and liaison with hospital colleagues re advice to children’s social care (CSC).
- Co-ordination and communication with acute hospital consultant paediatrician.
- Availability for daily advice
- Clear communication if responsibility is handed to another consultant within community team and request that hospital team document this in the hospital record

The Consultant Community Paediatrician will normally have ongoing responsibility for the medical interpretation of the safeguarding investigation with advice to CSC and police and continuing involvement in the post discharge care. Any health professional involved with a case may be expected to provide evidence in court as a witness or professional witness. The provision of a written report should be agreed between the professionals involved, particularly when specialist views are needed alongside safeguarding expertise. Appropriate supervision for juniors is imperative. Collaborative working is helpful in this area.

**The planned discharge of a patient should be agreed by both the consultant responsible for the inpatient stay and the community paediatrician and this documented with names of those involved in the discharge information on the ‘green’ paperwork and on the ICE/Medway summary.**
4. Planned Child Protection examination required semi-urgently, out of normal hours

Scenario: Social care have contacted community paediatrician and a child protection medical is needed. Important to assess: does it really need to be ‘now’; assess severity and whether needs to be undertaken out of hours by consultant community paediatrician or any other on-call staff. Any out of hours activity needs to be justifiable in terms of urgency.

In this circumstance the Consultant Community Paediatrician would arrange to see the child using the emergency department facilities (CPOP route). In non-complex, older children, a specialist consultant may not be needed, another member of staff could be asked to assist in undertaking the examination. This can be ascertained by contacting the general paediatric consultant and/or CED consultant to ascertain availability of RMO/CED

- generally speaking there is little ‘slack’ in the availability of the hospital doctors out of hours but it may be worth asking, especially during non-winter months
- The fall back responsibility lies with community paediatricians, unless it is so severe/acute that the child requires emergency care, when CED and community paediatricians will liaise.

If the task of performing a CP medical examination is delegated by the consultant community paediatrician, then it is important that they clarify what is expected of RMO/CED medical staff and also guide on actions, report writing etc. The consultant community paediatrician may need to see child to confirm findings and will need to give clear instructions as regards discharge, investigations, supervision etc (ie clinical supervision of the episode is the responsibility of the consultant community paediatrician).

Processes: Planned attendances during working hours will be booked into the level 5 clinic through OP (x27918) providing all details of the child. Call the child protection nursing team office to arrange nursing support (x21696)

Out of hours, ‘planned, but semi-urgent’ episodes will be undertaken with UHB hospital notes with children registering/booking in to the CPOP CED system.

- A record of these must be kept in the book at CED reception with a sticker and contact details of the clinicians involved.
- Child Protection Medical Packs are available at CED reception.
- The OP outcome form should be completed by whomever sees the child and then left at CED reception for attention of the emergency department secretary.
- Copies of the child protection report must be sent back to the CP office (currently all via Joanne Tucker, Child Protection Office Administrator) to be uploaded onto CDS/Evolve.
- The hospital notes should remain in the emergency department (at reception) with a memo recording the consultant contact details for the Child Protection Office Administrator. Copies of notes can be taken away.
- A Children’s Social Care Notification form should be completed

Writing reports for social services (CSC)
The doctor who performed the examination is responsible for writing (or supervising the writing of) the report for CSC. Templates with headings and prompts are available on http://connect/governanceandquality/Childprotection/Pages/EssentialPaperwork.aspx ‘medical reports’. or in the Emergency Department Child Protection packs. Junior doctors: ensure that the report is verified by your consultant, usually the consultant community paediatrician.
5. Importance of the Did Not Attend (DNA) Policy for Children

A common theme in the serious case reviews undertaken on children, who have died as a result of child abuse and neglect, is the frequency with which they DNA outpatient appointments.

When children are not brought, the issue is either with the parents - or possibly the appointment system. If the child has a potentially significant health problem, the inability of parents to bring them to have their health needs met becomes a safeguarding matter. Over recent years we have identified vulnerable families and children and put support in place to ensure their health needs are met.

The policy is available on the DMS. Did Not Attend (DNA) Policy for Children Summary

Important points:

- OP admin staff has a responsibility to check the contact details and then the notes are passed to the clinician to take appropriate action.

