



Safeguarding Children

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YOUR STATUTORY RESPONSIBILITIES

These cards should be used as a guide, and should you have a safeguarding concern they should always be used alongside your organisational and local multi-agency policy and procedures.

As NHS employees all health professionals have a statutory duty and responsibility to safeguard and promote the welfare of children and young people. This should be an integral part of care offered. (*Children Act 2004*)

All practitioners have a role to play in supporting children to achieve the 5 Every Child Matters outcomes:

- Be Healthy
- Stay Safe
- Enjoy and Achieve
- Make a Positive Contribution
- Achieve Economic Wellbeing

(*Every Child Matters 2004*)

A Child is anyone who has not yet reached their 18th birthday. This includes unborn children (*Children Act 1989 and 2004*).

Safeguarding and promoting the welfare of children is protecting children from maltreatment and preventing impairment of children's health or development. It involves ensuring that children are growing

up in circumstances consistent with the provision of safe and effective care, enabling optimum life chances and entering adulthood successfully.

Child Protection is the activity which is undertaken to protect specific children who are suffering or at risk of suffering significant harm.

'The Child's welfare is paramount.'

S.1 Children Act 1989.

Children have a "Right" (under the *UN Convention on the Rights of the Child - 1989*) **to have their best interests as the primary concern when decisions are made about them** (Article 3).

They also have the right under UN Convention to:

- Life and healthy development (*Article 6*)
- Be protected from hurt and mistreatment, physically or mentally (*Article 19*)
- Be properly cared for and protected from violence, abuse and neglect by their parents and anyone else who looks after them (*Article 19*)
- Be protected from activity which takes advantage of them and could harm their welfare and development, including sexual exploitation, sale and trafficking. (*Article 36*)

YOUR STATUTORY RESPONSIBILITIES

All staff who come into contact with children and their families have a responsibility to safeguard and promote their welfare and should know what to do if they have concerns about a child. This responsibility also applies to staff working primarily with adults who have dependent children that may be at risk because of their parent or carer's health or behaviours.

All health staff that come into contact with children and their families have a minimum responsibility to:

- Have the competencies to recognise and understand what constitutes child maltreatment
- Recognise the potential impact of parent/carers physical and mental health on the well-being of the child
- Act as an effective advocate for the child
- Be clear about own and other colleague's roles and responsibilities and professional boundaries
- Be aware of your Local Safeguarding Children Board's multi-agency child protection procedures
- Know where to seek expert

advice and support by knowing the contact details of your local/ organisations Named and Designated Professionals

- Know when and how to make a referral to your local Children's Services
- Know when and how to share Information about child welfare concerns
- Know how to record details of any concerns and any actions you take including reasons for no action
- You must be trained to the appropriate level, in line with Safeguarding Children and Young people: Roles and Competencies for Health Staff (Intercollegiate Document 2014 3rd Edition)
- You must access regular supervision or peer review to support you in managing safeguarding and child protection cases

WHISTLE BLOWING

If in doubt about whether appropriate action has been taken in relation to your concerns about a child contact your nominated safeguarding children lead or your Named/Designated Nurse for Safeguarding.

YOUR STATUTORY RESPONSIBILITIES

MANAGING ALLEGATIONS

Despite all efforts to recruit safely there will be occasions when allegations of abuse against children are raised. The allegations may relate to the person's behaviour at work, at home or in another setting. All allegations of abuse of children by those who work with children must be taken seriously. Allegations against people, who work with children, whether in a paid or unpaid capacity, cover a wide range of circumstances.

If you are aware of a person who works with children and has:

- Behaved in a way that has harmed a child, or may have harmed a child
- Possibly committed a criminal offence against or related to a child, or
- Behaved towards a child in a way that indicates he/she is unsuitable to work with children

All such allegations made against adults working with children must be referred to the Local Authority Designated Officer (*LADO*) who provides advice and guidance to employers and voluntary organisations, liaises with the police and other agencies and monitors the progress of cases to ensure that they

are dealt with as quickly as possible consistent with a thorough and fair process.

Local Safeguarding Children Boards will have arrangements in place for monitoring and evaluating the effectiveness of this process.

For further information see the resources section link to your local Safeguarding Children Board.

GOOD PRACTICE

Examples of good practice are stored on individual Local Authority Safeguarding Children's Board Websites which are listed below. In addition to these resources your local Designated Safeguarding Team will be able to signpost you to further resources, including a Safeguarding Self-Assessment Audit Framework, which is an excellent development tool and evidence for CQC registration.

CATEGORIES OF ABUSE & NEGLECT - PREVENT

WHAT IS ABUSE & NEGLECT?

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 in 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 child or children. The following are accepted definitions of abuse and are taken from Working Together to Safeguard Children 2013:

PHYSICAL ABUSE

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

- Conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person
- Not giving the child opportunities to express their views, deliberately silencing them or 'making fun' of what they say or how they communicate
- Age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond a child's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction
- Seeing or hearing the ill-treatment of another person or child
- Serious bullying (*including cyber bullying*), causing children frequently to feel frightened or in danger, or the exploitation or corruption of children

Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.

CATEGORIES OF ABUSE & NEGLECT - PREVENT

SEXUAL ABUSE

Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. It may involve:

- physical contact, including assault by penetration (*rape or oral sex*), or
- non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing
- non-contact activities such as involving children looking at, or in the production of, sexual images
- watching sexual activities or
- encouraging children to behave in sexually inappropriate ways or
- grooming a child in preparation for abuse (*including via the internet*)

Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.

