CHILD PROTECTION PROTOCOL

INTRODUCTION

The procedures set out in this document are to ensure that child protection concerns are recognised and addressed as they occur in the practice. By raising child protection issues within the practice all staff will be aware of how they may access advice, understand their role in protection, and understand the importance of effective Inter-agency communication.

These guidelines draw primarily upon national guidance including those listed under the resources section below. It is however vital that practices are aware of, and comply with the procedures in place locally and these may be obtained, and advice sought, from the Child Protection officer at the local PCT.

Child protection is a difficult area for general practice, which must consider the welfare of the child first, but must also maintain a relationship with the family. It is very important that all staff understand the need to get help early when they have concerns about a child.

Education involving case discussion and encouraging reflective practice is helpful. Case discussion with named or designated staff can be especially valuable. Child protection issues in general practice need a robust system of note-keeping and recording, message handling and communication of concern. The protocol will address:

- Key staff training
- Documentation
- Reporting
- Local procedures

Key Factors

- The welfare of the child is paramount
- Be prepared to consult with colleagues
- Be prepared to take advice from local experts
- Keep comprehensive, clear, contemporaneous records
- Be aware of GMC guidance about sharing confidential information

RECOGNISING CHILD ABUSE

There are 4 main categories of child abuse:

- Physical abuse
- Sexual abuse
- Emotional abuse
- Neglect/failure to thrive

These are not however exclusive, and abuse in one of these areas may easily be accompanied by abuse in the others.

Physical abuse may include:

- Hitting, shaking, throwing, poisoning, burning or scalding, or other forms of physical harm
- Where a parent or carer deliberately causes ill-health of a child
- Single traumatic events or repeated incidents

Sexual abuse may include:

- Forcing or enticing a child under 18 to take part in sexual activities where the child is unaware of what is happening
- May include both physical contact acts and non—contact acts

Emotional abuse may include:

- Persistent ill-treatment which has an effect on emotional development
- Conveyance of a message of being un-loved, worthless or inadequate
- May instil feeling of danger, being afraid
- May involve child exploitation or corruption

Neglect may include:

- Failure to meet the child's physical or psychological needs
- Failure to provide adequate food or shelter
- Failure to protect from physical harm
- Neglect of a child's emotional needs

Common presentations and situations in which child abuse may be suspected include:

- Disclosure by a child or young person
- Physical signs and symptoms giving rise to suspicion of any category of abuse
- The history is inconsistent or changes.
- A delay in seeking medical help
- Extreme or worrying behaviour of a child, taking account of the developmental age of the child
- Accumulation of minor incidents giving rise to a level of concern, including frequent A&E attendances

Some other situations which need careful consideration are:

- Disclosure by an adult of abusive activities
- Girls under 16 presenting with pregnancy or sexually transmitted disease, especially those with learning difficulties
- Very young girls requesting contraception, especially emergency contraception
- Situations where parental mental health problems may impact on children
- Parental alcohol, drug or substance misuse which may impact on children
- Parents with learning difficulties
- Violence in the family

RECOGNISING A CHILD IN NEED

A child in need is defined as a child whose vulnerability is such that they are unlikely to reach or maintain a satisfactory level of health or development without the provision of services (section 17, Childrens' Act 1989). This includes disabled children. The Childrens' Acts 1984 and 2004 define a

child as someone who has not reached their 18th birthday. The fact that a child has reached their 16th birthday, and may be living independently, working, or be members of the armed forces does not remove their childhood status under the Acts.

Local authority social services departments working with other local authority departments and health services have a duty to safeguard and promote the welfare of children in their area who are in need. If you are considering making a referral to Social Services as a child in need, it is essential to discuss the referral with the child's parents or carers and to obtain consent for the sharing of information. Social Services will then follow local procedures to undertake an assessment of the child and their family.

CHILD PROTECTION REGISTER / PROTECTION PLAN

The guidance Working Together to Safeguard Children 2006 announced the replacement of the Child Protection Register with the ICS – Integrated Childrens' System – from 1st April 2008, and more specifically this uses the mechanism of a Child Protection Plan. Every child on the register at the effective date will become the subject of a Plan.

