Supervision of Parents of Children in Acute Hospital Settings When There Are Safeguarding Concerns

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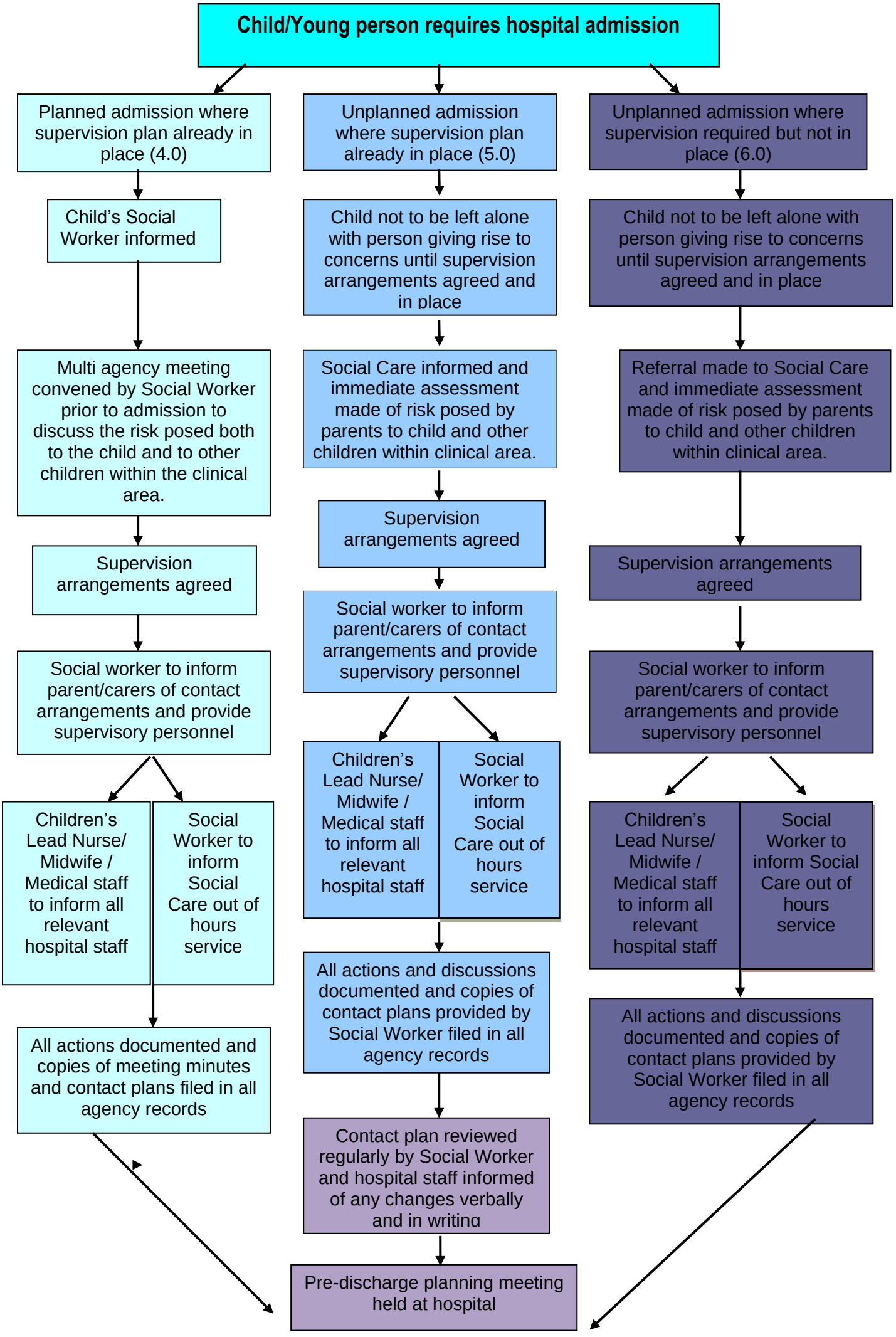
Child/Young person requires hospital admission
Planned admission where supervision plan already in place (4.0)
Child's Social Worker informed
Multi agency meeting convened by Social Worker prior to admission to discuss the risk posed both to the child and to other children within the clinical area.
Supervision arrangements agreed
Social worker to inform parent/carers of contact arrangements and provide supervisory personnel
Children's Lead Nurse/ Midwife / Medical staff to inform all relevant hospital staff
Social Worker to inform Social Care out of hours service
All actions documented and copies of meeting minutes and contact plans filed in all agency records
Unplanned admission where supervision plan already in place (5.0)
Child not to be left alone with person giving rise to concerns until supervision arrangements agreed and in place
Social Care informed and immediate assessment made of risk posed by parents to child and other children within clinical area.
Supervision arrangements agreed
Social worker to inform parent/carers of contact arrangements and provide supervisory personnel
Children's Lead Nurse/ Midwife / Medical staff to inform all relevant hospital staff
Social Worker to inform Social Care out of hours service
All actions and discussions documented and copies of contact plans provided by Social Worker filed in all agency records
Contact plan reviewed regularly by Social Worker and hospital staff informed of any changes verbally and in writing
Unplanned admission where supervision required but not in place (6.0)
Child not to be left alone with person giving rise to concerns until supervision arrangements agreed and in place
Referral made to Social Care and immediate assessment made of risk posed by parents to child and other children within clinical area.
Supervision arrangements agreed
Social worker to inform parent/carers of contact arrangements and provide supervisory personnel
Children's Lead Nurse/ Midwife / Medical staff to inform all relevant hospital staff
Social Worker to inform Social Care out of hours service
All actions and discussions documented and copies of contact plans provided by Social Worker filed in all agency records
Pre-discharge planning meeting held at hospital

