

Policy

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History Revision	Revision Date	Revised paragraphs	What has been changed; New directive Wording	Originator
July 2011		Throughout		JCB
November 2013	01/11/2013	Throughout	Wording & new directive	JCB
March 2014	11/03/2014	Throughout	All references checked, some wording amended	KV
May 2014	12/05/2014	Throughout	Title of the policy, some references & wording	DB
March 2016	17/03/2016	Throughout	All references and links checked, some wording amended, the main changes made in section 2.14-2.17	DB

Overarching Principle of Child Protection Practice

The investigation and management of a case of possible deliberate harm to a child must be approached in the same systematic and rigorous manner as would be appropriate to the investigation and management of any other potentially fatal disease.

Laming. H, The Victoria Climbié Inquiry, 2003, Recommendation 83

INTRODUCTION

PURPOSE AND SCOPE

This document is designed to provide details and information for staff working in the Auditory Implant Service, University of Southampton (USAIS) about child protection and Safeguarding issues.

Patients who attend USAIS may be children and adults with listening and hearing difficulties (ranging from mild to profound hearing loss).

Some hearing impaired patients may have additional disabilities. The procedures outlined below are designed to ensure that staffs are informed about the action they may need to take if they suspect any form of abuse to the vulnerable person. Types of abuse are also described below.

Child protection/safeguarding is a multi-agency, multi-disciplinary activity and USAIS department must work together with other agencies using common guidelines to ensure the safety and wellbeing of all children in our care. This includes making arrangements relating to those individual's:

- protection from harm and neglect
- physical and mental health
- education, training and recreation
- emotional, social and economic wellbeing

'Society has a duty of care to all children and the protection of children from harm is, quite simply, everybody's business.'

NSPCC 2002

These Procedures should be read in conjunction with:

- Working together to safeguard children – March 2015
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf
- The University of Southampton Code of Practice- Safeguarding Children and Vulnerable Adults
http://www.southampton.ac.uk/hr/services/safeguarding_children/how_do_i.php
- The University of Southampton Policy- Safeguarding Children and Vulnerable Adults
http://www.southampton.ac.uk/hr/services/safeguarding_children/how_do_i.php
- Hampshire Safeguarding Children Board 2013
<http://www.hampshiresafeguardingchildrenboard.org.uk/resources-policies-guidance.html>
- USAIS Was Not Brought Policy found at
<https://groupsite.soton.ac.uk/Enterprise/AIS/Assets/AIS%20Policy-%20Was%20Not%20Brought%20%28WNB%29.pdf>
- USAIS Code of Conduct Policy found at
<https://groupsite.soton.ac.uk/Enterprise/AIS/Assets/Guidance-%20Code%20of%20Conduct.pdf>

DEFINITION OF A CHILD

A child is anyone who has not yet reached their 18th birthday. This is regardless of domicile, marital status or any legal order in force. Although an unborn child does not have legal status as a child, consideration should be given to their needs and any risk factors taken into account and acted on.

1. STAFF RESPONSIBILITIES

1.1 All those working in the department must;

- know the signs and symptoms of actual and potential abuse or neglect in children
- be alert and observant for risk factors and any indications of abuse, including parental conditions that can impact on children
- know how to act effectively on their concerns
- work as part of the multi-agency team along with Social Services and Police colleagues
- be able to make explicit referrals to Social Services (known in Southampton as MASH (multiagency safeguarding hub) when required
- provide a written statement/report to Police and Social Services in all child protection/safeguarding cases
- maintain up to date knowledge and competent skills in these areas, through regular training and supervision
- be prepared to appear as a witness to give oral evidence in court proceedings
- prioritize all child protection/safeguarding cases in the best interests of the child
- have access to expert professional advice to talk over their concerns

1.2 Each health care professional has an individual responsibility to ensure that a child protection/safeguarding concern is referred to the Social Services Department. If a member of staff's concerns are considered to be unfounded by colleagues but that member of staff's concerns remain, further discussion is essential with the University of Southampton's safeguarding team.

1.3 Staff must maintain up to date knowledge and competent skills

through regular Child Protection &/or Safeguarding training.

1.4 All staff who work with children must have an enhanced CRB Check.

1.5 Resources for staff who work with children and families are listed below:

Working together to safeguard children – March 2015

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf

Hampshire Safeguarding Children Board 2013

<http://www.hampshiresafeguardingchildrenboard.org.uk/resources-policies-guidance.html>

The Children Act 2004 London: HMSO

http://www.legislation.gov.uk/ukpga/2004/31/pdfs/ukpga_20040031_en.pdf

Department of Health and Department for Education and Skills (2004)
National Service Framework for Children, Young People and Maternity Services

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/199952/National_Service_Framework_for_Children_Young_People_and_Maternity_Services_-_Core_Standards.pdf

HM Government – safeguarding children in whom the illness is fabricated or induced

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/277314/Safeguarding_Children_in_whom_illness_is_fabricated_or_induced.pdf

Royal College of Paediatrics and Child Health (2009) Fabricated or Induced Illness by Carers: A Practical Guide for Paediatricians

<http://www.rcpch.ac.uk/system/files/protected/page/Fabricated%20or%20Induced%20Illness%20by%20Carers%20A%20Practical%20Guide%20for%20Paediatricians%202009.pdf>

Department for Children, Schools and Families (2008) Safeguarding Children in whom illness is fabricated or induced: Supplementary guidance to Working Together to Safeguard Children
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/277314/Safeguarding_Children_in_whom_illness_is_fabricated_or_induced.pdf

