SAFEGUARDING CHILDREN LEVEL 3

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PRECOURSE WORKBOOK

This workbook has been designed for staff working with children. There is nothing more important than ensuring the well-being of children and as clinicians, that we have the skills to identify when a child needs help and protection. It is therefore important that we are able to work together in partnership with other agencies so that we can respond to the needs and interests of families.

This pre-course workbook aims to :

1. Improve your knowledge of current law and policy around Children
2. Provide a systematic approach to taking a history from the parent/caregiver or child
3. Discuss terminology and its significance when assessing if there is risk of harm.

Definition

In this document, a child is defined as anyone who has not yet reached their 18th birthday. 'Children' therefore means 'children and young people' throughout.

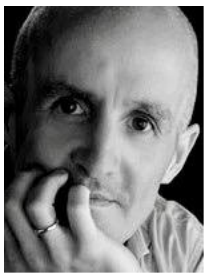
The term 'practitioners' is used throughout the guidance to refer to individuals who work with children and their families in any capacity.

Session Aims

This session aims to update your knowledge of current legislature and resources available to recognise red flags and identify children who are at risk. Safeguarding Children – Level 3 training course is aimed at clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concern

ABOUT THE LECTURER

This workbook has been especially prepared for those undertaking the more comprehensive Safeguarding Children Level 3 course taught by Kenny Gibson, Head of Safeguarding for NHS England. Kenny has recommended some additional reading before you start this course.



Kenny Gibson is the Deputy Director for NHS Safeguarding, overseeing several portfolios including tackling abuse, exploitation, radicalisation and violence. He leads nationally on Contextual

Safeguarding; Trauma Informed Care; Prevent in the NHS and Child Protection Information System.

Having begun his NHS career as a laundry assistant in 1980 at a mental health unit, Kenny was encouraged to become a nursing assistant and then trained as a nurse and then a midwife.

Kenny has held various operational, management and strategic posts in both community and public health but always with nursing at the heart of these roles. Prior to becoming the Head of Safeguarding for NHS England, Kenny was the Head of Public Health Commissioning for London. Kenny is passionate about connecting with and listening to patients, carers and health practitioners in order to improve services and experiences within the NHS, as well as to empower people about Their own well-being. Kenny was awarded his MBE in January 2022 for services to healthcare leadership.

You can follow Kenny on Twitter at: @KennyGibsonNHS or @NHSSafeguarding

ADDITIONAL READING

- RCPCH Purple Book - https://www.rcpch.ac.uk/shop-publications/physical-signs-child-sexual-abuse-evidence-based-review
- RCPCH Child Protection portal - https://childprotection.rcpch.ac.uk/
- National Child Safeguarding Review Panel - https://www.gov.uk/government/organisations/child-safeguarding-practice-review-panel
- Published Joint Targeted Area Inspections - https://www.gov.uk/government/news/new-frameworks-for-joint-targeted-area-inspections-jtais
- Independent Inquiry into Child Sex Abuse - https://www.iicsa.org.uk/final-report

QUESTIONS TO CONSIDER

Systems - where would you contact and connect with your Designated Professional, Named Safeguarding GP and the local Named Nurses for Looked After Children?

Baby and children - read the following article before considering :

https://mft.nhs.uk/rmch/services/camhs/young-people/adverse-childhood-experiences-aces-and-attachment/

1. How domestic abuse, controlling & coercive behaviour between adults, honour based abuse might impact babies and infants
2. How other adverse childhood experiences might impact the confidence of looked after children in their decision-making.

Transitional safeguarding -

Read the following material and find a Dez Holmes presentation video before reflecting on transitional safeguarding on the adolescents you care for.

https://www.justiceinspectorates.gov.uk/hmiprobation/wp-content/uploads/sites/5/2022/03/Academic-Insights-Holmes-and-Smith-RM.pdf

WEBINAR CONTENT

This webinar on Safeguarding Children – Level 3 training course provides a thorough understanding of child protection by covering a breadth of topics relevant to anybody with a responsibility for safeguarding children and young people. This online Safeguarding Children – Level 3 training course covers the following:

- An understanding of what safeguarding children and young people
- Child development and negative influences
- An awareness of the key legislation and guidance about the safeguarding of vulnerable children and young people,
- How to be aware of your professional responsibilities, as well as those of your colleagues and partner organisations,
- How to be able to document and report concerns relating to child abuse or maltreatment, including:
    - Taking adequate history,
    - Performing a physical examination in ways that are deemed appropriate in line with current legislation relating to safeguarding and protection of children and young people,
    - Assessing parenting capacity,

  The forms of abuse and signs of abuse, and
    - Recognising and responding to abuse, with specific guidance on note-taking and recording your concerns.
- Contributing to inter-agency assessments, as well as the gathering and sharing of information and where appropriate analysis of risk posed, How to participate in inter-agency working and be supportive to vulnerable children and young children, and their families/guardians where safeguarding concerns have been raised,
- How to be familiar with your local organisational protocols and referral processes to your local safeguarding team and/or social services, and how to minimise barriers in the referral

There are three agencies that are legally mandated to investigate safeguarding issues:

- National Society for the Prevention of Cruelty to Children (NSPCC)
- The Police
- Local Authority Child Protection Team.

Practitioners and local authorities, working with partner organisations and agencies, have specific duties to safeguard and promote the welfare of all children in their area. The Children Acts of 1989 and 2004 set out specific duties: section 17 of the Children Act 1989 puts a duty on the local authority to provide services to children in need in their area, regardless of where they are found; section 47 of the same Act requires local authorities to undertake enquiries if they believe a child has suffered or is likely to suffer significant harm.

THE CHILDRENS ACT

The Children Act 2004, as amended by the Children and Social Work Act 2017, strengthens this already important relationship by placing new duties on key agencies in a local area.

Specifically, the police, clinical commissioning groups and the local authority are under a duty to make arrangements to work together, and with other partners locally, to safeguard and promote the welfare of all children in their area.

Safeguarding and promoting the welfare of children is defined for the purposes of this guidance as:

- protecting children from maltreatment
- preventing impairment of children's health or development
- ensuring that children grow up in circumstances consistent safe care.
- and engagement: to be informed about and involved in procedures, decisions, concerns and plans
- explanation: to be informed of the outcome of assessments and decisions and reasons when their views have not met with a positive response
- support: to be provided with support in their own right as well as a member of their family
- advocacy: to be provided with advocacy to assist them in putting forward their views
- protection: to be protected against all forms of abuse and discrimination and the right to special protection and help if a refugee.

Under the Children Act 1989 and 2004, safeguarding and promoting the welfare of children means:

- Protecting children from maltreatment
- Preventing impairment of children's health or development
- Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care
- Undertaking that role so as to enable those children to have optimum life chances and to enter adulthood successful.

Establishing a child centred approach:

1. Keeps the child in focus when making decisions about them
2. Following the principles of the Children's Act 1989 and 2004 which highlights the importance of ensuring the child's welfare is given precedence and that ideally, they are best looked after by their parents who may need support.
3. Children may be vulnerable to neglect and abuse or exploitation from within their family and from individuals they come across in their day-to-day lives. These threats can take a variety of different forms, including sexual, physical and emotional abuse; neglect; exploitation by criminal gangs and organised crime groups; trafficking; online abuse; sexual exploitation and the influences of extremism leading to radicalisation. Whatever the form of abuse or neglect, practitioners should put the needs of children first when determining what action

Equality Act 2010, which puts a responsibility on public authorities to have due regard to the need to eliminate discrimination and promote equality of opportunity. This applies to the process of identification of need and risk faced by the individual child and the process of assessment. No child or group of children must be treated any less favourably than others in being able to access effective services which meet their particular need

United Nations Convention on the Rights of the Child (UNCRC). This is an international agreement that protects the rights of children and provides a child- centered framework for the development of services to children. The UK Government ratified the UNCRC in 1991 and, by doing so, recognises children's rights to expression and receiving information

Under the Children Act 1989, children that are defined as being "in need" are:

- Those who are unlikely to reach or maintain a satisfactory level of health or development
- Those whose health and development will be significantly impaired without the provision of services
- Those who have a disability.

Some children are in need of help because they are suffering or likely to suffer significant harm. The Children Act 1989 introduced the concept of significant harm as a threshold that justifies compulsory intervention in family life in the best interests of children.

There are two critical factors that must be taken into account when deciding whether a child is in need or not:

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

Powers and Duties Under Care Order: Sections 33(1)(3); (4); and 23 (10) Children Act 1989

The Local Authority is under a duty to receive the child into its care and keep him/her in care while the order remains in force. This includes providing accommodation and maintaining the child (Sections 33(1) and 23(1)).The local authority acquires responsibility for the child and although this is shared with parents, it can decide the extent to which a parent may meet his/her parental responsibility in order to safeguard the child's welfare.

Grounds for Child Assessment Order: Section 43(1) Children Act 1989

A Child Assessment Order may be made if the court is satisfied that:

- The applicant has reasonable cause to suspect that the child is suffering, or likely to suffer, Significant Harm; and
- An assessment of the state of the child's health or development, or the way in which (s)he has been treated, is required to determine whether or not the child is suffering, or is likely to suffer, Significant Harm; and
- It is unlikely that such an assessment will be made, or be satisfactory, if an order is not made

Section 46 Children Act 1989:

A police constable, having reasonable cause to believe that a child would otherwise be likely to suffer Significant Harm, may either remove the child to suitable accommodation or prevent his/her removal from a hospital or other safe place. No child may be kept in police protection for more than 72 hours.

The police must take steps as soon as reasonably practicable to inform the child's parents of what has been done and the reasons for that action being taken. If the child appears capable of understanding (s)he must also be so informed.

The police, where they have reasonable cause to believe that a child is likely to suffer Significant Harm, can apply for an Emergency Protection Order on behalf of the Local Authority. They can do this whether or not the Local Authority know or agree (Section 46(8)).

The police can obtain a warrant under Section 102 of the Children Act to enter premises and search for children

Emergency Protection Order (EPO): Section 44 Children Act 1989

An Emergency Protection Order is a short-term order which enables a child to be made safe when (s)he might otherwise suffer harm. Application for an Emergency Protection Order may be made by any person, a Local Authority or an authorised person.

SEXUAL OFFENCES ACT 2003

Sexual activity with a child under 16 is an offence and under 13 as a very serious offence.

If child is under the age of 16 and independently seeks help, you are not required to inform social services. However, you must discuss with a designated professional for child protection if the child seeks sexual health advice.

The Sexual Offences Act 2003 introduced a new offence of meeting a child following sexual grooming, which makes it a crime to befriend a child on the internet or by other means and meets or intends to meet the child with the intention of abusing them. The maximum sentence is 10 years imprisonment.

EUROPEAN CONVENTION ON HUMAN RIGHTS

Article 8 of the Convention states that:

- Everyone has the right to respect for her / his private and family life, home and correspondence;
- There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, protection of health or morals or for the protection of rights and freedom of others.

The right is not absolute and there are certain situations when Article 8 enables professionals to disclose

information without consent e.g. to:

- Safeguard a child;
- Protect her / his health or morals;
- Protect the rights and freedoms of others; or
- Prevent disorder or crime.

Article 8 is only one of the articles of the Convention. The Convention also expressly enshrined the right of all citizens not to live in degrading or inhuman conditions for instance and children are citizens under the Act just as are adults.

The principle of ‘proportionality’ applies to sharing confidential information i.e. when disclosing information without consent one must limit the extent of the disclosure to that which is necessary to achieve the aim of disclosure i.e. to protect the child.

ANTI-SOCIAL BEHAVIOUR, CRIME, AND POLICING ACT 2014

Anti-Social Behavior Injunctions can be granted against a person aged 10 or over, to prevent them engaging in anti-social behaviour. The injunction may include provisions requiring the young person to do specified things, and/or prohibiting them from doing specified things. For under-18s, the injunction must be for a specified period of time, which must be no more than 12 months.

These injunctions replace the previous Anti-Social Behaviour Orders (ASBOs) under section 1 Crime and Disorder Act 1998.