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. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may

involve a parent or carer failing to:

- provide adequate food, clothing and shelter (*including exclusion from home or abandonment*)
- protect a child from physical and emotional harm or danger
- ensure adequate supervision (*including the use of inadequate care-givers*), or
- ensure access to appropriate medical care or treatment

it may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

NOTE: a single indicator is not necessarily proof of abuse and it is important that information is gathered from a number of sources; however, abuse may occur when there are few indicators.

TRIGGER POINTS

Be alert to the possibility of abuse and neglect in children who present with:

- poor dental hygiene and dental caries
- poor physical appearance, dirty, unkempt and fetid
- bruising or marks which maybe bruising in children who are not independently mobile (*NIM*). See following.

CATEGORIES OF ABUSE & NEGLECT - PREVENT

BRUISING IN A NON-INDEPENDENTLY MOVING CHILD

IN ACCORDANCE WITH LOCAL BRUISING PROTOCOL/GUIDANCE IT IS CRUCIAL THAT ANY CHILD WHO IS NOT INDEPENDENTLY MOBILE WHO PRESENTS WITH ANY BRUISING, OF ANY SIZE, IN ANY SITE MUST INITIATE A REFERRAL TO CHILDREN'S SERVICES.

Not Independently Mobile (NIM):

A child who is not yet crawling, bottom shuffling, pulling to stand, cruising or walking independently. Includes all children under the age of six months or children with significant disabilities resulting in immobility.

Bruising:

Extravasations of blood in the soft tissues, producing a temporary, non-blanching discolouration of skin however faint or small with or without other skin abrasions or marks. Colouring may vary from yellow through green to brown or purple. This includes petechiae, which are red or purple non-blanching spots, less than two millimetres in diameter and often in clusters.

NICE guideline When to Suspect Child Maltreatment (*Clinical Guideline 89, July 2009*) states that bruising in any child Not

Independently Mobile should prompt suspicion of maltreatment.

Please refer to your LSCB Local Safeguarding Children Board's multi-agency child protection procedures for more information on your local Bruising Protocol. Additional advice and support with individual cases can also be obtained by contacting your Safeguarding Lead, Named or designated professional in your organisation.

Any child who is found to be seriously ill or injured, or in need of urgent treatment or further investigation, should be referred immediately to hospital. Such a referral should not be delayed by a referral to Children's Services, which, if necessary, should be undertaken from the hospital setting. However it is the responsibility of the professional first dealing with the case to ensure that, where appropriate, a referral to Children's Services has been made.

CYBER/INTERNET ABUSE

Cyber-bullying involves the use of information and communication technologies to support deliberate, repeated, and hostile behaviour by an individual or group that is intended to harm others.

New technologies have become central to modern life. They make it

CATEGORIES OF ABUSE & NEGLECT - PREVENT

possible for people across the world to have instant communication with one another. They allow for the rapid retrieval and collation of information from a wide range of sources, and provide a powerful stimulus for creativity. People may discuss sensitive topics which, face to face, they might find difficult. However, these technologies are also potentially damaging. They can enable children and young people to access harmful and inappropriate materials. Those they engage with may not be directly known to them and because of the anonymity offered by the internet children and young people may be harmed or exploited.

It is important to familiarise yourself with local E-safety processes:

- Policies, procedures and practices
- Education, training and information

PEER ABUSE

Peer Abuse can be defined as one who brings mistreatment, insult or deception in excessive amounts to another individual of the same peer group. This is done physically, mentally, emotionally or sexually.

VULNERABLE PARENTS

Many families can suffer challenges in bringing up their children in

warm, loving and supportive environments. Parenting capacity can be compromised through parental mental illness, learning disability, substance misuse and domestic violence. Sometimes practitioners may have limited or no contact with children. In these circumstances practitioners need to maintain a Child-Focused Approach and keep a strong focus on the outcomes intended for children and young people, which is central to delivering a child focused approach.

RADICALISATION

The processes by which people come to support violent extremism and, in some cases, join terrorist groups.

PREVENT is central to the safeguarding agenda and therefore will be a priority within safeguarding policy, procedure and training.

Any child who is found to be seriously ill or injured, or in need of urgent treatment or further investigation, should be referred immediately to hospital. Such a referral should not be delayed by a referral to Children's Services, which, if necessary, should be undertaken from the hospital setting. However it is the responsibility of the professional first dealing with the case to ensure that, where appropriate, a referral to Children's Services has been made.

CATEGORIES OF ABUSE & NEGLECT - PREVENT

The Government's counter terrorism strategy is known as CONTEST.

PREVENT is part of CONTEST and its aim is to stop people becoming terrorists or supporting terrorism.

CONTEST has four key principles:

1. **PURSUE** – stop terrorist attacks
2. **PREVENT** – to stop people becoming terrorists or supporting terrorism
3. **PREPARE** – where we cannot stop an attack, mitigate its impact
4. **PROTECT** – strengthen overall protection against terrorism attack

The Health Service is a key partner in Prevent and encompasses all parts of the NHS, charitable organisations and private sector bodies which deliver health services to NHS patients.

Three national objectives have been identified for the PREVENT strategy:

Objective 1: Respond to the ideological challenge of terrorism and the threat we face from those who promote it.

Objective 2: Prevent people from being drawn into terrorism and ensure that they are given appropriate advice and support.

Objective 3: Work with sectors and institutions where there are risks of radicalisation which we need to address.

PREVENT focuses on working with vulnerable individuals who may be at risk of being exploited by radicalisers and subsequently drawn into terrorism related activity. What is important, if you are concerned that a vulnerable individual is being exploited in this way you, can raise these concerns in accordance with your organisation's policies and procedures.

