Severn & Peninsula

Major Trauma Networks

South West Paediatric Major Trauma Network Safeguarding Policy

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Bristol Royal Hospital For Children

Severn Major Trauma Operational Delivery Network

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Summary

This policy outlines the way in which staff across the South West Paediatric Major Trauma Network will work together to safeguard and promote the welfare of children, according to statutory requirements.

This policy should be followed in conjunction with the South West Child Protection Procedures www.swcpp.org

What to do if you are worried a child is being abused

No matter where you work, you are likely to encounter children (or parents /carers) during your normal working activities. You are in a unique position to be able to observe signs of abuse or neglect, or changes in behaviour which may indicate a child may be being abused or neglected

You should make sure that you are alert to the signs of abuse and neglect, that you question the behaviour of children and parents/carers and don't necessarily take what you are told face value. You must know where to turn to if you need to ask for help, and that you should make a safeguarding referral if you suspect that a child is at risk of harm or is in immediate danger.

(HM Government 2015)

Clinical issues to consider:

- Does the story of the mechanism fit with the injury pattern seen?
    - Bruises on the buttocks or genitalia, cheeks, ears, neck, trunk, head, front of thighs, or upper arms are more likely to occur with physical abuse (1).
- Do the injuries fit with what is reasonable for the child's developmental age?
    - Particularly consider the issue of non-mobile children, i.e. a child who is too young to roll over as a cause of "falling off the bed". Fractures in children less then 18 months of age should be assessed for possible child abuse. (2)
- Could the parent(s) / carer(s) have done anything in advance to prevent the accident/incident from happening?
    - Appropriate supervision will vary with age, with younger children obviously needing greater supervision. It may also relate to whether or not the relevant risks of a particular activity have been appropriately assessed by a parent/carer. Similarly for older children neglect may relate to risk-taking behaviour, including significant deliberate self-harm, or involvement in interpersonal violence, e.g. assault or stabbing. (3)
- Could the parent(s) / carer(s) have done anything after the accident/incident to improve medical care?
    - Delays in presentation may be a reflection of both physical abuse and/or neglect, or it may reflect wider issues within the family.

Key Points to Remember:

- Inform whoever has disclosed information to you that the information cannot be kept confidential and will be passed to appropriate agencies (on a need to know basis).
- Discuss with your line manager, seek advice from a senior colleague, Safeguarding Named Nurse (or Nursing Team), or a Consultant Paediatrician.
- If after discussion and with reference to the relevant local guidance, it is deemed necessary to make a safeguarding referral this should be made, following the local trust internal referral process.
- Parents/carers and the child if appropriate should be informed of the referral, unless this would put the child or more rarely a professional at greater risk of harm or contaminate evidence.
- It is essential to maintain accurate, dated, contemporaneous and signed records. The appropriate paperwork should be used for all children admitted in whom child protection concerns are identified.

Introduction

Abusive injury or "Non-Accidental Injury" (NAI) forms a significant part of the paediatric major trauma workload and is known to be an important cause of major trauma in small children, particularly those under 1 year of age. Children injured as a result of NAI are likely to have higher injury severity scores, particularly severe brain injury, and higher mortality rates than children injured accidentally.(4)

A significant proportion of children with NAI will bypass the usual pre-hospital routes for identification of major trauma, and will frequently present to Major Trauma Units rather than directly to the Major Trauma Centre, arriving unannounced with serious head injuries several hours post-injury. It is therefore essential that all staff working across the Paediatric Major Trauma Network, particularly those in Major Trauma Units, are aware of the potential clinical presentations of these children and the importance of early identification of a victim of NAI as a "Major Trauma Patient", such that the child is appropriately escalated through the usual referral pathways (5), as per the South West Paediatric Major Trauma Escalation, Referral and Acceptance policy.

However NAI is not the only safeguarding issue that clinicians involved with Major Trauma need to consider. Neglect may manifest itself as inadequate supervision for younger children so as to protect them appropriately from danger. Repeated apparently accidental injuries may also suggest inadequate supervision. Likewise in older children, neglect may lead to significant deliberate self-harm, which can be life-threatening, or it can lead to inappropriate risk-taking behaviour, including involvement in interpersonal violence. Similarly sexual abuse may also lead to significant physical injuries, whilst some level of emotional abuse is involved in all types of maltreatment of a child.

