Safeguarding Children Policy and Procedures

Classification:	Policy
Authors Name:	Judy Preston, Keya Ali
Authors Job Title:	Lead Nurse for Safeguarding Children / Named Nurse for Child Protection, Named Doctor for Child Protection
Authors Division:	Directorate of Patient Care
Departments/Group this Document applies to:	All clinicians

Approval Group: Safeguarding Committee Paediatric PIG/CIG Trust Documentation Committee	**Date of Approval:**	03/10/2019
	Last Review:	October 2019
	Review Date:	January 2023

Unique Identifier: ORG/GL/25	**Status:** Approved	**Version No:** 11

Guideline to be followed by (target staff): All clinicians

To be read in conjunction with the following documents:

- Local Safeguarding Children Boards Policy and Working Together to safeguard children HM Government 2018b
- Maternity Multidisciplinary Confidential Communique
- FGM guideline
- Paediatric Escalation Policy
- Did not attend (DNA) or Was not brought (WNB) Policy for Children and Young People
- Paediatric HIV policy
- Interpreting and Translation Policy and Procedures
- Safeguarding Vulnerable Adults Policy
- Information Governance policy

CQC Fundamental standards:

Regulation 9 – person centred care
Regulation 10 – dignity and respect
Regulation 11 – Need for consent
Regulation 12 – Safe care and treatment
Regulation 13 – Safeguarding service users from abuse and improper treatment
Regulation 14 – Meeting nutritional and hydration needs
Regulation 15 – Premises and equipment
Regulation 16 – Receiving and acting on complaints
Regulation 17 – Good governance
Regulation 18 – Staffing
Regulation 19 – Fit and proper

Disclaimer

Since every patient's history is different, and even the most exhaustive sources of information cannot cover every possible eventuality, you should be aware that all information is provided in this document on the basis that the healthcare professionals responsible for patient care will retain full and sole responsibility for decisions relating to patient care; the document is intended to supplement, not substitute for, the expertise and judgment of physicians, pharmacists or other healthcare professionals and should not be taken as an indication of suitability of a particular treatment for a particular individual.
The ultimate responsibility for the use of the guideline, dosage of drugs and correct following of instructions as well as the interpretation of the published material **lies solely with you** as the medical practitioner.

Index

Policy Statement

All children deserve the opportunity to achieve their full potential. They deserve the right to grow up into an independent and confident adult. This may not always be achievable due to issues with the child's health or developmental issues. In which case all efforts should be made to ensure they are as independent as possible.

All practitioners should follow the principles of the Children Acts 1989 and 2004 - that state that the welfare of children is paramount and that they are best looked after within their families, with their parents playing a full part in their lives, unless compulsory intervention in family life is necessary.

Working Together 2018

The abuse of a child, regardless of whether it is physical, sexual, emotional abuse or neglect, is damaging and can have serious and longstanding effects on all aspects of their health, development and wellbeing.

Milton Keynes Hospital Foundation Trust (MKUHFT) is committed to safeguarding and promoting the welfare of children.

Children may come into contact with MKUHFT as direct service users or as children visiting the trust. We should also consider children who are unseen but where concerns have been identified due to contact with their adult carer (Child behind the Adult).

This policy sets out the national and local expectations in relation to safeguarding children and young people. The policy is intended for the use by all staff and Volunteers providing care within MKUHFT.

The policy relates to the unborn child and children and young people up to their 18th Birthday.

Working Together to safeguard children (2018) states that each agency must follow the child protection procedures agreed by their Local Safeguarding Children Board (LSCB) and therefore this policy must be read in conjunction with Milton Keynes Safeguarding Children Board Inter-Agency Safeguarding and Child Protection Procedures which can be accessed by using the link below.

www.mkscb.org.

This document reflects the principles contained within the United Nations Convention on the Rights of the Child (ratified by the UK in 1991), and the European Convention of Human Rights, Articles 6 and 8.

Working Together to safeguard children (2018), is particularly informed by the requirements of the Children Act 1989, which provides a comprehensive framework for the care and protection of children, and the Children Act 2004.

This document sets out how all staff providing care within MKUHFT should work to safeguard and promote the welfare of children. A shared responsibility, the need for effective joint working and communication between professionals and agencies that have different roles and expertise are required if children are to be protected from harm and their welfare promoted. Children are best protected when professionals are clear about what is required of them and how they need to work together.

Executive Summary

The objective of MKUHFT Safeguarding Children Policy and Procedures is to effectively safeguard and promote the wellbeing of children by:

- Providing guidance, knowledge and clarity for all staff, irrespective of role or client group, with regard to fulfilling their legal duty to safeguard and promote the welfare of children.

- Safeguard children:
- To embed the culture for responding to the need for early help to promote the welfare of children and their families.
- Child protection:
- To ensure all staff respond effectively to a child at risk of harm.
- To promote interagency working.
- To provide clear accessible procedures for staff to follow in regard to concerns about the welfare of a child.

Definitions

All of the following definitions come from Working Together to safeguard children (2018) HM Government.

Children

"Anyone who has not 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 a secure estate, does not change his /her statutes or entitlement to services or protection under the Children's Act 1989." (Working together to safeguard children, (2018))

Safeguarding and promoting the welfare of children
Safeguarding and promoting the welfare of children is defined as:
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; and
Taking action to enable all children have the best outcomes.

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.

Abuse

A form of maltreatment of a child.

Somebody may abuse or neglect a child by inflicting harm or failing to act to prevent harm. Children may be abused in a family or in an institution or community setting by those known to them or, more rarely by others (e.g. via the internet). They may be abused by an adult or adults, or another child or children.

Recognition of Abuse

IF YOU DON'T THINK, YOU WON'T DIAGNOSE

Definitions of abuse or neglect

Physical abuse

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

Emotional abuse
Emotional abuse is the persistent emotional ill treatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to children that they are worthless, inadequate or unloved. It may feature age or developmentally inappropriate expectations being imposed on children. It may also involve overprotection and limitation of exploration and preventing the child participating in normal social interaction.

Sexual abuse
Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, including prostitution whether or not he child is aware of what is happening. The activities may involve physical contact, including penetrative or non-penetrative acts. They may include non-contact activities, such as involving children in looking at, or in the production of pornographic material or watching sexual activities or encouraging children to behave in sexually inappropriate ways.

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

Neglect
Neglect is the persistent failure to meet a child's basic physical and/ or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. It includes exclusion from the home or abandonment, failing to protect a child from physical harm or danger or the failure to ensure access to appropriate medical care or treatment.

(RCPCH Child Protection Companion 2nd Edition June 2013)

Children in need
A Child in Need is defined under Section 17 of the Children Act 1989, as child who is unlikely to achieve or maintain a satisfactory level of health or development, or their health and development will be significantly impaired, without the provision of services; or a child who is disabled.

Common Assessment Framework
The CAF is a standardised approach to conducting assessments of children's' additional needs and deciding how these should be met.

Milton Keynes Safeguarding Board
MKSB is a multi-agency independent statutory partnership Board which agrees how services and professionals in Milton Keynes should work together to safeguard and promote the welfare of children and vulnerable adults.

Significant Harm
Significant Harm is a concept introduced by the Children Act (1989) as the threshold, which justifies compulsory intervention in family life in the best interests of the children. There are no absolute criteria to define significant harm; it may be a single traumatic event or more commonly a compilation of significant events. Consideration should be given to the severity of ill treatment,

degree and extent of physical harm, duration and frequency of abuse or neglect, extent of premeditation, and the presence of threat, coercion, sadism, and bizarre or unusual elements.

For further information on defining child abuse and the signs and indicators of child abuse, please refer to the Milton Keynes Safeguarding Children Board (MKSCB) Inter-Agency Safeguarding and Child Protections Procedures.

www.mkscb.org

Looked After Child
A child in public care of a Local Authority in accordance with section 22 of the Children Act 1989. E.g. a child in foster care or who is in the process of adoption.

1.0 Roles and Responsibilities:

This document applies to all staff providing care within MKUHFT, regardless of their race, sex, disability, religion, gender, sexual orientation or age, or whether they work full time, part time or are a volunteer.

"All those who come into contact with children and families in their everyday work, including people who do not have a specific role in relation to child protection, have a duty to safeguard and promote the welfare of children." (What To Do If You're Worried a Child Is Being Abused. 2006)

The document is divided in to two sections MKUHFT Safeguarding Policy and MKUHFT Safeguarding Procedures.

Safeguarding Declaration

The Board of Directors of Milton Keynes's University Hospital NHS Foundation Trust is committed to ensuring the safeguarding of children in their care.

The Trust also has a responsibility to liaise with other agencies and provide information to them where necessary, to ensure the ongoing safety of children once they leave hospital.

This includes having secure links with the Multi-Agency Safeguarding Hub and Milton Keynes Local Safeguarding Board.

1.1 Statutory Roles and Responsibilities

MKUHFT Safeguarding Accountability structure
The NHS Milton Keynes CCG Chief Officer is ultimately responsible for ensuring that the health contribution to safeguarding children is discharged effectively across the local health economy through the CCG's commissioning arrangements.

All Health Organisations – Section 11 requirements

Health professionals and organisations have a key role to play in actively promoting the health and well-being of children. Section 11 of the Children Act , (2004) places a duty on NHS England and Clinical Commissioning Groups (CCG'S), NHS Trusts and NHS Foundation Trusts to make arrangements to ensure that in discharging their functions they have regard to the need to safeguard and promote the welfare of children. (Working Together to safeguard children 2018)

Working Together to Safeguard Children (2018)

Chapter 2 of Working Together to safeguard children (2018) identifies what organisational responsibilities including Health care organisations need to have in place to fulfil their commitment to safeguard and promote the welfare of children: Including the duty to ensure safe recruitment for staff, students and volunteers.

MKUHFT must have in place;

- A clear line of accountability within the organisation for work on safeguarding and promoting the welfare of children.
- A senior board level lead to take leadership responsibility for the organisation's safeguarding arrangements.
- A culture of listening to children and taking account of their wishes and feelings, both individual decisions and the development of services.
- Arrangements which set out clearly the processes for sharing information, with other professionals and with the Local Safeguarding Children Board
- Safe recruitment practices for individuals whom the organisation will permit to work regularly with children, including policies on when to obtain clearance from the Disclosure and Barring Service.

1.2 Key individuals employed or contracted to work for MKUHFT

The Chief Executive

The Chief Executive has overall accountability for safeguarding children within MKUHFT, to ensure that the trust along with the board of directors is discharging its duty under section 11 of the children's act 2004.

The Chief Nurse

MKUHFT Chief Nurse is accountable to the Clinical commissioning Group (CCG) Chief Officer for MKUHFT safeguarding Children arrangements. This role acts as a link between the trust board of directors and the wider organisation.

The Chief Nurse has Board level responsibility for safeguarding children within MKUHFT and is the representative for MKUHFT on MKSCB.

Deputy Chief Nurse

This role is responsible for the strategic overview for safeguarding adults and children across the trust. The role is responsible for managing the Safeguarding Lead Professional for adults and children and being the link between operational and executive lead. The role is responsible for giving the Chief Nurse assurance on safeguarding.

Divisional Directors / Divisional Managers

All staff working in the Milton Keynes NHS healthcare economy have a duty to and are required to be competent to safeguard and promote the welfare of children and should know what to do if they have concerns about child protection. Managers should ensure this is reflected in individuals' job descriptions.

Divisional Managers are responsible for ensuring dissemination of the safeguarding policy and procedures within their directorates and for ensuring staff are working within their remit of the policy. They are also responsible for ensuring that managerial / senior staffs within their directorate are familiar with individual roles and responsibilities including their role in being the first point of contact by a staff member with safeguarding concern.

Divisional Managers / Divisional Directors will receive a quarterly compliance report for mandatory training they are responsible for ensuring their staff are compliant with safeguarding children training. They also have a responsibility to ensure that any agency staff employed within their clinical area is aware of the Trusts Safeguarding Children Policy and Procedures. They are also responsible for ensuring that all staffing posts within their directorate are set at the correct training level.

Clinical Site managers / on call managers
Clinical site and on call managers must be familiar with the procedures to follow in regard to safeguarding children. This includes Child Protection Pathway, Child Behind the Adult Pathway and procedure to follow in the event of an unexpected child death as they are likely to be the first line of contact. The site managers take a lead role in ensuring 16 to 18 year olds nursed on adult wards are cared for appropriately in line with the Safeguarding Children policy

Security and Communications Team
The hospital security team must ensure that they work closely with the Lead Professional for safeguarding children. Communicating any concerns about any individuals that may pose a risk to children that need to be denied access.

There must be a security door in place on Maternity units and all Paediatric areas. Staff must be advised not to let people on and off the ward (at the door or via any of the door release devices) without being clear on who they are and why they are accessing or leaving the ward.

If any staff member becomes aware that a person, accessing the Trust, who is deemed to be a risk to children, from any perspective, this must be dealt with on an individual case basis, always advising the security team, site team, the appropriate manager, the Lead Professional and Named Doctor for Safeguarding Children.

When official guest visitors or celebrities visit any Trust Paediatric, Maternity or in areas where they may have contact with babies, children or young people, they must be accompanied all times by a member of the Children/Maternity Unit staff; who will have undergone DBS enhanced checks prior to appointment. Guest visitors and celebrities must be made aware that they should not approach babies, children or young people randomly. Such visits need to be prearranged through the Trust communication team with close involvement with the Lead/Named Professionals, Security Team and department managers. Consent must be gained from parent and child prior to the visit.

All healthcare professionals
All health professionals working directly with children should ensure that safeguarding and promoting their welfare forms an integral part of all stages of the care they offer. Other health professionals who come into contact with children, parents and carers in the course of their work also need to be aware of their responsibility to safeguard and promote the welfare of children and young people.

This is important even when health professionals do not work directly with a child, but may be seeing their parent, carer or other significant adult and have knowledge which is relevant to a child's safety and welfare.

All health professionals who work with children and families should be able to;

- Understand the risk factors and recognise children in need of support and/or safeguarding;
- Recognise the needs of parents who may need extra help in bringing up their children, and know where to refer for help, and use the Common Assessment Framework (CAF) to access support as appropriate for them
- Recognise the risks of abuse or neglect to an unborn child
- Contribute to enquiries from other professionals about children and their family or carers
- Liaise closely with other agencies, including other health care professionals and share information as appropriate
- Assess the needs of children and the capacity of parents/carers to meet their children's needs including the needs of children who display sexually harmful behaviours.
- Plan and respond to the needs of children and their families, particularly those who are vulnerable
- Contribute to child protection conferences, family group conferences and strategy discussions
- Contribute to planning support for children at risk of significant harm e.g. children living in households with domestic abuse or parental substance misuse
- Help ensure that children who have been abused or neglected and parents under stress (e.g. those who have mental health problems) have access to services to support them
- Be alert to the strong links between adult domestic abuse and substance misuse and child abuse and recognise when a child is in need of help, services or at potential risk of suffering significant harm
- Play an active part, through the child protection plan, in keeping the child safe
- As part of generally safeguarding children and young people, provide ongoing promotional and preventative support through proactive work with children, families and expectant parents
- Contribute to serious case reviews and implementation of the lessons learned.

Safeguarding Children Team
Refer to the Safeguarding intranet web page for names and contact details.

Lead Nurse for Safeguarding Children / Named Nurse for Child Protection
Has the key role in promoting good professional practice within MKUHFT, providing advice, support and expertise for fellow professionals and ensuring safeguarding training is in place. The Lead Professional is responsible for collecting and collating information regarding child protection activity in the trust. The Lead Professional should work closely with other professionals within MKUHFT, Designated professionals, MKSCB and ensure a good multi-agency approach to safeguarding is untaken.

Named Midwife for Child Protection MKUHFT
Has responsibility for advising staff within the midwifery service with regard to safeguarding within maternity services and for auditing that activity to ensure compliance with policies and procedures. The Named Midwife's role also includes ensuring welfare information is shared effectively from the antenatal period through to paediatric services and adult safeguarding services to ensure continual support for the child and family.

Named Doctor for Child Protection MKUHFT
Has the key role in promoting good professional practice within MKUHFT, providing advice, training, support and expertise for fellow professionals. To work with the Lead Professional to ensure assurance is given that policies and procedures are in place and being followed.

On-call Paediatrician
Is responsible for supporting staff across the trust when safeguarding and child protection concerns are identified, in line with the Child Protection Pathway. They should be aware the completion of child protection medicals undertaken by senior medical staff. They may also be the first point of contact for the Police and Children's Social Care when a child protection medical is requested.

All named professionals as part of their roles:
Their role is to support other professionals in their organisations to recognise the needs of children, including identifying the risk from possible abuse or neglect. These roles should be explicitly defined in job descriptions and given sufficient time, funding, supervision and support to fulfil their child welfare and safeguarding responsibilities effectively.

Offer safeguarding supervision to staff and volunteers throughout the Trust. This can be on the spot supervision through day to day case management or a more formal arrangement where a member of staff / volunteer or their manager identify a specific issue that would benefit from further support from a Named professional.

Have a key role in assisting with debriefing staff after a significant incident involving a child. It is the responsibility of the consultant involved with the incident to liaise with the hospital Chaplin service to lead the de brief session and the role of the Named Professional to support this process.

Collectively the Named professionals have a responsibility to ensure that the trust and its employees fulfil their obligations to safeguard children through the process of regular audit and review of safeguarding practice across the trust.

Supervision, support and training
Appropriate supervision and support for staff, including undertaking safeguarding training:
Employers are responsible for ensuring that their staff are competent to carry out their responsibilities for safeguarding and promoting the welfare of children and creating an environment where staff feel able to raise concerns and feel supported in their safeguarding role;

Staff should be given a mandatory induction, which includes familiarisation with child protection responsibilities and procedures to be followed if anyone has any concerns about a child's safety or welfare; and

All professionals should have regular reviews of their own practice to ensure they improve over time.

Clear policies and procedures in line with those from the MKSCB for dealing with allegations against people who work with children.

Safeguarding Children Specialist Nurse
Shares responsibility alongside the Lead Nurse for Safeguarding to ensure that safeguarding children training is in line with national guidance and that as a trust we have a clear training strategy in place.

The role involves implementing a robust safeguarding audit program that provides assurance of compliance.

Assists the Safeguarding Lead in providing safeguarding advice and support for all staff within the trust.

2.0 Implementation and dissemination of document

This policy and its associated procedures will be disseminated via the trust intranet and will be available to view and download. The policy will be available in hard copy in all level 3 areas across the trust.

The policy will be reviewed formally every 2 years but will be amended when required following findings or recommendation from a serious case review or internal management reviews.

3.0 Processes and procedures

3.1 Training and Education for all staff including volunteers

Training and Education for all Staff including volunteers

Procedure: Training Requirements

Please read the information below to find out which training you require. If you are unsure then please contact the Learning and Development team on extension 85109.

LEVEL 1

This is for all staff working in health care settings (both clinical and non-clinical) that are not delivering care with parent, children and young people.

These include roles such as: Receptionists, administrators, catering, transport and maintenance staff.

Requirements: Staff should attend induction within the first three months of employment.

Staff must then attend an up-to-date session every three years. This can be done via e-learning/workbook or the preferred method of a face-to-face session.

LEVEL 2

This is for clinical and non-clinical staff that is in regular, direct contact with parents, children and young people.