1. Introduction

1.1 A sick child is best supported by their parent, carer or relevant family member who is well known to them during an inpatient stay in hospital. This ensures that the child receives family centred care and that an holistic approach for patient care is used. It also allows the nursing staff to focus on the medical/nursing care of the child. The importance of contact with parents / carers whilst children are in hospital is therefore recognised as beneficial to all concerned as well as being a significant factor in the process of care, treatment, rehabilitation and recovery. However there may be times when a child in hospital needs to be protected from a parent / carer.

1.2 This multi-agency protocol has been written in response to learning from Serious Case Reviews. It relates to cases where children are cared for in acute and hospital settings and where there are safeguarding concerns relating to the parent / carers. This applies in Southend, Essex and Thurrock (SET) and in situations where children normally resident in SET are provided with care outside SET.

1.3 It is expected that arrangements will be established between health trusts and those acute trusts from whom they commission services and which may provide care for SET children which will ensure that that they follow the principles of this protocol when children requiring supervision are transferred to settings outside of the SET area.

1.4 <u>Definitions:</u>

Supervision in this instance is usually associated with supervised contact which is provided by the child's responsible local authority where a child protection risk has been identified and restrictions have been imposed on parental contact with the child to ensure the child's safety.

1.5 Acute hospital settings include: paediatric wards, maternity units, mental health units, high dependency / intensive care units, neonatal units and similar. It may also include regional speciality units such as those providing burns treatment or plastic surgery.

1.6 Under the Children Act 1989 a child is defined as being less than 18 years of age. However the following guidance can also be applied to unborn babies where there are child protection concerns.

1.7 The term 'social care' refers to the relevant local authority that the child normally resides in.

1.8 Aim:

The aim of this document is to:

- Aid hospital staff and partner agencies in promoting and safeguarding the welfare of children.

- Provide clarity on the role and responsibilities of the different agencies and practitioners in the supervision of parents / carers in acute specialist hospital settings in cases where there are child protection concerns.

- Allow children contact with parents / carers within a safe and controlled environment in cases where there are child protection concerns.