The South West Paediatric Major Trauma Network, on behalf of the Severn and Peninsula Major Trauma Networks, is committed to promoting and safeguarding the welfare of children and young people who use the services provided within it. The child's welfare will always be paramount**.**

All reasonable measures must be taken to ensure that the risk of harm to children's welfare is minimised and, where there are concerns about the welfare of a child staff should take all appropriate actions to address these concerns. Staff should work collaboratively with other agencies involved in safeguarding and must follow national and local legislation, policy and guidance, including the following:

- The Children Act 1989 and 2004.
- The Adoption and Children Act 2002
- The Sexual Offences Act 2003
- Female Genital Mutilation Act 2003
- Working Together to Safeguard Children (HM Government 2010/2013/2015)
- Serious Crime Act 2015
- South West Child Protection Procedures
- Further legislation / guidance detailed in the references section of this policy.

The primary concern at all times is to promote the welfare and safety of the child/ren; it is best practice to work in partnership with parents, unless this is felt not to be in the best interests of the child. Where there is a conflict of interest between the child/ren and parents or carers, the interests of the child/ren are paramount. Children should be listened to and their views taken seriously.

No culture sanctions harm to a child. Working within diversity frameworks requires recognition of the additional vulnerability of some children and the extra barriers they face because of their race, gender, age, religion or disability, sexual orientation and social background. A balanced assessment must incorporate a cultural perspective but guard against being over sensitive to cultural issues at the expense of promoting the welfare and safety of the child.

Definitions

The Children Acts 1989 and 2004

Define a child as anyone who has not yet reached their 18th birthday**.** The fact that a child has reached 16 years of age, is living independently or is in further education, is a member of the armed forces, is in hospital or in custody in secure accommodation, does not change his/her status or entitlements to services or protection.

The term child/children therefore in this document means children and young people. For purposes of professional practice, actions may also be required to protect the future safety of an unborn child.

Children Act (1989) Definitions

Concerns regarding a child's welfare may, initially, be divided into two categories:

a. A child in need

b. A child in need of protection from significant harm or potential harm.

It is recognised that the categories are not always clear and may change at any time.

Definition of a "Child in Need" *(Children Act 1989 Section 17(10))*

He/she is unlikely to achieve or maintain or have the opportunity of achieving or maintaining a reasonable standard of health or development without the provision for him/her of services by the local authority

OR / AND

His/her health or development is likely to be significantly impaired or further impaired without the provision for him/her of such services

OR / AND

He/she is disabled.

Definition of "Significant Harm" *(Children Act 1989 Section 31 (2))*

"Where the question of whether harm suffered by a child is significant depends on the child's health or development, his health or development shall be compared with that which could be reasonably expected of a similar child".

Domestic Abuse and Safeguarding Children

The **Adoption and Children Act 2002** broadens the definition of significant harm to include emotional harm suffered by those children who witness domestic violence or are aware of domestic abuse in the home environment.

The new definition of domestic violence and abuse now states: Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality.

This can encompass but is not limited to the following types of abuse: psychological, physical, sexual, financial, emotional .

Home Office (2013)

Child Abuse

Children may be abused or neglected by inflicting harm, or by knowingly not preventing harm. Children may be abused in a family, an institutional 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 or, more rarely, by a stranger.

An abuser can be an adult or a child.

The sustained abuse or neglect of children, physically, emotionally or sexually can have major long-term effects on all aspects of a child's health development or wellbeing.

Safeguarding and promoting the welfare of children is further defined as:

Protecting children from maltreatment;

Preventing impairment of children's health or development;

Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care; and taking action to enable all children to have the best life chances.

(Working Together to Safeguard Children 2015)

Four categories of abuse are defined in Working Together to Safeguard Children 2015:

Physical Abuse

A form of abuse which 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.

Emotional Abuse

The persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to a child that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may include not giving the child opportunities to express their views, deliberately silencing them or 'making fun' of what they say or how they communicate.

It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond a child's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction. It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying (including cyber bullying), causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.

Sexual Abuse

Involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing.

They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet).

Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.