THE HUMAN RIGHTS ACT 1998

Children are protected by a comprehensive framework of powers and responsibilities set out in the Children Act 1989, its associated regulations and inter-agency guidance, Working Together to Safeguard Children.

Art 2 Is a simple and absolute right and requires that we respect the right of all individuals to life.

Art 3 Prohibition of Torture has been used by individuals over the years to challenge treatment they have received in institutions, including care institutions. It therefore has implications for the way that the public authorities treat children in their care. Art 4 The Prohibition of Slavery and Forced Labour again is a simple and absolute right and may have similar implications for the treatment of children as Article 3.

Art 5 Requires that public authorities must treat individuals with respect for their liberty and security. This may have implications on an application for a secure accommodation order.

Art 6 The right to a fair hearing – this has been used by individuals to challenge the procedures adopted by authorities in reaching decisions and so has implications for child protection procedures

WHO IS RESPONSIBLE FOR SAFEGUARDING

All practitioners have a responsibility to keep children safe. It is therefore important to have a structured approach to the consultation to gain information and identify concerns, share information if a needed and take prompt action. It is therefore important to have a good knowledge of the law affecting children and local resources available to help you support children and their families. Providing early interventions to safeguard children and identifying their need for support promotes the welfare of children more effectively than reacting later. Effective early help relies upon local organisations and agencies working together

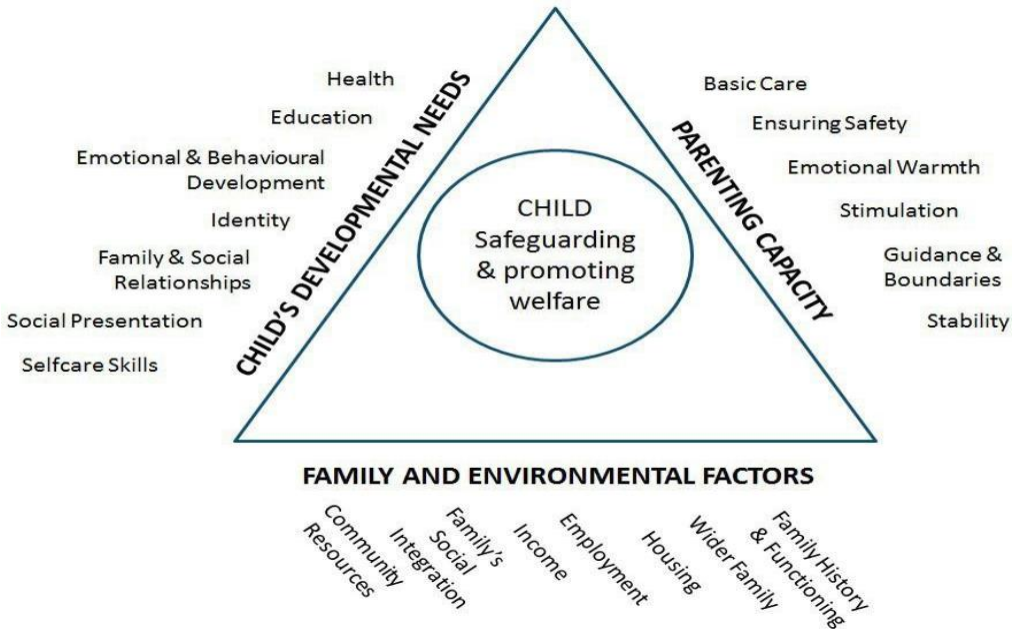
- identify children and families who would benefit from early help
- undertake an assessment of the need for early help
- provide targeted early help services to address the assessed needs of a child and their family which focuses on activity to improve the outcomes for the child

Your local authorities and CCG, under section 10 of the Children Act 2004, have a responsibility to promote inter-agency co-operation to improve the welfare of all children. You will therefore have a policy folder where you work, identifying local resources.
Practitioners 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 (whether or not they have a statutory Education, Health and Care Plan)

- is a young carer
- is showing signs of being drawn into anti-social or criminal behaviour, including gang involvement and association with organised crime groups
- is frequently missing/goes missing from care or from home
- is at risk of modern slavery, trafficking or exploitation
- is at risk of being radicalised or exploited
- is in a family circumstance presenting challenges for the child, such as drug and alcohol misuse, adult mental health issues and domestic abuse
- is misusing drugs or alcohol themselves
- has returned home to their family from care
- is a privately fostered child

If at any time it is considered that the child may be a child in need, as defined in the Children Act 1989, or that the child has suffered significant harm or is likely to do so, a referral should be made immediately to local authority children's social care.

THE ASSESSMENT PROCESS



STRUCTURED HISTORY TAKING

Taking a history from or about a child can be very daunting and during a paediatric consultation, it means that often the information is from the parent or carer who gives their interpretation. It is, therefore, very important to take a systematic history to ensure nothing is missed and helps build trust and rapport with the caller.

Demographics Always check child's age first as this information is key in determining what you need to ask in terms of illnesses, behavioural and developmental problems. It is therefore important to confirm the date of birth at the outset. Confirming the patients identify carefully ensures compliance with the Data Protection Act 2018 and GDPR regulations.

INTRODUCTION

Introduction : Identify who you and your role an obtain consent. Identify who you are speaking to and their role in child's life. If it is the child, ensure you identify their name, dob and where they are calling from. Check where the parents or carers are. Negotiating both talking to parents or carers without the child present and talking to the child alone requires tact and consideration. Generally, this is done to avoid embarrassing older children or adolescents and allow for the imparting of sensitive information. This can be done by talking separately to each in turn, introducing the idea through normalisation – "IT IS MY USUAL PRACTICE TO…". It is a good idea to speak to the parents first, then the adolescent or young adult – to ensure they know that the confidential information imparted to the doctor is not disclosed to the parents.

SPEAKING TO THE PATIENT

Speak directly to the patient if possible/appropriate to maximise the reliability of the information. A history from a third party may also play a role but ideally speak to the patient, even if you have to negotiate to do so.

PRESENTING COMPLAINT

- Ask open questions to get a broad idea of reason for visit. Let the child/caregiver recount their symptoms in their own words. Record the child's and parents' own words as faithfully as possible, using direct quotations if relevant.
- Where there are multiple symptoms set each one out separately with space to document the features of how it developed and the relationships between the symptoms.

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HISTORY OF PRESENTING COMPLAINT

Particular questions to have answered

- When did the current problem start? What was it like?
- Has the problem changed at all? If so, when and in what way?
- Has medical attention been sought before now? If so, what investigations have been done so far? What treatments have been tried?
- Previous episodes?
- Relieving or aggravating factors?
- Do the parents/carers have any photographic or video evidence on their phone? (especially when considering a rash or a seizure episode).
- In infants

Pattern of feeding, bowel movements, and number and wetness of nappies. Sleeping/waking cycle, alertness and activity. Whether there has been weight loss or gain

- Eating – Type of food, intake, the frequency of feeds (if applicable), dietary requirements?
- Drinking – Determine oral intake of fluids.
- Passing urine – The number of 'wet nappies' if applicable
- Stool – Determine the frequency and form of the stools.
- Vomiting – Determine frequency, volume and consistency (e.g. bilious, haematemesis). Also, clarify if it was projectile vomiting.
- Fever – Ask about readings and how they were recorded.
- Rash – Determine location and rate of spread. Coryzal symptoms (e.g. "runny nose" "sniffly" etc) Cough and/or increased work of breathing Weight change – Review growth charts if available. Pain – Explore using SOCRATES, as shown below.
- Is the child acting their normal self? – i.e. How active and lively have they been generally? When were they last their normal self?

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Site – Where exactly is the pain? Where is the pain worst?

Onset– When did it start? Did it come on suddenly or gradually? Character– What does it feel like (sharp stabbing/dull ache/burning)? Radiation– Does the pain move anywhere else? Associations– Any other symptoms associated with the pain?

Time course– Does the pain have a pattern (e.g. worse in the mornings)?
Exacerbating/relieving factors– Does anything make it particularly worse or better?
Severity– On a scale of 0-10, with 0 being no pain and 10 being the worst pain you've ever felt?

Ideas, Concerns and Expectations

Address the parent's/carer's and child's Ideas, Concerns and Expectations (ICE): What do they think, or fear is the issue?
Have they been searching the internet or discussing with others? What are they hoping to achieve from the consultation?

The scope and detail of the following section of the history is determined by the nature and severity of the presenting complaint and the child's age.

For example, if a young child presents with delayed speech, a detailed birth and neonatal history, as well as details of developmental milestones, are required – vs. an adolescent with headaches.

Prenatal history – Were there any obstetric problems including antenatal scans and screening tests? Were any medications taken during the pregnancy?
Birth history – Concerns during delivery? Interventions required? Birthweight and gestation?

Neonatal period – Admission to special care baby unit? Jaundice?

Child development – When did the child achieve key milestones – smiling, rolling over, sitting unaided, standing, speaking and toileting skills?
Normal growth – Following weight and height centiles?

Immunisation – Ideally this should be checked using the personal child health record. Identify any reasons for missed immunisations.
Past illnesses, hospital admissions, operations, accidents and injuries?

Medications and allergies? Including over the counter or alternative preparations.

Known to any other clinicians? What for?

- Prescribed medication.
- OTC medication.
- Recreational drug or solvent use - in teenagers such information is much more likely to be forthcoming if the patient is alone and reassured that confidentiality will be maintained.

Complementary formulations.

It is worth remembering that a parent's memory of medication may not be accurate. Corroborations may need to be sought if you can access their notes on the system. Pharmacists, GP computerised practice records and health visitors may be useful sources of additional information.
DRUG INTOLERANCES, ADVERSE DRUG REACTIONS AND ALLERGIES
It is important to enquire further about any allergy. Minor adverse reactions can often be labelled inappropriately as allergies.

Clarify details about the child's family and community. Identify who the child lives with and other non-related adults in the household.
Check parental/carer occupation, smoking habits, relationship or marital status. Establish the child's play or leisure activities and whether they are happy at home.
Impact of their illness on family, especially if chronic or ongoing. Have they been to school? Days off school or nursery.

Housing
Is the child under the care of social services, subject to a child protection plan or has there been any social services involvement? Do they have a health visitor or social worker?
* Child abuse comes in many guises and harm is inflicted in many different ways. Any such concerns may emerge from the social and family history and any concerns should be shared with colleagues and Social Services.

It may be appropriate to ask specific questions about a child's experience and attainments at school. This may include, for example, asking about ability to concentrate and to make progress with learning in reading, spelling, and mathematics. Any fear or anxiety about school should be explored. Bullying is common and can interfere with learning. Reports from teachers can be enlightening and supplement the history. Truancy and neglect.

Specific questions may be asked about mood, eating and sleeping habits, interests, hobbies and other activities. Life events and emotionally disturbing events can have a major effect on well- being and general development.
When taking a history from an adolescent or young child you can use the pneumonic HEADSSE taken from 'geeky medics". It's important that the content of the conversation remains confidential, and that you will not discuss any aspect of it with their parents/carers without their express permission.

However, it's also important the young person knows that confidentiality cannot be assured if they're at risk of harm – to themselves, or others. An opening statement similar to this may be helpful in establishing this verbal contract: "Anything we talk about today is confidential. That means I cannot tell others, including your parents, about it without your permission. The only exceptions would be if I thought you, or someone else, was at risk of serious harm. In that case I would need to tell someone else.

HOME AND RELATIONSHIPS

Who lives at home with you?
Do you have your own room?
Who do you get on with best and/or fight with most?
Who do you turn to when you're feeling down?

EDUCATION AND EMPLOYMENT

Are you in school/college at the moment? Which year are you in?
What do you like the best/least at school/college?

How are you doing at school?
What do you want to do when you finish? Do you have friends at school?
How do you get along with others at school? Do you work? How much?

EATING

Are you worried about your weight or body shape?
Have you noticed any change in your weight recently?
Have you been on a diet? Do you mind telling me, how?
Activities and hobbies What do you do to relax?

What kind of physical activities do you do?

Does anyone smoke at home?

