Safeguarding Children

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This policy supports CQC Standards to provide safe, caring, effective, well-led services that are responsive to people's needs.

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1. INTRODUCTION

This policy is intended for implementation by all BrisDoc employees both clinical and non-clinical. It is also applicable to self-employed contractors so they are aware of local requirements and processes. It is intended to provide guidance on who might be a vulnerable child, indicators of abuse, and what to do if abuse is suspected. It also describes the training and awareness-raising requirements that BrisDoc must help to provide which all staff groups must attend and their role and responsibility in the child protection process. This will support BrisDoc to achieve its corporate objectives for providing high quality patient care in accordance with its core values.

Patient Care

Patient focused - understanding our patients needs and ensuring we prioritise the "patients view" in all our everyday activities and actions.

Workforce Care

Teamwork and individual responsibility - every person counts, supporting each other, sharing information, valuing and encouraging.

Quality Care

Commitment to do what we say and improve what we do. A commitment to excellence and quality when serving patients and colleagues.

Resource Care

Optimising the use of all resources across the local health economy. Taking care of our working environment and equipment.

All health professionals have a duty to care for and protect children, to identify children at risk and act as their advocate to ensure that they are kept safe.

All staff have responsibility. It is also a shared responsibility. The role of primary care in the protection of children from abuse and neglect was highlighted within a position paper from the Royal College of General Practitioners (2002). This was re-affirmed within the '*Keep Me Safe', Strategy for Child Protection* (2005). In this context, primary care includes general practices and also urgent care and out of hours centres where children are seen and treated. The general practice or out of hours team however are not responsible for making a definitive diagnosis of child abuse and neglect; rather to share concerns appropriately and refer onto the relevant expert agency responsible for further investigation and arranging medical examinations to decide whether or not child abuse has occurred.

2. SCOPE

This policy sets out guidelines for all BrisDoc staff who should be trained to recognise signs of child abuse and know the appropriate process for communicating their concerns that will ensure the safety of the child.

All those working at BrisDoc, both administrative staff and clinicians, must be aware of this policy and trained in its use.

The policy also covers the checks necessary for staff recruited to work at BrisDoc before they commence work, to ensure that they are safe to work in contact with children.

The policy is not exhaustive and is based on:-

- Safeguarding Children and Young People: A toolkit for general practice 2009 RCGP and NSPCC

- Safeguarding Children Policies for Bristol, North Somerset and South Gloucestershire health and social care community areas,

This guidance can be accessed from the relevant websites which contains much additional information (see section 11).

To achieve a child-safe working environment, all those working at BrisDoc need to:

- be clear what their role and responsibility is
- be able to respond appropriately to concerns or disclosures of abuse
- understand what behaviour is acceptable
- understand what abuse is
- minimise any potential risks to children

3. LEGISLATION

The following is a list of key legislation, which underpins child protection policies.

3.1 Children Act 1989

An Act to reform the law relating to children; to provide for local authority services for children in need and others; to amend the law with respect to children's homes, community homes, voluntary homes and voluntary organisations; to make provision with respect to fostering, child minding and day care for young children and adoption; and for connected purposes.

This covers the welfare of children and the appointing of guardians who can assume parental rights for children when needed.

3.2 Protection of Children Act 1999

An Act to require a list to be kept of persons considered unsuitable to work with children; to extend the power to make regulations under section 218(6) of the Education Reform Act 1988; to make further provision with respect to that list and the list kept for the purposes of such regulations; to enable the protection afforded to children to be afforded to persons suffering from mental impairment; and for connected purposes.

