

Supervision of Parents of Children and Young People in Hospital (including the new-born baby)

– Multi-agency Protocol

1. Introduction

1.1. 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. Hospitalisation, even for brief periods, can be distressing for a child and separation from parent/carers may increase their anxiety throughout the course of the admission. The contribution of parents to their child's health care is seen as essential and there would be very few situations when it would be considered to be necessary for parental presence to be restricted or monitored on hospital wards.

1.2 There may be occasions, however, when the need for supervision of parents to occur is necessary due to the social circumstances in which the child/young person lives and/or the risk which adults may present to both the index child and any other children in the hospital. This protocol is intended to provide guidance to staff from a number of agencies and assist them to increase awareness of the need for effective planning when it is identified that an adult may present a risk to a hospitalised child or other children who may be cared for within the vicinity. This should be read in conjunction with single agency policies regarding individuals who pose a risk to others.

1.3. If there is a Court order regulating the contact that an adult can or can't have with the child/children, that information must be recorded in the hospital record .

2. Children requiring planned admission to hospital

2.1. As far as possible all planning for the admission needs to be carried out prior to the admission taking place. This includes compilation of supervision plans. There must be acceptance from all agencies that if parents require supervised access to their child outside of the hospital then the same arrangements should remain during hospital admission /attendance unless there is documented reason as to why this does not need to occur.

2.2. Prior to admission, if there are specific risks to be considered a multi-agency meeting should be called by the social worker to share information and concerns about the family as appropriate. The membership of the meeting should consist of the social worker, health visitor (in child under 5 years), school nurse (child over 5 years), police officer (if applicable), hospital safeguarding team, lead consultant, and the ward manager from area where child is likely to receive health care. The risks posed and any requirement for supervision will be discussed. **The decision as to whether or not it is safe for parents to remain unsupervised within hospital departments should be a multi-agency one which must be agreed by the hospital staff who are accountable for ensuring that the areas in which health care for children and young people is provided within their organisation is safe.**

2.4. Parents should be kept informed of the outcome of this meeting. This might be, for example, that the supervision is carried out by a family member, it is provided by children services staff or that there should be no contact. It is unlikely that hospital staff will be responsible for carrying out any supervisory responsibilities. The decision of the meeting will be relayed to the parents by the social worker. Parents may be asked to sign a working agreement in order to guarantee compliance.

2.5. It is the responsibility of the social worker to ensure that they provide staff for supervision if that is the plan. If children's services are unable to offer supervision of a parent, then it their responsibility to identify a key individual including another family member who may be able to supervise contact between parent and child. The hospital staff must be provided with the details of the person/s identified as appropriate to carry out the supervision.

2.6. The Lead Consultant, medical and nursing teams will ensure that the arrangements for supervision are communicated across the health professionals providing care to the child whilst in hospital. It is recognised that decisions regarding supervised contact may be subject to change as the child protection process continues. Close liaison is required with the allocated social worker and police (as required) to ensure that any changes in the supervision plan are clearly documented and communicated to the health team, the family and the child (where appropriate). The Hospital Safeguarding Team will support staff, ensure close multi-agency working and assist in the escalation of concerns where necessary.

3. Child requiring emergency admission to hospital

3.1. It must be recognised that unplanned admissions to hospital present an unknown risk and it may take some time to establish if the child is known to services, what level of risk that parents may pose to children and what supervision may be required. Clarifying these points may also be dependent upon the clinical condition of the child at the time of admission to hospital and the reason for the child's admission. For example a child who is admitted in an extremely sick condition whose clinical condition may be life threatening.

3.2. If a child is admitted with a medical condition unrelated to any child protection concerns, the parent /carer should routinely be asked if they have a social worker. However where there is facility for C-PIS hospital staff must check to see if the child is known. This information must be shared with the health visitor and school nurse as applicable.

3.3. If the child is 'looked after' in local authority care, with a relative or at home, consideration must be given to who holds parental responsibility, relationships between birth parents and foster carers and appropriate contact arrangements.

4. Child requiring emergency admission to hospital and where non-accidental injury/child abuse is suspected

4.1. When non-accidental injury/child abuse is suspected, a strategy meeting needs to occur between hospital staff, police and social worker as soon as possible. One of the aims of the strategy discussion is to establish the level of risk which parents may pose to the child or to others. If the child's admission is outside of normal working hours this must not prevent the meeting occurring - it is reasonable for this to be via telephone. The doctor/ nurse caring for the child must ensure that this conversation is documented in the child's medical records. If it is believed 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 may need to be refused entry to the ward. **Under no circumstances should a member of hospital staff be responsible for supervising parental contact with a child.**

4.2. A care plan (see appendix for example) must be compiled to ensure that all health staff in the hospital are clear as to the supervision arrangements for the family. The clinical team responsible for the child must ensure that the supervision plan is clearly documented and updated in liaison with children's social care and the police. This will be supported by the hospital safeguarding team.

4.3. The child's social worker will ensure that any new information regarding the risk posed by parents is shared with other agencies promptly and arrangements adapted accordingly. The police have powers under protection of vulnerable people if the risk is unacknowledged by the parents or there is a risk not able to be managed by agreement.

5. Considerations if the clinical condition of the child deteriorates.

5.1. Dependent upon the clinical condition of the child at the time of their admission to hospital a plan must be developed in case the patient deteriorates and their condition becomes critical. Contact arrangements must be verified with Children's Services and the Police in line with the allocated Consultant and Clinical Team during this time and documented accordingly.

5.2. If a child/young person deteriorates unexpectedly and it has been identified that the parents/carers pose a significant risk to the child then the decision regarding access would lie with the allocated responsible Consultant leading the child's care. If a decision is made to grant the parents access outside of the proposed agreement due to their child's deterioration then Children's Services and the Police must be contacted urgently and all decisions documented clearly within the hospital records.

5.3. Additional measures and actions may be required to be completed to ensure the safety of the child under such circumstances, such as the identification of additional clinical support for the ward/unit to ensure appropriate allocation of staff until Children's Social Care and/or the Police are able to put more appropriate measures in place. This should be agreed through the appropriate Trust management structure.

6. Supervision in Maternity Services.

6.1. Parental bonding with the newborn is expected and encouraged however there may be circumstances similar to those outlined in section 1.1. where it is deemed necessary for this contact to be supervised. Where at all possible, the need for supervision should have been identified and planned in a multi-agency meeting involving the social worker, safeguarding midwife, health visitor and police (where applicable) as part of the pre-birth assessment process.

6.2. If there are concerns regarding the safety of the newborn in the presence of the mother, until there is a court order there can be no action to limit contact between a baby and mother unless there is voluntary agreement to do so. These agreements would have been made prior to delivery by children social care, the police, safeguarding midwives and parents.

In those circumstances the baby would be cared for on another ward and brought to the mother for supervised feeds, or supervised contact when this can be managed by ward staff. Only in very exceptional circumstances would this be the case, even when the intention is to go for removal from parental care prior to discharge.

6.3 The Safeguarding midwives will ensure that information is shared between the multi-agency partners and the Consultants and other health professionals involved in the woman and baby's care.

