Policy, Procedures and Guidance for Registered Nurses, Midwives and Specialist Community Public Health Nurses on Safeguarding Children and Young People

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## Procedures

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1.0 Statement from the Southern Trust's Executive Director of Nursing

The Southern Health and Social Care Trust's primary duty of care is to protect vulnerable children and young people from abuse. In order to support staff in 2011 the Trust developed Policy, Procedures and Guidance for Registered Nurses, Midwives and Specialist Community Health Nurses on Safeguarding Children and Young People. This policy and the associated procedures and guidance have now been updated in line with the most recent evidence-based practice and research findings.

The policy, procedures and guidance directs registered nurses, midwives and specialist community public health nurses in how to recognise and appropriately respond to indicators that suggest a child or young person is, or is likely to, suffer significant harm or not achieve a reasonable standard of health or development. This document is applicable to all registered nurses, midwives and specialist community public health nurses employed by the Trust. In adhering to the procedures and guidance nurses and midwives significantly contribute to effective multi-disciplinary and agency working, essential to ensuring optimum health and well-being of our children and young people in our care.

My thanks to the Trust’s Named Nurses for updating this document and for their continued support to nurses and midwives in this vitally important area of patient care.

MR FRANCIS RICE

Director of Mental Health & Disability Services / Executive Director of Nursing

March 2014
2.0 Introduction

The practice of safeguarding children and young people is complex and constantly changes as new evidence and policies emerge. The Southern Health and Social Care Trust (Southern Trust) has adopted the Northern Ireland regionally agreed policies and procedures for safeguarding children and young people which all registered nurses\(^1\) are required to adhere to. Further, the NMC Code\(^2\) requires registered nurses to work with others to protect and promote the health and wellbeing of those in their care, their families and carers, and the wider community. Registered nurses have a responsibility to recognise and respond to indicators that a child may be in need\(^3\) or in need of protection\(^4\).

This document has been developed in accordance with the Trust's key principles for policy development. It outlines the Southern Trust policy, standards, procedures and guidance for registered nurses in relation to safeguarding children and young people and addresses key safeguarding practice areas.

It is the responsibility of each registered nurse and his/her manager to read and understand this policy and associated procedures and be in a position to act in accordance with its contents. This document should be used in conjunction with the Regional ACPC Child Protection Policy and Procedures and amendments.

3.0 Purpose

The purpose of this policy, procedures and guidance is to ensure that registered nurses working within the Southern Trust understand their responsibilities in relation to safeguarding children and young people, and have advice, support, supervision and training in order to practice competently.

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\(^1\) For the purpose of this document the term registered nurse(s) refers to nurses, midwives and specialist community public health nurses who are registered with the Nursing and Midwifery Council

\(^2\) The Code – Standards of conduct, performance and ethics for nurses and midwives, Nursing and Midwifery Council, April 2007

\(^3\) A child in need is assessed to be ‘…unlikely to achieve or maintain a reasonable standard of health or development without the provision of services’. Children (NI) Order

\(^4\) A child is in need of protection is where ‘…there is reasonable cause to suspect that he/she is suffering, or is likely to suffer significant harm’. Children (NI) Order
Policy
for Registered Nurses, Midwives and
Specialist Community Public Health Nurses
on
Safeguarding Children and Young People
4.0 Policy

The Trust has a legal responsibility and duty under the Safeguarding Board Act (Northern Ireland) 2011 to implement effective systems to safeguard children and young people through effective multi-disciplinary and inter-agency partnerships. Registered nurses who are employed by the Southern Trust must comply with:

- Southern Trust policy, procedure and guidance as outlined in the content and appendices of this document.
- DHSSPS Safeguarding Children Supervision Policy for Nurses and Midwives (2011)

5.0 Scope of the Policy

This policy is applicable to all registered nurses employed by the Southern Trust in permanent, temporary and ‘as and when’ contracts including those in generic or extended roles, whether temporary, permanent or bank / locum staff. It specifically applies to registered nurses who work directly with children and young people, and those who work with adults whose lives impact on children.

For the purpose of this policy the term ‘safeguarding children and young people’ refers to children and families who are subject of:

- Child protection policy and procedures
- Child in need case planning policy and procedures
- Looked After Child policy and procedures
- Domestic and inter-country adoption policy and procedures
- Concerns regarding childcare issues
6.0 Responsibilities

The Trust Chief Executive as the Accountable Officer has overall responsibility for ensuring the aims of this policy are met.

The Executive Director of Nursing is responsible for policy monitoring and review.

The Director of Children and Young People’s Services is responsible for the distribution of this policy and procedure to relevant directorates within the Trust.

Directors are responsible for ensuring that systems are in place to ensure that registered nurses are aware of and adhere to this policy.

Assistant Directors are responsible for monitoring and audit of this policy.

The Assistant Director Nursing Workforce Development and Training is responsible for training associated with the implementation of this policy.

Nurse Managers are responsible for the operational implementation of this policy and procedure.

The Safeguarding Children Nurse Specialist Team is responsible for bringing safeguarding issues relevant to this policy to the attention of senior managers.