These include roles such as: Clinical laboratory staff, pharmacists, ambulance staff, dentists, dental care practitioners, audiologists, adult physicians, surgeons, anaesthetists, radiologists, nurses working in adults acute/community services, allied health care practitioners.

Requirements: Staff should attend induction within the first three months of employment,

Staff must then attend and up-to-date session every three years. This can be done via e-learning or the preferred method of a face-to-face session.

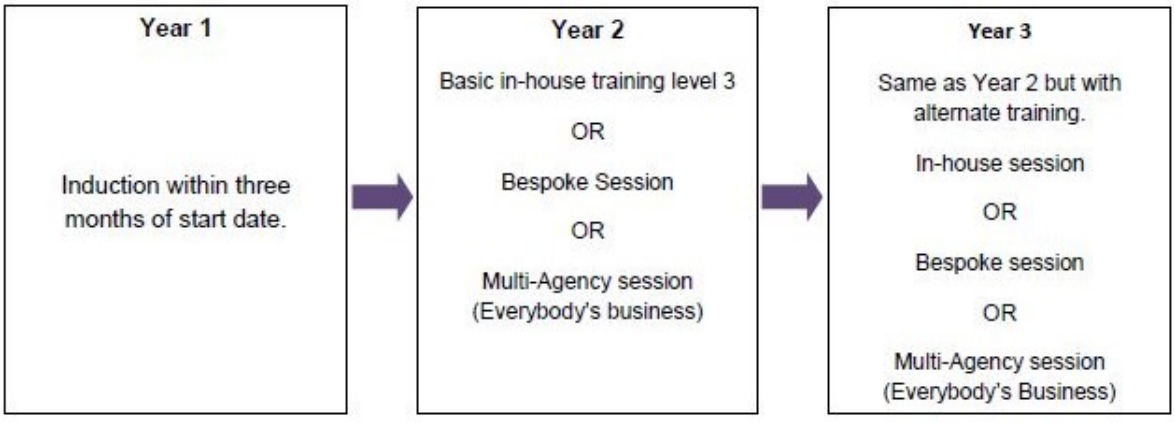
LEVEL 3

This is for all staff working predominantly with children, young people and parents, who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person where there are safeguarding/child protection concerns.

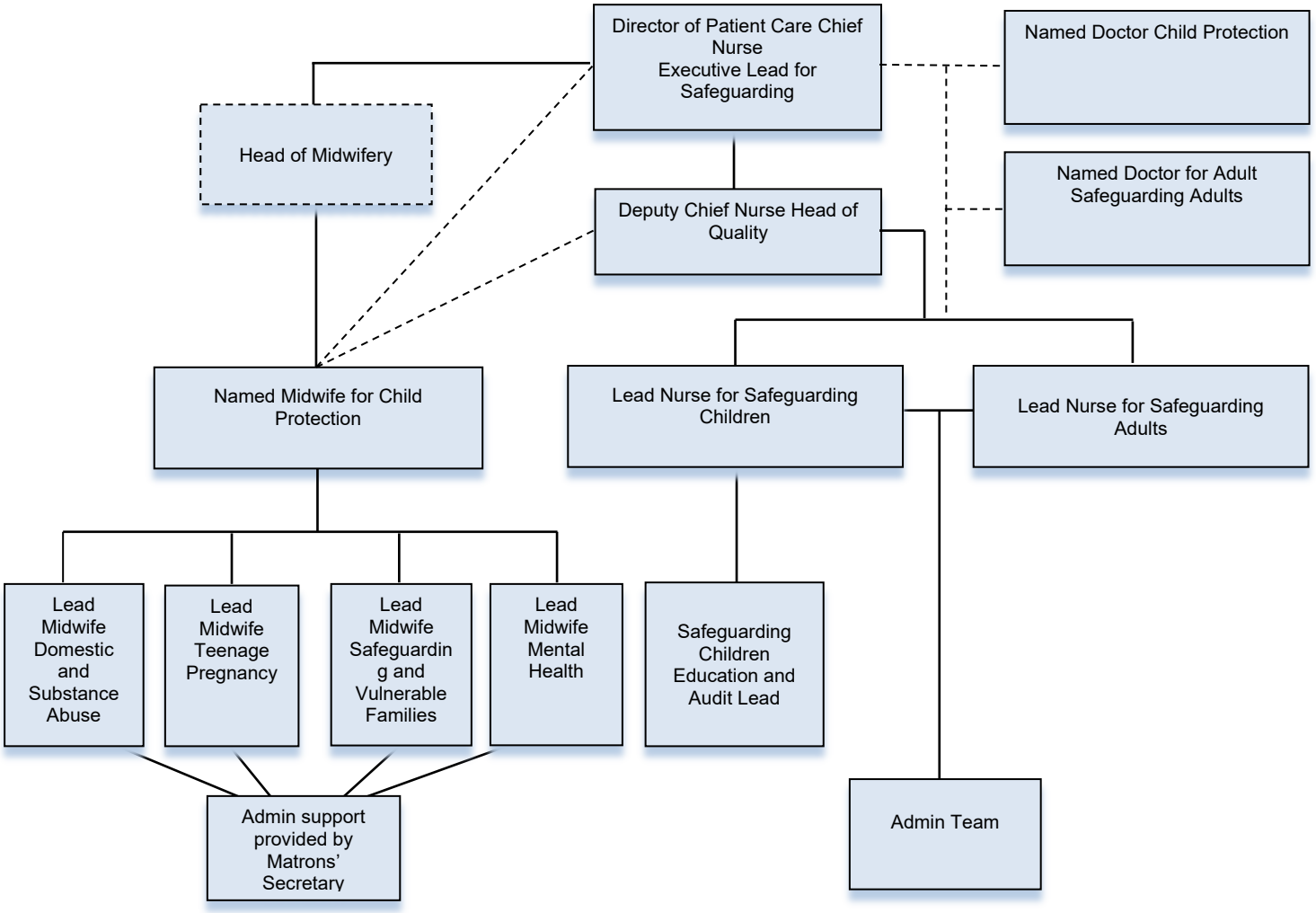
These include roles such as: Mental health staff (adults and CAMHS), adult learning disability staff, learning disability nurses, health professionals working in substance misuse services, paediatric health professionals, sexual health staff, midwives, obstetricians, all paediatricians, paediatric radiologists, Accident and Emergency staff.

Midwives will receive their own training within their protected training week,

Requirements: Level 3 training is yearly and works on a 3 year cycle as shown below:



Milton Keynes University Hospital NHS
NHS Foundation Trust



3.2 Information sharing

Successful interventions and positive outcomes for children cannot be achieved if we work in isolation; multi- agency working is fundamental to safeguarding children.

One of the biggest barriers to multi-agency working is the concerns around confidentiality and information sharing. It is therefore essential that practitioners understand when, why and how they should share information so that they can do so confidently and appropriately as part of their day-to-day practice.

Information sharing guidance for practitioners and managers HM Government (2008) states:

'The protection of children overrides the duty of confidentiality.

The Key factor in deciding whether or not to share confidential information are necessity and proportionality, i.e. whether the proposed sharing is likely to make an effective contribution to preventing risk and whether the public interest in sharing the information overrides the interest in maintaining confidentiality. In making the decision staff must weigh up what might happen if it is not and make the decision based on that professional judgement'.

Milton Keynes University NHS Foundation Trust has taken on the CPIS Information System. This will enable staff to access information on children and young people subject to child protection plans and / or Looked After Children.

3.2.1 Sharing safeguarding information and outcomes

All safeguarding concerns must be shared with the Lead Nurse for Safeguarding Children. For concerns that involve an unborn child, the Named Midwife for Safeguarding must also be informed.

All referrals to Children Social Care (CSC) completed by MKUHFT staff are received by the Lead Nurse for Safeguarding Children through the electronic referral system. If the referral includes an unborn child the Named Midwife for Safeguarding will also receive a copy.

Referrals into Children's Social Care are automatically sent to the MASH Multi-Agency

A copy of the MARF will be sent to the child's GP, Health Visitor, and / or School Nurse and to the Named Nurse within community health services by the safeguarding children's administration team.

If a child attends MKUHFT from another area and safeguarding concerns are raised a copy of the referral will be sent to MK Children Social Care who will forward it on to the child's local authority. MKUHFT safeguarding administration team will send a copy of the form to the child's GP, Health Visitor, School Nurse and Lead Nurse/ Professional for Safeguarding Children at the child's local hospital.

A copy of all safeguarding referrals is scanned into the patient's electronic record, under the Front sheet/Alert tab. This is the case for all children and young people identified on the referral form, including the adults. A red Promoting Welfare (PW) alert is put in place on the front page of each child's record.

For unborn children the referral cannot be scanned until the baby is born. It is the responsibility of the Named Midwife for Safeguarding to notify the safeguarding administration team when the baby has been born so that the referral and the PW alert can be put onto the baby's electronic record.

Children's Social Care in line with Working Together to Safeguard Children (2015) must notify the referrer of the outcome of their referral. Milton Keynes CSC has agreed to send MKUHFT Lead Nurse the outcomes as opposed to the individual staff member due to shift patterns and staff changes.

The Lead Nurse for Safeguarding Children and Named Midwife for Safeguarding will complete an Outcome Summary Form on every MARF which is scanned into the child's notes and will be scanned on to the child's notes under front/sheets alert, ensuring the PCW alert is in situ. Staff can then access the child's notes to check on the outcome of their referral.

3.2.2 Sharing information with Maternity

The electronic maternity confidential communique document (ECare) is used to share information between midwifery, health visiting/neonatal and paediatric services. A confidential communique is created by maternity when any safeguarding/child protection/additional support/ information is required or identified for a woman, her family and unborn child.

For information sharing guidance around referral to Children's Social Care and Children and Family Practices see Appendix 4

3.2.3 Sharing information with GP, Health Visitor and/or School Nurse regarding admissions and attendances to MKUHFT

All children ages 0-18 years who attend MKUHFT Emergency Department have an ED Sharing information form completed (Appendix 32). This records the reason for attendance, who they attended with as well as the outcome of the attendance. It asks if they are known to Children Social Care, if they are subject to a Child Protection Plan or a Looked after Child. Any safeguarding concerns are also documented as well as any action taken. An information sharing form should also be completed if there is a 'Child behind the Adult' concern.

The form goes to the Health Visitor and/or School Nurse. A copy is added to the child's notes and a third copy is sent to the Lead Nurse for Safeguarding Children. If an under 18 year old attends who is pregnant a copy will be sent to the teenage pregnancy midwife and the Named Midwife for Safeguarding by the safeguarding administration team.

Children Social Care must be informed of any child subject to a Child Protection Plan or who are a Looked after Child who attends MKUHFT by the nurse or doctor looking after them. It is good practice that the Designated Nurse/Named Nurse for Looked after Children is informed of all admissions and attendances of Looked after children to MKUHFT. Details can be sourced from the Safeguarding Administration team.

All children discharged from MKUHFT must have a discharged summary that is sent to the child's GP completed by doctor who saw the child.

3.2.4 Information Sharing: Sharing Child Protection Medical Reports with Police and Children Social Care

Assessment of children attending MKUHFT for Child Protection Medicals or who have had a Child Protection assessment as part of their attendance or admission, must be documented using the Proforma for Child Protection Medical Examinations (Appendix ??)

The medical report and body maps must be sent to Children Social Care and the Police by encrypted email or post within 72 hours. A copy must also be added to the patient's notes and sent to the Lead Nurse for Safeguarding Children within MKUHFT.

3.2.5 Staff being requested to provide a police statement about a case

All statement must be requested through the Information Governance Department to ensure staff are supported and trust policies are adhered too.

3.2.6 Action: Children who are not registered with a GP

In the event that a child is not currently registered with a GP, staff will document in the child's clinical notes. If the child is attending ED clinical staff should complete an ED information sharing form and advise parents to register with their local surgery. If either parent is already registered with a GP, staff will use this information and document on ED sharing form and advise parents to register with that GP practice. The Lead Nurse for Safeguarding Children will receive a copy of ED form and can follow up if required. The Specialist Health Visitor for Safeguarding can be contacted for children under 5 years to ensure a Health Visitor is allocated to them and they will pick up on getting the family registered with a GP. If we do not have a reasonable explanation as to why the child is not registered with a GP staff should consider doing a MARF.

3.2.7 Transition from Paediatric services to adult services

The paediatric medical team who are transitioning children in to adult services must ensure that if there are any current or pervious safeguarding concerns that the information is shared with the receiving clinician and this action documented in the child's notes.

3.3 Case Reviews

Professionals and organisations protecting children need to reflect on the quality of their services and learn from their own practice and that of others. Good practice should be shared so that there is a growing understanding of what works well. Conversely, when things go wrong there needs to be a rigorous, objective analysis of what happened and why, so that important lessons can be learnt and services improved to reduce the risk of future harm to children. Further guidance on case reviews can be found in Chapter 4 of Working Together to safeguard children (2018)

www.mkscb.org

All case reviews that MKUHFT are required to contribute too must be signed off by the Chief Nurse through the safeguarding Children committee before being shared with the Clinical Care Commissioning group (CCG) or Milton Keynes Safeguarding board (MKSB).

Case review action plans are reported quarterly to the CCG through the compliance dashboard. All evidence for each action must be gathered electronically against each recommendation and sent to the CCG once all actions completed, for final sign off.

Learning is shared through the Safeguarding Children training, Newsletters and dissemination through the safeguarding committee.

3.3.1 Serious case reviews

Serious Case Review for every case where abuse or neglect is known or suspected and **either:**

- A child dies; or
- A child is seriously harmed and there are concerns about how organisations or professionals worked together to safeguard the child

(Working Together to safeguard children (2015) (2015) 2018)

3.3.2 Notifiable incidents involving the care of a child and Serious Case Reviews

- A notifiable incident is an incident involving the care of a child which meets **any** of the following criteria:
- A child has died (including cases of suspected suicide), and abuse or neglect is known or suspected;

- A child has been seriously harmed and abuse or neglect is known or suspected
- A looked after child has died (including cases where abuse or neglect is not known or suspected); or
- A child in a regulated setting or service has died (including cases where abuse or neglect is not known or suspected)

The local authority should report any incident that meets the above criteria to Ofsted and the relevant LSB or LSBs promptly, and within five working days of becoming aware that the incident has occurred.

For the avoidance of doubt, if an incident meets the criteria for a Serious Case Review then it will also meet the criteria for a notifiable incident (above).

There will, however, be notifiable incidents that do not proceed through to Serious Case Review.

3.3.3 Definition of Serious Harm for the purpose of Serious Case Reviews
"Seriously harmed" in the context of paragraph 18 below and regulation 5(2)(b)(ii) above includes, but is not limited to, cases where the child has sustained, as a result of abuse or neglect, any or all the following:

- A potentially life-threatening injury;
- Serious and/or likely long-term impairment of physical or mental health or physical, intellectual, emotional, social or behavioural development.

This definition is not exhaustive. In addition, even if a child recovers, this does not mean that serious harm cannot have occurred. LSCBs should ensure that their considerations on whether serious harm has occurred are informed by available research evidence.

3.4 Staff Guidance and Procedures
Staff should access pathway poster in clinical areas for safeguarding information/advice in addition to safeguarding children web pages on Intranet.

Pathway poster can be found in Appendix 3.

Staff should access guidance information in appendices for:
Information sharing Appendix
Making a referral to Children's' Social Care. Appendix
Professional attendance to a Multi-Agency Safeguarding/ Child Protection Meeting. Appendices 5 and

Staff should access procedures in appendices for:

- Allegation/Disclosure of sexual abuse 0-18 Appendix
- Child Sexual Exploitation Screening tool
- Unexpected death of a child Appendix
- Child Mental Health Appendix
- Child subject to Child Protection Plan Appendix
- Domestic Abuse, - Includes Concern for unseen child Appendix
- Female Genital Mutilation, - Includes Concern for unseen child- Appendix
- Fabricated Induced Illness FII- Appendix
- Looked after Child – Appendix
- Parental Substance Misuse, - Includes Concern for unseen child- Appendix
- Parental Mental Health, - Includes Concern for unseen child- Appendix

- PREVENT (Supporting individuals susceptible to being drawn into extremism or terrorism) Appendix
- Referral to Adult Social care- adult welfare concerns Appendix
- Safeguarding Training Requirements Appendix

Other associated documents

- Maternity Multidisciplinary Confidential Communique.
- FGM guideline
- Paediatric Escalation Policy
- Did not attend (DNA) or Was not brought (WNB) Policy for Children and Young People.
- Paediatric HIV policy
- Interpreting and Translation Policy and Procedures.
- Safeguarding Vulnerable Adults Policy

4.0 Statement of evidence/references

4.1 Statement of evidence:

Advisory Council on the Misuse of Drugs [2003] *Hidden harm: responding to the needs of children of problem drug users: the report of an inquiry.* [Online]. [s.l.]: Home Office. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/120620/hidden-harm-full.pdf [Accessed 29 April 2019]

Department of Health [2017] *Responding to domestic abuse: a resource for health professionals*. [Online]. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/597435/DometicAbuseGuidance.pdf [Accessed 29 April 2019]

Her Majesty's Treasury (2003) *Every child matters*. [Online]. (Cm5860) London: The Stationery Office. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/272064/5860.pdf [Accessed 29 April 2019]

HM Government (2015) *What to do if you're worried a child is being abused: advice for practitioners.* [DFE-00124-2015]. [Online]. Available from: 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 [Accessed 29 April 2019]

HM Government (2018a) *Information sharing: advice for practitioners providing safeguarding services to children, young people, parents and carers.* [DFE-00128-2018]. [Online]. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/721581/Information_sharing_advice_practitioners_safeguarding_services.pdf [Accessed 29 April 2019]

HM Government (2018b) *Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children.* [DFE-00195-2018]. [Online]. Last updated February 2019. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/779401/Working_Together_to_Safeguard-Children.pdf [Accessed 29 April 2019]

HM Government (2018c) *Working together to safeguard children: Statutory framework: legislation relevant to safeguarding and promoting the welfare of children.* [DFE-00196-2018]. [Online]. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/722307/Working_Together_to_Safeguard_Children_Statutory_framework.pdf [Accessed 29 April 2019]

Home Office (2013) *Circular 003/2013: new government domestic violence and abuse definition.* [Online]. 14 February 2013. Available from: https://www.gov.uk/government/publications/new-government-domestic-violence-and-abuse-definition/circular-0032013-new-government-domestic-violence-and-abuse-definition [Accessed 29 April 2019]

Milton Keynes Safeguarding Board (2018) *MKSCB Inter-Agency policy & procedures.* [Online]. Available from: https://www.mkscb.org/policy-procedures/ [Accessed 29 April 2019]

Milton Keynes Safeguarding Board (2019) *Milton Keynes Safeguarding Children Board procedures manual.* [Online]. Available from: https://www.mkscb.org/policy-procedures/ [Accessed 29 April 2019]

National Institute for Health and Care Excellence (2009*) Child maltreatment: when to suspect maltreatment in under 18s.* [CG89]. [Online]. Last updated October 2017. Available from: https://www.nice.org.uk/guidance/cg89 [Accessed 29 April 2019]

National Institute for Health and Care Excellence (2014*) Domestic violence and abuse: multi-agency working.* [PH50]. [Online]. Available from: https://www.nice.org.uk/guidance/ph50 [Accessed 29 April 2019]