Sexual Offences Act 2003. London: HMSO.
<http://www.legislation.gov.uk/ukpga/2003/42/contents>

'It doesn't happen to disabled children.' NSPCC 2003:
https://www.nspcc.org.uk/Inform/publications/downloads/itdoesnthappen_todisabledchildren_wdf48044.pdf

Human Rights Act 1998. London: HMSO.
<http://www.legislation.gov.uk/ukpga/1998/42/contents>

Data Protection Act 1998. London: HMSO
<http://www.legislation.gov.uk/ukpga/1998/29/contents>

Home Office. Female Genital Mutilation Act 2003. Home Office Circular 10/2004. <http://www.legislation.gov.uk/ukpga/2003/31/contents>

HM Government (2008). Information Sharing: Guidance for Practitioners and Managers. London: DFES.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/277834/information_sharing_guidance_for_practitioners_and_managers.pdf

Safeguarding Vulnerable Groups Act (2006): London HMSO and
http://www.opsi.gov.uk/ACTS/acts2006/ukpga_20060047_en_1.htm

Responsibility for child protection belongs to everyone and all organization need to ensure that their Child Protection Procedures are stringent and robust.

An allegation of child abuse or neglect may lead to a criminal investigation, so do not do anything that might jeopardise a police investigation, such as asking a child leading questions or attempting to investigate the allegations of abuse.

2. PRINCIPLES OF PRACTICE

“The investigation and management of a case of possible deliberate harm to a child must be approached in the same systematic and rigorous manner as would be appropriate to the investigation and management of any other potentially fatal disease”

(Laming, H., 2003, Recommendation 83)

In all cases where there is concern that a child may have been abused or neglected the following principles should be applied:

2.1 Multi-agency working and child centered focus.

2.2 A child protection investigation, led by Social Services which is the lead statutory agency, must be undertaken if there is reasonable cause to suspect that a child is suffering or is likely to suffer significant harm from physical abuse, neglect, sexual abuse or emotional abuse.

2.3 In all cases where a child is thought to be at risk of harm, information must be shared with the multi-agency child protection team (USAIS Keyworker, other professionals, Consultant Otolaryngologist, Social Services and Police) in accordance with national and local procedures. Child protection/safeguarding is a multi-disciplinary, multi-agency process and no agency or practitioner should act alone or in a unilateral manner.

2.4 The primary purpose of all those involved in the child protection process is firstly to prevent child abuse, and secondly to minimise any damage to the child and work towards the child’s recovery in whatever way is relevant to that child’s needs. In all such cases the child is of paramount importance with the professionals’ duty of care being to the child.

2.5 The Children Act 1989 provides a legal framework for the care and protection of children, in which the welfare of the child is paramount. The

Children Act 2004 reinforces but does not supersede The Children Act 1989.

2.6 Children have the right to a life free from abuse and neglect. A child who may have been abused needs to be treated with sensitivity, dignity and respect irrespective of the nature of that abuse.

2.7 When working with families from ethnic minorities staff should respect the ethnicity of the child and endeavor to provide a culturally sensitive service. "Whilst all individuals have a right to expect that their cultural values and beliefs are to be respected, all children whatever their religious or cultural background must receive the same care and safeguards with regard to abuse and neglect. Child abuse cannot be condoned for religious or cultural reasons."

Confidentiality

2.8 Staff should ensure that the information shared is necessary and proportionate, relevant, adequate, accurate, timely and shared only with those who need to see it and it is shared securely.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419628/Information_sharing_advice_safeguarding_practitioners.pdf

Information Sharing/Communication

2.9 The child's best interests must be the overriding consideration when making any decision regarding information sharing. Sharing of information amongst practitioners working with children and their families is essential. In many cases it is only when information from a range of sources is put together that a child can be seen to be in need or at risk of harm. Sharing of confidential information without consent is justified if there is evidence that a child may be suffering or is at risk of suffering significant harm or if there is reasonable cause to believe this or to prevent harm or if failure to disclose information may expose the child or others to risk of death or serious harm. If in doubt seek advice from USAIS safeguarding team member.

2.10 If it is believed that a child or young person seeking advice, for example on sexual matters, is being exploited or abused, they should be counselled with a view to gaining their permission to share information with another agency. The law recognises that disclosure of confidential information without consent or a court order may be justified in the public interest to prevent harm to others.

2.11 Information obtained from a source outside the USAIS (e.g. GP or health visitor, etc.) should not be disclosed to a third party, i.e. Social Services or Police. Instead they should be advised to make direct contact with that professional.

2.12 Before faxing confidential information, a call must be made to ensure the recipient is in a position to receive it and to clarify the identity of the recipient. Receipt of the fax should then be confirmed by telephone.

Consent

Examination without consent may be held in law to be an assault.

2.13 Valid consent

- a) Must be informed
- b) Must be freely given
- c) Written consent is advisable if a child is brought, without parents, by any other person if they inform you that verbal consent has been obtained. This should be recorded in the USAIS and hospital notes if surgery takes place
- d) Attendance at a medical examination usually means implied consent but you should always seek permission from the parents and it is also good practice to ask the child
- e) As with consent, the discussion with the child will depend upon his or her age and understanding: it will be unnecessary in a small baby, good practice with a young child and essential with the older 'Gillick/Fraser Competent' child

2.14 Who can consent:

- a) A child of 16 years and over
- b) A child or young person who has the maturity and understanding to make a decision
- c) A person with parental responsibility
- d) A Court. If the child is subject to an interim care order, EPO or child assessment order the court may give consent (the local authority will transmit the request). If proceedings are on-going, the court may also order the nature of the examination and who should perform it
- e) The local authority if they have joint parental responsibility.