- Safeguard children within the wider context of support to children and families whilst being sensitive to the needs of children and their parents / carers in the best interests of the child.

2. The Role of this Guidance

2.1 This guidance provides a framework within which professionals and agencies can work together in the best interests of children and families both at local level and where there is out of borough involvement. It is informed by the requirements of the Children Act 1989, and reflects the principles contained within the United Nations Convention on the Rights of the Child, ratified by the U.K. Government in 1991. It also takes account of the European Convention of Human Rights, particularly Articles 6 and 8, which were incorporated into U.K. domestic law on 02 October 2000.

2.2 This is multi-agency guidance. All agencies involved in the care and safeguarding of the child have a shared responsibility to comply with it and in particular to ensure that all actions are documented and shared with all parties where applicable and relevant.

2.3 This guidance should be read in conjunction with the SET Procedures which can be found at:

www.escb.co.uk
www.southend.gov.uk/lscb
www.shapingthurrock.org.uk/safeguard/

2.4 NHS Trusts have a duty to provide a safe and secure environment for patients, staff and visitors. Violent or abusive behaviour will not be tolerated and individual NHS Trust policies for dealing with aggressive or violent situations should be followed as and when they occur.

2.5 This guidance is for acute settings within SET geographical boundaries. Hospitals outside these geographical boundaries but providing care to SET children will be operating under their own local guidance and may substitute

alternative hospital personnel as appropriate. Nevertheless, the basic procedures of referral, liaison and protecting the child / unborn baby should follow those described within this document.

NB: For supervised contact in relation to concerns about fabricated or induced illness, the guidance in '*Safeguarding Children in Whom Illness is Fabricated or Induced'* (DCSF 2008) should be followed.

3. General principles

3.1 The need for parents and carers to be involved in the health care of children and young people is a basic principle of the provision of effective health care within acute health care settings.

3.2 Parental responsibility should be clearly established in order that consent to treatment is given by the appropriate adult. This information should be recorded on the child's care plan and within admission documentation. In the case of planned admissions, parental responsibility should ideally be established during the pre-admission clinic appointment.

3.3 Parents and carers who bring their children to hospital for treatment should be encouraged to participate and work with medical and nursing staff in the care of their child.

3.4 Many parents / carers are resident on the ward with their child and should continue to provide as much care for the children as possible.

3.5 In certain circumstances however it may not be appropriate for parents to care for their child because:

- A safety plan is in place that requires the parent / carer to be supervised which would be agreed by the parents with parental responsibility.
- The parent / carers are implicated in an on-going Section 47 investigation and require supervision until the outcome can be concluded and risks identified. With consent of the parents.
- There are identified child protection concerns which require the parent / carer to be continuously supervised.
- There are restrictions to visiting/contacting the child laid down by a court order.

3.6 In addition to the above there are restrictions imposed by the court on a parent / carer's access to their partner / ex partner e.g. an injunction. In these cases the hospital will facilitate visiting arrangements in the best interests of the child and may ask parents to sign a written agreement in order to minimise the impact of distress on the child.

3.7 It is also important to note that it may be necessary to provide supervision for visits to a child who may be dying or has died. Advice should be requested from managers and senior colleagues to enable the most appropriate action

to be taken. Particular attention should be given to any requests made by the Designated Doctor for Child Deaths and / or the Coroner.

3.8 The purpose of supervision is to ensure safety while enabling the child to have contact with parents, carers and family members.

3.9 In certain circumstances where it becomes apparent that a child needs to be safeguarded from potential significant harm, a hospital may stipulate that access to the child should be supervised by an appropriate person supplied by or authorised by the relevant local authority.

3.10 Despite the absence of a legal order to enforce supervision, the responsible local authority should seek to work in partnership with the hospital where concerns have been identified which would place a child at risk of potential significant harm and provide a supervisor to carry out this task.