National Institute for Health and Care Excellence (2016*) Domestic violence and abuse.* [QS116]. [Online]. Available from: https://www.nice.org.uk/guidance/qs116 [Accessed 29 April 2019]

National Institute for Health and Care Excellence (2017*) Child abuse and neglect.* [NG76]. [Online]. Available from: https://www.nice.org.uk/guidance/ng76 [Accessed 29 April 2019]

National Institute for Health and Care Excellence (2019*) Child abuse and neglect.* [QS179]. [Online]. Available from: https://www.nice.org.uk/guidance/qs179 [Accessed 29 April 2019]

Royal College of Paediatrics and Child Health [2019] *Child protection companion.* [Online]. Available from: https://pcouk.org/companion [Accessed 29 April 2019]

Royal College of Radiologists and Society and College of Radiographers (2018) *The radiological investigation of suspected physical abuse in children.* [BFCR(17)4]. [Online]. Revised first edition. London: Royal College of Radiologists. Available from: https://www.rcr.ac.uk/system/files/publication/field_publication_files/bfcr174_suspected_physical_abuse.pdf [Accessed 29 April 2019]

Legislation

Note re: links to legislation.gov.uk website. Versions may be revised, annotated or original as enacted. A 'List of all changes' made by subsequent legislation affecting the statute or statutory instrument may be viewed by opening the statute or statutory instrument on the legislation.gov.uk website and clicking the 'More Resources' tab. See also:

HM Government (2018) *Working together to safeguard children: Statutory framework: legislation relevant to safeguarding and promoting the welfare of children.* [DFE-00196-2018]. [Online]. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/722307/Working_Together_to_Safeguard_Children_Statutory_framework.pdf [Accessed 29 April 2019]

Children Act 1989. (c. 41). [Online]. Available from: https://www.legislation.gov.uk/ukpga/1989/41/contents [Accessed 25 April 2019]

Children Act 2004. (c. 31). [Online]. Available from: https://www.legislation.gov.uk/ukpga/2004/31/contents [Accessed 25 April 2019]

Children and Social Work Act 2017. (c. 16). [Online]. Available from: http://www.legislation.gov.uk/ukpga/2017/16/contents [Accessed 25 April 2019]

5.0 Governance

5.1 Document review history

Version number	Review date	Reviewed by	Changes made
11	2019	Judy Preston	Reviewed and Updated

5.2 Consultation History

Stakeholders Name/Board	Area of Expertise	Date Sent	Date Received	Comments	Endorsed Yes/No
Child Health Patient Information and guidelines group meeting.	Group is made up of Paediatric Clinicians. Including some with high level of expertise in Safeguarding children.	February 2019	March 2019	Update with new working together document information. Every Child Matters documentation is now out of date and needs replacing with new information.	Yes Yes
Paediatric Consultants	Paediatrics Named Doctor Dr Ali	February 2019	March 2019	Update of SARC Policy. Take out information on Child Death as we now have a separate Policy for this.	Yes
Library Service	Checking of references.	March 2019	March 2019	References updated and list of evidence updated prior to going to safeguarding Committee.	Yes
Review by Safeguarding Team.	Safeguarding	February 2019	February 2019	Updated Referral pathways and procedures.	Yes
Review by Safeguarding Committee	Safeguarding	January 2019	January 2019	Update of Appendix and links for Mk Together	Yes
Trust Documentation Committee	Quality of documentation.	June 2019	June 2019	MK Together links update.	Yes

5.3 Audit and monitoring

Audit/Monitoring Criteria	Tool	Audit Lead	Frequency of Audit	Responsible Committee/Board
Quality of information within MARF forms.	Outcome analysis.	Judy Preston	Monthly	Safeguarding Committee

5.4 Equality Impact Assessment

As part of its development, this Guideline and its impact on equality has been reviewed. The purpose of the assessment is to minimise and if possible remove any disproportionate impact on the grounds of race, gender, disability, age, sexual orientation, religion or belief, pregnancy and maternity, gender reassignment or marriage and civil partnership. No detriment was identified.

Equality Impact assessments will show any future actions required to overcome any identified barriers or discriminatory practice.

Equality Impact Assessment			
Division	Corporate	Department	Safeguarding
Person completing the EqIA	Judy Preston	Contact No.	85111
Others involved:	Safeguarding Team	Date of assessment:	03/10/2019
Existing policy/service	Yes	New policy/service	No

Will patients, carers, the public or staff be affected by the policy/service?	Yes
If staff, how many/which groups will be affected?	*For example: community midwives, phlebotomists, all staff*

Protected characteristic	Any impact?	Comments
Age	NO	Positive impact as the policy aims to recognise diversity, promote inclusion and fair treatment for patients and staff
Disability	NO	
Gender reassignment	NO	
Marriage and civil partnership	NO	
Pregnancy and maternity	NO	
Race	NO	
Religion or belief	NO	
Sex	NO	
Sexual orientation	NO	

What consultation method(s) have you carried out?

Face to Face meetings
Information Gathering

How are the changes/amendments to the policies/services communicated?

E Mails and Consultation
Revised Legal documents

What future actions need to be taken to overcome any barriers or discrimination?

What?	Who will lead this?	Date of completion	Resources needed
N/A	N/A	N/A	N/A
Review date of EqIA	October 2022		

Appendix 1: Safeguarding Children Pathway: 0 – 18 Years

You need to share information with Children's Social Care (CSC) even if another agency has completed a referral

Do you have concerns about a child or young person's welfare?

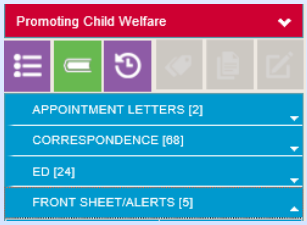
- Contact Milton Keynes Children's Social Care (CSC)
  via Multi Agency Safeguarding Hub (MASH)
  9am to 5pm 01908 253169
  Out of hours 01908 265545
- If the child is not from Milton Keynes, contact relevant CSC team.
- Complete Multi-Agency Referral Form (MARF) on the safeguarding intranet page.
- Always inform Children's Social Care (CSC) of all children subject to a child protection plan and all looked after children.

- Always share your concerns with:
  - Nurse in charge / department sister
  - Consultant in your department
  - Lead Nurse for Safeguarding Children (tel: 85111 or bleep 1101)
  - Senior paediatric medical team on call for advice, if necessary.
- If the child's first language is not English, use an interpreter and not a family member.
- Document discussions and actions.

Unsure?

Tools to Help

1. Information in your area
Check on EDM for "Promoting Welfare" alert where previous welfare information is shared:



Click on "Front sheets/alerts" to check for:
- Child Protection Plan (CP-IS)
- Looked after children (CP-IS)
- Minutes of professional meetings
- Previous referrals to CSC
- LOOK at previous ED attendances
- LOOK at missed appointments
- LOOK at addressed labels – P.O box address / mother and baby unit

2. Liaise with Other Health Professionals
- Health visitor or school nurse
- Family nurse partnership (FNP)
- Is the child registered with a GP
- Is the child known to CAMHS

3. Children and Social Care
- Is the child known to CSC or have they been known previously

If YES – what has their involvement been?
- Check for a Child Care Alert on Summary Care Record Application (SCRa)

4. School
- Attendance level
- Do school have concerns about the child or family

5. Other Agencies
- Brook Sexual Health Service
- Youth Offending Team (YOT)

Admit

- Think: child 0-18 years
- Include MARF in safeguarding handover
- Update CSC of admission
- Document safeguarding concerns on pink promoting welfare form
- Highlight concerns on handover sheet and board
- Promote safety:
  - Who is allowed to visit?
  - Where should the child be nursed; cubicle or open bay?

Discharge

- Involve consultant in your area
  - Consider liaising with senior / consultant paediatrician on call
- Document safeguarding concerns and actions taken on discharge summary
- Update CSC of discharge
- Consider discharge planning meeting
- Ensure minutes are taken (including attendance) and actions are monitored

Transfer

- Think: child 0 – 18 years
- Include a copy of MARF in safeguarding handover
- Document concerns and actions on transfer paperwork
- Update CSC of transfer

NICE Guidance to Recognise Abuse (0 – 18 Years)

Physical Abuse
- Unexplained bruisers
  - Follow procedure (appendix 4 of Safeguarding Children Policy)
- Unexplained burns or scalds
  - Follow procedure (appendix 5 of SGC policy)
- Human bite marks
- Intracranial injury with no confirmed accidental trauma (appendix 8)
- Unexplained fracture
  - Follow procedure (appendix 8)

Sexual Abuse
Contact the police in all cases of sexual assault (follow appendix 14)
- Persistent or recurrent genital or anal symptoms without medical explanation (associated with behavioural or emotional changes)
- Genital, anal, perianal injury with absent/unsuitable explanation
- Unusual sexualised behaviour
- Gonorrhoea, chlamydia, syphilis, genital herpes, HIV, Hep C or trichomonas in a child >13 years
- Sex with children under 13 years is unlawful (rape)

Emotional Abuse
- Domestic abuse
  - Refer all violent assaults and incidents where children were present especially if <12 months old or mother is pregnant.
- Fearful or withdrawn
- Persistent harmful parent interaction

Female Genital Mutilation (FGM)
Think risk factors
- Country of origin
- Other female family members have FGM
- Disclosure of overseas holidays
- Accounts of unexplained gifts and presents
  - Follow procedure (appendix 21 SGC policy)

Neglect
- Not engaging with health professionals
- Missing appointments
- Poor hygiene affecting health and wellbeing
- Scavenging for food or stealing food
- Unexplained weight loss

Child Sexual Exploitation (CSE)
- Going missing
- Self-harming behaviour and suicidal ideation
- Injuries, assault
- Drug and alcohol problems
- Poor self-care
- Sexually transmitted infections
- Termination of pregnancy
- Pregnancy
- Medically unexplained symptoms

Parents and Carers Presenting with *ADAM* Criteria
ALWAYS CONSIDER a referral to CSC and inform health visitor, school nurse, FNP and lead nurse for safeguarding children.

Acute alcohol – intoxication
Domestic abuse
Attempted suicide or Abuse of substances
Mental health problems

Appendix 2: What to do if you have a concern about a child or young person's welfare?

It is not your responsibility to prove that abuse has occurred

A professional may become concerned about the welfare of a child or young person in hospital. The situation could arise when:

- Child or young person discloses abuse
- Parent alleges/ discloses abuse
- Child presents as an emergency with an injury
- Another professional discusses a concern with you
- Parent complains of medical symptoms, signs or behaviour to the GP or health professional

Dos and Don'ts

Do

- Do listen and talk to the child
- Do use a trained interpreter if the child is unable to speak English (Refer to Interpreting and Translating policy)
- Do recognise the communication needs of the child remembering disabled children are particularly vulnerable (Refer to Sign Translate)
- Do assess harm with the same thoroughness and attention to detail as you would a life threatening illness
- Do consult and communicate widely both within the health service and with other agencies
- Do remember the child's welfare is always the paramount concern
- Do remember other children in the family may be at risk of harm
- Do keep contemporaneous records including telephone conversations
- Do take a detailed social and family history
- Do ensure adequate and appropriate follow up is arranged

Don't

- Don't use family members and friends as interpreters
- There is no need to make a firm diagnosis of child abuse prior to a referral to Children's Social Care
- Don't conduct interviews and examinations without having another professional with you
- Don't discharge a child from hospital when you have suspicions about possible harm unless it has been discussed with the statutory agencies and the consultant paediatrician that it is safe to do so.
- Don't assume that someone else will raise the concern or deal with it

Child Protection Companion (201?)

Appendix 3: Child or young person injury questionnaire (Now incorporated into the E Care records system)

Consider each indicator and circle answer as appropriate:

Circle as appropriate	Indicator	Circle as appropriate
No	**Has there been a significant delay between injury and seeking medical advice for which there is no satisfactory explanation?**	**Yes**
Yes	**Is the history consistent each time?**	**No**
No	**On examination are there unexplained injuries?**	**Yes**
Yes	**Is the child's behaviour and interaction appropriate**	**No**
Low suspicion injury **Diagnose and treat as normal**		**Any of the above circled Strongly Consider** **HIGH suspicion injury** **Discuss with senior ED doctor** **Discuss with Paediatrics** **Follow Safeguarding Children Pathway**

Sign…….. **Name……..…….**

Designation…….. **Date……Time…….**

Appendix 4: Management of bruises in children

Introduction

Bruising is the most common injury to a child who has been physically abused
Bruising that suggests the possibility of physical abuse:

- Bruising in children who are not independently mobile
- Bruising in babies
- Bruises that are away from bony prominences
- Bruises to the face, back, abdomen, arms, buttocks, ears and hands
- Multiple bruises in clusters
- Multiple bruises of uniform shape
- Bruises that carry an imprint of an implement or cord
- Bruises with petechiae around them

Assessment of bruises

History
Full paediatric history
Full documentation of all explanations given
Identify any previous child protection concerns
Check EDM for welfare tab
Contact CSC to check if family known to them

Examination
Undress the child and examine carefully

If Likely accidental bruising
Document assessment

Suspected non-accidental bruising

Documentation
Use child protection medical proforma
Use body maps for documentation of bruises
Request photographs
Consider blood investigations

Discuss with paediatric consultant
Consider a skeletal survey if the child is less than 2 years
Contact Milton Keynes Children's Social Care
Complete MARF

FOLLOW SAFEGUARDING CHILDREN PATHWAY

Appendix 5: Management of burns and scalds

Introduction

All childhood burns must be carefully assessed. Lack of supervision and failure to implement safety measures in the home together with failure to seek appropriate medical attention when required could indicate neglect.

Common patterns of abusive burn and scald injuries

- Contact burns are classically clearly demarcated, of universal depth and can carry the shape of the implement used e.g. iron, fire grid, cooker hot plate, hot fork/spoon, grill of the hairdryer, cigarettes and cigarette lighters.
- Deep cratered circular burns from cigarettes heal to leave scars
- Friction or carpet burns from dragging the child across the floor

Common sites for non-accidental thermal injury

- Feet and hands (particularly back of hands)
- Legs and buttocks
- Face

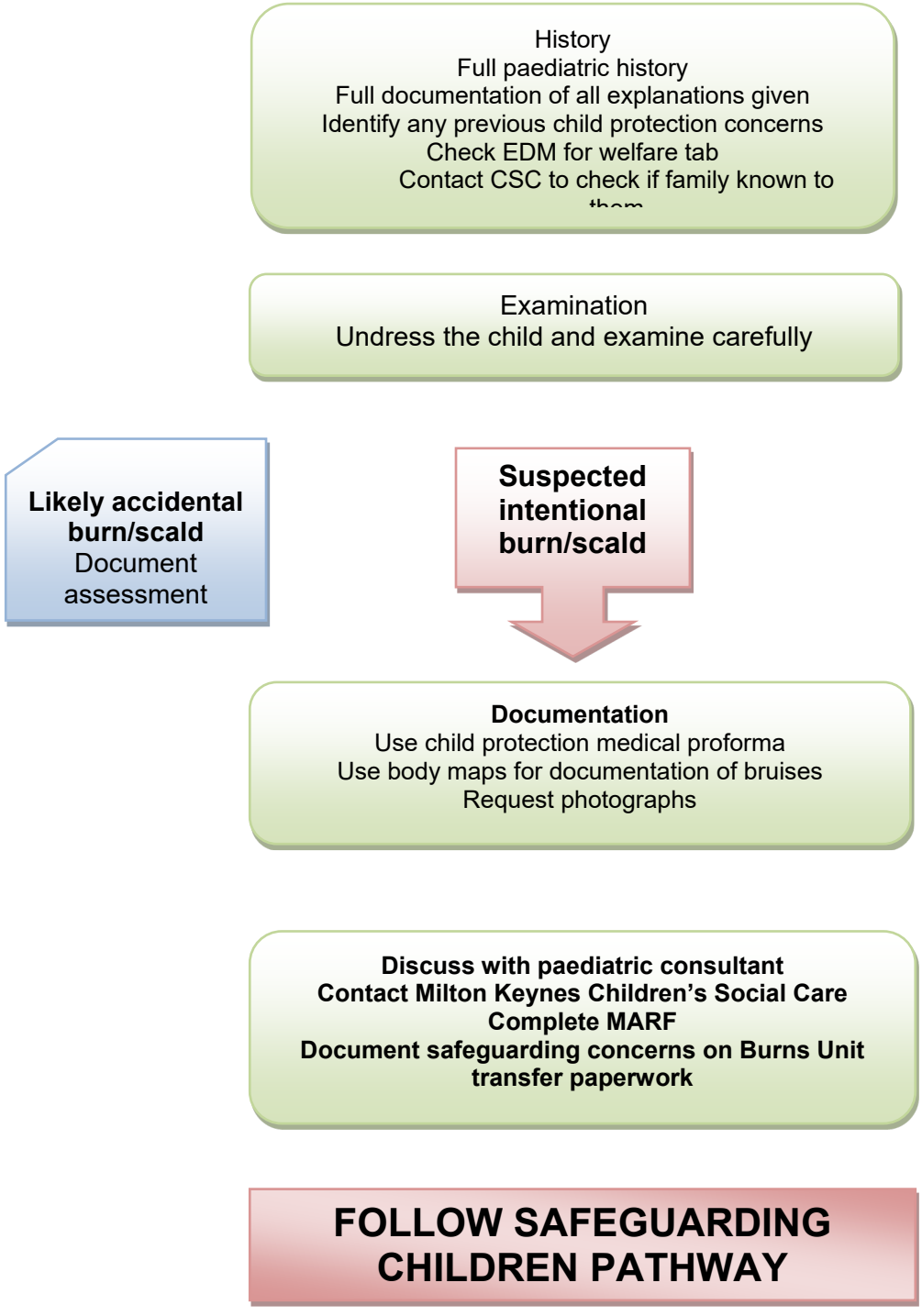
Indicators in the history of abusive burns or scalds

- Lack of a plausible explanation
- Delay in seeking treatment
- Surprising lack of pain described
- History incompatible with developmental age of the child
- Inconsistent story
- Inadequate supervision and admission of guilt
- Denial that a lesion is a burn
- Burn attributed to sibling
- Child contradicts history

Scald Triage Tool

When an intentional scald must be excluded	When an intentional scald must be considered	When and intentional scald is unlikely
Mechanism Immersion Agent Hot tap water Pattern Clear upper limits Scald symmetry (extremities) Distribution Isolated scald to buttock-perineum +/- lower extremities Isolated scald lower extremities Clinical feature Associated unrelated injury History incompatible with examination findings Coexisting fractures Historical/Social features Passive, introverted fearful child Previous abuse Domestic violence Numerous prior accidental injuries Sibling blamed for scald	Pattern Uniform scald depth Skin folds sparing Central sparing buttocks Distribution Glove and stocking distribution One limb glove/stocking Clinical feature Previous burn injury Neglect/ faltering growth History inconsistent with assessed development Historical/Social features Soiling/enuresis/misbehaviour Differing historical accounts Lack of parental concern Unrelated adult presenting child Child known to social services	Mechanism Spill injury Flowing water injury Agent Non tap water (hot beverage) Pattern Irregular margin and burn depth Lacks stocking distribution Distribution Asymmetric involvement of the lower limbs Head neck and trunk or face and upper body

Management of burns and scalds flow chart



Appendix 6: Management of fractures in children

Remember it takes considerable force to produce a fracture in a child or an infant. All fractures require appropriate explanation which is consistent with the child's developmental age

Assessment of fractures in suspected physical abuse should involve paediatrics, paediatric radiology and orthopaedics.