- It is important to check the Medway alert to find out if the child is known to social care already (remembering that this registers information only about those few hundreds of local children who are, or have been made subject to a child protection plan). The alert system does not include those in need or those unknown who may have unmet needs, nor those from out of local area.

- A holistic evaluation as to the potential outcome for the child as a result of them not being brought to outpatients should ensue, followed by appropriate action. This can include sending for them again and/or taking immediate steps to ensure a timely attendance.

- Whilst undertaking that holistic review: if you have concerns about a family, then it can be useful to gather any other DNA information from Medway and NBT. Copy letters to NBT child health record is of value (community child health notes are held separately from UHB notes; eye hospital, dental hospital, ahp records and other clinic UHB DNAs are not easily accessed by non-OP admin staff)

- If a referral to social care is made on the basis of non-attendance, then the reasons that this matters for the child must be explained, in non-medical terms, on the referral form and families should be made aware of this action.

- If the decision is made to discharge a patient without further assessment, this action, as a minimum, should include a letter to the family, GP and school nurse or health visitor.

With the change in the OP process following Medway implementation, accessing and acting upon the DNA information is critical. Cancellation of appointment is also important and should be evaluated and ‘signed off’ with written communication to family and GP in the same manner.

GMC update guidance is available at:
Protecting children and young people: the responsibilities of all doctors

The website address for the south west child protection procedures is: www.SWCPP.org.uk
Policies available through electronic links (on UHB network) are listed on connect
6. **Identification of FGM and those in family potentially at risk of FGM**

The trust has a requirement to notify the department of Health of any case of FGM, so please make it clear in your notes and on discharge information and when a new case is found in a child (under 18 yrs) notify the police on 101, so that a crime number is allocated.

For further information, please refer to policy.

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**Appendix 4 – Flowchart developed from RCN Guidelines, Working Together to Safeguard Children and South West Child Protection Procedures.**

- **Girl identified as at risk of, or had FGM**
  - Raise your concerns with your line manager/ follow your agency procedures
  - **Is it safe to discuss your concerns with the family?**
    - **No**
      - Is the CPP keeping the girl safe from harm?
        - **Yes**
          - Children’s Social Care should consider legal proceedings:
            - prohibited steps order;
            - supervision order;
            - Care Order (removal of child from care of family)
        - **No**
          - Children’s Social Care will convene an initial Strategy Discussion (including Health Professional, Police and education/school) to consider:
            - is the girl at risk of FGM?
            - is the girl at risk of being sent abroad for FGM?
            - has the girl already become a victim of FGM?
            - A s.47 Enquiry will be undertaken and if a further Strategy Discussion held to consider the outcome.
  - **Yes**
    - Discuss concerns with the family
    - **Do you still have concerns?**
      - **No**
        - Work with the family and girl as a child in need to support them remaining with their family safely; continue to monitor.
      - **Yes**
        - Strategy Discussion: Review
          - Within 10 working days of initial Strategy Discussion:
            - Evaluate, findings of s.47 Enquiry
            - Is a Child Protection Conference required?
          - Inform referring agency of outcome.
  - **Strategy Discussion: Initial**
    - Children’s Social Care will convene an initial Strategy Discussion (including Health Professional, Police and education/school) to consider:
      - Is the girl at risk of FGM?
      - Is the girl at risk of being sent abroad for FGM?
      - Has the girl already become a victim of FGM?
      - A s.47 Enquiry will be undertaken and a further Strategy Discussion held to consider the outcome.

**You should consider using an interpreter whose values on FGM are known, when talking to the family.**

**DO NOT use family members**
7. **Non-Mobile Baby Multi-Agency guidance**

This guidance is for all people working in the community (social workers, nursery nurses, child minders as well as all health professionals). Its importance is to aid identification of risk factors in families of a particularly vulnerable group and to raise awareness: promoting healthy scepticism and good communication between agencies, meeting. The full policy is available [here](#). This flow chart applies to babies not seen in hospital and should be adjusted appropriately for hospital practice. When a hospital consultant chooses to deviate from the policy, the reason for this should be recorded in the notes and the case details discussed at a child safeguarding peer review.