Lots of people your age smoke. Have you been offered cigarettes? How many do you smoke each day?
Many people start drinking alcohol around your age. Have you tried or been offered alcohol? How much/how often?
Some young people use cannabis. Have you tried it? How much/how often?

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Sex and relationships

Are you seeing anyone at the moment? Are they a boy or a girl?

Young people are often starting to develop intimate relationships? How have you handled that part of your relationship?

Have you ever had sex?

Self-harm, depression and self-image

How is life going in general?

Are you worried about your weight? What do you do when you feel stressed? Do you ever feel sad and tearful?

Have you ever felt so sad that life isn't worth living?

Do you think about hurting or killing yourself? Have you ever tried to harm yourself?

Safety and abuse

Do you feel safe at school/at home? Is anyone harming you?

Is anyone making you do things that you don't

want to? Have you ever felt unsafe when you're online or using your phone?

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Have any family members or friends had similar problems or any serious disorder?

At this point, drawing a family tree or genogram to assist in your note-taking – identifying key family and social history information.
Age of the parents and siblings?

Consanguinity? (approach with sensitivity) Consanguinity occurs more commonly in some cultures and may be relevant to inherited disease (particularly autosomal recessive conditions).
Do any conditions run through the family? If so, who has been affected (over several generations). History of seizures, asthma, cancer, heart disease, tuberculosis, or any other medical condition?
Deaths in the family – cause and age, especially if in infancy or childhood

Note whether siblings and parents are all alive and well. Consider conditions which may have a genetic component (such as coronary heart disease and cerebrovascular disease). Occasionally it is appropriate to address risk factors (such as familial hypercholesterolemia) during childhood.
It can be useful to present findings by using a two-generation family tree

GENERAL ENQUIRY & SYSTEMS REVIEW

This section involves performing a brief screen for symptoms in other body systems.

This may pick up on symptoms the parents/carers or the child failed to mention in the presenting complaint and some of these symptoms may be relevant to the diagnosis

Head – History of injury, headaches or infection?

Eyes – Visual acuity/glasses? History of injury, headaches or surgery?

Nervous system – Fits, faints, or funny turns? History of hearing concerns, seizures (febrile or afebrile), abnormal or impaired movements, tremors or change in behaviour? School performance? History of hyperactivity?

ENT – Earache, throat infections, snoring or noisy breathing (stridor)?

GENERAL ENQUIRY & SYSTEMS REVIEW

Chest – Cough, wheeze, breathing problems? Smokers in the family? Exposure to smoke?

Heart – Cyanosis, exercise tolerance, chest pain, fainting episodes? History of heart murmurs or rheumatic fever in the child or the family?
GIT – Vomiting, diarrhoea/constipation, abdominal pain? Rectal bleeding?

Genitourinary – Dysuria, frequency, wetting/accidents, toilet training?

Joints/Limbs – Gait, limb pain or swelling, other functional abnormalities?

Skin – General rashes? Birthmarks or unusual marks?

Pubertal development – Age of menarche?

SUMMARISING & SIGNPOSTING

Summarise what the patient/parent/carer has told you about the presenting complaint.

This allows you to check your understanding regarding everything the patient/parent/carer has told you. It also allows the patient/parent/carer to correct any inaccurate information and expand further on certain aspects. Once you have summarised, ask the patient/parent/carer if there's anything else that you've overlooked.
Continue to periodically summarise as you move through the rest of the history

SUMMARISING & SIGNPOSTIN

- If the child or family does not speak your language, try to find an interpreter, or arrange one for a subsequent consultation, to clarify what has been discussed.
- Specific skills and techniques need to be employed to take a good history of a child's illness:
- In very young children who have no speech, or limited speech, you must take the history through the parent or parents and learn to interpret it. Consider:
- A parent may be extremely anxious, tired or both. This can impair communication
- An empathetic approach is likely to improve communication.

COMMON PITFALLS

- The key stages in the paediatric consultation that are prone to error are information gathering, making a decision and giving advice.
- We must be aware of making premature decisions during consultations, keeping an open mind throughout and being willing to change our mind or management plan.
- We should include rare or serious conditions in our differential diagnoses, while we are listening to our patients' histories and be prepared to refer consultations if we pick up symptoms, or cues, that deviate from the common pattern.
- In older children there is a difficult line to tread between giving the child as much autonomy as possible and getting a full account of how an illness or problem has presented. It is often necessary to synthesise the accounts from parents and the child. In this situation you should remember that the child is your patient, not the parent(s), and focus your attention on their story whilst engaging the parent(s) and maintaining their trust and confidence.
- With teenagers, it may be difficult to give appropriate autonomy without offending the parent(s). With older teenagers it may be necessary to invite the parent(s) to let you speak to the teenager, so that further history can be taken.
- When dealing with older children and issues of confidentiality, if you are unsure of the legal and ethical implications of confidential medical information, seek the advice of a medico-legal advisor or consult your insurance or council for guidance on the subject. It may be appropriate to discuss difficulties with a medical indemnity or defence organisation.
- Unfortunately, some parents or carers very occasionally may not have a child's best interests at heart. They may attempt to conceal facts and keep secrets. In such a situation it is important to remember that your overriding duty is to the child. It can be very difficult to reach a conclusion about such matters without multidisciplinary or expert support[. Where child protection issues are important:
- Seek medico-legal advice from your medical indemnifier.
- Consider current and relevant guidelines[
- Access local child protection teams for support and advice on procedure.
- Privacy, dignity and confidentiality

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INFORMATION GOVERNANCE AND TELEPHONE RECORDINGS

- Some practices and out-of-hours providers record incoming and outgoing telephone calls. These electronic sound files form part of the patient's records and can provide useful information in the event of a complaint or claim. Such recordings must be made, stored and disclosed under the provisions of the relevant legislation, and the patient must be informed of the fact that the call is being recorded.
- Under the provisions of the Data Protection Act (1998), patients have a right to be provided with copies of information that is held about them.

DATA PROTECTION AND GDPR

- Practitioners must have due regard to the relevant data protection principles which allow them to share personal information, as provided for in the Data Protection Act 2018 and the General Data Protection Regulation (GDPR).
- To share information effectively:
- all practitioners should be confident of the processing conditions under the Data Protection Act 2018 and the GDPR which allow them to store and share information for safeguarding purposes, including information, which is sensitive and personal, and should be treated as 'special category personal data'
- where practitioners need to share special category personal data, they should be aware that the Data Protection Act 2018 contains 'safeguarding of children and individuals at risk' as a processing condition that allows practitioners to share information. This includes allowing practitioners to share information without consent, if it is not possible to gain consent, it cannot be reasonably expected that a practitioner gains cons, or if to gain consent would place a child at risk.

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CATEGORIES OF CHILD ABUSE

WHAT FORM DO YOU THINK CHILD ABUSE COULD TAKE IN THESE CATEGORIES?

Physical:

Sexual:

Emotional & Psychological:

Neglect:

What form do you think indicators of child abuse could take in these categories?

Physical:

Sexual:

Emotional & Psychological:

Neglect:

CATEGORIES OF CHILD ABUSE

WHAT FORM DO YOU THINK CHILD ABUSE COULD TAKE IN THESE CATEGORIES?

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SAFEGUARDING LEVEL 3

Take some time out to complete the questions below.

1. (a) How would you define 'child abuse'?

(b) How would you define a 'looked after child'?

2. What do you think are the main categories of child abuse?

1. 2.

3. 4.

3. Signs of abuse: What might lead you to suspect that a child is being abused?

4. Who do you think investigate allegations of child abuse?

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YOUR ROLE AS A CLINICIAN AND ADVOCATE

Within your role it is important that you know what to do if they suspect a child or young person is being abused or neglected.

This refers to a child or young person you may meet in any circumstance and is not limited to those you work with. By having the knowledge and understanding of the different types of child abuse, how to recognise signs and report your concerns, you may be able to prevent harm or further harm to a child or young person.

You may come in contact with a variety of child welfare concerns, including those where a child or family is already known to children's social care.

If you have concerns about a child's welfare it is your responsibility to report it either to your line manager, named or designated health professional or designated member of staff, this will depend on their organisational setting and the Safeguarding Policy of your workplace.

STATISTICS

- 560 children trafficked for sexual exploitation in 2015

- The latest government statistics have shown that social services identified around 280 potential abuse cases in the West Midlands linked to faith or belief in 2017/18.
- These include cases where the abuser believes a child is a witch, has been possessed by a spirit, demons or the devil, or has brought bad fortune into the home in other ways. Abuse linked to faith or belief can be physical, emotional or sexual, and the consequences can be profound and long- lasting.

- They can also include cases where fear of the supernatural is used to make children comply with being trafficked for domestic slavery or sexual exploitation.

Child Protection – Safeguarding

STATUTORY DUTIES

Practitioners have a statutory duty under the Children's Act (DOH 1989) to safeguard or protect children and to be aware of identifiable factors, signs, symptoms and indicators of abuse or neglect that constitute 'harm'.

There is also a duty of care to report abuse or neglect which underpins these statutory obligations. Failure to do so puts patients at risk and if you were the only person, they were brave enough to disclose to and you fail to act, they may never be brave enough to disclose again.

One of the key features replicated through all the high-profile cases of devastating abuse that hit the press have running through them is the amount of contacts with health and social care professionals which took place before the final and catastrophic episode of abuse occurred

Consider this:
You take a call from a parent who tells you their toddler has burnt their leg grabbing a cup of hot tea from a table. Through careful probing you establish the burn sounds like it may be circumferential. What is your responsibility here? Does your statutory duty require you to probe closely before making the decision to safeguard or does your responsibility end with reporting?

The statutory responsibility for practitioners ends at reporting; police and social care professionals have a statutory responsibility to investigate, so in this case once enough information has been gleaned to raise a concern, the practitioners should provide appropriate care and establish a safe plan and report onto the appropriate agency.
There are three agencies that are legally mandated to investigate safeguarding issues:

- National Society for the Prevention of Cruelty to Children (NSPCC)
- The Police
- Local Authority Child Protection Team.

Child Protection – Safeguarding

Some children need help because they are suffering or likely to suffer significant harm. The Children Act 1989 introduced the concept of significant harm as a threshold that justifies compulsory intervention in family life in the best interests of children.
There are two critical factors that must be considered when deciding whether a child is in need or not:

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

Under the Children Act 1989 and 2004, safeguarding and promoting the welfare of children means:

- Protecting children from maltreatment
- Preventing impairment of children's health or development
- Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care

Undertaking that role so as to enable those children to have optimum life chances and to enter adulthood successfully.

"Where there are child protection concerns (reasonable cause to suspect a child is suffering or likely to suffer significant harm) local authority social care services must make enquiries and decide if any action must be taken under section 47 of the Children Act 1989."
Importantly, the harm does not need to be intentional to trigger a need to safeguard. Unintentional harm – such as failing to seek appropriate medical care when it is needed can be equally devastating. We will look at recognising this more in the face to face training.
What is not so clear however is a fixed definition of 'significant harm' leaving a grey area for clinicians who must use their skill and judgement in assessing a situation in the same way they would for all their clinical decision making.
So, if there is no set definition or criteria, how can you assess whether 'significant harm' has occurred or not'. Significant harm may arise from a single traumatic event, but often it is a series of significant events, over a short or long period which impact on a child's wellbeing and development, often with devastating consequences.
In addition to all the clinical skills clinicians are used to deploying when gathering information over the phone, consideration should also include:

- The degree and extent of physical harm
- The duration and frequency of abuse and neglect
- The extent of premedication
- The degree of threat, coercion, sadism, unreasonable control and other aggravating factors.

WHAT IS SIGNIFICANT HARM

In addition to this, the child's own perception of their own safety or wellbeing is important to remember although of course with coercive and controlling behaviour the child may not be the best judge of their own wellbeing. The family's internal strengths and supports should also be considered (Adcock & White 1998) but of course most of this will be beyond the capacity of the clinician at the other end of the phone.

To understand and identify 'Significant Harm', it is necessary to consider:

- The nature of harm, in terms of maltreatment or failure to provide adequate care;
- The impact on the child's health and development.
- The child's development within the context of their family and wider environment;
- Any special needs, such as a medical condition, communication impairment or disability, that may affect the child's development and care within the family.
- The capacity of parents to adequately meet the child's needs.
- The wider and environmental family context – is anyone else at risk in the wider family?

