Whittington Health NHS

Child Protection and Safeguarding Children
Annual Report April 2010 – March 2011

(Whittington Hospital)

This annual report provides an overview of the Whittington Hospital's child protection and safeguarding children arrangements and key developments in the period April 2010 to March 2011. It includes sections on the following areas:

- governance
- quality and Assurance
- policy
- practice.

The terminology used in this report is as defined by the London Safeguarding Children Board 2010. The fourth edition of the *London Child Protection Procedures* sets out the procedures which all London agencies, groups and individuals must follow in order to safeguard children and promote their welfare in the home and within the community. These procedures apply to professionals coming into contact with or receiving information about children 0 to 17 years, including unborn children and adolescents up to their 18th birthday.

Safeguarding and promoting the welfare of children (proactive)

The process of:

- protecting children from maltreatment;
- preventing impairment of children's health or development;
- ensuring that children are growing up in circumstances consistent with the provision
- of safe and effective care;
- undertaking that role so as to enable those children to have optimum life chances
- and to enter adulthood successfully.

Child Protection (reactive) – The process of protecting individual children identified as either suffering, or at risk of suffering, significant harm as a result of abuse or neglect.

1. Governance

1.1 Child Protection and Safeguarding professionals

The Trust has a full complement of staff in post as recommended in Working Together to Safeguard Children (2010):

- Named doctor (0.1WTE),
- Named midwife (0.2WTE)
- Named nurse (1 WTE).

In February 2011 Dr Heather Mackinnon, named doctor for CP announced her retirement from the role and Dr Giles Armstrong took on the role from 1st March 2010. In addition the following posts support named professionals

- Lead nurse doctor in Emergency Department as recommended by the RCPCH (2007)
- The midwife for vulnerable adults and babies (VABs)
- Paediatric liaison nurse
- Consultant paediatrician with a special interest in education

The professionals are supported by an administrative team.

1.2 The Trust's executive lead for safeguarding children is the Director of Nursing and Clinical Development. The Trust Board receives an update on safeguarding children annually and a monthly update of progress and involvement in serious case reviews in relation to children. .

1.3 In March 2011 the Trust declared compliance with Care Quality Commission Standards This declaration is posted on the public access part of the Trust intranet.

The Board received specific assurance about the following areas:

1. The Trust meets statutory responsibilities in relation to Criminal Records Bureau checks

2. Child protection policies and systems are up to date and robust. They include a process for following up children who miss outpatient appointments and a system for identifying and referring children about whom there are safeguarding concerns

3. The Trust has a named nurse, named doctor and named midwife for child protection. They are professionally accountable to the Director of Nursing and Clinical Development.

2. Quality & Assurance

2.1 The Trust's Child Protection (and Safeguarding Children) Committee meets every two months and is chaired by the Director of Nursing and Clinical Development. It includes appropriate representation from all key clinical departments and external partners, including local Primary Care Trusts and Social Services.

2.2 Information from the Local Safeguarding Children Boards (Islington & Haringey) is discussed. The Haringey Joint Area Review (priority health action plan) and other report action plans are monitored. Additionally meetings between the Director of Nursing and child protection leads within the hospital were held bi monthly to ensure the Trust

complied with directives and timescales, as the safeguarding agenda was particularly challenging at this time with multiple requests for information.

3. Policy

3.1 The named child protection leads received child protection supervision in varying forms including regular sessions with the Islington designated professionals. There is a requirement for named child protection leads to provide child protection supervision to staff across the trust. Guidelines for child protection supervision were ratified in December 2010. An audit of compliance with these guidelines will be undertaken during 2011.

3.2 The Trust's child protection guidelines (2008) will be reviewed as part of the Integrated Care Organisation's policy review.

3.3 The Child Protection training guidelines (2009) will also be reviewed as part of the Integrated Care Organisation's policy review and will incorporate new national recommendations (RCPCH 2010).

4. Practice

4.1 **The Children's Emergency Department**

Between April 2010 – March 2011 19,492 individual patients (0-18 years old) attended the emergency department .

The Whittington Hospital worked with NHS London as one of the pilot sites to develop an electronic system (CP24) within the Emergency Department to enable staff to check whether any attending child was subject to a child protection plan. This was completed in January 2010 and NHS London have been unable to identify funds to continue the system. The written evaluation has not yet been published. An action plan for a local solution to replace CP24 was accepted by the Trust Executive Board and child protection committee.

