

Safeguarding Children and Young People: The RCGP/NSPCC Safeguarding Children Toolkit for General Practice



Enter contents



Primary Care Child
Safeguarding Forum

Contents

page

Click box to
go to section

Foreword

S1

The Toolkit

1

1.1 1.2 1.3

Objectives of the Toolkit
Introduction
Policy and Legislation

1
5
7

S2

Practice organisation

9

2.1 2.2 2.3 2.4 2.5 2.6 2.7

Practice policies and procedures
Role of the General Practice Lead(s) for Safeguarding Children and Young People
Practice records and coding
Training and Education for the Primary Healthcare Team
The Role of Regulators in inspecting General Practice Safeguarding Children arrangements
External Requests for Audits
Resources for Children, Parents, Carers, Survivors and the General Practice Team

10
12
13
14
17
19
21

S3

Working together with other Agencies

23

3.1 3.2 3.3a 3.3b 3.3c 3.4 3.5 3.6 3.7 3.7.1 3.7.2

Information sharing (inter and intra agency)
The role of the Public Health Nurse in Safeguarding Children
Referral to statutory services: early help
Referral to statutory services: the Child in Need
Referral to statutory services: the Child at Risk of Significant Harm and the Child in need of protection
What comes after a Child Protection referral
Report writing in Child Safeguarding and Child Protection
Case conferences and recommendations
Court Procedures relating to Children
The Child at Risk: Care proceedings
Marriage or Partnership breakdown

26
28
30
31
35
37
38
39
42
42
44

S4

Recognition, Presentation and Prevention of Child Maltreatment in Primary Care

45

4.1 4.2

Presentation of Child Maltreatment in Primary Care
Prevention, Early Recognition and Early Intervention

48
54

S5

Parent, Carer and Family Risks

58

5.1 5.2 5.3 5.4 5.5 5.6 5.7

Exposure of children to domestic violence
Parental mental health problems
Parental or Carer substance misuse
Working with missing, non-engaging or hostile families
Multi-Agency Risk Assessment Conferences (MARAC)
Multi-Agency Public Protection Arrangements (MAPPA)
Domestic Homicide Review

60
62
63
65
66
67
68

Click box to
go to section

Contents

page

S6

Communication with children and families

69

6.1	Facilitating communication	70
6.2	How to manage disclosure	74
6.3	Barriers to disclosure and intervention	74
6.4	The role of the GP in managing disclosures of abuse	75
6.5	Working with parents	77

S7

Looked After Children (LAC)

80

7.1	Improving the Health of Looked After Children and Young People Leaving Care	81
7.2	Private Fostering	82

S8

Sexual Violence Against Children and Young People

84

8.1	Child Sexual Exploitation	85
8.2	Female Genital Mutilation (FGM)	89
8.3	Forced Marriage	91

S9

Children in Special Circumstances

92

9.1	Children and Social Media	92
9.2	Gang abuse	93
9.3	Trafficking	94
9.4	Radicalisation as a form of abuse	95
9.5	Hidden Children	95

S10

Case Reviews

98

10.1	The Vulnerable Child and Family Meeting	99
10.2	Serious Incident Reviews and Root Cause Analysis	100
10.3	The Child Protection Review	100
10.4	The Child Death Review	101

S11

Commissioning Child Safeguarding in the NHS

103

11.1	Safeguarding Children (and Adults): Responsibilities of NHS Commissioning Organisations	104
11.2	Case History: A Clinical Network	105
11.3	The role of the Named Safeguarding Children GP	106

S12

Adult Survivors and Disclosures of Historical Abuse

108

Contents

S13

References

110

Downloadable Tools

T1	Tips for Writing Practice Policies and Procedures
T2	Specimen Safeguarding Policy for General Practice
T3	Recommended Codes
T4	Record Keeping Exercise for clinicians
T5	Safeguarding Children Self-Assessment Tool
T6	Reflective Tools
	6a Child Registration
	6b Record Keeping
	6c Information Sharing for Child Safeguarding
	6d Data Sharing Checklist
	6e Section 11 Standards
	6f Parental Risk Factors
	6g Domestic Abuse
	6h Serious Domestic Incident Meeting: When domestic abuse results in serious injury or death
	6i Template for recording reflective Practice meetings on Child Protection Adverse Events such as Critical Incident Reviews, Serious Case Reviews and Sudden Unexpected Death
T7	Specimen report for Section 47 Reports and Case Conferences
T8	Specimen Form for Child Registration
T9	Specimen form for vulnerable child leaving Practice
T10	Named Safeguarding Children GP Skills, Competences and Role Description
T11a	Early Years Child Development
T11	Poster Guide to Child Development
T12	Information Sharing Poster
T13	ChildSafe Trigger Tool
T14	Health Visitor SAFER Tool
T15	Responding to Domestic Abuse, Guidance for General Practices
T16	Domestic Abuse Risk Assessment Tool for Named Safeguarding GPs
T17	MARAC Toolkit
T18	Brook Traffic Light Tool
T19	Spotting the Signs of Sexual Exploitation:
	The BASHH proforma

Foreword

Children and young people are our future and it essential that we do whatever we can to ensure that they are safe and well.

As the largest medical royal college in the UK, representing nearly 50,000 family doctors, the Royal College of General Practitioners (RCGP) is pleased to be again working in partnership with the NSPCC to update this essential toolkit to support GPs and their practices in managing this important duty.

A quarter of a GP's patients are under 19 years of age and more children and young people are seen in general practice than in any other part of the health service.

As the world changes, our children and young patients increasingly become exposed to new and different risks to their health and well-being. This update comprehensively collates emerging and existing guidance in one place to ensure that general practices across the UK can operate an environment in which all staff feel confident in all their dealings with children and young people.

It will also reassure parents, carers and our partner agencies that general practice teams are as up to date as they possibly can be with the latest developments in safeguarding and assure them of our total commitment to promoting the safety and welfare of children and young people.

The toolkit is supported by the RCGP training curriculum that all potential GPs of the future must follow, as well as the RCGP Child Health Strategy 2010–15 and the Intercollegiate Guidelines (ICG) for Safeguarding Children and Young People 2014.

The health of our young patients is a priority for the RCGP – yet only half of our trainee GPs currently get the opportunity to undertake a specialist paediatric placement during their training. We are currently campaigning to extend GP training from three to four years, with a particular focus on child health and mental health.

The latest version of this toolkit adds further weight to our case for why this is necessary and so crucial.

Dr Maureen Baker
Chair, RCGP

Disclaimer

This [document] is a public resource of general information and not advice relating specific issues of its [readers]. It is intended, but not promised or guaranteed, to be correct, complete, and up-to-date at the time of its publication. The Royal College of General Practitioners does not warrant, nor does it accept any responsibility or liability for, the accuracy or completeness of the content or for any loss which may arise from reliance on information and material contained in this [document].

August 2014

S1

The Toolkit

Click box to
go to section

page

1.1	Objectives of the Toolkit	1
1.2	Introduction	5
1.3	Policy and Legislation	7

*'Health inequalities result from social inequalities.
Action on health inequalities requires action across
all the social determinants of health'*

Sir Michael Marmot (2010) *Fair Society, Healthy Lives*

1.1 Objectives of the Toolkit

This Toolkit aims to provide Practices in the UK with a framework for integrating safeguarding children and young people into existing practice systems and processes for delivering primary care. This is not intended to be a textbook of child safeguarding but a practical workbook for busy GPs and their teams, designed to help Practice staff to recognise when a child may be at risk of abuse, to know what to do if there are concerns and to ensure that as a Practice the team works with other disciplines and agencies to achieve the best possible outcomes for children by safeguarding and promoting their welfare.

This 2014 update takes account of new policies, legislation and emerging evidence as well as the constraints of the 10 minute consultation and the pressures of 21st century general practice. It will help ensure that general practices across the United Kingdom operate a safe environment, in which staff possess the knowledge and skills to be comfortable working with children and young people and will reassure parents, carers and our partner agencies that general practices are committed to improving outcomes for children and young people.

The Toolkit is devised to support GPs to improve outcomes for children and families by bringing together relevant guidance and information, focusing on good medical practice and signposting to existing safeguarding statutes, policies and tools. There is emphasis on the strong evidence base (Marmot 2010, Allen 2011) which supports the benefits of early identification of adverse factors and early intervention to improve life course. Most families are registered with a General Practice which gives GPs and their Teams a crucial role as possibly the only professionals in a position to identify emerging problems, unmet need and vulnerability in parents and families and to readily engage with pregnant women, infants and pre-school children in need of extra support or recognised as being at risk.

Using the Toolkit

This 2014 version is presented as a practical working guide. It is divided into self-contained sections providing information and guidance on specific topics of key relevance to GPs and their teams. It covers best practice guidance and clinical governance as well as the legal aspects of child safeguarding and while there are differences in legislation and practice between the four countries of the United Kingdom, it is intended that this Toolkit will be helpful to GPs throughout the different jurisdictions.

The core document of 12 Sections provides factual information on aspects of child safeguarding and child protection most likely to be encountered in general practice, with emphasis on what these issues mean for GPs in relation to patient care, patient safety, registration, GP appraisal, revalidation and regulation, plus guidance on what GPs will be required or expected to do when confronted with them. There are many links and references to enable those requiring more information ready access to detailed resources and recent developments.

It identifies fundamental policy, legal and regulatory features which will facilitate developing, maintaining and sustaining standards to meet professional, medico-legal, and regulatory requirements while improving patient safety. **Individual GPs and practices may choose according to interest and need which sections to consult but will find Essential Elements of Safeguarding is a useful starting point while Sections 1 to 5 contain key information.**

Later sections cover topical subjects including communication with children, looked after children, child sexual exploitation, female genital mutilation, social media, gang abuse, trafficking and radicalisation. As each section is self-contained there is inevitably a certain amount of cross-referencing, overlap and duplication.

The downloadable **Tools** offer practical advice and provide the user with a range of resources to adapt to their own Practice requirements as well as frameworks developed by other organisations to aid diagnosis and decision making.

T1 and **T2** give Guidance to writing a Practice Policy and Procedures, **T3** and **T4** deal with record keeping while the Audit Tool **T5** enables Practices to assess what arrangements are already in place, identify organisational, educational and development needs, problems and challenges and to draw up a strategy for addressing these issues.

In **T6** there are reflective exercises to be used for individual learning or by the whole Practice team and which when fully documented may be presented as evidence for GP Appraisal and Revalidation. **T7**, **T8** and **T9** are specimen forms for practice administration. The Tools also include posters and proformas developed by various organisations to help with diagnostic dilemmas and decision making processes. The posters are individually copyrighted and used with permission of their authors.

Links to websites and references are provided for user convenience and remain the copyright of the organisation or author as is information supplied by third parties. Such linkage or usage does necessarily not imply that the material is endorsed by the RCGP.

Basis of information: The toolkit is based on current safeguarding and child protection legislation, policy and procedures, existing child health resources, evidence gathered over several decades from a large number of Serious Case Reviews and Public Enquiries into child death from abuse and neglect at national, regional and local level, best practice knowledge of expert practitioners including Named Safeguarding GPs and through research carried out by various international and national institutions, such as NSPCC.

Every effort has been made to ensure that information is current and accurate at the time of publication but child safeguarding is a dynamic field and it is the responsibility of individual practitioners to ensure that they keep abreast of changes especially in country-specific legislation, local protocols, procedures and thresholds which may be subject to regular update and amendment.

It is the duty of practitioners to familiarise themselves with professionally relevant statutes in the country in which they practice (GMC [Good Medical Practice](#) 1.12) and with their local authority child safeguarding policies and procedures. The [NSPCC](#) website provides regularly updated child protection information for each of the four countries of the UK.

Toolkit Origins: The original Toolkit was published in 2007, born of the passion of a group of GPs, Paediatricians and NSPCC consultants to promote excellent child safeguarding practice in primary care thereby ensuring that all children and young people, but especially those who may be the most vulnerable, enjoy improved health and well-being and better life-course outcomes.