The term "Looked After" was introduced by the Children Act 1989 and refers to children and young people:

- under the age of 18
- who live away from their parents or family?
- are supervised by a social worker from the local council children's services department.

A looked after child may either be accommodated (which means that the council is looking after them with the agreement, at the request or in the absence of their parents) or subject to a Care Order made by the Family Courts.

A child or young person can be subject to different legal rules either:

- the parent retains full parental responsibility, or
- alternatively, if a child is subject to a Care order, parental responsibility is shared between the council and the parents.

LOOKED AFTER CHILD

Children can become “looked after” for a number of reasons; some children may have been abused or suffered distressing experiences, some may be in care due to family illness or the death of a parent. Others may have complex needs or disabilities and be unable to be cared for at home.
Often children become “looked after” for a short period of time due to family crisis and will return home. Some children do not have a parent or relative to look after them, possibly because of death or serious illness or because they have been separated e.g. unaccompanied asylum-seeking children.
Most children looked after are:

- cared for by foster carers - “ordinary” families living in “ordinary” houses who can offer a place in their family to another child
- older children may live in children’s homes or in specialist residential schools
- very young children or babies may be placed with prospective adoptive parents if the court has agreed that this would be in their best interests, or if a parent has requested that their child be adopted.

The local authority will always try to place brothers and sisters together where possible and sometimes children may be placed with relatives if this is felt to be best for them.
1. The safeguarding partners should publish a threshold document, which sets out the local criteria for action in a way that is transparent, accessible and easily understood. This should include:
the process for the early help assessment and the type and level of early help services to be provided the criteria, including the level of need, for when a case should be referred to local authority children’s social care for assessment and for statutory services under:

- section 17 of the Children Act 1989 (children in need)
- section 47 of the Children Act 1989 (reasonable cause to suspect a child is suffering or likely to suffer significant harm)
- section 31 of the Children Act 1989 (care and supervision orders)
- section 20 of the Children Act 1989 (duty to accommodate a child)

clear procedures and processes for cases relating to:

- the abuse, neglect and exploitation of children
- children managed within the youth secure estate

WHY ARE LOOKED AFTER CHILDREN AT RISK OF ABUSE

The NICE draft consultation document on study reports from adult survivors' experiences were as follows:

Participants in the study highlight the multiple placement moves they experienced while in the care system, over which they had little say or control, as a key factor in becoming sexually exploited due to: not being able to form attachments with adult professionals, leaving them open to forming attachments to 'predatory' older men and people 'embedded in the street prostitution community', experiences of trying to fit in at each new place led to a tendency to seek approval of others, which left people vulnerable to exploitation , seeking control through gaining financial stability via prostitution.

Abuse and neglect are forms of maltreatment of a child. Somebody may abuse or neglect a child either directly by inflicting harm, or indirectly, 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. (NSPCC Fact Sheet 2009)
There are types of child abuse. These are defined in the UK Government guidance Working Together to Safeguard Children (2006). Here we cover categories of abuse outlined by the UK Government & the NSPCC:

PHYSICAL ABUSE

Physical Abuse - Every child has the right to live in a safe environment and not be harmed by anyone sharing that environment. Physical abuse is non-accidental harm to the body. Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child or failing to protect a child from that harm. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces illness in a child.

Physical abuse can be anything from a one isolated and minor incident inflicted willfully and spitefully, to something leading to neurological damage, physical injuries, pain and disability or, in extremes, death.

Physical abuse goes hand in hand with the emotional destruction of the 'self' both at the time the abuse is occurring and long into the future after the abuse has stopped, with an associated fear of rejection. It has been linked to aggressive behaviour, emotional and behavioural problems and educational difficulties.

Where these behaviours manifest in childhood, injuries or behavioural symptoms may mistakenly be attributed to his or her 'behavioural issues' rather than the abuse.

Importantly however whilst correlation exists, it does not inevitably follow that where a child is abused, they will go on to become an abuser.

Spotting the signs: Physical Abuse

Sometimes recognising abuse is very straightforward.

Picture this:

You receive a call from an adult who is worried about their daughter's best friend who has come around for tea and has bruising in the pattern of a handprint on their face and bruising of various ages to their back.

You are likely to be concerned and fulfilling your professional and ethical obligations, you will undertake a safeguarding referral to protect this child.

Now consider this:

You receive a call from a parent who tells you their baby has fallen from the bed and seems fine, but they are just calling to check. As part of the questioning, you ask the caller to check the child down to skin level and discover there is bruising to their abdomen.

At this point, the clinician has to decide if this is accidental or abuse?

Probing for clues

Probing is an important skill, so with just a little bit more thought, there are many ways the factors listed below may be ascertained.

Research shows there are certain inconsistencies which increase the index of suspicion that physical abuse may underpin the injury or illness and careful and judicious questioning should target these areas.

These inconsistencies include:

- Unexplained delay in seeking treatment that is obviously needed, or treatment is sought at an inappropriate time.
- Denial of any injury or claiming that they didn't know it was there.
- Explanations which are inconsistent with the injury sustained (as in our example above with the circumferential burns);
- Injuries or behaviour which are Inappropriate in relation to the age of the child (we speak more about this in 'sexual abuse' in the face-to-face teaching); this would also include injuries in a child who has yet to learn to walk. Toddlers may be expected to have bruises on their legs where they bump into things for example. Bruises on the legs of a non-mobile baby are not so easily explained. In these cases, clinicians should be vigilant to the presence of more significant injuries which may previously been sustained, such as shaking or fractures.
- Where the parent is either unusually defensive or aggressive, or in contrast seems unconcerned, these would both give reason to start to wonder about what may be going on in the background.
- The parent or caregiver may instead by reluctant to provide any information or brush away previous significant injuries.
- Similarly, when the child does not respond in a 'normal' way. They may not have cried, or seem to feel no pain, or be incredibly watchful or conversely very defensive, this would also be a cause for concern.
- Consent for further medical investigation is refused
- Repeated presentation of minor injuries or illnesses, often to the GP or Accident and Emergency, which may represent a 'cry for help' and which, if not taken seriously, may lead to more serious injury.

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SEXUAL ABUSE

5. Gang and group exploitation

Young people in gangs or groups may be sexually exploited as part of gang initiation or as punishment.

EMOTIONAL OR PSYCHOLOGICAL ABUSE

Emotional or Psychological Abuse - Emotional or psychological abuse is any action which has an adverse effect on a child's mental wellbeing, causing suffering and affecting their quality of life and ability to function to their full potential. This may include the threat that other types of abuse could take place or a situation where a person is led to believe that this could happen. The NSPCC describe emotional abuse as the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person.
It may feature age- or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond the child's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction.

It may involve seeing or hearing the ill-treatment of another. It may involve serious 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.

TIPS FOR ASSESSING

Every assessment, including young carer, parent carer and non-parent carer assessments, should draw together relevant information gathered from the child and their family and from relevant practitioners including teachers and school staff, early years workers, health practitioners, the police and adult social care. Where a child has been looked-after and has returned home, information from previous assessments and case records should also be reviewed.

Abuse may include non-contact activities, such as involving children in looking at, or in the production of, pornographic material or watching sexual activities, or encouraging children to behave in sexually inappropriate ways.

Risk of going online include:

- Online grooming and child abuse
- Access to age-inappropriate content
- Bullying and cyberbullying
- Personal information falling into the wrong hands
- Talking to strangers or people who misrepresent themselves
- People hacking their accounts

INDICATORS OF CHILD ABUSE

Indicators are the signs and symptoms that draw attention to the fact that something is wrong. The presence of one or more indicators does not confirm child abuse. However, a cluster of several indicators may reveal a potential for abuse and a need for further investigation. Lists of indicators are not exhaustive and need to be used carefully and sensitively in the assessment of risk.

Children who are abused may develop a pattern of behaviour that they feel will reduce the chances of the abuse re-occurring. This needs to be borne in mind when trying to understand why a child is behaving in a certain way. It is important to remember that abuse occurs where there is a power imbalance, and a child may be reacting to living in a situation of fear based on threats and coercion.

NEGLECT

The NSPCC describe neglect as 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 and clothing; shelter, including exclusion from home or abandonment; failing to protect a child from physical and emotional harm or danger; failure to ensure adequate supervision including the use of inadequate care-takers; or the failure to ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

Neglect is the ongoing failure to meet a child's basic needs and the most common form of child abuse (Brandon et al 2013). A child might be left hungry or dirty, or without proper clothing, shelter, supervision or health care. This can put children and young people in danger. And it can also have long term effects on their physical and mental wellbeing. Neglect can be a lot of different things, which can make it hard to spot.
But broadly speaking, there are 4 types of neglect.

Physical neglect	A child's basic needs, such as food, clothing or shelter, are not met or they aren't properly supervised or kept safe.
Educational neglect	A parent doesn't ensure their child is given an education.
Emotional neglect	A child doesn't get the nurture and stimulation they need. This could be through ignoring, humiliating, intimidating or isolating them.
Medical neglect	A child isn't given proper health care. This includes dental care and refusing or ignoring medical recommendations

Neglect can be difficult to spot and even harder on the telephone. Having one of the signs doesn't necessarily mean a child is being neglected. But if you see from historical call records or the story you are being told that there are multiple references that last for a while, they might show there's a serious underlying problem.

NEGLECT

Children and young people who are neglected might have:

- Poor weight gain or conversely obesity due to poor diet
- Failure to use prescribed medication or medication is withheld by the parent or carer
- Severe nappy rash – modern products are so good now this should always ring alarm bells to the health care professional
- Tooth decay
- Failure to immunise
- Poor hygiene and dirty clothes or clothes not consistent with the weather.
- Poor growth or delayed development
- Failure to attend appointments or not registered with a GP
- Delayed presentation for significant problems
- Poor physical condition
- Child not at school

Neglect may occur in pregnancy because of maternal substance abuse.

A child might not understand they are being neglected – the circumstances they find themselves in may be entirely normal to them, however it is important to understand that neglect changes childhoods. Children who've been neglected might experience short-term and long-term effects which can include:

- problems with brain development
- taking risks, like running away from home, using drugs and alcohol or breaking the law
- getting into dangerous relationships
- difficulty with relationships later in life, including with their own children
- a higher chance of having mental health problems, including depression.

Neglected children have a higher incidence of not viewing others as a source of help, having a helpless outlook and other features identified were poor peer relationships, poor social interaction, greater aggression and conduct problems. Neglected children engaged in the least number of interactions with other children, lower self- esteem. They were also more likely to cheat, break the rules and demonstrate noncompliance, verbal and physical aggression, hostility and negative mood.

Keep this in mind when a parent or carer complains about the child's behavior.

Naughton AM, Maguire SA, Mann MK et al. (2013) Emotional, behavioral, and developmental features indicative of neglect or emotional abuse in preschool children: a systematic review. JAMA Pediatrics 167: 769-75 quoted in NICE -Child abuse and neglect: consultation draft (February 2017) 68 of 581

FEMALE GENITAL MUTILATION

It has been estimated that over 20,000 girls under the age of 15 are at risk of female genital mutilation (FGM) in the UK each year, and that 66,000 women in the UK are living with the consequences of FGM. However, the true extent is unknown, due to the "hidden" nature of the crime.

The practice is illegal in the UK. It is also illegal to arrange for a child to be taken abroad for FGM. If caught, offenders face a large fine and a prison sentence of up to 14 years. The Female Genital Mutilation Act 2003 (updated by Serious Crime Act 2015) makes it

- Illegal to practice FGM in the UK.
- Illegal to assist a girl to mutilate her own genitalia.
- Illegal to take girls who are habitually resident in the UK abroad for FGM whether or not it is lawful in that country.
- Illegal to aid, abet, counsel, or procure the carrying out of FGM abroad.
- An offence under this act has a maximum penalty of up to 14 years in prison and/or a fine.