Registered Nurses are responsible for their safeguarding practice and must adhere to the requirements of this policy.
7.0 Legislative Compliance, Relevant Policies, Procedures and References

Other related legislation, policies, procedures and guidance include:

- DHSSPS (2003) Co-operating to Safeguard Children
- DHSSPS Reform Implementation Team UNOCINI Guidance (see Trust Intranet for most recent version)
- DHSSPS (2010) Regional Adoption Policies and Procedures
- DHSSPS (2012) Regional Guidelines for Nurses. Midwives and Specialist Community Public Health Nurses when sharing information with the Guardian Ad Litem Agency
- DHSSPS (2011) Safeguarding Children Supervision Policy for Nurses
- DHSSPS (2011) Safeguarding Children Supervision Procedure for Nurses
- HMSO (2003) The Victoria Climbie Inquiry (Lord Laming)
- NMC (2010) Guidance for Nurses on Record Keeping: (nmc.uk.org)
- NICE (July 2009) When to suspect child maltreatment
- Southern Area Child Protection Committee Guidelines for the Medical Examination of Suspected Child Abuse (Updated 2006)
- SHSCT (2013) Nursing Guidance and Standards for notification, referral and community follow-up of Children and Young People discharged from Hospital, Emergency Department, Minor Injuries and Treatment Room Settings.
- SHSCT (2008) Policy for the safeguarding, movement and transportation of Patient/Client/Staff/Trust records, files and other media between facilities (see Trust Intranet)
- SHSCT (2014), Assessment, Admission and Discharge Policy and Procedures for Children and Young People about Whom there are Safeguarding Concerns
- Royal College of Paediatrics and Child Health and The Association of Police Surgeons (April 2002) Guidance on Paediatric Forensic Examinations in Relation to Possible Child Sexual Abuse
- SHSCT (2013) Bruising In Babies not Independently Mobile Protocol
- NIPEC (2012) Safeguarding Children and Young people A Core Competency Framework for Nurses and Midwives

This is not an exclusive or exhaustive list. Registered nurses should refer to other policies and procedures as appropriate (see Trust Intranet).
8.0 Equality and Human Rights Considerations

This policy has been screened for equality implications as required by section 75, schedule 9, of the Northern Ireland Act, 1998. Equality Commission for Northern Ireland Guidance states that the purpose of screening is to identify those policies which are likely to have a significant impact on equality of opportunity so that greatest resources can be targeted at them.

Using the Equality Commission screening criteria, no significant equality implications have been identified. This policy will therefore not be subject to an equality impact assessment.

This policy has been considered under the terms of the Human Rights Act, 1998, and was deemed to be compatible with the European Convention Rights contained in that Act.

This policy will be included the Trust’s register of screening documentation and maintained for inspection whilst it remains in force.

This policy can be made available on request in alternative formats, e.g. Braille, disc, audio cassette and in other languages to meet the needs of those who are not fluent in English.

9.0 Copyright

The supply of information under the Freedom of Information does not give the recipient or organisation that receives it the automatic right to re-use it in any way that would infringe copyright. This includes, for example, making multiple copies, publishing and issuing copies to the public. Permission to re-use the information must be obtained in advance from the Trust.

10.0 Alternative Formats

This document can be made available on request in alternative formats e.g. Braille, disc, audio cassette and in other languages to meet the needs of those who are not fluent in English.

11.0 Sources of Advice and Further Information regarding this policy

Registered nurses should contact a member of the Safeguarding Children Nurse Specialist Team for advice and further information regarding the implementation of this policy as follows:

Armagh and Dungannon Locality
St Luke’s Hospital, phone number 02837412082

Craigavon and Banbridge Locality
Brownlow Health Centre, phone number 02838341431

Newry and Mourne Locality
Dromalane House, phone number 02830825077
Procedures
for Registered Nurses, Midwives and
Specialist Community Public Health Nurses
to assist in complying with Southern Trust Policy
on
Safeguarding Children and Young People
1.0 STANDARD ONE: Confidentiality and Information Sharing

Confidential information is defined by DHSSPS (2009) as ‘...sensitive information given in a context where the giver understood it would not be shared with others’. There is a common law duty on practitioners not to pass on such information to others. However, this is not an absolute duty. Information can be shared if there is an overriding public interest in disclosure, a Court Order requires the information to be shared, or, informed consent has been given to share the information.

Patients and clients have a right to know the standards of confidentiality maintained by those providing their care and these standards should be made explicit by health professionals at the first point of contact.


‘The child’s welfare must always be paramount and this overrides all other considerations. A proper balance must be struck between protecting children and respecting the rights and needs of parents and families; but where there is a conflict the child’s interests are paramount’ (DHSSPS 2003, Cooperating to Safeguard Children).

The NMC requires nurses to:
- Respect people’s right to confidentiality;
- Ensure that people are informed about how and why information is shared by those providing their care; and
- Disclose information if they believe that someone may be at risk of harm, in line with the law of the country.

Criteria for Standard One:

Registered nurses and midwives must:
- Make reasonable efforts to seek consent from clients to disclose information (it is not essential to acquire consent if a child is thought to be at risk or potentially at risk of significant harm but it is preferable to do so, unless this might place the child or nurse at risk of harm);
- Advise clients about disclosure of information as soon as possible (the timing of this should be determined by the safeguarding needs of the child);
- Share all relevant information with the investigating social worker;
- Speak directly with social workers to ensure that information is understood, the level of concern is explicit and discrepancies clarified;
- Discuss requests to view records with a line manager including requests from clients, solicitors or guardian ad litem (GAL); and

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5 The Code – Standards of conduct, performance and ethics for nurses and midwives, Nursing and Midwifery Council, April 2007
• Adhere to Regional Guidelines for Nurses, Midwives and Specialist Community Public Health Nurses when sharing information with the Guardian Ad Litem Agency

2.0 STANDARD TWO: Recognition and Referral of Child Care Concerns to Social Services

Registered nurses must be able to recognise indicators of child abuse and neglect, (see Appendix 1), and refer to social services using regional and Trust policy and procedures, if concerned that a child may have suffered, or is likely to suffer significant harm or is in need.