(Child Protection Companion 2nd Edition 2013, P49, para 7.2.8)

2.15 Obtaining consent

Children and young people can only consent to investigation or treatment if they are able to:

- a) Understand the nature, purpose, benefits, risks and consequences of not proceeding;
- b) Retain the information discussed
- c) Use and weight this information and
- d) Communicate their decision to others.

This is the Gillick competency test.

Capacity is based more on understanding than age.

Children aged under 10 years are usually, but not exclusively, deemed not competent to give consent. You should explain to the child and obtain parental consent from the person who holds parental responsibility (PR). If the consent is not possible, act in the best interest of the child.

Children and young people between 10-16 years have increasing levels of competency. You should explain to the child and make an assessment of capacity (accordance of Gillick). It is important that the child is not pressured, the consent should be for specific purposes and it is good practice to obtain consent from both the child and the person with PR.

Young person aged 16-17 is usually able to consent although, in certain circumstances, such as special educational needs (SEN), it may be important to assess their capacity to consent.

(Child Protection Companion 2nd Edition 2013, P50, para 7.3)

2.16 Situations where consent is withheld or not available:

- a) If a **person with PR is unavailable** to give consent, then the decision to proceed will depend upon the circumstances of the assessment, such as who has attended with the child and the risk posed to the child. You should consider involving others and seek advice, obtain consent from local authority and always act in the child's best interests. Document the process which you followed.
- b) A **young person with capacity to consent, who refuses**, should be respected. The young person may agree to a limited examination and the process must be adapted, meeting the young person's agreement. The clinician should offer information about the consequences of refusal and offer a further opportunity. Any risks to the child should be discussed with experienced colleagues, including named professionals.

- c) Refused consent for photography should be respected and documented. Detailed and accurate notes should be accompanied by careful line drawings to illustrate findings.
- d) If **one person with PR consents but another person who holds PR refuses** consent, you should consider the case in its entirety and if you decide the examination is in the child's best interest and/or there is a public interest then you should refer to the local authority to obtain consent by court order. Advice can be taken from senior colleagues and indemnity organisations. However, consent from one party with PR is enough.
- e) If the **local authority wishes an examination to take place but the person with PR refuses** to give consent, you should consider the case in its entirety and if you decide the examination is in the child's best interest and/or there is a public interest then you should refer to the local authority to obtain consent by court order. The local authority will need court order to override the refusal of the party with PR.

(Child Protection Companion 2nd Edition 2013, P50, para 7.4)

Documentation

2.18 Good record keeping is an important part of the accountability of professionals and well-kept records provide an essential underpinning to good professional practice. Full accurate records of history, events, contacts, decisions and actions must be kept. Records must be clear, factual and objective, legibly signed, timed and dated. Opinions should be stated as such. Comments from the child, family or others should be clearly stated as quotations. Assessments made, decisions, interventions and plans must be carefully recorded.

2.19 The departmental notes (hard copies and electronic notes) are multi-disciplinary documents. These documents may be the primary source of information about all of the child's care in child protection/safeguarding cases and all disciplines must use it to record relevant information chronologically.

2.20 A clear picture of the family structure should be recorded with names of parents, carers, siblings and other household members, and a note of who has parental responsibility.

2.21 In all cases every attempt should be made to ascertain and document the

child's own feelings, views, wishes and concerns to ensure that the child's voice is heard and taken account of.

3. RECOGNISING ABUSE

Children may be abused or neglected through the infliction of harm or through the failure to act to prevent harm. Abuse can occur within the family or in an institutional or community setting.

Abuse can occur within all social groups regardless of religion, culture, socio-economic group, financial position or educational attainment. Children may be abused by those known to them or, more rarely, by a stranger. They may be abused by an adult or another child.

Presentations

3.1 Child abuse or neglect may present in a number of ways.

- A child may present openly for assessment or treatment of abuse (a non-accidental physical injury, neglect, emotional or sexual abuse)
- Abuse or neglect may be suspected as a cause of an injury, condition or presentation
- Concerns about abuse or neglect may develop while a child is being seen for an unrelated condition
- A child may be at risk from the behaviour or condition of an adult in the household. In this case it may be the adult who is the patient (see Hidden Harm document re children of drug and alcohol dependent carers https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/120620/hidden-harm-full.pdf)
- There may be concern about risk to an unborn child
- Staff may witness an incident of abuse or neglect to a child patient or other child attending the USAIS
- A child (or someone who knows them) may disclose that they have been abused
- An abuser may disclose a history of abuse to a child or children

3.2 The following may be indicators of concern:

- An explanation/history which is inconsistent/incompatible with an injury or presentation
- Several different explanations provided for an injury or presentation
- Injuries of different ages

- Injury incompatible with the child's age/development/ability
- Unexplained delay in seeking treatment
- Children not brought for appointments
- Parents/carers uninterested or undisturbed by accident or injury
- Parents absent without good reason when their child is presented for treatment
- Poor parent/carer-child interactions
- Poor parent/carer-staff interactions
- Repeated presentation of minor injuries (which may represent as a 'cry for help' and if ignored could lead to a more serious injury or may represent fabricated or induced illness)
- Repeated use of different doctors, A&E departments and other forms of direct health provision
- Reluctance to give information or mention previous injuries

Abuse or neglect should be considered particularly in the presentations found in Appendix 1:

3.3 Emotional abuse

Emotional abuse may be difficult to recognise as the signs are usually behavioral rather than physical. Manifestations of emotional abuse may also indicate the presence of other kinds of abuse. Emotional abuse is one of the most damaging forms of abuse and almost always accompanies other forms of abuse.