THE 2003 ACT HAS BEEN AMENDED BY THE SERIOUS CRIME ACT 2015, WHICH ADDS NEW SECTIONS 3A, 4A, 5A, 5B AND 5C. THESE NEW PROVISIONS

- Introduce ‘mandatory reporting’ to police via telephone (call 101) - a health care professional, teacher or social care professionals must make a “FGM Notification” to the police if, in the course of their duties, they discover that an act of FGM is known or has been seen on a girl under 18.
- Create an offence of failing to protect a girl under the age of 16 from FGM (the offence is committed by a person who has parental responsibility for her or has assumed responsibility for her care);
- Introduce Female Genital Mutilation Protection Orders, which may include such provisions, restrictions or requirements as the court considers appropriate in order to protect a girl from FGM; or to protect a girl after FGM has been carried out; and
- Give the victims of FGM a right of anonymity.
- In addition to complying with the mandatory duty, professionals should continue to have regard to their wider safeguarding responsibilities, which require consideration and action to be taken whenever there is any identified or known risk to a child, whether in relation to FGM or another matter.

Five signs to look out for (particularly for organisations such as health and education)

- The family belongs to a community which practices FGM.
- The family are making plans to go on holiday / requested extended leave from school.
- The child talks about a forthcoming special celebration.
- The child / woman may have difficulty walking or sitting.
- Their on mother or other siblings have had FG

CHILD TRAFFICKING

Child trafficking is child abuse. Children are recruited, moved or transported and then exploited, forced to work or sold. They are often subject to multiple forms of exploitation. Children are trafficked for child sexual exploitation; benefit fraud; forced marriage; domestic servitude such as cleaning, childcare, cooking; forced labour in factories or agriculture; criminal activity such as pickpocketing, begging, transporting drugs, working on cannabis farms, selling pirated DVDs, bag theft.

Many children are trafficked into the UK from abroad, but children can also be trafficked from one part of the UK to another. Child trafficking requires a network of people who recruit, transport and exploit children and young people. Each group or individual has a different role or task. Some people in the chain might not be directly involved in trafficking a child but play a part in other ways such as falsifying documents, bribery, owning or renting premises or money laundering.

Traffickers may be individuals or small groups who recruit a small number of children - often from areas they know and live in; medium-sized groups who recruit, move and exploit, often on a small scale; and large criminal networks that operate internationally, can deal with high-level corruption, money laundering and large numbers of victims.

SIGNS THAT A CHILD HAS BEEN TRAFFICKED MAY NOT BE OBVIOUS BUT YOU MIGHT NOTICE UNUSUAL BEHAVIOUR OR EVENTS. THESE INCLUDE A CHILD:

- who spends a lot of time doing household chores
- rarely leaves their house, has no freedom of movement
- no time for playing
- is orphaned or living apart from their family
- often in unregulated private foster care
- lives in substandard accommodation
- isn't sure which country, city or town they're in
- is unable or reluctant to give details of accommodation or personal details
- might not be registered with a GP or a school
- has no documents or has falsified documents; has no access to their parents or guardians; is seen in inappropriate places such as brothels or factories; and has injuries from workplace accidents.

SIGNS AN ADULT IS INVOLVED IN CHILD TRAFFICKING INCLUDE

making multiple visa applications for different children; acting as a guarantor for multiple visa applications for children; travelling with different children who they are not related to or responsible for; insisting on remaining with and speaking for the child; living with unrelated or newly arrived children; abandoning a child or claiming not to know a child they were previously with.

If you are worried that a child has been trafficked or you believe an adult is involved in child trafficking, you should contact the National Society for the Prevention of Cruelty to Children (NSPCC); The Police or Local Authority Child Protection Team.

RADICALISATION

Radicalisation is defined as the process by which people come to support terrorism and extremism and, in some cases, to then participate in terrorist groups.
Extremism is different: “Extremism is vocal or active opposition to fundamental British values, including democracy, the rule of law, individual liberty and mutual respect and tolerance of different faiths and beliefs. We also include in our definition of extremism calls for the death of members of our armed forces, whether in this country or overseas” (HM Government Prevent Strategy 2011)

Children and young people can be drawn into violence or they can be exposed to the messages of extremist groups by many means. These can include through the influence of family members or friends and/or direct contact with extremist groups and organisations or, increasingly, through the internet. This can put a young person at risk of being drawn into criminal activity and has the potential to cause significant harm. Children and young people are vulnerable to exposure to, or involvement with, groups or individuals who advocate violence as a means to a political or ideological end. Examples of extremist causes that have used violence to achieve their ends include animal rights, the far right, internal terrorist and international terrorist organisations.

Most individuals, even those who hold radical views, do not become involved in extremism. Numerous factors can contribute to and influence the range of behaviours that are defined as extremism. It is important to consider these factors in order to develop an understanding of the issue. It is also necessary to understand those factors that build resilience and protect individuals from engaging in violent extremist activity.
Safeguarding children and young people from radicalisation is no different from safeguarding them from other forms of harm. Indicators for vulnerability to radicalisation can include family tensions; sense of isolation; migration; distance from cultural heritage; experience of racism or discrimination; feeling of failure; etc.
Those in the process of being radicalised may become involved with a new group of friends, search for answers to questions about identity, faith and belonging, possess extremist literature or advocate violence actions, change their behaviour and language, and seek to recruit others to an extremist ideology.

Where a child/ young person is thought to be in need or at risk of significant harm, and/ or where investigations need to be carried out (even though parental consent is withheld), a referral to Children’s Services should be made. However, it should be recognised that concerns of this nature in relation to violent extremism are most likely to require a police investigation in the first instance.

INTERNET & ONLINE SOCIAL NETWORKING

Most children and young people use the internet positively. However, sometimes they behave in ways that may place them at risk. Some risks do not necessarily arise from the technology itself but result from offline behaviours that are extended into the online world, and vice versa.

POTENTIAL RISKS CAN INCLUDE, BUT ARE NOT LIMITED TO:

- bullying by peers and people they consider 'friends'
- posting personal information that can identify and locate a child offline
- sexual grooming, luring , exploitation and abuse contact with strangers
- exposure to inappropriate and/or content
- exposure to racist or hate material
- encouragement of violent behaviour, such as 'happy slapping'
- glorifying activities such as drug taking or excessive drinking physical harm to young people in making video content, such as enacting and imitating stunts and risk taking activities
- leaving and running away from home as a result of contacts made online.

There is also concern that the capabilities of online social networking services may increase the potential for sexual exploitation of children and young people.
Exploitation can include exposure to harmful content, including adult pornography and illegal child abuse images. There have also been a number of cases where adults have used social networking and user interactive services as a means of grooming children and young people for sexual abuse.
Online grooming techniques include gathering personal details, such as age, name, address, mobile number, name of school and photographs; promising meetings with sports idols or celebrities or offers of merchandise; offering cheap tickets to sporting or music events; offering material gifts including electronic games, music or software; paying young people to appear naked and perform sexual acts; bullying and intimidating behaviour, such as threatening to expose the child by contacting their parents to inform them of their child's communications or postings on a social networking site, and/or saying they know where the child lives, plays sport, or goes to school; asking sexually themed questions, such as 'Do you have a boyfriend?' or 'Are you a virgin?' asking to meet children and young people offline; sending sexually themed images to a child, depicting adult content or the abuse of other children; masquerading as a minor or assuming a false identity on a social networking site to deceive a child; using school or hobby sites (including sports) to gather information about a child's interests likes and dislikes.
Most online social networking sites set a child's webpage/profile to private by default to reduce the risk of personal information being shared in a public area of the site
If you require further information on sexual exploitation of children and young people online, they should see the Home Office Task Force on Child Protection and the Internet: Good practice guidelines for the providers of social networking and other user interactive services.

According to the NSPCC bullying may be defined as deliberately hurtful behaviour, usually repeated over a period of time, where it is difficult for those bullied to defend themselves. It can take many forms, but the three main types are physical (e.g. hitting, kicking, theft), verbal (e.g. racist or homophobic remarks, threats, name calling) and emotional (e.g. isolating an individual from the activities and social acceptance of their peer group).

The damage inflicted by bullying can frequently be underestimated. It can cause considerable distress to children to the extent that it affects their health and development or, at the extreme, cause them significant harm (including self-harm). All settings in which children are provided with services or are living away from home should have in place rigorously enforced anti-bullying strategies.

MENTAL HEALTH DISORDER

The Mental Health Act 2007 defines mental disorder as any disorder or disability of the mind. The majority of parents who experience mental illness do not neglect or harm their children simply as a consequence of the disorder. Children become more vulnerable to abuse and neglect when parental mental illness coexists with other problems such as substance misuse, domestic violence or childhood abuse. It is not inevitable that living with a parent/carer with mental health issues will have a detrimental impact on a child's development and many adults who experience mental health problems can parent effectively. However, there is evidence to suggest that many families in this situation are more vulnerable (Department of Education Children in Need Census 2015).

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As with mental health it is important not to generalise or make assumptions about the parenting capacity of parents with physical disabilities or illness.
Needs relating to the illness and disabling barriers would need to be addressed before making judgements about parenting capacity and it is beneficial for children's and adults' services to work together.

Depending on the nature of the physical disability or illness additional support may be needed to ensure that disabled parents can access the information and support that benefits all parents or will require additional assistance to carry out parenting tasks

Substance misuse is defined as intoxication by or regular excessive consumption of and/or dependence on psychoactive substances, leading to social, psychological, physical or legal problems.
When parents, or others in the home, stop taking drugs children can be particularly vulnerable. For example, the withdrawal symptoms both physical and psychological may interfere, at least for a while, with parent's capacity to meet the needs of their children.

Problematic drug use is likely to continue over time, and although treatment may prolong periods of abstinence or controlled use, for some individuals relapse should be expected. (Department of Education Children in Need Census 2015).

ALCOHOL MISUSE

Drinking alcohol affects different individuals in different ways. For example, some people may be relatively unaffected by the same amount of alcohol that incapacitates others. The primary concern therefore is not the amount of alcohol consumed, but how it impacts on the individual and, more particularly, on their role as a parent.

According to (Cleaver, H., Unell, I. and Aldgate, A. (2010) parental problem drinking can be associated with violence within the family and the physical abuse of children, but who has the alcohol problem is relevant. Alcohol misuse by a father or father figure can be related to violence and the physical abuse of children, while mothers with an alcohol problem are more likely to neglect their children.

Childline - http://www.childline.org.uk

Here there is brilliant web information and a telephone helpline with advice for young people about tackling bullying and other issues

need2know - relationships - http://www.need2know.co.uk/relationships/bullying

Good, clear advice and stories from young people about how they tackled bullying. Includes info on cyber-bullying.

Kidscape - http://www.kidscape.org.uk

Information and support about preventing bullying and child abuse, including a helpline, confidence-building courses, booklets and literature, child safety training and FAQs.

Don’t Stick It - http://www.dontstickit.org.uk/

A site campaigning to stop bullying of young people with learning disabilities

Bullying UK - http://www.bullying.co.uk/

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DOMESTIC VIOLENCE

Domestic Violence has been defined by the Home Office as: “Any incident of threatening behaviour, violence or abuse psychological, physical, sexual, financial or emotional between adults who are or have been intimate partners or family members, regardless of gender or sexuality.”
The effect of domestic violence on children should be seen as a child protection issue and professionals should follow the same steps as they would for any other child at risk of harm. Prolonged and/or regular exposure to domestic violence can have a serious impact on children’s safety and welfare, despite the best efforts of parents to protect them.

Birmingham Violence Against Women and Children Steering Group and Birmingham Safeguarding Children Board have endorsed the following best practice in working with children who are affected by domestic abuse:

- Do remember that your initial response is extremely important. Validate what the child is telling you, ensures/he knows that you are listening and that you believe what you are being told. Reassure the child that they have done the right thing in telling you and that Domestic Abuse is not their fault
- Do be honest with the child from the outset; explain the limitations to confidentiality to ensure that the child can control what s/he tells you. Explain what you will do and how you will record any information given
- Do ensure that the child feels comfortable talking to you; give her/him your name and encourage the child to contact you again in the future should s/he need to. If the child wants you to contact, her/him make sure that you have a safe way of doing this before agreeing to do so
- Do use language that is appropriate to the child's age and ability and ensure that you are not overloading the child with information. This is especially important when talking to children about confidentiality.
- Do listen for coded talking from children, don't assume or expect they will name things in the way that you do.
- Do be trustworthy in your work with children, do what you say you are going to do, set and maintain boundaries around your work and don't make promises you can't keep.
- Do allow the child to be in control wherever possible, offer choices, go at her/his pace; ask the child what they want to happen next and ask what you can do to help.
- Do allow children to be children and don't make them responsible for abusive behaviour.