4.2 **Paediatric Liaison Nurse**

The 1WTE nurse (funded jointly by NHS Islington and NHS Haringey & the Whittington Hospital) facilitates communication between hospital professionals, primary care, education and children's social care to ensure that information is shared. The primary focus of the service is safeguarding children: complex discharge planning is facilitated, missed outpatients appointments are followed up for the most vulnerable children and all children's emergency department attendances are reviewed and information shared with the appropriate professionals. A RAG (red, amber, green) system of prioritising communication has been introduced in partnership with neighbouring hospitals and NHS Haringey and NHS Islington provider services with agreed standards and operational policy. This has enabled RiO (community electronic health records) to be integrated into the communication pathway, facilitating information to be shared and accessed more efficiently by both hospital and community teams. This has been particularly useful in ensuring security when sharing confidential information between hospital and community health services e.g. child protection investigations.

4.3 **Care of the Next Infant Scheme**

This national scheme is supported by the Foundation for study of Infant Death, and offers support to parents with subsequent infants following a death. The national trend shows a drop in the number of referrals but the Whittington Hospital has had 4 referrals in the past 12 months, a four fold increase on the previous year. The profile of the families accessing the scheme locally differs from the national picture of young, unsupported & vulnerable mothers with loss of infants before 3 months of age. All the local referrals are older, professional supported mothers whose previous infants had died over the age of 1 year. This difference is unexplained.

4.4 **Midwife for Vulnerable Adults and Babies**

A 1WTE post is covered by two job sharing midwives who advise and support midwife colleagues with professional responsibility for vulnerable women and their unborn infants, and facilitates women to access intensive and specialist midwifery care. The communication between agencies is more efficient and the unborn child advocated for in a more holistic way and this role is valued by our children social care colleagues. During 2010 396 referrals were received. Presenting concerns were substance misuse (11%), domestic violence (24%) and mental health issues (56%). All concerns were assessed to have reached the threshold that would have a negative impact on the unborn and the newborn infant. Twelve percent of the women were already known to children social care.

4.5 **Child Death Review Process**

The Local Safeguarding Children Board (LSCB) has, since 2008, had a statutory responsibility to review all child deaths. The objective is for a multi agency (police, children's social care and health) group to review every child death to ascertain whether it could have been prevented, and if so what measures need to be taken to prevent similar deaths in future. The named nurse for child protection and the bereavement midwife are representatives on these borough specific (Haringey & Islington) panels and co-ordinate the hospital response to infant and child death.

There were 39 Whittington hospital recorded neonatal/child deaths between April 2010–March 2011. Eighty two percent of the deaths were infants who died before they reached the age of 1 year. This is in line with national statistics.

4.6 **Child Social Care Interface**

In response to financial constraints, the London Borough of Islington (LBI) Children in Need service has restructured service provision for children attending the Whittington Hospital. The outcome was that from January 2011 Whittington Hospital Children and Families Social Work team was integrated into another team and based off site.

This has been a challenging transition from both a staff and risk perspective. During this transition the ways of working of the unique and nationally recognised service provided child & adolescent mental health liaison team in conjunction the hospital social work team for young people has been required to modify and new referral and treatment pathways for these young people need to be considered. There are monthly meetings between Whittington Hospital safeguarding children leads, Islington Children Social Care and Haringey Child and Young Peoples Service to anticipate risks and to put in place processes that reduce such risks and support staff. Islington CSC agreed to take a phased approach to change in service provision giving time for new referral and advice systems to be put into place within Whittington Hospital.

4.7 **Local Safeguarding Children Boards** (LSCB)

The Director of Nursing and Clinical Development is the named representative at both Haringey and Islington LSCBs. The Lead Nurse for Safeguarding Children represents

the Trust on training and health subgroups. Business discussed and actions required by the LSCB are summarised at the Trust Child Protection Committee. This is a Trust responsibility as stated in HM Government (2010) **Working Together to Safeguard Children.**

4.8 **Training**

'Ensure all staff are competent and confident in caring out their responsibilities for safeguarding children and promoting their welfare' (Working together to Safeguard Children 2010 HM Government)

Provision of staff child protection training has continued to be prioritised throughout the year. The Trust are achieving just below the 80% NHS London targets with monthly average of 78 % of staff achieving level I training. Training provided by the Named Nurse and Named Midwife , and the Named Doctor, who is supported by another consultant paediatrician with a special interest in training and education. Level 1 Training is included in every induction programme, and in all annual mandatory updates for clinical and non-clinical staff. Attendance is recorded on the electronic staff record (ESR).