Criteria for Standard Two:

Recognition of child care concerns
Registered nurses and midwives must:
• Become familiar with regional and Trust child protection policies, procedures and guidance during their induction programme;
• Attend and participate in safeguarding awareness training within three months of appointment;
• Attend training programmes that are reflective of their safeguarding role and responsibilities with children and families, see Appendix 2; and
• Maintain a record of attendance at safeguarding training.

Referrals to Social Services:
Registered nurses and midwives must:
• Ensure that children deemed to be in need of protection are immediately discussed with the SCNS or line manager. This should not delay an urgent verbal referral to the Central Gateway Team, Out of Hours Service or hospital social worker;
• Seek consent for child protection referral to social services from a parent (with parental responsibility) and or young person if deemed sufficiently competent unless this might place the child/young person or staff member at risk of harm; In such circumstances consent will not be required. Reason for no consent should be clearly recorded on UNOCINI referral form
• Always gain consent for any Child in Need/Family Support referral
• Follow up all referrals in writing within one working day using UNOCINI documentation, standards and referral policy, and include a copy of body maps if there are suspicious physical injuries, see Appendix 3;
• Contact social services if they become aware that information or professional opinion provided by them has been misinterpreted so that misunderstandings can be promptly rectified and follow up corrections in writing and forward them within one working day;
• Forward a copy of all safeguarding referrals to the SCNS and team manager for audit and monitoring purposes at the time of referral;
• File a copy of UNOCINI referral in the child / family notes;
• Record referral on the ‘Chronology of Significant Events’ form if this is used within the nursing team;
• Record all discussions regarding referrals in the child’s notes; and
• Record outcome of referrals to social services in the child / family notes.

In addition, registered nurses working in the community must inform the child’s GPs if a UNOCINI referral is made.
3.0 STANDARD THREE: The Role and Responsibilities of Registered Nurses during the Examination of Children when Abuse and Neglect is Suspected

‘The health needs of the child are paramount in approaching any medical examination whatever the alleged circumstances leading to the need to gather forensic evidence. A comprehensive assessment considering the physical development and emotional well being of the child or young person against the background of any relevant medical, family or social history must be undertaken’. This enables a full evaluation of the degree of significant harm suffered or likely to be suffered’ ¹

Whilst medical examination is the responsibility of the doctor, registered nurses have a duty of care to the child / young person and must always act in their best interests. It is important to minimize any further emotional trauma. Nurse managers must ensure that guidance is available to all registered nurses who are present during the medical examination of children when abuse or neglect is suspected, see Appendix 4.

Criteria for Standard Three:

Registered nurses and midwives must ensure that:

- The rights of the child / young person are given serious consideration and that the child / young person is afforded support, confidentiality, privacy, dignity and respect;
- Relevant information and risk factors known to registered nurses are shared with the social worker and brought to the attention of the consultant paediatrician in charge;
- Nursing concerns in relation to the examination and its outcomes including any differences with the medical opinion, are brought to the attention of the consultant paediatrician and social worker immediately, and if not resolved brought to the attention of the Head of Service and SCNS; and
- The safeguarding children nurse specialist is informed of the child’s attendance for examination as soon as possible, and before the end of the nurse’s shift. This can be done by telephoning the SCNS office, mobile phone or email.

¹ The Royal College of Paediatrics and Child Health and the Association of Police Surgeons (2002) Guidance on Paediatric Forensic Examinations in Relation to Possible Child Sexual Abuse
STANDARD FOUR: Registered Nurses Contact with the Safeguarding Children Nurse Specialist

Safeguarding Children Nurse Specialists (SCNS) operate an ‘open door’ policy so that registered nurses, regardless of their role, responsibilities or level of seniority, can speak directly with a SCNS. SCNSs provide advice, support and supervision in keeping with regional and Trust policy. The minimum level of safeguarding nursing supervision for key nursing groups is outlined in Appendix 5. SCNSs work in partnership with team managers to ensure that practice including competency issues and training needs are addressed.

Nurse Managers must ensure that SCNS contact details are available at all nursing stations and facilities.

Criteria for Standard Four:

Registered nurses and midwives must contact the SCNS to:

- Seek advice if required regarding any child protection concerns as soon as possible after becoming aware of such concerns;
- Discuss concerns about a child’s welfare, safety or the ability of parents/carers to meet the needs of a child/children;
- Inform the SCNS of deviations from agreed child protection care plans;
- Inform the SCNS about unresolved disagreements about decisions regarding referrals or child protection thresholds;
- Discuss concerns about an unseen child where there are safeguarding concerns (usually following two planned contacts);
- Make arrangements for supervision appointments as required, see Appendix 4;
- Inform the SCNS if they have not received a SCNS record of contact within 72 hours of contact;
- Inform the SCNS that a nursing report for Court regarding safeguarding children has been requested. Court reports must not be provided / forwarded without receipt of a formal request from the Trust Legal Department or Barrister at Law; and
- Arrange support when providing evidence to a Guardian ad Litem or Court

5.0 STANDARD FIVE: Health Visiting/ Family Nurse and School Nursing Safeguarding case allocation

- Health visitors and family nurses will hold case responsibility for pre-school children whose names are on the child protection register. School nurses will primarily hold case responsibility for school aged children whose names are on the child protection register where there are identified health needs however Health visitors will maintain case responsibility for any family where there is a pre-school child

Criteria for Standard 5:

- Nurse Managers must allocate safeguarding cases taking into consideration practitioners current workload and caseload weighting
- Nurse managers can seek support and advice from SCNS when allocating cases
• School nurse and health visiting managers should liaise and agree case allocation in situations when school nursing cannot take the lead role in safeguarding cases due to capacity issues
• In situations where there is increased demand and reduced capacity within the team the nurse manager must escalate allocation difficulties with the Head of Service and Named Nurse for Safeguarding Children

6.0 STANDARD SIX: Child Protection Case Conferences and other Multi-Agency Safeguarding Meetings

Registered nurses and midwives are required to participate at Child Protection Case Conferences and other multi-disciplinary safeguarding meetings, including case planning and Looked After Children reviews, when they are or have provided a service to the child or family. This is to ensure that children are safeguarded through effective multi-disciplinary and inter-agency risk analysis and care plans. The SCNS service is available to support nurses involved in case conference and other safeguarding meetings as required.