Neglect

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

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

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

Young Carers

Children and young people may assume caring responsibilities for parents, siblings or other family members such as grandparents, who are disabled, have physical or mental ill health problems or misuses drug or alcohol. (Working together to Safeguard Children 2015).

Staff should consider a 'think family' approach and consider what additional support the young carer may require when caring for adult patients.

Duties, Roles and Responsibilities

Everyone shares a responsibility for safeguarding and promoting the welfare of children and young people, irrespective of individual roles (Working Together to Safeguard Children (HM Government 2015). This applies to all staff, including those who do not routinely see children, but who see parents or carers and those with long term care needs.

Trusts through their Chief Executive Officer and the Trust Board, all NHS Trusts and NHS Foundation Trusts have a duty under Section 11 of the Children Act 2004 to ensure their functions are discharged with regard to the need to safeguard and promote the welfare of children and young people, including ensuring compliance with the Care Quality Commission 'Fundamental Standard 13 - Safeguarding Service Users from Abuse'.

Guidance from Working Together to Safeguard Children (2015) also states that all NHS Trusts and NHS Foundation Trusts should identify a Named Doctor, Named Nurse and Named Midwife for safeguarding children.

Following the Laming report (HM Government 2003) child protection is 'everyone's responsibility'. All staff members have a statutory duty to safeguard children and must ensure that safeguarding forms an integral part of all stages of the care that they offer, even if they do not work directly with children. This requires that all NHS Trust and NHS Foundation Trust staff adhere to their local arrangements and procedures.

All medical staff should follow the General Medical Council guidance, 'Protecting children and young people: The responsibilities of all doctors' (2012). This includes the need to attend appropriate training and maintain their skills in the recognition of abuse, and be familiar with the procedures to be followed if abuse and neglect is suspected, incorporating relevant health recommendations from the Laming Report (2003). Supervision for medical staff managing complex or difficult child protection cases should be available on a regular basis, or as required, from the Named Child Protection Professional.

It is vital that all doctors have the confidence to act if they believe that a child or young person may be abused or neglected. Taking action will be justified even if it turns out that there is not a risk, as long as the concerns are honestly held and reasonable and the doctor takes actions through appropriate channels (GMC 2012).

All children attending or admitted to any NHS Trust or NHS Foundation Trust should have a named Lead Consultant, who will take overall responsibility for the child's care, and should take appropriate action if any child protection concerns are raised with him/her.

Training

Training is an essential feature of working together to safeguard and promote the welfare of children, and families.

The specific level of training required for all staff groups in NHS Trust and NHS Foundation Trusts should be based on the recommendations of the Intercollegiate Document (Third Edition 2014). The level of training required by all staff groups depends on their level of responsibility and contact with children.

Through training all staff should:

- Be aware of the risk factors for child abuse. This includes situations where adults may pose a risk to children
- Know how to recognize the different forms of abuse
- Know what to do if a child's welfare or safety may be at risk
- Be aware of local procedures in child protection
- Know who to contact to get advice and support
- Ensure they have access to adequate training to fulfil their role and the responsibilities of their role

Parenting Risk Factors – 'Think Family'

Think Family means securing better outcomes for children, young people and families with additional needs, by coordinating the support they receive from children's, young people's, adults' and family services.

Department for Children, Schools and Families (2009).

Much evidence exists to highlight to practitioners parenting risk factors, which will impact on the parents / carers ability to care for their children, including the 'New Learning from Serious Case Reviews' 2012 (Department for Education), which provides additional evidence to highlight the potential negative impact on children living in these circumstances. These parental risk factors may distort a family's ability to meet their children's needs in an appropriately responsive way.

Health professionals must consider the physical or emotional risk to children in the family**, even if the child is not their patient and remember that the welfare of the child is paramount.** Assessment of adults should include routine questioning on whether the adult is providing care for or living in a child's home. The impact of the adult's condition on the child's welfare should be considered. Information about potential risk factors should be shared including an effective analysis of the adult's ability to care for the child.

Risk factors may include:

- Parental mental health
- Substance misuse (drug and alcohol)
- Domestic abuse / violence.
- Parents with a Learning Difficulty

Confidentiality, Consent and Information Sharing

People using NHS services may normally be assured that their details and information known to professionals about them is kept confidential in line with current legislation and regulatory body guidance such as the Nursing and Midwifery Council and General Medical Council Codes, and the Data Protection Act.

