Policy Title: Safeguarding Children Policy	
Reference & Version No: C50 Version 8	
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Validated By: North Tees and Hartlepool Foundation Trust Safeguarding Committee	
Ratified By: Patient Safety Council	
Date Issued: 9 January 2024	
Date for Review: 9 January 2027	
Related Documents:	
C74	
C83	
C46	
C53	
C73	
C81	
IG14	
ICT06	
HR71	
HR24	
HR26	
M48	
C12	
Tees Safeguarding Children Procedures - www.teescpp.org.uk County Durham LSCB Procedures - https://www.proceduresonline.com/durham/scb/	
This Policy is Intended for: All Staff Groups/Trust Users	

Policy Summary

This policy is in place to ensure that North Tees and Hartlepool Foundation Trust staff understand their responsibility under current legislation to safeguard and promote the welfare of children, and to enable the Trust to meet its statutory duties in this regard.

North Tees and Hartlepool Solutions and North Tees and Hartlepool NHS Foundation Trust is committed to the fair treatment of all, regardless of age, colour, disability, ethnicity, gender, gender reassignment, nationality, race, religion or belief, responsibility for dependants, sexual orientation, trade union membership or non-membership, working patterns or any other personal characteristic. This policy will be implemented consistently regardless of any such factors and all will be treated with dignity and respect. To this end, an equality impact assessment has been completed on this policy.

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1. Introduction

Safeguarding Children is Everybody's Business 'Children have a right to be protected from harm and all adults have a responsibility to protect children from harm' (*Article 19, UN Convention on rights of the child*)

1.1 North Tees and Hartlepool Foundation Trust (NT&HFT) referred to hereafter as 'The Trust' provides a range of health services to children and their families and also to adult service users, who may have responsibility for caring for children, or have contact with children.

1.2 The Trust has a duty in accordance with the Children Act 1989 and 2004 as per Section 11 in making arrangements to ensure that its functions are discharged with regard to the need to safeguard and promote the welfare of children and young people. Working Together to Safeguard Children (2018) states that: In order that organisations, agencies and practitioners collaborate effectively, it is vital that everyone working with children and families, including those who work with parents/carers, understands the role they should play and the role of other practitioners. They should be aware of, and comply with this policy and the published arrangements set out by the local safeguarding partners both of which follow the statutory guidance for Practitioners set out in Working Together to Safeguarding Children 2023. https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

1.3 The Care Quality Commission Fundamental Standards Regulation 13 states that Safeguarding service users from abuse and improper treatment requires that all healthcare staff are compliant with statutory guidance. (Health and Social Care Act 2008) http://www.cqc.org.uk/content/regulation-13-safeguarding-service-users-abuse-and-improper-treatment.

1.4 This policy provides a framework for all Trust staff to enable them to fulfil their duties to safeguard and promote the welfare of children and young people. To fulfil these responsibilities, all health staff should have access to appropriate safeguarding training, learning opportunities, and support to facilitate their understanding of the clinical aspects of child welfare and sound information sharing. Guidance on the level of safeguarding training required dependent upon your role is set out in the trusts C73 Safeguarding Learning and Development Policy 2023.

1.5 The Children's Act 2004 amended by Children's and Social Work Act 2017 requires the Trust to work closely as a key statutory partner of which North Tees trust services work within two Local Safeguarding Partnerships; Hartlepool and Stockton Safeguarding Children Partnership (HSSCP) and Durham Safeguarding Children's Partnership (DSCP).

This policy is aligned to;

Tees Safeguarding Children's Procedures - www.teescpp.org.uk
County Durham - https://www.proceduresonline.com/durham/scb/
Darlington Children's Procedures - https://www.proceduresonline.com/darlington/cs/

This policy should be read in conjunction with Local Safeguarding Children's Partnership procedures and is supplemental and not meant as a replacement of these.

1.6 The NHS England Safeguarding Vulnerable People in the NHS accountability and assurance framework revised in July 2022, sets out with greater clarity the responsibilities of each part of the NHS and key individuals who work within it.
B0818_Safeguarding-children-young-people-and-adults-at-risk-in-the-NHS-Safeguarding-accountability-and-assuran.pdf (england.nhs.uk)

Under the Accountability and Assurance framework, the Trust is required to demonstrate a governance structure of strong safeguarding leadership with commitment at all levels of the

organisation fully engaged with Safeguarding Children Partnerships and commissioners. Most importantly, the Trust must ensure that a culture exists where safeguarding is everybody's business and poor practice is identified and addressed.

2. Purpose & Scope

2.1 The purpose of this policy is to ensure that all Trust staff and volunteers are aware of their overriding statutory duty to safeguard and promote the welfare of children and young people and the requirement to take action when they become aware of any risks of harm to children. This policy applies to all employees, locums and agency staff, contractors, volunteers, students and any other learners undertaking any type of work experience or work related activity on or on behalf of the Trust.

2.2 This document, along with Tees and Durham / Darlington Safeguarding Procedures, relates to children and young people up to 18 years of age, and their parents and / or carers.

2.3 This policy defines the local arrangements, roles and responsibilities and how the Trust works with and collaborates with other agencies to safeguard children and young people. Ensuring compliance with national recommendations and requirements of Working Together to Safeguard Children (2018)

2.4 Provides a signpost for trust staff to the procedures in place for safeguarding children and the roles and responsibilities of Named Professionals.

2.5 This document has been developed in line with the Trust's Policy for the Management, Identification and Authorisation of Policies.

3. Key Definitions

3.1 Working Together to Safeguard Children 2018 definitions are used throughout this Policy. https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

Term	Descriptor
A Child	"Anyone who has not yet reached their 18th birthday. The fact that a child has reached 16 years of age, is living independently or is in further education, is a member of the armed forces, is in hospital or in custody in the secure estate, does not change his/her status or entitlements to services or protection" Working Together to Safeguard Children (2018)
Safeguarding Children	• Protecting children from maltreatment. • Preventing impairment of children's health or development. • Ensuring that children grow up in circumstances consistent with the provision of safe and effective care. • Taking action to enable all children to have the best outcomes. Working Together to Safeguard Children (2018)
Child Protection	"Part of safeguarding and promoting welfare. This refers to the activity that is undertaken to protect specific children who are suffering or are likely to suffer significant harm" Working Together to Safeguard Children (2018)

Term	Descriptor
Child Abuse	Child abuse is defined in Working Together to Safeguard Children (2018) as: "A form of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting by those known to them or, more rarely by others. Abuse can take place wholly online, or technology may be used to facilitate offline abuse. Children may be abused by an adult or adults, or another child or children"
Child in Need	Section 17(10) of the Children Act 1989 states that a child shall be taken to be in need if: a) The child is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development b) The child's health or development is likely to be significantly impaired, or further impaired, without the provision of such services; or c) The child is disabled
Significant Harm	The threshold that justifies compulsory intervention into family life in the best interest of the child. A person may abuse or neglect a child by inflicting harm or by failing to act to prevent harm.
Children in Care (formerly Looked after children)	Under the Children Act 1989, a child is legally defined as 'looked after' by a local authority if he or she: • Gets accommodation from the local authority for a continuous period of more than 24 hours. • Is subject to a care order (the child is placed in the care of the local authority). • Is subject to a placement order.
Transitional Safeguarding	'an approach to safeguarding adolescents and young adults fluidly across developmental stages which builds on the best available evidence, learns from both children's and adult safeguarding practice and which prepares young people for their adult lives".

4. Duties

4.1 Chief Executive

4.1.1 North Tees and Hartlepool NHS Foundation Trust Chief Executive has the ultimate responsibility for ensuring the Trust contribution to safeguarding and promoting the welfare of children is discharged effectively across the whole Trust. The Chief Executive will seek assurance that the Safeguarding Children Policy is being effectively implemented via the Trust Safeguarding Committee and ultimately via the Trusts Governance Committee.

4.2 Chief Nurse & Director of Patient Safety & Quality

4.2.1 The Chief Nurse supports the Chief Executive in ensuring the Trust's contribution to safeguarding and promoting the welfare of children. The Chief Nurse is also the Lead Director on the Trust Board with the responsibility for safeguarding children and has responsibility for meeting all statutory requirements, and for implementing statutory guidance in relation to safeguarding children.

4.3 All Directors, Associate & Deputy Directors & Clinical Directors

4.3.1 All Directors, Associate, Deputy and Clinical Directors should ensure the delivery of the Safeguarding Children Policy and uphold the procedures and key documents referred to within it.

4.4 Deputy Chief Nurse

4.4.1 The Deputy Chief Nurse supports the Chief Nurse and Director of Patient Safety and Quality in ensuring the Trust's contribution to safeguarding and Promoting the welfare of children, representing the Trust as the Lead for Safeguarding Children.

4.5 The Named Nurse Safeguarding Children

4.5.1 The Named Nurse for Safeguarding Children has the responsibility to offer advice to the Trust Chief Executive and senior managers on safeguarding issues and acts on behalf of the Chief Nurse to ensure that the Trust Board is assured that all necessary measures and arrangements are in place to safeguard children and young people.

4.6 The Named Midwife

The Named Midwife has the responsibility to share the knowledge and understanding of safeguarding the unborn baby and child at birth ensuring safeguarding is central to the agenda for Maternity and Neonatal service, working closely with the Director of Maternity and other managers within the maternity service, to provide support and advice to staff on safeguarding procedures and policies.

4.6.2 **The Named Nurse and Named Midwife Safeguarding Children are also responsible for:**

- Promoting good professional practice.
- Ensuring that advice, support and supervision is available to all Trust staff in relation to safeguarding unborn and children issues.
- Supporting the Trust in its governance role by ensuring audits on safeguarding children policy and procedures compliance are undertaken.
- Responsible for conducting the organisations internal case reviews - except when they have had personal involvement in the case.
- Ensuring that strategies are in place to disseminate any learning, recommendations from Children's Safeguarding Practice Reviews and all other reviews to Trust staff, as well as developing action plans and ensuring any direct learning relevant to the trust staff that require practice improvement is implemented.
- Ensuring that safeguarding children's training is in place appropriate to role as per Children's Safeguarding Intercollegiate and Looked after Children Intercollegiate guidance documents recommendations (2019).
- Liaising with Clinical Commissioning Group colleagues, Designated Nurse safeguarding and looked after Children as a source of support and expert advice.

4.7 The Named Doctor Safeguarding Children

4.7.1 The Named Doctor for Safeguarding Children works in conjunction with the Named Nurse to support the Trust with safeguarding children matters, particularly in respect of medical staff.

4.7.2 **The Named Doctor is also responsible for**:

- Providing advice and support to senior management, supervision and professional guidance to medical colleagues.
- Playing a key role in ensuring staff are up to date with recent legislation, national documentation, latest guidance, best practice and evidence based research.
- To ensure all doctors are aware of their responsibilities in line with Protecting children and young people; the responsibilities of all doctors GMC (2012).
- Working collaboratively at a strategic level to ensure there is effective multiagency liaison and cooperation.
- Participate in Safeguarding Partnership Activities which may include attending relevant meetings or sub groups as appropriate.
- Liaising with Integrated Care Board Colleague's and Designated Doctor for Safeguarding within the ICB and Named Doctor for General Practitioners to break down and learn from any challenges identified in order to safeguard children effectively.

4.8 **The Safeguarding Children Team**

4.8.1 The Safeguarding Children team sits alongside the adult safeguarding Team within the Vulnerability Unit and includes the Safeguarding Children Named Nurse, Named Midwife and Named Doctor, Safeguarding Children Senior Nurses, Safeguarding Children Specialist Midwifes and Safeguarding Children and Adult trainers. There responsibility is to offer advice, support, supervision and training to all staff on all aspects of safeguarding and promoting the welfare of children, including the identification of children who may be vulnerable, in need or in need of protection.

4.9 **Chief People Officer**

4.9.1 The Chief People Officer has the responsibility to ensure that procedures are followed in respect of any Trust staff or volunteers who work with children who may have harmed a child, pose a risk of harm to children, have committed an offence against a child, be unsuitable to work with children and if required refers to the Local Authority Designated Office (LADO). Working closely with the Named Nurse for Children's Safeguarding to ensure, where risk of harm is identified appropriate safeguarding action is taken as required.

4.10 **All Managers & Clinical Matrons**

4.10.1 All Managers and Clinical Matrons have a duty to ensure their staff are aware of and comply with local safeguarding children policies and fulfil their duties in this regard. Are compliant with safeguarding children's training appropriate to their role and support attendance of staff to training to ensure they have the correct knowledge and skills to address safeguarding concerns.

4.11 **Trust Staff & Volunteers**

4.11.1 All Trust Staff and Volunteers have a duty to be alert to the possibility of child abuse and neglect and be aware of the Trusts, Tees and Durham safeguarding children policies and procedures.

4.11.2 All Trust Staff and Volunteers have a duty to attend mandatory safeguarding children training, as appropriate to their role and responsibilities.

4.12 Independent Clinical Commissioning Boards (ICB)

4.12.1 ICBs are statutory NHS bodies with a range of statutory duties, including safeguarding children and adults. ICBs are responsible for commissioning most hospital and community healthcare services. Safeguarding forms part of the NHS standard contract and commissioners agree with the Trust (Provider of services) through local negotiation, what contract monitoring processes are used to demonstrate compliance with safeguarding duties. North East and Cumbria ICB gain assurance throughout the year to ensure continuous improvement and this consists of assurance visits, section 11 audits and the completion of a safeguarding dashboard as well as attendance at the Trust Safeguarding Council

5. Safeguarding Children

5.1 Legislation & Statutory Guidance

5.1.1 In the UK, the foundations of children's safeguarding legislations are held with the United Nations Convention on the Rights of the child as well as the Convention on the Rights of Persons with Disabilities

Section 11 of the Children Act 2004 emphasises that we all share a responsibility to safeguard children and young people and to provide for their welfare. This act places a statutory requirement (is written in law) that safeguarding is **everyone's responsibility**, and the welfare of children is paramount.

Working Together to Safeguard Children (2023) states that 'health practitioners are in a strong position to identify welfare needs or safeguarding concerns regarding individual children and, where appropriate, provide support. This includes understanding risk factors, communicating and sharing information effectively with children and families. Liaising with other organisations and agencies, assessing needs and capacity, responding to those needs and contributing to multi-agency assessments and reviews.

5.1.2 Response to Safeguarding Children Concerns

5.1.3 Should Trust staff or volunteers become aware of information indicating harm or risk of harm to a child, including when an adult or child discloses something of concern they have a duty to take appropriate action without delay, as no action may increase the risk of harm to the child. Trust staff must follow appropriate local safeguarding children procedures and complete appropriate referrals according to the Local Authority in which the child lives. (Please see relevant links below) also referenced on the Trust Intranet Safeguarding Children Sharepoint page. (See Appendix 1 for the referral flowchart)

Childrens Safeguarding Referral forms (SAFERs) for Hartlepool and Stockton are to be sent directly to the Children's Hub sent via nhs.net secure mail to childrenshub@hartlepool.gov.uk
A copy of the referral should be sent to the Children's Safeguarding Team nth-tr.safeguardingchildrensupervision@nhs.net

Durham Children's Safeguarding referral procedures;
http://durham-lscb.org.uk/categories/professionals
Referrals forms completed for children who reside in County Durham should be sent via nhs.net secure email to First Contact in Durham firstcontact@durham.gov.uk

Darlington Children's Safeguarding referral procedures;
http://www.darlington.gov.uk/education-and-learning/local-safeguarding-children-board/professionals-and-volunteers/policy,-procedures-and-guidance/
Referrals to Darlington can be sent via nhs.net secure email to childrensaccesspoint@darlington.gov.uk

All Referral Forms should be copied to the Trust safeguarding children team within 24 hours and all concerns, discussions, advice and any action taken clearly documented.

5.1.4 When a member of staff requires advice / guidance in respect of a possible safeguarding children concern they should contact the Named Doctors / Named Nurse / Senior Nurses / Specialist Midwifes for safeguarding children and follow advice without delay. Safeguarding Children's Team available between 08;30 – 16:30, your manager or senior colleague or Emergency Duty Out of Hours services between 16.30 – 08:00.

5.1.5 **The National Institute for Health & Clinical Excellence (NICE) CG89**

5.1.6 When to suspect child maltreatment in under 18's – last updated October 2017, is a resource to help healthcare practitioners who are not specialists in child protection. This guidance seeks to highlight when abuse should be considered or suspected and provides sign posting when concerns are identified. All staff must familiarise themselves with the content of the guidelines available via the following link: - https://www.nice.org.uk/guidance/cg89

5.1.7 What to do if you're worried a child is being abused: Advice for practitioners. HM Government. March 2015 has been produced to help practitioners identify child abuse and neglect and take appropriate action.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/419604/What_to_do_if_you_re_worried_a_child_is_being_abused.pdf

5.1.8 In cases where physical injuries have been sustained by non-independently mobile children Trust staff should also refer to: Tees Procedure Bruising in Immobile Babies and Durham and Darlington Protocol for the assessment of bruising in non-mobile children. Where non accidental injuries are suspected in mobile children, please refer to Teeswide Child Protection Medical Assessment Procedure.

All above procedures can be accessed from the safeguarding SharePoint site:
http://commsport/Departments/Safeguarding_Children/SitePages/Home.aspx

5.1.9 Where a child is not brought for appointments the practitioner must proactively ensure Policy C83 'Children not brought for an appointment by parents / carers' is followed. When a child is subject to a Child Protection Plan or you are aware that they are in Local Authority Care their allocated Social Worker should also be notified of the non-attendance.