Updating of the Toolkit was required because of a number of policy and legislative changes throughout the UK. The 2014 amendment of the Intercollegiate Document [Safeguarding Children and Young people: roles and competences for health care staff](#) applies across the UK, while in England major changes were brought about by the [2012 Health and Social Care Act](#), publication of [Working Together to Safeguard Children 2013](#) and [Care Quality Commission](#) registration of GP surgeries in England from April 2013. **Section 1.3** sets out legislative and policy requirements for each of the four UK countries.

This Toolkit has been updated in 2014 on an entirely voluntary basis by members of the Primary Care Child Safeguarding Forum (PCCSF), a Primary Care Society affiliated to the RCGP, and formed in 2006 to support all doctors working at a community level to safeguard and protect children.

2014 Toolkit update and amendment

Editor and Co-Author Dr Vimal Tiwari, **Project Group:** Dr Kate Barusya, Dr Zoe Cameron, Dr Ian Dunn, Dr Matthew Hoghton, Dr Danny Lang

Contributors

Drs Chris Absolon and Jonathan Leach: Information Sharing
Dr Siobhan Barnes: Multi-Agency Hubs, Domestic Incident Report Read Code
Dr Zoe Cameron: Communication and Child Sexual Exploitation
Dr Ian Dunn: FGM and Forced Marriage, Consultant Dr Judy Shakespeare
Dr Nigel Farr: Health Visiting in Wales
Professor Gene Feder: The effect of domestic abuse on children
Dr Danny Lang: Parental risk factors – Mental Health and Substance Abuse
Dr Aisha Paulose: Safeguarding Training for GPs and the Practice Team

Tools

Tool 3 Multi-Site Audit Codes University of Surrey, UCL and RCGP
Tool 5 Practice Self-Assessment Tool developed from the Bournemouth Audit Tool
Tool 6i Recording Template Source: Luce, R., *Safeguarding Children: Legal Framework for Nurses, Midwifery and Community Practitioners*. Publishers: John Wiley & Blackwell
T7 Specimen report for Section 47 investigations and Case Conferences developed by members of the Primary Care Child Safeguarding Forum (PCCSF)
Tool 8 Practice Child Registration Form Mrs E Keenan, Practice Manager, Grovehill Medical Centre, Hertfordshire

Tool 10 Named Safeguarding GP Skills and Competences, guidance for commissioners developed by PCCSF

Tool 11 Child Development poster from [Contact a Family](#), developed by Dr Silvana Mengoni & John Oates of the Open University

Tool 12 Information Sharing HM Government

Tool 13 ChildSafe Trigger Tool Dr Barbara Gallwey and North Durham Clinical Commissioning Group

Tool 14 NHS Safer Leaflet Department of Health

Tools 15, 16, 17 Domestic Abuse guidance RCGP, IRIS AND CAADA

Tool 18 Traffic Light Poster Brook

Tool 19 Proforma for assessment of sexual exploitation

Reference Rogstad, K. and Johnston, G., (2014) Spotting the Signs: a national Proforma to identify child sexual exploitation in sexual health services. London: BASHH/Brook

Essential elements of Safeguarding Children reproduced courtesy of Jane Appleby, originally developed by East Midlands Safeguarding Children Network

Jurisdiction consultants and peer reviewers

England: Drs Chris Absolon, Janice Allister, Jonathan Leach

Northern Ireland: Dr Mary Larkin, Mary Rafferty

Scotland: Dr Kerry Milligan

Wales: Dr Nigel Farr, Kevin Hogan

Past Editors

2011: Dr Janice Allister Editor and Co-author, with Drs Danny Lang, Ian Dunn, Vimal Tiwari; Evender Harran former Senior Consultant NSPCC

2009: Dr Andrew Mowat Editor and Co-author, Evender Harran, former Senior Consultant NSPCC

2007: Dr Andrew Mowat Editor and Co-author with Rosie Luce, former Senior Training and Development Consultant, NSPCC

Stakeholder Group

Georgia Johnston, Brook

John Shale, Stephanie Brivio, Department for Education

Alan Bell, Department of Health

Moya Sutton, NHS England

Chris Cloke, Dawn Hodson and Dr Ruth Gardner, NSPCC

Harvey Ward, RCGP Patient Partnership Group

Fiona Smith, Royal College of Nursing

Dr Amanda Thomas and Emily Roberts, Royal College of Paediatrics and Child Health

Acknowledgments

This 2014 version has been produced with administrative support from the RCGP Clinical Innovation & Research Centre and largely funded by charitable donations, with a generous grant from the NSPCC.

Toolkit copyright

Copyright is held by the RCGP and the NSPCC. The materials in this Toolkit are intended to be used for non-commercial purposes by the general practice team either independently or with commissioning bodies or other provider groups. Complete or large scale reproduction for use other than that for which it is intended is prohibited.

Referencing

All material used has been referenced as far as possible. Any omission or infringement of copyright is accidental and will be rectified if brought to the attention of the RCGP.

Disclaimer

The RCGP will not be held responsible for any medico-legal or other legal liability caused by any inaccuracy or error contained in this Toolkit.

1.2 Introduction

Definition of a child: England, Northern Ireland, Scotland and Wales each have their own guidance setting out the duties and responsibilities of NHS organisations to keep children safe, but they agree that a child is anyone who has not yet reached their 18th birthday.

What role do GPs play in safeguarding and protecting children from abuse and neglect?

- The majority of children and their families in the UK are registered with a GP and general practice remains the first point of contact for most health problems.
- GPs and their practice teams have a key role not only in providing high-quality services for all children but also in detecting families at risk, supporting victims of maltreatment and providing on-going care and assessment while contributing to case conferences and care plans.
- Identification of child abuse has been likened to putting together a complex multi-dimensional jig-saw. General Practitioners and their Teams, who hold knowledge of family circumstances and can interpret multiple observations accurately recorded over time, may be the only professionals holding vital pieces necessary to complete the picture.
- It is important to acknowledge when there may be barriers to recognition of risk and taking action on child maltreatment (see Section 4) and to overcome them. Child maltreatment is a costly societal and public health issue but is preventable and should not be tolerated.

This toolkit has been developed from a child-centred perspective to help GPs and their teams safeguard the children and young people in their care. All staff working in general practice will be aware of families in difficulties where children may be at risk of maltreatment or may actually be harmed but may find acknowledging and managing such problems difficult, challenging and at times overwhelming. GMC Guidance 2012 *Protecting children and young people* clarifies the responsibilities of all doctors in safeguarding and protecting children especially in relation to treatment of adult patients who may pose a risk to a child, identification of environmental risk factors, obtaining support and advice if worried a child may at risk of abuse or neglect and knowing when and how to share concerns with other professionals.

Research studies show that pressures on families appear to be increasing. There is rising demand for service provision for substance misuse, mental health issues, domestic abuse and inter-parental conflict, also physical and learning disability. These parent and carer risk factors for child maltreatment are now acknowledged yet it is known from retrospective studies that there is unrecognised suffering associated with failure of professionals to identify children at risk of maltreatment and failure to act to provide effective early prevention and targeted intervention (Thoburn 2010).

There are two main strands to safeguarding children: the most beneficial is to predict the likelihood of maltreatment and prevent it; far less satisfactory is to identify abuse after the event. It is the latter scenario which attracts most attention and resources, but improving outcomes for the victim may be profoundly challenging and also the more costly option for the health economy, society in general and most of all to the victim.

Serious case reviews have identified those at greatest risk as being:

- Infants under 12 months who have the highest death rate from abuse and or neglect.
- Children under 5, in particular those under 1 who are at highest risk of neglect and/or abuse.
- Adolescents subject to abuse/neglect who are at increased risk of death from suicides.
- Teenage parents/carers who are particularly vulnerable.

What is child safeguarding and child protection?

Child safeguarding is not defined in law but has been described as; “Arrangements to take all reasonable measures to ensure that risks of harm to children’s welfare are minimised.”

It has the following components:

- protecting children from maltreatment;
- preventing impairment of children’s health or development;
- ensuring that children are growing up in circumstances in which care is safe and effective;
- enabling children to have optimum life chances and to enter adulthood successfully.

Child protection is the term used to refer to the activity taken to protect children who are suffering or at risk of suffering *significant harm*.

- Such harm is defined in England under section 31 of the [Children Act 1989](#) as: “ill treatment or the impairment of health or development”. To decide whether harm is significant, the health and development of the child is “compared with that which could reasonably be expected of a similar child” (see [NSPCC Inform](#) for guidance in Northern Ireland, Scotland and Wales).
- Thresholds for determining what constitutes [significant harm](#) vary between local authorities and also between UK jurisdictions.

Safeguarding children and young people is a responsibility for all of society and in healthcare is an essential element of child health provision, see **Section 1.3** for policy and legislation relating to individual jurisdictions.

This is supported by the *RCGP curriculum (Statement 3.04)*, *the RCGP Child Health Strategy 2010–15*, *RCGP Commissioning a good child health service (2013)*, and the *Safeguarding Children and Young people: Roles and Competences for Health Staff (Intercollegiate Document 2014)*.

While local authorities have overall responsibility for child protection, the health service also has a duty of care. General Practitioners are expected to be involved in early identification and supportive management of children in need of preventative and extra services and children at risk of maltreatment as well as working with other agencies in formal child protection interventions.

GPs also have a duty when receiving disclosures of historic abuse to ensure the information is shared appropriately to identify and protect children who remain at risk while adult survivors should be helped to access psychological and emotional support and therapies.

- The GP, unlike education, social care or health professionals in other settings, sees multiple family and household members **and may be the only professional to have contact with infants and pre-school children**. The GP team are also well placed to identify risk factors in the parents and carers, such as domestic abuse, substance or alcohol misuse or mental health problems which could affect parenting ability and lead to abuse and/or neglect of children.
- GPs are, as independent contractors in the NHS, subject to the statutory duties under various Children Acts, depending on country, placed on key persons or agencies to make arrangements to ensure that in discharging their functions, they have regard to the need to safeguard and promote the welfare of children. For country specific details see [NSPCC Inform](#).

- This duty extends to contracts and commissioning of services and as such, regulators as well as relevant commissioning bodies have a statutory right to inspect Practice arrangements with regard to safeguarding and promoting the welfare of children.
- Working safeguarding protocols and policies implemented in practices will help meet professional registration and regulators' requirements.

The NSPCC in 2013 estimated that 50,500 children were at risk of abuse, with 1 in 4 young adults disclosing a history of abuse. Children are at risk of many different forms of abuse and exploitation (including, but not restricted to: neglect, emotional, sexual and physical abuse, domestic violence, forced marriage, female genital mutilation, child trafficking, online exploitation and radicalisation). Child abuse and neglect may be concealed within the community and might never come to the attention of child protection agencies at the time of occurrence. Maltreated children are said to be at increased risk of becoming victims or perpetrators of violence in later life and many experience other adverse consequences of childhood experiences including diminished educational achievement and employment opportunities.

There are newly emerging forms of abuse related to social media and technology and old forms of abuse which are new to the United Kingdom. Child maltreatment is a complex phenomenon in which several forms of abuse often coexist and may be long-term and chronic. Any form of abuse can have a serious effect on a child's physical, mental and emotional development and subsequent life course.

Written procedures and guidance will not in themselves protect children; this requires a skilled, competent, confident and committed workforce willing to act against abuse and neglect in an organised response and in collaboration with other agencies and a caring community.

1.3 Policy and Legislation

This toolkit reflects [Article 19 of the United Nations Convention on Rights of the Child \(UNCRC\)](#) which states that: *Children have the right to be protected from being hurt and mistreated, physically or mentally. Governments have a duty to ensure that children are properly cared for and to protect them from violence, abuse and neglect by their parents or anyone else who looks after them.*

All of the relevant jurisdictions' legislation and welfare policies are underpinned by UNCRC and the European Convention for the Protection of Human Rights and Fundamental Freedoms 1950.

Essentially a child-centred perspective means that children should:

- be able to express and have their views taken into account in all matters affecting them ([UNCRC](#), article 12);
- be valued and respected as individuals;
- be respected for their identity and uniqueness;
- not be discriminated against;
- have the principle of primary consideration for the best interests of the child reflected throughout national and local policy and legislation;
- have the right to the highest standard of healthcare, including immunisations and care for disabilities (UNCRC articles 23, 24, 25).