However, in the case of concerns about child protection/abuse, the welfare of the child is paramount (The Children Act 1989, Human Rights Act 1998, United Nations Convention of the Rights of a Child 1991), and information that is relevant to child protection will be shared with other professionals within health or other agencies, as is necessary to safeguard a child's welfare.

The Caldicott Principles set out in "Information: To share or not to share? The Information Governance Review (Caldicott 2 Review)", March 2013, provide general principles that health and social care organisations should use when reviewing their use of client information, and exemplify good practice. A concern for confidentiality must never be used as a justification for withholding information when it would be in the child/young person's best interests to share information.

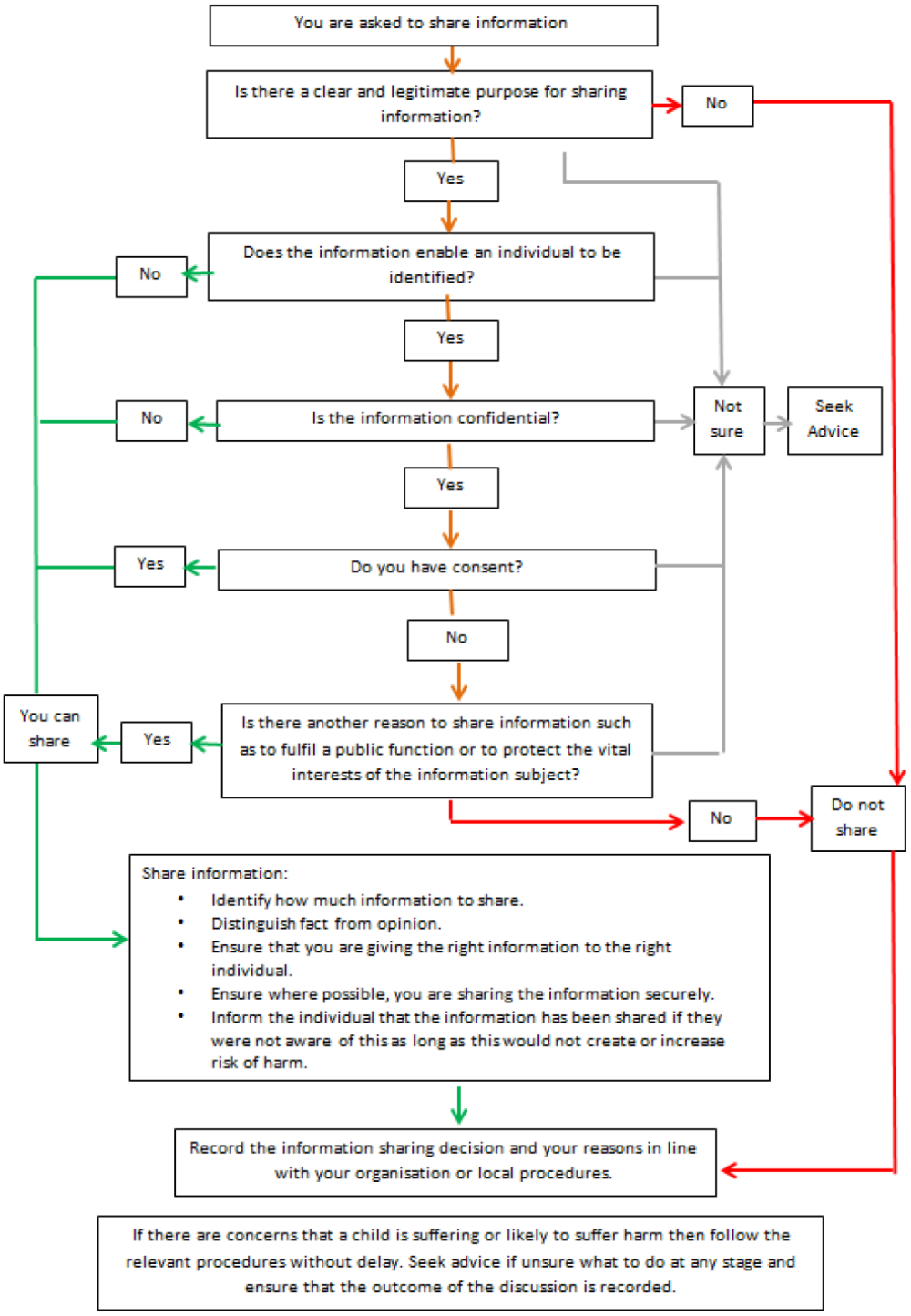
The child, who is of sufficient age and understanding, and the parent/person with parental responsibility, should normally be aware of and/or consent to any liaison and sharing of information with other professional colleagues, unless to do so would place the child/young person at greater risk of significant harm, place the practitioner at risk of harm, or allow evidence to be contaminated or destroyed.

