NHS
Liverpool Women's
NHS Foundation Trust

Safeguarding Children

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The Trust is committed to a duty of candour by ensuring that all interactions with patients, relatives, carers, the general public, commissioners, governors, staff and regulators are honest, open, transparent and appropriate and conducted in a timely manner. These interactions be they verbal, written or electronic will be conducted in line with the NPSA, 'Being Open' alert, (NPSA/2009/PSA003 available at www.nrls.npsa.nhs.uk/beingopen and other relevant regulatory standards and prevailing legislation and NHS constitution)

It is essential in communications with patients that when mistakes are made and/or patients have a poor experience that this is explained in a plain language manner making a clear apology for any harm or distress caused.

The Trust will monitor compliance with the principles of both the duty of candour and being open NPSA alert through analysis of claims, complaints and serious untoward incidents recorded within the Ulysses Risk Management System.

Content

1 Executive Summary

1.1 Policy Scope

i. This policy applies to all staff employed directly or indirectly by Liverpool Women's NHS Foundation Trust, including students, volunteers and those employed on temporary contracts, secondments, or other flexible working arrangements.

ii. This policy is also available to independent contractors and should be implemented by them as good practice.

iii. This policy relates to all children and young people under the age of 18 years.

2 Introduction

i. This policy has been developed to ensure that staff working for Liverpool Women's Trust will meet the fundamental requirements for effective safeguarding in the delivery of NHS care, ensuring that staff:

- Clearly understand the trusts expectation and their role and responsibilities for keeping children safe from harm. Principally, to Recognise, Respond, Report, Record and Refer (5 R's).

- Promote good practice and work in a way that prevents harm, abuse and coercion occurring through the provision of high-quality care with dignity as a core requisite

- Ensure that any allegations of abuse or suspicions are identified and responded to appropriately, the person experiencing abuse is supported and to prevent further abuse occurring.

- Ensure that all concerns are escalated if not dealt with appropriately.

ii. All staff who have contact with children and young people whether they be employed, volunteers or contractors/agency staff of the Trust have a responsibility to safeguard and promote their welfare and should know what to do if they have concerns about safeguarding issues, including child protection.

iii. Section 11 of the Children Act 2004 places a legal duty on all health organisations to ensure that in discharging their functions, they have regard to the need to safeguard and promote the welfare of children.

3 Policy Objectives

i. For services provided by Liverpool Women's NHS Foundation Trust to ensure that the safety and welfare of the child are paramount and that the best interests of the child should always be the focus of the service.

ii. Liverpool Women's NHS Foundation Trust aims to ensure that no act or omission on the part of the organisation, or that of its staff, puts a child or young person at risk; and rigorous systems are in place to proactively safeguard and promote the welfare of children and support staff in fulfilling their obligations.

iii. This Policy enables staff to:

- Promote good practice and work in a way that can prevent harm, abuse, exploitation and coercion occurring.
- To ensure that any suspicions or allegations of harm, abuse, exploitation and coercion are dealt with appropriately
- And to stop the alleged or actual harm, abuse, exploitation and neglect occurring.

4 Duties / Responsibilities

4.1 The Chief Executive Officer

i. The Chief Executive Officer (CEO) is responsible for ensuring that the health needs of all children and young people are at the forefront of local planning and that high quality health services that meet the identified quality standards are provided.

ii. The CEO will ensure that safeguarding activity is monitored to fulfil the requirement under Working Together to Safeguard Children (2018). The CEO has overall responsibility for ensuring that:

- There are safe and robust operational arrangements in place for safeguarding children in all services that are provided.
- That staff work in line with Pan- Merseyside (Liverpool, Knowsley, Wirral and Sefton) Multi-Agency Safeguarding Arrangements Committee (MASAC).

4.2 The Chief Nurse

The Chief Nurse has executive responsibility for Safeguarding Children, the role includes:

- Provision of Board level leadership for Safeguarding
- Ensuring that Safeguarding children key performance indicators are progressed
- Ensuring that learning from Safeguarding cases is embedded into practice

4.3 Associate Director of Nursing and Midwifery for Safeguarding / Named Nurse and Midwife for Safeguarding Children

i. Associate Director of Nursing and Midwifery for Safeguarding (ADN) has responsibility to:

- Promote good practice and effective information communication within, and between the Trust and partner agencies on matters related to the protection of children.
- To develop, monitor and review health service specifications and standards for child protection practice.
- To be a source of advice and expertise on child protection matters to all staff at the point of need. To co-ordinate child protection training within the Trust
- To provide safeguarding children advice and supervision.
- Review of safeguarding risks and appropriate escalation of risks in line with the Trust Risk Management Strategy
- To conduct Independent Management Reviews and contribute to Serious Case Reviews
- To work with managers to identify the resources needed by staff to enable them to carry out their roles in relation to child protection and safeguarding children

ii. The Named Nurse / Midwife for Safeguarding Children has responsibility to:

- Promote good practice and effective communication between the Trust and partner agencies
- To ensure all staff are appropriately trained in safeguarding children
- To provide advice and support to staff relating to safeguarding children issues
- To provide one to one safeguarding supervision to designated case load holder
- To coordinate attendance at child protection case conference

4.4 Named Doctor for Safeguarding Children

i. The duties are as follows:

- To promote good practice and effective communication within and between agencies on matters related to the safeguarding and protection of children.
- To be a source of advice and expertise on child protection matters to all staff at the point of need.
- To co-ordinate and monitor medical input into cases of abuse and or neglect.
- To provide safeguarding supervision for medical staff
- To participate and contribute to independent management reviews and serious case reviews.
- To ensure that there are effective systems of safeguarding audit to monitor the application of agreed child protection standards.
- To develop safeguarding training for medical staff and ensure this complies with local and national guidance

4.5 Named Nurse for Looked After Children (Children in Care)

i. The Named Nurse for Looked After Children has responsibility to

i. To ensure staff are appropriately trained in respect of the specific needs of Looked after Children.

ii. To promote good practice and effective communication between the Trust and partner agencies.

iii. To provide advice and support to staff in relation to Looked after Children/Children in Care.

4.6 Managers

i Managers are responsible for ensuring that all employees who encounter children are up to date with their safeguarding children training. This should be monitored through the Personal Development Review process.

ii Managers should ensure that staff that are involved in safeguarding cases are provided with appropriate support and advice. Managers should ensure that any learning from safeguarding cases is incorporated as part of the PDR process.

