Child protection – a tool kit for doctors

BMA

ABOUT THIS TOOL KIT

The aim of this tool kit is to provide a brief and accessible guide to doctors' responsibilities in child protection cases. Although it refers principally to child protection procedures for England and Wales, the guidance on best practice applies throughout the United Kingdom. It does not aim to be comprehensive, rather to act as a prompt for doctors where they believe that a child may be at risk of neglect or abuse. Although all health professionals have a role to play in promoting the wellbeing of children, the focus of this tool kit is on safeguarding, particularly in relation to children who are at risk of significant harm. It is designed more for a general audience of health professionals than those with specific management responsibilities or child protection expertise.

This tool kit should be used in conjunction with the more comprehensive guidance listed both at the foot of each section and in the Appendix. Advice should also be sought from designated child protection leads or from senior colleagues with experience in this area.

This tool kit contains a series of separate cards that highlight different aspects of the child protection process such as basic principles, definitions of abuse and neglect, responding to initial concerns and participation in statutory child protection procedures. Each card is intended to stand alone although there will be some areas of overlap. This tool kit is available

on the BMA's website and NHS Trusts, medical schools and individual doctors may download and adapt it to suit their own requirements. There are no copyright restrictions on the tool kit – please feel free to make multiple copies. The BMA would welcome feedback on the usefulness of this tool kit. If you have any comments please forward them to:

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CARD 1

INTRODUCTION

Working with children and families where there are concerns about neglect or abuse is difficult and demanding. No two cases are identical, and the needs of children and families vary. Decisions about how best to respond when there are concerns about harm to a child necessarily involve a degree of risk – at the extreme, of leaving a child for too long in a dangerous situation, or of removing a child unnecessarily from its family. In each case, these risks need to be weighed and advice may need to be taken from other professionals and local agencies such as Local Safeguarding Children Boards (LSCBs) see card 13.

The guidance in this document applies equally to those doctors directly involved in providing care to children, and to those doctors working with adults whose illness or condition may have an impact on the health or wellbeing of a child.

Where doctors have concerns about a child who may be at risk of abuse or neglect, it is essential that these concerns are acted upon, in accordance with the guidance in this tool kit and other local and national protocols. The best interests of the child or children involved must guide decision-making at all times.

Where suspicions of abuse or neglect have been raised, doctors must ensure that their concerns, and the actions they have either taken, or

intend to take (including any discussion with colleagues or professionals in other agencies) are clearly recorded in the child or children's medical record. Where doctors have raised concerns about a child with colleagues or with other agencies and no action is regarded as necessary, doctors must ensure that all individual concerns have been properly recognised and responded to.

When working with children who may be at risk of neglect or abuse, doctors should judge each case on its merits, taking into consideration the likely degree of risk to the child or children involved. Disclosure of information between professionals from different agencies should always take place within an established system and be subject to a recognised protocol. (See card 9 on information sharing.) This applies equally to information about children who may be subject to abuse, as well as to information about third parties, such as adults who may pose a threat to a child.

For the sake of ease of use, throughout this tool kit the term 'child' is used refer to young people who have not yet reached their 18th birthday. This is also the definition used in the Children Act 1989 and 2004. As is stressed throughout however, due recognition must be given to the capacity of the child or young person to make decisions on his or her own behalf. 'Doctor' includes both GP and hospital doctor, and although this tool kit is principally directed toward doctors, much of the information is applicable to other health care workers. Unless

expressly indicated otherwise, 'parent or carer' refers to those individuals with parental responsibility for the child or young person.

Key advice:
Working together to safeguard children. http://www.everychildmatters.gov.uk/workingtogether/

CARD 2

BASIC PRINCIPLES

- In child protection cases, a doctor's primary responsibility is to the well being of the child or children concerned. Where a child is at risk of serious harm, the interests of the child override those of parents or carers. Never delay taking emergency action (card 7).

- All doctors working with children, parents and other adults in contact with children should be able to recognise, and know how to act upon, signs that a child may be at risk of abuse or neglect, both in a home environment and in residential and other institutions (cards 5 and 6).

- Any doctor seeing a child who raises concerns must ensure follow-on care. In particular, children must not be discharged from hospital without a full examination (cards 13 and 14).

- Efforts should be made to include children and young people in decisions which closely affect them. The views and wishes of children should therefore be listened to and respected according to their competence and the level of their understanding. In some cases translation services suitable for young people may be needed (card 8).

- Wherever possible, the involvement and support of those who have parental responsibility for, or regular care of, a child should be encouraged, in so far as this is in

keeping with promoting the best interests of the child or children concerned. Older children and young people may have their own views about parental involvement (card 11).

- When concerns about deliberate harm to children or young people have been raised, doctors must keep clear, accurate, comprehensive and contemporaneous notes. This must include a future care plan and identify the individual with lead responsibility (card 12).

- All doctors working with children, parents and other adults in contact with children must be familiar with relevant local child protection procedures, and must know how to deal promptly and professionally with any child protection concerns raised during their practice (card 7).

- All doctors working directly with children should ensure that safeguarding and promoting their welfare forms an integral part of all stages of the care they offer. Where doctors have patients who are parents or carers, they must also consider the potential impact of health conditions in those adults on the children in their care (card 7).

- Wherever a doctor sees a child who may be at risk, he or she must ensure that systems are in place to ensure follow-up care (cards 1 and 3).

- As full a picture as possible of the circumstances of a child at risk must be drawn up (cards 13 and 14).

- Where a child presents at hospital, inquiries must be made about any previous admissions (cards 14 and 15).
- Where a child is admitted to hospital, a named consultant must be given overall responsibility for the child protection aspects of the case (cards 14 and 15).
- Any child admitted to hospital about whom there are concerns about deliberate harm must receive a thorough examination within 24 hours unless it would compromise the child's care or wellbeing (cards 14 and 15).
- Where a child at risk is to be discharged from hospital, a documented plan for the future care of the child must be drawn up (cards 14 and 15).
- A child at risk must not be discharged from hospital without being registered at an identified GP (cards 14 and 15).
- All professionals must be clear about their own responsibilities, and which professional has overall responsibility for the child-protection aspects of a child's care.