See Appendix 2 for further details

3.4 Sexual abuse

Child sexual abuse is the actual or likely sexual exploitation of a child or young person and includes any form of sexual activity involving children or involvement of children in pornographic activities.

- Boys and girls of all ages may be sexually abused and are frequently scared to say anything due to guilt and/or fear. The child may fear s/he will not be believed and/or repercussions consequent upon threats made
- This form of abuse is particularly difficult for a child to talk about
- Recognition of sexual abuse can be difficult as there may be no physical signs and the indications of sexual abuse are most likely to be

emotional / behavioral

See Appendix 3 for further details

3.5 Neglect

All professionals caring for children have a responsibility to recognise when the standard of care the child is receiving from parents/carers falls below acceptable standards.

Recognising neglect:

- Failure of care that leads to significant impairment of child's health, development or well-being e.g. poor hygiene, failure to attend for medical care
- Failure to protect child from exposure to any kind of danger
- Contextual explanations of abuse are important, i.e. the way in which a child is parented may be considered more important than any one discernible incident
- Evidence of neglect is built up over a period of time and can cover different aspects of parenting e.g. neglect of the child's physical needs possibly causing non-organic failure to thrive/faltering growth; neglect of the child's developmental emotional needs which may contribute to cognitive delay; neglect of the child's emotional needs resulting in behavioural markers

Child related indicators

- Non - organic failure to thrive/faltering growth
- Delay in achieving developmental, cognitive and/or other educational milestones over and above that expected due to hearing loss
- A child who is unkempt or inadequately clothed or dirty or smells
- A child who is perceived to be hungry frequently
- Behavioural signs may include a child seen to be listless, apathetic and unresponsive with no apparent medical cause, anxious, aggressive and indiscriminate friendliness
- Failure of child to grow or develop within normal expected pattern with accompanying weight loss or speech/language delay
- Recurrent/untreated infections or skin conditions e.g. severe nappy rash, eczema or persistent head lice/scabies
- Unmanaged/untreated health needs/medical conditions including poor dental health
- Frequent accidents or injuries
- Child frequently absent or late at school

- Poor self esteem
- Child thrives away from home environment
- Bruising in children who are not independently mobile

Indicators in the care provided

- Failure by parents/carers to meet the basic essential needs e.g. adequate food, clothes, warmth, hygiene
- Failure by parents/carers to meet the child's health and medical needs, dental health; failure to attend or keep appointments with health visitor, GP, hospital or USAIS; lack of GP registration; failure to seek or comply with appropriate medical treatment; failure to address parental substance misuse during pregnancy
- A dangerous or hazardous home environment including failure to use home safety equipment; risk from animals
- Poor state of home environment e.g. unhygienic facilities, lack of appropriate sleeping arrangements, inadequate ventilation (including passive smoking) and lack of adequate heating
- Lack of opportunities for child to play and learn
- Child left with adults who are intoxicated or violent
- Child abandoned or left alone for excessive periods

3.6 Fabricated or Induced Illness (FII)

FII is a form of abuse, not a medical condition. Previously known as Munchausen Syndrome by Proxy, this label applies to the child, not the perpetrator. The label is used to describe a form of child abuse. There is a spectrum of fabricated illness behaviour, and FII may co-exist with other types of child abuse and/or with a genuine pathology. The range of symptoms and systems involved is very wide and it is usually the parent or care giver who is the perpetrator. FII includes some cases of suffocation, non-accidental poisoning and sudden infant death.

See Appendix 4 for details

4. RISK FACTORS FOR ABUSE

4.1 The risk to children in the household should be considered in the following circumstances but remember any child can be at risk of abuse. Abuse crosses all boundaries however it is important not to make judgements but to thoroughly assess the situation for each individual child.

- Younger children

- Socially excluded families
- Domestic violence
- Mental illness of parent/carer
- Drug or alcohol misuse
- Chronically ill or disabled children (including hearing loss)
- Parental learning disability
- Children who abuse others (0-18 years)

4.2 Younger children

The younger the child, the greater the likelihood of abuse. Babies are particularly vulnerable because of their small size and their inability to communicate verbally. The homicide rates in babies under one year are four times higher than any other age group.

4.3 Socially excluded families

These families may face chronic poverty, social isolation, racism and the problems associated with living in disadvantaged areas, such as high crime rates, poor housing, lack of childcare, poor transport and poor education services, and limited employment opportunities. Many lack a wage earner. Social exclusion can also have an indirect effect on children through its association with parental depression, learning disability and long-term physical health problems, all of which can impact negatively on parenting capacity.

4.4 Domestic violence

When there is domestic abuse, the implications for children (including the unborn child if the victim is pregnant) in the household must be considered because research indicates a strong link between domestic abuse / violence and all types of abuse and neglect. Prolonged and/or regular exposure to domestic violence can have a serious impact on a child's development and emotional wellbeing, despite the best efforts of the victim's parent to protect the child. Families who are known to have issues can be referred for multi-agency risk assessment conference (MARAC).

4.5 Mental illness of parent/carer

For the purposes of safeguarding children the mental health or mental illness of the parent or carer should be considered in the context of the impact of the illness on the care provided to the child. Mental illness in a parent or carer does not necessarily have an adverse impact on a child's developmental needs, but it

is essential always to assess its implications for each child in the family.

4.6 Drug or alcohol misuse

Parental misuse of drugs or alcohol becomes relevant to child protection when the misuse of the substances impacts on the care provided to their children. Their effects on children are complex and require a thorough assessment. Children are particularly vulnerable when parents are withdrawing from drugs. The risk is greater when the adult's substance misuse is chaotic or otherwise out of control, and when both parents are involved. The risk is also greater where there is a dual diagnosis of mental health problems and substance misuse.