The four nations of the United Kingdom have their own [child protection laws](#) but although the framework set out by the various different acts is broadly similar, the practitioner must retain an awareness that policy and practice relating to child welfare is characterised by perpetual change.

In the United Kingdom the [Children Act 1989](#) introduced two particular concepts in child protection:

Child in Need (Children Act 1989 Section 17): Those whose vulnerability is such that they are unlikely to reach or maintain a satisfactory level of health or development, or their health and development will be significantly impaired, without the provision of services, including those who are disabled;

Child at Risk (Children Act 1989 Section 47) Circumstances in which a child is suffering or likely to suffer [significant harm](#) where the local authority has a duty to make enquiries.

Additionally the [Munro Review of Child Protection](#) in 2011 recommended reinforcement of early identification, [early intervention](#) and prevention especially relating to provision of 'Early Help', described in detail in English statutory guidance [Working Together to Safeguard Children 2013](#).

Across all jurisdictions there is guidance provided by the relevant governments to promote effective inter-agency working to safeguard and promote the welfare of children and young people. In addition, there are national and local strategies and frameworks that set out policies and procedures for improving outcomes for children and young people, of which being safe will be one.

Local Authority and Local Safeguarding Children Board (or national and regional equivalents) policies and procedures are regularly updated and it remains the responsibility of individual practitioners to familiarise themselves with local thresholds, keep abreast of changes and ask, *what does that mean for us?*

Detailed definitions of safeguarding, child protection and types of abuse may be found in child protection frameworks for the UK countries (see below).

England: [Children Act 1989](#), [Children Act 2004](#), [Working Together to Safeguard Children 2013](#): *A guide to inter-agency working to safeguard and promote the welfare of children*

Northern Ireland: [Child Protection resources](#), [Co-operating to Safeguard Children 2003](#) and [ACPC Regional Child Protection Policies and Procedures 2005](#), [The Children Northern Ireland Order 2005](#), [Standards for Child Protection Services 2008](#), [UNOCINI Understanding the Needs of Children in Northern Ireland](#)

Scotland: [Children \(Scotland\) Act 1995](#), 2010 '[Getting it Right for Every Child](#)' (GIRFEC), 2012 [National guidance for child protection in Scotland](#), 2013 [National Risk Assessment Framework](#), 2014 [Child Protection Guidance for Health Professionals](#) 2014 [Children and Young People \(Scotland\) Act](#)

Wales: 2006 [Safeguarding Children: Working Together Under the Children Act 2004](#), 2008 [All Wales Child Protection Procedures](#), 2011 [Rights of Children and Young Persons \(Wales\) Measure](#), 2012 [A guide for Safeguarding Children and Vulnerable Adults in General Practice](#), 2014 [Social Services and Well-being \(Wales\) Act](#)

Further information: The [NSPCC nation pages](#) set out the child protection system, framework, guidance, legislation, case review process, research and statistics as well as the NSPCC's training, consultancy and policy work in each nation. The pages are regularly updated.

S2

Practice organisation

Click box to
go to section

page

2.1	Practice policies and procedures	10
2.2	Role of the General Practice Lead(s) for Safeguarding Children and Young People	12
2.3	Practice records and coding	13
2.4	Training and Education for the Primary Healthcare Team	14
2.5	The Role of Regulators in inspecting General Practice Safeguarding Children arrangements	17
2.6	External requests for Audits	19
2.7	Resources for Children, Parents, Carers, Survivors and the General Practice Team	21

■ **Good practice organisation enables Practices to deliver high quality care while meeting increasingly complex levels of commissioner, public and patient demand and expectation.**

■ **Employers in General Practices are responsible for ensuring all staff are competent and confident in carrying out their duties including their responsibilities for safeguarding and promoting children's welfare. This also applies to urgent care centres and out-of-hours GP services.**

■ **Guidance on safeguarding children training requirements for general practice staff is set out in [Safeguarding children and young people: roles and competences for health care staff](#) INTERCOLLEGIATE DOCUMENT March 2014.**

Practices have to work towards keeping the patient at the centre of their organisational focus, to create a safe, timely, appropriate and reliable response to rapidly changing patient needs at the same time as meeting statutory and professional obligations, contractual demands and regulators' requirements. GPs in the 21st century are unable to deliver an efficient service without a supporting infrastructure of well-trained administrative, nursing and clerical staff hence resources must be identified and allocated to provide education and improvement opportunities for all staff, both non-clinical and clinical, to develop an organisation which is capable of continuous learning and development to meet ever-changing population needs.

Historically preparing support staff for service delivery has been overlooked but a framework for Practice development may be found within the RCGP [Quality Journey](#). This, while acknowledging the valuable diversity of General Practice, is devised to encourage design of an organisational structure and culture relevant to modern health care.

The Practice Safeguarding Self- Assessment Tool **T5** is intended to support organisational development in safeguarding children. It may be downloaded and amended to suit individual Practice needs. The Practice Team will be able to use it during or immediately after a training session

for a baseline assessment of organisational need, risk and gaps to allow development of an action plan which followed over a set period of time will result in achievement of required standards.

Safeguarding children training guidance is set out in the [Inter-Collegiate Guidelines](#), which advises that all staff including non-clinical staff should be trained as a basic minimum to Level 1 competencies. It is advisable that the Practice Safeguarding Lead review staff training needs on a regular basis for example considering if reception staff in daily contact with children and families should have Level 2 competencies. Training requirements for clinical staff are set out by their registration organisations and academic bodies; see [GMC](#), [RCN](#), and [RCGP](#). Practice Nurses and Nurse Practitioners will find Level 3 skills of value especially if they see babies and children on a regular basis and deliver childhood immunisations. GPs are expected to demonstrate Level 3 competences for purposes of appraisal and revalidation.

All new staff must be introduced to the Practice Child Safeguarding Policies and Procedures at induction and, if there is no training history, should have basic Level 1 training within six months of commencing duties. The whole Practice team must be updated annually on any recent changes in child safeguarding policy or procedures and specific local issues. This is an opportunity to review Practice protocols, to discuss any learning points from local case reviews (such as Serious Case Reviews or Child Death Reviews), and to reflect upon any significant Practice events involving children. This update may be facilitated by the Practice Safeguarding Lead or be part of single agency in-house training delivered by a Local Safeguarding Children Board approved trainer, Named Nurse or Named GP.

It is important that update sessions also consider the impact on the Practice of any relevant legislative, policy or procedural changes within the jurisdiction or local authority area and whether any changes in Practice policy or procedure are required as a consequence.

2.1 Practice policies and procedures

Practices will have developed several working policies and procedures dealing with different organisational matters to suit individual Practice needs and might discover substantial overlap between such policies. Tips on developing a child safeguarding policy are set out in **Tool 1**, while a specimen safeguarding procedures and policies document is available within **Tool 2**, but it is recognised that there is significant organisational diversity within UK General Practice and some Practices may wish to incorporate this within a comprehensive over-arching Practice policy or within their Child Health policy.

Child safeguarding policies and procedures apply to all staff both non-clinical and clinical, and must include the following essential elements:

General Principles of Safeguarding Children:

- The child's needs must come first.
- The child's well-being and welfare is everyone's shared responsibility for achieving better outcomes for children.
- The opinions of the child and family will always be taken into account and documented.
- The child and family will not be discriminated against on the grounds of age, ethnicity, religion, culture, gender, disability, class or sexual orientation.

Practice policies and procedures should also include:

- Provision for appointment and support of a lead and deputy lead for safeguarding children (for England see [Working together to safeguard children 2013](#) p51 and [Accountability and Assurance Framework](#) p18), see **Section 2.2**.

- Assessment of staff safeguarding training needs within the context of overall training needs and development, setting and monitoring of training intervals, and staff appraisals.
- Working with other Agencies and professionals involved with child/ren and families such as public health nurses; secondary and community health care, education as well as key child protection agencies such as social care and the police.
- Establishing and maintaining links to local services including Early Intervention Services, Child Protection Services and the Local Safeguarding Children Board or equivalent.
- Protocol for registration and deregistration of child patients (see **Tools 8** and **9**). Practices will have to carry out their own risk assessments if a decision is made not to see children for a holistic assessment at the time of registration or if the parent or carer refuses to allow the child to be seen.
- Effective record keeping including coding (see **Tool 3**), filing and summarising, receiving and acting upon correspondence from external agencies such as secondary and social care. Handling of correspondence and reports related to Child Protection will require prioritisation and special attention in relation to storage and release (see **Practice records and coding 2.3**).
- Procedures for receiving in and handling information requests including Section 17 and Section 47 requests and Case Conference invitations and reports both initial and review (see specimen report form **Tool 7**).
- Procedures for receiving in, acting upon, filing and storage of Child Protection information such as Case Conference reports.
- Procedures for cooperating with audit requests (e.g. in England Section 11 Audit requests from the LSCB, see **Section 2.5**).
- Procedures for handling requests to share information for statutory case reviews ([Serious Case Reviews](#) in England, [Case Management Reviews \(CMR\)](#) in Northern Ireland, [Significant Case Reviews](#) in Scotland, [Child Practice Reviews](#) in Wales, and [Child Death Reviews](#) in jurisdictions where these apply).
- Clear referral pathways including how to make a referral to a statutory agency such as social care, following up referrals and what to do if a referral is not accepted but concerns remain about the child/ren.
- Procedures for identifying and following children who do not attend scheduled appointments within the Practice or with other Agencies such as therapies, secondary or community care.
- Procedures to identify and follow up children with more than expected unscheduled appointments at the Practice, OOHs, A & E Departments, Walk-in Centres (see ChildSafe Trigger **Tool 13**).
- Care and examination of unaccompanied children and young people under 16.
- What to do if concerned about a child's or young person's welfare.
- What to do if concerned about vulnerable children and/or families who go missing (see **Section 9.5**).
- What to do when children registered with the practice are rarely or never seen and when to be worried about such children (see **Section 5.4**).
- Recording and communicating concerns (see Codes **Tool 3**), action taken and agreed plan.
- Where and how to seek advice including contact telephone numbers and email address of key local safeguarding personnel.
- Safe information sharing (see **Section 5.1**).
- Safe staff recruitment, employment and monitoring processes including students, temporary and volunteer staff.
- Ways of enabling children and families to become involved with decision making about their care, register concerns and complaints and processes to follow-up and act upon such concerns and complaints.
- Safe whistle-blowing processes (see GMC [Who can help if you're not sure what to do?](#)).
- Procedure for dealing with critical or sudden unexpected incidents including unexpected deaths.
- Regular review and monitoring of policies and procedures to ensure they are working effectively.
- Procedures for changing policies and/or practice in response to lessons from Case Reviews.

All Local Safeguarding Children Boards and Local Authorities offer web-based support which practitioners may use to obtain rapid access to up-to-date local procedures in a user friendly format. Practitioners can often also register for alerts when any updated material or training opportunities become available.

Note: NSPCC runs a number of specialist services across the country, including services focusing on the needs of children under one; neglect; physical abuse in high risk families; and sexual abuse. Find out about your local NSPCC services as it may be appropriate to make referrals to them. The NSPCC offers a comprehensive information service. You can keep up to date with developments in child protection by joining the free current awareness service, CASPAR. Visit NSPCC inform to sign up: www.nspcc.org.uk/inform. The NSPCC Helpline is available 24/7 for anyone concerned about the safety of a child – 0808 800 5000.

2.2 Role of the General Practice Lead(s) for Safeguarding Children and Young People

The Care Quality Commission (England) advised in 2009 that *“GPs and all staff working within a practice, including administrative and reception staff, should be familiar with the principles of child protection and with their own role in safeguarding children. Each practice should have a nominated lead and deputy lead to promote this work”*.

This recommendation has been reiterated in the English statutory document *Working together to safeguard children 2013* p51 and the NHS *Accountability and Assurance Framework* p18 and is supported by the RCGP/NSPCC Safeguarding Children Toolkit in all UK jurisdictions, as it is recognised that due to multiple and increasingly complex demands on General Practice, firm leadership is required to support Practice staff in fulfilling their safeguarding responsibilities.

This list of duties of a Practice Safeguarding Lead is for guidance only and is by no means comprehensive. Practices with limited resources might like to give consideration to incorporating this role with that of Child Health Lead.