![Flow chart for injuries in babies](image)

**Flow chart for injuries in babies**

- **Problem/mark noted by professional**
  - **Injury suspected or bleeding from nose/mouth**
    - **non-mobile (even if plausible explanation)**
      - Check with CYPS (First Point/First Response/EDT re social care history and relevant/proportionate police checks)
      - Refer Children’s Hospital ED (or Community Paediatrician if minor)
    - **mobile**
      - **Concerns** - (see Best Evidence Safeguarding Tool)
  - **Not injury (e.g. birthmark/skin or medical condition)**
    - Document and reassure/treat
- **No concerns**
- **Possible Non-accidental injury**
  - CYPS referral
  - Admit to hospital or accommodate in place of safety
  - Strategy discussion(s) and health/CYPS/police investigations +/- treatment
- **Non-concerning injury/event**
  - No relevant CYPS/police concerns
  - Consider GP/MIU assessment
- **Discharge planning — with CYPS and consultant paediatrician prior to discharge**
  - Discharge and inform referrer, Primary Care (GP/HV/midwife) and other professionals if appropriate

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**CYPS (change in nomenclature) refers to children’s social care (CSC)**

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**Phone Numbers**

**CYPS In Hours:**
- First Response (Bristol): 0117 6033444
- First Point (South Gloucestershire): 01454 888800
- CYPS (North Somerset): 01275 888826
- CYPS Out of hours: Emergency Duty Team
  - 01454 611155
- Refer to Bristol Children’s Hospital
  - Emergency Dept (or to discuss with Consultant Community Paediatrician on-call) 0117 6230000

**Those who don’t bruise rarely bruise — Multi-agency guidance for injuries in non-mobile babies Southwales and Bristol 2015**

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**Extended until September 2020**
8. **Recognition of risk factors for Child Sexual Exploitation (Signs of Safety)**

This area is emerging as high risk for children and young adults. Link to [spotting the signs](#) document is here. Should be considered in young people with risk taking behaviours or defensive injuries and in many other scenarios.

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**RELATED DOCUMENTS**

GMC update guidance is available at: [Protecting children and young people: the responsibilities of all doctors](#)

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**SAFETY QUERIES**

Contact Child Protection Office on x21696 (in office hours: 8:30-5:00)
Appendix:

Radiological Imaging in cases of Non-Accidental Injury

When there is concern about inflicted injury in a young child or infant and a skeletal survey or CT head is recommended,:

- The request should be made by or discussed with the consultant responsible for the child and the name of this consultant and the consultant community paediatrician (if different) should both be written on the imaging request.
- The request should be discussed with a consultant radiologist.
- Performing the skeletal survey investigation takes time and requires two radiographers. The process (19 X-rays) and the reason for undertaking this should be explained to families beforehand. No timeframe should be suggested until the timing is arranged with radiology.
- A follow-up chest X-ray is usually needed two weeks after the original request: this is to demonstrate callus formation on any previously occult rib fractures. This should be discussed, requested and arranged at the time of the initial request and recorded in any discharge information.

Positive findings are often significant and can be a straightforward guide to level of concern. **Remember that whether or not there are injuries does not lower the risk to a child if we have other concerns.**

Copies of Notes, X-Rays etc for Police

In order to proceed with their investigations, the police may need to have copies of any medical or nursing notes relating to the admission, including any A&E records. These records should normally be released with the written consent of the named paediatrician under whose care the child is admitted. In urgent situations where this is not possible, the notes could be released upon application, with the verbal authorisation of that named consultant or of one of the community paediatric consultants acting on their behalf.

In most situations the police would obtain the consent of the carers to gather the information they require. If this is not forthcoming and the police feel that the notes should be released in the public interest, this should be agreed between the Police Senior Child Protection Officer and the named consultant for the child. In order to access the records, the police will meet with a named representative of the medical records department to discuss their requirements and the necessary timescales.

The medical records department is then responsible for tracking all relevant notes (including liaising with radiology to arrange for copies of x-rays or reports); obtaining the consent of the named consultant; and copying the records to hand to the police.

**Sudden Unexpected Deaths in Childhood (under 18 yrs)**

A rapid response to the unexpected death of a child involves Health, Social Services and Police. Detailed policy of medical involvement in child death is on the DMS search under “Child Death”