4.7 All Trust staff

i. Each individual employee has a responsibility in safeguarding children and promoting their welfare. All Trust staff must:

- Participate in training on how to safeguard and promote the welfare of children and be alert to the potential indicators of abuse and or neglect in children

- Know how to act on their concerns in line with the safeguarding procedures

ii. Trust employees who work predominately or completely with adults who have parental responsibilities share a commitment to safeguard and promote the welfare of the child.

4.8 Multi-Agency Safeguarding Arrangements Committee (MASAC) *Previously Local Safeguarding Children Board (LSCB)*

The Trust is a statutory partner of Liverpool, Sefton and Knowsley Safeguarding Children Boards, with responsibility for the effective discharge of the MASAC functions and promoting compliance with multiagency safeguarding policies and procedures

5 Main Body of Policy

5.1 Outcomes for Children

i. Every Child Matters (2004) set out the five key outcomes for a child's wellbeing:

- Stay Safe
- Be Healthy
- Enjoy and achieve
- Make a positive contribution
- Achieve economic wellbeing.

5.2 Rights of the Child

i. Children and young people have their own rights which are independent of those of their parents. Children have the right to be free of harm and exploitation. When there is a conflict of interest between the parent and the child, the child's interests must be given priority and are paramount above all else.

ii. Children have a right to be consulted on all matters and decisions that affect their lives. Children should be consulted, and their wishes and feelings considered, having regard to their age and level of understanding.

iii. Staff must take every opportunity to talk to children about their wishes and feelings in an age-appropriate way.

5.3 Capacity and Consent

i. The Safeguarding Children Act 2004 is applicable to all children up to their eighteenth birthday, The Mental Capacity Act however is applicable from the age of sixteen and should also be considered in respect of consent. Staff should refer to the Trust Mental Capacity & Deprivation of Liberty Safeguards Policy for further guidance.

ii. All staff should be aware of the Mental Capacity Act (MCA) in relation to any concerns that staff may have in regard to parental understanding of procedures and actions clinical staff are taking or making, staff should always refer to the safeguarding team in this instance and also refer to the Trust Mental Capacity Act & Deprivation of Liberty Safeguards Policy.

5.4 Rights of the Parents

i. Parents have the right to an open and honest explanation for:

- the reason for concern about their parenting capacity
- the duties and powers of the relevant agencies
- the action that will be taken
- their entitlement for advice and support

ii. The parent's views should be sought and considered on all matters relating to their child. Parents should have the opportunity to appropriately challenge information held about them and the decisions taken that affect them.

5.5 Parental Responsibility

i. Section 3 of the Children Act (1989) states that Parental Responsibility is "all the rights, duties, and powers, responsibilities and authority which, by law, a parent of a child has in relation to the child and his property".

ii. The following are those who hold Parental Responsibility:

- Birth mothers automatically have parental responsibility.
- Fathers have parental responsibility if married to the child's mother at the time of the child's birth.
- An unmarried father can acquire parental responsibility if he becomes registered as the child's father on the birth certificate, also if a parental responsibility agreement is obtained with the mother or a parental responsibility order is obtained via the courts.
- Parental responsibility can also be obtained if the father is re-registered to name the unmarried father (this is not applicable to births prior to 1st December (2003).
- Stepparents can acquire parental responsibility if both parents agree to share it or when a Parental Responsibility Order is granted by the Court.
- Any person can have Parental Responsibility when a Special Guardianship Order has been granted.
- Any person adopting a child.
- Parental responsibility is granted as part of a formalised Adoption.

- A local Authority will share parental responsibility with parent/s when an Interim/ Care Order is granted (but not when parent/s provide consent for the child be accommodated in Local Authority care (Section.20 of the Children Act)

- A local Authority or other authorised person who holds an Emergency Protection Order in respect of the child.

5.6 Rights of Staff

i. The management of child abuse is complex, demanding and stressful. Those who undertake this role are entitled to receive support from the Trust. Practitioners have the right to receive preparation, specialised training and access to advice and supervision from experienced personnel.

ii. Practitioners also have the right to be protected from personal, verbal and physical abuse and aggression, please refer to the Trust violence and aggression policy for further guidance.

5.7 Safeguarding Supervision

i. Working Together to Safeguard Children (2018) identifies that all those involved in safeguarding children should have access to advice and support from peers, managers and named and designated professionals. At Liverpool Women's NHS Foundation Trust advice should first be sought from the shift leader or line manager if there is still a query then the Trust Safeguarding Team should be contacted.

ii. Liverpool Women's NHS Foundation Trust has specific arrangements for one-to-one case supervision for specific case load holders. Please refer to the Trust Safeguarding Supervision Policy for full details of the Supervision system that is in place at Liverpool Women's NHS Foundation Trust this policy can be accessed via the intranet.

5.8 Information Sharing

i. No single agency has the sole responsibility for the protection of children. Arrangements for the protection of children from abuse can only be successful if those involved do all they can to work in partnership and share relevant information.

ii. Before sharing information, the following considerations should be made:

- Is it necessary and appropriate to share the information?

- Is parental consent required to share this information?

- Who should the information be shared with?

- If consent is refused, is there sufficient concern to override this and share information in the best interests of the child / public?

iii. The Law permits the disclosure of confidential information without consent if deemed necessary to safeguard a child/ young person in the public interest. Public interest in child protection may override the public interest in maintaining confidentiality. The child's safety and welfare must be the overriding consideration when deciding whether to share information about them.

iv. In the case of an unborn, if individual staff members and professionals have concerns regarding any future risk to a child not yet born, they must make a Child Protection Referral to Children's Social Care for an assessment of the risks and concerns. If child protection concerns are identified and the concerns meet the threshold for Level 4 intervention, the unborn will require Children's Social Care to promote their welfare.

v. Although at this stage the unborn child has no statutory status, information must always be shared for pre-birth plans to be put in place to ensure the safety of the child following birth.

vi. Staff must ensure that information is:

- Accurate and up to date
- Necessary for the purpose
- Shared with only the relevant people
- Shared securely
- Record the reasons for the decision to share
- Record the name and details of any person who contacts Liverpool Women's NHS Foundation Trust for information, and the reason for their request for information
- Record if any information was not shared and why

vii. Where there is a lack of operational clarity as to the validity of sharing the information, advice should be sought from Safeguarding Team.

viii. When a patient is discharged from Liverpool Women's Hospital and there are safeguarding concerns this information must be shared with the health visiting team and/or community services for the area which the patient is returning. Should a patient attend Liverpool Women's Hospital where there are concerns in respect of and be open to another provider, this information should be shared via the appropriate channels.