3.3 Children Act 2004

An Act to make provision for the establishment of a Children's Commissioner; to make provision about services provided to and for children and young people by local authorities and other persons; to make provision in relation to Wales about advisory and support services relating to family proceedings; to make provision about private fostering, child minding and day care, adoption review panels, the defence of reasonable punishment, the making of grants as respects children and families, child safety orders, the Children's Commissioner for Wales, the publication of material relating to children involved in certain legal proceedings and the disclosure by the Inland Revenue of information relating to children

The Children Act 2004 places a duty on services to ensure that every child, whatever their background or circumstances, to have the support they need to:

- Be healthy
- Stay safe
- Enjoy and achieve through learning
- Make a positive contribution to society
- Achieve economic well-being.

3.4 Data Protection Act 1998

3.5 Human Rights Act 1998

3.6 Adoption and Children Act 2002

3.7 Sexual Offences Act 2003 - includes the offence of "grooming"

3.8 Safeguarding Vulnerable Groups Act 2009

3.9 Female Genital Mutilation Act 2003 updated in the Serious Crime Act (SCA) 2015

Female genital mutilation (FGM) was made a criminal offence in 1985. The SCA allows for orders to be made to protect a girl against being subjected to FGM. An order can be made to protect either a girl or vulnerable woman at risk of FGM. It also places a duty on persons who work in a 'regulated profession' in England and Wales, namely healthcare professionals, teachers and social care workers, to notify the police when, in the course of their work, they discover that an act of FGM appears to have been carried out, or is planned, on a girl who is under 18.

BrisDoc is basing its policy on the RCGP/NSPCC policy and procedure as set out in Safeguarding Children and Young People 2009 because it is the most comprehensive and up to date policy in this area. Relevant areas are set out below.

4. PRINCIPLES

Safeguarding is everyone's responsibility and for services to be effective each professional and organisation should play their full part. For services to be effective they must adopt a child centred approach and be based on a clear understanding of the needs and views of children. Every area should use these principles to underpin their safeguarding plans.

In addition, for safeguarding procedures to be effective they must reflect the following:

- The child's needs are paramount, and the needs and safety of each child, should be put first, so that every child receives the support they need before a problem escalates;
- All professionals who come into contact with children and families are alert to their needs and any risks of harm that individual abusers, or potential abusers, may pose to children;
- All professionals share appropriate information in a timely way and can discuss any concerns about an individual child with colleagues and local authority children's social care;
- High quality professionals are able to use their expert judgement to put the child's needs at the heart of the safeguarding system so that the right solution can be found for each individual child;
- All professionals contribute to whatever actions are needed to safeguard and promote a child's welfare and take part in regularly reviewing the outcomes for the child against specific plans and outcomes;
- All professionals involved in serious case reviews receive support and guidance;
- Local Safeguarding Children Boards coordinate the work to safeguard children locally and monitor and challenge the effectiveness of local arrangements;
- When things go wrong Serious Case Reviews (SCRs) are published and are transparent about any mistakes which were made so that lessons can be learned; and
- Local areas innovate and changes are informed by evidence and examination of the data.

5. DEFINITIONS

Child abuse and neglect is a generic term encompassing all maltreatment of children, including serious physical and sexual assaults, as well as cases where the standard of care does not adequately support the child's health or development.

Children may be abused or neglected through the infliction of harm, or through the failure to act to prevent harm.

Abuse can occur in a family or an institutional or community setting. The perpetrator may or may not be known to the child.

There are broadly four types of child abuse:

1. 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.

FGM is the partial or total removal of external female genitalia for non-medical reasons. It's also known as female circumcision or "cutting". Religious, social or cultural reasons are sometimes given for FGM. However, FGM is child abuse. It is dangerous and it is a criminal offence. There are no medical reasons to carry out FGM. It doesn't enhance fertility and it doesn't make childbirth safer. It is used to control female sexuality and can cause severe and long-lasting damage to physical and emotional health.

2. Emotional Abuse

Emotional abuse is 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 children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond the 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 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.

3. Sexual Abuse

Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, including prostitution, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative (e.g. rape, buggery or oral sex) 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.