5.1.10 Where there are safeguarding children concerns in relation to an E-Safety incident, staff should follow Tees or Durham or Darlington procedures (Can be accessed from SharePoint site) and follow the E Safety Incident flow chart (Appendix 3).

5.1.11 A child centred and coordinated approach should underpin the assessment of needs and views of children and young people should be sought dependent upon age and developmental capability. Staff should also adopt 'A think family approach' to understand the strengths, weaknesses and resilience within the family that effects the level of risk for the child and the impact of any actual or potential harm. This includes consideration of safeguarding for child's parents/carers where there may be care and support needs that may impact on their capacity to appropriately care for themselves and consequently their child and consideration for the need of an adult safeguarding referral where an increased level of support for the adult may prevent any potential harm to their child.

5.2 **Escalation of Concerns**

5.2.1 Any employee who has raised a concern about a safeguarding children issue and is worried that their concerns are not being addressed must use the procedures for Professional Disagreement. See appendix 4 and 5 for Internal or Interagency escalation and professional disagreement flowcharts.

5.3 Information Sharing

5.3.1 Information sharing is vital to safeguarding and promoting the welfare of children and young people. A key factor identified in past Serious Case Reviews (SCR's) has been a failure by practitioners to record information, share it, seek to understand its significance and then take appropriate action, and is an ongoing theme from Rapid Reviews and Child Safeguarding Practice Reviews (CSPR's) that have replaced SCR's. Trust staff need to be aware they will not hold all the answers and by working in silo are missing the bigger picture of what life is like for the child. Therefore staff need to remain professionally curious, communicate and work together with universal / specialist or multiagency services that surround that child to support the right help at the right time to reduce or remove any potential or actual harm that has been identified for the child within the family.

5.3.2 Trust staff are required to cooperate with requests from Children's Social Care to share information regarding children and their families, when there are concerns about a child's welfare.

5.3.3 The decision to share or not to share information about a child should always be based on professional judgement, supported by Trust Policies and by the cross governmental guidance.

Information Sharing: Advice for practitioners providing safeguarding services to children, young people, parents and carers July 2018 can be accessed via this link;
http://commsport/Departments/Safeguarding_Children/Information%20Sharing/Information_sharing_advice_practitioners_safeguarding_services.pdf

Further useful information can also be found in the Working Together to Safeguard Children Document 2018: https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

5.3.4 Information sharing must be done in a way that is compliant with the Data Protection Act, The Human Rights Act and the common law duty of confidentiality. However, a concern for confidentiality must never be used as a justification for withholding information when it would be in the child / young person's best interests to share information. The Caldicott Principles set out in information: To share or not to share? The Information Governance Review (Caldicott 2 Review), March 2013, provide general principles that health and social care organisations should use when reviewing their use of client information and exemplify good practice.
https://www.gov.uk/government/publications/the-information-governance-review

5.3.5 When in doubt, Trust staff should seek advice from the safeguarding children team.

5.4 Child Safeguarding Practice Reviews (CSPR) - Previously Serious Case Reviews SCR's

5.4.1 The purpose of a CSPR is explore serious child safeguarding cases, at both local and national level to identify improvements to be made to safeguarding and promoting the welfare of children. On completion of a local review co-ordinated by Safeguarding Children's Partnership the relevant of local learning is reported to and considered by the Children's Safeguarding Panel to determine any relevance to a National Learning Review. These reviews consider the wider importance for all practitioners working with children and families and for government and policy-makers. To understand systemic issues alongside individual practice and consider how policy and practice need to change and is critical to the system being dynamic and self-improving.

For further information, please consult Working Together to Safeguard Children 2018 Page 84-85 https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

5.4.2 **The Rapid Review (should be conducted within 15 days of notification of serious harm)**

5.4.2.1 The aim of this rapid review is to enable safeguarding partners to:

- Gather the facts about the case, as far as they can be readily established at the time.
- Discuss whether there is any immediate action needed to ensure children's safety and share any learning appropriately.
- Consider the potential for identifying improvements to safeguard and promote the welfare of children.
- Decide what steps they should take next, including whether or not to undertake a child safeguarding practice review.

5.5 The Trust places great importance in ensuring that there is a systematic approach to supporting staff during and following a child safeguarding practice review or learning lessons review. The C74 Safeguarding Children's Supervision Policy provides guidance to frontline practitioners and their managers on the support that should be offered, by who and when trust staff are involved in a case which has been notified to the Safeguarding Partnership and is to be reviewed. The Policy should be used in conjunction with HR71 Supporting staff involved in Stressful Situations Policy and the Trust Child Safeguarding Practice Review / Information for Professionals document, found in the Trust Safeguarding Children SharePoint site.

5.6 Staff who have had contact both historical and present with a child may be asked to complete a chronology supported by a summary and analysis of their involvement in preparation for the Children's Safeguarding Practice Review as requested by the Named Nurse/Named Midwife. This is within a short timeframe and should be supported by their manager to complete within a week of receiving request. The trust practitioner should consider identified lessons learned in terms of their own practice or failures in system and process, to support the analysis and learning shared by all professionals involved with the child from multiple agencies at the review.

5.6.1 The Named Nurse / Named Midwife and Named Doctor, Safeguarding Children Trainers and members of the Safeguarding Children Council and Professionals meetings are responsible for ensuring wide dissemination of learning from Children Practice Safeguarding Reviews (CPSR) across the Trust.

5.7 The NSPCC hold the National Repository for published CSPR and SCR's which can be found at: - https://www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/

5.8 Local CSPR's can be found on the Safeguarding Partnership website once published for a period of 1 year following publication. Further guidance on review process and guidance can be found on https://www.teescpp.org.uk/procedures-and-guidance-on-specific-issues-that-affect-children/serious-child-safeguarding-incidents-rapid-reviews-safeguarding-practice-reviews/

5.9 **Child Death Review**

5.9.1 The death of a child is a tragedy for his / her family and siblings and subsequent enquiries / investigations should keep an appropriate balance between forensic and medical requirements and the family's need for support.

5.9.2 Chapter 5 of Working Together to Safeguarding Children (2018) p.93 outlines the process and specific responsibilities to be followed in the event of an expected or unexpected death of a child and this process of review is coordinated by the Child Death Overview Panel (CDOP).

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1120062/child-death-review-statutory-and-operational-guidance-england.pdf

- An interagency Protocol ensures that information from the child death review process is systematically captured in every case to enable learning to prevent future deaths and, through the National Child Mortality Database, identify learning at a national level, and inform changes in policy and practice.

- The CDOP requests information from persons and/or organisations for the purposes of enabling and assisting the review/analysis process – the person or organisation must comply with these request, and if they do not, the CDOP may take legal action to seek enforcement.

5.9.3 The Child Death Review meeting (CDRM) as part of the Joint Agency Response (JAR) process is carried out where the child's death;

- Could be due to external causes

- Is sudden and there is no immediately apparent cause (including Sudden Unexpected Death in Infancy and Childhood (SUDI/C)

- Occurs in custody or where the child was detained under the Mental Health Act

- Where the initial circumstances raise any suspicions that the death may not have been natural

- Or in the case of a stillbirth where no healthcare professional was in attendance.

And should be attended by all on request from CDOP co-ordinators.
https://www.teescpp.org.uk/procedures-and-guidance-on-specific-issues-that-affect-children/tees-child-death-overview-panel/

6. Managing Risk to Safeguarding Children

6.1 No single professional can have a full picture of a child's needs and circumstances, and if families are to receive the right help at the right time, everyone who comes into contact with them has a role to play in identifying concerns, sharing information and taking prompt action. (Working Together to safeguard children 2018).

6.2 Recognising emerging problems and the potential for unmet needs of a child or young person is the simplest way to target support and intervention early and thus help reduce the risk of escalation and the need for statutory assessment under the Children Act 1989. Emerging research further highlights the significance of early intervention to prevent the multiple, overlapping, and co-occuring trauma, losses and stresses of adverse childhood experiences in their relationships that can impact on their development and recurring trauma in later adult life.

6.3 Early Help

6.3.1 All health professionals working with children or their parents must be aware of when it is appropriate to promote early help for families by seeking consent to refer to the appropriate Early Help hub an effective measure to safeguard children and meet the needs of a family where potential harm could be identified without support. Guidance for staff working with children and families on how to identify and respond to need is available in the local areas' procedures threshold guidance. If consent is not given and staff feel risk of potential harm may occur a safeguarding referral must be considered as per threshold documents below;

Durham Threshold Guidance: -
http://commsport/Departments/Safeguarding_Children/Lists/Threshold%20Documents/Attachments/2/0-19-Level-of-Need-Final-2016.pdf

Darlington Threshold Guidance: -
http://commsport/Departments/Safeguarding_Children/Lists/Threshold%20Documents/Attachments/4/Darlington%20Continuum%20of%20Need%20-%20Threshold%20Tool.pdf

Stockton and Hartlepool Threshold Guidance: -
http://commsport/Departments/Safeguarding_Children/Lists/Threshold%20Documents/Attachments/5/providing-the-right-support-to-meet-a-childs-needs-across-tees.pdf

6.3.2 Providing early help is more effective in promoting the welfare of children than reacting later. Early help means providing support as soon as a problem merges, at any point in a child's life, from the foundation years through to the teenage years. Early help can also prevent further problems arising; for example, if it is provided as part of a support plan where a child has returned home to their family from care, or in families where there are emerging parental mental health issues or drug and alcohol misuse.
More information on https://www.teescpp.org.uk/procedures-for-the-safeguarding-process/2-early-help/

6.4 The Voice of the Child

6.4.1 Effective safeguarding systems are child centred. Failings in safeguarding systems are too often the result of losing sight of the needs and views of the children within them, or placing the interests of adults ahead of the needs of children.

6.4.2 Children want to be respected, their views heard, to have stable relationships with professionals built on trust and for consistent support provided for their individual needs. Anyone working with children and young people should see and speak to the child; listen to what they say, take their views seriously; and work with them collaboratively when deciding how to support their needs. A child centred approach is supported by The Children Act 1989 and 2004.

6.4.3 As children rely on their parents and carers to ensure their medical needs are met, all episodes of child not brought to appointments must be followed up as robustly as possible to ensure that medical neglect is not indicated. Children not brought features in the majority of all reviews where children have been harm or have died and can be an indicator of wider form of neglect. Trust staff are required to refer to the trust's child not brought to appointments by parents / carers policy (C83) for further guidance aligned to www.tees.cpp.org.uk. Child not brought procedure.

6.5 Special Educational Needs & Learning Disabilities (SEND) and Autism

6.5.1 Every support should be provided to children with learning disabilities and autism to enable them to communicate their needs. Significant learning has been required where these needs and wishes have been ignored resulting in child deaths and poorer outcomes for children with protected characteristics. Disadvantage has also been highlighted in their transition between adult and children health services resulting deterioration of health outcomes and more consideration should be given by staff in the trust to age of maturity and not chronological age, turning 18 as a mark of how children with significant additional needs with cope moving into adult health care services and adaption of the adult health care services to the scaffolding the transitional care more.

6.5.2 The available UK evidence on the extent of abuse among disabled children suggests that disabled children are at increased risk of abuse, and the presence of multiple disabilities appears to increase the risk of both abuse and neglect. Staff need to be aware that in their

compassion for parents in managing a child with complex needs they don't miss the need to safeguard where harm or abuse may be occurring. The NSPCC has guidance on contributing factors to why safeguarding opportunities may be missed.

https://learning.nspcc.org.uk/safeguarding-child-protection/deaf-and-disabled-children#skip-to-content

6.6 **Contextual Safeguarding (Harm outside the Home)**

6.6.1 As well as threats to the welfare of children from within their families, children may be vulnerable to abuse or exploitation from outside their families. These extra-familial threats might arise at school and other educational establishments, from within peer groups, or more widely from within the wider community and/or online. These threats can take a variety of different forms and children can be vulnerable to multiple threats, including: -

- Exploitation by criminal gangs and organised crime groups such as County Lines https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/741194/HOCountyLinesGuidanceSept2018.pdf
- Trafficking https://www.teescpp.org.uk/specific-issues-that-affect-children/the-trafficking-of-children/
- Modern Day Slavery https://www.antislavery.org/slavery-today/modern-slavery/
- Online Abuse https://www.teescpp.org.uk/specific-issues-that-affect-children/information-technology-the-internet/
- Sexual Exploitation https://www.teescpp.org.uk/media/1019/cse_supplementory_guidance_to_wt.pdf
- Radicalisation https://www.teescpp.org.uk/specific-issues-that-affect-children/prevent-channel-referral-process/

6.6.2 Assessments of children in such cases should consider whether wider environmental factors are present in a child's life and are a threat to their safety and/or welfare. Children who may be alleged perpetrators should also be assessed to understand the impact of contextual issues on their safety and welfare. Interventions should focus on addressing these wider environmental factors, which are likely to be a threat to the safety and welfare of a number of different children who may or may not be known to local authority children's social care. Assessments of children in such cases should consider the individual needs and vulnerabilities of each child. They should look at the parental capacity to support the child, including helping the parents and carers to understand any risks and support them to keep children safe and assess potential risk to child. Navigating development in the adolescent years requires a different approach and staff need to be supported in having the right skills and knowledge to engage effectively through a trauma informed transitional safeguarding lens to respond appropriately to presenting behaviours of our young people presenting to the trust. Staff are encouraged to contact the safeguarding team to discuss concerning behaviours to support considering harm outside the home.

6.7 **Multiagency Child Exploitation (MACE) formerly VEMT (vulnerable, exploitation missing and trafficked)**

6.7.1 Practitioners may become aware of children and young people who are at risk of, or who are going missing, being sexually and/or criminally exploited and/or are being trafficked. The issues are likely to appear together in day to day practice and the overlap and interaction between them should always be borne in mind. Whilst children and young people go missing for a range of reasons, and for different lengths of time, there is always a concern for a child / young person when they are not where they should be and it is essential that any response to a missing child is timely, effective and proportionate.

6.7.2 Staff will be made aware of any children who are already identified as vulnerable and exploited through and discussed at MACE meetings as a flag should be placed on both the

child's Trak and SystmOne records by the Children's Safeguarding Team once notified by the MACE Team.

6.8 National Referral Mechanism

The National Referral Mechanism (NRM) is a framework for identifying and referring potential victims of modern slavery and ensuring they receive the appropriate support. Modern slavery is a complex crime and may involve multiple forms of exploitation. It encompasses:

- human trafficking
- slavery, servitude, and forced or compulsory labour

An individual could have been a victim of human trafficking and/or slavery, servitude and forced or compulsory labour. Victims may not be aware that they are being trafficked or exploited, and may have consented to elements of their exploitation, or accepted their situation.

If the potential victim is under 18, or may be under 18 (if unknown), an NRM referral must be made – children cannot be referred in using a Duty to Notify referral. Child victims do not have to consent to be referred into the NRM and must first be safeguarded and then referred into the NRM process. Therefore the expectation of trust staff is to ensure a children's safeguarding referral is completed to the Local Authority for a multiagency strategy discussion to be held on how best to safeguard the child.

6.9 Missing Children

6.9.1 Children who run away do so because they are unhappy or are afraid and missing can increase their vulnerability and place them in danger. Where staff suspect or become aware of a missing child, children's social care and the police should be informed at the earliest opportunity verbally and followed up by safeguarding referral. The 'Tees Statutory protocol for children missing from home and care' will be followed. Further guidance can be found on this protocol Tees procedures Children Who Go Missing - Tees Safeguarding Children Partnerships' Procedures (teescpp.org.uk)

6.10 Female Genital Mutilation (FGM)

6.10.1 Female Genital Mutilation (FGM) is illegal in England and Wales under the FGM Act 2003. It is a form of child abuse and violence against women. FGM comprises all procedures involving partial or total removal of the external female genitalia for non-medical reasons. Within the Trust the current care pathway for all children who have had or are suspected to have had FGM is via a referral to the Paediatric Forensic Network, Children and Young People's Clinic, GNCH, RVI. Advice on such cases should be sought, prior to a referral via the appropriate Specialist, please see Appendix 13 for Regional referral pathway for Sexual Abuse.

6.10.2 Section 5B of the Female Genital Mutilation Act 2003 introduces a mandatory reporting duty which requires regulated health and social care professionals and teachers' in England and Wales to report 'known' cases of FGM in under 18's to the police which they identify in the course of their professional work. The duty applies from 31 October 2015 onwards. Trust staff should report this through DATIX (Anonymised data will be provided to the Department of Health on a monthly basis via the Trust). Appendix 14 supports staff in ensuring risk assessment is correctly followed and should be recorded as such in patients records.

Further more detailed guidance and risk assessments can be found in the **Trust M48 Female Genital Mutilation guidance** on Guidance link on Sharepoint, informing a more detailed risk assessment to be carried out by our Midwives and Gynaecologists prior to and following the birth of a baby.

A guideline on how to record disclosures of FGM will be available on Tees procedures. https://www.teescpp.org.uk/specific-issues-that-affect-children/female-genital-mutilation-fgm/

Further guidance can be found at: - https://www.teescpp.org.uk/media/1022/fgm-guidance-email-with-links.pdf

Risk assessments for staff can be found on the Safeguarding Trust website also: - https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/585083/FGM_safeguarding_and_risk_assessment.pdf or Trust Children's Safeguarding SharePoint site.