5.9 Police Requests for Information

i. There is an expectation that Trust staff will cooperate with the police on enquires relating to safeguarding concerns.

ii. The police and other agencies can request access to personal information, under the Data protection Act 2018 held by health and local authorities for:

- The prevention or detection of crime
- The apprehension or prosecution of offenders

iii. However, it does not provide an automatic right of access to information and public bodies, including the Trust can assess the merits of a request and decide whether to apply the comply with the request or refuse.

iii. All requests from Police for information should be directed to the Safeguarding Team and made using a Schedule 2 disclosure request form, signed by an officer (rank of inspector or above).

iv.Out of hours all enquiries from Police should be directed to a Senior Manager. Trust staff **must not** give information to the police before speaking to a member of the Safeguarding Team or Senior Manager.

v. There may be occasions when a member of staff is asked to be interviewed by the police. All requests for police to interview staff should be made in writing and sent via the Safeguarding Team. Support should be provided to staff during police interview from the Trust Safeguarding Team.

5.10 Court Report

Staff may be asked to complete reports for court proceedings relating to safeguarding matters. All requests for reports should be sent to the Safeguarding Team. If staff are unsure how to complete a report, please contact the Safeguarding Team.

5.11 Record Keeping

i. Well-kept records provide essential information underpinning good safeguarding children practice. Professional records should be clear, comprehensive, accurate and contemporaneous. Clinical staff should ensure that they are conversant with the issues relating to the NMC Code of Conduct and Ethics and the legislative requirements for safe record keeping. Records should give a clear, documented account of involvement with a child or family.

ii. Records can be used as evidence for child protection investigations and enquires and may also be disclosed in court proceedings. Staff should ensure that they sign the

signature authorisation form at the front of patient's records. Any concerns raised in relation to poor practice of record keeping will be raised in individual staffs PDR and followed by competency checks to ensure correct procedures are followed.

iii. Patient records should:

- Detail any concerns or suspicions of deliberate harm or child welfare concerns, the actions taken such as a referral being made and the outcome of the action

- The name, age and any other relevant information about the child who is the subject of the concern (including information about their parents or carers and any siblings)

- Be contemporaneous

- Include a record of all discussions relating to safeguarding children including telephone conversations. The record should include the name of the person contacted and the date and time of the discussion

- Include any differences of opinion or disagreement between professionals in relation to a diagnosis of deliberate harm or child welfare concerns.

- Have the date, time of writing, a signature, printed name and designation.

iv. Please refer to the Trust Clinical Records Policy further guidance

5.12 Multiagency Procedures

i. Each Multi-Agency Safeguarding Arrangements Committee (MASAC) has a set of multiagency procedures which must be adhered to. The principal that is followed is that the normal area of residence of the child will dictate the MASAC procedures to follow.

ii. The multiagency procedures can be accessed at the following websites:

Liverpool	https://liverpoolscp.org.uk/scp
Sefton	https://seftonscp.org.uk/scp
Knowsley	https://www.knowsleyscp.org.uk/
St. Helens	https://sthelenssafeguarding.org.uk/scp
Halton	www.haltonsafeguarding.co.uk
Wirral	https://www.wirralsafeguarding.co.uk/

5.13 Access to Advice and Support

i. Guidance is available via the Trust safeguarding Intranet site and support is accessible from the Safeguarding Team (Out of hours Hospital Clinical Manager)

ii. Further guidance and support can be accessed via the Children's Emergency Duty Team.

iii. Safeguarding Supervision is available for all staff, please refer to the Trust Safeguarding Supervision Policy for further guidance.

5.14 Initial Contacts

i. Prior to meeting a patient, Trust staff must check the hospital electronic patient records (EPR) for any safeguarding concerns.

ii. Limited Safeguarding information is available on the PCI Bulletin board. The Bulletin Board flags up to date safeguarding information and can include instructions for staff to follow. Safeguarding Plans and further information will be available within the patient electronic records i.e. K2, Badger and PENS. Should staff wish to discuss this matter or seek support with the referral process the Safeguarding Team should be contacted.

5.15 Child Protection Information Sharing (CP-IS)

i. CP-IS connects Local Authority Children's Social Care systems with those used by NHS unscheduled care settings, such as Gynaecology Emergency Department, Delivery Suite and maternity Assessment Unit.

ii. It ensures that health care professionals are notified when a child or unborn baby with a child protection plan (CPP) or looked after child status (LAC) is treated at an unscheduled care setting. CP-IS is a secure system with clear rules governing the access and only authorised staff involved in the care of a child should access the information.

iii. Current information is available to check if an unborn has been placed on a child protection plan or in situations where the mother is a child and is subject to a Child Protection Plan or Care Order.

iv. Social care teams are alerted automatically on each occasion when a child in their care attends an unscheduled care setting.

v. This system does show concerns being assessed or open to Children's Services on a Child in Need Plan.

vi. It is important to note:

- CP-IS is for use in an unscheduled setting, i.e. not booked with our services and as such they have no current maternal notes.
- The expectant mother's details are checked on the system via smartcard access directly to the summary care record via NHS Spine Portal.
- The unborn is linked directly to the mothers NHS number and **therefore only staff** with the correct access (RBAC) codes can see maternal records.
- The information we receive from searches shows live and current data.
- The details of the plan will not be visible – normal safeguarding process will be followed if attendance is of a concern.
- The name and the title of staff requesting information (this can be defaulted for whole Trust e.g. Safeguarding Team) is recorded and becomes part of an attendance record that is visible to any other consequent departments that access the child records.
- The system will show if mothers are accessing multiple organisations.

vii. Criteria for CP- IS searches:

- Any children accessing LWH Emergency Department / MAU /Delivery Suite as an unscheduled attendance.
- All women presenting at LWH with a concealed/unbooked pregnancy

5.16 Threshold Guidance

i. The Children Act (1989) necessitates that there should be a process where the priorities of children's needs can be identified. Every MASAC has its own threshold guidance.

ii. Threshold guidance is designed to:

- Outline a framework by which children's and family's needs are identified and to ensure that services to help them are provided in a co-ordinated way
- To describe different levels of need and the services that may meet them.
- To guide practitioners and managers of services in their decision making about how to help a family

- To support effective inter-agency practice whether children are accessing, universal, targeted or specialist services

- To support people working with families to understand when to escalate, and when to step-down the level of service provided to a family

iii. The levels of need are defined as follows:

- **Level 1 – Children with no additional needs.** This level includes children and young people who make good overall progress in all areas of development. These children receive appropriate universal services, such as health, care and education.