4. 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 for example as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to provide adequate food and clothing, shelter, including exclusion from home or abandonment, failing to protect a child from physical and emotional harm or danger, failure to ensure adequate supervision, including the use of inadequate care-takers, or the failure to ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness, to a child's basic emotional needs.

5.1 General Indicators

The risk of child maltreatment is recognised as being increased when there is:

- parental or carer drug or alcohol abuse
- parental or carer mental illness
- intra-familial violence or history of violent offending
- previous child maltreatment in members of the family
- known maltreatment of animals by the parent or carer
- vulnerable and unsupported parents or carers
- pre-existing disability in the child
- home schooling

[NICE CG89: *When to suspect Child Maltreatment*, July 2009]

There are certain parental responses which are known, by research and experience, to suggest a cause for concern. These include:

- an unexplained delay in seeking treatment that is obviously needed, or it is sought at an inappropriate time
- a lack of awareness or denial of any injury
- incompatible explanations are offered; or the child is said to have acted in a way that is inappropriate to its age and development; or several different explanations are offered; (N.B. the child and/or other members of the family may support the explanations, however improbable)
- a reluctance to give information, or failure to mention previous injuries known to have occurred
- the family has attended Accident and Emergency departments unusually frequently with appropriate and inappropriate requests for attention
- a constant presentation of minor injuries, which may represent 'a cry for help', which, if ignored, may lead to more serious injury. Attention may be sought for other problems unrelated to the injury, which may not even be mentioned
- unrealistic expectations of the child, or constant complaints about the child. Parents may show a violent reaction to a child's behaviour
- consent for further medical investigation is refused
- the parents are drunk or under the influence of drugs or cannot be found
- the parents ask for the child to be removed from home or indicate difficulties coping with the child.

Signs that may suggest physical abuse:

- any bruising or injury to an immobile baby (see the BNSSG Injuries in Non-Mobile Babies protocol)
- multiple bruising to different parts of the body
- bruising of different colours indicating repeated injuries
- fingertip bruising to the face, chest, back, arms or legs
- burns or scalds with clear outlines e.g. gloves and socks effect or burns of uniform depth over a large area. Also, splash marks above the main scald area – associated with throwing
- retinal or pin point haemorrhaging – associated with shaking
- rib fractures in very young children

- adult bite marks
- an injury for which there is no adequate explanation

- A girl at immediate risk of FGM may not know what's going to happen. But she might talk about or you may become aware of:
  - a long holiday abroad or going 'home' to visit family
  - relative or “cutter” visiting from abroad
  - a special occasion or ceremony to 'become a woman' or get ready for marriage
  - a female relative being “cut” – a sister, cousin, or an older female relative such as a mother or aunt.

Signs that may suggest emotional abuse:

- excessive bedwetting/soiling, eating, rocking, head banging, aggression
- self harm
- attempted suicide
- high levels of anxiety, unhappiness or withdrawal
- seeking out or avoiding affection
- sleeplessness/night terrors
- food refusal
- attention seeking.

Signs that may suggest sexual abuse:

- injuries, infections, or abnormal discharge, in the genital / anal / oral area;
- pregnancy, and identity of the father is kept a secret or is vague;
- child shows worrying sexualised behaviour in their play or with other children or adults;
- child seems to have inappropriate sexual knowledge for their age;
- child demonstrates a confusion of ordinary affectionate contact, with abuse.

Signs which may suggest neglect:

- squalid, unhygienic or dangerous home conditions
- parents fail to attend to their children’s health or development needs
- children appear persistently undersized or underweight
- children continually appear tired or lacking in energy
- children suffer frequent injuries due to lack of supervision
- the child is not attached or is anxiously attached to the parent
- the child is not regularly sent to school including preschool
- developmental delay due to lack of stimulation
- the child has cold skin mottled with pink or purple
- the child has swollen limbs with pitted sores which are slow to heal
- the child’s skin condition is poor, especially in the nappy area
- the child has dry sparse hair
- the child stays frozen in one position for an unnaturally long time.