A list of children judged to be at continuing risk for whom there is a child protection plan in place, is maintained by social services. Social services, police and health professionals have 24 hour access to this. A child on the register has a "key worker" to whom reference can be made.

TRAINING

All staff will be trained in child protection at least once every 2 years, and within 6 months of induction. This will normally be via an external basic awareness course (minimum standard)

CHILD PROTECTION ADMINISTRATORS (or "CPAs")

Jackie Watson and Angela Alderson are the designated CPAs for the practice and are responsible for ensuring that all information relating to Child Protection issues is regularly updated in the relevant patient record, with appropriate alerts being added to (and removed from) the records of the child/family member. The Read Codes for alerts in use in the practice are kept up to date on the DS child protection and Child cause for concern templates on Systm One.

Note: reference in the Read Coding system to "Register" is assumed to identify children at risk under the recent guidance.

The Health Visiting team is (normally) routinely copied in to all inter-agency child protection correspondence and conference outcomes relating to children at risk and child protection issues. However, as a precaution, the CPAs will always check with the Health Visitor that she is aware of the case.

NURSING AND ADMINISTRATION STAFF

- All Nursing and Administration staff will be made aware of the practice procedures regarding child protection.
- If the Health Visitor is not immediately available, any member of staff who has concerns regarding the welfare of any child will report their concerns to the child's GP or, in their absence, to the duty doctor.

- Administration staff will be made aware of the need to look out for child protection related correspondence coming into the practice and ensure that it is dealt with appropriately and in strictest confidence.

TRUST AND ATTACHED STAFF

In the event of a member of the Trust's staff becoming aware of, or suspecting that a child has suffered significant harm, she/he should take appropriate action in accordance with the Trust's Child Protection guidelines.

GENERAL PRACTITIONERS

- GPs will familiarize themselves with the systems used in the practice for making child protection referrals.
- GPs will know how to access information and advice, and the referral pathways.
- It may be appropriate to check the notes of a child's siblings, parents, and other household members and to consider adding computer alerts to their records.
- GPs should consider informing other clinicians and health care professionals as appropriate
- A clear written entry of any action taken will be made by the GP.
- GPs will ensure that the practice Health Visitors are aware of the child protection issues.

IF A GP SUSPECTS THAT A CHILD IS AT IMMEDIATE RISK:

- The GP should seek advice or make a referral.
- Advice may be sought on a 'what if?' basis, which avoids consent issues.
- Advice sought on a named patient basis should have appropriate consent unless there are good reasons why this cannot be obtained.
- Advice may be sought from Social Services. Out-of-hours advice may be sought from a senior hospital paediatrician.

GENERAL

- All verbal referrals to Social Services must be followed up in writing by the referrer, giving full details, within 48 hours.
- All health care professionals must ensure that they keep a complete contemporaneous and accurate record of the nature of the injury, suspicion and all actions taken. Notes must be made as soon as possible, giving date, time and full legible signature.

ATTENDENCE AT CHILD PROTECTION CONFERENCES

"GPs should make available to child protection conferences relevant information about a child and family whether or not they, or a member of the primary health care team, are able to attend."

Working Together to Safeguard Children 1999 Para 3.30

The input of the GP at a Child Protection Conference can be extremely valuable. Often the GP is the only professional who has known the family and child over a period of years, and the GP can be in possession of relevant information not known to other professionals e.g. mental health of parents, or drug use.

If the GP cannot attend, then a report or letter will be submitted, to include all relevant information.

CONFIDENTIALITY

Doctors have a duty of confidentiality, and patients have a right to expect that information given to a doctor in a professional context will not be shared without their permission. The GMC emphasises the importance in most circumstances of obtaining a patient's consent to disclosure of personal information. In general, if you decide to disclose confidential information without consent, you should be prepared to explain and justify your decision and you should only disclose as much information as is necessary for the purpose. The medical defence organisation will be consulted in all cases.

GMC guidance "Confidentiality: Protecting and Providing Information" (Sep 2000) describes the following circumstances when disclosure may be justified:

Disclosures to protect the patient or others

"Disclosure of personal information without consent may be justified where failure to do so may expose the patient or others to risk or death or serious harm. Where third parties are exposed to a risk so serious that it outweighs the patient's privacy interest, you should seek consent to disclosure where practicable. If it is not practicable, you should disclose information promptly to an appropriate person or authority. You should generally inform the patient before disclosing the information."