The Practice Safeguarding Children Lead:

- Ensures that Practice child protection policy and procedures are developed, implemented and regularly monitored and updated (see **Tools 1 and 2**).
- Has regular meetings with others in the Primary Healthcare Team and personnel from other Agencies such as health visitors, school nurses, community children’s nurses and social workers to discuss particular concerns about vulnerable children and families, see **Sections 3.2 and 10.1**.
- Ensures that the Practice meets statutory responsibilities.
- Ensures that the Practice meets contractual guidance.
- Ensures that the Practice meets their national and local regulatory requirements relating to Safeguarding Children.
- Ensures that the Practice meets medico-legal and regulatory inspection requirements in relation to information sharing and record keeping, see **Tools 6a-i**.
- Ensures safe recruitment procedures including taking up references and Vetting and Barring checks where indicated.
- Engages the Primary Healthcare Team to establish effective Child Health provision including *“You’re Welcome”* policies (see also [RCGP Child Health Strategy](#)).
- Supports reporting and complaints procedures including safe ‘whistle-blowing’.
- Advises Practice members if they have concerns.
- Ensures that Practice members receive adequate assistance when dealing with child protection matters including
 - a) supporting GP colleagues with making Child in Need and Child Protection referrals,

- b) ensuring requests for child protection reports such as reports for statutory investigations, reports for Case Conferences, attendances at Case Conferences, participation in statutory and other Child Protection Reviews, and participation in Child Protection Audits conducted by the LSCB (or similar organisation depending on jurisdiction) receive a timely and accurate response.
- Supports participation in Child Death Reviews.
- Leads on analysis of relevant significant events and critical incidents.
- Determines training needs and ensures they are met, see Section 2.4, Tool 5.
- Ensures training is aligned to [Safeguarding children and young people: roles and competences for health care staff](#) INTERCOLLEGIATE DOCUMENT.
- Regularly reviews Practice safeguarding policies and procedures and makes recommendations for change or improvement.
- Regularly checks their LSCB or equivalent and local authority websites for updates on national and local policies, procedures and thresholds.
- Acts as a focus for external contacts including those from Public Health, Education, Social Care, the Named Safeguarding Children GP (see **Tool 10**), Designated Safeguarding Children Team, regulators and contractors.
- Ensures national and local recommendations from statutory Child Protection Case Reviews and Child Death Reviews are implemented.
- Has protected time and resources for appropriate training and carrying out above duties.

Reference

Care Quality Commission (2009) [A review of arrangements in the NHS for safeguarding children](#).

2.3 Practice records and coding

[GMC 2013 Guidance Good Medical Practice](#) states that ***'Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards.'***

In General Practice where patients can see a number of different health professionals over a period of time, it is essential that accurate, up-to-date records are kept. Good record keeping helps to protect the welfare and safety of patients by providing effective communication between members of the Primary Health Care Team. An accurate account of patient encounters, assessments and management can improve clinical outcomes and allow problems to be detected at an early stage.

All GPs in the UK now use electronic recording systems which permit coding of conditions and diseases to facilitate data searches and record retrieval. Accurate notes summarising and data entry help to build a picture of the patient's past medical and social history and current health needs. GPs may find comprehensive record keeping within the constraints of the 10 minute consultation to be challenging. However legally there will be an assumption that if something is not written down, it has not been done, see [The Good Practice Guidelines for GP electronic patient records v4 \(2011\)](#), and in Wales information on record keeping and record transfer in [Guidance for Safeguarding Children and Vulnerable Adults in General Practice](#).

When a child is seen it is good practice to record who accompanies the child and the relationship, if any, of the individual to the child. Modern families are complex and may consist of a number of related or unrelated individuals with different surnames living within the same or different households and addresses. It is important wherever possible to develop a system of linkage to include natural parents, step-parents and siblings whether whole, half- or step-, and some GP electronic recording systems have built-in templates to enable this to be carried out easily.

Poor record keeping and communication are significant factors cited in statutory Child Protection Reviews. In most Practices patient contact will also include appointment records, message books, home visits, telephone calls, and informal exchanges in other settings. There may also be unexpected and unplanned informal 'corridor' conversations with professional colleagues concerning a patient. It is important that all of these contacts be recorded as soon as possible after they occur with any relevant content and actions documented and followed up as necessary.

Records must be written in compliance with the [Race Relations Act](#), [Equality Act](#) and the [Disability Discrimination Act](#) and should provide evidence of history, examination and interventions including any management plans, medication prescribed or given, other care delivered, any information shared, with whom shared and reason/s for sharing. Records should ideally provide evidence that management was discussed and agreed with the patient (including consent to treatment). Consent to disclose information must be recorded as should a decision and reason/s to share information without consent.

The name of the professional seeing the patient should always be recorded as well as the date and time.

Poor record keeping can result in a practitioner being accused of professional negligence if records are found to be incomprehensible, inadequate or incomplete. Good medical records are evidence of good care and can be crucial in upholding or defending a complaint; they provide protection and contribute to keeping GPs, as well as patients, safe. It is reasonable to always assume that any entry made in a patient record will be scrutinised at some point by other parties including patients who may wish to exercise their legal right to see their records.

Where there is any concern of a safeguarding nature or any situation within the child's family or environment which are considered likely to impact on the child's health or well-being or contribute to risk of harm or maltreatment, this should be documented in the main body of the record and also coded (see list of recommended codes in **Tool 3**). Such concerns may include parental factors such as those described in **Section 5** or reflect confirmed incidents of domestic abuse or offending and care must be taken to record only objective factual data using appropriate codes. Police notifications of domestic abuse incidents may be coded using a special Read code for "Police domestic incident report received" V2 = 9NDJ, V3= Xaaqr.

Tool 4: Record Keeping Exercise for clinicians may be downloaded for use as a reflective exercise for GP appraisal and revalidation.

2.4 Training and Education for the Primary Healthcare Team

- All Practice staff both non-clinical and clinical require knowledge and skills in safeguarding children to the level indicated as appropriate to their roles in the [Safeguarding children and young people: roles and competences for health care staff](#) INTERCOLLEGIATE DOCUMENT 2014 (ICGs).
- All GPs are required to demonstrate Level 3 skills and competences for the purpose of revalidation.
- GP appraisal, revalidation and regulators' assessments will focus on evidence of how knowledge and skills are applied in practice to improve outcomes for children.

All health professionals have a crucial role to play in safeguarding children and young people. In England [Section 11 of the Children Act 2004](#) places a statutory duty on key people and bodies to make arrangements to safeguard and promote the welfare of those with whom they come into contact. Furthermore all Practices in England will be registered with the CQC and have to comply with the new safeguarding requirements; these are also built into the commissioning

arrangements transferred from primary care trusts to NHS England in April 2013. The minimum standard that the CQC will assess for registration is: “taking reasonable steps to identify the possibility of abuse and prevent it before it occurs; and responding appropriately to any allegation of abuse” ([Health and Social Care Act 2008, Part 4, Regulation 11](#)).

Regulatory bodies in N. Ireland, Scotland and Wales are likely to apply similar criteria, for more information see [NSPCC Inform](#).

Practices will be required to demonstrate safeguarding leadership and commitment and that they are fully engaged and in support of local accountability and assurance structures, in particular via structures such as [LSCBs](#), Safeguarding Adult Boards and commissioning bodies. Practices need to demonstrate safeguarding is everyone’s business and poor practice is identified and rectified. All Practices should have a lead for safeguarding, who works closely with Named GPs and Designated professionals, see **Section 2.2**.

The RCGP is one of over twenty colleges and professional groups to collaborate in producing joint training guidelines for staff updated in 2014. (Safeguarding Children and Young people: roles and competences for health care staff [INTERCOLLEGIATE DOCUMENT](#) henceforth referred to as ICGs).

The emphasis is on flexibility and relevant learning commensurate with roles and responsibilities. The concept of ‘levels’ (of minimum learning requirements) is described as follows:

- Level 1: All non-clinical staff working in health care settings including volunteers.
- Level 2: Minimum level required for all clinical staff and for non-clinical staff with some degree of contact with children and young people and/or parents/carers.
- Level 3: Clinical staff working on a regular basis 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 concerns.

All new members of Staff, both non-clinical and clinical, when beginning work in General Practice require basic awareness training to Level 1. If there is no training history, this may be organised by the practice as part of their induction, which also introduces them to the Practice Safeguarding Children Policies and Procedures. Staff can then build on this basic learning to achieve the Level required for their role while clinical staff should also be encouraged to familiarize themselves with their Local Safeguarding Children Board Policies and Procedures.

E-learning Safeguarding Children modules from www.e-lfh.org.uk meet the National Workforce Competences and provide essential information, which can then be used as a foundation for face-to-face training. This resource is supported by the Department of Health and written by safeguarding experts from the RCGP and RCPCH.

England: NHS England via its area teams and in collaboration with Health Education England is responsible for the coordination and funding of safeguarding training for GPs, (see [Safeguarding Vulnerable People in the Reformed NHS](#) p16) and potentially other primary care professionals while LSCBs have overall responsibility for training and monitoring the effectiveness of training ([Working Together to Safeguard Children 2013](#) Chapter 3). All Safeguarding Children Boards offer various types of safeguarding children training, usually free of charge to healthcare professionals.

Northern Ireland: see [Children in Northern Ireland](#) and [The Children’s Services Training](#) programme

Scotland: see [THE NATIONAL GUIDANCE FOR CHILD PROTECTION IN SCOTLAND](#),

Wales: Level 1 and 2 e-learning produced by the Wales Safeguarding Children NHS Network is freely available for all NHS staff from Learning@NHSWales.

Practices might find it beneficial to organise an annual training session which all clinical and non-clinical staff are expected to attend, where at least one critical incident involving safeguarding children is discussed and recorded, updates are delivered and practice safeguarding policy and procedures can be reviewed. Such training sessions may be facilitated by the Practice safeguarding children Lead and will help to foster and embed a culture in which the welfare of child patients is regarded as a Practice priority, see **Tools 6a-i**.

All staff undergoing training will be expected to keep a learning log for their appraisals and personal development records.

GPs will need to be aware of relevant NICE Guidance relating to children and families and to demonstrate Level 3 skills and competences for the purposes of appraisal and revalidation. Most GPs will have had exposure to safeguarding children training during undergraduate and post-graduate Child Health education and will already possess many of these skills. However child safeguarding is a vast, dynamic subject and while the ICGs are not prescriptive about training requirements, it should be noted that clinicians are expected to keep abreast of changes in key statutory and non-statutory policy, guidance and legislation.

Hence GPs may find it advantageous to attend formal update training sessions at regular intervals. Level 3 training is best delivered by expert child protection multidisciplinary teams who are familiar with current child protection issues both nationally and locally and knowledgeable about new policies, emerging evidence and research findings.

GPs can then refine their competences further by reading, reflection and targeted work with colleagues both in-house and with other agencies, using means such as vulnerable family and critical incident meetings as well as attendance at Case Conferences and multi-agency strategy or review meetings. This will facilitate development of a portfolio of cumulative evidence of competence using reflection as a way of learning and beneficial change in practice as the outcome to be demonstrated at Appraisal and Revalidation. Reflective Learning Exercises are to be found in **Tool 6**.

Reflective exercises for GPs and the Practice Team

Some important national issues have emerged from statutory Child Protection Reviews in relation to how GPs handle Child Safeguarding and Child Protection. This list is not comprehensive but may be useful to reflect upon during training.

- Registration procedure for child patients.
- Record keeping, identification, coding and flagging of vulnerable children and families.
- Risk assessment – especially in relation to infants where there may be underestimation of vulnerability and frailty.
- Sharing information in a timely and effective manner.
- Diagnosis of non-accidental injury (taking an adequate history and performing a thorough examination).
- Understanding the impact of adverse parental factors such as Domestic Abuse, Drug and Alcohol Abuse, Mental Health issues, on pregnancy outcomes and parenting ability.

The NSPCC produce an informative range of materials and educational tools for professionals, including on-line training packages and, in collaboration with Cardiff University, has also developed a series of useful evidence-based leaflets called [CORE – INFO](#), including:

- Bruises on children.
- Fractures in children.
- Head & spinal Injuries.
- Neglect and emotional abuse.
- Oral injuries and bites on children.
- Thermal injuries on children.