- **Level 2 - Children with additional needs.** This level includes children and young people who require some extra support/ intervention. This may be short term but requires a co-ordinated response from services. Children and young people may benefit from an Early Help Assessment to ensure needs are met and escalation of need is minimised. An Early Help Assessment is an offer of support and requires the consent of parent/s. If any members of staff have concerns in relation to EHAT; refer to intranet and or the appropriate MASAC website and follow appropriate area guidance.

- **Level 3 – Children with complex needs.** Children and young people with un-met needs that are more significant or complex. Early Help and a co-ordinated multi-agency response to needs can prevent concerns escalating to a level that may require statutory interventions.

  The Early Help Assessment identifies a lead professional, the aim of which is to ensure support is appropriate and timely and impact is measured. Where concerns escalate beyond early help, and significant harm is likely or a child's level of development/ welfare is compromised, the concern can be 'stepped up' for Social Care interventions where appropriate i.e., where Early Help has been declined and concerns remain.

  Similarly, where there has been Social Care interventions, and needs have been addressed, it can be 'stepped down' to ensure continuation of support that is appropriately provided through multi-agency arrangements, which should prevent re- escalation at a later stage.

  If any members of staff have concerns in relation to EHAT; refer to intranet and or the appropriate MASAC website and follow appropriate area guidance.

- **Level 4 - Children in need of protection.** Children and young people who are 'in need' and require a statutory service to promote their welfare (section 17), and children and young people whose needs demonstrate significant harm or risk of significant harm (section 47). Needs at Level 4 are complex and cross many domains/determinants.

These are cases of a Child Protection nature where there is 'reasonable cause' to suspect suffering or likely suffering of significant harm, (as defined by Children Act). They will be co-ordinated and led by a Social Worker.

5.17 Procedure for Referral to Children's Social Care

i. If a member of staff has concerns about the welfare of a child, the following steps should be taken:

ii. If the member of staff is unfamiliar with the process for referring to Children's Social Care, the concerns and need for referral should be discussed immediately with either their line manager or the Safeguarding Team.

iii. The member of staff should discuss their concerns with the person with parental responsibility or in the case of the unborn child with the prospective mother and make them aware of the reason for the concern and the steps that will be taken. The only exception to this would be if it is likely that through informing the person with parental responsibility you would be likely to cause further harm to the child, a member of staff or another member of the family. Refer also to the safeguarding team.

iv. A referral by completion of a Multi-Agency Referral Form (MARF) should be made to Children's Social Care within 24 hours and this will be to the children's Social Care in the geographical area where the child or the prospective parent is normally resident.

v. When completing a MARF ensure all relevant information is contained including concerns, family details (names and dates of birth) for all children and significant adults.

vi. If the concern relates to the child having suffered significant harm or there is an immediate risk of significant harm then the appropriate Local Authority must be contacted immediately first by telephone and then followed up by completion of the MARF (advice available on the Trust Safeguarding Intranet).

vii. Once a MARF is completed a referral to the Safeguarding Team should be completed and Bulletin Board should be updated along with patient electronic record to advise that a referral has been made to Social Care and the Safeguarding Team.

viii. The written referral must match all concerns that were raised in the verbal referral. If additional concerns have been raised since the verbal referral was completed, a further verbal referral should be undertaken to ensure that children's Social Care receive a clear update. Staff should keep record of the referral reference number and include this in the referral to the safeguarding team and the electronic patient record update. If staff using K2 the record the update must be within the confidential Safeguarding contemporaneous note. The referrer should include the safeguarding team email for the outcome of the referral to be received.

ix. When Children's Social Care informs the safeguarding team of the outcome of the referral, a note will be placed on the patient electronic record If no feedback is received the safeguarding team will liaise with Children's Social care for an outcome.

x. If a referral needs to be made outside of normal working hours the Emergency Duty Team (EDT) at Children's Social Care should be contacted.

xi. If the Emergency Duty Team cannot be contacted and if deemed necessary, the Police can be contacted for assistance.

5.18 Social Care roles and responsibilities after referral

i. Once the referral has been accepted by local authority children's Social Care the lead professional role falls to the allocated Social worker.

ii. The Social Worker should clarify with the referrer, when known, the nature of the concerns and how and why they have arisen.

iii. Within one working day of a referral being received a local authority Social Worker should decide the type of response that is required. This will include determining whether:

- The child requires immediate protection and urgent action is required.
- The child is in need, and should be assessed under section 17 of the Children Act (1989)
- There is reasonable cause to suspect that the child is suffering, or likely to suffer, significant harm, and whether enquires must be made and the child assessed under section 47 of the Children Act (1989)
- Any services are required by the child and family and what type of services; and
- Further specialist assessments are required to help the local authority to decide what further action to take.

iv. The Safeguarding Team at Liverpool Women's Hospital should be advised of the outcome of the referral. Action to be taken:

- The child and family must be informed of the action to be taken.
- Local authority children's Social Care should see the child as soon as possible if the decision is taken that the referral requires further assessment.

- Where requested to do so by local authority children's Social Care, professionals from other parts of the local authority such as housing and those in health organisations have a duty to cooperate under section 27 of the Children Act (1989) by assisting the local authority in carrying out its Children's Social Care functions. This duty also applies to other local authorities.

v. Staff must always follow up and ensure the referral has been actioned by Social Care.

5.19 Multi-agency Meetings

i. The purpose of a multiagency meeting is to:

- Share information relevant to an identified concern/s.
- Plan to reduce the risk to the child
- Be transparent with the child, parent(s)/Carer(s) about the sharing of information to effect change.
- Monitor the effectiveness and escalate if deemed necessary.

ii. Where relevant Trust staff may be invited to a multiagency meeting to:

- Share key knowledge and information regarding the unborn/child and/or their circumstances, environment, parents, etc.
- Impact of changes within the household and significant visitors
- Information shared based on a professional perspective and curiosity
- Offer a perspective on how agencies are working together
- Consider the information pertinent to the Levels of Need Assessment Framework

iii. There are numerous multiagency meetings that staff from Liverpool Women's NHS Foundation Trust may be asked to attend as part of a Social Care assessment i.e. Child In Need, Child Protection and Looked After Children process.