Liaise with the safeguarding children team

When to be concerned about non accidental injury

Age of child

The younger the child the greater the risk of abuse

- 80% of abused children with fractures are < 18 months
- 85% of accidental fractures occur in children> 5 years

Fracture type (in the absence of organic bone disease)

- Multiple fractures
- Rib fractures
- Femoral fracture in a child not yet walking
- Metaphyseal fractures in very young children
- Spiral or oblique fracture of humerus
- Skull fracture (linear common in accidental and abused children)
- Tibia and fibula fracture sin children under 18 months

Flow Chart for the Management of Fractures in Children

History
Full paediatric history: avoid leading questions, do not offer suggestions on how fracture could have occurred

Full documentation of all explanations given
Family history: osteogenesis imperfecta, recurrent fractures
Birth history: mode of delivery, prematurity, risk of osteopenia
Identify any previous child protection concerns
Check EDM for welfare tab
Contact CSC to check if family known to them

Examination
Undress the child and examine carefully

Likely accidental injury
Document assessment

Suspected non-accidental fracture

Documentation
Use child protection medical proforma
Use body maps for documentation of injuries

Discuss with paediatric consultant
Consider a skeletal survey in a child < 2 years
Consider blood investigations i.e. bone profile, vitamin D levels,

FOLLOW SAFEGUARDING CHILDREN PATHWAY

Appendix 7: Flow chart for Indications for a Skeletal Survey

Please refer to 'The Radiological Investigation of Suspected Physical Abuse in children', November 2018

Skeletal Survey - NECESSARY

AGE: 0 – 23 months with history of:

- Confessed abuse
- Injury during Domestic Violence
- Impact from object e.g. toy) causing fracture
- Additional injuries on examination, unrelated to fracture `(e.g. burns and bruises)
- No trauma/explanation for fracture

AGE: 0 – 11 months old with:

- Delay in Presentation >24hours
-
- ANY type of fracture

EXCEPT

- Distal radial/ulna buckle fracture or toddler fracture of tibia/fibula in a cruising child >9months old with a history of a fall
- Linear, unilateral skull fracture in a child >6months with a history of a significant fall
- Clavicular fracture related to birth (infant <22 days old with acute fracture or healing fracture in <30 days old)

AGE: 12 – 23 months old with:

- Rib fracture
- Classic metaphyseal fracture
- Complex/depressed skull fracture
- Humeral fracture epiphyseal separation due to a short fall (<3 feet)
- Femur diaphyseal fracture attributed to a fall from any height
- Delay in presentation >24hours with distressed child

AGE: 12 – 23 months (Ambulatory) old with no other features of abuse with:

- Distal spiral fracture of tibia/fibula with a history of a fall while running/walking
- Distal radial/ulna buckle fracture with a history of fall onto the outstretched hand.

Skeletal Survey – NOT routine

Skeletal Survey may be appropriate and should be considered in other cases if relevant.

Appendix 8: Inflicted head injury (Non-accidental head injury)

Introduction

Inflicted brain injury (iBI) is commonly under recognised and is a diagnostic challenge. More than 40% of deaths from child abuse occur in children < 1 year old with iBI being the most common cause. Often there is significant brain injury with a history of minor trauma / no injury at all. Clinical features range from non-specific to obvious neurological signs e.g. decreased level of consciousness. NAI / iBI should be suspected as follows:

Note that documentation of all concerns, examination findings and discussions with parents, carers, child, medical and nursing staff and other agencies is paramount.

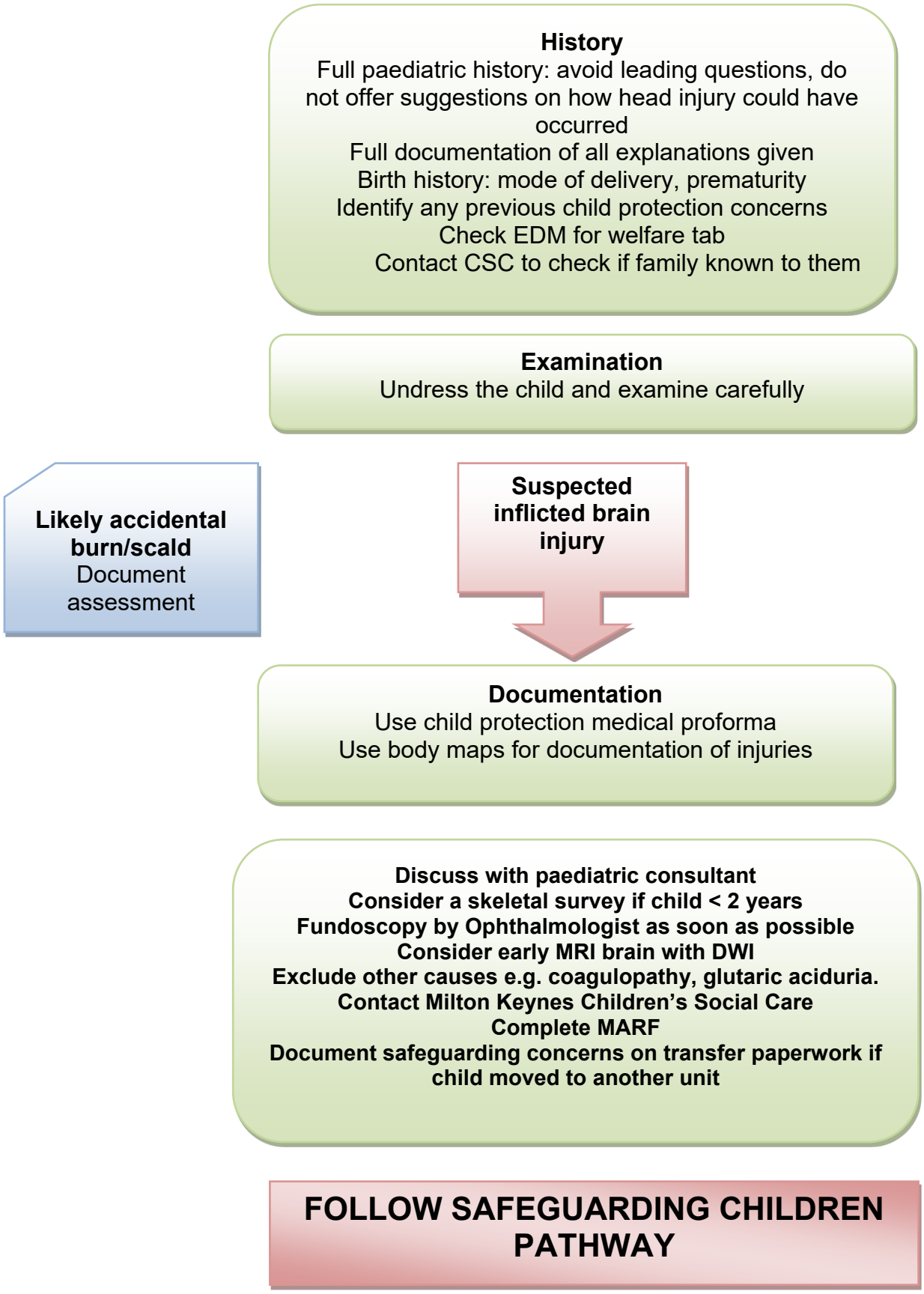
Assessment

History:
- Explanation implausible / inadequate / inconsistent:
- With child's:
- Presentation
- Normal activities
- Existing medical condition
- Age / developmental stage
- Account compared with that given by parent(s) / carers
- Between parents or carers
- Between accounts over time
- Any disclosure from the child / young person / third party
- Any previous suspicions – check EDM for Promoting Child Welfare tab

Observation:
- Child's appearance, behaviour or demeanor
- Symptoms
- Physical signs e.g. bruises
- Interaction between child and parent / carer

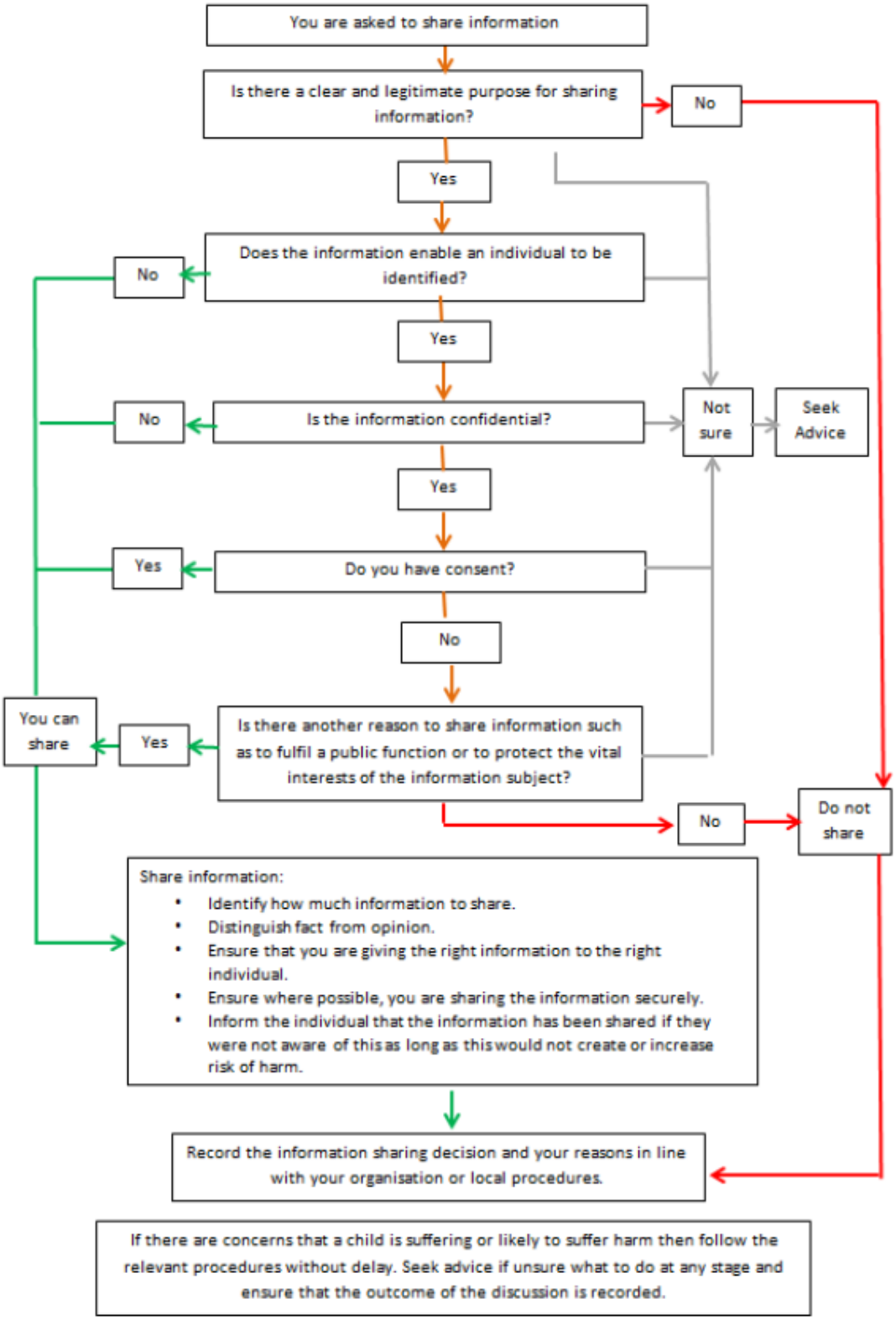
Intracranial injuries:
If noted in absence of major confirmed accident / trauma or known medical causes in ≥1 of the following:
- Explanation inadequate / absent / unsuitable
- Child <3 years of age
- Presence of:
- Retinal haemorrhage
- Or rib / long bone fracture
- Or other associated inflicted injuries
- Or unexplained apnoea
- Multiple subdural haematomas +/- subarachnoid haematomas with / without hypoxic ischaemic damage to the brain.

Flow chart for Inflicted head injury (Non-accidental head injury)



Appendix 9: Guidance: Information Sharing and Seven Golden Rules

Flowchart of when and how to share information



The seven golden rules to sharing information

1. Remember that the Data Protection Act 1998 and human rights law are not barriers to justified information sharing, but provide a framework to ensure that personal information about living individuals is shared appropriately.

2. Be open and honest with the individual (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so.

3. Seek advice from other practitioners if you are in any doubt about sharing the information concerned, without disclosing the identity of the individual where possible.

4. Share with informed consent where appropriate and, where possible, respect the wishes of those who do not consent to share confidential information. You may still share information without consent if, in your judgement, there is good reason to do so, such as where safety may be at risk. You will need to base your judgement on the facts of the case. When you are sharing or requesting personal information from someone, be certain of the basis upon which you are doing so. Where you have consent, be mindful that an individual might not expect information to be shared.

5. Consider safety and well-being: Base your information sharing decisions on considerations of the safety and well-being of the individual and others who may be affected by their actions.

6. Necessary, proportionate, relevant, adequate, accurate, timely and secure: Ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those individuals who need to have it, is accurate and up-to-date, is shared in a timely fashion, and is shared securely (see principles).

7. Keep a record of your decision and the reasons for it – whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose.

Appendix 10: Guidance for Referral to Children's Social Care

Guidance: For professionals when completing a referral to Milton Keynes Integrated Referral Hub- including informing families of concerns.

All referrals are completed electronically direct to the council Link can be found on the intranet via:

CHILD PROTECTION
To make a referral due to child protection concerns you should speak with the Multi Agency Integrated Referral Hub (01908 253169 / 253170) and then provide written information by completing the electronic referral form (MARF).

You must provide information specific to the concerns being raised with as much detail as possible, you must also include your view of the risk that is posed to the child in relation to your concerns.

You do not need the consent of the family to share information to keep a child safe; you should however inform the family that it is being made unless it increases the risk of harm to the child. The family's view of the referral being made should be included within the referral or clear documentation of why they have not been informed of the referral. A printed copy should be filed in their clinical notes.

EARLY HELP:
If you have identified that a family is in need of services that our own organization can't provide you can make a referral for early help from one of Milton Keynes Children and Family Practices. You need to complete the electronic referral (MARF). When the form asks you to identify if the risk is higher than level 2 tick yes and the CAF Form will open up. You must provide information specific to the concerns being raised with as much detail as possible, you must also include what support / services you and the family think that they are in need of.

The family needs to consent to this referral being made and to the information being shared with the Multi Agency Integrated Referral Hub. They should sign a printed copy of the referral which should be filed in the clinical notes.

Ensuring the family, child or young person are informed.

STOP: Think about your location / think about who is present!

As a professional making a referral to the Multi Agency Referral Hub (MASH) you must ensure that the family is informed of the following:

That you have safeguarding concerns and what those concerns are specifically. This should reflect what is written on the referral form that you have completed.

That you have a duty of care to the child or young person to share any welfare concerns with the local authority.

That you have completed a referral to the MASH and that this referral has also been shared with the Child's GP, Health Visitor and/or School Nurse.

- You should give them the supporting leaflet for parents and carers 'Safeguarding Children and Young People 0 to 18 years.
- And if relevant an information leaflet about Milton Keynes Children and Family Practices. **http://www.milton-keynes.gov.uk/children-young-people-families/early-help/children-and-families-practices-your-local-support**

Appendix 11: Guidance for Interagency Report for Child Protection Conference

AGENCY REPORT TO CHILD PROTECTION CONFERENCE

Guidance for Completing the Conference Report

Reports need to be sent to the social worker and conference chair at least 24hrs before the initial conference and 3 working days before a review conference is taking place. Reports should be typed, submitted electronically if possible, to the email address listed above and will be sent out with the minutes of the Conference.

Agency reports will form the majority of the partner agency's contribution at the conference. Therefore, the reports need to be clear and reflect the agency's concerns with regards to safeguarding the child and level of risk.

Key areas of information needed at conference to make informed and focused decisions to safeguard children, Your report needs to broadly address what you are worried about for the child(ren) and what is going well under the domains of the Assessment Framework and focus in the following areas;

- The Child's Developmental Needs
- Parenting Capacity
- Environmental Factors
- The function of the Core Group
- Views regarding a Child Protection or Child in Need plan
- Recommendations for the plan
- The Child of Young Person's views
- The Parent's views

For review conferences, an update of the information and detail of any positive developments, new issues, or concerns since the last meeting, will be required.

As this a multiagency template, please feel free to add and include areas which are specific to your agency if these are not already covered by the headings provided in the template. Addendum reports can be submitted if these contain detailed information. Please attach theses to the main report.

Please remember that is your responsibility to share the content of your report with parents, and child if appropriate, prior to the Children Protection Case Conference. Reports should be provided to the parents and older children (to the extent that is believed to be in their interests) at least 48 hrs. in advance of the initial conference and five working days before review conferences. If there are exceptional circumstances why this has not been possible, please record the reason in your repot.

For further information and guidance, please refer to www.mkscb.org

Appendix 12: Guidance for professional attendance at multi-agency meeting

Guidance: Professional attendance at a multi-agency safeguarding/ child protection meeting

As a professional you may be invited to attend a multi-agency safeguarding meeting due to your involvement with a child and family. There are different types of multi-agency meetings, this guidance is on what each meeting is for , what you can expect to happen and what you may need to prepare.

The Lead Professional must be informed of all invites and attendances to multi-agency meetings.

The Named Midwife must be informed of all invites and attendances to multi-agency meetings that involve an unborn child.

A professional meeting: A professional meeting is a meeting that helps bring together all professionals involved with a child and family where there are safeguarding concerns emerging. Any agency can initiate a meeting. Professionals attending are required to share the information that they have about the child and family and discuss any concerns that they have. An agreed plan of action is established during the meeting. These meetings must have minutes taken and a copy to be sent to the Lead Professional for safeguarding children to be scanned in to the child's notes and a Promoting Child Welfare alert put in place. If a MKUHFT professional is arranging the meeting there is pro forma to assist with the organisation.

A Strategy meeting: A strategy meeting is a meeting that is arranged by Social Care with the support of Police. A strategy meeting takes place when a child protection concern has been raised and the risk of immediate significant harm needs to be assessed and plan of action identified. If the Child has been admitted to hospital the strategy meeting normally takes place at the hospital. The consultant who saw the child will be required to attend along with the Nursing staff looking after the child. Details of the examination and history of the injuries will need to be presented by the consultant along with a copy of the body maps. Nursing staff are required to share information of how the child and family have been on the ward.

Child Protection Conference: There are 4 types of child protection conference meetings:

- Initial child protection conference
- Review child protection conference
- Pre-birth conference
- Receiving in conference

More information can be found in the MKSCB procedures via the link below.

For all child protection conference meetings, the professional that has been asked to attend must complete a child protection conference report using the template provided.

Template is sent with the request for information from the administration team of the Child Protection Team.

MKSCB Inter-agency types of child protection conferences

Guidance as to the type of meeting and what information is required is sent with the request for information from the administration team of the Child Protection Team.