The NSPCC also runs a number of specialist services across the country, including services focusing on the needs of children under one; neglect; physical abuse in high risk families; and sexual abuse. Find out about your local NSPCC services as it may be appropriate to make referrals to them.

In addition the NSPCC offers a comprehensive information service. You can keep up to date with developments in child protection by joining the free current awareness service, CASPAR. Visit NSPCC inform to sign up: www.nspcc.org.uk/inform. The NSPCC Helpline is available 24/7 for anyone concerned about the safety of a child – 0808 800 5000.

References and useful websites

[BMA child protection toolkit](#)
[BMA \(2012\) What is CQC Registration](#)
[C4E0 Effective interventions for complex families where there are concerns about, or evidence of, a child suffering significant harm](#)
[Child Accident Prevention Trust](#)
[Care Quality Commission \(2013\) Our safeguarding protocol: The Care Quality Commission's responsibility and commitment to safeguarding](#)
[CQC 2014 New Inspection Model](#)
[NICE CG110 2010 Pregnancy and Complex Social Factors](#)
[NICE and social care](#)
[NHS Revalidation Support](#)
[RCGP \(2011\) Supporting information for appraisal and revalidation: guidance for General Practitioners](#)
[RCGP E-Learning](#) a wide choice of e-learning modules on a range of topics
[RCPCH Safeguarding](#) multiple resources mainly for specialists but some useful for GPs
[Spotting the Sick Child](#): A useful resource to support assessment of the acutely sick child

2.5 The Role of Regulators in inspecting General Practice Safeguarding Children arrangements

GPs are expected to:

- Take reasonable steps to identify the possibility of abuse and prevent it before it occurs.
- Respond appropriately to any allegation of abuse.
- Ensure that government and local guidance about safeguarding people from abuse is accessible to all staff and put into practice.

GP surgeries in all jurisdictions are expected to have clear procedures followed in practice, monitored and regularly reviewed which take account of relevant legislation and guidance for the management of alleged abuse including use of restraint. Staff and patients who use their services must understand those aspects of the safeguarding processes that are relevant to them. Staff should be alert to signs of abuse and know who to turn to when those signs are noticed. The Practice should also have methods in place to receive feedback from all patients including ways in which patients may express concerns about staff and/or services.

Staff must:

- Know how to identify, report and respond appropriately to suspected or actual abuse.
- Understand diversity, differing beliefs and values and be able to treat patients fairly and equally.
- Recognise what abuse is, including the differences between child and adult safeguarding and be able to support children and adults who are at risk of abuse.
- Be familiar with the risk factors for abuse and know what they must do if a person is being abused, suspected of being abused, is at risk of abuse or has been abused.
- Follow the referral process and timescales as described in all relevant local and national multi-agency procedures when responding to suspected abuse.

England, Scotland and Wales

The [Health and Safety Executive \(HSE\)](#) is the national independent regulator for health and safety in the workplace. Several other bodies are responsible for regulating different aspects of healthcare services. These may include healthcare professional bodies and country specific regulators who possess more precise powers and legislation than HSE and are therefore better situated to respond to patient incidents or complaints. For **Northern Ireland:** see [Health and Safety Executive Northern Ireland](#).

The [GMC](#) website provides advice and guidance on good practice relating to equality and diversity, with links to information on equality law and human rights legislation.

England: since 1 April 2013 all providers of NHS general practice and other primary medical services in England must be registered with the [Care Quality Commission \(CQC\)](#) and demonstrate compliance with essential standards of quality and safety. These standards are described in the publication [Guidance about compliance: Essential standards of quality and safety](#).

In England CQC have powers to carry out unannounced inspections on GP premises and to access or obtain documents or records (including medical records) during the course of an inspection when considered necessary. Under such circumstances patient consent is not required. CQC recommendations for safeguarding children in general practice are described in detail in their [2009 Review of arrangements in the NHS for Safeguarding Children](#).

CQC also operates an [inspection programme](#) in England to review how health services keep children safe and contribute to promoting the health and wellbeing of looked after children and care leavers with focus on quality and effectiveness.

The role of CQC can overlap with that of Ofsted in relation to certain services. [Ofsted](#) inspect and regulate services which care for children and young people, and those providing education and skills for learners of all ages.

Northern Ireland: the key regulator is the [Safeguarding Board for Northern Ireland \(SBNI\)](#) an independent multiagency body established by legislation and having statutory function for developing, implementing and monitoring safeguarding and child protection guidance in NI. It is made up of key partner agencies from statutory community and voluntary sectors and its work is carried out by means of local safeguarding panels and key subgroups.

Scotland: [Child Protection Committees](#) these are the primary strategic planning fora for developing and implementing multi-agency child protection work and are established in each local authority. Chief Officers are responsible for ensuring that their agencies, individually and collectively, work to protect children and young people.

The [Care Inspectorate](#)'s duty is to inspect local authority services that have a responsibility to protect children. Local authorities work to protect children using a 'multi-agency' approach. This means they work together with other agencies such as: health, education, police, social work, children's reporters and voluntary services.

Wales: the [Healthcare Inspectorate Wales \(HIW\)](#) is responsible for reviewing the quality and safety of patient care commissioned and provided by healthcare organisations in Wales while the [Care and Social Services Inspectorate Wales](#) inspects bodies providing social care.

2.6 External requests for Audits

GPs in England may expect to receive requests from the [Local Safeguarding Children Board \(LSCB\)](#) to contribute to safeguarding and child protection audits at regular intervals as evidence that their organisation has arrangements in place which reflect the importance of safeguarding and promote the welfare of children and young people. While these audits are not statutory, compliance is mandatory and failure to complete them or to provide information requested will reflect adversely upon the organisation's reputation and ability to work together with other agencies to safeguard children.

Chapter 3 of [Working Together to Safeguard Children 2013](#) page 60 specifically outlines the responsibility for all LSCB members in England and the performance management function for LSCBs to

- "Assess the effectiveness of the help being provided to children and families, including early help.
- Assess whether LSCB partners are fulfilling their statutory obligations set out in chapter 2 (of [Working Together to Safeguard Children 2013](#))
- Quality assure practice, including through **joint audits of case files involving practitioners and identifying lessons to be learned** and
- Monitor and evaluate the effectiveness of training, including multi-agency training, to safeguard and promote the welfare of children."

The practitioners referred to above include GPs who as health service providers have a statutory duty to safeguard children under [Section 11](#) of the Children Act 2004.

Tool 6e is an example of a Section 11 Audit for use in Practice self-assessment and staff training and it would be a good habit to use this as an annual review tool even if the LSCB has not requested an audit that year.

Wales

NHS Wales Health Boards and Trusts are members of LSCBs. Each LSCB undertakes Section 28 audits (see [Safeguarding Children: Working Together Under the Children Act 2004](#)). Currently there is no universally agreed audit toolkit as each LSCB has developed their own audit tool which includes the audit of 'all health' but not specific audits for each health provider.

The Child's Journey

Following [The Munro Review of Child Protection](#) some LSCBs have adopted an assurance framework based on the [Quality Assurance Framework](#) developed by Local Government Improvement and Development Board and the London Safeguarding Children Board (LSCB). It aims to foster a better understanding of how safe children are within a given locality and how well local services carry out their safeguarding responsibilities, focusing on improved outcomes for children and young people.

GPs may expect to receive requests to complete multi-agency audits relating to patients who have travelled through the Early Help, Child in Need, Child Protection or local authority care systems. The main objective is to discover what difference the services, strategies and interventions provided made to the lives of children and their families: *'Is anyone better off?'* This could involve internal quality reviews and providing excerpts from patient records including records of a child's, parents or other significant adults within the family or household.

GPs are often concerned that such information is requested without patient consent to disclosure. While it is always good practice to seek patient consent before sharing records, if the child is already in the child protection or care systems records may be shared without consent if this is considered in the patient's or public's best interest (see **Section 3.1** and GMC [Protecting children and young people: The responsibilities of all doctors](#)).

It is usual for Early Help and Child in Need services to be provided with full parent/carer consent and collaboration and if in such circumstances consent to share information is with-held, these may be grounds for escalation to a Child Protection concern. If in doubt the local safeguarding team, Named Safeguarding GP or Designated Doctor should be consulted. In areas with a Named GP this individual will be able to help with completion of audit forms which can be lengthy and complex.

Annual Safeguarding Children Reports

It is usual for NHS Providers to compile an annual safeguarding report for submission to commissioners and for this report to be available for inspection by regulators. Historically GPs have not compiled such reports but in the future this may become a contractual requirement to enable external bodies to monitor compliance with statutory requirements.

Such reports include the following information:

- A list of Practice policies and procedures relating to child safeguarding with date of implementation and review dates (this list would obviously contain the Practice Safeguarding Children Policy but could also include for example Staff Recruitment, Data Management, Complaints Handling, Equality and Diversity, Health and Safety, use and storage of patient images etc.)
- A summary of safeguarding training undertaken by staff with levels reached.
- Report on new staff recruitment (including disclosure and barring and taking up of references) and induction.
- Additional training undertaken by Lead Safeguarding Children GP.
- Number of children/families discussed at vulnerable child and family meetings.
- Number of children referred for Early Help and number accepted.
- Number of children referred under Section 17 and number accepted.
- Number of children referred under Section 47 and number accepted.
- Numbers of requests received to share information with other agencies.
- Number of requests where information shared.
- Number of requests where information not shared (reasons for not sharing should be disclosed).
- Number of safeguarding reports written for Section 47 investigations.
- Number of Case Conference Reports written.
- Number of Case ConferenceS invitations received.
- Number of Case Conferences attended, both initial and review.
- Number of children on Child Protection Plans.
- Number of Looked After children on Practice register.
- Number of allegations against staff reported.
- Any other comments/observations on safeguarding activity during the year including identified areas for improvement, barriers to full compliance and action plan to achieve compliance.

2.7 Resources for Children, Parents, Carers, Survivors and the General Practice Team

[Barnardo's](#) run services for vulnerable children throughout the country including some sexual exploitation support services.

[CEOP](#) Child Exploitation and on-line protection centre
Advice for children, parents and carers

[Childline](#) Children can phone on a free-phone line 0800 1111 which is not registered on the call register or write to Freepost NATN 1111 London E1 6BR

DH Foundation Years [Health Visiting and School Nursing Factsheet](#) information for patients on what help and support is provided by public health nurses

[Just Whistle](#) provide support for victims and training on tackling Child Sexual Exploitation

[National Working Group](#) for sexually exploited children & young people provide support for victims and training for professionals

NHS Choices [Abuse, Domestic Violence and Sexual Assault](#)

NHS Choices [Protect them from child abuse](#)

NSPCC [Help and Advice](#)

NSPCC [TheSafeNetwork](#)

RCPsych [Parents and Youth Info](#), resources for patients as well as professionals on a range of topics including bereavement and drug misuse

[The Lucy Faithfull Foundation](#) a registered child protection charity which works across the UK to prevent sexual abuse

Scotland has a 24-hour Child Protection Line, 0800 022 3222, for easy access to local child protection services.

For adult survivors

Abuse by Clergy: [MACSAS](#) Ministry and Clergy Sexual Abuse Survivors Helpline 0808 801 0340

[National Association for People Abused in Childhood](#)
Support line 0800 085 3330

[Patient.co.uk](#) Resources for patients suffering from substance misuse as well as survivors of abuse

[Samaritans](#) Helpline 08457 90 90 90

SAFE: Supporting Survivors of Satanic Abuse Helpline 01722 410 889

[Victim Support](#) Offers emotional support and information Tel 0845 30 30 900

Resources for the Practice Team

Guidance for each of the Four Nations: NSPCC Inform [Child Protection information for the UK's nations](#)

BMA [Child Protection Toolkit](#) acts as a prompt where it is believed that a child may be at risk of neglect or abuse. The tool kit is designed more for a general audience of health professionals than those with specific management responsibilities or child protection expertise.