6.11 Abductions Policy

Infant and child abductions are rare, however, the trauma and publicity surrounding such events highlights the importance of ensuring that, should an incident occur, the Trust has a comprehensive easy to follow response plan to:

- Ensure that staff are aware of how to raise the alarm quickly as time is critical.
- Ensure that staff are fully aware of their roles and responsibilities.
- Ensure that staff are deployed effectively to conduct a search of the area.
- Ensure effective communication and co-operation between Trust staff, the police and security services.
- Ensure effective communication with other agencies including Social Care.

If a member of staff becomes aware of the unexplained absence they should follow the guidance. Please see C12 Prevention & Management of Infant & Child Abduction Policy

6.12 Forced Marriage

6.12.1 Forced marriage is a marriage conducted without the full consent of both parties and where duress is a factor. This could involve threats of or actual violence or by putting psychological pressure on the victim (e.g. by suggesting that they will "shame" or "dishonour" their family if they do not comply) or by "tricking" the victim (e.g. taking them abroad without explaining the purpose). Forced marriage is an abuse of human rights and falls within the Government's definition of domestic violence. It is important to note that a forced marriage is not the same as an arranged marriage (where couple may be matched but where there is still a choice as to whether to marry or not). Victims of forced marriage can be both male and female. Please complete a safeguarding referral to social care and inform the police if a child presents and discloses they are married. It is now an offence to cause a child under the age of 18 to enter a marriage in any circumstances, without the need to prove that a form of coercion was used. Please contact our Local HALO support if you feel you have identified indicators suggestive of forced marriage link:-Halo House- BME Refuge Tees Valley (haloproject.org.uk) https://www.gov.uk/government/publications/the-right-to-choose-government-guidance-on-forced-marriage/multi-agency-statutory-guidance-for-dealing-with-forced-marriage-and-multi-agency-practice-guidelines-handling-cases-of-forced-marriage-accessible#healthcare-professionals-guidelines

6.13 Information Communication Technology & E-Safety

6.13.1 Professionals working with children, adults and families should be alert to the possibility that:

- child may have been / is being abused and the images distributed on the internet or by mobile phone.
- An adult or older child may be grooming a child for sexual abuse, including for involvement in making abusive images, or a child may be shown abusive images.
- An adult or older child may be viewing and downloading child sexual abuse images.

6.13.2 The Trust has an identified lead for E–Safety and policy in place. Please refer to ICT06 Email, Internet & Digital Media Acceptable Use Policy.

6.14 Prevent

6.14.1 Prevent is one of the four strands of Contest, the Government's strategy for countering terrorism and extremism in the UK. The four strands are: -

- PURSUE: to stop terrorist attacks.
- PREVENT: to stop people becoming terrorists or supporting terrorism.
- PROTECT: to strengthen our protection against a terrorist attack; and
- PREPARE: to mitigate the impact of a terrorist attack.

6.14.2 Healthcare professionals have a key role in PREVENT as this focuses on working with vulnerable individuals who may be at risk of being exploited by radicalisers and subsequently drawn into terrorist related activity. If staff are concerned that a vulnerable individual is being exploited they can raise their concerns via the Channel referral process managed by the Trust Adult Safeguarding Team

https://www.gov.uk/government/publications/prevent-duty-guidance

6.15 FII: Fabricated or Induced Illness

6.15.1 Fabricated or Induced Illness by parents or carers (FII) can cause significant harm to children. FII involves a well-child being presented by a parent/carer as ill, or a disabled or ill child being presented with more significant problems than he or she has in reality. This may result in extensive, unnecessary medical investigations being carried out in order to establish the underlying causes for the reported signs and symptoms. The child may also have treatments prescribed or investigations, procedures or operations which are unnecessary. These interventions can result in children spending long periods of time in hospital and some, by their nature, may also place the child at risk of suffering from harm or even death. (Appendix 12 and 13)

6.15.2 All health professionals must seek advice and support on concerns about FII from the Safeguarding Children Team and follow local procedures.

6.15.3 In all cases the overriding consideration in making decisions about information sharing in cases of FII must be the child's safety and wellbeing.

For further information, please see links below:
https://www.teescpp.org.uk/specific-issues-that-affect-children/fabricated-and-induction-of-illness-fii/

Perplexing Presentations (PP)/Fabricated or Induced Illness (FII) in children – guidance – RCPCH Child Protection Portal

6.16 Mental Capacity Act

6.16.1 The Mental Capacity Act applies in the same way as it does for adults in children over the age of 16 and a young person has capacity unless it is established he or she lacks it (Mental Capacity Act 2005 section 1 principle 1). The trust Mental Capacity Assessment should be used with children over the age of 16 who lack capacity because of an impairment of, or a disturbance in the functioning of, the mind or brain, and treatment or safeguards should be discussed with parents where best interests decisions are made around health care and treatment. If the child is deemed as having capacity but is making unwise decisions and placing themselves at significant risk a safeguarding referral should be made to support multiagency decision on how best to support and safeguard the young person. See Trust Policy (Mental Capacity Act, Deprivation of Liberty Safeguards (DoLS) C53).

6.17 Safeguarding Children in Emergency Department and those whose Parents / Carers are Receiving Adult Healthcare in the Emergency Department

6.17.1 Trust health professionals providing services to adult patients will be aware that those patients may be parents and any assessment must be considered in the context of their children's need for safe care and whether the adult's healthcare need compromises their ability to perform their parenting role effectively.

6.17.2 Professionals who become concerned that patient disclosures or health care needs that may prevent them from offering adequate care to any child in their care must seek advice and follow the Adult Risk Behaviour and Child Distress (ABCD) Safeguarding Pathway and associated risk assessment form and guidance (Appendix 8 and 8a). These enquiries should also be made of older adult patients who may be providing care for grandchildren. Consideration should also be given to other adults with vulnerabilities in the family home who the patient may have caring responsibilities for as part of 'think family' safeguarding approach. The adult safeguarding team should be contacted on 01429 522746 if you have any concerns.

6.17.3 When a pregnant woman presents at the Emergency Department. The Midwife or Specialist Midwife should be informed as per pathway in Appendix 9 of this policy.

6.17.4 The Emergency Department staff must utilise A CHILD mnemonic as an aide memoire to consider safeguarding issues when children and young people present for emergency care. In response to the increasing numbers of children at risk to extra familial harm through exploitation staff in the CYPED / ED and Urgent Care must also use the Child Exploitation screening tool for all children who attend over the age of 10 with indicators as per tool.

6.18 Domestic Violence & Abuse – including FGM

6.18.1 The Domestic Abuse Act 2021 defines;

Behaviour of a person (A) towards another person (B) is 'domestic abuse if;

(a) A and B are each aged 16 or over and are personally connected to each other, and
(b) The behaviour is abusive which is include

Physical or sexual abuse, Violent or threatening behaviour, Controlling or coercive behaviour, Economic abuse, Psychological, emotional or other abuse and it does not matter whether the behaviour consists of a single incident or a course of conduct.

6.18.2 Domestic violence and abuse often exists as the result of and/or alongside other presenting problems for the parent/s e.g. drug and alcohol abuse, mental health difficulties, adverse childhood experiences. These factors can increase the difficulty for parent/carers to provide adequate care and can result in abuse or neglect of the child.

6.18.3 **Trust staff must follow The Trust C81** Domestic Abuse Policy and the Safeguarding Partnership procedures to understand how Domestic violence and abuse can impact on the development and well-being of a child. As the Domestic Abuse Act 2021 recognises children as a victim of Domestic Abuse and acknowledges the harm that children under the age of 18 years who see, hear, or experience the effects of the abuse require safeguarding. Consent to submitting a children's safeguarding referral is not required from parents where an adult is suspected of being a victim of domestic abuse or makes a disclosure.

6.18.4 **Multi Agency Risk Assessment Conference (MARAC)**

6.18.5 The Trust and safeguarding teams are committed to supporting the MARAC process. MARAC provides a consistent approach to supporting victims of domestic violence and abuse who are identified at risk of serious harm. The conference aims to agree plans and actions

that improve the safety and wellbeing of the identified person and if appropriate their children. The MARAC process does not override pre-existing procedures where safeguarding children issues are concerned. Further information and the risk indicator checklist is available in the Trust Policy Domestic Abuse C81.

Staff are required to check for alerts on Trakcare or SystmOne as this will indicate when an adult is discussed at MARAC and is vulnerable as a victim of domestic abuse. Where there is an alert staff need to record clearly their enquiries with the patient as to how the injury was caused and whether this was perpetrated by another. Ask about children, check with CHUB or EDT if there is social care involvement, if no involvement consider children's safeguarding referral if adult's presentation is in response to injuries or emotional distress due to domestic abuse. Staff can contact Children's Safeguarding team or EDT if out of hours if they require further information or advice regarding the detail of the MARAC alert.

6.19 MAPPA

6.19.1 MAPPA stands for Multi-Agency Public Protection Arrangements. It is the process through which the Police, Probation and Prison Services work together with other agencies including NTHFT to manage the risks posed by violent and sexual offenders living in the community in order to protect the public.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/819400/MAPPA_Guidance.odt
The trust has an internal guideline which communicates, the measures in place in the Trust to facilitate the exchange of information in relation to violent, sexual and terrorist offenders, and victims, who may attend hospital sites, or other external premise (including their homes) to access a healthcare service / or receive healthcare as a patient or as a visitor, this is managed by Head of the trusts security services.

6.20 MATAC

6.20.1 MATAC is a Multi-Agency Tasking and Coordination protocol, with regular meetings led by Cleveland Police, along with key partners including NTHFT to assesses and plan a bespoke set of interventions to target and disrupt serial perpetrators of domestic abuse and/or support them to address their behavior. The core objective of MATAC is to ensure that agencies work in partnership to engage serial domestic abuse perpetrators in support, take enforcement action where required, and protect vulnerable and intimidated victims.

6.21 Private Foster Carers

6.21.1 A Private foster arrangement is essentially one that is made privately (that is without the involvement of the local authority) for the care of a child under the age of 16 (18 if disabled) by someone other than a parent or a close relative for a period of 28 days or more it is important to follow local procedures and notify children's social care to ensure appropriate checks are carried out to protect the child.

6.22 Safeguarding the Unborn Baby

6.22.1 Where an unborn baby is likely to be in need of services from children's social care when born, a referral is to be made as per Safeguarding Partnership procedures. Wherever possible the referrer should share their concerns with the prospective parent(s) and seek to obtain agreement to refer to children's social care, unless this action may place the unborn child at risk.

6.22.2 These circumstances include (but are not limited to):

- Where concerns exist regarding the mother's ability to protect.
- Where alcohol or substance abuse is thought to be affecting the health of the expected baby.

- Where the expectant parent(s) are very young and a dual assessment of their own needs as well as their ability to meet the baby's needs is required.
- Where a previous child in the family has been removed because they have suffered harm or been at risk of significant harm.
- Where a person who has been convicted of an offence against a child, or is believed by child protection professionals to have abused a child, has joined the family.
- Where there are acute professional concerns regarding parenting capacity, particularly where the parents have either severe mental health problems or learning disabilities.

6.22.3 A pre-birth assessment will be completed by children's social care, if the case progresses to an Initial Child Protection Conference and the Unborn is subject to a child protection plan. An appropriate birth response plan will be put in place following consultation with the multi-agency team around the family to ensure a safety plan is in place to safeguard the baby once delivered

6.23 **Responding to bruising, injuries or unusual marks in immobile babies, non independently mobile children and young people.**

Injuries in non-mobile babies are unusual and highly suggestive of a non-accidental cause. Non-mobile babies cannot cause injuries to themselves and therefore must be considered to be at significant risk of abuse if presenting with an injury.

Non-mobile babies with injuries may present to any healthcare setting across Teesside and a unified, consistent approach to these injuries should be taken.

It is also vital that a robust, consistent process is followed for non-independently mobile infants, children and young people who present with injuries. Whilst the likelihood of an injury having a legitimate, accidental cause in these children is slightly greater than in a non-mobile baby, the likelihood of a non-accidental injury remains high and must be considered.

Injuries in non-mobile and non-independently mobile children must never be interpreted in isolation and must always be assessed in the context of a medical and social history and the child's developmental stage. Any suggested explanations offered by the parents or carers must be fully explored and appropriately questioned with a high degree of professional curiosity. If an accidental injury has occurred, the history is usually very clear and the parent or carer presents to a healthcare professional quickly. Even injuries that are accidental may have safeguarding concerns in relation to supervision, for example, mitigations may need to be put in place to prevent further injuries to this or other children.

Partnership working between all healthcare agencies, social care and, if required, police is key. Please refer to the trust guidance document 'Teesside procedure for management of non-mobile babies non-independently mobile infants, children and young people with bruising, injuries or unusual marks presenting to emergency services' alongside the Tees procedures multiagency guidance. Appendix 19,20,21,22,23 present a flowchart of expectations by trust staff to support safe decision making.

6.24 **Handling Historic Abuse Allegations**

6.24.1 The term 'historical abuse' is commonly used to refer to disclosures of abuse that were perpetrated in the past.

6.24.2 When an adult makes a disclosure to a professional that s/he suffered abuse as a child, the professional to whom the disclosure is made should follow Tees or Durham procedures, where it is believed that the alleged perpetrator has contact with a child a referral should be made to Children's Social Care so that information can be gathered and a decision can be made whether to apply child protection procedures in respect of the child/ren with whom the alleged perpetrator has contact.

6.25 **Historic Sexual Abuse**

NHS South Tees Hospitals Foundation Trust carries out all historic Child Sexual Abuse (CSA) medicals for the Teesside population. Historical cases are considered to be 7+ days following the assault. Where a disclosure is made in relation to historical CSA, this should be reported to Children's Social Care for the area they reside in and they will then contact Cleveland Police, who then liaise with the nominated Consultant Paediatrician at South Tees NHS Foundation Trust to arrange the CSA medical.

6.26 **Acute Child Sexual Abuse Medical Assessment**

6.26.1 Where acute child sexual abuse is suspected, (acute meaning within the preceding seven days) the children will be seen at the Paediatric Forensic Network (PNF) at Newcastle Great North Children Hospital (GNCH).

6.26.2 The Social Worker or Police Vulnerability Unit will directly contact the Unit above and arrange for the child to be examined there. The child should not be taken to the Emergency Department or Local Paediatric Ward.

6.26.3 Where a child presents to a doctor with a genital injury / problem it may be appropriate for the child to be seen directly by the GNCH. This should be discussed with the Local Consultant Paediatrician On call and Paediatric Forensic Network (PFN) Doctor. A Safer Referral may not be required at this time. In suspected cases of CSE consideration should be given to a referral to the Paediatric Forensic Network even if the CYP has stated that sex was consensual.

6.26.4 Where a child has presented to a doctor with genito urinary symptoms or concerning medical history but there is no disclosure or consideration of abuse and they would like a second opinion they should refer the child to the Local Paediatric Consultant for same day assessment on Paediatric Day Unit for a medical opinion only (not for sexual abuse examination as NTHFT is not commissioned to do this) Please refer to appendix 10 flowchart for further guidance.

6.27 **Child Protection Medicals**

A medical assessment should always be considered when there is an allegation, a suspicion or a disclosure of child abuse involving a suspicious injury, suspected sexual abuse or serious neglect.

A medical assessment involves a holistic approach to the child and is carried out by a Paediatric Consultant at the request of the social care following receipt of a safeguarding referral to considers the child's well-being including an assessment of the child's development and a broad understanding of their cognitive ability.

7. Staff Monitoring

7.1 The Trust recognises that involvement and managing safeguarding issues can have an impact on staff. All Trust staff are given the opportunity for appropriate safeguarding children supervision and debriefing, Staff should refer to the Trust Safeguarding Children Supervision Policy C37.

7.2 Safeguarding children supervision is mandatory for all, community paediatric nurses, community neonatal nurses, community midwives, speech and language therapists and looked after children senior nurses working in the Trust and these groups of staff are required to attend a supervision session quarterly, the supervision is delivered by the safeguarding children team. Records are kept of attendance shared with managers whose responsibility is to ensure appropriate attendance.

7.3 Safeguarding children advice and guidance is available to any member of Trust staff on request from the safeguarding children team within working hours.

8. Incident Reporting

8.1 Certain incidents which involve safeguarding children issues should be reported via the Trust Datix incident reporting system, please refer to Appendix 7.

8.2 It is the role of the Named Nurse to ensure that all serious incidents related to safeguarding children are identified, thoroughly investigated and lessons learned trust wide.

9. Recruitment & Selection

9.1 The Trust recruits and selects in accordance with Recruitment Selection Policy (HR26) and one person on the interview panel must have undertaken the safe recruitment training ensuring that they are aware of safe recruitment principles when selecting and appointing an individual.

9.2 The Trust is legally required to conduct a Disclosure and Barring (DBS) check on staff appointed who will work or volunteer with vulnerable groups as part of the appointment process.

10. Training

10.1 Safeguarding children training is mandatory for all Trust staff and is governed by the 2019 Intercollegiate Document Framework https://www.rcn.org.uk/Professional-Development/publications/pub-007366 supported by Trust Safeguarding Learning and Development Policy C73 which identifies five levels of competence, and gives examples of trust staff groups that fall within each of these.