5.20 Strategy Meetings

i A Strategy Meeting (sometimes referred to as a Strategy Discussion) is normally held following an assessment completed by Children's Social Care or incident which indicates that a child has suffered or is likely to suffer Significant Harm.

ii. The purpose of a Strategy Meeting is to determine whether there are grounds for a Section 47 Enquiry. In these instances, staff will be asked to attend or provide as much information as possible in respect of their involvement with a family.

iii. When a Strategy Meeting has been convened following a Sudden Infant Death or an Acute Life-Threatening Event it is expected that a member of the Trust Safeguarding Team will attend the meeting alongside the named practitioner. If the practitioner is directly informed of the meeting it is their responsibility to ensure that a member of the Safeguarding Team has been alerted to the meeting details.

5.21 Child Protection Conferences

i. Child Protection conferences brings together family members (and the child where appropriate) and practitioners most involved with the child and family, to make decisions about the child's future safety, health and development.

ii. They are chaired by an Independent Reviewing Officer (IRO) with the purpose of bringing together and analysing, in an inter-agency setting, all relevant information and plan how best to safeguard and promote the welfare of the child.

iii. It is the responsibility of the conference to make recommendations on how organisations and agencies work together to safeguard the child in future. A decision will be made regarding whether the child will be made the subject of a Child Protection Plan.

iv. LWH staff should attend the conference and share relevant information and are expected to contribute to the decision making. The outcome of the conference must be shared with the LWH safeguarding Team and the relevant EPR must be updated.

v. Prior to discharging a baby who is subject to a child protection plan LWH staff must ensure:

- All action points on the child protection plan have been completed and recorded in the patient's electronic notes.

- Safeguarding plan of care has been followed for inpatient stay and arranging discharge of baby from hospital including a discharge planning meeting has been held (if required in the plan).

- Safeguarding Team has been notified of the plan to discharge.

- Social Worker/Emergency Duty Team are notified of baby discharge
- Health professionals involved are notified of discharge from hospital.

5.22 Interim Care Order (ICO)

i. An ICO is granted by the Court when there is evidence to suggest a child is at risk of suffering significant harm. An ICO means that the Local Authority will share Parental Responsibility for the child and will have the power to make decisions about where the child lives and the welfare of the child.

ii. In situations where a baby is being discharged into the care of the Local Authority, LWH staff **must** have documentary evidence of the ICO prior to discharge.

5.23 Emergency Protection Order (EPO)

i. An EPO can only be granted once a baby has been born and there is reasonable belief that a baby is at immediate risk of significant harm. It will impose conditions and may direct who has contact with the child.

ii. EPO's are issued via contact with Children's Social Care services and the Safeguarding Team **must** be made aware of all EPO's.

iii. The member of staff and their manager caring for the baby must examine and be familiar with the terms and conditions of the EPO.

5.24 Police Protection (PP)

i. If an emergency occurs out of hours and it is thought that a baby is at immediate risk of significant harm PP can be sought; an example of this would be to prevent a baby's removal from the hospital by their parents or to place them into the care of foster carers. If PP is required a call to the Police via 999 must be made.

ii. Police protection does not give the police parental responsibility and does not, for example, give the police the ability to consent on behalf of the child.

This is seen as a draconian action and the police will only use their powers in exceptional circumstances. Before exercising their powers, the police may consider whether the Local Authority can apply instead for an EPO. However, given that it takes time to make an application, the police would also have to be satisfied that the child will be protected in the interim. Normally, this cannot be achieved.

iii. The member of staff and their manager caring for the baby must examine and be familiar with the terms and conditions of PP.

iv. The Safeguarding Team, bleep holder and Consultant on call must always be informed if there is a child in the hospital who is subject to an EPO / PP.

v. If a parent attempts to remove a child who is subject to an EPO / PP, the staff member caring for the baby must inform the senior manager, the bleep holder and the Safeguarding Team, they must also inform the police and request their immediate presence. Security staff should be informed of the situation. The Social Worker should be informed and if the incident occurs out of hours the Emergency Duty Team should be informed.

vi. Some EPO's / PP's or care orders require that contact with the baby is supervised. LWH staff provide clinical care and should not be expected to supervise contact between babies and parents.

5.25 Private Fostering Arrangements

i. A private fostering arrangement is essentially one that is made privately (without the involvement of a local authority) for the care of a child under the age of 16 (under 18, if disabled) by someone other than a parent or close relative with the intention that it should last for 28 days or more.

ii. Private foster carers may be from extended family, such as a cousin or great aunt. However, a person who is a relative under the Children Act (1989) i.e. a grandparent, brother, sister, uncle or aunt (whether of the full or half blood or by marriage) or step-parent will not be a private foster carer. A private foster carer may be a friend of the family, the parent of a friend of the child, or someone previously unknown to the child's family who is willing to privately foster a child.

iii. Trust staff should notify the Local Authority and the Safeguarding Team of any private fostering arrangements that come to their attention. Some of these arrangements may be recent, some may have been in existence for some time as the parent or carer may not be aware that it is a private fostering arrangement and so unaware of the need to tell the Local Authority.

5.26 Discharge of babies who are subject to a child protection plan

i. Prior to discharging a baby who is subject to a child protection plan staff from Liverpool Women's NHS Foundation Trust must ensure that:

ii. All action points on the child protection plan have been completed and recorded in the patient electronic notes.

iii. Safeguarding plan of care has been followed for inpatient stay and arranging discharge of baby from hospital. Staff to ensure verbal contact has been made with the Social

worker/Social Care team and plan for discharge confirmed and they are informed of discharge.

iv. Staff to ensure discharge meeting facilitated if requested prior to discharge of baby.

v. Safeguarding Team has been notified of the plan to discharge.

vi. Health professional involved are notified of discharge from hospital.

5.27 Child Protection / Looked After Children Flagging

i. Children or Young People who are subject to a Child Protection Plan or who are Looked After Children should be clearly identified as such by using the Electronic Patient Record (EPR). If known, the allocated Social worker should be informed regarding the young person's attendance at Liverpool Women's Hospital.

ii. Should staff have significant concerns regarding a child or young person or feel that they are at risk of immediate harm they should discuss their concerns with the allocated Social worker or if out of hours the emergency teams. For further advice staff should contact the safeguarding team.

iii. Children who are Looked After or who are subject to Child Protection Plans are sometimes placed in Liverpool or the surrounding area by other Local Authorities. In these cases, the child's record should be updated to include the name of the allocated Social Worker and area from which the child originated, and a note should be made of their status. Staff should contact the Safeguarding Team for further advice if necessary.