Key advice: Royal College of General Practitioners. Safeguarding children and young people: a toolkit for general practice. http://www.rcgp.org.uk/clinical_and_research/circ/safeguarding_children_toolkit.aspx

CARD 3

SCOPE OF MEDICAL INVOLVEMENT IN CHILD PROTECTION CASES

All health professionals have a role to play in ensuring that children and families receive the support they need to promote children's health and development. Health professionals are often among the first to have contact with children or families in difficulty. Medical participation in child protection encompasses a range of activities. In its guidance, *Working together to safeguard children* the *Government* has identified the following key competencies. Health professionals who work with children and families should be able to:

- understand the risk factors and recognise children who may be in need of support and/or safeguarding, including unborn children who may be at risk of future harm

- recognise the needs of parents who may need extra help in bringing up their children, and know where to refer to help and help provide support for children at risk of significant harm where children are living in households with domestic violence or substance misuse

- liaise closely with other agencies, including other health professionals and contribute to enquiries from other professionals about children and their family or carers

- 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 behaviour
- contribute to child protection conferences, family group conferences and strategy discussions and contribute to serious case reviews and their implementation
- help ensure that children who have been abused and parents under stress, such as those with mental health problems, have access to services to support them
- play an active part, through the child protection plan, in safeguarding children from significant harm
- as part of generally safeguarding children and young people, provide ongoing promotional and preventative support to children, families and expectant parents.

Key advice:
Working together to safeguard children. http://www.everychildmatters.gov.uk/workingtogether/

CARD 4

DEFINITIONS OF ABUSE AND NEGLECT

'Child abuse and neglect' is a generic term that includes all ill-treatment of children including serious physical and sexual assaults, serious psychological harm, as well as cases where the standard of care does not adequately support the child's health or development. Children can suffer abuse or neglect through the direct infliction of harm, or through the failure to prevent harm occurring. Abuse can occur in a family or institutional setting and the perpetrator may or may not be known to the child.

In its guidance note *Working together to safeguard children*, the Government defines four broad categories of abuse, and these are given below.

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 feigns the symptoms of, or deliberately causes ill-health to a child whom they are looking after. This situation is commonly described using terms such as factitious illness by proxy or Munchausen syndrome by proxy.

2. Emotional abuse

Emotional abuse is the persistent emotional ill-treatment or neglect 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 in so far 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 capacity, 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 ill-treatment 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 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 or psychological needs, likely to result in the serious impairment of the child's health or development. It may involve a parent or carer failing to provide adequate food, shelter and clothing, failing to protect a child from physical harm or danger, 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.

Where physical and sexual abuse involve some deliberate harm on the part of carers, emotional abuse and neglect may reflect the carer's own health or social difficulties and therefore involve consideration of the adult's needs.

Key advice:
Working together to safeguard children.
http://www.everychildmatters.gov.uk/workingtogether/

CARD 5

PHYSICAL SIGNS OF POTENTIAL CHILD ABUSE

Symptoms of physical child abuse may include:

- broken bones that are unusual and unexplained
- bruise marks shaped like hands, fingers, or objects (such as a belt)
- bruises in areas where normal childhood activities would not usually result in bruising
- burn (scalding) marks, seen when a child is placed in hot water as a punishment – particularly 'glove' or 'sock' burn patterns
- burns from an electric stove, radiator, heater or other hot objects, usually seen on the child's hands, arms or buttocks
- cigarette burns on any part of the body
- black eyes in an infant or a similar injury that does not have an appropriate explanation
- human bite marks
- lash marks
- choke marks around neck
- circular marks around wrists or ankles (indicating twisting or tying up)
- separated sutures
- bulging fontanelle
- evidence of unexplained abdominal injury (such as bruised or ruptured intestines due to punching)
- unexplained unconsciousness in infant.

Typical injuries in abused children include:

- bleeding in the back of the eye, seen with shaken baby syndrome or a direct blow to the head
- internal damage, such as bleeding or rupture of an organ from blunt trauma
- any fracture in an infant too young to walk or crawl
- evidence of fractures at the tip of long bones or spiral-type fractures that result from twisting
- fractured ribs, especially in the back
- evidence of skull fracture (multiple fractures of different ages may be present)
- subdural hematoma (collection of blood in the brain) without plausible explanation
- multiple bruises that occurred at different times – especially in unusual areas of the body or in patterns that suggest choking, twisting, or severe beating with objects or hands
- other unusual skin damage, including burns or burn scars.

Key advice:
Royal College of Paediatrics and Child Health.
http://www.rcpch.ac.uk/

CARD 6

SOCIAL AND EMOTIONAL SIGNS OF POTENTIAL NEGLECT OR ABUSE

Typical emotional indicators of potential abuse or serious neglect can include:

- a baby or child who cries constantly
- a baby or child who fails to thrive normally without clinical explanation
- a child who is often bruised or injured
- a child who is often very withdrawn
- a child who is often very dirty or smelly
- a child who is often hungry, or under or over-dressed for the time of year
- a child who is often left at home alone
- a child who is left in unsafe situations, or without medical attention when they need it
- a child who is constantly 'put down', insulted, sworn at or humiliated
- a child who seems very afraid of particular adults, and reluctant to be alone with them
- a child who has unexplained changeable emotions, such as depression, anxiety or severe aggression
- a child who shows sexual knowledge or behaviour that is inappropriate for their age
- a child who is growing up in a home where there is domestic violence
- a child who is living with parents or carers who are involved in serious drug or alcohol abuse.