The professional must discuss the conference report with the family before submission. The submission of the report must be sent 48 hours prior to the meeting.

Discharge planning meeting: A discharge planning meeting may be arranged when there have been safeguarding / Child protection concerns identified during the child's admission and by arranging a discharge planning meeting it ensures that all professionals that are going to be involved with the child once discharged are aware of the ongoing issues and plan.
This must always happen with all Babies that are being discharged from the Neonatal unit where there have been safeguarding/child protection concerns; due to the increased vulnerability of being in the neonatal unit from birth. Safeguarding planning meeting checklist can be used

Safeguarding Support / supervision

Diabetes
Respiratory
HIV
Sickle Cell
Oncology

Appendix 13: Multi-agency Meeting Safeguarding Children Checklist

- **ALL Meetings must be minuted and the Lead Professional must be informed.**
- **The Lead Professional/Named Midwife can provide support and supervision to all staff invited to a multi-agency**

MULTI- AGENCY SAFEGUARDING CHILDREN
MEETING CHECKLIST

For staff use only:

Surname:

Forenames:

Date of birth:

Hospital No:

Room Booked	Date/Time	Location

	Invited	Attending	Comments
Link Person			
Parents			
Consultant			
Community Nurses			
Complex Care			
Dietician			
Health Visitor			
Midwife			
Physiotherapist			
Safeguarding Lead			
Speech and Language Therapist			
Social Worker			
Ward Staff			
Other			

Appendix 14: Procedure for Allegation or Disclosure of Sexual Abuse

Procedure: Allegation / Disclosure of sexual abuse 0-18 years

Think! **Consider Chiild Exploitation (Click www.mkscb.org for signs and indicators)**

CHILD &YOUNG PERSON

- **Involve Paediatric on call consultant**
- **Consider STI / BBV / Contraception.**
- **Consider vfgfgs CAMHS input**
- **Inform MKHFT Lead for Safeguarding Children**

CONTACT SOLACE

0845 5197638

- **Examination of alleged Sexual Assault**

CONTACT SOCIAL CARE

- **Tel: verbal referral**
- **Complete written referral MARF**
- **Document**
- **Inform MKHFT Lead for Safeguarding Children**

CONTACT THE POLICE

TEL: 101

THINK! WHAT NEXT?

ADMISSION

1. Inform other agencies / professionals of admission
2. Where child should be nursed
3. Who can visit?
4. Can this child be allowed off the ward?

DISCHARGE

1. Ensure discharge is to a place of safety
2. Ensure consultant in your area & paediatric consultant are involved in discharge
3. Share information with other agencies as appropriate
4. Document concern, action, outcome
5. Inform Lead for Safeguarding Children.

TRANSFER

1. Ensure concerns clearly communicated & documented on transfer paperwork.
2. Include a copy of the written referral to Social Care (MARF)

Appendix 15: Procedure to request examination of a child at Solace Sexual Assault Referral Centre (SARC)

Advice can be taken from the Solace SARC and/or Dr Paul at any time

Telephone Numbers:
Solace Centre
0845 519 7638
Dr Sheila Paul
07899 870 679

Child alleges or discloses abuse OR
Acute cases

Contact Solace Centre **0845 5197638**
Share the following information with crisis support worker

- Child's details
- Brief account of allegation
- Time elapsed since alleged assault

Child under 12 years

Child with severe disabilities

Child over 13 years but pre-pubertal

If Forensic Physician (FP) is not trained to examine this group of children, then duty FP will contact on call paediatric consultant for joint examination

This is best done **at Solace**

Child aged over 13 years and pubertal

Examination will be done by FP at Solace

Non-urgent cases should be planned with Dr Sheila Paul at an agreed time

Appendix 16: Management of Child Exploitation

Introduction

Child sexual exploitation (CSE) is a form of child sexual abuse. Children and young people affected by sexual exploitation can present with a range of physical and/or emotional problems to a wide range of health settings.

Vulnerability factors for exploitation

- Family dysfunction
- Prior (sexual) abuse or neglect
- Going missing / running away
- Substance misuse
- Disengagement from education
- Social isolation
- Low self esteem
- Socio-economic disadvantage
- Learning difficulties / disabilities
- Peers who are sexually exploited
- Gang-association
- Attachment issues
- Homelessness
- Being in care

Presentation of CSE

PHYSICAL HEALTH presentations of CSE	MENTAL HEALTH presentations of CSE
These may include: Poor self-care Injuries Sexually transmitted infections Contraceptive advice Termination Pregnancy Drug and alcohol problems Medically unexplained symptoms	These may include: Emotional symptoms Trauma symptoms Self-harming behaviour Problem behaviours e.g. running away, risk-taking behaviours Problems in relationships

If you have concerns that a child or young person may be at risk of Exploitation, then follow the Safeguarding Children Pathway.

If the young person has made a disclosure of sexual abuse/ assault, follow the procedure for Allegation/ disclosure of sexual abuse 0-18 years.

Appendix 17: Sexual Assault Referral Pathway for Under 18 Years for Milton Keynes

Complaint of/suspicion of sexual assault

↓

Treat any life threatening injury as needed
Refer to Paediatric Team

↓

Contact the Police

- Medical Professional to report via 101. Use 999 if imminent danger
- Ensure duty social worker at MASH contacted and MARF completed
- Identify who has parental responsibility for child and share this information with relevant agencies

↓

Police will co-ordinate with SARC and Children's Social Care

↓

Doctor to speak directly to the Forensic Physician regarding actions

↓

Medical assessment and treatment may be needed prior to discharge (e.g. X-rays, plaster casts etc)
If this is required, limit the number of staff who has direct contact with the patient
Ensure all care given is clearly and accurately documented. Include body mapping if appropriate and record all staff who have had any contact with the patient during attendance

↓

Ensure children's Social Care are aware of planned discharge and patient/family have SARC contact details given to patient before

If in doubt, contact SARC and speak to the Forensic Physician

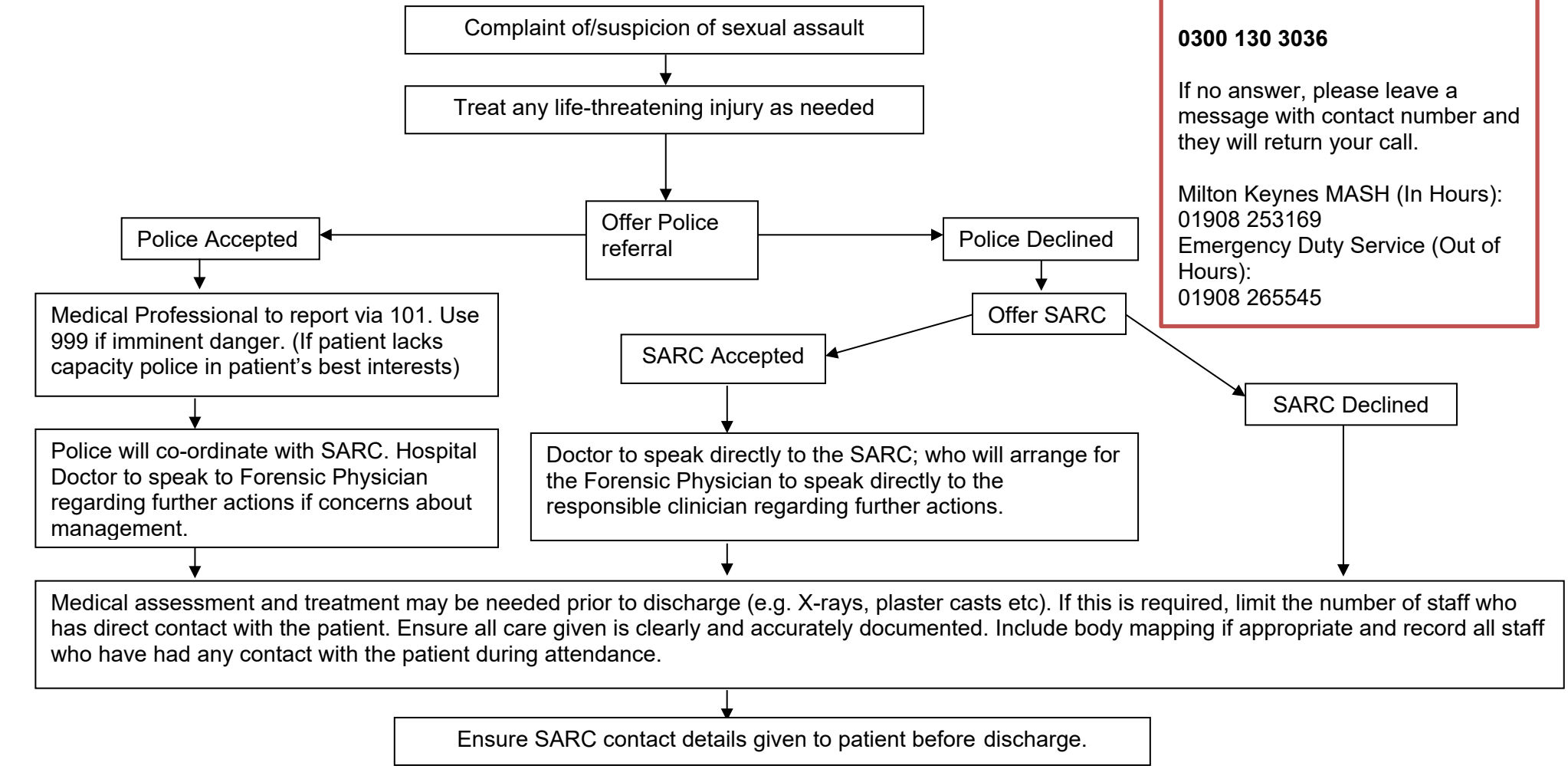
SARC (24 hour):

0300 130 3036
(if no answer, please leave a message and contact number and they will return your call)

Milton Keynes MASH (In Hours):
01908 253169
Emergency Duty Service (Out of Hours):
01908 265545

If you wish to raise any concerns/issues with regards to this process, please contact the hospital safeguarding team.

Sexual Assault Referral Pathway for 18 Years and Over for Milton Keynes



If in doubt, contact SARC and speak to Forensic Physician:
SARC 24 hour helpline:

0300 130 3036

If no answer, please leave a message with contact number and they will return your call.

Milton Keynes MASH (In Hours):
01908 253169
Emergency Duty Service (Out of Hours):
01908 265545

If you wish to raise any concerns/issues with regards to this process, please contact the hospital safeguarding team.

Appendix 18: Procedure for Child Mental Health

Procedure: Child Mental Health

Responding to an Incident of self-harm:
Where the child has presented at hospital due to a self-harm or attempted suicide, the doctor should undertake a preliminary examination and seek further advice from the 24 hours on call CAMHS emergency service.

In cases of attempted suicide, a hospital admission will usually be arranged to enable a psycho-social assessment, which should consider whether or not the child is at risk of significant harm and the need to refer to Children's Social Care for assessment

Where a child has been hospitalised as a result of self-harm, any discharge must involve co-ordinated planning with community services, including Children's Social Care and CAMHS.

What should happen when CAMHS see a child in the emergency department?

- CAMHS must see the Child/ Young person in Emergency department
- CAMHS must complete an assessment using their assessment paperwork.
- CAMHS must leave a copy of the assessment paperwork in the child's notes.
- CAMHS must document what the safeguarding plan is at the back of the assessment paperwork and actions must be signed for.
- If safeguarding concerns are raised it is essential that CAMHS professionals and Emergency department professionals discuss the concerns together and a referral form is jointly completed in the Emergency department and sent. This is a joint responsibility.
- The MKHFT Lead for safeguarding children must be informed of all child mental health attendances and admissions.
- Child mental health attendances and Admissions will be shared with the child's health visitor or school nurse via the Emergency Department sharing information form.

What should happen when CAMHS see a child/young person on the ward?

- CAMHS must complete an assessment using their assessment paperwork.
- CAMHS must document what the safeguarding plan is at the back of the assessment paperwork and actions must be signed for
- If safeguarding concerns are raised it is essential that CAMHS professionals and Nursing /Medical ward staff discuss the concerns together and a referral form is jointly completed in through the hospital intranet page. This is a joint responsibility.
- A clear discharge plan must be in place before the child /young person is discharged, this must include liaison with Social Care, CAMHS and Medical staff. This must be clearly documented in the hospital notes and on the discharge form to GPs.

The MKHFT Lead for safeguarding Children must be informed of all child mental health attendances and admissions.

MKSB Interagency self harm and suicide
www.mkscb.org

Appendix 19: Procedure: Children subject to Child Protection Plan

Procedure: Children Subject to a Child Protection Plan

Children may be Subject of a Child Protection Plan for one or more than one of the categories of abuse: PHYSCIAL ABUSE, EMOTIONAL ABUSE, SEXUAL ABUSE, and NEGLECT.

MKHFT are notified of all children who are subject of a Child Protection Plan within the Milton Keynes area. All Core meetings and outcomes of the core meeting are also sent to MKHFT.

All notifications of Child Protection Plans are scanned in to the child's electronic patient record on EDM and a Promoting Child Welfare Banner applied. To access the information, log in to EDM patients record system and entre the child's details, then click on 'Front *sheets/alerts'* the information should be scanned in date order.

Children's Social Care must be informed of all children who are Subject of a Child Protection Plan who attend MKHFT for emergency treatment or admission.
TEL: 01908 253169 9-5pm or OUT OF HOURS TEL: 01908265545

The Lead Professional for Safeguarding Children for MKHFT must be informed of all children who are Subject of a Child Protection Plan who attend MKHFT for emergency treatment or admission.

Professionals Invited to a Child Protection Conference
Professionals who are providing regular care to a child who is Subject of a Child Protection Plan may be asked to attend a Child Protection Conferences. The Lead Professional for Safeguarding Children and your Matron must be informed of any invites to conference.

A conference report must be completed and sent securely prior to conference. It must be discussed by the professional with the parents. The Lead Professional can support with this process.

Information can be sought from MKSCB website for MK Together

Appendix 20: Procedure for Domestic Abuse

Procedure: Domestic Violence – including the child behind the adult (concern for the unseen child)

Domestic abuse: "An incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults (Including young people 16-18yrs) who are or have been intimate partners or family members, regardless of gender or sexuality. It can also include forced marriage, female genital mutilation and 'honour violence'." (NICE 2010) Men and women can be victimized in this way although women are more likely to be affected. Prolonged and regular exposure to domestic violence can have a serious impact on children's safety and welfare despite best efforts of parents to protect them.

Working Together to Safeguard Children (2010/ 2012) clearly states that when domestic violence is identified in families with a child under 12 months (including an un-born child) even if the child was not present, professionals should make a referral to children's social care.

Your Role

Your role in responding to domestic abuse should be focused on:

- focusing on the individual's safety and that of their children'
- giving information and referring to relevant agencies;
- consider a Vulnerable Adult referral
- making it easy for a them to talk about their experiences;
- support and reassure, provide discrete local and national support numbers
- being non-judgemental

Consider the risk to the children; is there a pregnancy or child below the age of 1 year?
Information disclosed antenatally should be kept confidentially and NOT in hand-held notes.

For Further information on Domestic Abuse please go to the:

MK ACT Website

MK Together Website: https://mkscb.procedures.org.uk/

MKUHFT internet Site (View the Safeguarding Pages for further information

Appendix 21: Procedure for Female Genital Mutilation

Procedure: Female Genital Mutilation (FGM)

Female Genital Mutilation (FGM) is a violation of a girl's rights as a child and her entitlement to her bodily integrity. It is a cruel act perpetrated by parents and extended family members upon young girls who are entrusted to their care. FGM is not simply an exotic or 'cultural' ritual that girls need to undergo, but a practice which has intolerable long-term physical and emotional consequences for the victims. FGM causes death, disability, physical and psychological harm for millions of women and children every year. (RCM,2013)

Definition - The term 'Female Genital Mutilation' (FGM) comprises all procedures involving partial or total removal of the external genitalia or other injury to the female genital organs for non-medical reasons. The WHO classifies FGM into four types. The most extreme of which (Type III) involves narrowing of the vaginal orifice. (RCM,2013)

The Law - FGM has been a specific criminal offence since 1985 (Prohibition of Female Circumcision Act- 1985), which was replaced by the Female Genital Mutilation Act (2003) (in England, Wales and Northern Ireland). Under the terms of these Acts, it is criminal to:

- Excise, infibulate or otherwise mutilate the whole or any part of the labia majora or labia minora or clitoris of another person.
- Aid, abet, counsel or procure a girl to mutilate her own genitalia.
- Aid, abet, counsel or procure another person who is not a UK national to mutilate a girl's genitalia outside the UK.

Action

Any suspicion of **intended or actual** FGM must be immediately referred to Children's Social Care via MARF and telephone consultation and Datix completed.

- Police should be contacted if child at imminent risk.
- Inform senior safeguarding leads for advice and support with the family. Informing the family of referral to Police and Children's Social care may put the child/ren at increased risk.
- Refer to MK Hospital Local Procedures and MKSCB Guidelines and procedures.
- Contact NSPCC helpline **0800 028 3550**
- Download FGM Leaflet for parents here: and FGM Toolkit from MKSCB.

MK Together Website: https://mkscb.procedures.org.uk/

NSPCC website:
http://www.nspcc.org.uk/Inform/resourcesforprofessionals/minorityethnic/female-genital-mutilation_wda96841.html

Appendix 22: Procedure for Fabricated Induced Illness

What is FII?

Fabricated and Induced Illness (FII) was first described as Munchausen Syndrome by Proxy (MSbP) in 1977. The term FII was introduced in the UK by the Royal College of Paediatrics and Child Health (RCPCH) in 2001 and subsequently adopted by the Department of Health.
FII involves a well-child being presented by a carer as ill or disabled, or an ill or disabled child being presented with a more significant problem than he or she has in reality, and suffering harm as a consequence. The carer actively promotes the sick role by exaggeration, fabrication (lying) or falsification of signs and in severe cases inducing illness.

The defining characteristics of FII are:
Illness in a child which is fabricated or induced by a parent or someone who is in the position of a parent;
The child is presented for medical assessment and care, usually persistently, often resulting in multiple medical procedures;
The perpetrator often denies the aetiology (explanation of the causes) of the child's illness.
Acute symptoms and signs cease when the child is separated from the perpetrator.

Indicators which should alert professionals to the possibility of FII:

- A carer reporting symptoms and observed signs that are not explained by any known medical condition
- Physical examination and results of medical investigations that do not explain symptoms or signs reported by the carer
- There is an inexplicably poor response to prescribed medication or other treatment, or intolerance of treatment
- Acute symptoms that are exclusively observed by/in the presence of the carer
- New symptoms are reported by the carer on resolution of previous ones or carer reporting symptoms in different children in sequence
- Over time the child is repeatedly presented with a range of signs and symptoms
- The child's normal daily life activities are being curtailed, for example, school attendance, beyond that which might be expected for any medical disorder from which the child is known to suffer or the use of seemingly unnecessary special aids
- Objective evidence of fabrication, for example, test results such as toxicology studies or blood typing
- The carer expressing concern that they are under suspicion of FII, or relatives raising concerns about FII
- The carer seeking multiple opinions inappropriately

What to do if you are concerned about FII?