5.28 Home visits where there are known safeguarding concerns

When Trust staff complete home visits the following should be completed:

- The baby is seen at each visit
- The baby must be undressed and examined at each visit
- If access to the baby is denied the reason for lack of access to the baby must be documented and arrangements must be made to see the baby again within 24 hours. If access is denied at a subsequent visit children's Social Care must be informed immediately.
- Staff should review the sleeping arrangements for the baby and advise or refer accordingly. For further guidance please access multi-agency-safe-sleep-guidance .

5.29 Looked After Children (LAC)

i A child who has been in the care of their local authority for more than 24 hours is known as a Looked after Child. Looked after children are also referred to as Children in Care (CiC) this will include Unaccompanied asylum-seeking children (UASC).

ii Looked after children may reside in a number of settings including at home, Foster Care, residential settings including Schools and respite care.

iii Parental responsibility for a looked after child is shared between children's Social Care and the birth parents.

iv Local Authorities have an obligation to support any young person over the age of 16 who is or has been a looked after child until they are 21 (or 25 if engaged in a programme of education or training).

v An officer for children's Social Care can give consent for investigations and or medical treatment.

vi Parents for the child should be involved in the decision making or where this is not possible informed of the decision about treatment.

vii Looked after children must be identified when they attend any hospital to ensure appropriate consent for care and treatment is obtained.

viii If a looked after child attends for treatment the following steps should be taken:

- Identify their looked after status
- Identify and inform the Social worker for the child.
- Record the looked after status of the child on the child's record
- Make a decision about parental responsibility and consent and record this – please refer to the Trust Consent Policy
- Treat and support as appropriate
- Inform the GP and Children's Liaison service by means of a Health Professional Letter
- If the child is pregnant a referral must be made to children's Social Care in respect of the unborn child

5.30 Procedure to follow if there are concerns about deliberate injury to an inpatient (infant)

- Initially treat and ensure the safety of the child, consideration should be given to calling police if there is suspicion of a crime

- A Senior Paediatrician should review the child

- Trust staff must ensure appropriate documentation is recorded including any bruising or injury (utilising a body map), who was present and history of events prior to injury. This must be recorded in the Safeguarding Contemporaneous Notes section of K2 or Badger.

- If there are suspicions that the injury is non-accidental and there is no clinical rationale for the injury an immediate referral to Children's Social Care via a telephone call followed by completion of an online referral and the Trust Safeguarding Team must be completed. Children's Social care will then direct as necessary.

- Please refer to Pan Merseyside Bruising in Children who are Not Mobile for further guidance

5.31 Procedures to follow relating to prevention of Sudden Unexpected Death in Infancy (SUDI) / Sudden Unexpected Death in Childhood (S.U.D.i.C) – 0 to 18 years

i In the event of a sudden unexpected death of a baby or child the following guidance should be followed PAN Merseyside SUIC Policy

ii The Safeguarding team in conjunction with a Senior Manager should be immediately notified.

iii When a Strategy Meeting has been convened following a Sudden Infant Death it is expected that a member of the Trust Safeguarding Team will attend the meeting.

5.32 Child Death Review Procedures

i. Liverpool Women's NHS Foundation Trust has a duty to assist with the Child Death Review Panel (CDRP) known locally as *Child Death Overview Panel (CDOP)*.

ii Staff must ensure that any child death is notified to the Children's Liaison Service so they can commence the CDRP notification process.

ii. Specific staff from the Neonatal Unit have the responsibility to complete the CDRP research forms. The forms are forwarded to the named staff from the corresponding Local Safeguarding Partnership areas.

iii. The Named Doctor for Safeguarding Children participates on the Merseyside CDRP and provides expert advice, highlighting any issues and lessons learnt to Liverpool Women's NHS Foundation Trust by means of the Trust Safeguarding Sub-Committee.

5.33 National and Local Safeguarding Reviews (previously Serious Case Reviews)

i Working Together to Safeguard Children (2018) sets out the process for National and Local Safeguarding Children Practice Reviews (previously Serious Case Reviews – SCR's). The responsibility for how the system learns the lessons from serious child safeguarding incidents will now lie at a national level with the Child Safeguarding Practice Review Panel (the Panel).

ii At a local level, the safeguarding partners have strict timeframes to complete a rapid review of cases to ascertain whether cases meet the criteria for the Panel. This is usually when:

- A child dies and abuse or neglect are known or suspected to be a factor in the death
- A child has sustained a potentially life-threatening injury, serious or permanent impairment or has been subjected to particularly serious sexual abuse

iii The Child Safeguarding Practice Review Panel are responsible for identifying and overseeing the Review of serious child safeguarding cases and that raise issues that are complex or of national importance.

5.34 Infant Abduction

If a baby is abducted from any clinical area, please refer to the Trust Infant Security Policy of Suspected or Actual Infant Abduction.

5.35 Abandoned Babies

i. The definition of an abandoned baby is a child who has been left in a public or private place, without an adult who assumes responsibility for them, where the child's identity is unknown and where the parents of the child are unknown.

ii. In the event a baby is thought to be abandoned the following actions must be completed:

- In the event the baby and mother are admitted to the Trust, attempts should be made to locate the mother. Please see Missing Patients Policy for further guidance.
- Appropriate care of the baby should be provided in the interim.
- If it is established that the mother cannot be contacted or located Senior Management, the Safeguarding Team and Children's Social Care must be notified immediately.
- In the event the baby is not an inpatient, a Senior Paediatrician must review the baby and the Police, Children's Social Care, Senior Management and the Safeguarding team notified immediately.
- No information should be provided to the press or members of the public.
- If a person/s attend claiming to be a baby's parents they must not be allowed access to the baby and Senior Management, Safeguarding Team and the Police must be informed.

5.36 Delayed access to Antenatal Care (Late Bookers)

Women who book in for antenatal care after the 20th week of pregnancy **without reasonable explanation or cause** should be regarded as high risk. A referral to Children's Social Care should be undertaken, EPR updated and a referral to the Safeguarding Team completed.

5.37 Women who attend to deliver un-booked

i The Child Protection Information Sharing (CP-IS) must be accessed and all women who deliver un-booked must be referred to Children's Social Care. The woman should be informed of the action that has been taken and a referral completed to the Safeguarding Team.

ii When informing children's Social Care, it should be established if the woman is already known to their service. The woman and baby should not be discharged until there has been communication from children's Social Care on the actions that they are going to take.