Key advice source: NSPCC.
www.nspcc.org.uk

CARD 7

WHERE DOCTORS HAVE INITIAL CONCERNS ABOUT A CHILD

Where a doctor has a reasonable belief that a child is at serious risk of immediate harm, he or she should act immediately to protect the interests of the child, and this will involve contacting one of the three statutory bodies with responsibilities in this area: the police, the local authority social services or the National Society for the Prevention of Cruelty to Children (NSPCC), and making a full report of concerns. The precise action taken should be governed by the procedures set out by the LSCB. While professionals should ordinarily seek to involve the family in discussions relating to these concerns and to seek their agreement in the course of action, this should only be done where it will not place the child at an increased risk of significant harm.

In some cases signs of abuse or neglect are not straightforward or clear-cut. Patterns of behaviour or of symptoms develop over time and children and adults can become adept at masking difficulties and misleading professionals. Doctors are therefore often forced to make difficult decisions on the basis of fragmentary and ambiguous evidence. Where doctors believe that there may be genuine grounds for concern, it is important that they do not ignore any early warning signs, even where they may consider the evidence too uncertain to warrant the immediate commencement of child care

proceedings. In these circumstances, doctors should initially consider discussing the matter with other colleagues and health care professionals and should also seek the advice of trained professionals such as named doctors or nurses with experience in child protection. Where uncertainty exists, it can be extremely helpful for doctors to test out hypotheses in this way, without necessarily disclosing identifying data about the patient. It is also important that the option of talking to the carers or family at an early stage is not ruled out. Obviously this needs to be sensitively done and is not feasible in all cases, but it may indicate opportunities to work constructively with parents to improve parenting skills. It is difficult to over-emphasise the importance of documented professional discussion and support in this area.

In Working together to safeguard children the Government gives the following guidance in this area:

- never delay emergency action to protect a child from harm
- always record in writing concerns about a child's welfare, including whether or not further action is taken
- always record in writing discussions about a child's welfare. At the close of a discussion, always reach a clear and explicit recorded agreement about who will be taking what action, or that no further action will be taken.

It is important to bear in mind that the history given by a child or carer may not be accurate and consideration should be given, where appropriate, to seeking corroboration from other sources.

A key source of advice in this area is the *Common Assessment Framework* (CAF). It contains a standardised approach to conducting an assessment of a child's additional needs and deciding how those needs should be met and is used by practitioners across children's services in England.

Consideration must also be given to early identification of vulnerable children and families before the children are directly at risk. Early intervention to support families who are in difficulty has been shown to be effective at preventing harm to children.

Key advice:
Common Assessment Framework.
http://www.everychildmatters.gov.uk/deliveringservices/caf/

CARD 8

COMMUNICATING WITH CHILDREN

It is imperative that doctors listen to children and take their views into account as far as possible, even where the doctor believes that the child or young person concerned does not have the capacity to fully engage in any decision-making process. Children can have a very clear idea of what needs to be done to ensure their safety and wellbeing. Communicating sensitively with children, and establishing sufficient trust to enable them to be open about distressing information and experiences takes considerable skill, and doctors who are likely to be involved in child protection work require special training in this area.

Doctors need to ensure that children understand the extent and nature of their own involvement in decision-making. They should be helped to understand how child protection processes work, how they can be involved, and that they can contribute to decisions about their future to the extent that their age and understanding allows. Doctors should make it clear, however, that children, particularly young children, will not necessarily have the final say in decisions concerning their welfare, and that decisions may have to be taken based upon information contributed by a number of professionals and carers.

It is vital that doctors attempt, as far as possible, to develop a relationship of trust with children they believe to be at risk, and it would be difficult to exaggerate the importance of good communication in this process. Although in practice this may be difficult, as their trust in adults may have been abused in the past, doctors should work towards establishing as far as possible, a positive professional relationship with children. At whatever stage in their development, children should be encouraged to talk openly to health professionals about their experiences, and be assured that confidential information will only be revealed if it is absolutely necessary and in their best interests. Doctors should use methods of communication that are appropriate to the age, understanding and needs of the child, particularly where the children are young, disabled or have a limited understanding of English. As mentioned previously, translators from outside the family may be needed in some cases. Wherever possible, medical professionals with expertise in caring for children should be involved, either directly or through consultation.

When children are first involved in discussions about potential abuse or neglect, the extent of any possible harm, or whether criminal acts have been committed may not be obvious. It is important that even initial discussions with children are conducted in a way that minimises any distress caused to them, and increases the likelihood that they will provide accurate and complete information. It is important, wherever possible, to have separate communication with a

child. Children may need time, and more than one opportunity for discussion, in order to develop sufficient trust before they can begin to discuss their experiences, particularly if they have communication difficulties, are very young, or have learning or mental health problems.

Doctors and other health care workers should be honest and open with children and families about professional roles and responsibilities. They should be clear about what professionals can offer in the way of services, and on the limits of their powers. Doctors should take care that children are clear about any legal and professional restrictions they operate under, such as in relation to confidentiality.

Significant harm to children gives rise to both child welfare and law enforcement concerns. The police have a duty to carry out thorough and professional investigations into allegations of crime, and the obtaining of good evidence is often in the best interests of a child, as it may make it less likely that a child victim will have to give evidence in court. It also contributes to the development of a sound empirical base upon which to develop future support and help for the child and family. Doctors and other health care workers therefore need to keep in mind that child protection work can lead to criminal proceedings. Leading or suggestive communication with children or other members of the family should always be avoided. Advice should be sought either from the police or the Trust legal team where a doctor believes that criminal offences may have been committed.

Initially, such discussions should respect the confidentiality of the individuals concerned, unless or until evidence of harm is established when it may be necessary to proceed without the consent of parents, carers, or, exceptionally, the children concerned. It is important to emphasise that it is not the role of a doctor to undertake criminal investigations into child maltreatment. This is the role of the criminal justice system.