3.11 Where there is professional disagreement about whether or not a parent / carer needs to be supervised, concerns should be escalated within the individual organisations in accordance with the guidance in SET Procedures.

3.12 The hospital setting is defined as a “Safe Place” by The Children Act 1989 but it is neither reasonable nor practical for nursing or midwifery staff to be expected to monitor a level of contact between parents / carers and child which exceeds what would be expected during the clinical nursing care / observation roles / responsibilities of nursing staff. Nurses and midwives are not able to be continuously present to supervise or monitor one to one social contact.

3.13 It is the responsibility of children’s social care to organise and fund child protection supervision. If they are unable to provide a staff member, then the social worker must identify either an agency social worker or another family member, who is able to undertake safe supervised contact between parent and child.

3.14 Any deliberations in relation to the contact allowed with the child must take into account what is in their best interests, ensuring that the welfare of the child is paramount as defined within the Children Act (1989). Where appropriate the wishes of the child should be sought and their needs kept central to all decisions and discussions.

3.15 The local authority should be sensitive to the impact of supervision of children on the child, other patients and parent/carers.

3.16 Hospital staff should be committed to ensuring that any child / young person who requires medical care is also provided with emotional care. This should form part of the holistic approach to care of the child whilst in hospital.

3.17 Some children may be admitted to hospital with supervision arrangements outlining specified contact arrangements for their parent / carer in the community already in place and agreed by the responsible local authority.

3.18 If a child is subject of a child protection plan, it may state that parents are only allowed supervised contact with their child. This would need to be agreed by parents with parental responsibility.

3.19 A child may be subject to an Emergency Protection Order, Interim Care Order or Care Order. A court order may stipulate that a parent/s is / are not allowed contact with their child at all, or only if the contact is supervised.

3.20 Parents will be fully aware if a Plan or Order is in place and the requirement to cooperate.

3.21 While these general principles should be consistently applied, the procedure to follow will vary depending on whether:

- The admission is planned or unplanned
- The need for child protection supervision has been agreed with parent / carers
- Child protection concerns are being investigated but the need for supervised contact has not yet been agreed with parent / carers
- Appropriate supervised contact plan is in place
- Appropriate supervised contact plan is not in place

4. Planned Admission where supervision is already in place

4.1 As far as possible all planning for the child's hospital stay needs to be carried out prior to the date of admission. Unborn babies may have a pre birth plan in place which requires supervised contact immediately after delivery. This should have been previously agreed at a multi-agency meeting pre-birth.

4.2 When any professional becomes aware that a child requiring supervised contact with their parent / carer is to be admitted to hospital they must alert the relevant social worker within one working day.

4.3 Information sharing between agencies must take place prior to admission, an inter-agency meeting should be convened by the social worker to ensure that the child's needs during their admission are both known and considered by all involved agencies. This should be held with the full co-operation of other agencies involved with the child.

4.4 If a decision is made not to convene a meeting and another form of information sharing is chosen i.e. phone this should be with the agreement of safeguarding manager in both health and social care and take into account the contents of 4.7, documentation should record the reasons for the decision.

4.5 Action must not be delayed unreasonably because of the absence of key individuals and the achievement of vital outcomes such as protecting the welfare of the child must be paramount.

4.6 As a minimum, this meeting should include the social worker and representatives from the hospital setting, for example, the lead consultant and the ward manager. It may also involve other professionals such as a member of the hospital safeguarding team, the health visitor, midwife, school nurse or a member of the Police Child Abuse Investigation Team as appropriate.

4.7 The focus of this multi-agency meeting should be to discuss the risk which the parent / carers pose both to the child and to other children within the clinical area. The meeting should reach a decision on what supervision arrangements need to be in place and how they will be implemented. The supervision plan must clearly identify who is being supervised, by whom, when and where. Consideration should also be given as to who else may have access to the child.