- Discuss your concerns with the Named Nurse and Named Doctor for safeguarding Children at MKHFT.
- Document your concerns and compile a Chronology of concerns – Use the Interagency Chronology template (Your Named Professional can support you with this).
- Although it is usual practice to discuss concerns with the parents and carers, in the cases of fabricated or induced illness this may put the child at further risk.
- With the support from your named professional a multi-agency emerging concerns meeting should be considered to gather information from all agencies and discuss further action needed.

Appendix 23: Safeguarding Paperwork FII Chronology Template

milton keynes council | Milton Keynes University Hospital NHS Foundation Trust | Central and North West London NHS Foundation Trust – Milton Keynes Community Health Services | Milton Keynes Safeguarding Board | Milton Keynes Clinical Commissioning Group

Professional's chronology for the management of FII concerns

Name of child:	NHS no:	DOB:

Once the chronology is triggered by a professional please be aware all professionals are responsible for keeping their own chronology of involvement up to date, as this could be required for future Professionals Meetings

Warning indicators of Fabricated Induced Illness:

- Symptoms only appear when the parent or carer is present
- The only person claiming to notice symptoms is the parent or carer
- Physical examination and results of medical investigations do not explain reported symptoms or observed signs
- New symptoms and problems are reported on resolution of previous ones
- The affected child has an inexplicably poor response to medication/ treatment
- One parent (commonly the father) has little no involvement in the child's care
- Objective evidence of fabrication; for example, the history of events given conflicts with what is observed or is biologically implausible (such as small infants with a history of very large blood losses who do not become anaemic or infants with large negative fluid balance who do not lose weight). Test results such as toxicology studies or blood typing
- The child shares conflicting and concerning reports regarding their parent's involvement in their symptoms or illness
- The parent/ carer develops close and friendly relationships with health care staff but may become abusive or argumentative if their own view about what is wrong with the child is challenged
- The parent/ carer encourages medical staff to perform painful tests or procedures on the child (tests that most parents would only agree to if they were persuaded that this was necessary)
- The parent/ carer has a history of changing GPs or visiting different hospitals for treatment particularly if their views on treatment are challenged
- The parent/ carer does not appear too worried about their child's health despite being very attentive
- There a pattern of missing or rescheduling clinic appointments at which the parent/ carer is likely to be reassured that the child does not have a particular diagnosis?
- The child's normal daily life is being impacted beyond what might be expected for the medical / developmental disorder that the child has been diagnosed with
- Family history includes unexplained illnesses, deaths or multiple surgeries in parents or siblings.
- Exaggerated incidents/ fabricated illnesses of other family members reported
- The parent/ carer expressing concern that they are under suspicion of FII or a relative raising concern about FII
- History of child abuse, self-harm, mental health of the carer

FII Chronology

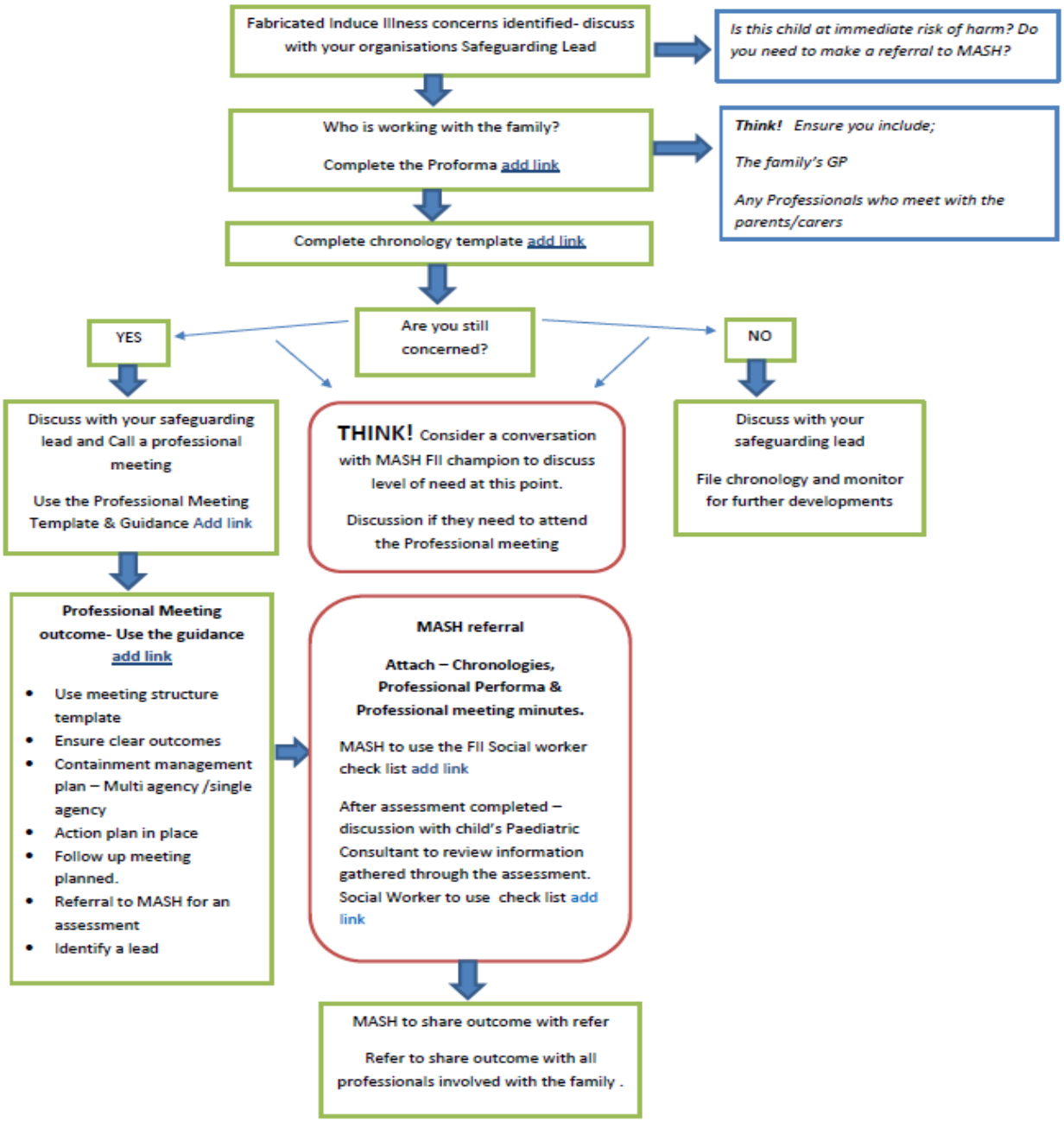
Date	Name	Source	Episode/Event	Comment

milton keynes council | Milton Keynes University Hospital NHS Foundation Trust | Central and North West London NHS Foundation Trust – Milton Keynes Community Health Services | Milton Keynes Safeguarding Board | Milton Keynes Clinical Commissioning Group NHS

Date	What are we worried about? (What is the impact on the child?) Refer to Levels of need document	What needs to happen Outcome/ Decision

See MKSCB Inter-agency Fabricated Illness https://mkscb.procedures.org.uk/

Fabricated Induced Illness Pathway



milton keynes council | Milton Keynes University Hospital NHS Foundation Trust | Central and North West London NHS Foundation Trust – Milton Keynes Community Health Services | Milton Keynes Safeguarding Board | NHS Milton Keynes Clinical Commissioning Group

Professional's working with the family proforma - Management of FII concerns

Name of child : -	NHS no	Date:-

Family composition:
(please record all who lives with the child or has contact with the child on a regular basis and their relationship with the child)

Name	Name	Name
Name	Name	Name

Please record all professionals involved with the child and family. Please include any professionals also working with any of the other siblings or parents. Suggestions :- GP, Health visitor/ School Nurse, Specialist Services – Paediatrician, CAMHS, Speech and Language therapists, Occupational Therapists, Physiotherapists, Dieticians, Specialist nurses, Hospices, Tertiary centres, schools and nurseries, children's centres, Children and Family Practice and Children's Social Care.

Professionals involved

Name	Role	Contact details	Date seen	Advice given	Action needed

milton keynes council | Milton Keynes University Hospital NHS Foundation Trust | Central and North West London NHS Foundation Trust – Milton Keynes Community Health Services | Milton Keynes Safeguarding Board | NHS Milton Keynes Clinical Commissioning Group

Meeting with Social Worker and Child's consultant post Child and Family Assessment

NO:	Meeting Check list	Date completed:
1	Ask for Professional Chronologies (if not got them from Professional meeting)	
2	What is the evidence for FII?	
3	Discussion about what unnecessary harm has occurred?	
4	What is the Consultants view of the parents/carers behaviours and conduct and how is this impacting on the child?	
5	What conversations have taken place with the parents and what is their understanding of what has been told to them?	
6	Depending on age – What has the child said?	
7	Discussion in regard to what parents have told Social worker and what is fact in the medical notes. Triangulate the information to get facts.	
8	Next steps:	

Appendix 24: Procedure for Looked after Child

Procedure: Looked After Children and Young People

Looked after Children include children in foster or residential homes or those still living with their parents but subject to a 'Care Order'. It also includes children who are temporarily looked after for respite on a planned basis.

Just under two thirds of looked after children come into care following child protection concerns such as neglect or abuse.

MKHFT receive notification of all children who are Looked After by the local authority.

All notifications of Looked After Children are scanned in to the Child's electronic patient record on EDM and a Promoting Child Welfare Banner applied. To access the information log in to EDM patients record system and entre the child's details, then click on 'Front *sheets/alerts'* the information should be scanned in date order.

Children and Social Care must be informed of all Looked After Children who attend MKHFT for emergency treatment or admission .TEL: 01908 253169 9-5pm or OUT OF HOURS TEL: 01908 265545

MKHFT Named Nurse for Safeguarding Children must be informed of all Looked After children who attend MKHFT for emergency treatment or admission.
The Named Nurse for safeguarding Children will ensure that the Named Nurse for Looked After Children is informed.

Appendix 25: Procedure for Parental Substance Misuse

Procedure: Parental Substance Misuse – including child behind the adult (Concern for the unseen child)

Parental substance misuse can cause significant harm to children at all stages of development. The potential risks to a child's health and well-being include: Neglect of parental responsibilities, leading to physical, emotional and psychological harm.

Family resources are used to finance parent's dependency, resulting in inadequate food, heating and clothing for the child

Presence of unsuitable care givers or visitors in the home.
Exposure to criminal and other inappropriate adult behaviour.
Chaotic drug use can lead to increased irritability, emotional unavailability, and irrational behaviour and reduced parental vigilance. This can be particularly acute when the parent is experiencing withdrawal symptoms.
Unsafe storage of drugs and paraphernalia, thereby exposing children to the risk or overdose and / or blood borne viruses.
Delayed grown and development of the unborn child if mother misuses substances during pregnancy. This can cause possible permanent dysfunction of the brain and central nervous system.

Remember - The misuse of drugs and alcohol is strongly associated with significant harm to children when combined with parental mental ill health and domestic violence and abuse. By working collaboratively and maintaining a clear focus on the needs of the child, services can protect and improve the well-being of children living in households affected by substance misuse.
Identification - Professionals in drug and alcohol services must identify those adults who are parents or carers and share this information with Children's Social Care, GPs, Health Visitors, Midwives and School Nurses. Professionals must then assess the likely impact of the substance misuse on the parent's capacity to care for their child / unborn baby. Care Programme Meetings held in relation to any substance misusing parents must include consideration of the needs and risk factors for children. 'Think child; Think parent; Think family'.

Adult substance misuse workers should take part in strategy meetings, child protection conferences and core groups meetings. Professionals must, in every case, assess the likely impact on…

Where a child is suffering or likely to suffer significant harm then a referral should be made to Children's Social Care. A referral should also be made where a woman who is pregnant is involved in significant substance misuse.
Where the child has unmet needs, but is not likely to suffer significant harm, consider undertaking a CAF.

Information available on the MK Together Website
https://mkscb.procedures.org.uk/

Appendix 26: Parental Mental Health

Procedure: Parental Mental Health Concerns – including child behind the adult (Concern for the unseen child – The Child Behind the Adult)

The majority of parents who suffer significant mental ill-health are able to care for and safeguard their child/ren and/or unborn child, but it is essential always to assess the implications for each child in the family. In some cases, the parent's condition may seriously affect the safety, health and development of children particularly when subjected to known stressors or alcohol/substance misuse.

MARF to be completed if:

- A concern or problem, suspicion about a child becomes apparent, or if the child's own needs are not being met.
- If service users express delusional beliefs or any psychotic ideation involving their child; and/or
- If service users might harm their child as part of a suicide plan.

MARF to be considered:

- When considering whether a child is at risk the following parental risk factors must be considered and justify a referral to Children's Social Care for an assessment of the child's needs:
- Previous history of parental mental health, especially if severe and/or enduring, e.g. previous diagnosis of Bipolar disorder or Schizoaffective disorder are a significant risk of relapse due to birth hormones;
- Predisposition to, or experience of, severe post-natal illness;
- Self-harming behaviour and suicide attempts;
- Altered states of consciousness e.g. dissociation, misuse of drugs, alcohol, medication;
- Obsessional compulsive behaviours involving the child;
- Non-compliance with treatment, reluctance or difficulty in engaging with necessary services, lack of insight into illness or impact on child;
- Disorders designated 'untreatable' either totally or within time scales compatible with the child's best interests;
- Mental health problems combined with domestic violence and/or relationship difficulties;
- Unsupported and/or isolated parents with mental health problems;
- Parental inability to anticipate needs of the child.

Information available on the MK Together Website: https://mkscb.procedures.org.uk/

Appendix 27: PREVENT

Procedure: (PREVENT) Supporting Individuals Susceptible to Being Drawn into Extremism or Terrorism

The process outlined below aims to support those who are at risk of being drawn into extremism or terrorism. It uses existing partnership working between the police, health, local authorities, statutory partners and the local community.

If I have a concern, who can I speak to confidentially?

Guidance from the Trust
Single Point of Contact (SPOC) for *Prevent*

Lead Nurse for Safeguarding Adults
Bleep 1329

Police

Urgent: 999
Non-urgent: 101

In Person at a Police Station or to a Prevent Engagement Officer

Confidential Anti-Terrorist Hotline
0800 789 321

Crimestoppers
0800 555 111
(Anonymous)

Support processes established by multi-agency partners.

Appropriate level of support is provided.

There is no single profile of a person likely to be involved in extremism or terrorism. However, experience has shown that there can be early warning signs most likely to be identified by family, friends and professionals which are indicative of the need for support.

The earlier we can identify and provide appropriate support, the more effective this support is likely to be.

You can be reassured that any information received will be handled sensitively and treated with the strictest of confidence.

Information on Prevent available on the Internet

Appendix 28: Referral to Adult Social Care

Procedure: Referral to Adult Social Care – adult welfare concerns

Safeguarding adults is everybody's business. Safeguarding adults means helping adults at risk live free from abuse and neglect.

If you have a concern about an adult at risk of abuse and they are in immediate danger you should first notify the relevant emergency services by ringing 999.
If the adult you are concerned about is not in immediate danger you should report your concern to Milton Keynes Council Adult Social Care using the Adult Safeguarding Alert (SABR1)

Who is an Adult at Risk?
'Any person over the age of 18 years who is unable to look after their own wellbeing, property, rights or other interests; and is at risk of harm (either from another person's behaviour or from their own behaviour); and because they have a disability, mental disorder, illness or physical or mental infirmity, are more vulnerable to being harmed than other adults.'

Safeguarding Adults Basic Reporting Form - SABR1 Form
This form is to be completed to report a concern for any adult you believe to be at risk of abuse. It is a multi-agency form and is encrypted when sent.
A vulnerable adult is someone aged 18+ who is currently in receipt of/or who may be in need of adult social care or health services and is unable to protect him or herself against significant harm or exploitation.

Please complete the form as directed. Ensure that a copy of the SABR1 form is printed off BEFORE pressing send and is kept in the patients notes and a copy is sent to the Lead Nurse for Safeguarding Adults based in Post Grad Centre. Please also contact ext. 85091 and leave the patients name and clinical area in which the alert has been raised.
Access the SABR1 FORM via the MKUHFT Internet Site. (Access the Safeguarding pages)

Vulnerable Adults
If you are concerned that an adult may be vulnerable BUT it is not a concern about abuse, then please DO NOT complete an SABR1 alert form but contact ASCAT directly on tel: 01908 253772.

Useful Contacts: Lead Nurse Safeguarding Adults
Tel: 01908 995091

Safeguarding Adults Policy

Available on the Milton Keynes Hospital Intranet

Appendix 29: Safeguarding Allegations against health care staff

It is important that all adults working with children understand that the nature of their work and the responsibilities related to it, place them in a position of trust.

'Guidance for Safer Working Practice for Adults who work with Children and Young People (2007) provides clear advice on appropriate and safe behaviours for all adults working with children in paid or unpaid capacities, in all settings and contexts.

When information has been received about a staff member's actions or behaviour regarding a child, it is important that a decision is made about whether the information should be treated as an allegation against a staff member or a complaint against a staff member. If this decision is not obvious then it should be made by the NHS Milton Keynes CCG Head of Safeguarding in consultation with the Designated Professionals for Child Protection and the Local Authority Designated Officer, regardless of which health organisation the staff member works for.
There may be up to 3 strands in the consideration of an allegation:

A police investigation of a possible criminal offence;
Enquiries and assessment by Children and Families about whether a child is in need of protection or in need of services;

Consideration by an employer of disciplinary action in respect of the individual

As soon a MKUHFT becomes aware of an allegation (or potential allegation), either directly or via another agency, it should be reported immediately to the Chief Nurse for the hospital who will lead the investigation and will involve Human resources, the Lead Professional for Safeguarding children and the staff members Senior Manager within the organisation.

The allegation must be reported to the Designated Officer within 1 working day, who can provide advice and support. They should also report the allegation to the Designated Nurse Safeguarding Children. This is in line with the MKSCB interagency policy.

http://www.mkscb.org/mkscb/documents/LADO_Leaflet_270613.pdf

Appendix 30: Individuals who pose a risk to children

Any person identified as posing a 'Risk to Children' should have had an assessment completed about the risks they pose to children; this information may or may not be known to health professionals.

(Please note: The term 'Schedule One offender' is no longer used. It has been replaced with 'Risk to Children'. This clearly indicates that the person has been identified as presenting a risk, or potential risk, of harm to children.)

If you become aware that an individual who may pose a risk to children is having contact with children, you should make a referral to Milton Keynes Integrated Support and Social Care Referral Hub; asking them to ascertain that an up to date risk assessment has been completed and details of any children you are aware the person is having contact with.

The Multi-Agency Public Protection Arrangements (MAPPA) enables agencies to work together within a statutory framework for managing risk of harm to the public. Its focus is on specified sexual and violent offenders in, and returning to, the community. MAPPA meetings are held monthly to share information, assess and manage risk to best protect the public from serious harm. Health is represented by the NHS Milton Keynes CCG Designated Nurse who will share relevant information from meetings, to other health organisations, as required.

Appendix 31: Safeguarding Paperwork Pink sheet

Milton Keynes Hospital NHS
NHS Foundation Trust

Surname:
Forename:
DOB:
Hospital No:
Or affix Patient Label

Date of attendance Date: ___/___/____

Presenting Complaint (if injury-how caused)

.....