Key advice:
Royal College of General Practitioners.
http://www.gp-training.net/training/communication_skills/consultation/children.htm

CARD 9

CONFIDENTIALITY AND INFORMATION SHARING

Children may try and elicit a promise of confidentiality from adults to whom they disclose abuse. Doctors must avoid making promises of confidentiality that they cannot keep. Where there is a risk of significant harm either to the patient, siblings or to others, doctors have a duty to take action, including, where necessary, the disclosure of relevant confidential information ('significant harm' is the threshold that triggers assessment and intervention under the Children Act 1989, see card 19). Where doctors believe that, in the interests of the child or others, it is important that action is taken, they need to discuss disclosure with the child, and, if possible, the child should be given sufficient time to come to a considered decision. If the child cannot be persuaded to agree to voluntary disclosure, and there is an immediate need to disclose information to an outside agency, he or she should be told what action is to be taken, unless to do so would expose the child or others to increased risk of serious harm. It can also be helpful in certain circumstances if professionals arrange a 'safe' way to contact the child.

Doctors are sometimes unsure whether they can breach the confidentiality of other patients, such as a child's relatives, on the basis of an unconfirmed suspicion or hearsay reports. Each case must be considered on the available

evidence, but the keeping of children safe from harm requires professionals and others to share information. Often, it is only when information is pieced together from a number of sources that it becomes clear that a child is at risk or is suffering harm.

The difficulty for doctors is that they may have some initial concerns about a child but are uncertain whether the appropriate threshold of severity has been reached to justify a disclosure of information without consent. Doctors should recognise that personal information that is held about children and families is confidential and should not normally be released without the consent of the subject. However, both the law and the GMC permit the disclosure of information where it is necessary to protect a child against a risk of significant harm. In these cases, the public interest in protecting children overrides the public interest in maintaining confidentiality.

It is sometimes the case that both the abused or neglected child, and the person suspected of the abuse or neglect, are registered with the same doctor. Doctors in these circumstances have reported feeling a sense of divided loyalty, as they have professional responsibilities to both parties. The doctor's primary responsibility is to the child, as the more vulnerable party, and where the interests of the child and the suspected abuser conflict, the latter's interests should always give way to the child's. Doctors should, however, treat all parties sensitively and professionally, and try to respect both party's

wishes, in so far as this is conducive to promoting the best interests of the child or children concerned.

Key advice:
General Medical Council. 0-18 years: guidance for all doctors. http://www.gmc-uk.org/guidance/ethical_guidance/children_guidance/contents.asp

CARD 10

EXAMINATION OR ASSESSMENT FOR CHILD PROTECTION PURPOSES

The need for consent

In ordinary circumstances, any examination or assessment which involves physical contact with the child requires consent from the patient, or carer, or authorisation from a court (see cards 8 and 11). Even if the assessment does not involve physical contact, for example an interview as part of a psychological or psychiatric assessment, consent would be required. In the sort of circumstances considered here, where children, particularly young children, are at risk of significant harm, it could well be in the best interests of the child to undergo an examination without explicit consent. These circumstances require clear justification based upon an informed judgement of the best interests of the child. In these circumstances doctors should make a clear record of the decision to go ahead, and its justification in the child's medical notes. Doctors should try as far as possible to work with the child, explaining in ways meaningful and sensitive to the child, the nature of the examination and the reasons that lie behind it.

Requirements for valid consent to a child protection assessment

To obtain valid consent, it is necessary for the person giving consent to be informed of the nature and purpose of the proposed assessment. The person giving consent should not be deceived or misled about the purpose of an

assessment. Being open about the purpose is clearly necessary when an assessment is requested by a statutory agency responsible for child protection such as social services or the police.

The need to avoid unnecessary assessments

It is harmful for children to be exposed to an unnecessarily large number of assessments. Once legal proceedings have begun, the court is responsible for deciding whether an assessment is required for the purposes of the proceedings, having regard to the child's welfare. There is still a danger that children may be repeatedly assessed *before* court proceedings have been initiated. For example, one parent may be convinced that the other parent is abusive, and be determined to seek evidence to confirm this. In other cases, a parent may agree to a series of assessments at the request of a local authority, because of a fear that the local authority will initiate care proceedings if consent is not granted. In such situations, professionals must exercise independent judgement in deciding whether a further assessment is necessary and in the child's interests.

Where there are concerns that inappropriate and unnecessary assessments are being carried out, it has been suggested that an order could be sought from the court, prohibiting a parent from granting consent for further assessments. Before considering an assessment, doctors must be clear what it is designed to achieve and ask themselves if the outcome of the assessment is likely to make a difference to the proposed course of action.

Refusal of examination

The Children Act states that even where a court directs that an assessment should take place, a child who is of 'sufficient understanding to make an informed decision' may refuse to submit to the examination or assessment. Where an assessment has been specifically authorised by a court, it is still necessary to assess the level of the child's understanding, and to seek the child's agreement, before proceeding with the assessment.

Recommendations concerning a child's refusal

Where a child refuses to cooperate with an assessment, there are several possibilities.

- Assessment is impossible without the child's cooperation, or it is inappropriate to proceed in the face of the child's objections. In these circumstances, legal advice should be sought.

- The child lacks sufficient understanding to make an informed decision. An authorised assessment can lawfully proceed despite the child's objections, although health professionals may well be unwilling to proceed in such circumstances. If it is necessary to use force or sedatives to overcome the child's resistance, legal advice should be sought.

- The child has sufficient understanding to make an informed decision. In these circumstances, in England and Wales the court alone has the power to override a competent child's refusal. In the case of *South Glamorgan*

County Council v W and B it was decided that the High Court, exercising its 'inherent jurisdiction', may authorise an assessment against the wishes of a competent child if the child would otherwise be likely to suffer 'significant harm'. This power is not available in magistrates' or county courts. The position in Scotland, where this precedent is unlikely to be followed, is slightly different and legal advice should be sought.

Key advice:
British Medical Association. Consent, rights and choices for young people.

CARD 11

INVOLVING PARENTS AND CARERS

Doctors can be uncertain about the extent to which parents or carers should be involved in decisions relating to children who may be victims of intentional harm. The following key points should be taken into consideration.

- Where children are competent to make decisions, their views are very influential although, exceptionally, decisions that are clearly contrary to their best interests can be challenged.