Criteria for Standard Six:

Registered nurses must and midwives:

• Attend any safeguarding children meeting when they are or have provided a service to the child or family in order to share relevant information, if in exceptional circumstances a nurse/midwife is unable to attend, discuss the submission of their report with their line manager and SCNS;
• Present written reports summarizing the details of their involvement and relevant information and analysis using the UNOCINI framework, see UNOCINI guidance on Trust Intranet and Sample UNOCINI referral Sample Report Writing Template for Nurses Midwives and SCPHN (see Trust Intranet)
• Encourage the participation of children, young people and parents in the child protection process;
• Request a confidential slot if the nurse/midwife feels that it is not appropriate to share all information with family members attending the meeting;
• Contribute to risk analysis and decision making regarding child protection registration and recommendations at case conferences;
• Ask for dissenting views to be recorded in the notes of the meeting;
• Read the notes of the meeting and inform the case conference chairperson of any inaccuracies within 7 working days of receipt;
• Attend and inform the core group of the nursing/midwifery care plan if it has been agreed that the nurse/midwife will be a core group member;
• Contact the SCNS regarding any deviation from the agreed child protection or nursing care plan;
• Be alert to indications that the child protection plan may be failing to protect the child (see par. 6.97 RCPC policy and procedures) and immediately inform the case coordinator and SCNS of concerns.
Following case conference registered nurses and midwives must:

- Continue to support the child and family following deregistration as per care plan;
- Ensure that information, recommendations and plans have been translated into appropriate nursing/midwifery care plans, analysis and documentation;
- Read notes or minutes of meetings on receipt, check for factual accuracy and forward any amendments to the Chairperson within 7 working days;
- Retain a copy of all nursing/midwifery reports within records; and
- Retain most recent minutes of safeguarding meetings in the child / family file.

The SCNS or those acting on behalf of the SCNS at case conference will provide advice and support to registered nurses participating at case conferences as required. They will:

- Provide specialist views regarding risk, the need for registration and the decision of case conference regarding registration, and
- Liaise with team managers regarding nursing or other issues arising from the case conference.

7.0 STANDARD Seven: Nursing/Midwifery Reports for Case Conference and other Safeguarding Meetings

Nursing/Midwifery reports must be relevant and reliable. They must provide an accurate and comprehensive account of assessment, planning, interventions, provision of services, outcomes and analysis of assessment, as well as any future plan of intervention for the parents/careers and each individual child. Nurses and midwives should be mindful that the written report may be used in subsequent court hearings.

Criteria for Standard Seven:

Registered Nurses and Midwives must:

- Use UNOCINI framework and guidance (see Trust intranet);
- Use Sample UNOCINI referral Sample Report Writing Template for Nurses Midwives and SCPHN (see Trust Intranet);
- Maintain a child-focused approach;
- Present objective and measurable evidence;
- Distinguish between factual information and substantiated professional opinion;
- Agree date for submission of nursing report with the social worker so that nursing information and assessment can be included in the multi-disciplinary Pathway Assessment. Health visitors should attach a copy of centile chart if there are concerns regarding growth measurements;
- Explain professional terminology and avoid abbreviations;
- Include information regarding no access to planned and unplanned visits, non attendance for appointments and reasons if provided;
- Seek advice from a team manager or SCNS at least 3 weeks before review case conferences if uncertain regarding the contents or format;
- Forward nursing/midwifery reports or contribution to pathway assessments to SCNS for proof reading before sending to the social worker if required; at least 2 weeks in advance of review case conference.
- Forward contribution to pathway assessments to family social worker at last 10 days in advance of review case conference to enable final report to be complied.
- Ensure that the multi-disciplinary Pathway Assessment has been read, the information and views provided by the nurse are accurately reflected, and, the overall content and analysis agreed by the nurse and social worker and countersigned;
- In circumstances where a nurse is providing a stand alone report ie Initial Case Conference – It is the responsibility of the nurse to forward report to Independent Chair at least 48 hours in advance of the meeting.
- Share and explain the contents of nursing reports with parents, and young people in an age appropriate manner, prior to the meeting;
- Discuss requests for copies of nursing reports with a team manager or SCNS with each page of reports provided to parents stamped ‘Parent’s Copy’.
Guidance
for Registered Nurses, Midwives and
Specialist Community Public Health Nurses
to assist in complying with Southern Trust Policy
on
Safeguarding Children and Young People
Appendix 1

When to suspect child maltreatment (NICE Clinical Guideline, 2009) Issued: July 2009 last modified: March 2013

The following are possible symptoms and signs of child abuse. Usually one single feature is not diagnostic of abuse - more important is the overall pattern or combination of features.

PATTERNS OF INJURY OR ILLNESS

Injuries which are multiple, frequent, or of different ages.