4.7 Chronically ill or disabled children

Disabled and chronically ill children may be especially vulnerable to abuse for a number of reasons, i.e. fewer outside contacts, communication difficulties, impaired capacity to resist and receive intimate personal care which may both increase the risk of exposure to abusive behaviour and make it more difficult to set and maintain physical boundaries. UK evidence suggests that disabled children are at increased risk of abuse and that the presence of multiple disabilities appears to increase the risk of both abuse and neglect. Where a disabled child has communication impairment or learning disabilities special attention should be paid to communication needs and to ascertaining the child's perception of events and his/her wishes or feelings.

4.8 Parental learning disability

Where a parent has a learning disability it is important not to generalise or make assumptions about their parenting capacity. However, learning disabled parents may need support to develop the understanding, resources, skills and experience to meet the needs of their children. Such support is particularly needed where they experience additional stressors. It is these additional stressors, when combined with a learning disability, that are most likely to lead to concerns about the care a child or children may receive.

4.9 Children who abuse (up to 18 years)

Those who work with children and young people who abuse others- including those who sexually abuse/offend - should recognise that such children are likely to have considerable needs themselves. Such children and young people are likely to be children-in-need and some will, in addition, be

suffering, or at risk of suffering, significant harm and may themselves be in need of protection. They may, however, pose a significant risk of harm to other children, particularly in a hospital setting.

5. Process

5.1 If actual or potential abuse or neglect is known or suspected a child protection referral must be made by telephone by a member of the USAIS Safeguarding Team (or Social Services Emergency Duty Team out of hours) within 24 hours.

5.2 If you are unsure whether a child protection referral is appropriate, you should discuss with the USAIS Safeguarding designated officer or supporting safeguarding officers (or Multiagency Safeguarding Hub Emergency Duty Team out of hours).

5.3 Child protection referrals should usually be made with the knowledge of the child's ENT surgeon. However, if the consultant is unavailable this should not delay referral to Social Services.

5.4 Referrals made verbally must be followed up in writing within 48 hours. Social Services must acknowledge referrals within one working day of receipt of the written referral. If no acknowledgement is received within three working days, the referrer must contact Social Services again.

5.5 Staff must be prepared to offer a prima facie opinion to the investigating social worker or to the police about the likelihood of abuse or neglect.

5.6 Professionals must always discuss the timing and the way parents/carers are told about the referral with the multi-agency child protection team in the first instance. In some cases, Police and/or Social Services may decide not to inform the parents/carers until after a strategy meeting because of concerns about increased risk of significant harm especially in cases of sexual abuse and FII.

5.7 USAIS Staff must remember not to promise confidentiality to a child in case of a disclosure.

5.8 It is important that comprehensive information is given to families at the appropriate time and that they understand the implications of a referral to Social Services. Where information regarding a strategy meeting is given to the

family, the name of the consultant and the contact numbers of the relevant social work team should be given in writing to them at the time of that discussion.

5.9 From this point on Social Services are responsible for taking the lead for the process of the child protection procedure. However, staff will need to contribute as appropriate to any strategy discussion, investigation, child protection conference, protection plan, reports and in some cases court proceedings.

5.10 “All doctors involved in the care of a child about whom there are concerns about possible deliberate harm must provide Social Services with a written report/statement of the nature and extent of their concerns. If misunderstandings of medical diagnosis occur, these must be corrected at the earliest opportunity in writing. It is the responsibility of the doctor to ensure that his or her concerns are properly understood.”

Initial child protection conference

5.11 A Child Protection Conference is held when the above enquiries indicate the child may continue to suffer, or be at risk of suffering, significant harm. It should take place within 15 working days of the strategy discussion or the last strategy discussion if more than one has taken place.

5.12 The purpose of the Child Protection Conference is to bring together the child (if of appropriate age), the family and those professionals most involved with the child and family following S47 enquiries. It provides them with an opportunity to exchange information, analyse risk, plan together and decide what further action is required to safeguard and promote the welfare of the child, how that action will be taken forward and with what intended outcomes.

5.13 Professionals attending a conference should have a significant contribution to make arising from their professional expertise, knowledge of the child or family, or both.

5.14 All professionals are expected to prepare their information in advance, and must present a written report.

5.15 Parents, and if appropriate the child, will be present and it is good practice to ensure that opinions and concerns expressed in the report have

previously been shared with the family, unless doing so would have placed the child at further risk.

5.16 Staff attending the conference are responsible for making a note of the outcome on the Safeguarding Pro-forma/medical notes, and informing team members of the protection plan.

5.17 When Child Protection Conference Minutes are received by attendees they should be checked for accuracy and then the appropriate sections of the minutes are placed in the USAIS notes of the child

Child Protection Core Group meeting (Planning meeting)

5.18 A core group of professionals meet with the family to agree a protection plan within 10 days of a child protection conference.

Review Child Protection Case Conferences

5.19 Attendees of the initial Child Protection Conference will be invited to the review. The USAIS Keyworker should attend, or arrange for another member of staff with current involvement to attend.

Requests for statements and reports from staff

5.20 All USAIS staff involved in the care of a child about whom there are concerns about actual or suspected abuse or neglect must provide Police, Social Services, Court, etc with a written report/statement of the nature and extent of their concerns and/or input to that child. If USAIS staff are asked to give statements to the Police or any other agency, the USAIS Safeguarding Team must be informed before the statement is given.