Promoting Child and Family Welfare

Parents names (include step parent/foster carers if applicable)

1: ..... D.O.B: ..... Occupation: .....

2: ..... D.O.B: ..... Occupation: .....

Main carer Parents ☐ Other ☐ ..... Child lives with Parents ☐ Other ☐ .....

Siblings (name & D.O.B) 1: ..... 2: .....

3: ..... 4: .....

Name of School/Nursery/Childminder.....

Name of GP/Surgery .....

Professionals involved with the family (please tick where appropriate)

Dietician ☐ Community nurse ☐ Family nurse partnership ☐ Paediatrician ☐ Children's Centre ☐ CAMHS ☐

Social Services ☐ Health Visitor ☐ Other ☐ .....

Name: .....

Involvement .....

Anyone else living in the house NOT Family (specify) .....

Visitors

Is there anyone who should not be allowed access to the unit? (Reason/Details)

.....

Name: .....D.O.B.....Relationship to Child: .....

Telephone Numbers:

Nurse Signature..... Print Name.....

Author Beth Blanchette- Children's Nursing Sister/Safeguarding Children Named Nursing Team
Ve[illegible]1
Or[illegible]l Date of approval 02/2013
Date of version approval
Hospital Code

We CARE

Milton Keynes Hospital NHS
NHS Foundation Trust

Surname:
Forename:
DOB:
Hospital No:
Or affix Patient Label

Child and Family Welfare Care Plan:

Name of Key Worker: ..... Position: .....
(Considerations: Parent/child interaction/visiting/feeding/general care & suspension of child/sharing information between professionals)
Evaluation to be documented on purple safeguarding sheets

Full history to be taken by Registrar/Consultant and body mapping to be completed for every child where there are welfare concerns !..

Named Nurse Informed ☐ Enquiry made to children's social care ☐ Referral sent ☐

Author Beth Barchetta- Children's Nursing Sister/Safeguarding Children Named Nursing Team
Version 1
Original Date of approval 02/2013
Date of version approval
Hospital Code

We CARE

Appendix 32: Safeguarding paperwork- ED Sharing Information Form

Emergency Department Sharing Information Form for all 0 - 18 years

Milton Keynes University Hospital NHS
NHS Foundation Trust

For staff use only:
Surname:
Forenames:
Date of birth:
NHS No:

Date: …… Reason for attendance: ……

GP Practice: ……

Who does the child/young person live with? ……

Who has Parental responsibility? …… School: ……

Who accompanied the child/young person? ……

Is Child/Young Person Known to Social Care or Children and Family Practice? Yes/No

Is Child/Young Person a Looked After Child? Yes/No

If consent required Social Worker contacted? Yes/No

Is Child/Young Person on a Child Protection Plan Yes/No

Which Local Authority? ……

Social Workers name: ……

Contact Number: ……

Is this a **"Child Behind the Adult"** Attendance? Yes/No
(All adult attenders to ED with drug, alcohol, mental health or domestic abuse who have childcare responsibilities)

If Yes: Name of Child/ren if known: …… Date of Birth: ……

Please document any safeguarding/child protection actions below:

……

……

……

Outcomes:-

☐ Discharged Home ☐ Admitted ☐ Self Discharged ☐ Transferred to another Hospital

Print Name: …… Signature: ……

Appendix 33: Safeguarding Paperwork - Outcome Summary Form

Surname:
Forename:
DOB:
Hospital No:

Or affix Patient Label

Safeguarding Referral Outcome Summary

This document records outcomes of Referrals made to Social Care.

The document is to be completed and saved in the Childs notes under Front sheet Alerts and the "Promoting Child Welfare" alert.
For adult Patients save in the notes under correspondence.

Date of Referral made to Social Care:

Name of the Social Care the Referral went to:

Part 1 – (MARF) ☐ Part 2 – Early Help ☐ Safeguarding Alert SABR1 ☐

Summary of reason for referral;

Outcome of referral from Social Care;

Outcome obtained by: Telephone ☐ Letter ☐ Other ☐

Date Outcome Received:

Name:

Designation:

Sign:

Appendix 34: Safeguarding paperwork-Proforma for Child Protection Medical Examinations

Note Please do not print from here please access form from trust documents too large a form to attach to policy.

Milton Keynes University Hospital NHS
NHS Foundation Trust

For staff use only:
Surname:
Forenames:
Date of birth:
Hospital No:

Proforma for Child Safeguarding Examination

1. Demographics		
Name D.O.B:	Address:	
MRN:	Date:	
Interpreter Required:	Location:	
GP Name/ Practice	Health Visitor	Examined by (1) Name: Signature: Bleep: Designation:
GP Contact details	School / Nursery	Examined by (2) Name: Signature: Bleep: Designation:

Referral Information	
Who was present during examination? Name: Name: Name:	 Contact: Contact: Contact:
Source of referral: GP Social Worker ED MKUHFT Other If other, please state:	
Initial Concerns:	

Milton Keynes Hospital NHS
NHS Foundation Trust

For staff use only:
Surname:
Forenames:
Date of birth:
Hospital No:

Is the Child known to Social Care: Yes / No. If yes, please give contact details of Social Worker and Agency:
Is the Child known to Children and Family Practices?: Yes / No. If yes, please name the CFP worker and contact details
Have you checked Electronic Medical Records of MK hospital for Promoting Child Welfare Tab and Information? Yes / No Please briefly list if known previous issues:

Family Information	
Name of responsible person: Contact details: Relationship:	Name of responsible person: Contact details: Relationship:

Who else lives in the house: (Name, relation and ages?)
Contact arrangement (if applicable)?
School/ Nursery:

Author: Directorate of Patient Care
Version:
Original Date of Approval:
Hospital Code: DOC
Date of Version Approval:
To be Filed in: Promoting Child Welfare

Milton Keynes Hospital NHS
NHS Foundation Trust

For staff use only:
Surname:
Forenames:
Date of birth:
Hospital No:

2. Consent obtain from parent(s) or other(s) with parental responsibility for the child and/or from the child as appropriate

I .....give permission for Medical Examination of myself /child named

.....as explained to me by Dr. .....to include:

Full medical examination YES / NO Use of anonymised data / imaging / records

Collection of forensic / medical specimens YES / NO for teaching / audit / research purposes YES / NO

Photography / Video of clinical findings YES / NO

I understand that Dr (s) ....may have to produce a report based on the examination and that details of the examination / and any photographs may have to be revealed in court.

I also understand that information from this report will be shared with professionals involved in my / the child's care and these may include the GP, social worker, health visitor, school nurse, children's services department, child protection team and the police.

I have been advised that I may delete any of the above before I sign and at any stage of the examination withdraw my consent.

Signed..... Date.....

Name .....

Status (delete as applicable) self / parent / carer / professional with parental responsibility

Witnessed.....

Name ..... Date.....

Author: Directorate of Patient Care
Version:
Original Date of Approval:
Hospital Code: DOC
Date of Version Approval:
To be Filed in: Promoting Child Welfare

Milton Keynes Hospital NHS
NHS Foundation Trust

For staff use only

Surname:

Forenames:

Date of birth:

Hospital No:

3. Background information from referral agency (Use continuation sheet if required)

(Information from .....)

4. Information from child (it is good practice to ask the child themselves what has happened, without using leading questions. Verbatim documentation of both the questions asked and the answers given is extremely useful) Use continuation sheet if required

(Who was present when history recounted .....

5. Presenting symptoms

Symptoms described by child e.g. headaches / abdominal symptoms

Any History of Secondary Wetting / Soiling / Aggression or Anger / Sexualised Behaviour / Self Harm / Conduct Disorder / Eating Disorder / Sleep Disturbance / Other (detail):

Author: Directorate of Patient Care
Version:
Original Date of Approval:
Hospital Code: DOC
Date of Version Approval:
To be Filed in: Promoting Child Welfare

Milton Keynes Hospital NHS
NHS Foundation Trust

For staff use only:
Surname:
Forenames:
Date of birth:
Hospital No:

6. Information from parent / carer use continuation sheet if required

(Information from .....)

Who was present when history recounted .....)

Parental Mental Health Problems	Parental Substance Misuse (Alcohol or Drugs)
Domestic Abuse	Employment

Other relevant family / social issues
(e.g. housing, residence/contact issues, family illness, other adults contributing to child care, pets)

Author: Directorate of Patient Care
Version:
Original Date of Approval:
Hospital Code: DOC
Date of Version Approval:
To be Filed in: Promoting Child Welfare

Milton Keynes Hospital NHS
NHS Foundation Trust

For staff use only

Surname:

Forenames:

Date of birth:

Hospital No:

7. Past Medical History

Birth
Birth weight
Gestation
Delivery Place of birth
Neonatal Health Feeding
Post natal depression

Immunisations

Allergies

Chronology of medical history	Date

Hearing

Vision

Milton Keynes Hospital NHS
NHS Foundation Trust

For staff use only:
Surname:
Forenames:
Date of birth:
Hospital No:

Current Medication

Developmental history / School progress

Summary of development (for age under 5 years or as appropriate)
0=normal 1=mild delay 2=moderate delay 3=severe delay 4=profound delay 9=unknown

Gross motor / Locomotive skills ( )
Fine Motor / Manipulation skills ( )
Visual skills ( )
Hearing & Language skills ( )
Speech & Language skills ( )
Social Interactive skills ( )
Social self-help skills ( )
Cognitive skills( )
Other information:

Education (school / nursery, mainstream education, learning support etc)

2. Family background (Draw family tree / include dates of birth and details of siblings)

Author: Directorate of Patient Care
Version:
Original Date of Approval:
Hospital Code: DOC
Date of Version Approval:
To be Filed in: Promoting Child Welfare

Milton Keynes Hospital NHS
NHS Foundation Trust

For staff use only:
Surname:
Forenames:
Date of birth:
Hospital No:

8. General physical examination

General physical appearance of child (note clothing, signs of infection, neglect or injury etc)

Demeanor / behaviour include interaction with parent / carer if present

Skin and hair
(Describe bruises with location, shape and measurement and also note any injuries on body diagrams)

S No	Location	Size	Shape	Colour	Comment
1					
2					
3					
4					
5					

Author: Directorate of Patient Care
Version:
Original Date of Approval:
Hospital Code: DOC
Date of Version Approval:
To be Filed in: Promoting Child Welfare

Milton Keynes Hospital NHS
NHS Foundation Trust

For staff use only:
Surname:
Forenames:
Date of birth:
Hospital No:

Examination continued

Teeth and mouth (obvious decay, injuries, frenulum intact etc

Eyes (pupils, conjunctiva, retina)

ENT (include tympanic membranes)

Cardiovascular

Respiratory

Gastrointestinal

Author: Directorate of Patient Care
Version:
Original Date of Approval:
Hospital Code: DOC
Date of Version Approval:
To be Filed in: Promoting Child Welfare

Milton Keynes Hospital NHS
NHS Foundation Trust

For staff use only:
Surname:
Forenames:
Date of birth:
Hospital No:

Examination continued

Genitourinary (Appropriately ask for exposing and clearly document nappy rash, injuries and other signs)

Nervous system

Locomotion / posture

Height cm	centile	
Weightkg	centile	
Head Circ (<2yrs)	cm	centile
Temp		
A V P U		
CRT	Seconds	
HR		

Author: Directorate of Patient Care
Version:
Original Date of Approval:
Hospital Code: DOC
Date of Version Approval:
To be Filed in: Promoting Child Welfare

Milton Keynes Hospital NHS
NHS Foundation Trust

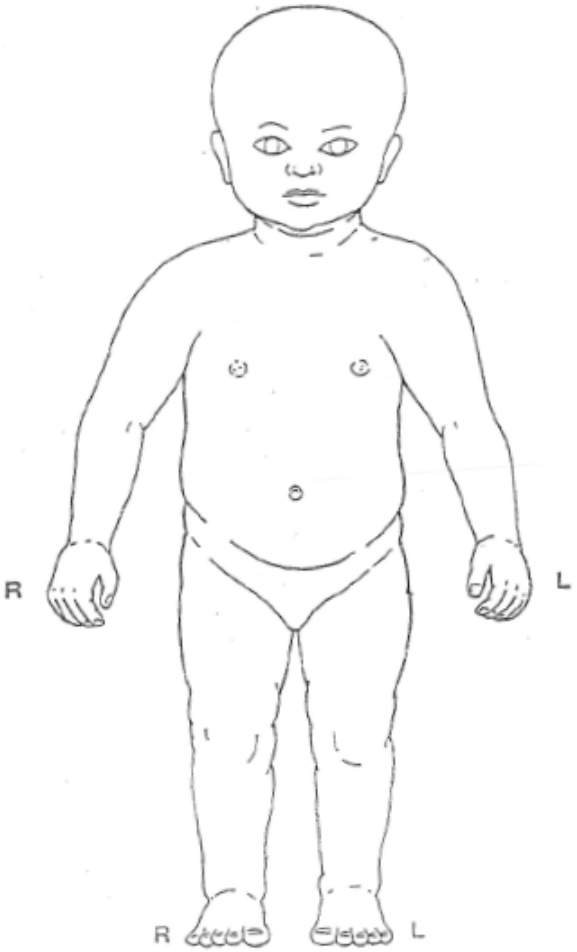
Name of CP Medical Examiner.....

Signature.....

Date/Time.....

Designation.....

For staff use only:
Surname:
Forenames:
Date of birth:
Hospital No:



Author: Directorate of Patient Care
Version:

Original Date of Approval:
Hospital Code: DOC

Date of Version Approval:
To be Filed in: Promoting Child Welfare

Milton Keynes Hospital NHS
NHS Foundation Trust

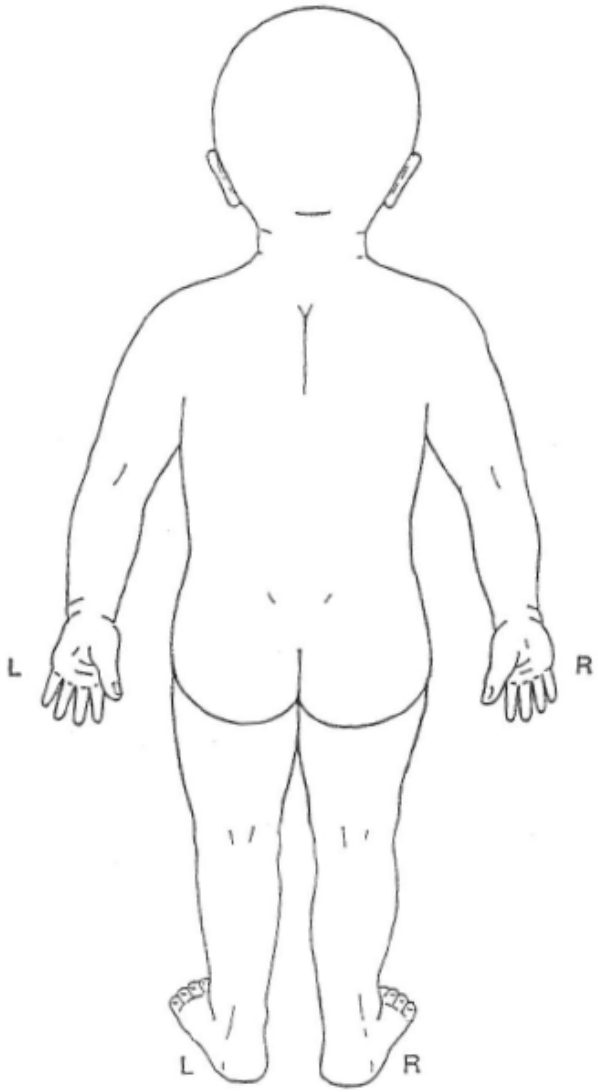
Name of CP Medical Examiner.....

Signature.....

Date/Time.....

Designation.....

For staff use only:
Surname:
Forenames:
Date of birth:
Hospital No:



Author: Directorate of Patient Care
Version:

Original Date of Approval:
Hospital Code: DOC

Date of Version Approval:
To be Filed in: Promoting Child Welfare

Milton Keynes Hospital NHS
NHS Foundation Trust

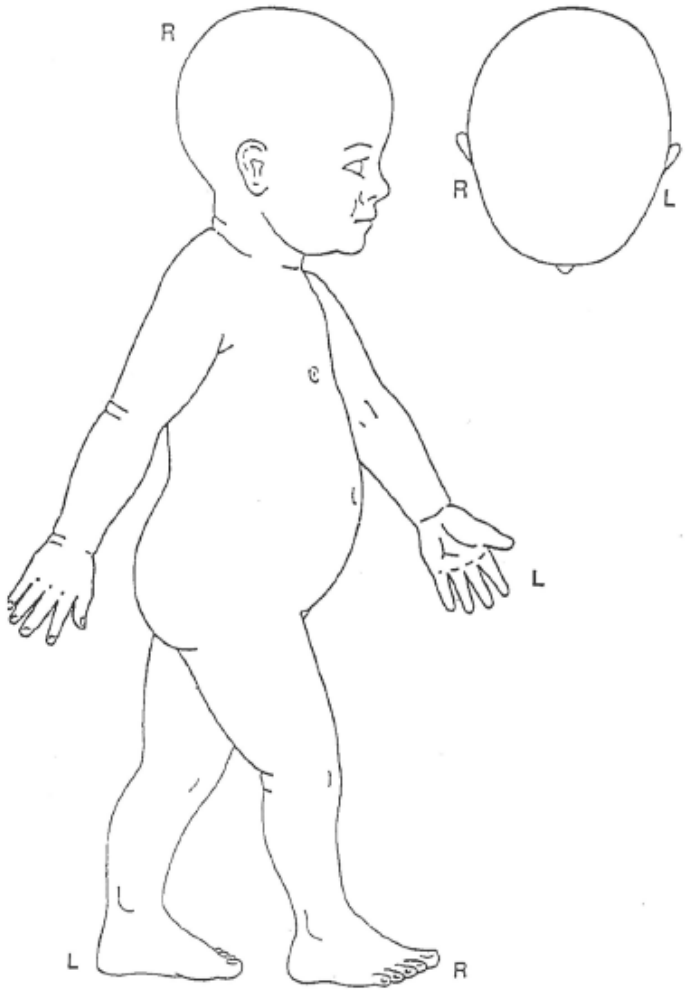
Name of CP Medical Examiner.....

Signature.....

Date/Time.....

Designation.....

For staff use only:
Surname:
Forenames:
Date of birth:
Hospital No:



Author: Directorate of Patient Care
Version:

Original Date of Approval:
Hospital Code: DOC

Date of Version Approval:
To be Filed in: Promoting Child Welfare

Milton Keynes Hospital NHS
NHS Foundation Trust

Name of CP Medical Examiner.....

Signature.....

Date/Time.....

Designation.....