Contracts of employment and professional codes of conduct require all healthcare staff to exercise a duty of care to patients and, where necessary, take action for safeguarding and crime prevention.

If you have a concern, discuss it with your Safeguarding Lead and they will advise and identify local referral pathways.

WHEN TO SUSPECT CHILD MALTREATMENT

RECOGNITION & RESPONSE TO SAFEGUARDING/CHILD PROTECTION

The sustained abuse or neglect of children physically, emotionally or sexually can have major long term effects in all aspects of a child's health, development and well-being.

Any abusive incident has to be seen in context in order to assess the extent of harm to a child and to determine the appropriate intervention. Often it is the interaction between a number of factors which serve to increase the likelihood or level of actual significant harm. Prompt action to help a family in trouble may prevent minor abuse escalating into something more serious. All health professionals must always act in the best interests of the child whose welfare is of paramount importance. If there are concerns about the safety or welfare of a child, even if there is no firm evidence to substantiate child abuse or risk of significant harm, some action must follow, such as obtaining advice from your Safeguarding Lead or Named professional or sharing concerns with a colleague who has greater knowledge and experience in relation to child protection.

**DOING NOTHING
IS NOT AN OPTION**

If the child has an injury the following must always be taken into consideration when making an assessment:

- **Is there an explanation for the injury?**
- **Is that explanation compatible with the injury and the developmental stage of the child?**
- **Is it consistent with the history given?**
- **Has there been a delay in seeking help?**
- **Is the parent's or carer's response abnormal or unusual in any way?**

The order in which actions are taken will depend upon the urgency of the situation and the degree of perceived immediate risk or threat to a child. **Urgent concerns must be referred to Children's Services or the Police immediately**

RECORD KEEPING

A record, including completion of a body map must be kept of any injuries noted and disclosures made (*as far as possible using the child's own words*). Records must be:

- legible
- factual
- accurate
- completed contemporaneously

WHEN TO SUSPECT CHILD MALTREATMENT

Where there is a difference in opinion in relation to the diagnosis of possible abuse or neglect, a written record **MUST** be made documenting the different views and the decision made with the rationale.

In most circumstances any concerns should be discussed with the parents or carers and, where possible, their agreement gained to a referral to Children's Services being made. The exception to this is where to do so would put that child, young person or others at increased risk of significant harm or an adult at risk of serious harm, or if it would undermine the prevention, detection, or prosecution of a serious crime including where seeking consent might lead to interference with any potential investigation. If you are in doubt contact your Safeguarding Lead or Named or Designated professional.

Principles to apply when responding to a safeguarding/child protection concern:

- The child's welfare is paramount
- Delay in taking action will often be prejudicial to the child's welfare
- The duty of confidentiality is over-ridden by the duty to protect the child from abuse

- Investigation of the alleged abuse is the duty of the Local Authority Children's services and the police, but investigation will incorporate medical, legal, educational and other services as appropriate
- No single agency or professional can have a full picture of a child's needs and circumstances and, if children and families are to receive the right help at the right time, everyone who comes into contact with them has a role to play in identifying concerns, sharing information and taking prompt action
- All health professionals will work in partnership with parents and carers unless it conflicts with the interest of the child
- Children's best interests are served by being cared for within their own families wherever this is possible

DIVERSITY

Due regard should be given to issues of race, religion, culture, language, gender and disability in all child protection work, however, respect for differences should not be confused with acceptance of any form of abuse or neglect, including "honour" based violence, female genital mutilation (FGM) and forced marriage. The use of specialist

WHEN TO SUSPECT CHILD MALTREATMENT

translators/interpreters may be required in specific circumstances. For further information see the Vulnerable Children section.

Referring your concerns to the Local Authority Children's Services

The person with the concern should make the referral; however, a referral can be made by anyone. Prior to a referral you are advised to discuss concerns with a more senior colleague and if necessary consult with your organisations Safeguarding Lead or Named Professional.

Remember: urgent concerns must be referred to Children's Services or Police immediately.

It is your responsibility to ensure you know the contact details of your local Children Services, Safeguarding Lead or Named Professional and are familiar with local multi-agency child protection/Safeguarding procedures and referral pathway.

When making a referral ensure:

- The information you provide is clear and concise and that the person receiving it will understand your concerns and what you consider needs to happen next.
- Include with your referral, if you have completed one, a risk

assessment, body maps or chronology of involvement

- Telephone referrals are followed up in writing and in accordance with your local child protection procedures
- You keep accurate and up to date records documenting every discussion, action and decision
- Ensure that if you have not heard back from Children's Services within 24 hours you follow up the referral urgently.
- You see seek further advice from your Safeguarding Lead/Named Professional if you disagree with the outcome and decision of Children's Services. LSCB Local Safeguarding Children Board's have policy or guidance on managing Professional Disagreement that should be followed

Remember: You are accountable for what you do or choose not to do.

Please see the following flowchart 'When to Suspect Child Maltreatment' as a quick reference Guide.

WHEN TO SUSPECT CHILD MALTREATMENT

If you consider or suspect child maltreatment it is good practice to follow the process outlined below – A Quick Reference Guide

Listen and observe...

Take into account the whole picture of the child or young person. Sources of information that help to do this include:

Seek an explanation...

for any injury or presentation from both the parent or carer and the child or young person in an open and non-judgemental manner.

Record...

in the child or young person's clinical record exactly what is observed and heard from whom and when.

Record why this is of concern.

CONSIDER child maltreatment...

CONSIDER means maltreatment is one possible explanation for the alerting feature or is included in the differential diagnosis.