- Ordinarily, where children cannot make decisions for themselves, those with parental responsibility have a legal right to make decisions on their behalf. Such rights, however, are not absolute, and when children are at risk of avoidable harm, professionals involved in caring for them have a clear duty to take appropriate action.

- Where children lack the competence to make decisions, those with parental responsibility should therefore be involved, *provided it is in the best interests of the child or young person concerned.*

- Parents or carers should not be involved where it would put a child at further risk of harm. This might include situations where

there is a possibility that a child would be threatened or otherwise coerced into silence; where there is a strong likelihood that important evidence would be destroyed; or that the child in question does not wish the parent to be involved at that stage and is competent to make that decision.

- When harm or neglect is identified as a possible diagnosis by a doctor, taking a history directly from the child may be essential. Where it is, the history should be taken even when the consent of the carer has not been obtained, with the reasons for dispensing with consent recorded in the medical record.

- A decision to exclude an individual with parental responsibility is a serious one, and, if time allows, it should be made in consultation with colleagues with expertise in this area. Doctors should bear in mind that almost all children about whom child protection concerns are raised either remain with, or are returned to their families. Involving the family in child protection processes, to the extent that it promotes the interests of children, is therefore likely to be productive.

- Doctors need to bear in mind that family structures are increasingly complex. In addition to those adults who have daily care of a child, a variety of other adults such as estranged parents, grandparents or other family members may play a significant part in the child's life. Some children may also have

been supported by adults outside the family during periods of difficulty, depending on their age and maturity. Children may themselves be able to identify adults who provide a supportive influence in their lives.

Key advice:
British Medical Association. Consent, rights and choices for young people.

CARD 12

MEDICAL NOTE KEEPING

- Accurate, comprehensive and contemporaneous notes must be made. Where the child is unknown to the doctor, detailed factual information about the child should be recorded at the point of contact, including information about those with parental responsibility and any primary carers, if these are different. This information should be verified at appropriate intervals.

- Doctors must record all their relevant concerns, without venturing into speculation that cannot be justified.

- A record must be kept of any discussions about the child, including telephone conversations, any decisions that are made, and the reasons behind the decisions.

- Where doctors are working in situations in which case notes are not available, any relevant information should be entered into the notes as soon as is practicable.

- Notes should clearly show the difference between information given by the child or carers, the health care worker's own direct observations, and any subsequent interpretation or assessment of the situation. Notes should also record any action that has been taken or will be taken, as well as any action by, or intended by, other relevant parties.

- Doctors should have a clear means of identifying in records those children (together with their parents and siblings) about whom child protection concerns have been raised, although due consideration will have to be given to ensuring that the means of identification remains confidential. GPs will use appropriate codes on their computer systems to identify children about whom child protection concerns have been raised

- Where paper records are still in use, the tagging of medical records should only be considered where other systems that involve less likelihood of inadvertent disclosure cannot be used. Ordinarily, tagging should only be used with the consent of the individual concerned. Where young children's records are tagged, permission will usually come from the parent until the child is able to decide for him or herself.

- In order to ensure that the highest possible standards of practice in relation to child protection and support are maintained, regular audit of the way child protection concerns are managed should be undertaken. Potential problems should be identified, outcomes recorded and examples of best practice shared.

Key advice:
General Medical Council. Good Medical Practice. http://www.gmc-uk.org/guidance/good_medical_practice/index.asp

CARD 13

THE STRUCTURE OF CHILD PROTECTION SERVICES

Local authorities

Overall responsibility for the safety and welfare of children is the responsibility of local authorities, working in partnership with other public organisations, including health providers. Within local authorities, children's social care staff are the main point of contact for children about whom welfare concerns have been raised. Where statutory child protection proceedings have been instigated, the appropriate local authority social care worker will therefore take the lead in supporting and safeguarding the child or children concerned.

Local Safeguarding Children Boards (LSCBs)

The Children Act 2004 imposed a duty on local authorities to establish a LSCB. The LSCB has overall responsibility for deciding how the relevant organisations will work together to safeguard and promote the welfare of children in its area.

Strategy discussion

Whenever there is reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm, there should be a strategy discussion involving LA children's social care and the police, and other bodies as appropriate including health professionals and, in particular, any referring agency. The strategy discussion should be convened by LA children's social care, and those participating should be sufficiently

senior to be able to contribute to the discussion of available information and to make decisions on behalf of their agencies. If the child is a hospital patient (inpatient or outpatient) or receiving services from a child development team, the medical consultant responsible for the child's health care should be involved, as should the senior ward nurse if the child is an inpatient. Where a medical examination may be necessary or has taken place, a senior doctor from those providing services should also be involved.

Other statutory authorities

Doctors and other health professionals do not have statutory powers to intervene directly in relation to children who are at risk. Where doctors are concerned that a child may be at risk of harm, they will need to work, as appropriate, with other statutory authorities. In addition to the local authority social services indicated above, this includes both the police and, in certain circumstances, the NSPCC.

The principal role of the police is to prevent and to prosecute crime. The police will therefore ordinarily be involved where a crime has been or may be committed in relation to a child or children. In addition, the police have emergency powers to enter premises and remove a child to a place of safety. All police forces have child abuse investigation units (CAIUs) and these will normally take primary responsibility for investigating child abuse cases.

The NSPCC is a specialist child protection agency that operates helplines and other services

throughout England, Wales and Northern Ireland. Its national child protection helpline provides advice to adults and children about child protection concerns. Parentline Plus offers support to anyone parenting a child. The NSPCC is the only voluntary organisation authorised to initiate proceedings to protect children under the terms of the Children Act 1989.