4.8 Where a child protection plan is already in place and includes the need for supervised contact with parents / carers, the meeting must consider whether it will remain fit for purpose for the duration of the child's stay in hospital.

4.9 If the child is Looked After by the local authority and a supervision agreement is already in place, the plan may continue exactly as before with the exception that the hospital may be substituted as the agreed venue depending on the child's health. Agreement should be sought from the hospital before any decision is taken.

4.10 The social worker will take minutes of the meeting and disseminate them, together with a copy of the parentally signed, supervised contact plan to all relevant agencies before the child's admission. Once received, both documents should be filed within the child's record for each attending agency.

4.11 The social worker must inform the duty social worker team so that they are fully aware of the arrangements in place should any issues arise out of hours. The social worker will ensure that the ward has the contact details for the Emergency Duty Team both in and out of hours.

4.12 Where a court order is in place, the social worker should provide the relevant agencies with a copy which should also be placed within the child's record for each agency. Where the situation is not clear, agency representatives should work together, sharing known information, to determine appropriate arrangements.

4.13 Parent / carers must be informed as soon as possible of the supervision arrangements. The decision of the meeting will be relayed to them by the social worker. Parents requiring further guidance can be provided with advice about alternate sources of support or advice e.g. solicitors or the Citizen's Advice Bureau.

4.14 The children's lead nurse / nurse or midwife in charge of the ward / medical staff will ensure that staff responsible for day to day care of the child are made aware of the supervision arrangements. The named nurse / midwife should

also be informed. All nursing care plans must record the requirements of the supervised contact plan.

4.15 The plan should be reviewed when new information is received and updated as required by the child's social worker. If it is considered to be in the best interests of the child to alter the amount of supervised contact whilst they are in hospital, the social worker in partnership with the parents / carers must draw up the new agreement, clearly detailing the amended arrangements.

4.16 Any change to the agreed plan or supervisory personnel together with the explanatory reasoning must be notified immediately by the social worker to the children's services lead nurse / senior midwife in writing and copied into the named nurse / midwife safeguarding children.

4.17 Any practitioner supervising the family must be fully conversant with the associated child protection concerns.

4.18 If the parents / carers arrive on the ward at a time other than agreed within the supervised contact plan, they should be asked to leave by the nurse in charge of the ward and directed towards the local authority social care team. If they refuse to comply the Trust's policy for dealing with violence or aggression should be followed.

4.19 Social care must be informed before the child is discharged from hospital. A pre-discharge planning meeting must be convened in accordance with SET Procedures.

4.20 If SET criteria for pre-discharge meeting is not met a decision, information from the admission and subsequent plan must be shared between involved agencies. Discussion must take place between the social worker and safeguarding manager on how this will happen including documenting actions

5. Unplanned Admission where supervision is already in place

5.1 When any professional becomes aware that a child requiring supervised contact with their parent / carer has been admitted to hospital they must immediately alert the social worker. If out of hours the emergency duty team should be contacted.

5.2 Action must not be delayed unreasonably because of the absence of key individuals and the achievement of vital outcomes such as protecting the welfare of the child must be paramount. The child should not be left alone with the person giving rise to concerns until a multi-agency agreement can be reached about who can have unsupervised contact.

5.3 An inter-agency discussion should be facilitated by the social worker to ensure that the child's needs during their admission are both known and considered by all involved agencies.

5.4 As a minimum, this discussion should include the social worker and representatives from the hospital setting, for example, the lead consultant and the ward manager. It may also involve other professionals such as a member of the hospital safeguarding team, the health visitor, midwife, school nurse or a member of the Police Child Abuse Investigation Team as appropriate.

5.5 The focus of this multi-agency discussion should be to determine the risk which the parent / carers pose both to the child and to other children within the clinical area. A decision should be reached as to what supervision arrangements need to be in place and how they will be implemented. The supervision plan must clearly identify who is being supervised, by whom, when and where. Consideration should also be given as to who else may have access to the child.