In general, the law does not prevent individual sharing of information with other practitioners if:

- Those likely to be affected consent.
- The public interest in safeguarding the child's welfare overrides the need to keep the information confidential
- Disclosure is required under court order or other legal obligation

Please refer to the local Information Governance policies and 'Information Sharing: Practitioners Guide' (HM Government 2015). Further advice can be obtained from local Named Professionals, NHS Trust and NHS Foundation Trust legal departments, or the local Caldicott Guardian.

Flowchart of when and how to share information



Information Sharing: Practitioners Guide (HM Government 2015)

Clinical considerations for safeguarding children with major trauma

Bruising is the commonest injury in physical child abuse. The number of bruises a child sustains increases as they get older and their level of independent mobility increases. There can be difficulty in distinguishing abusive from non-abusive bruises and determining the age of the bruise when attempting diagnoses. However, bruising is often a "sentinel injury" in children prior to the recognition of child abuse, highlighting the importance of recognising abnormal patterns of bruising particularly in young non-mobile infants.(1)

On that basis, for any infant (a child less than 1 year of age) who is brought to an Emergency Department by the South West Ambulance Service (SWASFT) and is noted to have an injury (e.g. bruising), a pre-alert call should be made to the Emergency Department by the ambulance crew, such that the Consultant in Emergency Medicine can review the infant within 5 minutes of arrival, to ascertain the likelihood of whether or not this is a presentation of NAI, which requires appropriate clinical and safeguarding escalation.

A similar escalation procedure should be in place within Emergency Department triage systems across the Network, such that infants with injuries including bruising are rapidly assessed by a Consultant in Emergency Medicine, to ascertain the likelihood of this being a presentation of NAI.

Fractures in children less than 18 months of age should be assessed for possible child abuse. Multiple fractures are more suspicious of abuse.(2)

Certain features (retinal haemorrhage, apnoea) appear to correlate strongly with Abusive Head Trauma (AHT) rather than non-abusive head trauma in children less than three years of age.(6) It is vital that all children with suspected AHT have their eyes examined thoroughly by an ophthalmologist (dilated pupils and indirect fundoscopy) for the presence of retinal haemorrhage. Skeletal survey including oblique views of the ribs should be performed in all children less than two years of age with suspected AHT. In the child sustaining head injury or who is unconscious as a consequence of their abusive injuries, abdominal injuries must be considered during their investigation.(7)

Many abdominal injuries, in particular hepatic injury, may be clinically occult and thus active consideration of blunt abdominal injury in children with suspected abuse is necessary. Abdominal injuries such as transection or laceration of the third / fourth part of the duodenum in children aged less than five years, particularly those less than two years old, who have not experienced a motor vehicle collision should prompt specific child protection investigations.

Many children sustaining abusive abdominal injury have evidence that there has been repeated blunt abdominal injury, although they have not come to attention with previous injuries. Thus, non-specific symptoms in young children with suspected abuse should prompt abdominal investigations. Infants less than 6 months of age with an isolated bruise may still have occult abdominal injury.