5.2 BNSSG Injuries in Non-Mobile Babies Protocol

The aim of this guidance is to ensure that professionals in all agencies:

- are aware that even minor injuries could be a pointer to serious abuse in non-mobile
- babies
- know that such injuries, however plausible, must routinely lead to multi-agency information sharing
- know how to refer such a baby for a medical opinion
- know whom to contact for safeguarding purposes.

This protocol recognises that professionals use their professional judgement and common sense which is based on their experience, training and role. However, it is important to remember that non-accidental injuries often occur in the same body areas as accidental ones, and professionals are often taken in by plausible explanations. Professional judgement may for example mean allowing a family to take a well-baby with a plausible minor injury home from a busy surgery before the clinician is able to make checks through social care, but advising the family that they will be called within 24hrs once checks have been made. Social care and police checks are just as important a part of the safeguarding net around the child as the medical examination, and the two should take place together, in parallel, to allow professionals to make a risk analysis together.

BrisDoc clinicians are strongly advised to discuss cases with peers or senior colleagues if deciding not to follow the guidance. Such colleagues could be the Clinical Coordinator in OOHs, line manager, safeguarding lead, or a consultant community paediatrician. Reasons for such decisions must be clearly documented.

6. ROLES AND RESPONSIBILITIES

The BrisDoc Medical Director has overall responsibility for children's safeguarding and has delegated leadership for children's safeguarding in each BrisDoc practice to its Lead GP. The Lead GP in Broadmead Medical Centre will provide advice and support to the Head of Out of Hours Nursing for the GP Out of Hours Service. Children are not seen as patients in the Acute GP Team. There is therefore no designated lead for this service and support, if required, will be provided by either the BMC Lead GP or the Head of Out of Hours Nursing. Children are not seen in the Homeless Health Service. However, it is recognised that there may be safeguarding issues for the children of patients accessing that service. The Lead is not a full-time function but instead complements the individual's daily duties.

6.1 Safeguarding Children Leads

The BrisDoc Leads for Safeguarding Children & Young People will for their service:

- act as a focus for external contacts on safeguarding/ child protection matters
- be fully conversant with all aspects of the BrisDoc child protection policy, operating procedures and incident handling procedures
- disseminate safeguarding/child protection information to all BrisDoc personnel in their service,
- act as a point of contact for clinical and non-clinical staff to bring any concerns that they have and record it
- assess the information promptly and carefully, clarifying or obtaining more information about the matter as appropriate
- know and establish links with local child protection agencies, such as the children's social care services
- know and establish links, and when appropriate take advice from Named and Designated Professionals in Child Protection

- take a lead role in planning and delivering regular staff training, reviewing policy and operating procedures, and conducting audit/review of children's safeguarding at BrisDoc
- lead on audits of child protection
- liaise appropriately with Community Child Health Teams
- work collaboratively to provide peer review of each other's services and ensure there is always a Lead availability to BrisDoc
- be appropriately trained in child protection, Prevent and FGM for their role.

6.2 BrisDoc Employees and Locums

All Staff are responsible for:

- undertaking induction and refresher training in child protection including FGM at the level appropriate for their role
- raising alerts with the appropriate child protection team when they identify issues of concern in accordance with appendix 1
- liaising with their Child Protection Lead so alerts may be followed up for learning and further action
- providing clear and accurate documentation of consultations, including the issues of concern, in the case record.

6.3 Head of Governance

The Head of Governance is responsible for:

- supporting the Leads to ensure that BrisDoc meets its contractual and clinical governance guidance on safeguarding children/ child protection
- ensures that the BrisDoc team records safeguarding incidents appropriately in the Integrated Risk Management System for GP Out of Hours and Risk Register in BMC, (for example of significant event forms see appendix 2) and analysis of significant events (see appendix 3)
- ensuring appropriate audits are undertaken and reported to the Executive Directors.