5.38 Potential Concealed Pregnancies

i A concealed or denied pregnancy is defined as one where a woman knows she is pregnant and has concealed the pregnancy or denied to herself that she is pregnant.

ii The Child Protection Information Sharing (CP-IS) must be accessed in all cases of potential concealed pregnancies.

iii For further guidance please refer to MERSEYSIDE-CONCEALED-PREGNANCY-PROTOCOL or refer the Trust Unbooked/Concealed Pregnancy SOP.

5.39 Fabricated or Induced Illness (FII)

i. Concerns may be raised when it is considered that the health and development of a child is likely to be significantly impaired or further impaired by the parent or caregiver who has fabricated or induced illness in the child.

ii. Trust staff must be aware of the signs and symptoms of fabricated or induced illness and follow the procedures set out in the following guidance PAN Merseyside FII Guidance

iii. Trust staff must ensure all documentation relating to concerns of FII must be documented in the Safeguarding Contemporaneous notes or Badger.

5.40 Allegations of Child Abuse against Trust staff

All allegations against Trust staff must follow the Trust Allegations against Staff policy

5.41 'VIP' and Celebrities

When a VIP or celebrity is visiting the trust, it is recognised that the privacy of patients, families and staff needs to be protected.

- Priority should be given to full consideration of patients, families and staff when arranging and undertaking visits
- Employees and other trust users should be aware of the correct procedures for organising visits to the hospital
- Staff should be aware of their responsibilities in ensuring visits are handled efficiently
- Visits should be arranged in conjunction with the marketing and communications department.

- The Safeguarding Team will advise on the implications of any interactions and or behaviours by VIP or celebrity visitors, which may give rise to a cause of concern.

5.42 Escalation Procedures

Sometimes referrals that are made to children's Social Care are rejected, not accepted, closed or no further action is taken. If the member of staff remains concerned about the welfare of the child and disagrees with the actions that children's Social Care have taken the following steps should be taken:

- A discussion should take place with the Safeguarding Team who will escalate if deemed appropriate via LSP Escalation process.

- All discussions will be clearly documented by the Safeguarding Team within the patient notes.

5.43 Language Barriers

i. An interpreter is defined as a person who translates a spoken or signed (British Sign Language) message from one language to another. This can be either face to face or by telephone.

ii. It is unacceptable to use a friend or family member as an interpreter when discussing treatment, care and medical or social issues with a child/young person, as the interpreter must be impartial.

iii. **In the case of a child a professional interpreter must be used on all occasions.** This, of course, does not prevent the family from being present to provide support as they would do in other circumstances. For further advice please refer to the Trusts Use of Interpreters Policy.

5.44 Children being treated in an Adult Healthcare setting

If children are admitted to Liverpool Women's NHS Foundation Trust staff should refer to the Trust policy for Children Treated in an Adult Healthcare setting.

5.45 Capturing the voice of the child

i. Children want to be respected, their views to be heard, to have stable relationships with professionals built on trust and for consistent support provided for their individual needs. This should guide the behaviour of professionals.

ii. Anyone working with children should see and speak to the child; listen to what they say, take their views seriously and work with them collaboratively when deciding how to support their needs.

iii. In situations where the child is nonverbal or unborn, their individual needs and the potential impact of adverse childhood experiences should be considered by Trust staff.

6 Key Reference

i. Working Together to Safeguard Children (2018)

ii. Safeguarding children, young people and adults at risk in the NHS: Safeguarding accountability and assurance framework (2023)

iii. CQC; Regulation 5: Fit and proper persons: directors (guidance for providers and inspectors)

iv. CQC; Regulation 13: Safeguarding service users from abuse

7 Associated Documents

i. Whistleblowing Policy

ii. Domestic Abuse Policy

iii. Mental Capacity Act & DoLS Policy

iv. Safeguarding Supervision Policy

8 Training

i All staff will complete safeguarding training as per Trust Safeguarding Strategy

9 Policy Administration

9.1 Consultation, Communication and Implementation

Consultation Required	Authorised By	Date Authorised	Comments
Impact Assessment			None required
GDPR	PGP		
Have the relevant details of the 2010 Bribery Act been considered in the drafting of this policy to minimise as far as reasonably practicable the potential for bribery?	Yes		
External Stakeholders			
Trust Staff Consultation via Intranet	Start date: Feb 2022		End Date: Feb 2022

Describe the Implementation Plan for the Policy (and guideline if impacts upon policy) (Considerations include; launch event, awareness sessions, communication / training via CBU's and other management structures, etc)	By Whom will this be Delivered?
This revised policy will be made available to all staff through the Trust's intranet pages.	Head of Safeguarding

Version History

Date	Version	Author Name and Designation	Summary of Main Changes
2004	1	Carole O'Keefe Named Nurse for Safeguarding	First version of policy
2009	2	Carole O'Keefe Named Nurse for Safeguarding	Revision
2010	2.1	Carole O'Keefe Named Nurse for Safeguarding	Revision
2013	3	Esther Golby, Head of Safeguarding	Revision
2015	4	Mandy McDonough, Head of Safeguarding	Revision
2016	4.2	Mandy McDonough, Head of Safeguarding	Minor Revision
2017	4.3	Head of Safeguarding	Annual review

2018	4.4	ADN for Safeguarding	Annual Review
2019	4.5	ADN for Safeguarding	Annual Review, (include working together 2018)
2020	4.6	ADN for Safeguarding	Annual Review
2021	4.7	ADN for Safeguarding	Annual Review
2022	4.8	ADN for Safeguarding	Minor Revision -EPR revision

9.2 Monitoring Compliance with the Policy

Describe Key Performance Indicators (KPI)	Target	How will the KPI be monitored	Which Committee will be monitoring this KPI	Frequency of Review	Lead
Compliance with Safeguarding Children Policy Standards.	100%	A range of internal and external Audits	Trust Safeguarding Subcommittee	Annual	ADN Safeguarding

9.3 Performance Management of the Policy

Who is Responsible for Producing Action Plans if KPIs are Not Met?	Which Committee Will Monitor These Action Plans?	Frequency of Review (To be agreed by Committee)
ADN for Safeguarding	Trust Safeguarding Sub-Committee	Annual

10 Appendices

10.1 Appendix 1 – Glossary of Terms

Abuse and Neglect
Child abuse is when a child is intentionally harmed by an adult or another child, it can be over a period of time but can also be a one-off action. It can be physical, sexual or emotional and it can happen in person or online. It can also be a lack of love, care and attention, this is referred to as neglect.