Management of allegations against staff

5.21 This section should be followed whether the allegation is contemporary in nature, historical, or both. The new statutory guidance applies to a wider range of allegations that might indicate that the alleged perpetrator is unsuitable to continue to work with children i.e.

- Behaved in a way that has harmed, or may have harmed, a child
- Possibly committed a criminal offence against, or related to, a child, or
- Behaved towards a child or children in a way that indicates that he or she is unsuitable to work with children.

5.22 If any allegation of abuse or neglect of a child is made it is not appropriate for the person who is the subject of the allegations to be made aware of the allegations or challenged at this stage.

5.23 Where an allegation of a safeguarding nature (ie. inappropriate behaviour, abuse or neglect) is made against a member of staff (occurring in the course of their work), the University, in accordance with the University's employment procedures, will carry out a full investigation in to the circumstances before any action is taken. It may be necessary to suspend the individual for their own protection until this is concluded. The involvement of the local authority designated officer (LADO) may also be required.

5.24 The USAIS Safeguarding Team and University of Southampton Legal Services must be informed of the situation at the earliest opportunity.

5.25 The matter must be referred following advice to Social Services and Police in the same way as another concern about possible abuse, and the allegations investigated under the child protection procedures.

6. DISABLED CHILDREN

6.1 UK evidence suggests that disabled children are at increased risk of abuse and that the presence of multiple disabilities appears to increase the risk of both abuse and neglect.

6.2 The disabled child with a hearing loss is especially vulnerable due to:

- Carers and staff lacking the ability to communicate adequately with her/him
- Carers working in isolation
- Communication or learning difficulties preventing disclosure
- Bullying or intimidation (possibly because the child has to wear CI equipment)
- Abuse by peers (possibly because the child has to wear CI equipment)
- Fear of complaining in case services are withdrawn
- Some sex offenders may target disabled children in the belief that they are less likely to be detected

Essential Safeguards

Safeguards for disabled children are essentially the same as for non-disabled

children and should include enabling them to:

- Make their wishes and feelings known: in an audiology setting this will include the provision of appropriate communication support e.g British Sign Language interpreters, speech to text typist
- If a deaf child has communication difficulties, special attention should be paid to those needs. When a child is unable to tell someone of her/his abuse s/he might convey anxiety or distress in some other way e.g. behaviour or symptoms and staff must be alert to this
 - Raise concerns
 - Have access to more than one adult with whom they can communicate
- In the induction period, a new member of staff whether paid or unpaid must be informed about the Safeguarding Policy and the designated named Safeguarding Officer and the supporting safeguarding officers
- All staff should take individual responsibility in knowing the contents of the Safeguarding Policy and the Department of Health's Children's Service Guidance booklet 'What to do if you're worried a child is being abused', and where it is kept
- The named Safeguarding Officer(s) require regular training to ensure good up to date knowledge of child protection and take responsibility to inform staff of any changes
- All staff must have a CRB certificate at the enhanced level

Safeguarding strategies for all children – Good Practice Guidelines

- Respond appropriately to suspicions of abuse (see below)
- Confidentiality of information is paramount however information may be disclosed without informing the family if it may safeguard a child or prevent a crime occurring
- A response to an incident must be actioned within 24hrs
- The children attending the USAIS for audiological services have various levels of hearing impairment and deafness (some patients are also deaf/blind). Thus it is sometimes necessary to touch a patient to gain their attention, remove their aids and/or attach test equipment such as electrodes or ear plugs. Cochlear implant wearers must be touched on their shoulder or elsewhere to earth them if their processor is to be removed. Staff should always touch children as necessary as for

- performing the clinical tasks. Staffs are encouraged to gain permission from the child or from the parents before touching the child
- Wherever possible a member of staff should avoid being alone with a child
- If a child or vulnerable adult is seen in a room on their own with a member of staff, there must be an observation panel in the door, or the door should be left open. Another member of staff should be in the vicinity
- g. Repeated non-attendance for essential appointments is considered to be ‘a neglect of medical needs’. Social Services can take Court Action and make a ‘Specific Issues Order’ compelling the family to address the situation

Responses to Incidents

- All staff to be prepared to work with other agencies in the patient’s best interest and for their safety.
- All incidents witnessed on or off-site, should be logged in the medical section of the patient’s notes and the journal of the department’s database. These notes should be timed, dated, and signed. Evidence of unusual injury and/or excessive bruising will be logged in the same manner. Please note, any urgent concerns must be telephoned immediately and then written up fully.
- If a member of staff has concerns about a patient’s welfare they should discuss this with the designated safeguarding officer/ safeguarding officers.
- If after this discussion, there are still concerns, a referral is made to social services, followed up in writing within 24 hours.
- The local Safeguarding Team will acknowledge receipt of the referral and decide on the next course of action within 1 working day.
- USAIS to provide written and verbal reports to Safeguarding multi- agency meetings or care proceedings if necessary.

Physical	Classification of main kinds of abuse physical harm to a child. Highest incidence <1 year old. Probe – is the account consistent with the injury? If in doubt check with local staff/hospital or social services.
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Sexual	Around 70% of children with have no physical signs on examination. Likely to be behavioral changes.
Neglect	Most common form. May be physical, safety, emotional, medical. In the case of repeated non-attendance for essential appointments, this is considered to be a 'neglect of medical needs'.
Emotional	Only been recognised as a separate category for about 20 years. Lack of bonding/love, inappropriate expectations for age, threatening behaviour.
FII (Fabricated Induced Illness)	Fabricated - child presents with a plausible medical history Induced - carer tampers with equipment, deliberately harms child Probes - child repeatedly presented medically. Parents overly concerned with all aspects of care. Symptoms improve when they are not around.