6.4 HR Department

The HR Department is responsible for:

- sourcing and organising child protection and FGM training at all levels,

6.5 Executive Directors

Executive Directors are responsible for:

- Ensuring adequate provision of resources that enable all staff to be knowledgeable of, and able to manage child protection issues appropriately to a consistently high standard
- Receiving audit and investigation reports.

7. STAFF EMPLOYMENT AND TRAINING

7.1 Employment of clinical and non-clinical staff (including health professionals working as independent contractors)

BrisDoc will carry out thorough checks on all new employees. This will include:

- Disclosure and Barring System checks
- Recognising and discussing gaps in work history.

- Taking up references prior to employment, one of which must be the employee's current manager or employer.
- All employed staff will have a face to face interview

7.2 Staff Training

All new members of staff will undergo in-house basic awareness training in child protection as part of their induction process. All members of staff will undergo child protection training at least every three years.

- Non-clinical staff Level 1*
- Clinical staff [GPs, Practice Nurses and Nurse Practitioners] Level 3*
- Safeguarding Lead Level 3+*

All staff undergoing training will be expected to keep a learning log for their appraisals and or personal development review (PDR).

**as defined in Safeguarding Children and Young People: Roles and Competences for Health Care Staff. Intercollegiate Document [RCPCH lead] 2010.*

Training will include discussion of all the barriers, which can potentially prevent abuse being recognised or concerns about a child's safety being voiced.

All Clinical Staff in BrisDoc will undergo "Spotting the Sick Child" on line training once which also includes elements of safeguarding.

All BrisDoc clinical staff will undergo FGM training every 3 years.

8. BARRIERS TO RECOGNITION OF ABUSE AND CHALLENGES OF TAKING ACTION

Experience in the child protection field has shown that there are many barriers individuals often have to overcome before taking appropriate action when faced with a concern about a child's welfare. *Keep me Safe*; RCGP strategy for Child Protection identified the following barriers to recognising and responding to child abuse.

These are:

8.1 Looking for the wrong thing: Looking for physical signs of physical abuse as the sole markers for child abuse misses a lot. Child abuse comes in different forms and is a problem that will be hidden

8.2 Under estimating the problem: For example, failing to appreciate the danger to a child where there is domestic violence (ref learning from past experience) or parental mental health problems.

8.3 Normalising the problem: Being tolerant of neglectful behaviour where there is material deprivation. Neglect is more common where there is deprivation, but deprivation does not cause neglect.

8.4 Not seeing the child: The needs of the child must be put above all others (The Children Act 1989 Paramountcy Principle 48) and the child seen, not just the parents. The needs of the child can easily be overshadowed by those of the parents.

8.5 Not looking: There is no doubt that child abuse is upsetting. It is easier to ignore the problem or seek other, more comfortable explanations for our observations. Clinicians themselves may be or have been the victims of abuse or domestic violence.

8.6 The problem is hidden: Parents will present their child with something other than abuse, such as an 'accident', or not present their child at all. Parents may be frightened or feel ashamed.

They may want help, but be unwilling to accept responsibility for their actions. Rarely, they may actually induce illness: in Fabricated and Induced Illness (previously referred to as Munchausen's Syndrome by Proxy).

8.7 **Doing nothing:** Acknowledging that there is a problem can cause a lot of work and strife. It is less trouble, at least in the short term, to do nothing.

8.8 **The patchwork or jigsaw nature of child protection:** Different people hold pieces of information, it is only when these are put together that the picture is complete. Doing this involves sharing information.

8.9 **Relationships:** Staff are often concerned for their relationship with the family; they will be angry and upset and staff may fear for their safety if they raise the issue of child abuse. The family may feel betrayed by staff if they express their concerns. Relationships may be fragile anyway or staff may feel that the family is doing their best under very difficult circumstances.