5.6 Where a child protection plan is already in place and includes the need for supervised contact with parents / carers, the discussion must consider whether it will remain fit for purpose for the duration of the child's stay in hospital.

5.7 If the child is Looked After by the local authority and a supervision agreement is already in place, the plan may continue exactly as before with the exception that the hospital may be substituted as the agreed venue.

5.8 All agencies must document the content of the discussion within the child's notes. The social worker will disseminate a copy of the agreed, parentally signed, supervised contact plan to all relevant agencies. Once received the plan should be filed within the child's record for each agency.

5.9 The social worker must inform the duty social worker team so that they are fully aware of the arrangements in place should any issues arise out of hours. The social worker will ensure that the ward has the contact details for the Emergency Duty Team both in and out of hours.

5.10 Where a court order is in place, the social worker should provide the relevant agencies with a copy which should also be placed within the child's record for each agency. Where the situation is not clear, agency representatives should work together, sharing known information, to determine appropriate arrangements.

5.11 Parent / carers must be informed as soon as possible of the supervision arrangements. The decision of the discussion may be initially relayed to the parent / carers by the children's lead nurse / nurse or midwife in charge of the ward / medical staff but this must be followed up by face to face contact with a social worker within 24 hours. Parents requiring further guidance can be provided with advice about alternate sources of support or advice e.g. solicitors or the Citizen's Advice Bureau.

5.12 The children's lead nurse / nurse or midwife in charge of the ward / medical staff will ensure that staff with day-to-day care of the child and the named nurse / midwife safeguarding children are made aware of the supervision

arrangements. All nursing care plans must record the requirements of the supervised contact plan.

5.13 The plan should be reviewed when new information is received and updated as required by the child's social worker. If it is considered to be in the best interests of the child to alter the amount of supervised contact whilst they are in hospital, the social worker in partnership with the parents/carers must draw up the new agreement, clearly detailing the amended arrangements.

5.14 Any change to the agreed plan or supervisory personnel together with the explanatory reasoning must be notified immediately by the social worker to the children's services matron / senior midwife in writing and copied into the named nurse / midwife safeguarding children.

5.15 If the parents / carers arrive on the ward at a time other than agreed within the supervised contact plan, they should be asked to leave by the nurse in charge of the ward and directed towards the local authority social care team. If they refuse to comply the Trust's policy for dealing with violence or aggression should be followed.

5.16 Any practitioner supervising the family must be fully conversant with the associated child protection concerns.

5.17 Before the child is discharged from hospital a pre-discharge planning meeting must be convened in accordance with SET Procedures.

6. Unplanned Admission where supervision is required but not in place

6.1 When a child who has suffered significant harm presents in an acute hospital setting or child protection concerns for an unborn child arise during labour, a referral must be made to children's social care in accordance with SET Procedures.

6.2 However where it is thought that a parent / carer has inflicted the harm, a referral should be made immediately to children's social care informing them of the risk that the parents / carers may pose to the child. A multi-agency meeting should be convened following the referral which includes assessing the risk that the parent / carers may pose to:

- the child/unborn baby
- other children in the family home
- other children in the clinical setting

6.3 Identified risks need to be discussed and a shared response and plan needs to be made in collaboration with all agencies involved. Any arrangements for supervision need to be agreed at this meeting. A risk assessment regarding patient and staff safety needs to be considered regarding any wider safety concerns and internal policies should be adhered to.

6.4 If it is agreed that parents present a high level of risk to the child and to others but that they need to be present on the ward due to the clinical condition of the child then it is the responsibility of the social worker to ensure that supervision arrangements are made for the family. If this cannot be facilitated then parents will need to be refused entry to the ward.

6.5 A joint decision based on a risk assessment should be reached as to what supervision arrangements must be put into place and how they will be implemented. The supervision plan must clearly identify who is being supervised, by whom, when and where. Consideration should also be given as to who else may have access to the child. The child should not be left alone with the person giving rise to concerns until a multi-agency agreement can be reached about who should have unsupervised contact.