- Injury is not consistent with history stated or the developmental age of child. For example, **bruising** in a baby, fractures in infants, injury too severe for the cause described
- Repeated apparent life-threatening events, if witnessed by only one carer and no medical explanation
- Infant with bleeding from nose or mouth after apparent life-threatening event, with no clear explanation
- Ingestion of toxic substance or drug overdose - may be deliberate or may suggest inadequate supervision
- Hypernatraemia without clear medical cause - may be salt poisoning
- Near-drowning, unexplained or suggesting lack of supervision
- Consider fabricated illness where reported symptoms or response to treatment do not seem plausible, or where symptoms are only ever observed by the carer.

BEHAVIOUR

Carers’ behaviour

- Delayed presentation, reluctance to seek help, fear of medical examination
- Bring child to different surgeries/departments (to avoid detection of repeated injuries)
- Unexplained denial or aggression
- No explanation for the injuries, a story that changes on repetition, or child’s story differs from carer’s
- Carers prevent health professional speaking to the child alone
- Carers show hostility or excess punishment to the child, have unrealistic expectations, or are unresponsive to the child (‘emotionally unavailable’)
- Child is excessively meeting carer’s needs (emotional or practical).

Child’s behaviour

- Unexplained **depression**, anxiety, fearfulness, aggression or withdrawal, **self-harm** behaviours, running away from home
- Marked change in behaviour or emotional state, not explained by known stressful event. Includes dissociation (episodes of ‘detachment’ outside the child’s control)
- Emotional problems not consistent with age or known disorder, e.g. excessive tantrums, recurrent nightmares
- Seems afraid of particular adults, or reluctant to be alone with them
- Unusual reluctance to undress, fear of physical contact, or extreme passivity during medical assessment
- Frozen watchfulness: the child looks watchful yet unresponsive, carefully tracking the adults with his eyes (as if awaiting the next blow). **This sign indicates a severe level of abuse**
- Abnormal interaction with carers, e.g. over-obedient, too eager to please
- Low self-esteem, excessive clinginess, indiscriminately affection-seeking towards strangers
• Does not seek comfort from carers when distressed
• Role reversal - child controlling carers, very young children excessively comforting distressed carer
• Secondary enuresis, encopresis (defaecation in inappropriate place), deliberate wetting
• Habitual body-rocking
• Unexplained absences from school.

PHYSICAL ABUSE - symptoms and signs

Bruising

- Bruising in the shape of a hand, ligature, stick, teeth mark, grip, fingertips or an implement
- Petechiae (tiny red or purple spots) not caused by a medical condition - may be due to shaking or suffocation
- Bruises at sites where accidental bruising is unusual: face, eyes, ears (bruising around the pinna may be subtle), neck and top of shoulder, anterior chest, abdomen
- Multiple or symmetrical bruises; bruises similar in shape and size.

Note: accidental bruises tend to be on bony prominences. Toddlers commonly have accidental bruises on shins, upper leg and forehead. The age of a bruise cannot be exactly determined from its colour, but bruises show a progression of colour change over time (red/purple/blue initially, followed by green/yellow/brown).

Thermal injuries (burns and cold injury)

• Burns
  - Showing the shape of an implement, e.g. cigarette, iron.
  - On areas unlikely to be accidentally burned, e.g. backs of hands, soles of feet, buttocks, back.[/i]

• Scalds
  - Deliberate scalds tend to have clear demarcation and a symmetrical pattern. (This contrasts with accidental scalds where the child will quickly try to withdraw and the burn pattern will probably be irregular.)
  - Suspicious patterns are a glove or sock pattern, or a 'doughnut' pattern (where child's buttocks are pressed against the hot water container, so the central area is spared).

• Unexplained cold injury
  - Hypothermia
  - Cold injuries (for example, swollen, red hands or feet)

Other surface marks

• Human bite marks (if unlikely to be from young child)
• Lash marks
• Red lines around neck, wrist or ankles, from tying up
• Oral injury, including torn frenulum of the upper lip
• Lacerations, abrasions or scars in sites where accidental injuries are unusual (as for Bruising, above).
Fractures

- Any fracture in a baby too young to walk or crawl
- Multiple fractures in different stages of healing
- Rib fractures, especially if in a young child or posterior fractures. There may be subdural haemorrhage due to the infant being squeezed and shaken
- Sternal fracture
- Long bones:
  - Metaphyseal or spiral fractures.
  - Subperiosteal haemorrhage (occurs with pulling/grabbing, may not be visible on X-ray until 14 days later).

- Spinal injuries without confirmed major accidental trauma
- Skull fractures - see below under Head and eye injuries.

Head and eye injuries

May occur from a blow to the head or from shaking.

- Intracranial injury with no major confirmed accidental trauma or medical cause, especially if child aged <3 years, there are other injuries, retinal haemorrhages, rib or long bone fractures, or with multiple subdural haemorrhages
- Retinal haemorrhages or eye injury without major confirmed accidental trauma or medical explanation
- Accidental skull fractures are rare in children <5 years, even after a fall of 90 cm. A history of a fall from a bed or sofa should be questioned.

Internal injuries

- Intra-abdominal or intrathoracic injury without confirmed major accidental trauma.

Emotional abuse - symptoms and signs

- Delayed development (physical, mental or emotional; speech disorders)
- Low self-esteem, self-blame, over-reaction to mistakes
- Carers repeatedly humiliate the child
- Behavioural symptoms (as above).