For staff use only:
Surname:
Forenames:
Date of birth:
Hospital No:

Author: Directorate of Patient Care
Version:

Original Date of Approval:
Hospital Code: DOC

Date of Version Approval:
To be Filed in: Promoting Child Welfare

Milton Keynes Hospital NHS
NHS Foundation Trust

For staff use only

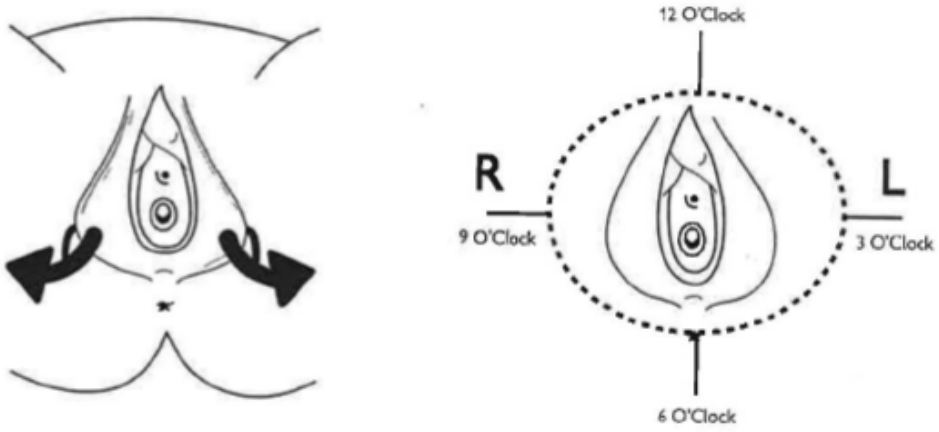
Surname:

Forenames:

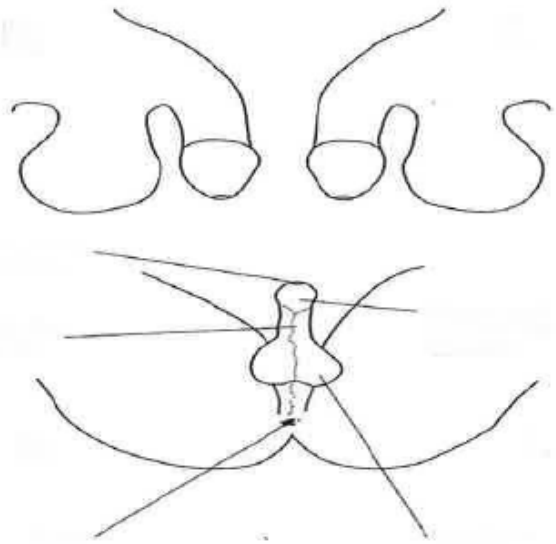
Date of birth:

Hospital No:

Female Perineum



Male Perineum



Author: Directorate of Patient Care
Version:

Original Date of Approval:
Hospital Code: DOC

Date of Version Approval:
To be Filed in: Promoting Child Welfare

Milton Keynes Hospital NHS
NHS Foundation Trust

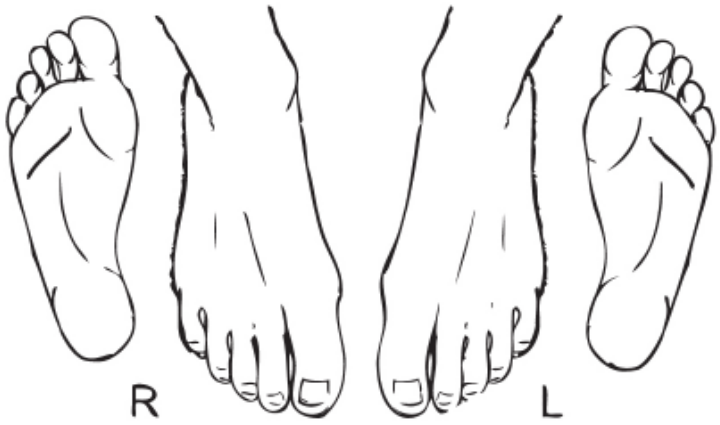
For staff use only

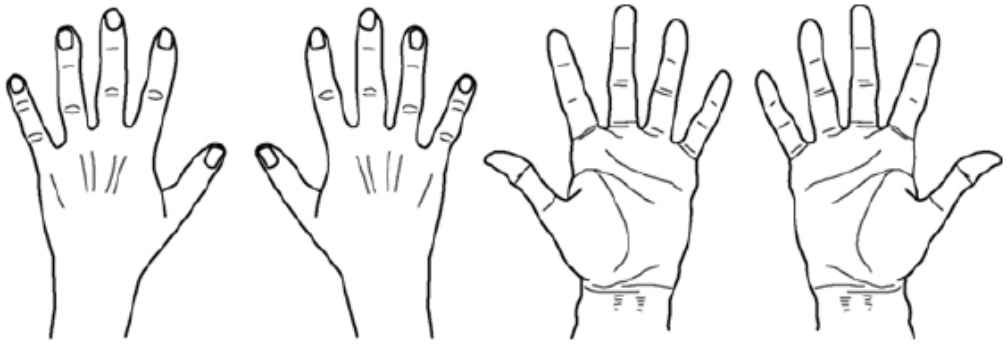
Surname:

Forenames:

Date of birth:

Hospital No:





Author: Directorate of Patient Care
Version:

Original Date of Approval:
Hospital Code: DOC

Date of Version Approval:
To be Filed in: Promoting Child Welfare

Milton Keynes Hospital NHS
NHS Foundation Trust

For staff use only

Surname:

Forenames:

Date of birth:

Hospital No:

Notes/Continuation sheet

Author: Directorate of Patient Care
Version:

Original Date of Approval:
Hospital Code: DOC

Date of Version Approval:
To be Filed in: Promoting Child Welfare

Milton Keynes Hospital NHS
NHS Foundation Trust

For staff use only:

Surname:

Forenames:

Date of birth:

Hospital No:

9. Summary of actions and recommendations separate report provided (circle) YES / NO / ON REQUEST

(Always think about siblings who may also be at risk and whether they need medical assessment as well)

SUMMARY (include information provided to social work / police on outcome of assessment)

Follow up / referrals

Author: Directorate of Patient Care
Version:

Original Date of Approval:
Hospital Code: DOC

Date of Version Approval:
To be Filed in: Promoting Child Welfare

Milton Keynes Hospital NHS
NHS Foundation Trust

For staff use only:
Surname:
Forenames:
Date of birth:
Hospital No:

List of Investigations

Investigation	Specify	DATE	RESULT
X – ray			
Skeletal survey			
CT / MRI			
Blood Tests	FBC		
	Clotting		
Urine			
Swabs			
Photography			
Others			

Author: Directorate of Patient Care
Version:
Original Date of Approval:
Hospital Code: DOC
Date of Version Approval:
To be Filed in: Promoting Child Welfare

Milton Keynes Hospital NHS
NHS Foundation Trust

For staff use only:
Surname:
Forenames:
Date of birth:
Hospital No:

Checklist

Actions	Yes	No	Date
Consider whether siblings also need to be examined			
Has the Multi Agency Referral Form (MARF) been completed			
Inform Lead for Safeguarding Children			
Need for Admission to Hospital			
Plan for Foster Care			
Any Follow up arranged			
Appointment made for follow up			
Any previous safeguarding reports available for the child?			
Miscellaneous:			
Information shared with:			

Name:	Contact:	Position:
Name:	Contact:	Position:
Name:	Contact:	Position:

Signed	Designation
Name	Date

Signed	Designation
Name	Date

Author: Directorate of Patient Care
Version:
Original Date of Approval:
Hospital Code: DOC
Date of Version Approval:
To be Filed in: Promoting Child Welfare

Appendix 35: Professionals Meeting Guidance

Milton Keynes Safeguarding Board Guidance

Multi-Agency & single agency Professional meetings

Purpose

A multi-agency professionals meeting is a tool to support practitioners in all agencies who have a genuine desire to work openly with families, but who may need the opportunity to talk with other professionals without the family being present.

This may be important where there is a concern that the family is undermining attempts to understand potential risks to children in the family; or where there is uncertainty amongst professionals about the necessary steps to protect children.

A professionals meeting may be helpful where professional disagreements are impacting on effective work with the family, or where professionals need an opportunity to reflect on the plans for working with a family when progress is not being made.

Scope

This guidance has been designed to be used in both a single and multi-agency setting

A professional meeting can take one of several forms, but only some are covered by this guidance.

What is covered:

- A professional planning meeting;
- A meeting to resolve professional disagreements regarding the management of a case with respect to a child or young person.

What is NOT covered:

- A child protection Strategy Discussion (Children's Social Care, Police, Health, and others, as required);
- Professional advice and management meetings where the child/family name isn't shared;

MKSG Multi agency Professional meeting Guidance
Approved July 2018
Written by Andrea Piggott Designated Nurse on behalf of MKSB

Criteria for convening a multi-agency professionals meeting

This type of meeting would not be intended as a routine element in practice, since wherever possible professionals should aim to work in partnership with families, but could be considered in the following situations:

- an agency or agencies working with a family need to share information to clarify a concern or address difficulties in working with a family and to involve the family would inhibit discussion;
- to resolve concerns within the professional group for example;
  - understanding of the degree of risk
  - Clarification need on information given
  - the approach and priority actions
  - reasonable expectations of other professionals;
- an agency or group of professionals feels that the work with a child or young person and their family is not resulting in improved outcomes for children
- to resolve disagreements regarding an agency's response to a referral request, or concern raised regarding a child or young person;
- the family/child/young person's needs cannot be met from within the agency's own resources and the need or concern remains unaddressed; sharing of information by phone or email is not considered adequate to facilitate discussion and decision-making.
- when there are concerns about Fabricated or Induced Illness and there is a need to clarify the nature and extent of the concerns and the next steps.

Who can call a Multi-Agency Professionals Meeting?

If any agency feels that there is a need for a meeting that is covered by the above criteria they should discuss the rationale with their organisations safeguarding lead. In the case of a disagreement about the need for a professionals meeting or concern about the lack of engagement from any invited party that cannot be resolved across the partnership, the Milton Keynes Safeguarding Board Escalation Policy applies.

When arranging a Multi-agency professional meeting the check list in appendix one should be used and once completed and all actions completed should be stored in the child's notes.

Chairing a multi-agency meeting

This should be someone who is used to chairing meetings of a similar type (supervisory level), and must ensure that the meeting focuses on the needs of the child or young person.

The Chair should have sufficient knowledge of the MK safeguarding board's *Level of need when working with children and their families'* document 2016.

MKSG Multi agency Professional meeting Guidance
Approved July 2018
Written by Andrea Piggott Designated Nurse on behalf of MKSB

Key elements for the chair to consider when chairing a multi-agency meeting:

- Understand and communicate effectively the reason why a professional meeting has been called. Establishing if the parents are aware of this meeting and if not why not.
- Ensure there is a clear agenda, expectations and timeframe for the meeting; and that this is communicated to all attendees at time of invite.
- At the start of the meeting ensure all the attendees know who each other are, which agency they are from and what involvement they have with the family.
- Be disciplined and start the meeting on time regardless of attendees. This will help run to time and encourage participants to arrive promptly at future meetings
- Keep track of the time during the meeting. This will improve meeting efficiency and encourages people to stay on track.
- Ensure that everyone has had the opportunity to be heard. 'Draw out' the quieter, more reflective participants; whilst managing and controlling the louder, more vocal participants. In addition, the chair will need to constructively resolve any conflict that arises within the meeting.
- A chair doesn't use the position as an opportunity to impose personal views. The chair is there to facilitate the meeting, not dominate it.
- Don't be under-assertive
- Ensure a clear plan and outcome to the meeting is reached.
- Being very clear at the end of each meeting what information is going to be or not going to be shared with the parents and the reason for that .
- Ensure all who attend have the opportunity to check for the minutes for factual accuracy.
- It is the chairs responsibility to sign off the minutes and ensure all who was invited to the professional meeting receive a copy within the timescales set out in the check list (Appendix one).

Administration and Recording

The convening agency is responsible for initiating the meeting and should ensure that arrangements are in place to ensure the minutes of the meeting and the 'Actions arising' are distributed to all professional invited (even if they do not attend) and where appropriate the family (See appendix one for Professional meeting check list) All attendees must sign the attendance sheet (see appendix three)

The minutes should capture the main areas of need and the action plan developed to address them. Where there is an existing plan for the child/family, this should be reviewed. (See Appendix two for Professional meeting minute's template.)

When a multi-agency meeting is being arranged due to concerns regarding Fabricated Induce Illness the invite should request all agencies to complete a chronology with their concerns and bring that with them to the meeting (add link to FII policy and tool kit)

Each meeting should address the level of need through using a signs of safety model approach this looks at, *What is working well? What are we worried about? What needs to happen next?* This will ensure the meeting ends with clear agreed actions (or updated Action Plan) to address the needs and concerns that have been raised.

Consideration must be given to what information should be shared with the parents and child and the reasons for this decision must be recorded on the meeting minutes (See meeting minute template in appendix 2) .

Consideration for future meeting dates must be given to ensure progress on outcomes.

Attendance

The meeting needs to bring together all those who can provide relevant information about the child/young person and family. There may be professional involved with the child or family who are not aware of any concerns and therefore may decline attendance at the meeting, even if they don't have any concerns they must be encouraged to attend to understand and be aware of the concerns from others.

The invite to the meeting should clearly set out the reason for the meeting, who has called the meeting, expectations, agenda and timeframes for the meeting. The meeting invite must clearly state if the parents are aware of the meeting taking place ,if they are not aware what is the reason for that decision being made at this time.

For some professional meetings the attendees may be asked to complete a chronology to bring and share at the meeting to gain a greater understanding of the concerns. If a professional cannot attend the meeting and cannot send a deputy they should send their chronology electronically to the meeting organiser prior to meeting so that it can be shared.

Venue

The venue should be the most convenient and comfortable place to meet for a confidential discussion.

Permissions / Family Involvement / Confidentiality

The agency who is requesting the meeting should consider whether the parents should be informed of the meeting beforehand. However, professional judgment may need to be brought to bear on whether this is appropriate in all situations.

If the parents have not been informed of the meeting, then agreement should be sought from invited agencies that the meeting will take place without the family being informed. If the parent(s)/Carer(s) raise an objection to the meeting taking place, consideration should be given to whether concerns are sufficient to require a different approach (i.e. a Strategy Discussion)

MKSG Multi agency Professional meeting Guidance
Approved July 2018
Written by Andrea Piggott Designated Nurse on behalf of MKSB

Where the issues to be discussed relate to difficulties with engagement with the parents, then seeking permission for the meeting to take place is unlikely to yield the desired result.

Where the meeting is to discuss complex matters and to develop a fuller picture of the family's circumstances it is not necessary to gain consent for the meeting to take place. Where appropriate, a record of the meeting will be sent to the parents and children/young people that are subject of the meeting.

Consideration should be given by agencies to the child's age for the most appropriate method of feedback. Normal rules of confidentiality apply in that only information relevant to ensuring the safety and welfare of the children in the family should be shared.

Any action plan developed as a result of the meeting should address how the issues discussed are then raised with the parents, unless to do so would potentially place the children concerned at risk of further harm. In some situations it may be appropriate to conduct the meeting in two parts involving the relevant professionals in the first part and inviting the parent(s)/Carer(s) to the second part of the meeting.

This could be the case where the professionals are in disagreement and airing these issues in a frank discussion would not be appropriate with the parent(s)/ Carer(s) or child present. Where the parents have not been directly involved in the meeting the Lead Practitioner will be expected to feedback the outcomes of the meeting and to discuss the plan with the parent(s)/Carer(s) after the meeting. If the Action Plan is not implemented as agreed, or fails to meet the needs or address the concerns, the Lead Practitioner will consult and decide whether to reconvene another multi-agency professionals meeting before the agreed review date.

<u>Actions and next steps</u>

The chair of the meeting must ensure that once all the concerns have been raised and the information shared, prior to concluding the meeting, the chair summaries the main discussion points and what impact these concerns are having on the child /young person.

A clear way forward and actions must be agreed, along with who will complete the actions and in what timeframe.

A discussion about what 'level of need' this family now sits at in light of the information shared within the meeting and the actions should reflect this (add level of need document)

A common understanding must be reached in regard to what information should now be shared with the parents and why and consideration for future meetings should be discussed.

Minutes from the meeting should be checked and circulated using the process and timeframes set out in the Professional meeting check list (see appendix one)

MKSG Multi agency Professional meeting Guidance
Approved July 2018
Written by Andrea Piggott Designated Nurse on behalf of MKSB

Appendix One

Professionals Meeting Check list

Actions to be completed ***prior*** to Professional meeting in regard to Fabricated Induce Illness:

No:	Prior Meeting Actions	Date Completed
1	Date , Time & Venue arranged	
2	Meeting Chair arranged – ***Think!*** *Who is the best person to chair, consider someone not involved in the case discuss with safeguarding lead for your organisation.*	
3	Invites to all the professionals from the contact Performa. ***Think!*** Expectations of the meeting have been clearly communicated in the invite including if parents are aware of the meeting or not	
4	If relevant request for completed Chronology to be brought to meeting (FII concerns attach the template - If apologies are sent ensure they send electronic chronology to be share at the meeting)	
5	Minute taker arranged	

Note: ***If professionals who are involved with the family respond by saying they are not aware of any concerns it is important that they still attend the meeting.***

Acton to be completed ***after*** a professional meeting:

No:	After meeting Actions	Date Completed
1	Draft Minutes typed and sent to be checked by Chair within 3 working days of the meeting date.	
2	Minutes get emailed out to all professionals invited to the meeting (even if they did not attend) within 7 working days of the meeting date.	
3	All attendees asked to check for accuracy and send any amendments back within 3 days working from receiving the minutes.	
4	Minutes amended and discuss with chair for sign off.	
5	Final signed off minutes sent to all invited	
6	Final copy of the minutes, stored in the child's notes and safeguarding icons add as appropriate.	

Signature:
Designated:
Date completed:

MKSG Multi agency Professional meeting Guidance
Approved July 2018
Written by Andrea Piggott Designated Nurse on behalf of MKSB

Appendix Two

CONFIDENTIAL contents not to be disclosed without the permission of the Chair

Professionals Meeting

MINUTES OF THE PROFESSIONALS MEETING held at *(add venue)*
On *(Add date)* **at** *(Add Time)* **In respect of:** *(Add Child's Name)*

Childs name	
DOB	
Address	
Who else lives in the house? E.g.; Relationship; Named, DOB	
Parent details include absent parent (if relevant)	

Chair :
Name, Designation, Agency

Minutes Taker:
Name, Designation, Agency

In Attendance:
Name, Designation, Agency, Involvement with the family

Chair outlines the reason for this meeting:

Who called the meeting, what is the concern, do the parents know about this meeting if no why? Are these minutes to be shared with the parents?

Each Agency shares update and Chronology:
What is the concern?
What is the evidence for that concern?
So what? What does this mean for this child?
What is the current impact to the child?
Is there any agency that is not represented that needs to be?

Discussion lead by the chair pulling all the information together using Signs of Safety :
What is working well? , What are we worried about? , The voice of the child?

MKSG Multi agency Professional meeting Guidance
Approved July 2018
Written by Andrea Piggott Designated Nurse on behalf of MKSB

What needs to happen? / Plan – Individual Tasks

- *Use the level of need document – Does a referral to MASH need to be completed?*
- *What is the containment strategy? Who is going to do what; specify Name and agency.*
- *Communication with both parents – Who is best place to do this,? What are the constant messages?*
- *Does there need to be a follow up meeting to monitor plan and actions?*

NO:	ACTION	BY WHOM	TIMEFRAME

End Time:

Appendix Three

Date of professional meeting:
Please sign in below:

NAME:	Designation :	Organisation /Agency	Contact email & Phone number