6.6 All agencies must document the content of the discussion within the child's notes. The social worker will disseminate a copy of the agreed, parentally signed, supervised contact plan to all relevant agencies. The plan should be filed within the child's record for each agency and a copy sent to the named nurse / midwife.

6.7 Parent / carers must be informed as soon as possible of the supervision arrangements. Following a formal referral to social care it is generally the responsibility of the social worker to explain the plan at every stage of the process to the parents, although out of hours the police or health staff may do this.

6.8 Parents requiring further guidance can be provided with advice about alternate sources of support or advice e.g. solicitors, Patient Advice & Liaison Services (PALS) or the Citizen's Advice Bureau.

6.9 The social worker must inform the Emergency Duty Team so that they are fully aware of the arrangements in place should any issues arise out of hours. The social worker will ensure that the ward has the contact details for the Emergency Duty Team both in and out of hours.

6.10 If a court order is obtained, the social worker should provide details of the order to all professionals involved. Where the situation is not clear, agency representatives should work together, sharing known information, to determine appropriate arrangements.

6.11 The children's lead nurse / nurse or midwife in charge of the ward / consultant / specialist registrar will ensure that staff with day-to-day care of the child and the named nurse / midwife safeguarding children are made aware of the supervision arrangements. All nursing care plans must record the requirements of the supervised contact plan.

6.12 The plan should be reviewed when new information is received and updated as required by the child's social worker. If it is considered to be in the best interests of the child to alter the amount of supervised contact whilst they are

in hospital, the social worker in partnership with the parents / carers must draw up the new agreement, clearly detailing the amended arrangements.

6.13 Any change to the agreed plan or supervisory personnel together with the explanatory reasoning must be shared with the relevant professionals.

6.14 If the parents / carers arrive on the ward at a time other than agreed within the supervised contact plan, they should be asked to leave by the nurse in charge of the ward and directed towards the local authority social care team. If they refuse to comply, the Trust's policy for dealing with violence or aggression should be followed.

6.15 Any practitioner supervising the family must be fully conversant with the associated child protection concerns.

6.17 Before the child is discharged from hospital a pre-discharge planning meeting must be convened in accordance with SET Procedures.

Patient Transfers

6.18 When transferring children to another hospital setting the supervision plan must be shared with the receiving hospital and be directed to senior nursing and medical staff.

This information should include:

- risks posed to child by parent / carers
- the level of supervised contact required
- arrangements currently in place

6.19 If a supervision plan has not been established prior to the child being transferred from one setting to another (for example in the case of an emergency admission / transfer), social care should take responsibility for contacting the receiving hospital and setting up a multi-agency meeting / discussion in accordance with the above guidance on unplanned admissions.

6.20 In cases where supervision is required it is expected that social care will continue to take responsibility for arranging this even if the child is transferred into a hospital setting outside of SET. Social care will make alternative arrangements when it is not possible for a member of social care to undertake this role, for example by using agency staff.

7. Record Keeping

7.1 Each agency should record an accurate history of what was said or done, by whom and in what circumstance; it must be factual and not include supposition or opinion. All interventions and their resolution must be contemporaneously documented, recording the time and place and signature of the author and the supervised contact arrangements must be included. Associated documents should be filed in the child's record for each agency.

References

1. Children Act 1989 (2001) London, The Stationery Office.

2. Working Together to Safeguard Children (2015) London, The Stationery Office.

3. The Human Rights Act (1998) London, The Stationery Office.

4. The United Nations Convention on the Rights of the Child 1991 (1992) London, The Stationery Office.

5. National Commission of Inquiry into the Prevention of Child Abuse (1996) *Childhood Matters: Volumes One and Two,* Stationery Office, London. DOH

6. SET Child Protection and Safeguarding Procedures (2015)