Key advice:
Working together to safeguard children. http://www.everychildmatters.gov.uk/workingtogether/

CARD 14

THE GENERAL PRACTITIONER AND THE PRIMARY HEALTH CARE TEAM

General practitioners and the wider primary health care team are likely to be among the first professionals to come in contact with children who are either at risk, or who are in need of additional support. Consultations, home visits, as well as information from health visitors, midwives and practice nurses can all help to build up a picture of a child in difficulty. GPs and all members of the local primary health care team should know how to act on concerns they may have about a child, and, in particular, what steps to take when a child is considered to be at risk of significant harm. All members of the primary health care team should therefore be familiar with both local procedures, and the names and contact details of colleagues with experience in child protection procedures, such as the named and designated professionals within their Trust. GPs are also well placed to recognise when a parent or other adult carer has problems which may affect their ability to look after a child and GPs should always bear in mind 'the child behind the adult'. While GPs have responsibilities to all their patients, the welfare of children at risk must be their primary concern.

Health visitors have an important role in the protection of vulnerable children. Their knowledge of individual children and families,

combined with their expertise in monitoring and assessing child health and development means that they have an important role to play in all stages of family support and child protection. Midwives, as a result of their involvement with the mother throughout pregnancy and with the mother and child during the months after birth, are also well placed to identify any problems during pregnancy, birth and the child's early care. It is important that doctors collaborate closely with all members of the primary care team to secure the safety and wellbeing of children. There should be structured liaison between health visitors and GPs in order to identify and support children who may be at risk.

Overall moves toward an increasingly multi-professional approach to child protection mean that teachers, school nurses and nursery nurses can be an important source of information about children who may be vulnerable or at risk.

Practices should have written protocols that identify roles and responsibilities for the entire GP team, including receptionists. These should lay out best practice in relation to child protection and the management of confidential information.

Best practice example

In addition to supporting children at risk, some practices also keep registers of vulnerable families – those whose children are not yet at risk, but who might become so. They have a named person in the practice who is responsible for maintaining the register. Following

discussion with the family or child as appropriate, any member of the team can raise concerns by adding the family to the list. Each week, two GPs sit down with the health visitor and midwife and discuss how these families can best be supported.

Key advice:
Royal College of General Practitioners. Safeguarding children and young people: a toolkit for general practice. http://www.rcgp.org.uk/clinical_and_research/circ/safeguarding_children_toolkit.aspx

CARD 15

HOSPITAL-BASED DOCTORS

As full a picture of the child's situation as possible should be developed. Where a child presents at hospital, this must include inquiring about any previous hospital admissions, and efforts must be made to gain access to all relevant notes and records. Where children are admitted to hospital, a named consultant must be given overall responsibility for the child protection aspects of the child's case. The identity of this consultant must be clearly marked in the notes.

Any child admitted to hospital about whom there are concerns about deliberate harm must receive a thorough, carefully documented examination within 24 hours of their admission, except when doing so would, in the opinion of the examining doctor, compromise the child's care or the child's physical and emotional wellbeing.

Do not discharge such children until a discussion has taken place with the LA children's social care authorities and appropriate medical and social follow up has been arranged. Although it may prove difficult in some cases, such children must not be discharged without being registered at an identified GP. Decisions relating to discharge should be made by the consultant in charge of the child's care, or by another senior trained paediatrician. Where social care and other agencies are also involved in continuing care, it

is important that individual areas of responsibility are clearly demarcated, and all professionals involved are clear about both their own responsibilities, and about which professional has overall responsibility for the child-protection aspects of the child's care.

- Where differences of medical opinion arise

Where there are disagreements between health professionals it is important that a full discussion takes place between those with differing views, and is recorded in the child's medical record, bearing in mind that parents and the child have legal rights to view the record. Where deliberate harm has been raised as a possible diagnosis, it must not be rejected without proper consideration and, if necessary, a second opinion should be sought.

- Should children be retained in hospital?

Where children are competent to make the decision, their own wishes will normally be determinative. Where children are competent, but seem to be making decisions that are significantly at odds with their best interests, legal advice should be sought.

Where children are not competent, those with parental responsibility should ordinarily be asked to consent. Where doctors are concerned that parents are either responsible for neglect or abuse, or are unable to protect their children from abuse, then an assessment must be made of the risks to the children.

Where doctors believe there is a risk to the life of a child, or a risk of serious immediate harm, the police or LA children's social care authorities should be contacted immediately and emergency protection procedures should be initiated. Police have powers to remove children to a place of safety for up to 72 hours.

Where there is no immediate risk of serious harm or death and parents wish them to be discharged, but health professionals do not believe it to be in their best interests, legal advice should be sought as a matter of urgency. Doctors should discuss the matter with parents and explain why they believe that further clinical supervision would be advisable.

- Weekend admission

The fact that a child is admitted over the weekend should not be allowed to interfere with an assessment of his or her needs, and of any risks of harm.

Where admitting doctors have concerns that a child is at risk but cannot secure an immediate assessment from a specialist, the child should be encouraged, with discussion with those with parental responsibility where appropriate, to remain in hospital for supervision. Where there is a risk of serious harm to the child, emergency protection proceedings should be commenced immediately.

All local authorities have a social services officer permanently on call with access to information about children who are subject to a child

protection plan. He or she can also take referrals if concerns are raised about a child who is not subject to a protection plan. Doctors with concerns about child protection can contact this officer out of hours.

Where children are admitted over the weekend, doctors must ensure that full notes of relevant findings are made, with clear indications of any future referral and follow-up that are required. Responsibility for any actions that are to be taken should be clearly marked. Children who are at risk of serious harm should not be allowed to 'slip through the net' as a result of weekend admission.

Key advice:
The Victoria Climbié Inquiry.
http://www.victoria-climbie-inquiry.org.uk/finreport/finreport.htm

CARD 16

DOCTORS WORKING IN ACCIDENT AND EMERGENCY (A&E) SETTINGS

Parents and carers who are abusing children may make strenuous efforts to ensure that children do not have routine contact with professionals who may identify abuse. A visit to A&E may be the first or only contact an abused child has with professional services. Abusive adults may also take children to different hospitals to prevent a history of abuse being suspected, and may fabricate names, addresses and the causes of injuries.