USAIS Designated Safeguarding Officer:

Devyanee Bele, Pediatric Coordinator ext 25990 email db@isvr.soton.ac.uk

USAIS safeguarding officers

Sarah Flynn

22964

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Rebecca Ricaud

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Appendix 1 Physical Abuse

I. Bruising

- Bruising is the commonest injury in children who have been physically abused and can occur on any part of the body
- Children can have accidental bruising, but the following bruising may mean physical abuse has taken place. It is vital that a full history is taken and that the USAIS professional is satisfied that the history is compatible with the injury and any bruises/marks, etc, are documented medical records

Patterns of bruising that are suggestive of physical abuse:

- Bruising in children who are not independently mobile
- Bruising in babies
- Bruises that are seen away from bony prominences
- Bruises to the face, back, abdomen, arms, buttocks, ears and hands
- Multiple bruises in clusters
- Multiple bruises of uniform shape
- Bruises that carry the imprint of implement used or a ligature.
- Grasp marks on small children, i.e. fingertip bruising on limbs, face and chest wall

The evidence is that the age of a bruise cannot be accurately estimated from an assessment of colour – either by a clinical assessment or a photograph

Bruising may not be easily noticeable or distinguishable when children have darker skins (black / ethnic groups). Greater vigilance is required in noticing other possible indicators of injury e.g. wincing or demeanour of the child

- Differential diagnosis of bruising:
 - Clotting disorders

- Skin diseases
- Birth marks

'Mongolian blue spots' closely resemble bruising. They are typically grey / blue pigmented areas over the lower back, trunk and limbs, and may be extensive. There is no over-lying damage or palpable swelling. They remain essentially unchanged in the first year of life and progressively disappear in childhood

II. Oral injuries

The commonest injury to the mouth is laceration or bruising to the lips

The oral cavity must be examined in all cases of suspected physical abuse and, if any abnormalities found, seek a maxillofacial/dental opinion

A torn frenum – the flap of tissue in the midline under the upper lip – is highly suspicious in non-mobile children, but occurs accidentally amongst those who are mobile

III. Bite marks

Bite marks can leave clear impressions of the teeth. Human bite marks are oval or crescent shaped

IV. Thermal injury (burns & scalds)

It can be difficult to distinguish between accidental and non- accidental burns and scalds. A history of the injury is vital and a second opinion should be sought. Characteristics of inflicted scalds:

- Majority inflicted scald injuries are with hot tap water
- Forced immersion scald injuries are commonest
- Scald margins have clear upper limits
- Scald is symmetrical and/or bilateral
- Skin fold sparing is found, e.g. in popliteal area or central sparing of buttocks
- Circumferential (glove or stocking distribution) scalds to upper or lower limbs
- Uniform scald depth found
- Usually lower limbs

Characteristics of inflicted non scald burns:

- Contact burns are the most commonly described non scald burns
- Intentional burns were most commonly reported on back, shoulders and/or buttocks
- Intentional burns had sharply demarcated edges which could be matched to the specific implement in many cases.
- Circular burns from cigarettes are characteristically punched out lesions
- Friction burns resulting from being dragged
- Linear burns from hot metal rods or electrical fire elements
- Burns of uniform depth over a large area
- Old scars indicating previous burns / scalds which did not have appropriate treatment or adequate explanation
- Non scald burns can also be caused by open flames, hot ovens/microwaves and caustic agents

V. Non accidental head injury (NAHI)

Head injury is the commonest cause of death in physical child abuse

A significant number of subdural haemorrhages caused by trauma, excluding perinatal injury, in children under 2 years old are inflicted. Infants with NAHI present to hospital with a variety of symptoms, including lethargy, vomiting, fits, respiratory difficulty to sudden death

VI. Fractures

It takes considerable force to produce a fracture in a child or infant. All fractures require appropriate explanation and this must be consistent with the child's developmental age.

Non-mobile children rarely sustain fractures accidentally. The younger the child, the greater the likelihood of abuse.

See Appendix 4 for details

The following fractures are more suspicious of abuse:

- Humerus -Spiral fractures of the humerus are uncommon and strongly linked with abuse
- Multiple fractures -Multiple fractures are significantly commoner in abused children

- Rib fractures- Highly suspicious in abuse in the absence of major trauma or underlying bone disease
- Femur fractures- Suspicious, particularly in children who are not mobile
- Spinal fractures- Usually result from forced extension and flexion injuries
- Metaphyseal fractures- Outside the neonatal period, under the age of 2 years may indicate abuse
- Skull fractures- Skull fractures require considerable force. A linear parietal fracture is the commonest accidental and non-accidental fracture. Other skull fractures require a greater degree of force, which should be reflected in the history. A history of a fall less than 3 feet rarely produces a fracture

All children under 18 months with a fractured bone, or of any age where there is a concern, should be referred to their GP immediately

VII. Scars

A large number of scars or scars of different sizes or ages, or on different parts of the body, may suggest abuse

Appendix 2 Emotional abuse

Children at risk of emotional abuse may be:

- Perceived as the wrong sex, unwanted, disabled, abused as child, rejected
- Seen as ill or difficult
- Born into difficult situations – marital difficulty, separation, violence
- Born to vulnerable parents – alcohol or drug abuse, depressed, mentally or otherwise ill

Recognition of emotional abuse is usually based on a series of observations over time