[CEOP](#) Child Exploitation and on-line protection centre
Advice for professionals

[e-learning for health](#) safeguarding, online resource free to all with a nhs.net email account

Department of Health (2011) *You're Welcome* – quality criteria for young people friendly health services. London: Department of Health

DH (2012) Health Visiting and School Nurse Programme: Supporting implementation of the new service offer *No. 5: Safeguarding children and young people: enhancing professional practice – working with children and families*

Family Nurse Partnership <http://www.fnp.nhs.uk/>

[GMC 0–18](#) Ethical guidance for providing health care to children

GMC (2012) Protecting Children and Young People: the responsibilities of all doctors

GovUK (2006) *What to do if you are worried a child is being abused*

GovUK (2010) *Essence of Care: Benchmarks for Recordkeeping*

GovUK (2013) *Working Together to Safeguard Children*

GovUK (2013) *NHS Services and Children's Centres – how to share information appropriately with children's centre staff*

GovUK (2014) *Giving all children a healthy start in Life* Update on the [Healthy Child Programme](#)

NHS Choices [Self-Harm](#)

NSPCC [On-line training courses](#)

[NICE \(2007\) Antenatal and postnatal mental health \(CG45\)](#)

[NICE \(2009\) When to suspect child maltreatment \(CG89\)](#)

[NICE \(2011\) clinical guideline 123 Common mental health disorders: Identification and pathways to care \(CG 123\)](#)

[NICE \(2012\) Social and emotional well-being – early years \(PH40\)](#)

[NIPE 0–5](#) e-learning resources, including some for GPs,

RCGP [Domestic Violence](#)

RCGP [Practice Management Resources](#)

[RCPCH Child Protection](#) frequently updated site with much useful information and links

Scotland has a 24-hour Child Protection Line, 0800 022 3222, for easy access to local child protection services.

[UNICEF Child Protection 2013](#)

Note this list is not comprehensive, consult your local safeguarding services if the resource you require is not listed.

S3

Working together with other Agencies

Click box to
go to section

page

3.1	Information sharing (inter and intra agency)	26
3.2	The role of the Public Health Nurse in Safeguarding Children	28
3.3a	Referral to statutory services: early help	30
3.3b	Referral to statutory services: the Child in Need	31
3.3c	Referral to statutory services: The Child at Risk of Significant Harm, and the Child in Need of protection	35
3.4	What comes after a Child Protection referral?	37
3.5	Report writing in Child Safeguarding and Child Protection	38
3.6	Child Protection Case Conferences and recommendations	39
3.7	Court procedures relating to Children	42
3.7.1	The Child at Risk: Care proceedings	42
3.7.2	Marriage or Partnership breakdown	44

The role of the GP

- GPs and their Practice teams are not a statutory child protection agency and as such are not responsible for investigating child abuse and neglect.
- GPs have a responsibility for raising concerns, sharing information, and working together with statutory agencies to contribute to the 'early help', 'child protection' and 'child in need' processes.
- GPs have a statutory duty to cooperate with other Agencies to improve the well-being of children.
- GPs have a duty to refer children to social care (in England under Sections 17 and 47 of the Children Act 1989) when indicated, and may receive requests from social workers, the police and occasionally the NSPCC, to share information about a child or family (see Sections 1.3 and 3.1).

The Practice Safeguarding Children Lead in must ensure relevant information and contact details for the Local Child Safeguarding Board (or local equivalent), Children's Services Department, Police Child Protection and Domestic Abuse Units and NSPCC is available to all Practice staff and linked to Practice Policies and Procedures, and that representatives from these Agencies know who to contact in the Practice if there are concerns about a child.

In each Trust area of **Northern Ireland** there is a Named Doctor for Safeguarding, who is a lead paediatrician available to give advice on child protection matters to all medical staff including GPs.

In **Scotland** there is a Lead Paediatrician for Child Protection who should advise health boards on child protection matters and contribute to child protection strategic planning arrangements, standards and guidelines. They must ensure accessible expert child protection advice is available for all medical staff including GPs. The [National Risk Framework](#) is a national risk assessment 'toolkit' for child protection to support practitioners in identifying and acting on child protection risks in children and young people.

Wales: see [Guidance for Safeguarding Children and Vulnerable Adults in General Practice](#).

Agencies involved in Child Safeguarding

In England these are set out in full in [Working Together to Safeguard Children 2013](#) Chapter 2, pp 47–57. Functions of Agencies most likely to contact GPs are briefly described below.

The Local Safeguarding Children Board in England (LSCB):

These were established by the [Children Act 2004](#) which gives a statutory responsibility to each local authority area to have this mechanism in place with joint funding from Health, the Police and Social Care, see also [Working Together to Safeguard Children 2013](#) Chapter 3 pp 58–64. An LSCB can cover more than one local authority area. NHS England has a statutory duty under [Section 10](#) of the Children Act 1989 to cooperate with other Agencies to improve the well-being of children.

LSCBs are expected to publish a **threshold document** that includes:

- 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](#) (child in need), [section 47](#) (risk of significant harm), [section 31](#) (care orders), [section 20](#) (duty to accommodate) of the Children Act 1989.

They have a duty to scrutinise the safeguarding arrangements of statutory agencies and promote effective working together and a particular role in developing policies and guidance, in providing training, and in undertaking statutory reviews (Serious Case Reviews and Child Death Reviews), as well as non-statutory reviews of incidents which fall below the threshold for statutory reviews. All LSCB have websites providing useful information about local policies, procedures and training.

They also expect completion of regular self assessment audits to ascertain compliance in meeting safeguarding standards for the organisations listed under [section 11 of the Children Act 2004](#), and [Working Together to Safeguard Children 2013](#). These organisations include NHS commissioners and providers. GPs will at regular intervals be sent audit forms about children who are patients of their Practice and who are or have been within the Child Protection process. These multi-agency audits are part of LSCB quality assurance procedures and also improve understanding of how individual Agencies comply with statutory requirements to fulfil their safeguarding duties. Sample audit tools may be found at http://www.londonscb.gov.uk/audit_tools/. Compliance with such audits if requested are considered necessary for health service providers; see also **Tool 6c**, [Section 11 Standards](#), and it might be useful for Practices to carry out self-assessment at regular intervals even if no audit requests are received.

The Local Child Safeguarding Board in Wales

NHS Wales Health Boards and Trusts are members of LSCBs. The task of each [LSCB](#) is to safeguard and promote the welfare of children and young people in their area. Each LSCB undertakes section 28 audits (Children Act 2004). Currently there is no universally agreed audit toolkit as each LSCB has developed their own audit tool which includes the audit of 'all health' but not specific

audits for each health provider. Guidance '[Safeguarding Children: Working Together Under the Children Act 2004](#)' sets out how all relevant agencies and professionals in Wales should work together to safeguard and promote children's welfare and protect them from harm, as well as how this should be coordinated by LSCBs. See also

[A Guide for Safeguarding Children and Vulnerable Adults in General Practice](#) and [All Wales Child Protection Procedures](#).

The Local Authority:

England: under section 11 of the Children Act 2004 [local authorities](#) have a statutory duty to "safeguard and promote the welfare of children in need" at all ages up to 18 years old.

The Director of Children's Services, under section 18 of the Children Act 2004 has responsibility for ensuring that a local authority meets their specific duties to organise and plan services and to safeguard and promote the welfare of children.

The local Children's Social Care department have a responsibility for responding to concerns about a particular child, and if necessary commencing child in need or child protection proceedings. This may lead to the child being made subject to a [child protection plan](#) (previously they were *placed on the child protection register*) if they are thought at risk of significant harm.

Social care services work with health services, education, police, prison and probation services, district councils and other organisations such as the NSPCC, domestic violence forums, youth services and armed forces, all of whom contribute and work together to share responsibility for safeguarding children and promoting their welfare.

Northern Ireland: The Department of Health, Social Services and Public Safety through its Child Care Directorate has key responsibility for child protection policies and operational matters. Child care social work teams lead on investigation of child protection allegations (see [Cooperating to Safeguard Children 2003](#)).

Scotland: Social Work Children and Families services have a specific responsibility for:

- supporting families to maintain children within their own home and community where appropriate;
- investigating allegations of child abuse;
- where necessary providing appropriate care placements for children.

The Local Authority have a statutory duty under the [Children \(Scotland\) Act 1995](#) and [Children and Young People \(Scotland\) Act 2014](#) to safeguard and promote the welfare of children in need and to enquire into the circumstances of children and young people who may require compulsory measures of supervision, who may have been abused or neglected or be at risk of abuse or neglect, and take all measures to protect them from further harm.

All Social Work services staff have responsibilities to respond to the needs of children who may be vulnerable and/or at risk of abuse, this also includes those working in Criminal Justice, mental health workers, substance abuse workers, Hospital Social Workers and Child and Adolescent Mental Health workers. All staff must work in close collaboration with their colleagues in children and families services to protect children who may be at risk of abuse and have a duty to contribute to the assessment of that risk.

Wales: see [A Guide for Safeguarding Children and Vulnerable Adults in General Practice](#), [All Wales Child Protection Procedures](#), and [Social Services](#).

Police service

The [police service](#) in addition to its many other duties is a statutory body in safeguarding and promoting the welfare of children. Whilst their principal role in safeguarding is the investigation of child abuse allegations, they also have a key role in preventing crime against or involving children and minimising the potential for children to become victims.

The police service contribution also includes:

- identifying vulnerable children in domestic violence cases;
- using police powers to take children into protective custody when appropriate under [Section 46 of the Children Act 1989](#);
- protecting the needs of children as witnesses or victims;
- working with partner agencies in the criminal justice system dealing with youth offenders to divert children away from crime;
- and working with partner agencies to educate children and young people on issues such as substance misuse and the prevention of crime.

This responsibility lies with all police officers and police staff and not just specialist child abuse investigation units within the force.

The Police will also contribute to Child Protection reviews such as [Serious Case Reviews](#) and to [Child Death Reviews](#).

In Wales the Police are involved in the [Child Practice Review](#) and [PRUDIC](#) processes.

Police notifications of **domestic abuse** incidents may be **coded** on GP recording systems using a special code for 'Police domestic incident report received' V2 = 9NDJ, V3= Xaaqr.

Court Procedures relating to Safeguarding and Protecting Children

Relevant [court procedures](#) are described in [3.7](#).

3.1 Information sharing (inter and intra agency)

Appropriate information sharing is vital to protect children, and failure to share information in a timely and appropriate manner has often been identified when children have been significantly harmed.

GPs have a responsibility for raising concerns, sharing information, and working together with statutory agencies to contribute to the 'early help', 'child protection' and 'child in need' processes, see [Section 3](#).

The General Medical Council in [Protecting Children and Young People](#), 2012, offers the following guidance on information sharing:

- Ask for consent to share information unless there is a compelling reason for not doing so.
- Information can be shared without consent if it is justified in the public interest or required by law.
- Do not delay disclosing information to obtain consent if that might put children or young people at risk of significant harm.

General Practitioners are increasingly asked to supply clinical information for safeguarding reasons.

As a general rule in safeguarding children, consent is not required for [Section 47](#) referrals where a child is considered at risk or is thought to have suffered significant harm, nevertheless consent should be sought unless to do so would increase harm to the child. [Section 17](#) referrals are usually made with parent/carer consent but consent is not required in cases where failure to share information could result in the situation deteriorating. However for [Early Help](#), consent would be required unless failure to provide early help would result in risk or harm to child.

On most occasions the decision to divulge information is straightforward; however it can become problematic especially when third party information is requested (for example when it relates to the medical history or care of parents, carers or unrelated adults living in the household).

What to do if a request for information is received

Given the statutory framework and very clear guidance on the requirement to share information, the following process is recommended with the clear understanding that there would need to be very good reasons **not** to share relevant information. Remember that some children have come to harm due to a lack of information sharing, but none have been harmed because information has been shared.

- Confirm the identity of the requestor and *bona fide* nature of the information requested. This should usually be in writing and should include some information on why the request is being made.
- Confirm whether you hold any information on the patient.
- GPs in England may consult the '[Seven Golden Rules of Information Sharing](#)' or [Caldicott Principles](#) (similar guidance is available for Northern Ireland, Scotland and Wales, see below), and Information Sharing Flowchart in **Tool 12**.