DOMESTIC VIOLENCE

- Do prepare yourself for disclosures of abuse and domestic violence; be aware of other organisations who can offer support. Where appropriate give the child contact telephone numbers for her/him to access in their own time and ensure that you are aware of out-of-hours support in the event of an emergency
- Do be aware of the link between Domestic Abuse and Child Protection; be clear about your responsibilities with regard to child protection and ensure that the child understands what might happen.
- Do be non-judgmental in your response to children; respond to each child's individual needs and be aware that children's experiences will differ depending on ability, age, culture, ethnicity, gender, race, religion or sexuality.
- Do record any information you are given. This will validate what the child has told you and ensure continuity in support.
- Do develop links with other agencies working in this field and make the most of networking opportunities
- Do be aware of your own and your own organisations limitations; seek advice from other professionals and acknowledge that other services may be more appropriate
- Do follow up any referral that you have made with the organisation and the child, and ensure that the child understands what is going on throughout the process
- Do remember that often the best way to support children is to support the non-abusing parent/carer, who is usually mum.

RECOMMENDED READING

National Institute for Health and Care Excellence: Domestic violence and abuse quality standard

- Domestic Violence Risk Identification Matrix (DVRIM)
- Safelives DASH Risk Checklist
- SafeLives (2015) Toolkit for MARAC, Children and Young People's Services.

CHILDRENS DISCLOSURES

It can be daunting for a child to disclose abuse because of the following fears and beliefs:

- They may feel the abuse is their fault, They will get into trouble
- Nobody will believe them. Nobody can stop it. The abuse will get worse
- Their abuser will be sent to prison and it will be their fault. Their mother and other people they love will be hurt if they tell. They may feel the abuse is their fault. They told before and nobody listened. They will be taken into care. Their abuser has said that they will hurt them if they tell
- They believe that this is what happens in families
- They love their dad. They may blame their behaviour i.e. If I'm good, they won't do it again
- They may believe that they are a bad child. They feel ashamed of what the abuser does

Where children have been more deeply emotionally affected by their experiences and need more intense support, you may consider a referral to the Child & Adolescent Mental Health Teams which aim to support, help and intervene with children and young people who are experiencing emotional and mental health problems.

RECOMMENDED READING

www.thehideout.org.uk is aimed specifically at children who have experienced domestic violence

Birmingham & Solihull Women's Aid Helpline: 0808 800 0028 / **www.bswaid.org**

Rights of Women Legal Advice Line: Free confidential legal advice on family law, divorce and relationship breakdown, children and contact issues, domestic violence, sexual violence, discrimination and lesbian parenting. A number of fact sheets are available free to download.

www.rightsofwomen.org.uk

Legal Advice Line: 020 7251 6577.

National Domestic Violence Helpline: 0808 2000 247 - 24-hour freephone

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RESPONDING AND REPORTING

- All staff who are accredited or contracted by them to provide a service, have a duty to report any allegations or suspicions of the child abuse or potential child abuse to their immediate manager.
- If staff think that their manager is colluding with the abuse or not taking it seriously, they should report their concerns directly to the duty manager at the Local Authority's Children's Services Team. Additionally, they could follow the 'whistle-blowing' procedures in their own organisation.
- If a child is in immediate danger or in need of urgent medical attention, action must be taken to ensure their immediate safety and well-being. This may include calling the appropriate emergency services and suspending staff.
- If there is reason to believe a serious crime has been committed the Police should be called immediately and the incident, then referred to the appropriate Local Authority Children's Services team. In cases involving physical or sexual abuse care must be taken to preserve evidence.
- You may be made aware of a possible child abuse by verbal disclosure by the victim or perpetrator, through your own observations, or by a third-party report.

Whatever the source, it is important for you to:

ï Remain calm and try not to sound shocked or vocalise disbelief. Any shock or disbelief
ï Listen very carefully to what is said
ï Reassure the child by telling them that; they have done the right thing by sharing the information with you; you are treating the information seriously; and that the abuse is not their fault (if the information is being shared by the Victim')
ï Explain that you are required to share the information with your safeguarding team, but not with other staff or other children
ï Reassure the child that any further investigation will be conducted sensitively and with their full involvement, wherever possible
ï Reassure the child that steps will be taken to support and, where appropriate, protect them in the future.

If concerns are raised by your own observations, it may be necessary to establish the cause by asking open-ended questions: e.g. "That's sounds like quite a fall: How did that happen?" You must not:

RESPONDING AND REPORTING

- Press the child for more details. This may be done during any subsequent investigation, so it is important to avoid unnecessary stress and repetition for the child concerned
- Promise to keep secrets
- Make promises you are unable to keep
- Be judgmental; e.g. "Why didn't you try and stop them?"
- Stop a child who is freely recalling significant events
- Break the confidentiality agreed between the child disclosing the information, yourself and your line manager.
- if you saw the event, or when the allegation was made including the date, time and place
- Record exactly what was said, using their words, and by whom, this must not include your own opinion
- Make sure other people will be able to read your writing and put your signature and date.

You will also need to be aware of your organisations policies and procedures with regard to: Confidentiality, Data Protection, Whistleblowing, Safeguarding, Code of Conduct and Gaining Consent.

With the issue of consent any information you share must only be on a need-to-know basis, this should be decided on a case by case basis and adhere to your organisations policies and meet all national guidelines and legislation.

Explain to children, young people and families at the outset, openly and honestly what and how information will or could be shared and why and seek their agreement. However, if seeking their agreement would put that child or young person or others at increased risk of significant harm or an adult at risk of harm you may consider not gaining this agreement.

You must record your decision when you document your concerns or suspicions.

At the rear of your workbook are flowcharts taken from HM Government guidance and is in line with English legislation. "What to do if you are worried a child is being abused – Every Child Matters Change for Children".

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Your organisation will have its own Safeguarding Children Policy and will follow local guidance. Your manager or Designated Safeguarding Children's Officer will ensure that a signed record of the allegation is made as soon as possible within the organisations recording system. The recording will include an accurate, detailed record of what was said to the member of staff or volunteer by the child, any significant conversations and what was observed. You may also have to complete a body map.
If you are not in the workplace you must report your concerns to your local authority who have a duty to respond to your concern and investigate them. If you make a referral to social care by the phone you are required to follow with a completed referral form within 48hours.
Once you have reported your concerns or suspicions to the relevant person you must document in the following way.

- Complete the relevant paperwork for your organisation, this must be in a black pen
- Consider confidentiality

PARENTAL, FAMILY & CARER FACTORS

Child abuse is sometimes due to the relevance of parental, family and carer factors such as domestic abuse, mental and physical ill-health, substance and alcohol misuse.
You also need to be aware of the relevance of parental, family and carer factors such as domestic abuse, mental and physical ill-health, substance and alcohol misuse and you will briefly cover these.

CRITERIA FOR REFERRING A CASE TO MARAC

Any agency can refer a case which fits the criteria under one of the following categories, Professional Judgement, Visible High Risk or Potential Escalation. It is important to recognis that professional judgement may be adequate where there are serious concerns about the victim.

The role of a MARAC meeting is to enable partner agencies to discuss primarily how to safeguard an adult victim of domestic abuse who is identified as being at high risk of homicide or serious harm. At the meeting agencies will share information about the situation and formulate an action plan addressing the victim's safety and the safety of their children. The MARAC will assist in linking measures to safeguard the adult victim and measures to safeguard children and young people and manage the behaviour of the perpetrator (Safe Lives, 2015). Attendees at a MARAC include the police, an Independent Domestic Violence Advisor

(IDVA) who is the voice of the victim (the victim does not attend), children's social services, health and other agencies such as probation and housing. The MARAC referral should be discussed with the victim where this is safe, professional judgement should be exercised. In cases where the victim does not consent to information being shared consideration should be given to sharing it in line with the Data Protection Act, Human Rights Act, Caldicott guidelines, Common Law and in the public or vital interest where there is a high risk of harm (Multi- Agency MARAC Referral Form, 2015).

The aims of MARAC are:

- to share information to increase the safety, health and well-being of victims – adults and their children
- to determine whether the perpetrator poses a significant risk to any particular individual or to the general community
- to construct jointly and implement together a coordinated risk management plan that provides professional support to all those at risk and that reduces the risk of harm
- to reduce repeat victimisation
- to improve agency accountability
- to improve support for staff involved in high-risk DVA cases

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PROFESSIONAL JUDGEMENT

If a professional has serious concerns about a victim's situation, they should refer the case to MARAC. There will be occasions where the context of a case gives rise to serious concerns even if the victim has been unable to disclose the information that might highlight their risk more clearly. This could reflect extreme levels of fear, cultural barriers to disclosure, immigration issues or language barriers, particularly in cases of 'honour-based' violence. The judgement would be based on the professional's experience and/or the victim's perception of their risk even if they do not meet criteria 2 and/or 3 below.

'VISIBLE HIGH RISK'

The number of 'ticks' on the Safe lives DASH Risk Identification Checklist. If you have ticked 14 or more 'yes' boxes, the case would normally meet the MARAC referral criteria.

POTENTIAL ESCALATION

The number of police callouts to the victim because of domestic violence in the past 12 months. This criterion can be used to identify cases where there is not a positive identification of a majority of the risk factors on the list, but where abuse appears to be escalating and where it is appropriate to assess the situation more fully by sharing information at MARAC.

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REFERRAL TO MARAC

Referrals should be made by completing the Safelives DASH risk checklist. All referrals to MARAC must relate to an adult victim. Where there are children in the family, they will be considered as part of the MARAC discussions; however, where professionals have a concern about a child in relation to DVA they must follow the usual safeguarding procedures set out in Responding to concerns about a child. Where there are concerns about an unborn child a copy of the MARAC referral should automatically be sent to
the Multi-Agency Safeguarding Hub(MASH), or via the local arrangements for making a referral/if you have a concern about the safety or welfare of a child.

INDEPENDENT DOMESTIC VIOLENCE ADVISORS (IDVAS)

Independent Domestic Violence Advisors (IDVAs) provide primary and essential support to the MARAC. The IDVA service is available to all sectors of the community aged over 16 who are assessed to be at high risk of DVA, including those from minority ethnic groups, forced marriage, honour-based violence, those involved in sex work, same-sex relationships and male victims.

To contact the IDVA Service refer to your local Council website for further information on Domestic Abuse support services.

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DOMESTIC VIOLENCE PROTECTION NOTICES AND DOMESTIC VIOLENCE PROTECTION ORDERS

These notices and orders may be used by the police following a domestic incident to provide short-term protection to the victim when arrest has not been made but positive action is required, or where an arrest has taken place, but the investigation is in progress. This could be where a decision is made to caution the perpetrator or take no further action, or when the suspect is bailed without conditions. They may also be considered when a case is referred by MARAC.

The DVPN/DVPO process can be pursued without the victim's active support, or even against their wishes, if this is considered necessary to protect them from violence or threat of violence. The victim also does not have to attend court. This can help by removing responsibility from the victim for taking action against their abuser.

With DVPOs, a perpetrator can be banned with immediate effect from returning to a residence and from having contact with the victim for up to 28 days, allowing the victim time to consider their options and get the support they need.

DOMESTIC VIOLENCE DISCLOSURE SCHEME ('CLARE'S LAW')

The Domestic Violence Disclosure Scheme (DVDS; also known as 'Clare's Law') commenced in England and Wales in 2014. The DVDS gives members of the public a formal mechanism to make enquires about an individual who they are in a relationship with, or who is in a relationship with someone they know, where there is a concern that the individual may be violent towards their partner. This scheme adds a further dimension to information sharing

about children where there are concerns that domestic violence and abuse is impacting on the care and welfare of the children in the family. This process should only be used for those with concerns whom are not already engaged with any agencies who can provide help and share information.