At any stage during the process of considering maltreatment the level of concern may change and lead to exclude or suspect maltreatment.

SUSPECT Child maltreatment...

if an alerting feature or considering child maltreatment prompts you to suspect child maltreatment refer the child or young person to children's social care, following Local Safeguarding Children Board procedures.

EXCLUDE child maltreatment...

if a suitable explanation is found for the alerting feature. This may be the decision after discussion of the case with a more experienced colleague or gathering collateral information as part of considering child maltreatment.

RECORD... all actions taken and the outcome.

Remember you are accountable for ensuring that appropriate help is provided to the child following any referral.

ASSESSMENT OF NEED/MANAGEMENT OF RISK

PROVISION OF EFFECTIVE EARLY HELP

Early help assessments, provides a systematic way of analysing, understanding and recording what is happening to children within their families and the wider context of the community in which they live.

The purpose of an early help assessment is to prevent needs escalating to a point where intervention would be needed via a statutory assessment under the Children Act 1989. Effective early help means providing support as soon as a problem emerges and relies upon all professionals and agencies to work together to identify children and their families who would benefit from early help.

Professionals should, in particular, be alert to the potential need for early help for a child who:

- Is disabled and has specific additional needs
- Has special educational needs
- Is a young carer
- Is showing signs of engaging in anti-social behaviour
- Is in a family circumstance presenting challenges for the child, such as substance

misuse, adult mental health, domestic abuse, and/or

- Is showing early signs of abuse and/or neglect

The early help assessment should be undertaken by a lead professional who should provide support to the child and family, act as an advocate on their behalf and coordinate the delivery of support services. The lead professional role could be undertaken by a General Practitioner (GP), health visitor, family support worker, teacher, and/or special educational needs coordinator. Decisions about who should be the lead professional should be taken on a case by case basis and should be informed by the child and their family.

For an early help assessment to be effective:

- The assessment should be undertaken with the agreement of the child and their parents or carers. It should involve the child and family as well as all the professionals who are working with them
- A GP, health visitor, or other professional should be able to discuss concerns they may have about a child and family

ASSESSMENT OF NEED/MANAGEMENT OF RISK

with a social worker in the local authority. The local children's services should set out the process for how this will happen, and

- If parents and/or the child do not consent to an early help assessment, then the lead professional should make a judgement as to whether, without help, the needs of the child will escalate. If so, a referral into local authority children's services may be necessary

ASSESSMENTS UNDER THE CHILDREN ACT 1989

If following your assessment it is necessary to refer a child and family to Children's Services the local authority may complete the following statutory assessments under the Children Act 1989

Section 17: (*Child in Need*).

A Child in need is defined as a child who:

- is unlikely to achieve or maintain a satisfactory level of health or development, or
- their health and development will be significantly impaired, without the provision of services, or
- is disabled

The critical factors to be taken into account in deciding whether a child is in need under the Children Act 1989 are:

- What will happen to a child's health or development without services being provided
- the likely effect the services will have on the child's standard of health and development

Section 17

Children in need under section 17 may be assessed by children's services in relation to their special educational needs, disabilities, or as a carer, or because they have committed a crime. A section 17 assessment should also be undertaken for children whose parents are in prison and for asylum seeking children.

Section 47 (*protective action*)

Some children are in need of protection because they are suffering, or likely to suffer significant harm. Section 47 places a duty on a Local Authority children's service to make enquiries to decide whether they should take action to safeguard or promote the welfare of a child who is suffering or is likely to suffer significant harm. It identifies significant harm as the threshold

ASSESSMENT OF NEED/MANAGEMENT OF RISK

that justifies compulsory intervention in family life in the best interest of the child. In some cases, there may be a need for immediate protection whilst the assessment is carried out.

There are no absolute criteria for identifying significant harm. The severity of ill-treatment depends on:

- The degree and extent of physical harm
- The duration and frequency of abuse and neglect
- The extent of premeditation
- The degree of threat and coercion, sadism and/or unusual elements

Harm is defined in the Children Act 1989 s. 31 (9) as:

- Ill-treatment (*including sexual abuse and physical abuse*)
- Impairment of health (*physical or mental*)
- Impairment of development (*physical, intellectual, emotional, social or behavioural*)

Sections 20 & 31A (Accommodation by the Local Authority)

Some children in need may require accommodation because there is no one who has parental responsibility for them or because they are alone or abandoned. Where the child is subject of a care order (*section*

31A) the local authority must assess the child's needs and draw up a care plan which outlines the services which will be provided to meet the child's needs.

THE PURPOSE OF ASSESSMENT

Whatever legislation the child is assessed under, the purpose of the assessment is always:

- to gather important information about a child and family
- to analyse their needs and/or the nature and level of any risk and harm being suffered by the child
- to decide whether the child is a child in need (*section 17*) and/or is suffering or likely to suffer significant harm (*section 47*); and
- to provide support to address those needs to improve the child's outcomes to make them safe

Assessment should be a dynamic process, which analyses and responds to the changing nature and level of need and/or risk faced by the child. A good assessment will monitor and record the impact of any services delivered to the child and family and review the help being delivered. Whilst services may be delivered to a parent or carer, the assessment should be focused on the needs of the child and on the impact any services are having on the child.

ASSESSMENT OF NEED/MANAGEMENT OF RISK

THE PRINCIPLES OF GOOD ASSESSMENT:

- are child centred. Where there is a conflict of interest, decisions should be made in the child's best interests
- are rooted in child development and informed by evidence
- are focused on action and outcomes for children
- are holistic in approach, addressing the child's needs within their family and wider community
- ensure equality of opportunity
- involve children and families
- build on strengths as well as identifying difficulties
- are integrated in approach
- are a continuing process not an event
- lead to action, including the provision and review of services, and
- are transparent and open to challenge.