Requests for information are usually made by social care colleagues who are governed by very similar professional guidance to health professionals.

Whilst health professionals quite correctly may be concerned about divulging sensitive clinical information, guidance from the [General Medical Council](#) 0–18 and others is that a doctor is more likely to be criticised for **not** passing on relevant information.

Seven golden rules for information sharing:

■ Remember that the Data Protection Act is not a barrier to sharing information.

It provides a framework to ensure that personal information about living persons is shared appropriately.

■ **Be open and honest** with the person (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so.

■ **Seek advice** if you are in any doubt, without disclosing the identity of the person where possible.

■ **Share with consent where appropriate** and, where possible, respect the wishes of those who do not consent to share confidential information. You may still share information without consent if, in your judgement, that lack of consent can be overridden in the public interest. You will need to base your judgement on the facts of the case.

■ **Consider safety and well-being:** Base your information sharing decisions on considerations of the safety and well-being of the person and others who may be affected by their actions.

■ **Necessary, proportionate, relevant, accurate, timely and secure:** Ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those people who need to have it, is accurate and up-to-date, is shared in a timely fashion, and is shared securely.

■ **Keep a record** of your decision and the reasons for it – whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose. If you decide not to share, then record why.

Taken from Government Guidance, Every Child Matters, “[Information Sharing: Guidance for practitioners and managers](#)” (2008).

Northern Ireland: see [Cooperating to Safeguard Children 2003](#) and [Sharing to Safeguard](#)

Scotland: see [GIRFEC](#) and [GIRFEC update](#)

Wales: [The Wales Accord on the Sharing of Personal Information](#)

Tools 6c1 and **6c2** offer exercises on information sharing for the whole Practice Team.

Further guidance is provided in [GMC 0–18](#) and [GMC Protecting Children and Young People](#) while the NSPCC provides a factsheet on [Gillick competency](#) and [Fraser guidelines](#).

3.2 The role of the Public Health Nurse in Safeguarding Children

■ **Health visitors and school nurses are public health nurses who lead in delivering health promotion and disease prevention activities, of which safeguarding is a key part.**

GPs have a responsibility to include public health nurses in their vulnerable child and family meetings, and to share information on children and families appropriately when indicated. This may take the form of shared records e.g. TPP SystemOne.

Health visitors are expected to communicate effectively across Agencies including midwives and social workers, and to work closely with General Practices to identify and monitor vulnerable children and families including vulnerable pregnancies, children in need, children at risk, children within the Child Protection system and children in care as well as families subject to domestic abuse.

‘Appropriate sharing of information where necessary can help to improve outcomes for young children and their families. It is important in promoting the well-being of children and families, as well as, in more serious cases, protecting children and young people from harm, abuse or neglect. The risks of not sharing data can be great, while sharing appropriately can have considerable benefits for the development of children and their families. The risks attached to sharing information must always be considered alongside any risks that might arise from not sharing’ (GovUk 2013)

In England, there are four components of [The National Health Visitor Plan](#) and vision for school nurses:

Community: This is targeted to meet the identified needs of the local community. Communities may have a range of services including some Sure Start services, Children’s Centres, school health services, voluntary sector services and the services families and communities provide for themselves.

Practices will find it useful to develop and maintain regular contact with their local Children’s Centre/s and to keep a register of local services to which patients may be referred.

Universal Services: Universal services are for all families. Health visitors and school nurses deliver the Healthy Child Programme to all under 19 to ensure a healthy start for children, young people and families. Health visitors are well placed to provide:

- Assessment of parenting to identify areas of actual or potential parenting issues, and early identification of risk factors e.g. limited parenting skills, negative attitudes towards child rearing, quality of mother child interaction, parental perception of child behaviour, parental experience of adverse family interactions.
- Early identification of those women at risk of postnatal depression through post-natal depression screening.
- Developmental assessments to indicate developmental concerns and delays;
- Support for breastfeeding, fostering development of parenting skills and attachment, health promotion and change management around issues such as obesity, smoking, drugs, relationship issues through promotional and motivational interviewing.
- Early identification of risk factors for domestic violence.

Universal Plus: With services targeted according to assessed or expressed need, Universal Plus gives a rapid response from the health visiting and school nursing teams when children, young people and families need specialised expert help.

Universal Partnership Plus: Services are targeted according to identified need. Universal Partnership Plus provides ongoing support from the team plus a range of local services working together with children, young people and families to deal with more complex issues over a period of time.

- These include specialist services from [Sure Start Children's Centres](#), other community services including voluntary organisations and, where appropriate, the [Family Nurse Partnership](#), and other agencies including Child and Adolescent Mental Health Services.

England: the emphasis is on achieving particular outcomes as described in the [Healthy Child Programme 0–19](#) and [Giving all children a healthy start in life policy](#) and health professionals including GPs are expected to work with public health nurses to enable the outcomes.

Northern Ireland: see <http://www.nidirect.gov.uk/community-nurses-and-health-visitors>

Scotland: [The Early Years Good Health for Every Child](#)

Wales: [Health Visiting Model for under 5s](#), see also [A vision for health visiting in Wales](#)

Universal Service

This service is offered to all families and children and includes antenatal contact with all pregnant women, post natal visits at home and regular reviews of child's development, health needs assessment of whole family and health promotion. Groups may be available e.g. baby clubs, baby massage. Also includes evidence based time-limited interventions e.g. breastfeeding support, maternal mental health. This service would also include information to parents regarding other services available in their areas e.g. mother and toddler groups, [MEND](#).

Enhanced Service

In addition to the universal service, enhanced packages of targeted interventions are provided e.g. post natal depression listening visits, Post-Natal Depression Self-Help Groups.

Enhanced Plus Service

An enhanced plus service would involve a multi agency care plan and provide multi agency specialist support for complex families, this could include, for example, services provided in [Flying Start](#), Team Around the Child models, [ISCAN](#), [IFSS](#), [IFST](#).

Early identification of need is a theme throughout the levels of the service and safeguarding of children and young people. This preventive service model aims to provide a continuum of support for families and children with an emphasis on prevention and protection so that the requirement for remedial action is reduced.

3.3a Referral to statutory services: early help

- Providing early help is more effective in promoting the welfare of children than reacting later.
- Early help means providing support as soon as a problem emerges, at any point in a child's life, from the mother's pregnancy (help for the unborn child) through to the teenage years.
- Early sharing of information is the key to providing effective early help, for guidance see NSPCC [Child abuse reporting requirements for professionals](#) and **Section 3.1**.

National Guidance:

England: Clinical commissioning groups and the NHS are subject to [Section 10](#) of the Children Act 2004 hence so are GPs who have an important role in identifying families where issues are emerging and ensuring that they are given the support within primary care if possible or encouraged to access help– this could be through the Health Visitor, School Nurse or local services such as Children's Centres. ([Working Together to Safeguard Children 2013](#) Chapter 1 p11). Local authorities, also under section 10 of the Children Act 2004, have a responsibility to promote inter-agency cooperation to improve the welfare of children. If parental consent is not forthcoming, the referral may need escalation to a child protection process.

Northern Ireland: see [Understanding the Needs of Children in Northern Ireland \(UNOCINI\)](#).

Scotland: see [Early Years Collaborative, EARLY YEARS AND EARLY INTERVENTION](#) and [Information Sharing](#).

Wales: GP guidance '[A guide for Safeguarding Children and Vulnerable Adults in General Practice](#)' (2012) includes a section on the importance of information sharing. Under [Section 25](#) of the Children Act 2004 there is a duty on agencies including local authorities to cooperate to improve the wellbeing of children and young people.

Alerting Factors

The Primary Care Team should, in particular, be alert to a potential need for early help if a child:

- Is disabled and has specific additional needs;
- Has special educational needs;
- Is a young carer;
- Is showing signs of engaging in anti-social or criminal behaviour;
- Is in a family circumstance presenting challenges for the child, such as substance abuse, adult mental health, domestic violence; and/or
- Is showing early signs of abuse and/or neglect.

Effective early help relies upon local agencies working together to:

- identify children(including the unborn child) and families who would benefit from early help;
- share information effectively (and this will require parent/carer consent);
- undertake an assessment of the need for early help and
- provide targeted early help services to address the assessed needs of a child and their family which focuses on activity to significantly improve the outcomes for the child.

3.3b Referral to statutory services: the Child in Need

Section 17 of the [Children Act 1989](#) defines a child as being in need in law if:

- He or she is unlikely to achieve or maintain or to have the opportunity to achieve or maintain a reasonable standard of health or development without provision of services from the LA.
- His or her health or development is likely to be significantly impaired, or further impaired, without the provision of services from the LA.
- He or she has a disability.

Development can mean physical, intellectual, emotional, social or behavioural development. Health can be physical or mental health.

Under the [Equality Act 2010](#) having a disability means having a physical or mental impairment causing substantial and long-term adverse effects on an individual's ability to carry out normal day to day activities.

The GP role in helping the Child in Need

Not all children with a disability will require extra services and some may have needs which can all be met by their GP or possibly a single extra service for example speech and language therapy or physiotherapy.

GPs are able to identify and refer children in need of more than one service using their local procedures (usually set out on the local authority website) and will be expected if required to contribute to the child in need referral process by supplying medical information about the child and if relevant the parents or carers; and participating in the team around the child and/or family where there are health needs requiring Primary Care input.

This information is usually incorporated in **England** within the [Common Assessment Framework](#) (CAF), see also [Working Together to Safeguard Children 2013](#) Chapter 1, which is a standardised approach to conducting assessments of children's needs and can be used by frontline practitioners from all Agencies such as Education, Health, Social Care and the Voluntary Sector across the country. It takes into account the roles of parents, carers and environmental factors on children's development, to make an assessment of how children's needs should be met. This is used to develop an action plan and coordinate service delivery.

If health needs are identified the GP will be expected to be part of the [Team Around the Child](#) or Team Around the Family and to review and monitor progress at regular intervals to ensure management of health conditions is effective and responsive to the child's changing needs as s/he grows and matures. Effective communication and collaboration with the child, family and other service providers is essential, as is preparation for transition to adult services and support during the process.

A common assessment can be done at any time – on unborn babies, new babies, and children or young people. It is designed for use when:

- There is concern about how well a child (or unborn baby) or young person is progressing.
- Their needs are unclear, or broader than a service can address on its own.
- A common assessment would help identify the needs, and provide a basis for defining which services are required then involving them.

Assessments for some children – including young carers, children with [Special Educational Needs](#) (SEN) who may require statements of SEN or Education Health and Care Plans subject to the

[Children and Families Act 2014](#), unborn children where there are concerns (commonly drug and alcohol abuse, domestic abuse or mental health in pregnancy, see [NICE CG110](#)) asylum seeking children, children in hospital, disabled children, children with specific communication needs, children considered at risk of gang activity, children who are in the youth justice system – will require particular care.

As with Early Help, it is usual for the child's parents and/or carers to have full involvement in [Section 17](#) referral and assessment processes. Written consent is required from the carer with parental responsibility and indeed it is difficult to make an adequate referral and supply required information without parental partnership and concordance. Where there are concerns and consent to refer is refused this may in itself raise your anxieties to the level of a [child protection referral](#).

Where a child has assessments from other services it is important that these processes are coordinated to avoid duplication and to ensure the child does not become lost between the different agencies involved.

Northern Ireland: see [Understanding the Needs of Children in Northern Ireland](#).

Scotland: see Scotland's Children: [The Children \(Scotland\) Act 1995 Regulations and Guidance: Volume 1 Support and Protection for Children and Their Families](#).

Wales: The '[Framework for Assessment of Children in Need and their Families](#)' (FFA) is used by Children's Services for the assessment of all Children in Need, including those in Need of Protection. In addition GPs and their teams can refer to '[A guide for Safeguarding Children and Vulnerable Adults in General Practice](#) (2012)'.

The GP and Child Neglect

Identification of neglect in general practice depends on recognition of parental risk factors, see **Section 5**, observation of the parent-child relationship and being alert to health indicators in the child such as failure of ante-natal care (neglect of the unborn child), failure to thrive, failure to attend for preventative care, dental neglect, delay in seeking help for acute illness and/or injury, excess 'accidental' injuries and inappropriate attendances for unscheduled care. Children with physical disability and/or learning disability and difficulties are at greater risk of all forms of abuse including neglect.