Sexual abuse - symptoms and signs

Note:

- Examination of the genitalia should only be performed by an expert (see Initial management section)
- Sexual activity with a child aged <13 years, by law is sexual abuse; the child's 'consent' is irrelevant at this age
• For a child >13 who has had sex, consider whether the relationship with their partner is consensual and equal. For example, is the partner of similar age and maturity to the child?
• Be concerned if the partner is not a peer, if there is an imbalance of power, imbalance of mental capacity, or the partner is in a position of trust

Possible symptoms and signs are:

• Sexual behaviour or knowledge inappropriate to age; sexually explicit play.
• Unexplained fear of known adult, e.g. relative or babysitter.
• Emotional or behavioural changes, e.g. depression, self-harm, low self-esteem, running away from home, eating disorders, insecurity, 'ultra-good' behaviour.
• Secondary enuresis, encopresis or fecal soiling.
• Pregnancy in girl <13; unexplained pregnancy; where the partner is not a peer.
• Genital symptoms and signs:
  - Dysuria, soreness, itching, bleeding or discharge from genitals or anus, which is recurrent or persistent (and not explained by medical condition, e.g. UTI, worms, skin condition).
  - Unexplained genital or anal symptom that is associated with behavioural or emotional change.
  - Gaping anus observed during an examination (without a medical explanation, e.g. neurological disorder or severe constipation).
  - Anal fissure - if constipation, Crohn's disease and passing hard stools have been excluded as the cause.
  - Genital, anal or perianal injury without suitable explanation.
  - Foreign body in the vagina or anus (may present as offensive vaginal discharge).
  - Sexually transmitted infection (including genital warts, hepatitis B) without clear evidence of vertical transmission, or without a consensual sexual relationship in a child >13.

NEGLECT - symptoms and signs

• Malnutrition or failure to thrive - measure height, weight and use growth charts.
• Excessive crying, tiredness, hunger or scavenging.
• Poor hygiene and clothing; severe and persistent infestations e.g. scabies or headlice.
• Developmental delay - may be due to lack of stimulation, e.g. being kept in a cot or pram much of the time.
• Child often left alone or left in unsafe situations - accidental injuries may indicate lack of appropriate supervision.
• Frequent school absence.
• Untreated medical problems, including untreated dental decay (where NHS treatment available).
• Persistent failure to attend important child health programmes or follow-up appointments.
• No social relationships.
• Emotional or behavioural symptoms (see under Behaviour, above).
• Often show catch-up growth and improved emotional response in a new environment.
## Appendix 2 Safeguarding Competencies and Minimum Training for Registered Nurses as per NIPEC Competency Framework (2012)

<table>
<thead>
<tr>
<th>Level</th>
<th>Nursing Group</th>
<th>Competence</th>
<th>Minimum Training/Learning Activity</th>
</tr>
</thead>
</table>
| 1     | All Registered Nurses | • Establishes effective relationships with clients / patients and their families;  
• Recognises child abuse and neglect; and understands the factors that can affect parent and increase the risk of abuse eg Domestic violence, poor mental health  
• Reports concerns and avails of SCNS advice;  
• Understands own role and responsibilities and that of the multi-agency team.  
• Understands importance of keeping accurate and complete records | • Basic safeguarding information at induction to post  
• 3 yearly Safeguarding Children awareness training - including definitions and examples of child abuse and neglect, nursing policy, UNOCINI framework, role of SCNS and governance structures |
| 2     | Registered Nurses working predominantly with children, young people and/or their parents/carers who could potentially contribute to assessing, planning, intervening and evaluating the needs of child/young person and parent capacity where there are safeguarding issues | As for Level 1, plus  
• Recognises the potential impact of a parent’s/carer’s physical and mental health and environmental factors (including domestic violence) on the wellbeing of a child or young person;  
• Understands professional roles of key agencies;  
• Uses UNOCINI framework for referral and assessment; Contributes health and nursing perspective to interagency safeguarding assessments and risk analysis;  
• Documents nursing assessment and analysis using UNOCINI Pathway Assessment format;  
• Ensures that health issues are discussed at core groups and appropriately included in safeguarding plans;  
• Contributes to practice improvement initiatives including the application of learning from research, audit and case reviews. | As for Level 1, plus  
• At least 1 Level 2 training opportunity relevant to role and responsibilities 3 yearly Plus at least one personal learning activity (PLA) per year relating to safeguarding children |
| 3     | Specialist nurses for child protection and looked after children, named nurses and Designated nurses Senior Nurses who have a lead role in Safeguarding Children | As for Level 2, plus  
• Provides safeguarding supervision to practitioners;  
• Develops safeguarding policy, procedures and guidelines;  
• Communicates safeguarding knowledge, research and audit findings;  
• Conducts training needs analysis, facilitates training;  
• Contributes to case reviews;  
• Provides specialist advice regarding policies, legal issues and case management;  
• Chairs safeguarding sub-groups;  
• Contributes to safeguarding governance processes. | As for Level 2, plus three personal learning and development activities per year - including non-clinical knowledge acquisition such as management appraisal and supervision training  
SCNSs should also have:  
• an educational module relating to child care and law  
• a recognised safeguarding supervision course as soon as possible after appointment  
• Advance or enhanced court room skills training  
Named nurses should complete  
• a management programme with a focus on leadership and change management within three years of taking up their post. |
Appendix 3

BODY MAP FOR CHILD PROTECTION ISSUES (5-19 years)

When you notice an injury to a child try to record the following information in respect of each mark:

- Exact site of injury on the body, e.g. upper outer arm/leg/cheek
- Size of injury - in appropriate centimetres or inches
- Approximate shape of injury, e.g. round/square or straight line
- Colour of injury - if more than one colour, say so
- Is the skin broken?
- Is there any swelling at the site of the injury, or elsewhere?
- Is there a scab? Any blistering? Any bleeding?
- Is the injury clear? Or is there grime/fruit etc?
- Is mobility restricted as a result of the injury?
- Does the site of the injury feel hot?
- Does the child feel hot?
- Does the child feel pain?