Research has shown that taking a systematic approach to enquiries using a conceptual model is the best way to deliver a comprehensive assessment for all children. (*Assessment*

Framework Triangle as set out in the diagram on the following page).

A good assessment is one which investigates the following three domains:

- the child's developmental needs, including whether they are suffering or likely to suffer significant harm
- parents' or carers' capacity to respond to those needs, and
- the impact and influence of wider family, community and environmental circumstances

The interaction of these domains requires careful investigation during the assessment. The aim is to reach a judgement about the nature and level of needs and/or risks that the child may be facing within their family.

It is important that:

- information is gathered and recorded systematically
- information is checked and discussed with the child and their parents/carers where appropriate
- differences in views about information are recorded, and
- the impact of what is happening to the child is clearly identified

ASSESSMENT OF NEED/MANAGEMENT OF RISK

SUMMARY

Your role in assessing children & families in need of additional Services:

All Health Professionals, including those who do not normally work with children, will be expected to play an essential part in ensuring that children and families receive the care, support and services they need in order to promote children's health and development.

Health professionals have a duty to work in partnership with families/ children and other professionals.

Health professionals have a role in: Safeguarding & protecting children. They have a statutory responsibility under the Children Act (1989) to identify any child who may be at risk of significant harm and to refer to a statutory agency.

- Identifying children in need of services and parents who may need extra support in meeting the needs of their children by completing an Early Help Assessment/ Common Assessment Framework (CAF)
- Assessing and Contributing to requests for essential information about a child and family by Children's Services

- Contributing to Children's Services statutory assessments
 - Planning and providing support to vulnerable children and families, ensuring effective communication with other professionals involved in providing services to the family
 - Participating when required in child protection conferences including the provision of written reports in support of their contribution to child protection decision-making, contributing to the Child Protection Plan
 - Attending Core Group meetings when required
 - Contributing when necessary to serious case reviews
 - Ensuring relevant confidential information is shared timely and appropriately on a "need to know" basis
-

Assessment of Need/Management of Risk

Assessment Framework Triangle



VULNERABLE CHILDREN GROUP

LOOKED AFTER CHILDREN

Children looked after are by definition children that are cared for by the local authority.

The term 'looked after children and young people' refers to children and young people who may be accommodated under a voluntary agreement with their parents or their own, under section 20 (2) (1) of the Children Act (1989) or an Emergency Protection Order under Section 44 of the Children Act (1989). If new information is received about a child who is looked after where there are concerns or he/she is likely to be suffering from significant harm a decision should be made in consultation with Children's Services about whether a strategy discussion is held.

It is important to review any unmet health needs in Looked After Children, and ensure follow up of any outstanding issues such as missed appointments or incomplete assessments are followed up.

CHILDREN WITH DISABILITIES

The available UK evidence suggests that disabled children are at increased risk of abuse, and that the presence of multiple disabilities appears to increase the risk of both abuse and neglect. Disabled children may be especially vulnerable to

abuse for a number of reasons:

- Increased risk of being socially isolated with fewer outside contacts than non-disabled children
- Their dependency on parents and carers for practical assistance in daily living, including intimate personal care, increases their risk of exposure to abusive behaviour
- They have an impaired capacity to resist or avoid abuse
- Safeguards for disabled children are essentially the same as for non disabled children

CHILDREN WHO GO MISSING FROM HOME/CARE

The terms 'young runaway' and 'missing' in this context refer to children and young people up to the age of 18 years who have run away from their home or care placement, have been forced to leave, or whose whereabouts are unknown. Children who decide to run away are unhappy, vulnerable and in danger. As well as short term risks to their immediate safety there are longer term implications as well with children and young people who run away being less likely to fulfil their potential and live happy, healthy and economically productive lives as adults.

VULNERABLE CHILDREN GROUP

CHILDREN AT RISK OF SEXUAL EXPLOITATION

Children and young people who are sexually exploited are the victims of child sexual abuse, and their needs require careful assessment. This group may include children who have been sexually abused through the misuse of technology, coerced into sexual activity by criminal gangs or the victim of trafficking.

The strong links that have been identified between different forms of sexual exploitation, running away from home, gang activity, child trafficking and substance misuse should be borne in mind in the development of procedures. *For further information, see the resources section at the back of this guide.*

UNACCOMPANIED ASYLUM SEEKING CHILDREN (UASC)

These are "children who are under 18 years of age who have been separated from their parents and who are not being cared for by an adult who by law or custom has the responsibility to do so" (UNHCR, 1994). In June 2003 guidance was issued that stated where children seeking asylum are alone the 'presumption should be that they fall into Section 20 of the Children Act' (DH, 2003).

Where there are safeguarding concerns relating to the care and welfare of any UASC then these must be investigated in line with Local Safeguarding Children Board multi-agency procedures in the area in which they are living, in the same way as any looked after child.

FEMALE GENITAL MUTILATION

The term 'Female Genital Mutilation' (FGM) comprises all procedures involving partial or total removal of the external genitalia or other injury to the female genital organs for non-medical reasons. The WHO classifies FGM into four types the most extreme of which (*Type III*) involves narrowing of the vaginal orifice.

Female genital mutilation is medically unnecessary as it interferes with the normal functioning of the external female genitalia and can give rise to a range of physical health complications. Except for a few cases where FGM is performed on adult women, FGM is usually performed on girls under the age of 18 years.