10.2 It is the responsibility of the individual member of staff to ensure they arrange and complete relevant training; in addition, managers have a responsibility to monitor staff attendance and facilitate attendance.

11. Managing Safeguarding Children Allegations Against Staff

11.1 The framework for managing allegations is set out in Working Together to Safeguarding Children (2018). The framework applies to all who work with children and young people, including those who work in a voluntary capacity. It also covers a wider range of allegations other than child protection, including 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.
- Behaved in a way that indicates s/he is unsuitable to work with children.

11.2 It is essential that any allegation of abuse made against a person is dealt with consistently, fairly, quickly and in a way that provides effective protection for the child and at the same time supports the person who is the subject of the allegation. An integral part of the framework for managing allegations against staff is the role of the **Local Authority Designated Officer (LADO)**. The LADO is responsible for the management and oversight of individual cases and must be informed of all allegations or concerns relating to staff or volunteers that fit the criteria above.

11.3 The LADO will provide advice and guidance to any employer providing services for children. Where necessary they will liaise with Children's Social Care and other agencies, monitor the progress of cases and work to ensure that all allegations are dealt with appropriately.

11.4 It is essential that, following agreement with the LADO, managers ensure that they keep the LADO informed of the on-going investigation.

11.5 Managers should seek advice and discuss any concerns with the Trust HR Named Senior Officer for allegations against staff who will contact the relevant LADO and they will liaise with as necessary social care and the police. Please refer to the Trust Disciplinary Policy HR24 for further information on HR responsibilities.

12. Review & Revision Arrangements

12.1 This policy will be reviewed tri annually or sooner if revisions are required in line with statutory guidance and developments.

13. Consultation Details

13.1 This document has been developed in consultation with:

- Chief Nurse, Director of Nursing, Quality and Patient Safety.
- Deputy Chief Nurse.
- Named Doctor
- Designated Nurse Safeguarding and LAC Hartlepool and Stockton CCG.
- Designated Nurse Safeguarding and LAC Durham Dales Easington and Sedgefield CCG.
- Senior Clinical Matron, Healthy Lives.
- Senior Clinical Matrons, Responsive Care
- Head of Midwifery.
- Trust Safeguarding Children Professionals.
- Heads of Training Departments.
- Human Resources.

14. Policy Monitoring

14.1 Section 11 of the Children Act 2004 audits are undertaken by the Named Nurses / Doctors Safeguarding Children for each Safeguarding Partnership. Action plans are developed as required and monitored through the Trust Safeguarding Children Steering Group work programme.

14.2 The Safeguarding Children Professionals have an audit programme which is monitored through the Trust Safeguarding Children Steering Group.

15. References & Recommended Reading

15.1 This policy has been developed in line with current legislation and guidance for the protection of children and the promotion of their welfare.

1. Children Act 1989 London HMSO. http://www.legislation.gov.uk/ukpga/1989/41/contents

2. Children Act 2004 London HMSO. http://www.legislation.gov.uk/ukpga/2004/31/contents

3. Care Quality Commission: Fundamental Standards (Last updated August 2022). The fundamental standards - Care Quality Commission (cqc.org.uk)

4. HM Government (2014) Multi-agency guidance for dealing with Forced Marriage. https://www.gov.uk/guidance/forced-marriage

5. HM Government (2016) Multi-agency statutory guidance on FGM. https://www.gov.uk/government/publications/multi-agency-statutory-guidance-on-female-genital-mutilation

6. Information to share or not to share? The Information Governance Review Caldicott 2 Review), March 2013.https://www.gov.uk/government/publications/the-information-governance-review

7. Information Sharing: Advice for practitioners providing safeguarding services to children, young people, parents and carers (HM Government, 2018). Information sharing: advice for practitioners (publishing.service.gov.uk)

8. Safeguarding children, young people and adults at risk in the NHS Safeguarding accountability and assurance framework https://www.england.nhs.uk/wp-content/uploads/2015/07/B0818_Safeguarding-children-young-people-and-adults-at-risk-in-the-NHS-Safeguarding-accountability-and-assuran.pdf

9. The National Institute for Health and Clinical Excellence (NICE) CG89 When to suspect child maltreatment - July 2009. Changed to When to suspect child maltreatment in under 18's February 2016.http://www.nice.org.uk/nicemedia/pdf/CG89QuickRefGuide.pdf

10. HM Government (2015) Prevent Duty Guidance. https://www.gov.uk/government/publications/prevent-duty-guidance

11. Protecting Children and Young People: the responsibilities of all Doctors (GMC2012). http://www.gmcuk.org/static/documents/content/Protecting_children_and_young_people_-English_1015.pdf

12. RCPCH (2014) Safeguarding Children and Young People: roles and competencies for health care staff; Intercollegiate Document London. https://www.rcoa.ac.uk/system/files/PUB-SAFEGUARDING-2014_0.pdf

13. RCPCH (2021) Child Protection Portal – Perplexing presentations (PP) / Fabricated or Induced Illness (FII) in children – guidance. https://childprotection.rcpch.ac.uk/resources/perplexing-presentations-and-fii/

14. Fabricated and Induced illness tees procedures https://www.teescpp.org.uk/procedures-and-guidance-on-specific-issues-that-affect-children/perplexing-presentationsfabricated-induced-illness/

15. Safeguarding Disabled Children Practice Guidance. https://www.gov.uk/government/publications/safeguarding-disabled-children-practice-guidance

16. What to do if you are worried a child is being abused (HM Gov. 2015). https://www.gov.uk/government/publications/what-to-do-if-youre-worried-a-child-is-being-abused--2

17. Working Together to Safeguard Children (2023) Working together to safeguard children 2023: statutory guidance (publishing.service.gov.uk)

16. Monitoring & Compliance

The following processes will be monitored for compliance as outlined in the table below. Where monitoring identifies deficiencies, an action plan will be produced.

Process Reference	Process	Lead Auditor (Job Title)	Scrutiny Committee	Frequency
Section	FGM	Midwifery	Safeguarding Operational / Summary to Safeguarding Committee	As per audit calender within work programme
Section	Child Not Brought Audit			As per audit calender within work programme
Section	NICE CG89			As per audit calender within work programme
Section	Non mobile Baby Procedure			As per audit calender within work programme
Section	Adult risk taking behaviour			As per audit calender within work programme

Incident Reporting:

This policy will be monitored primarily through exception reporting via the Incident Reporting System as and when an incident occurs.

If any deviation from the policy occurs, an Incident report is created using the following categories:

Incident Reporting System

Category:	Safeguarding Incident
Sub category:	
Adverse Event:	

17. Policy Revisions Change Control

The table below identifies the areas where this policy has been reviewed; where these are minor changes staff should ensure that they take this opportunity to refresh knowledge of the whole policy and their responsibilities in relation to this and not just focus on the minor changes.

Policy Ref	Version Number	Revision to Page	Description of Revisions Made	Approved Date
Appendix 10	1	p.42	Trust Genital injuries pathway	2022
Appendix 12,13,14,15	1	p.45 - 48	FII / PP Trust Guidance documents.	2021
Appendix 16	1	p.49	Regional referral pathway for Child Sexual Abuse Forensic Medical Assessment	2023
Appendix 19,20,22,23, 24	1	P 52 - 59	Non mobile baby and non independently mobile infant and child procedures	Nov 2023
Appendix 24	1	p.60	Guidance for staff re the purpose and aim of CPiS system.	2018

Appendix 1

Referral flowchart for ALL Trust Health Staff
When you are concerned about a child / young person who is at risk of significant harm

TIMESCALES | **ACTIONS**

Same Day

Be open and honest with parents and carers, where you intend to share your concern and with other colleagues. Unless to do so would place the child, carer or health professional at risk of harm. Wherever possible communicate with the child in a way that is appropriate to their age and understanding. **(Care must be taken not to ask leading questions)** If the child or family is unable to communicate effectively in English or uses another form of communication or an interpreter should be used. **If there are immediate safeguarding risks do not allow the child to leave the department or be left in the sole care of parent/ carer**

Same Day

Discuss if required with Senior colleague in Department. Own manager /clinical lead. Named Nurse /Senior Nurse Safeguarding Children (01642 624477) **or Consultant Paediatrician on call**

- Make a VERBAL referral to the appropriate local authority social care Hub – Durham MASH require an email .
- Be clear that you are making a verbal Child Protection referral and what your safeguarding concerns are.
- Follow up with a written referral on the same working day using the **appropriate** referral form for the local authority area in which the child lives and send as per local process.
- Retain a copy for your records and record referral made, when and why.
- A copy MUST also be sent to the Trusts Safeguarding Children Team nth-safeguardingchildren@nhs.net.
- The practitioner who has identified the risks and has the concerns or conversations with the child or family should be the person who completes the referral.

Same Day

STOCKTON and HARTLEPOOL Social Care (CHUB)
Office Hours: The Children's Hub 01429 284284
Email: childrenshub@hartlepool.gov.uk
Emergency Duty Team (EDT) Out of Hours 01642 524552

DURHAM Social Care (MASH)
03000 267979
Email;
firstcontact@durham.gov.uk

Please visit Children's Safeguarding SharePoint site if you need any other Local authority details.

Record Inform

Record information on health records, within 24 hours, send a copy to the safeguarding team on nth-tr.safeguardingchildren@nhs.net who will then send a copy to GP and HV/SN

Social Care should inform the referrer in writing of their decision within 1 Working day. This can include;

1. No further action
2. Referred to other services/ manage under early help assessment
3. Undertake S17 or S47 enquiry

If no feedback is received within 3 working days contact the social worker to confirm the outcome and to clarify any decisions made

If you are dissatisfied with the decisions and there are conflicting views. You should immediately contact the manager responsible for the decision. Individual cases must be dealt with urgently and at source. All discussions are to be recorded

If still dissatisfied with the outcome contact the Safeguarding Children Team to discuss use of professional challenge process (App. 4 and 5 in this Policy)

Appendix 2

Flowchart from NICE Guideline CG89 – When to suspect Child Maltreatment

If you encounter an alerting feature described in this guidance it is good practice to follow the process outlined below.

Listen and observe
Take into account the whole picture of the child or young person. Sources of information that help to do this include:

- any history that is given
- report of maltreatment, or disclosure from a child or young person or third party
- child's appearance, demeanour or behaviour
- symptom
- physical sign
- result of an investigation
- interaction between the parent or carer and child or young person

Seek an explanation
Seek an explanation for any injury or presentation from both the parent or carer and the child or young person in an open and non-judgemental manner. An **unsuitable explanation** is one that is;

- Implausible, inadequate or inconsistent:
  - With the child or young person's presentation, normal activities, medical condition (if one exists), age or developmental state, or account compared with that give by parent and carers.
  - Between parents or carers
  - Between accounts over time
- Based on cultural practice, because this should not justify hurting a child or young person.

Record
Record in the child or young person's clinical record exactly what is observed and heard from who and when. Record why this is of concern.

CONSIDER Child maltreatment
If an alerting feature prompts you to consider child maltreatment:

- Look for other alerting features of maltreatment in the child or young person's history, presentation or parent – or carer – child interactions now or in the past.

And do one or more of the following;

- Discuss your concerns with a more experienced colleague, a community paediatrician, child and adolescent mental health service colleague, or a named or designated professional for safeguarding children.
- Gather collateral information from other agencies and health disciplines.
- Ensure review of the child or young person at a date appropriate to the concern, looking out for repeated presentations of this or any other alerting features.

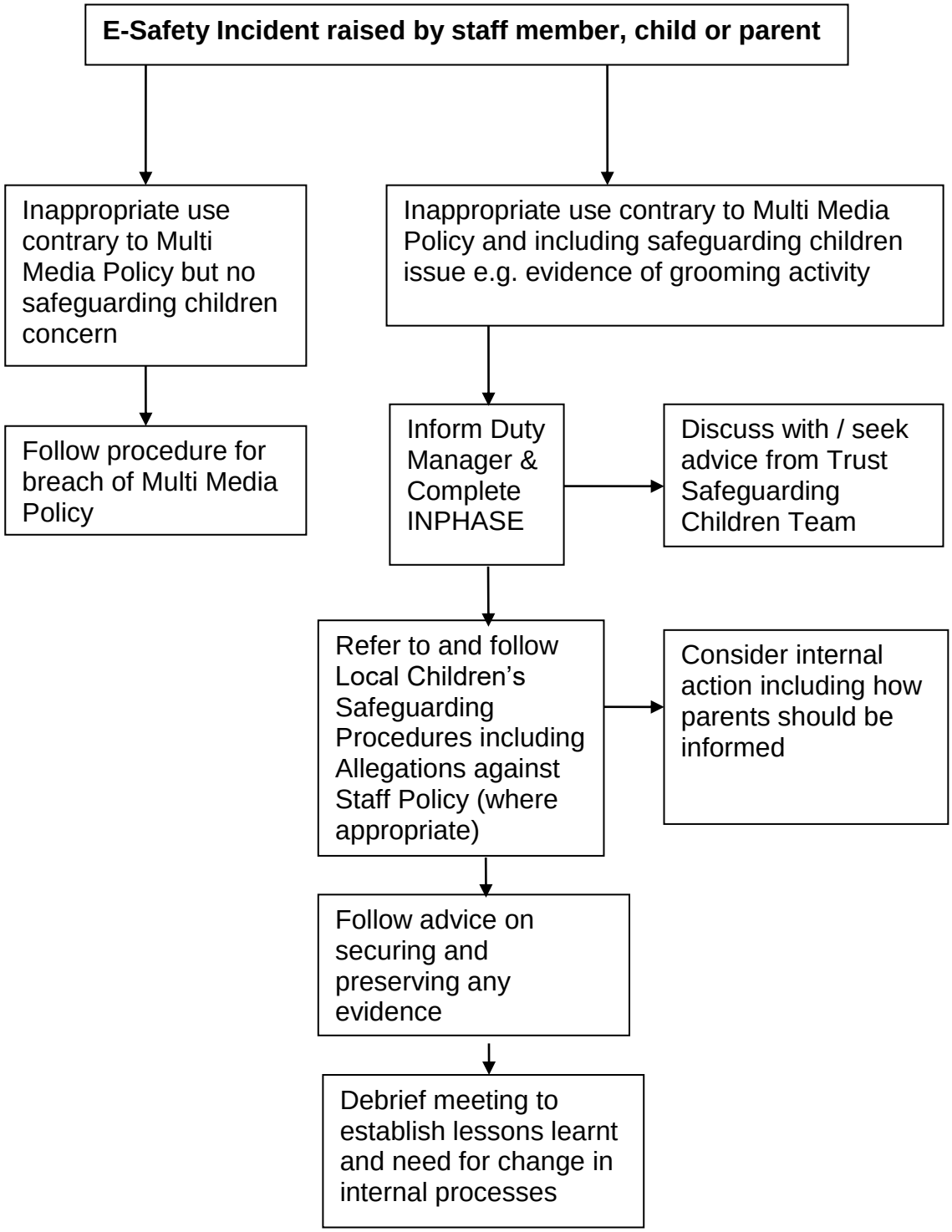
At any stage during the process of considering maltreatment the level of concern may change and lead to exclude or suspect maltreatment.

SUSPECT child maltreatment
If an alerting feature or considering child maltreatment prompts you to suspect child maltreatment refer the child or young person to children's social care, following Local Safeguarding Children's Partnership procedures. www.teescpp.org.uk

Exclude child maltreatment
Exclude child maltreatment if a suitable explanation is found for alerting feature.
This may be the decision after discussion of the case with a more experienced colleague or gathering collateral information as part of considering child maltreatment.

Record
Record all actions taken and the outcome.