Members of the public can make an application for a disclosure, known as the 'right to ask'. Anybody can make an enquiry, but information will only be given to someone at risk or a person in a position to safeguard the victim. The scheme is for anyone in an intimate relationship, regardless of gender.

Partner agencies can also request disclosure is made of an offender's past history where it is believed someone is at risk of harm. This is known as 'right to know'.

If a potentially violent individual is identified as having convictions for violent offences, or information is held about their behaviour which reasonably leads the police and other agencies to believe they pose a risk of harm to their partner, the police will consider disclosing the information. A disclosure can be made if it is legal, proportionate and necessary to do so.

ETHICAL AND LEGAL ISSUES

Assessment of a child under the Children Act 1989

- lead on an assessment and complete it in line with the locallyagreed protocol according to the child's needs and within 45 working days from the point of referral into local authority children's social care
- see the child within a timescale that is appropriate to the nature of the concerns expressed at referral, according to an agreed plan
- conduct interviews with the child and family members, separately and together as appropriate. Initial discussions with the child should be conducted in a way that minimises distress to them and maximises the likelihood that they will provide accurate and complete information, avoiding leading or suggestive questions
- record the assessment findings and decisions and next steps following the assessment
- inform, in writing, all the relevant agencies and the family of their decisions and, if the child is a child in need, of the plan for providing support
- inform the referrer of what action has been or will be taken

- assist other organisations and agencies to carry out their responsibilities where there are concerns about the child's welfare, whether or not a crime has been committed. If a crime has been committed, the police should be informed by the local authority children's social care

All involved practitioners should:

- be involved in the assessment and provide further information about the child and family
- agree further action including what services would help the child and family and inform local authority children's social care if any immediate action is required
- seek advice and guidance as required and in line with local practice guidance

- Anyone who has not yet reached their 18th birthday. The fact that a child has reached 16 years of age, is living independently or is in further education, is a member of the armed forces, is in hospital or in custody in the secure estate does not change their status or entitlements to services or protection.

Assessment of a child under the Children Act 1989

Safeguarding and promoting the welfare of children

Defined for the purposes of this guidance as:

a) protecting children from maltreatment
b) preventing impairment of children's health or development
c) ensuring that children are growing up in circumstances consistent with the provision of safe and effective care
d) taking action to enable all children to have the best outcomes

ï Part of safeguarding and promoting welfare. This refers to the activity that is undertaken to protect specific children who are suffering, or are likely to suffer, significant harm.

ï A form 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 others. Abuse can take place wholly online, or technology may be used to facilitate offline abuse. Children may be abused by an adult or adults, or another child or children.

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

Assessment of a child under the Children Act 1989

The persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to a child that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may include not giving the child opportunities to express their views, deliberately silencing them or 'making fun' of what they say or how they communicate. It may feature 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. It may involve seeing or hearing the ill-treatment of another. It may involve 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.

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. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse Sexual abuse can take place online, and technology can be used to facilitate offline abuse. Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.

CHILD SEXUAL EXPLOITATION

Child sexual exploitation is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology.

Assessment of a child under the Children Act 1989

DEFINITION

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:

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

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

Extremism goes beyond terrorism and includes people who target the vulnerable – including the young – by seeking to sow division between communities on the basis of race, faith or denomination; justify discrimination towards women and girls; persuade others that minorities are inferior; or argue against the primacy of democracy and the rule of law in our society. Extremism is defined in the Counter Extremism Strategy 2015 as the vocal or active opposition to our fundamental values, including the rule of law, individual liberty and the mutual respect and tolerance of different faiths and beliefs. We also regard calls for the death of members of our armed forces as extremist.

A young carer is a person under 18 who provides or intends to provide care for another person (of any age, except generally where that care is provided for payment, pursuant to a contract or as voluntary work).

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Assessment of a child under the Children Act 1989

A person aged 18 or over who provides or intends to provide care for a disabled child for whom the person has parental responsibility.

EDUCATION, HEALTH AND CARE PLAN

A single plan, which covers the education, health and social care needs of a child or young person with special educational needs and/or a disability (SEND). See the Special Educational Needs and Disability Code of Practice 0-25 (2014).

LOCAL AUTHORITY DESIGNATED OFFICER

County level and unitary local authorities should ensure that allegations against people who work with children are not dealt with in isolation.
Any action necessary to address corresponding welfare concerns in relation to the child or children involved should be taken without delay and in a coordinated manner. Local authorities should, in addition, have designated a particular officer, or team of officers (either as part of multi-agency arrangements or otherwise), to be involved in the management and oversight of allegations against people who work with children. Any such officer, or team of officers, should be sufficiently qualified and experienced to be able to fulfil this role effectively, for example qualified social workers. Any new appointments to such a role, other than current or former designated officers moving between local authorities, should be qualified social workers. Arrangements should be put in place to ensure that any allegations about those who work with children are passed to the designated officer, or team of officers, without delay.

SAFEGUARDING PARTNERS

A safeguarding partner in relation to a local authority area in England is defined under the Children Act 2004 as: (a) the local authority, (b) a clinical commissioning group for an area any part of which falls within the local authority area, and (c) the chief officer of police for an area any part of which falls within the local authority area. The three safeguarding partners should agree on ways to co-ordinate their safeguarding services; act as a strategic leadership group in supporting and engaging others; and implement local and national learning including from serious child safeguarding incidents. To fulfil this role, the three safeguarding partners must set out how they will work together and with any relevant agencies as well as arrangements for conducting local reviews.

Assessment of a child under the Children Act 1989

A child death review partner in relation to a local authority area in England is defined under the Children Act 2004 as (a) the local authority, and (b) any clinical commissioning group for an area any part of which falls within the local authority area. The two partners must make arrangements for the review of each death of a child normally resident in the area and may also, if they consider it appropriate, make arrangements for the review of a death in their area of a child not normally resident there. They must also make arrangements for the analysis of information about deaths reviewed under this section.

The purposes of a review or analysis are

(a) to identify any matters relating to the death or deaths that are relevant to the welfare of children in the area or to public health and safety, and

(b) to consider whether it would be appropriate for anyone to take action in relation to any matters identified.

As set out in the Serious Violence Strategy, published by the Home Office, a term used to describe gangs and organised criminal networks involved in exporting illegal drugs into one or more importing areas within the UK, using dedicated mobile phone lines or other form of 'deal line'. They are likely to exploit children and vulnerable adults to move and store the drugs and money, and they will often use coercion, intimidation, violence (including sexual violence) and weapons.

CHILD CRIMINAL EXPLOITATION

As set out in the Serious Violence Strategy, published by the Home Office, where an individual or group takes advantage of an imbalance of power to coerce, control, manipulate or deceive a child or young person under the age of 18 into any criminal activity(a) in exchange for something the victim needs or wants, and/or (b) for the financial or other advantage of the perpetrator or facilitator and/or (c) through violence or the threat of violence. The victim may have been criminally exploited even if the activity appears consensual. Child criminal exploitation does not always involve physical contact; it can also occur with technology.

REFERENCES

- Child sexual exploitation: definition and guide for practitioners
- Children Act 1989: care planning, placement and case review
- Children Act 1989: court orders
- Children Act 1989: private fostering
- Information sharing: advice for practitioners providing safeguarding services
- Keeping children safe in education: for schools and colleges
- Knowledge and skills statements for child and family social work
- Listening to and involving children and young people Department for Education and Home Office
- Mandatory reporting of female genital mutilation: procedural information Department for Education and Home Office
- Multi-agency statutory guidance on female genital mutilation Department for Education, Department of Health and Social Care, and Home Office
- National action plan to tackle child abuse linked to faith or belief
- National minimum standards for private fostering
- Non-Maintained Special Schools Regulations 2015
- Pathways to harm, pathways to protection: a triennial analysis of serious case reviews, 2011 to 2014
- Preventing and tackling bullying
- Safeguarding children Department for Education, Home Office, Ofsted, Department of Health and Social Care, Ministry of Housing, Communities & Local Government, Care Quality Commission, Department for Digital, Culture, Media & Sport, and Foreign & Commonwealth Office
- Safeguarding Children in whom illness is fabricated or induced Department for Education, Department of Health and Social Care and Home Office
- Safeguarding children who may have been trafficked Department for Education and Home Office
- Safeguarding strategy - unaccompanied asylum seeking and refugee children
- Sexual violence and sexual harassment between children in schools and colleges
- Statutory framework for the early years [under 5s] foundation stage (EYFS)
- Statutory guidance on children who run away or go missing from home or care
- Statutory visits to children with special educational needs and disabilities or health conditions in long-term residential settings Department for Education and Department of Health and Social Care.
- The Child Safeguarding Practice Review and Relevant Agency (England) Regulations 2018
- The prevent duty: for schools and childcare providers
- United Nations Convention on the rights of the child
- Use of reasonable force in schools
- Visiting children in residential special schools and colleges Department for Education and Department of Health and Social Care
- What to do if you're worried a child is being abused: advice for practitioners

GUIDANCE ISSUED BY OTHER GOVERNMENT DEPARTMENTS AND AGENCIES

- Achieving Best Evidence in Criminal Proceedings: Guidance on interviewing victims and witnesses, and guidance on using special measures Ministry of Justice
- Advice to parents and carers on gangs Home Office
- Advice to schools and colleges on gangs and youth violence Home Office
- Apply for a forced marriage protection order Foreign & Commonwealth Office
- Arrangements to Safeguard and Promote Children's Welfare (original title "Every Child Matters") UK Visas and Immigration
- Asset Plus: assessment and planning in the youth justice system Youth Justice Board
- Carers Strategy: Second National Action Plan 2014-2016 Department of Health and Social Care
- Carers Strategy: the second national action plan 2014-2016 Department of Health and Social Care
- Channel Duty guidance - Protecting vulnerable people from being drawn into terrorism Home Office
- Criminal exploitation of children and vulnerable adults: county lines Home Office
- Cyber Aware National Cyber Security Centre
- DBS barring referral guidance Disclosure and Barring Service
- Developing local substance misuse safeguarding protocols Public Health England
- Disclosure and Barring Services Disclosure and Barring Service
- Female Genital Mutilation Protection Orders: factsheet Home Office
- Forced marriage Foreign & Commonwealth Office and Home Office
- Forced Marriage Protection Orders HM Courts & Tribunals Service
- Guidance for health professionals on domestic violence Department of Health and Social Care
- Handling cases of forced marriage: multi-agency practice guidelines Foreign & Commonwealth Office
- Indecent images of children guidance for young people Home Office
- Mental Health Act 1983 Code of Practice: Guidance on the visiting of psychiatric patients by children Department of Health
- Mental Health Act 1983 Code of Practice: Guidance on the visiting of psychiatric patients by children Department of Health
- Missing Children and Adults - A Cross Government Strategy Home Office
- Modern slavery Act statutory guidance Home Office
- Multi-agency public protection arrangements (MAPPA) Ministry of Justice, National Offender Management Service, and HM Prison Service
- National service framework: children, young people and maternity services Department of Health and Social Care

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HEALTHCARE TRAINING

GUIDANCE ISSUED BY OTHER GOVERNMENT DEPARTMENTS AND AGENCIES

- NHS England safeguarding Policy NHS England
- Prison, probation and rehabilitation: Public protection manual National Offender Management Service and HM Prison Service
- Probation service guidance on conducting serious further offence reviews framework Ministry of Justice
- Radicalisation - Prevent strategy Home Office
- Recognised, valued and supported: next steps for the carer's strategy 2010 Department of Health and Social Care
- Safeguarding vulnerable people in the reformed NHS: Accountability and Assurance Framework NHS England
- Serious and Organised Crime Toolkit: An Interactive Toolkit for practitioners working with young people Home Office
- Thinkuknow [Supporting children to stay safe online] National Crime Agency
- Understanding the female genital mutilation enhanced dataset: updated guidance and clarification to support implementation Department of Health and Social Care
- Violence against women and girls Home Office

GUIDANCE ISSUED BY OTHER GOVERNMENT DEPARTMENTS AND AGENCIES

- Child maltreatment: when to suspect maltreatment in under 18s NICE
- Child protection and the Dental Team British Dental Association
- Children's Commissioner
- Children's rights and the law - Children's Rights Alliance for England
- Cyberbullying: Understand, Prevent, Respond – Guidance for Schools Childnet International
- How we protect children's rights – Unicef
- Inter parental relationships Early Intervention Foundation
- NICE guideline on child abuse and neglect NICE
- Prison and Probation Ombudsman's fatal incidents investigation
- Private fostering CoramBAAF
- Protecting children and young people: doctors' responsibilities General Medical Council
- Safeguarding Children Toolkit for General Practice Royal College of General Practitioners
- Standards for safeguarding and protecting children in sport NSPCC
- Sudden unexpected death in infancy and childhood: multi-agency guidelines for care and investigation Royal College of Pathologists
- Whistleblowing advice line NS

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HEALTHCARE TRAINING

SCENARIO 1

Janet, a thirteen year old, had recently moved into a new children's residential home. One day a teenage boy came to visit her saying she was his 'girlfriend'. Janet greeted him enthusiastically and they went into the garden. Later, another child came indoors and told you that Janet is doing naughty things with that boy!