The UK law on FGM

FGM has been a specific criminal offence since 1985, under the Prohibition of Female Circumcision Act (1985), which was replaced by the Female Genital Mutilation Act (2003) (in England, Wales and Northern

VULNERABLE CHILDREN GROUP

Ireland) with similar terms ratified in the Prohibition of Female Genital Mutilation Act (2005) in Scotland. Both Acts carry a maximum penalty of 14 years imprisonment. The offence includes taking a girl abroad for the purpose of undergoing FGM.

Safeguarding girls at risk of FGM

FGM is a form of child abuse and an act of violence against women and must be reported as professionals have a legal duty to protect girls from FGM.

Some professionals will have greater opportunities to identify girls at risk of FGM; these include general practitioners, paediatricians, midwives, health visitors, school nurses, and accident and emergency professionals.

Three main groups affected by FGM may be identified by frontline professionals:

1. A girl at risk of having FGM
2. A girl who has undergone FGM
3. A baby girl born to a mother who has undergone FGM

Risk to the child must be considered if:

- Any female child is born to a woman who has undergone FGM
- Any female child whose older sibling has undergone FGM must be considered at immediate risk

Risk to other children in the woman's or child's household must also be considered.

*For more information on FGM see resource section at the back of this guide - **Tackling FGM in the UK: Intercollegiate recommendations for identifying, recording and reporting FGM.***

DOMESTIC ABUSE

This section should be read in conjunction with your Local Safeguarding Children Board multi-agency child protection procedures, information sharing guidance and local multi-agency information sharing protocols.

These can be found via the Local Safeguarding Children Board websites listed at the beginning of these cards. Contact your organisations Safeguarding Lead or Named Professional if you require specific advice on issues relating to domestic abuse.

Remember: It is your responsibility to ensure that you have received the appropriate level of training in relation to domestic abuse and that you remain up to date.

Domestic abuse* is defined as:

"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality.

This can encompass, but is not limited to, the following types of abuse:

- psychological
- physical
- sexual

- financial
- emotional"

Controlling behaviour is:

"A range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behavior."

Coercive behavior is:

"An act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."

** This definition, which is not a legal definition, includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.*

A document providing information for local areas on the change to the definition can be found by visiting: www.homeoffice.gov.uk and following links to the publications section.

DOMESTIC ABUSE

An adult is defined as any person aged 18 years or over and family members are defined as mother, father, son, daughter, brother, sister and grandparents, whether directly related, in-laws of step-family.

The definition has been widened by the government to incorporate violence by family members as well as between adults who are or were intimate partners, regardless of genders and same sex relationships. It should also be noted that this could include a vulnerable person, adult or child, who is living in an environment where they are witnessing domestic abuse.

Reference The Home Office 2013

MARAC

Multi-Agency Risk Assessment Conferences (MARACs) are regular local meetings where information about high risk domestic abuse victims is shared between local agencies. By bringing all agencies together at a MARAC, and ensuring that whenever possible the voice of the victim is represented, a risk focused, co-ordinated safety plan can be drawn up to support the victim.

Any professional can refer a high risk case to MARAC. Contact your Safeguarding Lead or Named Professional for more information about the MARAC process in your area.

Reliable sources for professional information on domestic abuse can be found at:

www.womensaid.org.uk www.caada.org.uk www.nspcc.org.uk

The flow chart on the next card is a quick reference guide in managing a disclosure of domestic abuse.

If you are in doubt about the management of a case, or what you should do next following a disclosure of domestic abuse ALWAYS seek advice from your Safeguarding Lead or Named Professional.

DOMESTIC ABUSE

Disclosure of Abuse

or

Potential Indicators of Abuse

Ask the Question

Document when you ask the domestic abuse question and the response.

Disclosure of Domestic Abuse and/or sexual violence. Explain the limits to confidentiality of the disclosure and what actions you may have to take.

Is the patient (and any child) in immediate danger?

YES



IMMEDIATE ACTION

Contact Police on 999 and initiate child and adult safeguarding procedures.

NO



Does the patient have children or is she pregnant?

YES



Talk to patient about the risks to children and the unborn child.

NO



Give information safely:

Women's Aid
National 24 hour
helpline:
0808 2000 247

Local Helpline
Number:

999 in emergency

Local Domestic Abuse
- explore options

Consider and act if children are at risk: initiate child protection procedures

Best Practice

Always talk to the individual alone

- Never pressure an individual to leave their partner
- Discuss and ensure a safety plan is in place
- Reinforce options
- Explain the role of expert agencies
- Always use a professional interpreter. Never use family members or the individual's friend if English is not his/her first language.
- Always ensure complex Domestic Abuse cases are brought to supervision for discussion
- Document all contacts, when asking 'the question', disclosures, actions, observations etc

INFORMATION SHARING & CONSENT

Where there are safeguarding concerns staff have a duty to share information.

It is important to remember that in many serious case reviews, lack of information sharing and poor communication have been highlighted as significant contributors when things go wrong.

Except in certain exceptional circumstances, for example, where evidence of abuse is likely to be removed or where a child will be placed at increased risk by alerting parents or carers, it is good practise to seek consent before sharing information.

Be open and honest with the child or with their parents or carers from the onset, about what, how, why and with whom information will be, or could be shared.

A person's right to confidentiality is not absolute and may be overridden where there is evidence that information sharing is necessary to support an investigation and is in the best interests of the child.