Body Map: Child

<table>
<thead>
<tr>
<th>Child/Young person's name</th>
<th>Date of birth</th>
<th>Date marks observed</th>
<th>Name of person completing this map</th>
</tr>
</thead>
</table>

Signed: ____________________

Designation: ____________________

Other: ____________________

Counter Signature: ____________________

Phone number: ____________________
When you notice an injury to a child, try to record the following information in respect of each mark:

- Does the child feel pain?
- Does the child feel hot?
- Is the site of the injury red?
- Is the injury cleaned or is there any dirt/stick?
- Is there any swelling at the site of the injury or elevated?
- Is there any bleeding?
- Is the skin broken?
- Colour of injury - if more than one colour, say so
- Exact site of injury on the body: e.g. upper arm, shin, back, etc.
- Approximate size of injury: e.g. round/square or
- approximate shape of injury: e.g. "hand-size"
- Number/number of injuries
**Body Map: Baby/Toddler**

When you notice an injury to a child, try to record the following information in respect of each mark:

- Exact site of injury on the body, e.g. upper outer arm/left cheek
- Size of injury - in appropriate centimetres or inches
- Approximate shape of injury, e.g. round/square or straight line
- Colour of injury - if more than one colour, say so
- Is the skin broken?
- Is there any swelling at the site of the injury, or elsewhere?
- Is there a scab? / any blistering? / any bleeding?
- Is the injury clean? or is there grit/fluff etc?
- Is mobility restricted as a result of the injury?
- Does the site of the injury feel hot?
- Does the child feel hot?
- Does the child feel pain?

Child/Young person's name ____________________________

Date of birth ____________________________

Date marks observed ____________________________

Name of person completing this map ____________________________

Designation ____________________________

Base ________________

Signed ________________

Phone number ____________________________

Counter Signature: ____________________________
Body Map: Baby/Toddler

When you notice an injury to a child, try to record the following information in respect of each mark:

- Exact site of injury on the body, e.g. upper outer arm/left cheek
- Size of injury - in appropriate centimetres or inches
- Approximate shape of injury, e.g. round/square or straight line
- Colour of injury - if more than one colour, say so
- Is the skin broken?
- Is there any swelling at the site of the injury, or elsewhere?
- Is there a scab? / any blistering? / any bleeding?
- Is the injury clean? or is there grit/fluff etc?
- Is mobility restricted as a result of the injury?
- Does the site of the injury feel hot?
- Does the child feel hot?
- Does the child feel pain?

Child/Young person’s name ____________________________

Date of birth ____________________________

Date marks observed ____________________________

Name of person completing this map ____________________________

Designation ____________________________

Base ____________________________

Signed ____________________________

Phone number ____________________________
Appendix 4

**Southern Trust Guidance on the Role and Responsibilities of Registered Nurses during Medical Examination of Children and Young People When Child Abuse and Neglect is Suspected**

Senior nurses¹ are well placed to contribute to the assessment of children who are suspected to be at risk of child abuse. Nurses must use their knowledge and expertise to support medical and other colleagues in a manner that enhances best outcomes for children and young people. This guidance describes the role and responsibility of nurses during medical examinations of children and young people when child abuse is suspected. Examinations usually take place in paediatric wards but may be carried out in community facilities.

For the purpose of this guidance, child abuse refers to the clinical conditions associated with non-organic failure to thrive, physical abuse, neglect, emotional maltreatment and sexual abuse as defined in SACPC Guidelines for the Medical Examination of Suspected Child Abuse, Feb 2006. The purpose of the medical examination is to:

1. Ensure appropriate necessary treatment;
2. Ensure that there are no other injuries which may not be immediately apparent;
3. Provide expert opinion on the nature of the injuries, their likely cause and the plausibility of any explanation given;
4. Secure forensic evidence; and
5. Ensure collaborative working and that children are not subjected to repeated medicals for evidential purposes.

¹ For the purpose of this guidance, senior nurses are considered to be nurses, midwives or health visitors who have been registered with the NMC for more than three years

### 1.0 NOTIFICATION that a child is to attend for child protection examination

The Nurse in Charge / Team Manager will:

1. Ensure that the child/young person’s attendance is managed in a sensitive, discreet and confidential manner that reflects principles outlined in the United Nations Convention of the Rights of the Child;
2. Record the child/young person’s name, date of birth and reason for attendance in the ward / team diary and nursing documentation;
3. Allocate a senior nurse of 3 or more years post registration experience who has undertaken training in safeguarding children and is aware of the nurse’s role and responsibilities during the examination of children when child abuse or neglect is suspected;
4. Identify a suitable room;
5. Inform the Safeguarding Children Nurse Specialist (SCNS) of the child’s attendance; and
6. Request previous records (or a new PAS number, chart and addressographs if examination in hospital setting).
2.0 PREPARATION for the child / young person's arrival / examination

The senior nurse will:

1. Prepare all the necessary documentation. These should include the child's name, DOB, address, primary carer and GP. If the examination is to take place in the hospital, the following should be available:
   a. Ambulatory/Ward Attender form
   b. Body chart
   c. Medicines Kardex
   d. Growth chart
   e. PEWS chart (if required)

2. Prepare the room
   a. Ensure that the room has adequate lighting;
   b. Ensure all equipment required is readily available including oxygen and suction if sedation is to be used; and
   c. Ensure that specimen equipment and forms are available if required e.g. swabs, sterile gloves.