Doctors working in A&E should be able to recognise abuse, and be familiar with local procedures for child protection. They should also be able to use local procedures for finding out whether a child is subject to a child protection plan. Doctors in A&E must be alert to the possibility that parents or carers are trying to conceal the abusive nature of injuries. Specialist paediatric advice should be available at all times to A&E departments. If a child, or children from the same household, presents repeatedly, even with slight injuries, in a way that staff find worrying, these concerns must be acted upon in accordance with guidance in this tool kit or other local child protection protocol.

Doctors working in A&E who suspect that a child may be the victim of abuse or neglect should discuss the matter with a named professional or

other professional with expertise in abuse or neglect such as a consultant paediatrician. Care must be taken to ensure that children about whom child protection concerns are raised are not released back into the community without a plan being in place that documents how these concerns are going to be addressed.

The child's GP should be notified of visits to an A&E department. Where a child is not registered with a GP, the appropriate contact in the Primary Care Trust (PCT) should be notified to arrange registration, bearing in mind duties of confidentiality. For more information on confidentiality and disclosure, see card 9.

Where in the view of the treating professional the child is at immediate risk of significant harm, action must be taken without delay. This will usually involve contacting the police or social services to make a full report of concerns. Health professionals should contact the named professional or other expert in child protection issues who should be involved in the referral process. Although consent should ordinarily be sought, in accordance with the previous paragraph and the guidance in card 9, where there is an immediate risk of significant harm, the public interest in disclosing information is likely to override the requirement to seek consent.

Key advice:
The Victoria Climbié Inquiry.
http://www.victoria-climbie-inquiry.org.uk/finreport/finreport.htm

CARD 17

CHILD PROTECTION CASE CONFERENCES

The child protection conference is a key feature of the child protection process. A conference is usually called after the social services and police have investigated some initial concerns about the welfare of a child (s.47 enquiries under the Children Act 1989 see card 19) and decided that the child may continue to suffer, or to be at risk of suffering, significant harm. The case conference usually brings together a variety of professionals who have involvement with the child concerned.

The main role of the child protection conference is to enable those professionals most involved with the child and family, and the family themselves, to safeguard and promote the welfare of the child or children. A decision will also be made as to whether or not the child or children will be the subject of a child protection plan. The conference usually makes recommendations about whether it is necessary to take any legal action to protect the child, and whether the police should take any action if a crime has been committed. If the child is at risk of significant harm, the conference must also put together a child protection plan that sets out how the child's needs will be met in the future. This plan should make it clear what is expected of each agency involved in the child's care and protection. The details of the care plan are usually decided at a core group meeting

held after the conference, composed of those agencies who are most closely involved with supporting the child. Once the child protection conference has taken place, an initial follow-up review conference is usually held after three months, and then, if the child remains on the register, at six-monthly intervals thereafter.

Membership of the initial child protection conference will usually include:

- those with parental responsibility
- the child
- social/key worker and first line manager
- police officer
- health services involved with child or children
- education services
- standing members, if applicable, such as child protection officers.

Doctors have a key role to play in child protection case conferences and the BMA considers it important that, as far as possible, doctors should attend them in person, in addition to sending a written report containing relevant information such as immunisations, A&E and out-of-hours attendance and non-attended appointments.

Child protection case conferences and confidentiality

- Doctors attending case conferences should only release information that is both relevant to the purposes of the case conference and in the best interests of the child or children concerned.

- Doctors may need to request that sensitive information is released in a limited fashion, either to selected individuals or to the chairman of the conference.
- Once a child protection conference has been convened, parents or carers should have been informed of the proceedings, and their cooperation should be sought, if appropriate when disclosing information.
- When doctors are attending case conferences, it is important to avoid jargon or clinical terms as much as possible.

Who should take the lead in child protection cases?

Ordinarily the lead is taken by nominated individuals in one of the statutory bodies: the social services, the NSPCC or the police. Where doctors are involved in child protection cases, it is important that they identify the lead professional as soon as possible and ensure that lines of communication remain open. Doctors often have a good relationship with the family and can be influential in encouraging good parenting and assisting the family in remaining together.

Having passed on concerns about a child to the police or social services, doctors will often continue to see the child in a professional capacity. If the doctor considers that there is new evidence of abuse, or that initial concerns have not been listened to, then he or she must take action, even where another professional

has overall responsibility. This could include further discussion with the lead professional or the Trust's named and designated professionals. If the concerns are sufficiently serious, doctors may consider requesting that social services convene, or reconvene, a child care conference.

Where a doctor has raised concerns about deliberate harm he or she must ensure that, in any future appraisal, each of the concerns has been fully addressed, accounted for and documented. Where doctors or other health care workers have been involved with caring for the child or family, or have taken part in enquiries, they have the right to request that social services convene a child protection conference if they have serious concerns that a child may not otherwise be adequately protected.

Key advice:
Working together to safeguard children. http://www.everychildmatters.gov.uk/workingtogether/

CARD 18

AFTER THE CHILD PROTECTION CONFERENCE

The child protection conference will decide whether the child will be the subject of a child protection plan. This supersedes the placing of a child on the child protection register, which has now been phased out. When a child is the subject of a child protection plan, one of the child care agencies with statutory powers, either the NSPCC or the social services, takes responsibility for the child's case and designates a member of its staff as a key worker. Where doctors and other health care workers are professionally involved with children who have been placed on the register, they should identify the name and contact details of the key worker. This information should be placed in the child's medical record. The key worker is responsible for acting as lead worker for the inter-agency work with the child and family. She or he should coordinate the contribution of health workers and other agencies in order to put in place the child protection plan.

At the initial child protection conference, a decision may be made that the child should not be the subject of a child protection plan. This does not necessarily mean that the child or the family does not require additional support or protection. If they do require further support a care plan must be drawn up and all

professionals involved must be clear about their responsibilities in implementing the plan.