Evidence indicates a child with a torn frenulum should undergo a full child protection evaluation, but if no other injuries, nor any social concerns are identified, the presence of a torn frenulum alone is not diagnostic of physical abuse.(8)

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Other resources

South West Child Protection Procedures 2017 https://www.proceduresonline.com/swcpp/

The Children Act 1989 and 2004

http://www.legislation.gov.uk/ukpga/1989/41/contents

http://www.legislation.gov.uk/ukpga/2004/31/contents

Human Rights Act 1998 http://www.legislation.gov.uk/ukpga/1998/42/contents

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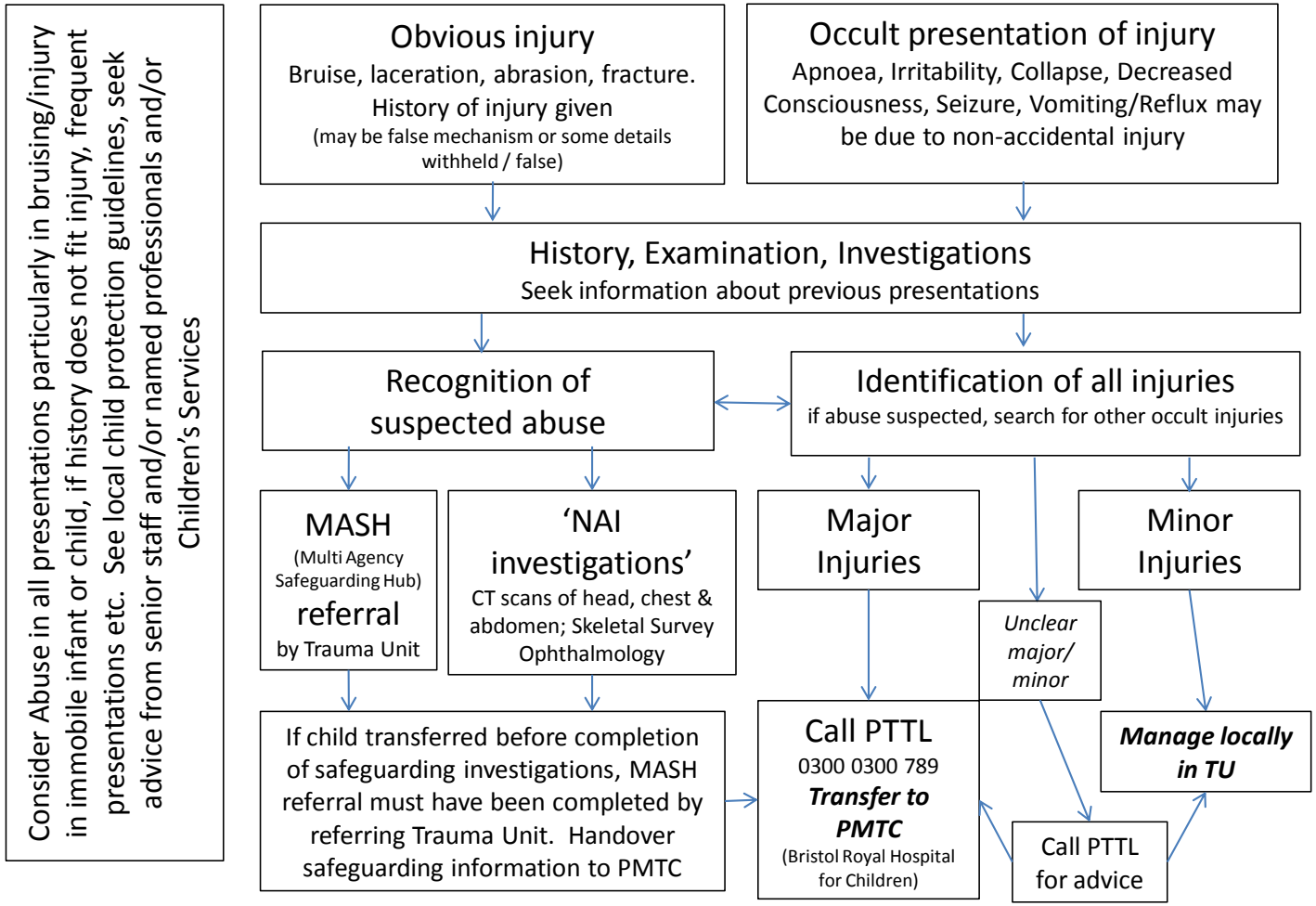
Working Together to Safeguard Children (2015)
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/592101/Working_Together_to_Safeguard_Children_20170213.pdf

Appendix 1

South West Paediatric Major Trauma Network Safeguarding Flow Diagram



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