Appendix 3

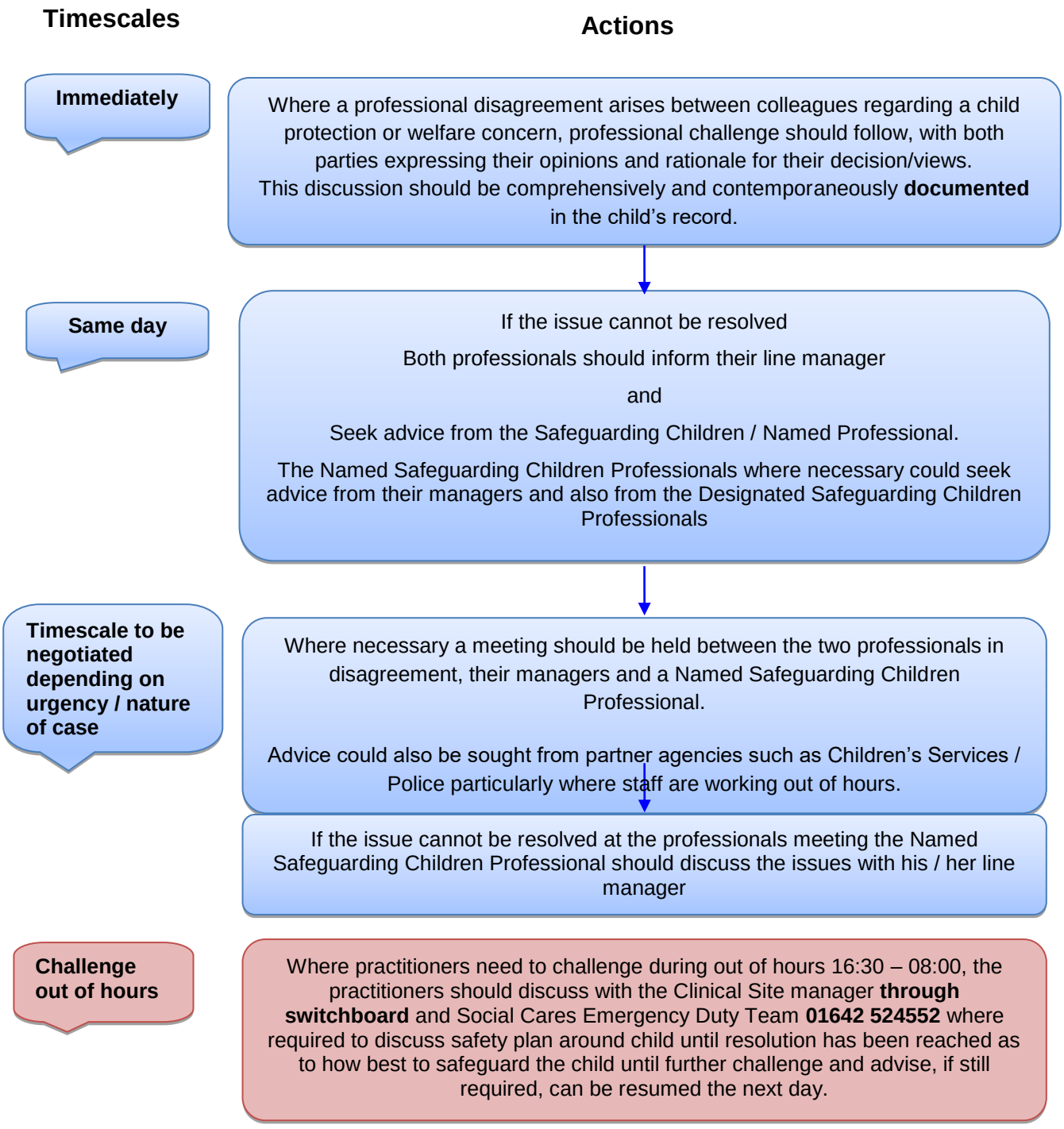


ICT06 Email, Internet & Digital Media Acceptable Use Policy

Appendix 4

North Tees and Hartlepool NHS Foundation Trust

Internal Escalation flowchart for professional challenge and resolution of professional disagreement in work relating to Child Protection or Welfare concerns must be read in conjunction with tees proceduresHttps://www.teescpp.org.uk/procedures-for-the-safeguarding-process/17-professional challenge-and-resolution-of-professional-disagreement/



Title: Internal professional challenge flowchart
Updated by Named Nurse: Lorraine Mulvey as part of policy review and Ratified by Safeguarding Council 2023

Appendix 5

North Tees and Hartlepool NHS Foundation Trust

Interagency Escalation flowchart for professional challenge and resolution of Professional disagreement in work relating to Child Protection or Child Welfare concerns with tees procedures https://www.teescpp.org.uk/procedures-for-the-safeguarding-process/17-professional-challenge-and-resolution-of-professional- disagreement/

Timescales	Actions
Immediately	If a professional disagrees with a decision or response from any partner agency regarding child protection or child welfare concerns the professional challenge should follow, with both agencies expressing their opinions and rationale for their decision/views This discussion should be comprehensively and contemporaneously documented in the child's record.
Same day	If the issue cannot be resolved between the professionals the professional should inform their line manager and seek advice from Safeguarding Children / Named professional. *The initial reason for referral to partner agency should be further explored and if additional information to support the referral is available this should be shared*
	The Safeguarding children/Named professional should attempt to resolve the disagreement by having a discussion with the partner agency which will be documented and copied to the partner agency
	It the Safeguarding Children / Named professional considers it appropriate an interagency meeting should be held between the agency raising the professional challenge and the receiving agency to discuss the difference in views. At this point the LSCB Business Support Team should be notified of the nature of the professional challenge: this is in accordance with Tees LSCB procedures
	If the issue cannot be resolved at the interagency meeting the Named Safeguarding children professional should discuss the issues with his / her line manager
	If resolution still cannot be found, the relevant head of service should raise the issue with the Trust's representative on the Local Safeguarding Children Board
Challenge out of hours	Where practitioners need to challenge during out of hours 16:30 – 08:00, the practitioners should discuss with the Clinical Site manager **through switchboard** and Social Cares Emergency Duty Team **01642 524552** where required to discuss safety plan around child until resolution has been reached as to how best to safeguard the child until further challenge and advise, if still required, can be resumed the next day.

Title: Interagency professional challenge flowchart
Updated by Named Nurse: Lorraine Mulvey as part of policy review and Ratified by Safeguarding Council 2023

Appendix 6

Standard Operating Procedure Supporting staff involved in a Rapid Review or Children's Safeguarding Practice Review

1. Purpose and Background

North Tees and Hartlepool Foundation Trust places great importance in ensuring that there is a systematic approach to supporting staff during and following involvement in a Child Safeguarding Practice Review (CSPR).

The overall aim of this standard is to give guidance to frontline practitioners and their managers on what support should be provided and by who when they are involved in a case which is under review by Safeguarding Partnership.

This Standard should be used in conjunction with **Trust Policy (HR71) Procedure for supporting staff involved in stressful situations** and the Child Safeguarding Practice Review / Information for Professionals document found in the Trust Safeguarding Children SharePoint Site.

2. Scope

The purpose of reviews of serious child safeguarding cases, at both local and national level, is to identify improvements to be made to safeguard and promote the welfare of children. Learning is relevant locally, but it has a wider importance for all practitioners working with children and families and for the government and policy-makers. Understanding whether there are systemic issues, and whether and how policy and practice need to change, is critical to the system being dynamic and self-improving.

Principles for learning and improvement:

- There should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the welfare of children, identifying opportunities to draw on what works and promote good practice.
- Professionals must be fully involved in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith.

Case reviews are not part of disciplinary procedures relating to an individual. If information comes to light which indicates action should be taken, this is for the employing agency to consider.

3. Responsibilities

Expectations: Named Nurse Safeguarding Children

- To brief the line manager of any professionals who may be involved in the review once the decision has been made to proceed to a case review.
- To update the line manager of any planned meetings / interviews which may involve practitioners and when they will take place.
- To update the line manager of the findings of the review and when it is to be published and if there is any media interest.
- To inform the practitioners safeguarding children supervisor to offer reflective supervision regarding the case and review.

Expectations: Line Manager

- To contact staff member and offer immediate and on-going support.
- To arrange face to face briefing as appropriate.
- To support staff in advance of any review meetings to ensure the staff member is fully prepared and aware of internal and external sources of support.
- To formally debrief staff member once review is published.

Expectations: Staff Members

- To seek support as necessary and follow Trust policy HR71.
- To be supportive of colleagues involved in any case reviews.
- To seek additional reflective safeguarding supervision if required.

4. Standard

The Trusts appointed reviewer usually Named Nurse Safeguarding Children will update the Line manager of the names of professionals who may be or have been involved in the case to be reviewed and request that those professionals be informed, the Trust professionals document will be shared

Staff will require support from their Line manager when involved in a CSPR

Support should be timely and appropriate, before, during and after the review

Head of Department, Clinical Lead or Safeguarding Children Supervisor may be the appropriate person to ensure on-going support is given

Staff members line manager (where appropriate) is responsible for supporting staff and implementing Trust Policy HR71 Procedure for supporting staff involved in stressful situations

Trust Policy HR71 highlights the process to be implemented and information regarding support agents within the organisation who can provide ongoing support and an opportunity for a debrief prior to publication of reports

It is not appropriate for the Trust lead carrying out the review to offer direct support to staff members involved in the review, however as part of the review process the Trust lead may be required to have conversations with staff involved.

Appendix 2 of Trust Policy HR71 must be completed and stored in the member of staff's personal file

5. Monitoring and Compliance

Following a case review line managers will be able to evidence that staff have been supported in line with Trust Policy HR71

6. References

Working Together to safeguard children (2018) Government available as download from https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

7. Contacts

Named Nurse Children's Safeguarding
01642 624474 nth-tr.safeguardingchildrensupervision@nhs.net

Appendix 7

Standard Operating Procedures

Reporting Safeguarding Children and Child Protection Incidents via INPHASE

1. Purpose and Background

North Tees and Hartlepool Foundation Trust is required by section 11 Children Act (2004) to discharge its duties with regard to the safety and welfare of children. Trust staff identify, assess and manage safeguarding children and child protection situations on a daily basis. The Trust is responsible for employing, training and providing good quality safeguarding children supervision to competent staff to enable them to carry out this role responsibly, safely and successfully in line with the Trust's statutory responsibilities to safeguard and promote the welfare of children.

The overall purpose of this Standard Operating Procedure (SOP) is to give guidance to services and staff to manage relevant and significant safeguarding children and child protection adverse events are correctly and safely in line with statutory process via the Trusts DATIX system to support identification of learning and data trends.

This SOP should be used in conjunction with Trust Policy **RM15 Reporting Management of Incidents including Serious Incidents Never Events.**

2. Scope

The outcome expected in the application of this standard on the reporting process is the production of relevant, timely and uniformly presented adverse event information from which lessons can be learnt.

This SOP is for all services and staff groups regardless of their role and responsibilities and all staff should use this SOP when reporting adverse events involving children and young people

A child is anyone aged between 0 and their eighteenth birthday. For the purposes of child protection this SOP also applies to unborn babies.

3. Responsibilities

The Trust Safeguarding Children Team will refer all staff to the standard as an event relevant to its use occurs. The standard will be available to staff on the Trust intranet and will also be referred to during mandatory training.

All Trust staff are accountable to the organisation for their actions in helping to protect children and young people by reporting events affecting the well-being of children, as part of their role and responsibility with regard to safeguarding all children. This applies to any child seen on Trust property or in the community during working hours.

All Trust staff are accountable for the application of this standard whether or not they are providing services directly to children and young people.

All Trust Managers and Heads of Services are required to support the application of this standard within their relevant services.

4. Standard

All Trust staff will consider whether or not there is a need to use DATIX system, based on the following points.

Definitions of safeguarding children and child protection adverse events which require DATIX reporting.

All staff are required to report incidents and events as listed below. Staff should note that this list is not exhaustive and may be updated at any time: -

- Any death or serious injury of a child where the cause is not known.
- Unexplained or non-accidental injury to a child, including admission of the child to hospital for investigations in relation to a suspected non–accidental injury (this excludes children attending for child protection medicals).
- Any untoward event, involving a child, to include events such as abduction, hostage taking,

abandonment or violence.

- Any case referred for consideration as a serious case review or learning lessons review.
- Any injury to a child on Trust premises or caused by any property of the Trust.
- Any receipt of an allegation made by a child about a Trust employee involved in their care.
- Any allegation made against a Trust employee who works with children.
- Any E-Safety /information governance breaches.
- All incidents where a member of staff is unable to carry out priority child protection duties, such as attending an Initial / Review Child Protection Conference and they are on duty.
- Any incident when communication between agencies has not occurred and opportunities to intervene in a timely manner to protect a child has been missed, e.g. not being notified of Strategy / professionals meetings or ICPC.
- Any incident of child abuse or maltreatment which is recognised by or disclosed to a member of staff which was not previously acted on by another member of staff who held the information earlier, resulting in a delay or failure to refer to children's social care. Failure to follow safeguarding children procedures (includes FGM Female genital mutilation).
- Any incident when a child attends for a child protection medical without written background information from a social worker.
- Any incident where a partner agencies have failed to respond to clinician's communications regarding a child not having been brought to appointments.

5. Monitoring and Compliance

Regular audit and analysis of DATIX incidents will inform the Safeguarding Children professionals in the Trust of event trends and will be included in risk management processes as agreed within the organisation.

The Named Nurse Safeguarding Children will prepare a quarterly report on all DATIX incidents or child protection events to the Safeguarding Children Steering Group

Significant learning may be shared across the Trust via the Safeguarding Children Steering Group. Team meetings and training.

6. References

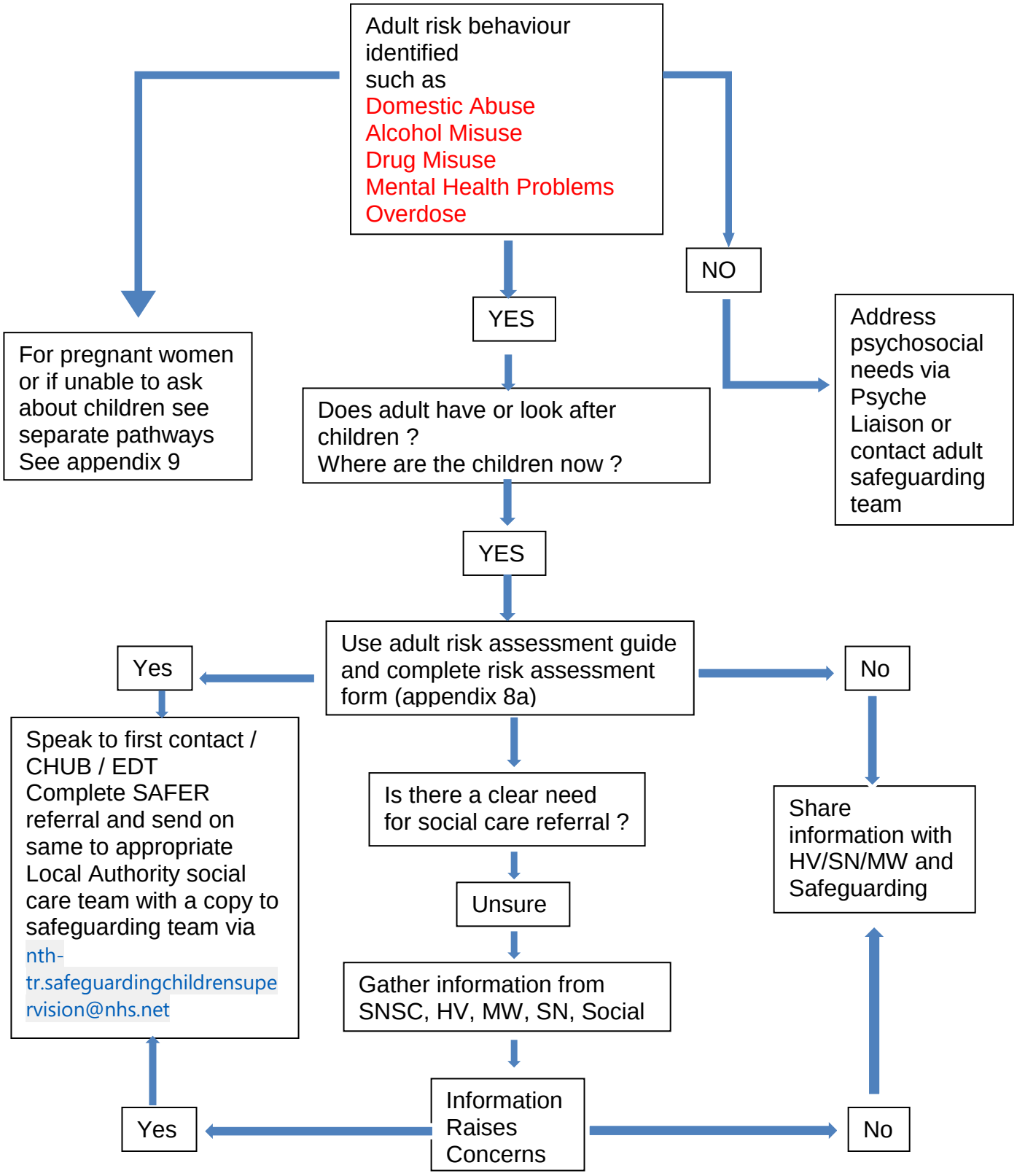
RM15 - Reporting Management of Incidents including Serious Incidents Never Events.
Serious Incident Framework (2015) NHS England.

7. Contacts

Named Nurse Safeguarding

Appendix 8

Adult Risk Behaviour Pathway



Key: HV – Health Visitor
SN – School Nurse
SAFER – Children's Safeguarding Referral
MW – Midwife
EDT – Emergency Duty Team
SNSC –Senior Nurse Safeguarding Children

Appendix 8a

Adult Behaviour Risk Assessment Form

If an adult ≥ 18 years attends with the following behaviours or risk factors and has their own or cares for other children, please complete this risk assessment to understand when information needs to be shared or a safeguarding referral is required: all cases where :-

- Domestic violence even if children not present or it took place away from home disclosed
- Acute mental health crisis
- Overdose and deliberate self-harm
- Substance abuse / misuse including recreational
- Alcohol misuse / abuse

Adult's name: **Date of birth**:

Adult's address:

☐ ☐ ☐ ☐ ☐

Describe the event leading to the attendance: Insert text here

Is the patient pregnant? Yes ☐ No ☐ If yes consult Pregnancy & Adult Risk behaviour pathway

Does adult have children: Yes ☐ No ☐ **Relationship to children:** Choose an item.

Does adult live with the children: Yes ☐ No ☐

Does adult have parental responsibility: Yes ☐ No ☐

Does adult care for other people's children? Yes ☐ No ☐

Relationship to children: Choose an item. **Where were the children during the event?**

Where are children now and who are they with?

Was a child physically injured? Yes ☐ No ☐ **If yes then a referral to social care is mandatory**

Is the adult capable of looking after a child on discharge? Yes ☐ No ☐ Unable to comment ☐

Have there been incidents of a similar nature? Yes ☐ No ☐

Where is the patient going on discharge from the ED?