The Trust's Training and Competencies strategy for child protection was completed and ratified in March 2010. New national (intercollegic) child protection guidance was published in September 2010. It is envisaged that an increased percentage of staff will require to be level 3 competent. A plan to increase access to level 3 training opportunities, supported with advice about how to achieve and maintain this level of competency. It continues to be a challenge to accurately record number of staff attending level 2 training but a plan has been agreed to enable an electronic record of existing and future data to be compiled during 2011.

4.7 **Safeguarding Children Improvement Team (SIT) visit**

The NHS London Safeguarding Children Improvement Team carried out a two day visit to Islington in May 2010. Whittington Hospital was one of the Provider Trusts that participated in the visit, which found that safeguarding was well embedded in practice, with high levels of commitment and partnership. Particular areas highlighted by the SIT team in relation to Whittington Hospital were:

- There are stronger links with community paediatric colleagues than often seen elsewhere.
- There are good links with social care.
- The Whittington Hospital Emergency department -has 'Excellent processes' and strong links with the excellent hospital social work team.
- There is stability in Child protection leads
- The Whittington Hospital held in high regard by other local professional.
- A recommendation to review of the joint role (Matron/named midwife role)
- There was a concern regarding lack of access to mandatory Child Protection Supervision
- There was an Identified under use of the Common assessment Frame work (a nationally recommended multi disciplinary assessment framework)

An action plan to address concerns was put into place and will be monitored through the Trust Child Protection Committee.

4.8 **Announced Ofsted / CQC inspection**

An Announced Ofsted Inspection of Safeguarding Children and Children Looked After services in Haringey took place in January 2010. The service was assessed as adequate with the following comments

"The overall effectiveness of the council and its partners in safeguarding and promoting the welfare of children in Haringey is adequate. Highly visible and committed leadership within the partnership, including the HSCB and Haringey Children's Trust, has strengthened safeguarding provision and systems over the past 18 months. The arrangements for contact, referral and assessment of children in need or who are at risk of harm are good and the improvements reported after the last unannounced inspection of the service in August 2010 have been sustained. Effective partnership working between council children's services, health services, the police, the voluntary sector and other agencies is helping to ensure the early identification and assessment of children and young people in need or who are at risk of harm".

It is anticipated that an Announced Ofsted Inspection of Safeguarding Children and Children Looked After services will be carried out in Islington in 2011. In preparation for this, a gap analysis and robust review of service evidence is being led by the Islington Designated Nurse for Child Protection.

4.9 **Serious Case Reviews (SCR)**

A monthly report on all SCR is reviewed by Trust Child protection Committee and Trust board.

A Local Safeguarding Children Board (LSCB) should always undertake a serious case review when a child dies (including death by suicide), and abuse or neglect is known or suspected to be a factor in the child's death. This is irrespective of whether LA children's social care is or has been involved with the child or family. (London Child Protection Procedures 2010 LSCB)

During 20010/11 the Trust were involved in five SCR's, as follows:-

4.9.1 **Child A Serious Case Review**

In the summer of 2009, a four month old child died in Islington from unexplained injuries. The serious case review into his death has been concluded and learning disseminated, but the publication of the Executive Summary will be delayed until after the conclusion of the trial of both parents. The trial is likely to provoke media interest and was due to commence in mid May 2011, but has been postponed with no current information on a rescheduled commencement date.

As a result of the individual management review (joint Islington PCT and Whittington Hospital) the community midwifery service instigated a robust electronic information sharing process.

4.9.2 **Child S Serious Case Review**

In November 2009 a 9 year old girl was brought into emergency department and died. A decision was made by Hackney Safeguarding Children Board to undertake a Serious Case Review. Whittington Hospital was one of the agencies required to provide an Individual Management Review (IMR) of services provided to her and her family, as it was believed that her death was caused by abuse or neglect. She was undernourished and autopsy indicated clinical rickets.

The Whittington Hospital IMR was produced by the Named Nurse for child protection and was submitted to the serious case review subgroup of Hackney Safeguarding Children Board within the required timescale. This was a challenging SCR, with the importance of identifying children's fathers, the role they play within the family and the care and support they provide, and the importance of identifying, exploring and assessing the impact of culture and belief systems on the care and nurturing of children. A detailed action plan has been completed and learning disseminated through training.

4.9.2 **Family Q Serious Case Review**

This was a review of four children who were present in the family home in December 2009 when their mother was murdered. There was a long history of domestic violence between mother and father. A decision was made by Haringey Safeguarding Children Board to undertake a Serious Case Review, and Whittington Hospital was one of the agencies required to provide an Individual Management Review (IMR) of services provided to the family.