Parent / carer & child relationship factors

- Abnormal attachment between a child and parent / carer e.g. anxious, insecure or avoidant, indiscriminate or no attachment
- Indiscriminate attachment or failure to attach
- Conveying to children they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person e.g. persistent negative comments about the child or ‘scape- goating’ within the family
- Developmentally inappropriate or inconsistent expectations of the child which is outside what is considered reasonable and acceptable cultural / legal norms e.g. over-protection, limited exploration and learning, interactions beyond the child’s developmental capability, prevention of normal social interaction
- Causing children to feel frightened or in danger e.g. witnessing domestic violence, seeing or hearing the ill treatment of another Child presentation concerns
- Behavioural problems e.g. aggression, attention seeking,

hyperactivity, poor attention

- Frozen watchfulness, particularly in pre-school children
- Low self-esteem, lack of confidence, fearful, distressed, anxious
- Poor peer relationships including withdrawn or isolated behaviour

Parent / carer related issues

- Dysfunctional family relationships including domestic violence
- Parental problems that may lead to lack of awareness of child's needs e.g. mental illness, substance misuse, learning difficulties
- Parent or carer emotionally or psychologically distant from child
- Child not brought for appointments

Appendix 3 Sexual Abuse

Behavioural indicators of sexual abuse

Behavioural indicators of sexual abuse may include:

- Inappropriate sexualised behaviour with other children or adults
- Inappropriate sexual knowledge
- Sexually explicit behaviour, play or conversation, inappropriate to the child's age
- Continual and inappropriate or excessive masturbation
- Self-harm (including eating disorder), self-mutilation and suicide attempts
- Involvement in prostitution or indiscriminate choice of sexual partners
- An anxious unwillingness to remove clothes for sports events (but this may be related to cultural norms or physical difficulties)
- Running away
- Hyperactive
- Withdrawn
- Acting out/disruptive behaviour
- Aggression
- Decreased academic achievements

Physical indicators

- Sexually transmitted diseases
- Vaginal soreness or bleeding, perineal itching, soreness, pain on micturition, bleeding
- Pregnancy
- Bruises, scratches or other injuries to the genital or anal areas, insides of thighs, or to other "sexual" areas such as breasts and lips: these injuries may be minor but inconsistent with accidental injury
- Ano-genital warts
- Semen in vagina, anus or on external genitalia
- Recurrent urinary tract infections
- Recurrent abdominal pain, headaches or other psychosomatic features
- 'Eccentric' sexual patterns of family interaction without other observable or reported symptomology

Appendix 4 Fabricated or Induce Illness (FII)

There are three main and not mutually exclusive ways of the carer fabricating or inducing illness in a child:

- Fabrication of signs and symptoms, including fabrication of past medical history, fabrication of hearing loss
- Fabrication of signs and symptoms and falsification of hospital charts, records, letters, documents and specimens of bodily fluids
- Induction of illness by a variety of means

It may also involve influencing the health beliefs of others.

Harm to the child may be caused through unnecessary or invasive medical treatment, which may be harmful and possibly dangerous, based on symptoms that are falsely described or deliberately manufactured by the carer, and lack independent corroboration.

The child may additionally suffer emotional harm through limitations placed on her/his development and social interaction e.g. overprotection, limitation of exploration and learning, prevention from participation in normal social interaction and frequent hospital attendances.

Think of FII when:

- inconsistent or unexplained symptoms and signs
- poor response to treatment
- unexplained or prolonged illness
- different symptoms on resolution of previous ones, or over time
- child's activities inappropriately restricted
- parents/carers unable to be assured
- problems only in the presence of parent/carer
- erroneous or misleading information
- family history of unexplained illness or death
- exaggerated catastrophes or fabricated deaths.

Non-accidental head injury (NAHI)

Important features of NAHI:

Such injury arises from impact to the head or as a result of severe repetitive rotational injury with or without additional impact. Combinations of mechanisms frequently occur.

The consequences may include:

- Bruising/abrasions or lacerations to the head including scalp or face
- Skull fracture(s) usually with overlying haematoma
- Intracranial bleeding – subdural, subarachnoid or intraventricular/parenchymal, Extradural haemorrhage is rare
- Subdural collections are often bilateral, and common sites are over the convexity of the cerebral hemisphere, along the falx or in the posterior fossa. In the acute stage they are typically small and do not cause mass effect
- Brain injury – includes hypoxic - ischaemic injury and direct traumatic injury of the brain substance
- Retinal haemorrhage in one or more usually both eyes
- Neck and cervical spinal cord injury
- Skeletal injury – fractures of ribs where the child is grasped, long bone fractures when child is held, swung or limbs flail. Vertebral injury is rare
- Bruising to body or limb

Guidance procedure

1. If you think a child is in immediate danger, please call the emergency services on 999 and then extension 3311 within the University to allow security to help direct the emergency services.
2. If you are concerned about the general health, welfare and safety of any child, but feel there is no immediate danger, please discuss this with your designated Safeguarding Officer:

Devyanee Bele

25990

d.bele@soton.ac.uk

3. If the designated officer is not available, speak to the safeguarding officers or the director of the department mentioned below.

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4. If your Safeguarding Officer agrees, or they are not available, please make a referral.

For Southampton children, contact Southampton MASH (multiagency safeguarding hub)

Tel: 02380 832 300 (Professionals number)

Out of hours contact: 02380 233 344 (emergency duty team)

5. If the child is from a different area then you can still contact the Southampton MASH to ask for the contact number of the patient's local safeguarding organisation.
6. Note your comments in the patient's medical notes and BCS journal immediately (signed, dated and including the time, location and if anyone else was present).
7. Write a summary and pass to Devyanee Bele for the Safeguarding file.