Children's details: Name: DOB:

Name: DOB:

Name: DOB:

Summary of concerns: Write here what you consider the impact of the adult's behaviour could have on their ability to parent / look after children

Once information has been gathered consider which of the following options is most appropriate:

There is a risk of significant harm / vulnerability: Yes ☐ No ☐

If yes complete a SAFER referral and attach this form

The information gathered is important to share with another involved professional: Yes ☐ No ☐

If yes consider threshold and inform patient that safeguarding referral is to be complete or request consent to shared with universal service Health Visitor/School Nurse/GP if promoting the health and wellbeing of children patient is in contact with is required.

Actions taken: Choose an item.

Practitioners details:

Name: Designation:

Date of assessment:

Appendix 8b

Safeguarding Children of Adults with Mental Health, Substance, Alcohol or Domestic Abuse Issues in the Emergency Department/ Minor Injuries Unit

Adult Behaviours & Child Distress Guide (ABCD)

Research tells us that when parents or carers have one or more of the following issues it can significantly increase the possibility of a safeguarding concern for the children* in their care.

- mental health issues (including self-harm behaviours)
- substance misuse problems (including alcohol & drugs)
- domestic abuse within the family relationships

This risk assessment guide should be used to gather relevant information, aid risk assessment, prompt good record keeping and support referrals (if required) when an adult attends the Emergency Department where one or more of these issues are present

1. Is the patient pregnant? (See pathway for pregnant women (**Appendix 9**)
2. Does the patient have care of their own or other people's children? If **yes,** consider the points below
3. Where were the children at the time of the incident?
4. Did the patient have care of the child at the time of the incident?
5. Did the children witness the incident?
6. Were the children physically injured during the incident? (If yes to this question a referral to Social Care should be made)
7. Where are the children now and who is caring for them?
8. Will the patient be caring for their own or other children when discharged and are they capable of doing so?
9. Will the patient be returning to their own or an alternate address? (record the detail)
10. Who will be at the address the adult is returning to?
11. Is this the first attendance or have there been further incidents of a similar nature?
12. Do you need to check if the child is subject to a Protection Plan**?

PLEASE ENSURE YOU RECORD CAREFULLY THE OUTCOME OF THE ABOVE ASSESSMENT

Adult Behaviours and Child Distress Guide (ABCD) Dr Gill Davidson V2 200116

YOU MUST ALWAYS RECORD, WHERE POSSIBLE, THE DEMOGRAPHIC DETAILS OF THE CHILD Once you have gathered the above information you should consider the following options:

- Is there is a risk or potential risk of significant harm to the child(ren), if so you must follow Tees procedures and make a referral to social care

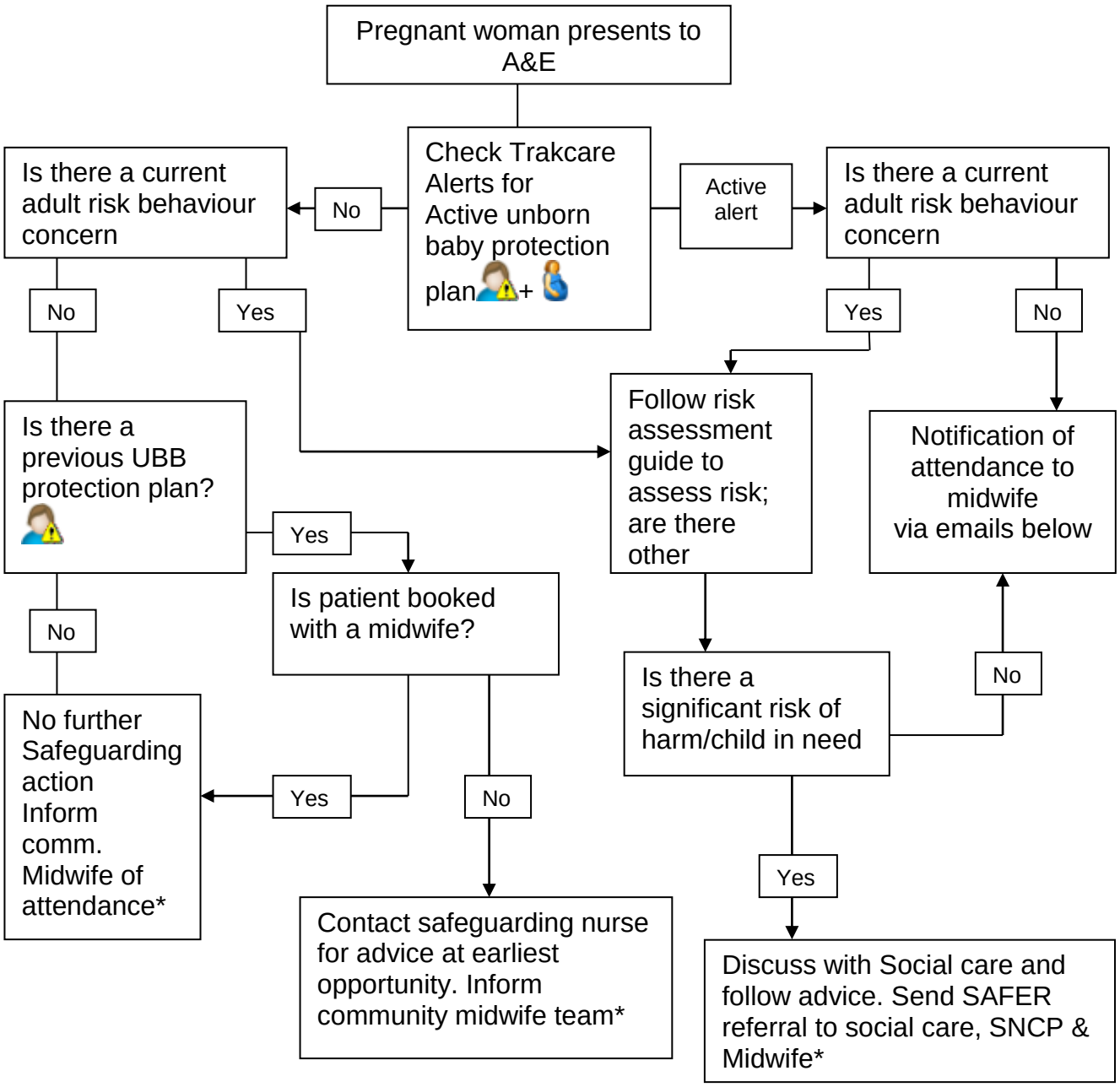
- If you do not consider there to be a risk of significant harm but you wish to share information with relevant professionals complete the sharing of information form (you must have consent from the parent to do so)

The Trust Safeguarding Children Team can provide you with advice around individual cases; if they are not available you can seek advice from a duty social worker

In law children remain children up until their 18th birthday

***Tees PROCEDURES WEBSITE for specific locality www.teescpp.org.uk for Hartlepool and Stockton Children and www.durham-lscb.gov.uk for County Durham Children

Appendix 9



Please inform community midwife relevant to the area and address pregnant woman resides of attendance at A&E or UCC.

1. Peterleecommunity.midwives@nhs.net
2. Nth-tr.hartlepoolcommunitymidwives@nhs.net
3. Nth-tr.stocktonsouthmidwives@nhs.net

Appendix 10

Genital Injury Pathway for Children presenting to Urgent Care/A and E/Children's Admission Units at North Tees and Hartlepool NHS Foundation trust

Child presents with genital

⇩

Detailed history of mechanism of injury, social background and identify any safeguarding concerns

⇩

Straightforward history eg caught in zipper, straddle injury. No delay in presentation or safeguarding concerns

⇩

If examination of child with chaperone present is consistent with mechanism of injury reported, address as any other injury.

⇩

Concerns raised from history or mechanism of

⇩

External assessment of injury in the presence of a chaperone is required to determine any immediate medical treatment i.e excessive bleeding. Monitor PEWS.

If concerns regarding **management of injury** discuss with A&E Consultant (if child in UCC /Paediatric Consultant /Gynaecologist or Urologist on call

If further discussion prompts concern Paediatric Consultant to discuss with Paeds Forensic Network

⇩

If mechanism of injury unclear or safeguarding concerns sexual abuse needs to be considered and discussed with on call Paediatric Consultant

ALL DISCLOSURES AND GENITAL FOREIGN BODIES should prompt further discussion with

⇩

If Paediatric Consultant has safeguarding concerns or mechanism of injury is unclear to discuss with Paediatric Forensic Network (0191 282 4753), available for advice/support/referrals 24 hours a day
Child will require a referral to Children's Social Care who will involve the Police
Refer to Children's Safeguarding Policy
Appendix 13 Sexual Abuse including FGM
Appendix 14 Regional Sexual Abuse Pathway
Also on www.teescpp.org.uk

Note - Child identified as needing assessment by Police for acute sexual abuse (within last 7 days) - Direct referral by Police/Social Worker to Paediatric Forensic Network

Appendix 11

Information Sharing (CP-IS) SystmOne and Trakcare.

CP-IS alerts clinicians to the presence of a **Child Protection Order** or **Looked After Child Plan**

- For unplanned care attendances (Urgent Care and Emergency Department)
- On Pregnant woman record whose unborn child has a pre-birth child protection plan in place.

CP-IS connects more than 80 different IT systems used across health and children's social care organisations in England, to share safeguarding information, and better protect society's most vulnerable children. The system is dedicated to developing an information sharing process that will deliver a higher level of protection of children who visit NHS unscheduled care settings. It provides additional child protection information to staff, shares local authority information with the NHS and allows staff to deliver a higher level of child protection.

Sharing information effectively across health and care settings is vital in protecting vulnerable children and young people and preventing further harm. CP-IS focuses on three specific categories • Those subject to a child protection plan. If a child/pregnant women presents at any of these unscheduled care settings and CP-IS identifies that a child/unborn has an allocated social worker, the social worker should be informed of attendance as per routine departmental procedures and midwifery services as per Appendix 9 of this policy.

Alert is displayed as either red, amber or green 

on the patient banner.

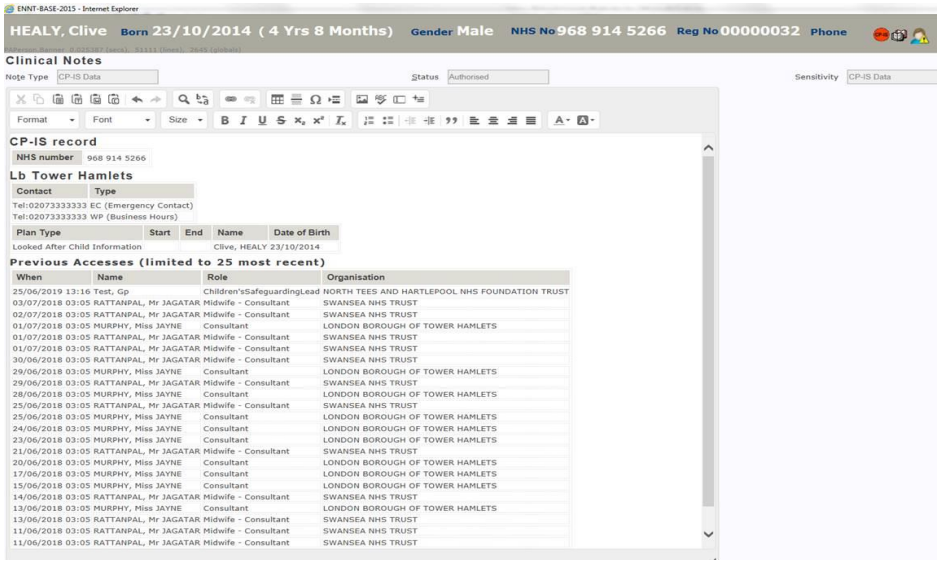
When the record is retrieved on Trak or SystmOne this triggered a call to be made via patients NHS number to Local Authority informing them of the attendance.

A Red 

alert will be displayed to indicate that a CP-IS call has been made where there is Safeguarding Data present for the patient.

The user MUST select the alert to view the entire data associated with the patient which includes the type of safety plan, social service and contact details, associated for this visit and up to 25 previous visits to unplanned care centres (including date and time when viewed previously).

Appears like this on Trakcare



If there are safeguarding concern identified at this visit then a safeguarding referral needs to submitted verbally to the social worker named on CP-IS system verbally and forwarded in writing in 24 hours. If CP-IS does not identify the above three categories, but trust staff still have a safeguarding concern a full risk assessment is still required and actions to safeguard as normal.

If named social worker cannot be reached verbal referral followed by written referral should be sent to the appropriate local authority social care front of house contact numbers / emails as listed on children's safeguarding sharepoint site.

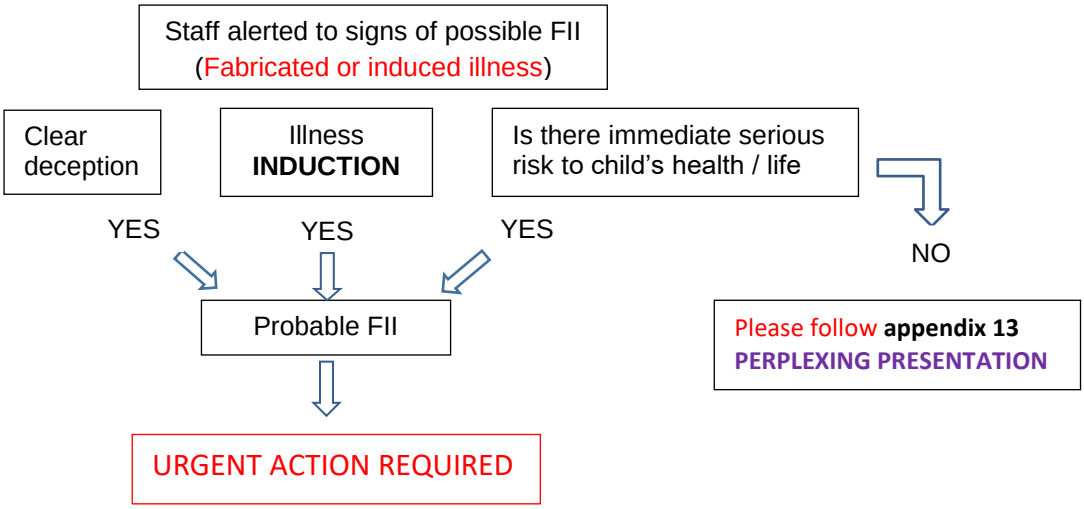
The Green 

will be displayed to indicate that a CP-IS call has been made and there is NO data present for the patient. When this icon is selected nothing will occur as there is no data present.
The Amber will be displayed to indicate that a CP-IS call has been made but the message failed to connect. When this icon is selected nothing will occur as there is no data present. NOTE: three attempts are made to connect before the message will timeout. However, each time the Patient Banner is accessed during the visit a further call will be initiated to try and retrieve the data, if a successful call to CP-IS is made this icon will be replaced by one of the above depending on what is returned. It does NOT include information from GP practices, schools or health visitors.

Note: Users must check the patient banner to view the CP-IS icons.

Appendix 12

Safeguarding response to Fabricated Illness



Refer to children's social care, or police as Fabricated or Induced Illness. A COPY of SAFER referral to be sent to NAMED DOCTOR / Please inform Safeguarding Senior Nurse of your referral verbally and send copy of SAFER referral to nth-tr.safeguardingchildrensupervion@nhs.net

Following referral, discussions must take place with children's social care / Police / Paediatrician to determine;

- If the child is ill and requires immediate medical attention this should be sought with consideration to supervision of parents around the child during transfer to hospital.
- Immediate protection is required until further investigations are completed as determined with the Paediatrician as to the needs for a child protection medical.
- Professionals need to agree who is going to inform the parents of the referral and when it is safe to do so.

Multiagency Strategy to be held with relevant professionals and Lead Paediatrician and Named Doctor / Safeguarding Senior Nurse to review evidence of FII concerns and future medical and placement needs of the child.

If further chronology information is required, Named Nurse or Senior Nurse to provide Urgent Care / A&E attendance information, co-ordinate with other relevant health professionals information for any re-convened Strategies, ICPC etc.
Further guidance on FII / PP can be found at
https://childprotection.rcpch.ac.uk/resources/perplexing-presentations-and-fii/ and

Guidance on chronology writing

Any professionals requested to complete a chronology by the safeguarding team must do so on the following template as per **appendix 15** as this will support the team in collating health information together. An analysis or your involvement and any areas of concerns or unusual presentation of child must be considered when completing your chronology in preparation of this being requested within any professional or social care meeting that may follow. If you require any guidance on chronology writing please contact the team on 01642 624477 or visit https://www.teescpp.org.uk/procedures-and-guidance-on-specific-issues-that-affect-children/childs-chronology-policy-procedure-practice-guidance/

Appendix 13

Trust Staff response to PERPLEXING PRESENTATION – Where there is no evidence of immediate harm

- Trust staff who have concerns re FII/PP should contact Children's Safeguarding Team on 01642 624477 or nth-tr.safeguardingchildrensupervision@nhs.net to seek advice from a Senior Nurse Children's Safeguarding Specialist.
- If immediate risk has not been identified and PP suspected Senior Nurse to identify all health professionals involved, including any Paediatrician (s) and offer safeguarding supervision to practitioner where possible to analyse risks with the practitioner identifying concerns.
- Senior Nurse to contact CHUB / MASH regarding any previous history of FII/PP.