The Whittington Hospital IMR was produced by the Named Nurse for child protection. It was submitted to the serious case review subgroup of Haringey Safeguarding Children Board within the required timescale and to Ofsted November 2010, and rated to be good. The Serious Case Review Executive Summary is available on the Haringey council website. Criminal proceedings have been completed and father given a prison sentence. An action plan has been completed and learning will be disseminated.

4.9.3 **Child W Serious Case Review**

As a result of the death of a ten month old child from alleged forced feeding in Waltham Forest in March 2010, a decision was made by Waltham Forest Safeguarding Children Board to undertake a Serious Case Review. Prior to the death of the baby, the parents and three older siblings had resided in Islington for a number of years, and attended the Whittington Hospital. One attendance resulted in the referral of an older sibling to children social care following an disclosure that she had been force fed. Consequently the hospital was one of several agencies required to provide an Individual Management Review (IMR) of services provided to the family during the period that they were known to have lived in Islington.

The Whittington Hospital IMR was produced by the general manager for women & children's services, as the named nurse for child protection was deemed to have a conflict of interest. It was submitted to the serious case review subgroup of Waltham Forest Safeguarding Children Board within the required timescale. The Serious Case Review Executive Summary cannot be published until completion of criminal proceedings. Police charges have been brought against both parents and the trial is due to begin in mid September 2011, with likely media interest. Whittington Hospital staff have been interviewed by the police and it is anticipated that staff may be called to give evidence at the trial.

As a result of the individual management review a revised robust process of recording and storing information in the emergency department when there are child protection concerns and the child does not require admission has been instigated. Senior paediatric medical and nursing staff have been reminded of their responsibility to document all meetings and conversations in the hospital records in addition to formal children social care minutes. The importance of acknowledging role of fathers in children's lives and ensuring fathers names are recorded. The paediatric register and staff nurse in ED were identified as exhibiting excellent practice.

4.9.4 **Child B and Child C Serious Case Review**

In mid February 2011 two siblings aged 10 years and 8 years were killed in Southwark whilst in the care of their father. The mother and both children were Islington residents and had received services from both the Whittington Hospital and community health services. A decision was made by Islington Safeguarding Children Board to undertake a Serious Case Review into the deaths of the children and Whittington Health was one of the agencies required to provide an Individual Management Review (IMR) of services provided to the family.

The Whittington Health IMR will be co-produced by the Islington Named Doctor and Named Nurse. The timescale for completion of the serious case review and submission of reports to Ofsted and the Department for Education is mid August 2011. The Health Overview IMR will be co-produced by the Islington Designated Doctor and Designated Nurse. The police investigation into the deaths of the children is ongoing and some community health staff have been interviewed. Police charges have been brought against the father and the trial is due to begin in mid September 2011, with likely media interest.

Progress on action plans will be reported to the Whittington Health Child Protection Committee and monitored by the Quality and Assurance Subgroup of the Islington Safeguarding Children Board, and any learning disseminated through training.

4.10 **Whittington Health – the Integrated Care Organisation (ICO)**

In preparation for the formation of the new organisation, an ICO Safeguarding Children Subgroup was formed as part of the clinical governance transition workstream. This group met monthly from December 2010, and was chaired by Maggie Buckell, then Joint Director, Children's Community Services (Islington). The purpose of the subgroup was to map existing child protection service provision in the legacy organisations and agree a work plan moving forward to the new organisation.

Great care was and will continue to be taken to ensure that during the period of transition staff remained clear about which local child protection policy and guidance is to be followed. Each organisation currently has in place an agreed child protection operational policy/guidelines; training strategy/guidelines; staff supervision policy. Work will commence in April 2011 to create a single Whittington Health NHS Trust child protection operational policy which will incorporate guidance on training and supervision. Until this work has been completed staff will continue to follow their existing local organisational guidance and a position statement to this effect will be widely disseminated to staff.

Priorities for 2011-2012:

- Review and amalgamated community and hospital Child Protection guidelines and develop a Whittington Health Child Protection Strategy.
- Continue to improve quality of training and the recording of training activity to provide assurance to the Whittington Health board to ensure that children can rely on staff to advocate for them.
- Review and develop existing Whittington Health Child Protection audit strategy/plan
- Provide assurances to the Whittington Health Trust board that statutory child protection requirements are being met .

Jo Carroll
Lead Nurse – Safeguarding Children
Named Nurse for Child Protection
July 2011

References

HM Government (2010) **Working Together to Safeguard Children** Stationary office
RCPCH (2010) **Roles and Competences for Health Care Staff**
London safeguarding Children Board (2010) **London Child Protection Procedures** LCPP