The Data Protection Act is not a barrier to information sharing. It provides a framework for ensuring that personal information about a living person is shared appropriately. Ensure that the sharing of

information is proportionate, relevant, accurate, timely, up to date and secure. Ensure that information is only shared with those people who need to have it and that it is only used for the purpose for which it was shared.

If you are in any doubt about whether or how to share information, seek advice of your named or designated safeguarding children professional.

Whether you decide to share information or not, keep a record of your decision and the reason for it. If you decide to share record what you have shared, with whom, when, for what purpose and in what format.

When sharing information;

- Be clear regarding the nature of the problem and the purpose of sharing information
- Ensure it is based on fact not assumptions
- If certain information is based on your opinions, ensure that this is clear
- Ensure that it is restricted only to those with a legitimate need to know
- Ensure it is relevant to the specific cause for concern

INFORMATION SHARING & CONSENT

- Ensure that it is recorded in writing with the reasons stated
- Make it clear what your expectations are of what will happen next, i.e. a full assessment or child protection enquiry

You should make yourself aware of your own Organisational policies and procedures for information sharing as well as your local Safeguarding Children Board Child Protection Procedures.

CAPACITY OF THE CHILD OR YOUNG PERSON TO CONSENT

Considerations about whether a child has sufficient understanding are often referred to as Fraser Guidelines, although these were formulated with reference to contraception they have been more widely used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

When working with children and young people practitioners must follow these guidelines:

- The child or young person must be capable of making a reasonable assessment of the advantages and disadvantages of the treatment or action proposed, so that the consent, if given can be properly and fairly

described as true consent

- Parental right yields to the child's right to make his own decisions when he reaches a sufficient understanding and intelligence to be capable of making up his own mind on the matter requiring decision
- Professionals working with children need to consider how to balance children's rights and wishes with their responsibility to keep children safe from harm
- Underage sexual activity should always be seen as a possible indicator of child sexual exploitation. Sexual activity with a child under 13 is a criminal offence and should always result in a child protection referral

THE MENTAL CAPACITY ACT (MCA) 2005

In order to protect those who lack capacity, and to enable them to take part as much as possible in decisions that affect them, there are Five statutory principles:

- You must always assume a person has capacity unless it is proved otherwise
- You must take all practicable steps to enable people to make their own decisions
- You must not assume incapacity

INFORMATION SHARING & CONSENT

simply because a person makes an unwise decision

- Always act, or decide, for a person without capacity in their best interests
- Carefully consider actions to ensure the least restrictive option is taken

Do not make assumptions about capacity based on age, appearance or medical condition. Consider the person's past and present beliefs, values, wishes and feelings. Encourage the person to participate as fully as possible.

When assessing capacity you must consider if the person has an impairment of the mind or brain (*temporary or permanent*). If so you must consider if the person is able to:

- Understand the decision they need to make and why they need to make it
- Understand the need to retain, use, and weigh information relevant to the decision
- Understand the consequences of making, or not making, this decision
- Communicate their decision by any means (*i.e. speech, sign language, written*)

Failure on any point may indicate lack of capacity. Consider whether the person will in the future have capacity in relation to the matter in question. Take into account the views of others such as carers, relatives, friends or advocates.

The full text of the MCA and code of practice is available at:
www.dca.gov.uk/legal-policy/mental-capacity/mca-cp.pdf

INFORMATION SHARING & CONSENT

You are asked to, or wish to, share information

Is there a clear and legitimate purpose for sharing information?

NO

YES

Does the information enable the person to be identified?

NO

YES

Is the information confidential?

NO

YES

Do you have consent?

YES

NO

Is there sufficient public interest?

YES

YOU CAN SHARE

NO

DO NOT SHARE

NOT SURE

SEEK ADVICE

Share information:

- Identify how much information to share
- Distinguish fact from opinion
- Ensure you are giving the right information to the right person
- Ensure you are sharing information securely
- Inform the person that the information has been shared if they were not aware of this and it would create increased risk of harm

Record the information sharing decisions and your reasons, in line with local agencies or procedures

If there are concerns that a child may be at risk of significant harm or an adult may be at risk of serious harm, then follow the relevant procedures without delay. Seek advice if you are not sure what to do at any stage and ensure that the outcome of the discussion is recorded.

THINK CHILD WHEN WORKING WITH ADULTS

When seeing adult patients you may become aware of information that gives you concerns about whether they are safe to have contact with children, or whether they lack parenting capacity for any dependent children.

It is your responsibility to “Think Child” when seeing adults, and share any such concerns. Remember you may be the only professional who knows this relevant piece of information. For example, a father or stepparent may be registered with a different Practice than the rest of the family.

Examples of information that may need sharing if this adult has dependent children (*this is **NOT** an exhaustive list*):

- History of violence, especially domestic violence
- Problems with alcohol or substance abuse
- Previous children in Care Proceedings
- Request for anger management referral
- Abuse of prescription medicines
- Aggressive intimidating behaviour towards you or your staff
- New, or currently unstable, mental health problems

Remember that only GP records follow a person who moves from one county to another. Relevant information held in Police or Social Care records may not be known in their new area except to the new GP. Some people deliberately move around to try and avoid relevant information following them.

HISTORIC SEXUAL ABUSE

People often don't disclose their childhood sexual abuse until they are adults, eg. When finding an internal examination difficult. Always check if the alleged perpetrator still has access to children.