Senior Nurse to provide summary of concerns to the NAMED DOCTOR and discuss the need for '**Multiagency Meeting** and '**Chronology**' requests. (**See appendix 15**) To inform Named Doctor the name of the Paediatrician (RPC) who the child is open to in the Trust (if applicable)
Named Doctor to discuss with the **Responsible Paediatric Consultant (RPC)** concerns raised and request to lead and explore concerns further. If not open to local consultant the Named Doctor to share concerns with Named Doctor of the Trust the child is open to. Senior Nurse to review child and family records and inform Safeguarding admin team details of the professionals who need to provide chronologies and send out Trust chronology template with date for completion of chronologies and when these need to be returned for collation by the admin team (date/ time and, venue for meeting) including any Paediatricians from Tertiary centres. A&E / UCC data to be provided by Senior Nurse for chronology. Paediatrician to seek appropriate support for completion of their chronology.
Trust chronology TEMPLATE to be used to support collation of chronologies from professionals and to highlight TIMELINE of potential concerns / pattern recognition / cumulative harm / false reporting between professionals etc.)

Named Doctor and Responsible Paediatric Consultant (RPC) to consider discussing CONSENT with parents / carers to ascertain a response to holding a multiagency meeting to develop an assessment plan; ***'to understand the state of child's health and medical needs'*** and to inform parents of all professionals who are to be invited and required to share information. **GP / HV / SN / or any other identified specialist health professionals, Education and Social Care (if involved)**
Legal Basis: Best Interests of the Child, Necessary and Proportionate where INDUCTION IS NOT SUSPECTED.
To ascertain: **-** Collating all current health service involvement

- Verifying all reported diagnoses
- Identifying whether children's social care is already involved.
- Professionals exploration of parents, views, fears, beliefs, wishes
- Professionals exploration of child's views, fears, beliefs, wishes.
- Siblings health and family functioning.

If CONSENT is NOT given by parents / carers and doctors are unable to **establish the state of health and medical needs** of the child a children's safeguarding referral should be considered for submission with collated health chronologies and request for Strategy discussion to establish multiagency opinion on presenting indicators of risk around FII / PP.

Outcome of MDT Consensus reached that the child is at significant risk of harm ? Consider risk to discussing with parents need for safeguarding referral.

Safeguarding referral to be completed by the Responsible Paediatric Consultant with support from NAMED Doctor / NAMED or SENIOR NURSE

If social care determine threshold has been met and Strategy to be held Lead Paediatrician, and Senior Nurse should attend Strategy with support if requested from NAMED DOCTOR / NAMED NURSE. If Paediatrician cannot attend then Named Doctor should attend on their behalf. SN to make sure social care are aware of all the staff involved in MDT

OUTCOME OF STRATEGY MEETING – **Section 47 assessment.** RPC to invite parents for MDT meeting to feedback outcome of MDT meeting with social workers and develop a HERP alongside single assessment of risk.

Parents do not support health and social care plan

Reconsider the need for children's safeguarding referral

Physical and / or psychopathology does not fully explain the concerns around

- Child's current state of health
- Areas of continuing uncertainties
- Nature and level of harm to child
- **'Health and Education Rehabilitation Plan' (HERP)** ***Please see Appendix 14*** offered to parents.

Parents support **'Health and Education Rehabilitation Plan' (HERP)**

Rehabilitation Proceeding

LONG TERM MONITORING
SN to follow up in 6 months via safeguarding supervision

Physical and or psychopathology is explained and FII/ PP is no longer a concern

Appendix 14

Health and Education Rehabilitation Plan Template

Child's Name		Name of Responsible Clinician:	

What does the child need ?	Actions to achieving goal	Who will ensure this happens ?	When By ?	Outcome for child:	Date for Review:

Appendix 15

FII Chronology

Name of child:	
DOB (dd/mm/yy):	**National Health Service Number (NHS No.)**
Address	**Other Professionals**
Complied by:	**Agency:**

Date of Event dd/mm/yy	Age of child at time of event	Significant Event	Recorded by which Agency / Professional	Action Taken and Outcome if known	Analysis of Event / Current Situation and the Impact if known

Aligned with Chronology on www.teescpp.org.uk updated December 2023

Appendix 16

Regional Referral Pathway for Child Sexual Abuse (CSA) Forensic Medical Assessment

The aim of a medical assessment is to meet the **medical/sexual health and forensic needs** of the child/young person. If there are concerns about sexual abuse, sending patients to the Emergency Department (A&E dept) or GP is **never** appropriate ***unless they are medically unwell***.

Children/young people are seen via the Paediatric Forensic Network (PFN) at the Great North Children's Hospital, RVI for recent (within 7 days) cases and in a local service for non-recent cases (over 7 days- years). **Consideration should be given** for a forensic examination up to **10 days** in penile/vaginal penetration in a pubertal young person. ***Advice can always be sought from PFN.***

- **A normal examination** is a neutral finding and doesn't exclude sexual abuse including penetrative abuse.
- **The swab is not the job:** Forensic evidence is injuries (fresh or healed), sexually transmitted infections AND DNA. Non-DNA forensic evidence can be found in both recent and non-recent cases.

YP Information Video	**Ctrl + click:**	PFN Charlie Video
Children's Information Video	**Ctrl + click:**	PFN Doctopus Video

In both services the following apply:

- Patients are always seen by a female doctor.
- Pre-pubertal children **never** have an invasive examination.
- The carers & young people are **always** able to stop the assessment at any time & are distracted during the process, which is conducted in an unhurried, sensitive manner.
- Both services see children and young people (C&YP) from 0 to their 16th birthday.
- Young people may be seen up to 18yr if they:
  - Have learning disabilities.
  - Are fostered or in care (Children who are Looked After) and have special needs.
  - YP 16 years or older & not in the categories above, are seen by **Adult SARC** service.

Adult cases ≥ 16 years old 24/7 - Cleveland Police, Durham Police & Northumbria Police: 03302230099

Sexual abuse is likely to have occurred within **the last 7 days**
In pubertal YP if penile/vaginal penetration discussion with PFN should be considered up to 10 days

YES

Paediatric Forensic Service 24/7

- Child/young person should be referred to the local children's services or Police by telephone.
- They will then arrange the assessment.
- Will be seen on the **same day or the following day at the Children & Young People's clinic, GNCH, RVI, Level 3 Victoria Entrance, Victoria Rd, NE1 4LP.**
- Child/young person are accompanied by a social worker and/or Police officer.

Paediatric Forensic Network
Office hours: 0191 282 4753
Out of Hours: 0191 233 6161
Ask for the paediatric consultant on call for child sexual abuse

NO

Non Recent CSA–local service – Office hours

- Contact local non-recent CSA service
- Will be seen **within a few weeks** at local clinic.

Non Recent Sexual Abuse Service

Durham 0191 387 6371

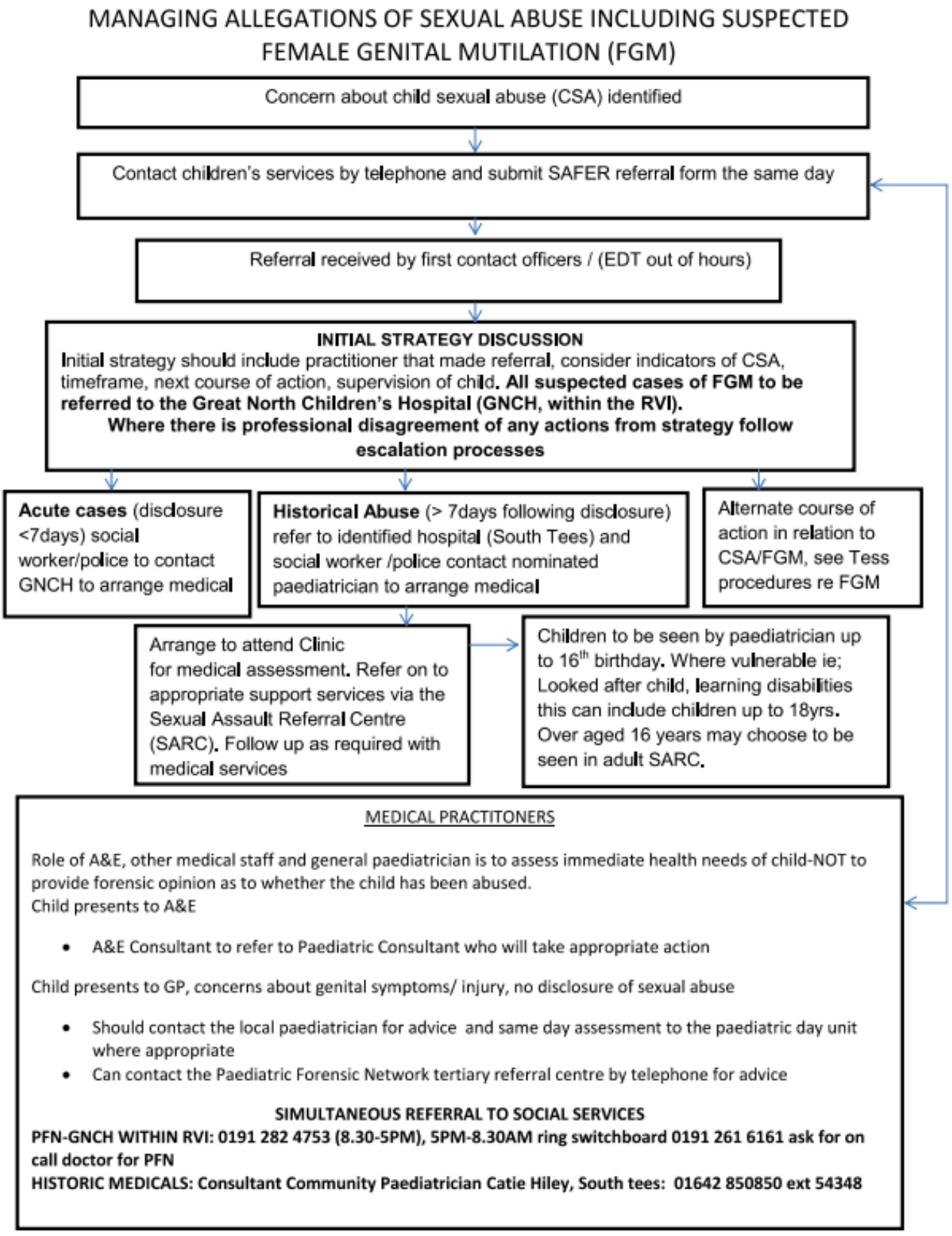
Newcastle & Gateshead 0191 282 4753
tnu-tr.nepaediatricforensicservice@nhs.net

Northumberland & North Tyneside 0344 811 8111
& ask for the Child Protection consultant on call

Teesside area 01642 854 348

South Tyneside & Sunderland 0191 569 9012
stsft.ccsunderlandreferrals@nhs.net

Appendix 17


MANAGING ALLEGATIONS OF SEXUAL ABUSE INCLUDING SUSPECTED FEMALE GENITAL MUTILATION (FGM)
Concern about child sexual abuse (CSA) identified
Contact children's services by telephone and submit SAFER referral form the same day
Referral received by first contact officers / (EDT out of hours)
INITIAL STRATEGY DISCUSSION
Initial strategy should include practitioner that made referral, consider indicators of CSA, timeframe, next course of action, supervision of child. All suspected cases of FGM to be referred to the Great North Children's Hospital (GNCH, within the RVI).
Where there is professional disagreement of any actions from strategy follow escalation processes
Acute cases (disclosure <7days) social worker/police to contact GNCH to arrange medical
Historical Abuse (> 7days following disclosure) refer to identified hospital (South Tees) and social worker /police contact nominated paediatrician to arrange medical
Alternate course of action in relation to CSA/FGM, see Tess procedures re FGM
Arrange to attend Clinic for medical assessment. Refer on to appropriate support services via the Sexual Assault Referral Centre (SARC). Follow up as required with medical services
Children to be seen by paediatrician up to 16th birthday. Where vulnerable ie; Looked after child, learning disabilities this can include children up to 18yrs. Over aged 16 years may choose to be seen in adult SARC.
MEDICAL PRACTITONERS
Role of A&E, other medical staff and general paediatrician is to assess immediate health needs of child-NOT to provide forensic opinion as to whether the child has been abused.
Child presents to A&E
A&E Consultant to refer to Paediatric Consultant who will take appropriate action
Child presents to GP, concerns about genital symptoms/ injury, no disclosure of sexual abuse
Should contact the local paediatrician for advice and same day assessment to the paediatric day unit where appropriate
Can contact the Paediatric Forensic Network tertiary referral centre by telephone for advice
SIMULTANEOUS REFERRAL TO SOCIAL SERVICES
PFN-GNCH WITHIN RVI: 0191 282 4753 (8.30-5PM), 5PM-8.30AM ring switchboard 0191 261 6161 ask for on call doctor for PFN
HISTORIC MEDICALS: Consultant Community Paediatrician Catie Hiley, South tees: 01642 850850 ext 54348

Appendix 18

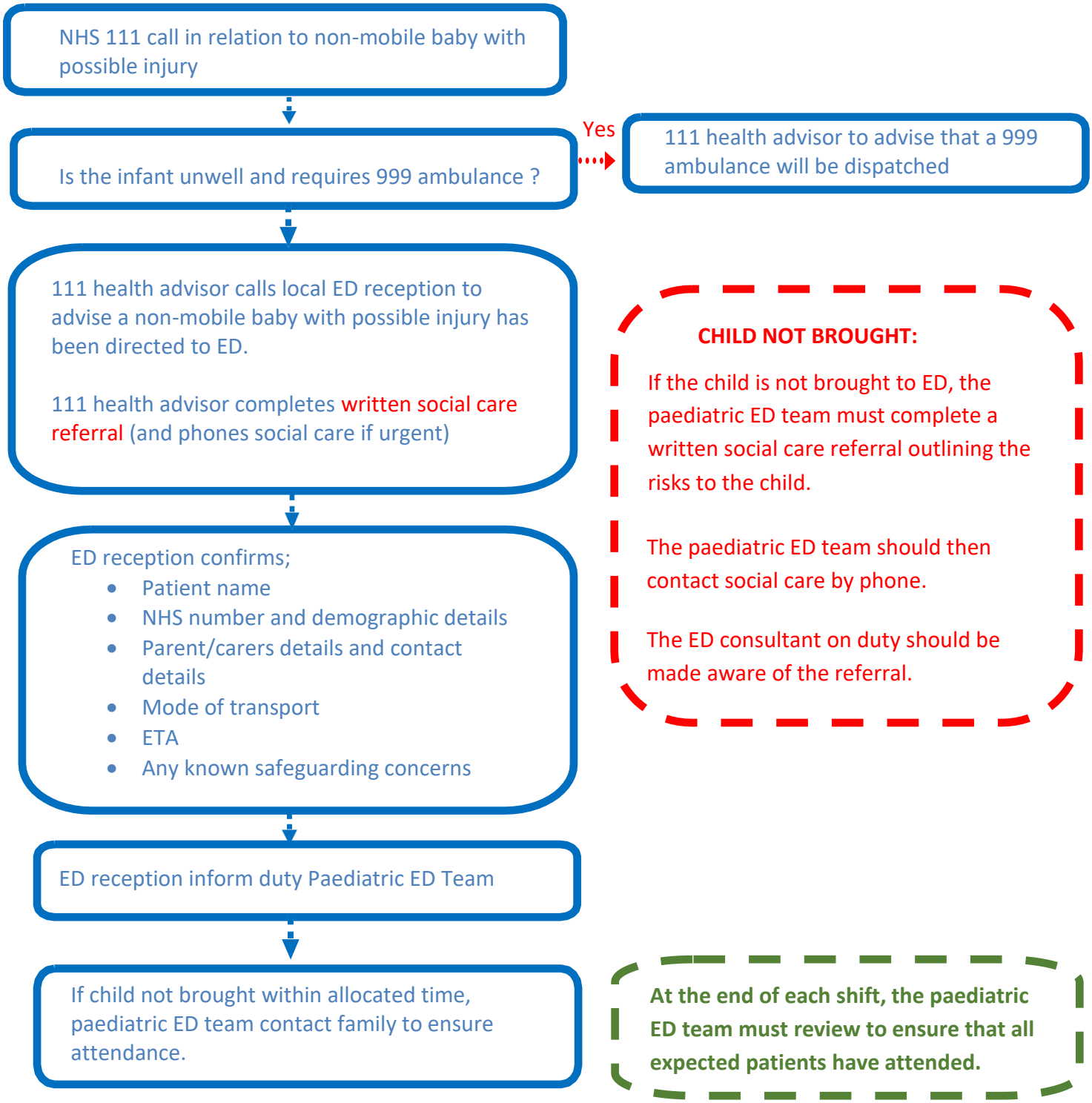
FGM Risk Assessment Checklist Have you:

- ☐ Discussed FGM with the patient and their family.
- ☐ Completed an FGM risk assessment template.
- ☐ Recorded your actions and the outcome of the assessment on the patient's healthcare record.
- ☐ Followed your local safeguarding process and made a referral to children's social care, if appropriate.
- ☐ Reported a known case of FGM to a child under 18 to the police under the FGM mandatory reporting duty, if appropriate.
- ☐ Shared relevant information with other health professionals including the GP, health visitor, school nurse, your local safeguarding lead.
- ☐ Provided a copy of the patient leaflet 'More information about FGM' – available FREE from Orderline in 11 languages.