Collaborative working

Effective support and protection for vulnerable children can only be provided by an inter-disciplinary team of health and social care professionals, and the effectiveness of this team depends upon good liaison and communication between separate agencies and professionals. All doctors who may have contact with vulnerable or at risk children must ensure that they know who to contact in the local hospital, health authority, social services and police should they need to raise concerns. A 'common language' should be used across different agencies to ensure that an evidence-based consensus can be reached by all those involved in decision-making. Health professionals must ensure that any communication they have with external agencies is expressed in language that is, as far as possible, clear to non-health professionals.

Key advice:
Working together to safeguard children. http://www.everychildmatters.gov.uk/workingtogether/

CARD 19

CHILDREN'S RIGHTS

The United Kingdom ratified the United Nations Convention on the Rights of the Child in 1991. The Convention places a duty on the state to promote the wellbeing of all children in its jurisdiction. The Convention sets out standards that should be reflected in health care. Article 3 of the Convention states that any decision or action affecting children, either as individuals or as a group, should be focused on their best interests.

In addition to these Convention rights, doctors should bear in mind that the rights of children and parents under the Human Rights Act 1998 will be engaged by child protection proceedings. Where these rights are in tension, they may need to be traded against each other. Of particular importance here are Article 2, the right to life, Article 3, the prohibition of torture, inhuman or degrading treatment or punishment, Article 6, right to a fair trial, and Article 8, respect for private and family life.

Discussion of children's rights in relation to health care can be complex. It can introduce an adversarial or confrontational element into an area that has traditionally focused on consensual care. Societal attitudes are also generally more complex here than in relation to adults' rights, as society tends to have a vested interest in ensuring that children's health is not avoidably put at risk, even though a young person may

want to refuse medical treatment. In cases of abuse, for example, it may be necessary to override the wishes of a competent young person and refer concerns about significant harm to an appropriate body. The following are generally regarded as children's basic health rights:

Children have rights:

- to be protected from physical or emotional harm or neglect
- to child-centred health care
- to be looked after appropriately, without discrimination of any kind
- to be encouraged in every possible way to develop their full potential
- to take opportunities to be involved, from the beginning, and to choose not to be involved in decision-making
- to receive clear information about matters closely affecting themselves and about the right to decline detailed information at a particular time
- to have opportunities to express opinions without pressure or criticism
- to ask someone else to decide a particular issue

- to receive an explanation of the reasons when their preference cannot be met
- to confidentiality – subject to certain constraints; and
- to redress – where appropriate – through a fast, accessible complaints procedure.

Key Advice:
http://www.direct.gov.uk/en/Parents/ParentsRights/DG_4003313

CARD 20

GLOSSARY

Abuse: The concept of abuse is wide ranging and incorporates causing physical, emotional and sexual harm, as well as neglect, which refers to the persistent failure to meet a child's basic physical or psychological needs in a way that is likely to result in serious impairment in the child's health or development. See card 4 for further information.

At risk: Since the Children Act 1989 came into force, the term 'at risk' has generally been used to describe a child believed to be at risk of 'significant harm' and therefore in need of protection by the local authority.

Child: For the purposes of this tool kit, and in accordance with the Children Act 2004, 'child' refers to any young person who has not yet reached his or her 18th birthday.

Child protection conference: This is a formal inter-agency meeting convened following a Section 47 enquiry. It brings together family members (including the child, where appropriate) and professionals involved with the child and the family, in order to make a judgement about whether the child is at continuing risk of significant harm in which case a child protection plan will be drawn up.
Child protection plan: This is a detailed

inter-agency plan for a child who is at risk of significant harm. The plan is based on current findings from the assessment and information held from any previous involvement with the child and family.

It sets out what needs to change in order to safeguard the child from harm. A key worker from social services is appointed, the core group members are identified, and decisions are made about what further assessments are required to inform the outline plan.

An outline of the child protection plan is drawn up at the initial child protection conference, and is further developed by the core group members; it is reviewed at each subsequent child protection review conference.

Designated professional: The 'designated professional' is the senior doctor and nurse who have overall strategic responsibility for all aspects of the health service contribution to safeguarding children across a Primary Care Trust (PCT) region. Designated professionals provide advice and support to the named professionals in each provider Trust. They are a vital source of professional advice in relation to child protection, both for other health professionals, and for other statutory authorities, such as local authorities and LSCBs. They are at the strategic centre of child protection activities within a PCT.

Local Safeguarding Children's Board (LSCB): The Children Act 2004 imposed a duty on local authorities to establish a LSCB. The LSCB has overall responsibility for deciding how the relevant organisations will work together to safeguard and promote the welfare of children in its area. It replaces the Area Child Protection Committee (ACPC).

Named professional: Where designated professionals have a more strategic role, named professionals take the lead on child protection concerns in the organisation in which they work. All NHS Trusts, NHS Foundation Trusts and PCTs providing services for children should identify a named doctor and a named nurse or midwife to provide specialist expertise on child protection issues. Named professionals have an important role in promoting good professional practice within the Trust, and in providing advice and expertise to fellow professionals

Section 47 enquiry: Section 47 of the Children Act 1989 places a duty on every local authority to make enquiries when it has 'reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm'. These are known as Section 47 enquiries. Social services have lead responsibility for undertaking these enquiries with other agencies in particular the police, health bodies and schools.

Significant harm: The Children Act 1989 introduced the concept of 'significant harm' as the threshold for compulsory intervention in child protection cases. As discussed above, where local authorities have reasonable cause to suspect that a child is suffering, or is likely to suffer significant harm they are under a duty to investigate the claim. Furthermore, courts can only make a care or supervision order if they are satisfied that:

- the child is suffering, or is likely to suffer, significant harm; and
- that the harm or likelihood of harm is attributable to a lack of adequate parental care or control.

There are no absolute criteria by which significant harm can be judged, but decisions in this area will involve a consideration of the effect of any ill-treatment on the child's overall physical and psychological health and development.

Key advice:
http://www.everychildmatters.gov.uk/deliveringservices/multiagencyworking/glossary/

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