What would you do?

SCENARIO 2

You are a care worker in a children's residential home. You and another member of staff suspect that a third member of staff is sexually abusing the children.

Discuss what action you would take.

SCENARIO 3

The manager of a children's residential home told her staff any child who was naughty must be locked up in one of the rooms which did not have furniture or lighting to teach them a lesson.

Discuss what you would feel about this and what if anything you would do.

SCENARIO 4

A child who was known to have been abused sexually by her dentist, was forced to have dental treatment. She was frog-marched to the surgery, held down, and later punished for making a fuss.

Discuss this.

SCENARIO 5

Carol was brought to your children's home for a short respite stay. While assisting with personal care you notice fingertip bruising on her arms. Carol could not tell you how she had got them.

Discuss what action you would take.

SCENARIO 6

You are made aware that a child is regularly accessing radical sites on the Internet that glorify the terrorist activities of various groups.

Discuss what conclusions you make from this and any action that you might take.

IS THIS ABUSE?

Is this abuse?

You cover a plate of food in pepper and leave it out to teach a child who steals food a lesson.

IS THIS ABUSE

Is this abuse?

You restrain a child from hitting themselves by holding their arm's firmly.

IS THIS ABUSE

Would you report this?

You hear a member of staff telling a child she is worthless and a waste of everyone's time.

IS THIS ABUSE?

Would you report this?

A child in care is regularly meeting a group of men and says she likes the naughty things they do to her.

WOULD YOU REPORT?

Would you report this?

A teenage girl tells you she is going abroad on holiday and her parents have told her she will be of age when she returns. The family come from a country where female genital mutilation is still practiced.

WHAT WOULD YOU DO?

Would you report this?

A colleague's computer has been left on in the staff room and you notice that it is logged into a child pornography site.

IS THIS ABUSE?

Would you report this?

You notice that a child has a series of bruises on their legs and arms indicating that some were new and some old.

IS THIS ABUSE?

Would you report this?

A child tells you that she is having to search a neighbour's waste bin for food as her mother is not feeding her.

IS THIS REPORTABLE?

Is this abuse?

A teacher forced a child to eat soap to clean out his mouth because he swore during the lesson.

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IS THIS ABUSE?

Would you report this?

You are made aware that a child is being repeatedly bullied via social media and she has told you she wants to end her life.

IS THIS ABUSE?

Would you report this?

You are aware that a member of staff is regularly referring to the children you look after as, “Those low life kids”.

IS THIS ABUSE?

Would you report this?

You see a member of staff repeatedly doing personal care for a child without wearing gloves.

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SAFEGUARDING CHILDREN

For Markers Use	Total Score /50	Date	Assessor Name

The questions below are an opportunity for self-study and testing. Some of these are I included in the MCQ's. I would recommend working through these to identify gaps in knowledge. Please use the competencies as a guidance for practice.

Full Name:	
Date of Birth:	
Male or Female:	
Place of Work:	
Email:	
Phone Number:	

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QUESTION 1

Q1. Which 3 agencies are legally mandated to investigate safeguarding issues. Mark which ones are correct.

1. National Society for the Prevention of Cruelty to Children(NSPCC)
2. School authorities
3. The Police
4. Local Authority Child Protection team

YOUR ANSWER

TOTAL MARKS GIVEN____/ 3

QUESTION 2

List 3 cases where the clinician must be alert for potential need for early help.

1.

2.

3.

TOTAL MARKS GIVEN____/ 3

QUESTION 3

List 4 Acts that protect Children

1.

2.

3.

4.

TOTAL MARKS GIVEN____/ 4

QUESTION 4

Looked After Child

1. Explain what the term “Looked after child” means?

2. Why are looked after children at risk of abuse:

3. What are the 4 types of neglect. Give an example of each:

1.

2.

3.

4.

TOTAL MARKS GIVEN____/ 6

QUESTION 5

List 4 red flags during a telephone conversation that would initiate a safeguarding referral?

1.

2.

3.

4.

TOTAL MARKS GIVEN____/ 4

QUESTION 6

What does HEADSS stand for and what is its relevance

H

E

A

D

S

S

TOTAL MARKS GIVEN____/ 6

QUESTION 7

What do you understand by the following terms?

County Lines

FGM

Breast ironing

“Honour killing”

TOTAL MARKS GIVEN____/ 4

QUESTION 8

Domestic Violence

1. Can we call the police if the parent is involved in domestic violence but have asked you not to call police?

2. In what circumstances can you call the police?

3. What is a DVPO or DVPN and in what circumstances can it be pursued without the victims active support?

4. What is ‘Clares Law”

TOTAL MARKS GIVEN____/ 4

QUESTION 9

ABUSE

List 4 types of child abuse and give an example of each

1.

2.

3.

4.

List inconsistencies in a telephone consultation that could indicate underlying abuse.

List common pitfalls during telephone triage and identifying safeguarding cases.

TOTAL MARKS GIVEN____/ 6

QUESTION 10

Criteria for Referring to MARAC

What is MARAC and what do they do?

Who can refer MARAC?

How is a “visible high risk’ case identified?

How do you make a referral to MARAC?

TOTAL MARKS GIVEN____/ 4

QUESTION 11

Once a safeguarding concern has been highlighted, what should you always document in patients records at the outset?

How do you prioritise Urgency of a referral?

List 3 things you should not do when a child discloses to you that they have been abused or at risk.

TOTAL MARKS GIVEN____/ 6

THE COMPETENCY FRAMEWORK

This document has been adapted to provide guidance for healthcare professionals undertaking consultations with a focus on safeguarding children.

This competency document supports the individuals learning after completion of the pre-course learning, on-line material, and face to face training day. We recognise that there are different ways of learning and development, and the following activities will support achievement of competencies.

- Completion of mandatory Level 3 safeguarding training
- Completion of in-house training by 111
- Precourse- workbook
- E-Learning courses
- Face to face one day course
- Personal research such as conferences, articles and literature.
- Learning and knowledge from experience.

The competencies in this workbook contains suggestions of evidence that can be used and assessments can be formal or informal.

The Safeguarding Children Competency Framework is underpinned by two Core Values that all staff and volunteers and safeguarding trainers should demonstrate throughout their evidence in meeting the competencies:

- **Place the child at the centre** and promote the importance of understanding the child's daily life experiences, ascertaining their wishes and feelings, listening to the child and never losing sight of his or her needs
- **Create and support an ethos** that values working collaboratively with others (valuing different roles, knowledge and skills), respects diversity (including culture, race, religion and disability), promotes equality and encourages the participation of children and families in the safeguarding processes.

	CORE COMPETENCIES	*SUGGESTED EVIDENCE
1	Consider the daily 'lived' experience of the child or young person and place them at the centre, listening to their voice, working out what they are trying to communicate and never losing sight of their needs.	Professional discussion regarding a case or a specific incident stating how the daily lived experience of the child had been considered.
2	Know how to recognise possible signs and indicators of abuse and neglect.	Through e-learning and/or a training event and discussion afterwards.
	Have an awareness of background sounds and cues to identify safeguarding issues	
3	Know how to respond and communicate with children, young people or adults when they may be trying to tell you something.	Evidenced during professional supervision or discussing a situation/case where individuals have raised issues around safeguarding.
4	Know what to do with important information; how it should be recorded, how it should be shared safely and with whom it should be shared.	Demonstrated through daily documents in the work place, such as case files, logs, handover diaries.
5	Understand the importance of sharing information and what could act as a barrier to doing this.	Professional discussion during induction or when something has happened in the workplace. Possibly through a multi-agency training event.
6	Understand that safeguarding requires working effectively across teams, different agencies and professions, as well as with children, young people and families themselves.	Through induction by understanding own role and who else is involved in assisting children to meet their potential. Considering the law and how it applies to role. Possibly through a multi-agency training event.

	CORE COMPETENCIES	*SUGGESTED EVIDENCE
7	Be persistent in your response to safeguarding needs, notice, check and share. Follow up with enquiries, escalate where necessary and 'whistle blow' as required.	Demonstrate that, when other people have been contacted with safeguarding information, it is known what happened next. This may be through a discussion of 'what would you do?'
8	Understand what to do if your referral is not accepted.	Demonstrate that more information has been sought following referral. This may be through a professional discussion of 'what would you do?'
9	Understand what might make some children more vulnerable taking into account diversity, difference and promoting equality.	Through a training course with a discussion or team/group meeting following. When having an admission into a setting.
10	Have knowledge of safeguarding legislation, statutory and non-statutory guidance, as well as other 'Safeguarding' bodies/agencies appropriate to role	Through induction into role and/or everyday working practice. Reading/accessing the website and procedures
11	Understanding of Child Development, to help identify changes in behaviour or progress, which may indicate abuse.	Through a professional qualification relevant to role. By being involved in the lives and outcomes of children.
12	Know how to contribute to assessments of children, young people and/or parents/carers	Through observing a competent worker in this role. By discussing situation with manager/safeguarding lead.
13	Ability to assess risk, need, and to follow procedures/pathways to engage with appropriate services	Through attending a multi-agency training event and following discussion/actions. Written evidence from referring to other services.
14	Ability to use professional judgement to make decisions as to whether a child or young person is suffering, or is likely to suffer significant harm	Professional discussion or written evidence, regarding an incident/case where such a decision has been made.

	CORE COMPETENCIES	*SUGGESTED EVIDENCE
15	Participate in all relevant statutory multi-agency meetings such as Strategy Meetings, Core Groups etc.	Evidence of attending meetings as required.
16	Ability to give effective feedback and offer professional challenge to those you are advising.	Written evidence from meetings or supervision.
17	Understand the Safer Recruitment practices where relevant to role.	Demonstrated through recruitment of staff/volunteers.
18	Supports contributions to Serious Case Reviews (SCRs) and other multiagency reviews and audits. Co-ordinate any action plans arising from these.	Evidence of having completed documentation. Attendance at meetings. Evidence that actions are complete from any plan.
19	Know how to lead and/or contribute to assessments of children and/or parents/carers	Through observing a competent worker in this role. Evidence through written assessment report.
20	Ability to look holistically at children, families and their communities considering: the child's developmental needs; parenting capacity; and family and environmental factors.	Evidence through written assessment report. Through a professional qualification relevant to role. Demonstrated through every day working.
21	Recognising the role of other agencies and their limitations as well as your own	Attending multi agency training and following discussion. Professional discussion with manager.
22	Ability to work with children and families where there are safeguarding or child protection concerns, as part of a multidisciplinary team, when assessing a child	Through induction by understanding own role and who else is involved in assisting children to meet their potential. Demonstrated through every day working and/or specific scenarios/cases.
23	Ability to complete reports and present safeguarding/child protection concerns verbally and in writing for professional and legal purposes as required	Through written evidence of a Court Report. By giving evidence in court and/or at other legal meetings.

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