3. Share any previous safeguarding concerns known to the nurse with the paediatrician and social worker - if the examination is to be held in the hospital.

4. Participate in any multidisciplinary discussions prior to the child's examination and record agreed actions and by whom, in the child's records.

5. Ensure that an interpreter is available if required

6. Commence a child specific care plan.
3.0 On the child / young person’s ARRIVAL at the ward / facility

The senior nurse will:

1. Meet and welcome the child / young person, parents and professionals and show to the allocated waiting area or room;
2. Ensure that consent has been sought (from a person with parental responsibility and from young person if sufficient understanding);
3. Ensure that an age appropriate explanation has been provided regarding all nursing interventions and that consent is obtained for these (the child’s / young person’s level of understanding must be documented);
4. If the parents are asked to leave whilst the examination takes place, ensure that they are shown to an appropriate waiting area, for example, the parent’s room or coffee shop / canteen, advised when to return and given the contact phone number for the ward (contact phone numbers should be obtained in case their presence is needed by the child or professionals);
5. Record the date and time of the child’s arrival to the ward;
6. If the examination takes place in the hospital, record clinical observations including:
   a. height and weight and plot on the growth chart
   b. Obtain urine sample for urinalysis (if deemed appropriate, in consultation with the paediatrician)
   c. baseline observations on the PEWS chart if sedation is to be used
   d. age appropriate assessment and record; and
7. If appropriate administer sedation as prescribed as per Trust policy

4.0 DURING THE EXAMINATION

It is the doctor’s role to examine the child / young person and to record the findings.

The senior nurse will:

- Act as a chaperone during the examination – ensure privacy, protect modesty, distract and support the child, and, assist if required;
- Raise any concerns regarding nursing observations, the examination or outcomes immediately and discreetly with the doctor and PSNI responsible for carrying out the examination and agree appropriate actions; and
- Make nursing records of their involvement in any discussions regarding injuries, child’s behaviour or other matters deemed relevant to the care of the child and decision making.
5.0 AFTER the examination

The senior nurse will:

1. Provide support and care for the child / young person post examination;
2. Provide support and any relevant information to parents or carers (the outcomes of the examination will be provided to parents by the doctor or social worker as deemed to be appropriate in the circumstances);
3. Record observations post examination as deemed necessary in consultation with the paediatrician;
4. Record the contact details of those present during the examination
   i. names of social workers present on ward
   ii. name of PSNI Officer responsible
   iii. names of those present during the examination;
5. Bring any nursing concerns regarding the child’s safety and welfare following discharge to the attention of the consultant, social worker and safeguarding children nurse specialist immediately and make a record of all discussions and decisions made;
6. Ensure safe and appropriate arrangements are in place for discharge following multi-disciplinary safeguarding children meeting as per Admission and Discharge Policy
7. Ensure the child / young person’s attendance is recorded in the Daily State Book or Team Diary
8. Record the date and time of the child’s discharge from the ward or community facility and who accompanied the child;
9. Liaise with health visitor /school nurse manager by telephone and follow up in writing using the Acute Community Referral Form (C&YP aged 0 – 18 years); and
10. Update the safeguarding children nurse specialist regarding outcome of assessment and discharge arrangements.
Nursing Record following Medical Examination of Child or Young Person when Child Abuse or Neglect is Suspected

Name of Child: 

DOB: 

Address: 

Present: 
- Paediatrician 
- Social Worker 
- PSNI 

Parent (if not state reason): 
- Interpreter 
- Other 

Venue: DDH / CAH / Other (please specify) 

Reason for Attendance: 

Consent Obtained (if not state reason): 
- Parent Yes/No 
- Young Person Yes/No 

Clinical Observations (as required) 
- Height 
- Weight 
- Urinalysis 

Nursing Information and Comments 

Senior Nurse’s Signature 

Date 

Time 

Please file this record in the child’s file.
## Appendix 5

### Minimum Levels of Safeguarding Children Nursing Supervision

<table>
<thead>
<tr>
<th>Nursing Group</th>
<th>Individual</th>
<th>Group</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>All registered nurses</td>
<td>As requested by the nurse</td>
<td>As requested by a team manager</td>
<td></td>
</tr>
<tr>
<td>Health Visitors, School Nurses</td>
<td>4 monthly by CPNS</td>
<td>Yearly</td>
<td>Required for those school nurses taking a lead nursing role in safeguarding cases</td>
</tr>
<tr>
<td>Midwives, Band 5 school nurses, Community Children’s Nurses, Learning Disability Nurses (including those providing autism and ADHD services), CAMHS and Community Psychiatric Nurses (CPN), Advanced &amp; Specialist Nurses in Neonatal &amp; Paediatric Services</td>
<td>To be arranged with CPNS as and when the nurse is involved in a child protection case. Managers to provide safeguarding children supervision at managerial supervision sessions.</td>
<td>6 monthly by CPNS</td>
<td></td>
</tr>
<tr>
<td>Nursing Team Managers responsible for services to children and families including adult mental health</td>
<td>6 monthly by Named Nurse</td>
<td>Individual safeguarding supervision by a SCNS is available on request of the manager.</td>
<td></td>
</tr>
<tr>
<td>Specialist Nurses for Child Protection and LAC</td>
<td>Monthly by Named Nurse for Safeguarding Children</td>
<td>4 monthly by Named Nurse</td>
<td></td>
</tr>
<tr>
<td>Named Nurses for Child Protection</td>
<td>2 monthly peer</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Minimum levels of safeguarding training are in addition to professional supervision as per the CNO Nursing Supervision Standards and the Southern Trust Nursing Supervision Policy and Procedures (June 2008)