"Such circumstances may arise, for example:

Where a disclosure may assist in the prevention or detection of a serious crime. Serious crimes, in this context, will put someone at risk of death or serious harm, and will usually be crimes against the person such as abuse of children."

Paras 36 & 37c

Children and other patients who may lack competence to give consent

"If you believe a patient to be a victim of neglect or physical, sexual or emotional abuse and that the patient cannot give or withhold consent to disclosure, you should give information promptly to an appropriate responsible person or statutory agency, where you believe that the disclosure is in the patient's best interests. You should usually inform the patient that you intend to disclose the information before doing so. Such circumstances may arise in relation to children, where concerns about possible abuse need to be shared with other agencies such as social services. Where appropriate you should inform those with parental responsibility about the disclosure. If, for any reason, you believe that disclosure of information if not in the best interests of an abused or neglected person, you must still be prepared to justify your decision."

Para 39

Key Points:

- You can disclose information without consent if you are making a child protection referral (subject to the guidance above)
- You should always obtain consent if you are making a referral as a child in need
- If you are in doubt about whether to refer a child as a 'child protection referral' versus a 'child in need' referral, ask advice from one of your local advisers such as the Designated or Named Doctor or Nurse.
- Clear and comprehensive records relating to all events and decisions will be maintained

RECORDS

Registration

It is good practice to offer a medical examination. Record the following additional information:

- Child's name and all previous names
- Current and previous address detail
- Present school and all previous schools
- Previous GP, Health visitor and / or school nurse
- Mother and father's names, dates of birth and addresses if different to the child's
- Name of primary carer and any significant other persons
- Name of person (s) with parental responsibility

The practice will expect full co-operation in the supply of these details from the parent / carer otherwise registration will be refused.

The Health Visitor will be informed within 5 days of registration of all children under 16 who register with the practice, including temporary registrations.

Staff should be vigilant in the instance of multiple short-term temporary registrations for the same child, especially if consecutive. In the event of concern the permanent GP should be contacted.

Medical Record

A paper based note will be prominently made and an alert placed on the clinical system – see coding issues above. The medical record relating to child protection issues may also include clinical photography / video recordings, and it is recommended that a significant event form [*] be utilised within the medical record where a clinician identifies issues leading to increasing concern for the patient, or where an event occurs of particular note. Other aspects which may be recorded are:

- Evidence of abuse
- Criminal offences
- A&E attendances
- Child Protection Plan
- Case Conferences
- Meetings
- Drug / substance abuse
- Mental Health issues
- Non-attendance at meetings or appointments
- Hostility or lack of cooperation
- Cumulative minor concerns

Where a child moves away or changes GP the practice will inform both social services and the health visitor within 5 working days.

Data Protection

- Current guidance suggests that written records relating to child protection issues should be stored as part of the child's permanent medical records, either manually or on computer, or both. This is a change to the previous recommendation. The practice should be alert to the fact that this guidance may be reviewed or amended in the future and must seek the guidance of the

local PCT in all instances. It is expected that practices will have permanent access to the local child protection instructions as part of the routine PCT pathway procedures.

- As a normal part of compliance with the data protection act it is likely that third party information will be stored within these records, and the normal duty of non-disclosure of this third party information may apply when information is to be released – it may be appropriate at such times to take advice.

De-Registration

- When a child whose record contains a child protection alert, moves to a new surgery, the Child Protection Co-ordinator at Darlington PCT is notified, normally by the Health Visitor. The Practice CPAs will ensure that the Health Visitor is made aware that the child is moving out of the area.
- The Child Protection Co-ordinator at Darlington PCT will contact the child's new GP or Health Visitor and will arrange for the transfer of any necessary records.
- CP files forming part of the practice computer system will remain in place after the patient has de-registered in line with all other permanent medical records. Particular care must be taken by the transferring practice to ensure that all child protection documents and information is passed over to the receiving practice. This is again a departure from previous guidelines. This also applies to any confidential files which may (according to the needs of the case0 be filed separately.