8.10 **Trust:** Relationships with patients are founded on trust and mutual respect. Where there are suspicions of child abuse, staff have to adopt a much more assertive and forensic approach that cuts across this relationship of trust.

8.11 **Inter-professional relationships:** Working effectively in child protection demands an inter-professional approach involving at least health, education, social services and the police. This creates problems, over confidentiality and information sharing, the different languages, cultures and expectations of the different agencies, and the practical difficulties of finding the right professional at the right time and being able to talk to them.

8.12 **Lack of confidence in the system:** Sometimes staff feel that the cost of engaging the child and family in the child protection system outweighs the benefits. It can feel easier to 'go it alone'.

8.13 **Individual freedom versus the nanny state:** Child rearing practices vary; all individuals have a right to a private and family life without undue interference from the State. Judging someone else's child rearing practices is uncomfortable.

9. GENERAL GUIDELINES FOR STAFF BEHAVIOUR

These guidelines are designed to protect children and staff alike. The list below is by no means exhaustive and all staff should remember to conduct themselves in a manner appropriate to their position.

Wherever possible, staff should be guided by the following advice.

- Unacceptable behaviour must be challenged
- Provide an example of good conduct for others to follow
- Respect a young person's right to personal privacy, and encourage children, young people and adults to feel comfortable to point out attitudes or behaviours they do not like
- Involve children and young people in decision-making as appropriate
- Be aware that someone else might misinterpret a staff member's actions
- Don't engage in or tolerate any bullying of a child, either by adults or other children
- Never promise to keep a secret about any sensitive information that may be disclosed by a child but do follow the practice guidance on confidentiality and sharing information
- Never offer a lift to a young person
- Never exchange personal details such as a home address with a young person
- Don't engage in or allow any sexually provocative games involving or observed by children, whether based on talking or touching
- Never show favouritism or reject any individuals.

Internet, mobile phones and electronic equipment

Staff must always act responsibly with regard to internet, electronic and telecommunications equipment (including use of mobile phones), and use them in a professional, lawful and ethical manner.

Inappropriate types of websites

Accessing or downloading data from inappropriate websites, (e.g., pornographic websites or emails, racist, sexist or gambling websites or emails, sites promoting violence and illegal software) at any time is forbidden and may lead to disciplinary proceedings.

10. RECOGNITION OF ABUSE

Recognising child abuse is not easy and it is not our responsibility to decide definitively whether or not abuse has taken place. However, it is our responsibility to act if we have any concerns. Guidance is set out in section 4.1 on recognising the possible symptoms of abuse in the four main areas: physical (including FGM), emotional, and sexual and neglect.

The South West Child Protection Procedures website (http://www.online-procedures.co.uk/swcpp/) sets out the following questions may help staff discuss their concerns with colleagues in order to reach a decision about what to do next:

- What is your concern?
- How long have you been concerned?
- Who else has concerns?
- What do you think could be happening to the child?
- List a range of possible things that could be happening, rather than jumping to one conclusion. How could you find out whether each of these possibilities is true?
- What information do you have already?
- What have you already done to address your concerns?
- Have you discussed your concerns with the parents and the child or young person?
- If yes, what did they say?
- If no, why not?
- What would be the possible impact on the child?

Colleagues should question each other about the reasons for their concerns.

10.1 Process to follow if worried a child is being abused (Appendix 1)

While every precaution may be taken to prevent an incident from occurring, it is recognised that thorough and professional reactive measures are necessary. The procedures, which follow, set out those steps to be taken with respect to any concerns relating to child protection. A health professional may suspect abuse (in any of the 4 categories) while carrying out a consultation with a child. Non-clinical staff such as receptionists, drivers, and call handlers may become concerned about a child from noting their behaviour of the behaviour of adults accompanying a child, while in waiting or reception areas. Everyone has a duty to voice their concerns to the senior health professional on duty (see 10.4 Reporting below).