Appendix 19

Tees Pathway for NHS 111 Calls for Non-Mobile Babies with Possible Injuries

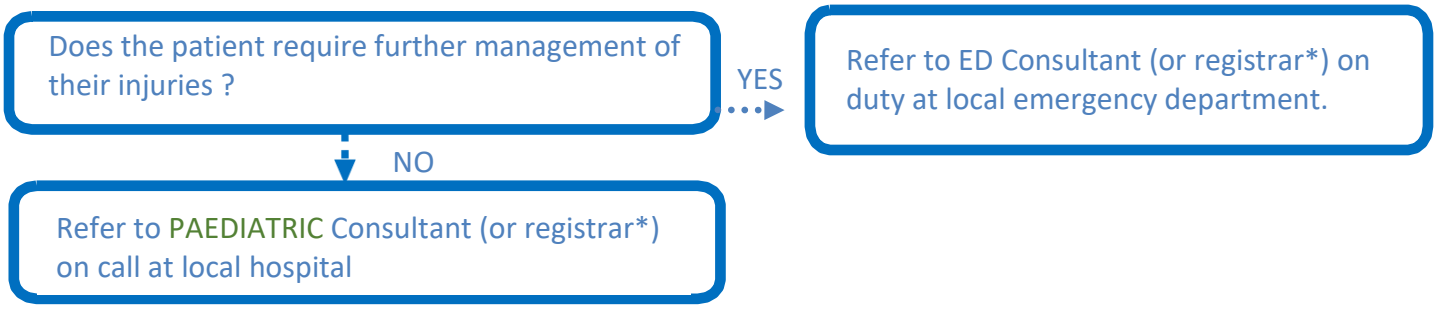
To be used in conjunction with the Teesside procedure for management of non-mobile babies and non-independently mobile infants, children and young people with bruising, injuries or unusual marks.



Appendix 20

Tees Decision Tool: Referral Pathway from Urgent Treatment Centre to Hospital (non-mobile babies with Possible Injuries)

To be used in conjunction with the Teesside procedure for management of non-mobile babies and non-independently mobile infants, children and young people with bruising, injuries or unusual marks.

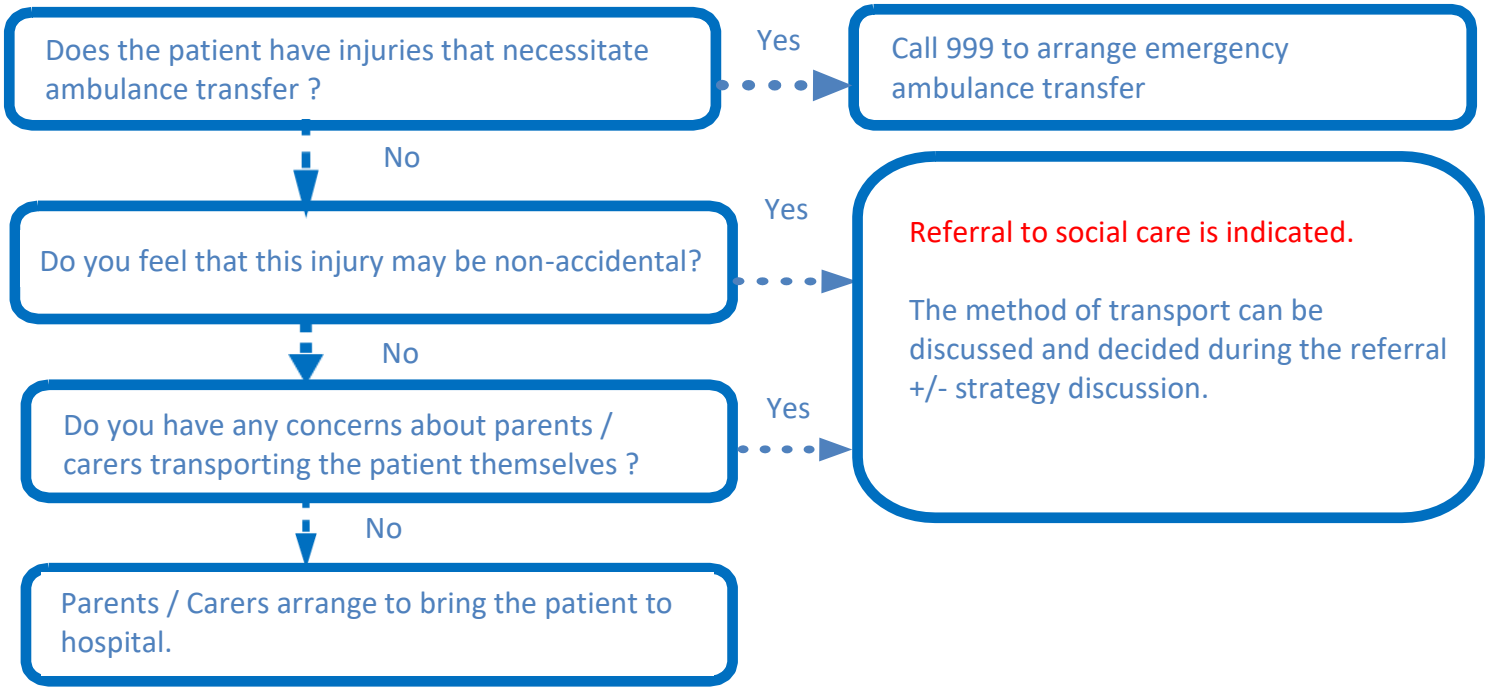


NB Out of hours it may be more appropriate to refer to the ED or paediatric registrar in the first instance.

Appendix 21

Tees Decision Tool regarding **Transport** from Urgent Treatment Centre to Emergency Department (Non-mobile babies with Possible Injuries)

To be used in conjunction with the Teesside procedure for management of non-mobile babies and non-independently mobile infants, children and young people with bruising, injuries or unusual marks.



Appendix 22

Tees health and social care information sharing processes to support the Teesside procedure for management of non-mobile babies and non-independently mobile infants, children and young people with bruising, injuries or unusual marks

Child protection information sharing (CP-IS)

This is a national safeguarding information sharing between health and social care for children presenting to unscheduled care. The CP-IS will only hold information on whether a child is looked after (children in our care/LAC) or on a child protection plan or a pregnant women with unborn child protection plan. It will not inform if child in need or child has social worker or open to early help.

Obtaining information from social care

Information should be obtained from social care for **ALL** non-mobile babies and non-independently mobile infants, children and young people presenting with injuries. This should occur even if the health professional is not intending to compete a social care referral at this time. It is good practice to inform the parents that you are doing so unless to do so would put the child at further risk.

A. In hours

During office hours, this should be via an email with the title “URGENT: Non-mobile/non-independently mobile child in ED”. This should be sent to the appropriate children’s hub as outlined in the table below. A reply email should be received relatively urgently whilst the child is still in the emergency department. If necessary, a phone call can also be made.

An example email is shown here;

> *Child XXXX dob XXX NHS number XXXX is a non mobile/non-independently mobile baby who has presented to ED with an injury. On assessment in ED we have not identified any vulnerabilities or concerns. Prior to discharge however we need to ensure there are no safeguarding concerns that social care are aware of that family have not disclosed.*
>
> *Mothers name*
> *Fathers name*

Other siblings/carers names.
Please contact the department on 01642 617617 ext XXX and ask to speak to XXXXX

B. Out of hours

Out of hours, the appropriate emergency duty team should be contacted by phone using the details in the table below.

Children's Services	Office hour	Out of hours	Email
Hartlepool	01429 284284 01642 130080	01642 524552	childrenshub@hartlepool.gov.uk
Middlesbrough	01642 726004	01642 524552	MiddlesbroughMACH@middlesbrough.gov.uk
Redcar & Cleveland	01642 130700	01642 524552	RedcarMACH@redcar-cleveland.gov.uk
Stockton-on-Tees	01642 130080 01429284284	01642 524552	childrenshub@hartlepool.gov.uk
North Yorkshire	01609780780	01609780780	children&families@northyorks.gov.uk
Durham	03000 267979	03000 267979	Firstcontact@durham.gov.uk
Darlington	01325 406252	01642 524552	PLEASE NOTE: This email address is for out of hours only and should only be used if contact cannot be made by telephone: childrenfrontdoor@darlington.gov.uk

Non-accidental injuries

If there is any suspicion that an injury may be non-accidental, the child must be referred to children's social care using a written referral form (and phone call if appropriate). The child must not be discharged until a suitable plan has been made.

Accidental injuries: Further discussion and information sharing

All non-mobile and non-independently mobile infants and children sent home from ED with accidental injuries, should have a **detailed** discharge letter to GP, with a copy to the health visitor documenting the clinical details and the answers to vulnerability questions.

On receipt of this notification, the health visitor will review the family record as per the significant event policy and consider extra visit to family home. If the health visitor has any concerns, then they should consider submitting a SAFER referral and discuss with the safeguarding team at respective Trust.

If a the family already have a social worker, they must be informed of the attendance by the ED or paediatric staff. A SAFER form can be used as a method of notification.

Appendix 23

Tees **Emergency Department** Pathway for NON-MOBILE Babies with Injuries

A NON-MOBILE baby is a baby who cannot roll independently. This will include most babies under the age of six months. For any child who can roll but who is not yet independently walking, please refer to the non-INDEPENDENTLY mobile pathway.

INITIAL ED CLINICAL ASSESSMENT

Does the practitioner have any safeguarding concerns ?

YES → SAFEGUARDING REFERRAL: REFER TO PAEDIATRICS AND CHILDREN'S SOCIAL CARE

No ↓

SAFEGUARDING RISK FACTORS

Is the answer YES to ANY questions below ?

- **ALL STAFF:** Are there any safeguarding concerns from any staff member who has cared for the child in ED ☐
- **MULTIPLE INJURIES:** More than one single injury ☐
- **DELAY:** Was there an unreasonable delay in the child attending ? ☐
- **FRACTURE OR BURN:** Is the injury a burn or fracture? ☐
- **WITNESS**: Event not directly witnessed or unable to obtain clear account from a definite witness ☐
- **DEVELOPMENT:** Injury is not consistent with developmental age *(any developmental milestones must be confirmed in ED)* ☐

YES →

No ↓

FACE-TO-FACE ED CONSULTANT ASSESSMENT

Are there any safeguarding concerns ?

YES →

No ↓

UNCERTAINTY

Is there any uncertainty about the diagnosis ?

YES →

No ↓

VULNERABILITY

Is the answer YES to ANY question below? Ask family AND obtain information from social care*

- Overnight presentation (between 21:30 and 08:00) ☐
- Child is subject to CP Plan, child in need or looked after ☐
- Domestic Abuse* ☐
- Mental Health difficulties* ☐
- Substance Misuse* ☐
- Parents/Carers are on CP plan or looked after ☐
- Concerns about appropriate supervision ☐

YES →

No ↓

CONSULTANT TO CONSULTANT DISCUSSION

Are there any potential safeguarding concerns ?

PAEDIATRIC REFERRAL

Refer to paediatrics for assessment. Paediatrics to refer to social care if required.

Must be seen by Paediatric ST3+ doctor and must be discussed with consultant prior to discharge.

Paediatric team to obtain social care history and vulnerability questions if not already done by ED.

DISCHARGE AND SAFETY NETTING

Baby can be discharged. Give appropriate safety net advice. Detailed letter to GP and HV.

SAFEGUARDING REFERRAL: REFER TO PAEDIATRICS AND CHILDREN'S SOCIAL CARE

ED Team to manage any injuries with speciality input as required prior to referral.

Admit under Paediatrics. Must have been assessed by ST+3 doctor and seen by consultant before discharge.

Safeguarding risk factors and vulnerability questions to be completed by Paediatric Team, if not done so already.

Discuss supervision arrangements with social care, including any children at home. Investigate according to guidelines.

Strategy meeting to be held.

***Please note vulnerability questions apply to all adults in household or any other adults known to be in regular contact with the child. Information to be obtained from family AND via discussion with Social Care (verbal or email).**

Appendix 24

Tees **Emergency Department** Pathway for NON-INDENDENTLY MOBILE Infants, Children and Young People with Injuries

A NON-INDEPENDENTLY mobile infant, child or young person who is not able to walk independently. It is based on developmental rather than chronological age. It includes babies who are actively rolling, crawling, bottom shuffling, pulling to stand or cruising and older children who are not able to walk independently, including children and young people with a disability. For babies who are not yet mobile please refer to the NON-MOBILE baby pathway.

INITIAL ED CLINICAL ASSESSMENT

Does the practitioner have any safeguarding concerns ?

YES → SAFEGUARDING REFERRAL: REFER TO PAEDIATRICS AND CHILDREN'S SOCIAL CARE

No ↓

SAFEGUARDING RISK FACTORS

Is the answer YES to ANY questions below ?

- **ALL STAFF:** Are there any safeguarding concerns from any staff member who has cared for the child in ED ☐
- **MULTIPLE INJURIES:** More than one single injury ☐
- **DELAY:** Was there an unreasonable delay in the child attending ? ☐
- **WITNESS**: Event not directly witnessed or unable to obtain clear account from a definite witness ☐
- **DEVELOPMENT:** Injury is not consistent with developmental age *(any developmental milestones must be confirmed in ED)* ☐

YES → SAFEGUARDING REFERRAL: REFER TO PAEDIATRICS AND CHILDREN'S SOCIAL CARE

ED Team to manage any injuries with speciality input as required prior to referral.

Admit under Paediatrics. Must have been assessed by ST+3 doctor and seen by consultant before discharge.

Safeguarding risk factors and vulnerability questions to be completed by Paediatric Team, if not done so already.

Discuss supervision arrangements with social care, including any children at home. Investigate according to guidelines.

Strategy meeting to be held.

No ↓

DISCUSSED WITH ED CONSULTANT ASSESSMENT

Are there any safeguarding concerns ?

YES → SAFEGUARDING REFERRAL: REFER TO PAEDIATRICS AND CHILDREN'S SOCIAL CARE

No ↓

VULNERABILITY

Is the answer YES to ANY question below? Ask family AND obtain information from social care*

- Child is subject to CP Plan, child in need or looked after ☐
- Domestic Abuse* ☐
- Mental Health difficulties* ☐
- Substance Misuse* ☐
- Parents/Carers are on CP plan or looked after ☐
- Supervision concerns (including most burns and fractures) ☐

YES → PAEDIATRIC REFERRAL

Refer to paediatrics for assessment. Paediatrics to refer to social care if required.

Must be seen by Paediatric ST3+ doctor and must be discussed with consultant prior to discharge.

Paediatric team to obtain social care history and vulnerability questions if not already done by ED.

NON ACCIDENTAL ?

Is there any possibility this could be non-accidental?

YES / UNSURE → PAEDIATRIC REFERRAL

DISCHARGE AND SAFETY NETTING

Infant / Child can be discharged. Give appropriate safety net advice. Detailed letter to GP and HV.

***Please note vulnerability questions apply to all adults in household or any other adults known to be in regular contact with the child. Information to be obtained from family AND via discussion with Social Care (verbal or email).**

Appendix 25

SAFEGUARDING ALERTS

All alerts should be opened and read as part of every patient attendance to consider vulnerability and risk which will inform further potential actions and decision making relating to safeguarding.

Trak Care Safeguarding Alerts

 - This is the symbol for 'All patients alerts,' it is usually located at the top right hand of the screen in a patient record specifically or in the 'icon profile' column when viewing from a ward view e.g

When you click on the symbol it will break down further into what patient alerts are present and will look something like this;

Edit	Alert Category	Alert
	At Risk	Safeguarding
	Do Not Attempt Cardiopulmonary Resuscitation	Do Not Attempt Cardiopulmonary F
	Deprivation of Liberty	Deprivation of Liberty
	Active Delirium	Active Delirium
	Prone to Delirium - Please Screen	Prone to Delirium - Please Screen

There may be multiple pages in which case you may see navigation buttons underneath;

Common patient alerts may appear grey and say 'inactive' next to them:
This means that the alert has been closed for whatever reason, some such as 'safeguarding' will be manually removed by the safeguarding team when we receive information to advise the case has been closed, others can be closed at the end of admission (such as DoLS) or when they reach an expiry date defined when the alert is added. For example;

COVID Negative	COVID Negative	Automatically closed on Patien	26/05/2022	26/05/2022	☑	Inactive
Functionally / Socially Optimised	Discharge Pathway 1	Automatically closed on Patien	16/01/2023	16/01/2023	☑	Inactive

SystmOne Safeguarding Alerts

The local authority inform child health when a child has been placed on a child protection plan or when a child comes into the care of local authority and is a 'child in care formerly referred to as looked after child.' CPiS is an electronic system that is built into Trak and SystmOne that informs social care of all children who have a child protection or Child in Care/ LAC flag to unschedule care centres (UCC/ED). However if there is additional safeguarding information that you would like the named social worker to know regarding indicators of risk during the child's attendance the practitioner should have a verbal conversation with social worker and complete safeguarding referral. Contact details for the social worker should be flagged up through the CPiS system. Please see Appendix 11 for further details re CPiS system.

Children may also be supported by the local authority under Section 17 and have a 'child in need' plan in place however there is nothing to alert staff to this. Therefore staff are expected to review the records for other agency involvement where they may have safeguarding concern and share relevant information to support child in need assessments.