WHAT TO DO

In all the above situations:

- Try to get the child's name and DOB/address
 - Look up the child to find whether they have a Child Protection Plan
 - Inform keyworker if so
 - Discuss with child's HV, school nurse, and/or GP
 - Discuss with DAT if necessary
 - If unsure, take advice from your Practice Lead and/or Named GP/Nurse
-

TOP TEN SAFEGUARDING CHILDREN TIPS

1. Remember **everybody has a responsibility** to safeguard children whether working directly with the child or a family member
 2. You must be **aware of, recognise and understand abuse** and the different ways it can present
 3. If you have concerns you **must act** and **never assume** someone else has taken the concerns forward
 4. If you see **bruising in a non-independently mobile child** or baby, you must always follow your local safeguarding children board multi-agency child protection procedures
 5. You must know **how to access all safeguarding and child protection policies and procedures** that include your Local Safeguarding Children Board multi-agency child protection procedures and related policies such as domestic abuse and your organisations
 6. You must know **where to access the key contact details of professionals** who are available to discuss concerns – *this includes: Practice Safeguarding Lead, Named and Designated Professionals, Children's Services*
 7. You must ensure you and your team have **undertaken safeguarding children training** to the appropriate level
 8. You must be **aware of the procedure to follow if there is an allegation** against a member of your practice, organisation or service
 9. Remember, **the Data Protection Act is not a barrier to sharing information**. Ensure you understand and apply good practice in sharing information. You must be clear regarding the limits to confidentiality
 10. Remember, to **record clearly, accurately and contemporaneously** all decisions, discussions and actions

RESOURCES

SAFEGUARDING BOARDS:

SURREY

Direct link to Surrey Safeguarding Children Board multi-agency procedures:

www.sscb.proceduresonline.com

Main link to guidance and protocols including, training, serious case reviews & child death review process:

www.surreycc.gov.uk

BRIGHTON AND HOVE

Brighton and Hove Local

Safeguarding Children Board:

www.brightonandhovelscb.org.uk

WEST SUSSEX

West Sussex Local Safeguarding Children Board:

<http://www.westsussex.gov.uk/default.aspx?page=8935>

EAST SUSSEX

<http://www.eastsussexlscb.org.uk/index.html>

Sussex Multi-Agency Safeguarding Children Procedures:

<http://pansussexscb.proceduresonline.com/index.htm>

GENERAL:

Working Together to Safeguard Children 2013 – A Guide to Inter Agency Working to Safeguard and Promote the Welfare of Children:
<http://www.workingtogetheronline.co.uk/index.html>

NICE: Guidance on When to Suspect Child Maltreatment:
<http://guidance.nice.org.uk/CG89>

General Medical Council: Protecting Children & Young People – The Responsibilities of All Doctors:
http://www.gmc-uk.org/guidance/ethical_guidance/13257.asp

Royal College Paediatrics & Child Health: Safeguarding Children & Young People: roles & competencies for health care staff – Intercollegiate Document 2010:
http://www.rcpch.ac.uk/sites/default/files/asset_library/Health%20Services/Safeguarding%20Children%20and%20Young%20people%202010.pdf

National Society for the Prevention of Cruelty to Children:
www.nspcc.org.uk

RESOURCES

WHEN TO SUSPECT MALTREATMENT:

What to do if you're worried a child is being abused – Department for Education 2006:

<https://www.gov.uk/government/publications/what-to-do-if-youre-worried-a-child-is-being-abused>

VULNERABLE CHILDREN GROUP:

Safeguarding Disabled Children: Practice Guidance:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/190544/00374-2009DOM-EN.pdf

TACKLING FGM IN THE UK:

Intercollegiate recommendations for identifying, recording and reporting FGM :

http://www.rcn.org.uk/__data/assets/pdf_file/0004/547996/Tackling_FGM_in_the_UK_Intercollegiate_recommendations_for_identifying,_recording_and_reporting.pdf

NICE guidance – Looked After Children and Young People:

<http://publications.nice.org.uk/looked-after-children-and-young-people-ph28>

Promoting the Health and Well-being of Looked After Children - DoH 2009:

<https://www.gov.uk/government/publications/promoting-the-health-and-wellbeing-of-looked-after-children>

DOMESTIC ABUSE:

Relationship Abuse:

<http://thisisabuse.direct.gov.uk/>

Department of Health: Responding to domestic abuse: A handbook for health professionals: http://www.domesticviolencelondon.nhs.uk/uploads/downloads/DH_4126619.pdf

Women's Aid – National charity working to end domestic violence: www.womensaid.org.uk

Co-ordinated Action Against Domestic Abuse: www.caada.org.uk

INFORMATION SHARING & CONSENT:

Information Sharing Guidance for Managers and Children 2008:

<https://www.gov.uk/government/publications/information-sharing-for-practitioners-and-managers>

Mental Capacity Act 2005

– Code of Practice:

http://www.direct.gov.uk/prod_consum_dg/groups/dg_digitalassets/@dg/@en/@disabled/documents/digitalasset/dg_186484.pdf

Key Contacts

Safeguarding Children Lead/Named professional

.....

PREVENT Co-ordinator / Lead

.....

Local Authority Safeguarding Children Boards

Brighton and Hove Local Safeguarding Children Board

www.brightonandhovelscb.org.uk

East Sussex Local Safeguarding Children Board

www.eastsussexlscb.org.uk

Surrey Safeguarding Children Board

www.surreycc.gov.uk/social-care-and-health/childrens-social-care/information-for-child-social-care-professionals/surrey-safeguarding-children-board

West Sussex Safeguarding Children Board

www.westsussexscb.org.uk

This set of cards was produced by Designated Safeguarding Professionals across Surrey and Sussex and the NHS England Surrey and Sussex Safeguarding Team, with thanks to the East Midlands Safeguarding Adults Health Network for the original idea.