10.2 Disclosure of an allegation of abuse

If a child discloses information about abuse, whether concerning themselves or a third party, the employee must immediately make an alert/referral direct to the relevant Child Protection Team, following the child protection procedures in 9.4, and must also inform the lead for Child Protection.

It is important to also remember that it can be more difficult for some children to tell than for others. Children who have experienced prejudice and discrimination through racism may well believe that people from other ethnic groups or backgrounds do not really care about them. They may have little reason to trust those they see as authority figures and may wonder whether Staff will be any different.

Children with a disability will have to overcome barriers before disclosing abuse. They may well rely on the abuser for their daily care and have no knowledge of alternative sources of support. They may have come to believe they are of little worth and simply comply with the instructions of adults.

10.3 Responding to a child making an allegation of abuse

- Stay calm
- Listen carefully to what is being said
- Find an appropriate early opportunity to explain that it is likely the information will need to be shared with others – do not promise to keep secrets
- Allow the child to continue at his/her own pace
- Ask questions for clarification only, and at all times avoid asking questions that are leading or suggest a particular answer
- Reassure the child that they have done the right thing by telling
- Tell them what will be done next and with whom the information will be shared
- Record in writing what has been said using the child’s own words as much as possible – note date, time, any names mentioned, to whom the information was given and ensure that paper records are signed and dated, and electronic subject to audit trails
- Do not delay in passing this information on.

10.4 Reporting

If a member of staff who is not a health professional has concerns about a child, they should immediately, and while the child is still in the building, speak to the most senior health professional, whether nurse or doctor, who is on duty. The health professional will then assess the urgency of the situation and may need to examine the child and obtain more information from adults accompanying the child.

In the first instance, and if the risk to the child is not increased by doing so (situations such as Sexual Abuse or Fabricated & Induced Illness might increase risk; consult local guidance), the health professional will inform the child and accompanying carer/ parent that they need to discuss or report their concern.

Information will be passed to the appropriate Child Protection Team whether the child is being seen in an out of hours setting or at a BrisDoc practice.

When external authorities need to be contacted, the relevant details are below. As a general rule Staff should contact the relevant child protection team by telephone first unless the issue is more immediate, in which case the Police may be called.

Child Protection Contact Numbers	In Hours	Out of Hours
Bristol	0117 903 6444	01454 615165
North Somerset	01275 888808	01454 615165
South Gloucestershire	01454 866000	01454 615165
Community Children's Health Partnership		
Bristol	0117 323 5371	
South Gloucestershire		
Community Child Health Team		
North Somerset	Community Paediatrics	01934 881340
	CAMHS	01934 881262

11. RELATED POLICIES AND GUIDANCE

Safeguarding Vulnerable Adults
Induction and Training
BNSSG Injuries in Non-Mobiles Babies protocol

South West Child Protection Procedures http://www.online-procedures.co.uk/swcpp/

12. CHANGE REGISTER

Date	Version	Reviewed and amended by	Revision details
10.1.2018	5	CLN	Inclusion FGM and non-mobile baby protocol. Removal fax numbers for referral. Inclusion new values slide.

13. IMPLEMENTATION RECORD

Action	Comments	Name

APPENDIX 1

Flow Chart for Staff reporting the Suspected Abuse of a Vulnerable Child

Clinician has concerns about a child's welfare

Staff member discusses with senior health professional on duty

Still has concerns

Be aware of retaining forensic evidence

Child in immediate danger

Call the Police on 101

No immediate danger

Telephone referral to child protection team. Complete referral form if requested.

No longer any concerns

No further action

Inform service child protection lead of the referral using an incident form/copy of referral form

Child protection lead follows up referral with relevant professional and child protection team.

Child protection leads ensure referral is recorded in a safeguarding register/record or the governance database

OOHs	01454 615165
In hours	
Bristol	0117 9036444
North Somerset	01275 888808
South Gloucestershire	01454 868000