Assessment
The process of defining an individual person's needs, making a judgement about the risk of harm, deciding on the help that they require and determining their eligibility for services.

Cause for concern
A reason to be worried about the health, development or welfare of a child and recognising that this cause may be preventable by seeking services for the child and/or their family.

Child
Anyone who has not yet reached their 18th birthday.

Child protection
Process of protecting individual children identified as having suffered, or at risk of, significant harm because of abuse or neglect.

Child Protection conference
The child protection conference is arranged to enable those Practitioners most involved with the child and family, and the family themselves, to assess all relevant information, and plan how best to safeguard and promote the welfare of the child who has suffered, or is at risk of, significant harm.

Child Protection enquiry
This is carried out, under section 47 Children Act 1989, when there is reasonable cause to suspect that a child has suffered, or is at risk of, significant harm. The enquiry is carried out by Children's Social Care and the Police.

Child protection meeting
A meeting arranged by Children's Social Care to consider how best to protect a child from harm.

Child Protection Plan
A detailed inter-agency plan setting out what must be done to protect a child from further harm, to promote the child's health and development and if it is in the best interests of the child, to support the family to promote the child's welfare.

Children's Social Care
The Local Authority Children's Social Care have a statutory duty to safeguard and promote the welfare of children has lead responsibility for child protection enquiries.

Confidentiality
Confidentiality is the process of handling information that is identified as being of a personal and sensitive nature. Under the GDPR and Data Protection Act 2018 you may share information without consent if, in your judgement, there is a lawful basis to do so, such as where safety may be at risk.

Core Group
A 'Team Around the Child', that is brought together once a child becomes subject to a child protection plan. Members of the core group are parents/carers and practitioners who are working with the child and/or family. They should meet on a regular basis. The child may also be a member subject to age and level of understanding. A judgement has to be made about whether it is in the best interests of the child to attend the core group meetings.

Fraser Guidelines
The 'Fraser guidelines' **specifically** relate to contraception and sexual health advice to those under 16 years old without parental consent. The guidelines state advice may be given to the child when:

- He/she has sufficient maturity and intelligence to understand the nature and implications of the proposed treatment
- He/she cannot be persuaded to tell her parents or to allow the doctor to tell them
- He/she is very likely to begin or continue having sexual intercourse with or without contraceptive treatment
- His/her physical or mental health is likely to suffer unless he/she received the advice or treatment
- The advice or treatment is in the young person's best interests.

Gillick Competence
Children under the age of 16 can consent to their own treatment if they're believed to have enough intelligence, competence and understanding to fully appreciate what's involved in their treatment.

Level of Needs Framework (LNF)
The LNF provides a common approach to identifying and describing levels of need for children and young people. It has been developed for use by practitioners to support joint working and communication between all agencies. It will support earlier intervention by providing a tool to identify needs at the earliest opportunity and a consistent approach to coordinating services.

Multi Agency
A more general term to describe the involvement of different agencies. For example, Liverpool Womens, Social Care & Police

Risk
The probability of something (e.g. harm to a child) happening. The harsher the damage caused by it happening and the more likely the event, the greater the overall risk.

S47 enquiry
See Child protection enquiry

Safeguarding and promoting the welfare of children
The process of protecting children from abuse or neglect, preventing impairment of their health and development, and ensuring they are growing up in circumstances consistent with the provision of safe and effective care which is undertaken so as to enable children to have optimum life chances and enter adulthood successfully.

Significant Harm
The Children Act 1989 introduced the concept of significant harm as the threshold that justifies compulsory intervention in family life in the best interests of children. Whether harm or likely harm suffered by a child is significant is determined by comparing the child's health or development with that which could reasonably be expected of a similar child.

10.2 Appendix 2 – Categories of Abuse

The following definitions are taken from Working Together to Safeguard Children (HM Government 2018).

Abuse and neglect are forms of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family or an institutional or community setting, by those known to them or, more rarely, by a stranger. They may be abused by an adult or adults, or another chid or children

Physical abuse: May involve hitting, shaking, throwing, poisoning, burning, or scalding, drowning, suffocating, or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces, illness to a child.

Emotional abuse: The persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development.

Sexual abuse: involves forcing or enticing a child or young person to take part in sexual activities, including prostitution, whether the child is aware of what is happening. The activities may involve physical contact, including penetrative or non-penetrative acts. They may include, non-contact activities, such as involving children in looking at, or in the production of, sexual online images, watching sexual activities, or encouraging children to behave in sexually inappropriate ways.

Child sexual exploitation: A form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity for something that the victim needs or wants, and/or for the financial advantage or increased status of the perpetrator or facilitator.

Neglect: The persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development.

10.1 10.3 Appendix C – Safeguarding Escalation Flowchart

What to do if you have a Safeguarding concern for a CHILD or ADULT

↓

DO NOT DISCHARGE PATIENT UNTIL:

1. Inform and escalate to line manager
2. Discuss concerns with a Safeguarding Professional (between 08:30 – 17:00)
3. If out of hours call CARELINE
4. Document all actions and details in subjects medical records and inform patients Consultant
5. If concern is for a child under 5 years old – Share information with Health Visitor

What to do if you have an IMMEDIATE concern for the safety of a CHILD or ADULT

↓

DO NOT DISCHARGE PATIENT UNTIL:

1. Inform and escalate to line manager
2. Discuss concerns with a Safeguarding Professional (between 08:30 – 17:00)
3. If out of hours call CARELINE
4. Contact Merseyside Police
5. Document all actions and details in subjects medical records and inform patients Consultant
6. If concern is for a child under 5 years old – Share information with Health Visitor

Still concerned?

1. ESCALATE CONCERN TO ON CALL DUTY MANAGER
2. EXECUTIVE ON CALL VIA SWITCH

CONTACT NUMBERS

SAFEGUARDING TEAM		–	Internal x4181, x4267, x4367, x4375 or via Switchboard		
MERSEYSIDE POLICE		–	0151 709 6010		
SOCIAL CARE:	LIVERPOOL	–	0151 233 3700 (Child)	0151 233 3800 (Adult)	(24 hour Careline)
	KNOWSLEY	–	0151 443 2600 (Child / Adult, 24 hour line)		
	SEFTON	–	0345 140 0845 (Child)	0151 934 3555 (Out of Hours)	0151 934 3737 (Adult)