GPs may use the following [questions](#) devised by Professor Jan Horwath to help decide when to refer a child:

- What are my fears about this child?
- How has consultation with colleagues influenced my decision?
- What do I think is likely to happen to this child if I make a referral and how is this influencing my judgement?

GPs might want to consider what would happen to the child if they do not refer and whether the child and family would benefit from Early Help (see **3.3a**) or if concerns meet the threshold for a Child Protection (**3.3c**) referral. If neglect is suspected, doing nothing is not an option. Parent/carers consent is required for Early Help and Child in Need referrals. If consent is withheld then escalation to a Child at Risk referral will be required if failure to obtain help will result in harm to the child. For more information, see [In Brief: The Science of Neglect](#).

Neglect is the most commonly found form of child abuse and responsible for the majority of Child Protection Plans. It is also the most difficult to manage successfully and carries the greatest long term societal and public health costs. It is known that neglected children have generally poorer health, behavioural and educational outcomes, and are more likely to succumb to

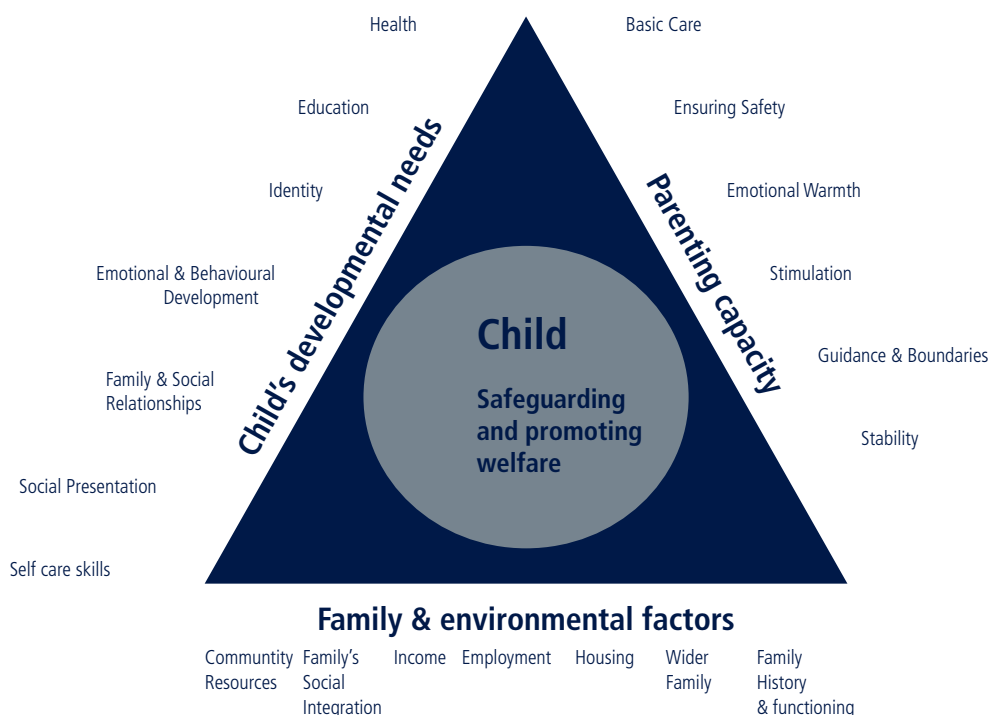
substance addictions, mental health problems and offending as well as chronic and long-term illness. Neglected children display persistent abnormalities of brain function, as well as persistent cognitive, behavioural and emotional problems (Wilson 2010).

The impact of neglect may be difficult to demonstrate due to the disruption not being evident for a period of time, because there is a lag between the neglectful parenting and the impact becoming obvious. For example if parents do not speak to a baby this may lead to the child having delayed speech and language, a condition with several differential diagnoses and where neglect as a cause might not be initially considered.

Neglect of adolescents has historically been overlooked. Teenage years may be a time of increasing caring responsibilities as well as family tensions and conflict. Some teenagers are forced to leave home thereby entering into situations of homelessness, poverty, physical and sexual risk. Guidance on helping teenagers is available at [Neglect Matters: a multiagency guide for professionals working together on behalf of teenagers](#).

The assessment triangle below is an analytical model published by the Department of Health in 2000 and features in [Working Together to Safeguard Children 2013](#) p20. It is used in England to support good practice in identifying and assessing neglect by helping to build a picture of the child's circumstances and identify areas of need and areas for intervention. Such intervention may take the form of improved management and treatment of parental mental health issues, addictions or chronic ill-health, as well as measures to enhance parental competence and social support.

The child's health needs may include catch-up immunisations, attention to dental care and nutrition and improving management of chronic or long-term conditions such as eczema and asthma. It is important that any plan for managing neglect is regularly monitored to check that intended outcomes are being achieved and that the child's life is changing for the better.



Another assessment model for neglect increasingly being adopted by local authorities is the [Graded Care Profile](#), developed by two paediatricians Drs Polnay and Srivastava.

Northern Ireland: see The UNOCINI Assessment Framework within [Understanding the Needs of Children in Northern Ireland](#)

Scotland: see [Children with Support and Care Needs](#) and [GIRFEC](#)

Wales: GPs can refer to the [Framework for Assessment of Children in Need and their Families](#) (FFA) which is used by Children's Services for the assessment of all Children in Need, including those in Need of Protection and in addition can consult [A guide for Safeguarding Children and Vulnerable Adults in General Practice \(2012\)](#).

Child Protection referrals

England: Professionals do not have to complete a [Common Assessment Framework](#) before making a child protection referral. If they believe that a child is at risk of harm or has been harmed, they should act immediately in accordance with local procedures, in England as set out by [Local Safeguarding Children Boards](#). While it is good practice to involve parents and/or carers in any referral, their consent is not required for a Child Protection referral if it is considered that applying for such consent may lead to increased risk to the child (or referring professional).

Northern Ireland: see [Understanding the Needs of Children in Northern Ireland](#).

Scotland: see [THE NATIONAL GUIDANCE FOR CHILD PROTECTION IN SCOTLAND](#)

Wales: the [Framework for Assessment of Children in Need and their Families](#) (FFA) is used by Children's Services for the assessment of all Children in Need, including those in Need of Protection. In addition GPs and primary care teams can refer to [A guide for Safeguarding Children and Vulnerable Adults in General Practice \(2012\)](#).

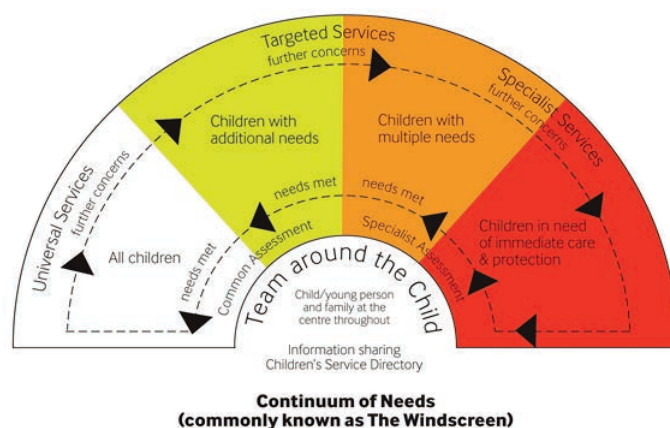
The Child in need: duties of the Local Authority

[Local Authority](#) (LA) children's services have a statutory duty to 'safeguard and promote the welfare of children who are in need within their area'. Any professional who has concerns about a child may refer the child to children's Social Care under section 17 if the child or young person has needs that require the services/support of different agencies, and it is thought that a common assessment can help facilitate access to relevant services.

Many local authorities use diagrams such as that below, originally provided by the Department for Children, Schools and Families, to illustrate the continuum of needs and identify at which points services need to be provided, stepped up or stepped down. The lead professional is the person responsible for co-ordinating the actions identified in the assessment process; a single point of contact for children and young people with additional needs, supported by more than one practitioner in a Team Around the Child (TAC) or Team Around the Family (TAF).

Continuum of needs and services

Information sharing, Common Assessment Framework (CAF) and lead professional support across the continuum



A service may be provided to the child's family or any member of his or her family so long as the aim is to safeguard and promote the child's welfare and can include providing financial assistance to a family. LAs must also do whatever possible to ensure sufficient services and measures are in place to promote a child being raised within his/her own family, if it is safe to do so.

The LA is legally obliged to offer the following specific services/support for children in need in their area:

- Advice, guidance and counselling.
- Occupational, social, cultural and recreational activities.
- Home help (including laundry facility).
- Facilities or assistance with travel to and from any services provided under the Act or similar service such as education and healthcare.
- Assistance to enable the child and the family to have a holiday.

In England [The Children and Families Act 2014](#) "will mean changes to the law to give greater protection to vulnerable children, better support for children whose parents are separating, a new system to help children with special educational needs and disabilities, and help for parents to balance work and family life.

The act also ensures vital changes to the adoption system can be put into practice, meaning more children who need loving homes are placed faster".

It is not known at this stage how this new Act may apply to [Wales](#).

Reference

[Center on the Developing Child at Harvard University, \(2012\)](#) *The Science of Neglect: The Persistent Absence of Responsive Care Disrupts the Developing Brain: Working Paper 12.*

3.3c Referral to statutory services: the Child at Risk of Significant Harm and the Child in need of protection

- GPs have a responsibility to refer a child to Children's Social Care under [Section 47](#) of the Children Act 1989 when it is believed or suspected that a child has suffered *significant harm* and /or is likely to suffer *significant harm*.
- Commonly encountered parental risk factors for child maltreatment are domestic abuse, substance misuse, and mental health problems.
- GPs must familiarise themselves with their local referral thresholds and ensure that appropriate procedures are followed to keep the child safe.
- If there is risk that the parent or carer might refuse to permit treatment or abscond with the child, the Police will have to be notified.

Thresholds of risk and the concept of 'significant' harm liable to trigger local authority intervention in family life may vary significantly between local authorities. GPs work to professional standards following professional guidelines from organisations such as the GMC and NICE and at times a decision to refer could appear to conflict with local authority procedures which may be constrained by resource limitations and budgetary considerations.

GPs need to understand social care procedures and what is meant by 'significant harm' within the local authority/ies in which they practice. This is best carried out by developing links with the local

Safeguarding Children Team and with local services working with children, as described in **Section 5**, by developing a shared understanding of thresholds for referrals and referral pathways which incorporate processes for escalation of concerns if a referral is refused and the practitioner remains concerned. GPs must know where to find the necessary support within their local system if worried about a child.

If a child is found to be suffering from an apparently serious injury or illness, referral must be made immediately to an emergency paediatric service. Infants under 12 months old are at increased risk of non-accidental injury — remember when examining an infant that *“those who can’t cruise rarely bruise”* and a small apparently insignificant bruise in a baby might be a marker for serious life-threatening injury.

If maltreatment is considered a possible cause, in some localities simultaneous referral to social care may be required to set in motion the child protection process; the history and examination findings should be carefully documented and also discussed with the admitting paediatrician. Concerns should be set out clearly and without ambiguity as well as any other information about increased vulnerabilities regarding child, parents or wider family/environmental factors; referral letters or forms in addition to relevant medical information should include any actions already taken e.g. Early Help, CAF or a Child Protection Plan.

Practice Protocols and Procedures (see **Tool 2**) should set out understandable guidance for all staff on how to handle disclosure of abuse by a child, parent or carer. Before making a non-urgent referral, GPs and their staff should have the opportunity to discuss their concerns both internally with the Practice Safeguarding Children Lead and externally with the Named Child Safeguarding GP, a member of the local Child Safeguarding Team or Children’s Social Care.

While children need to be protected from harm, they and their parents also need to be protected from inappropriate interference in family life by public authorities so referrers should be able to clearly articulate their concerns and should also raise any concerns they hold about the family and significant adults in the household as well as those directly involving the child. Such concerns may include domestic abuse, parental or carer mental or physical illness, substance misuse and/or learning disability.

If, as a result of discussion/s, Children’s Social Care or other expert resources advise that a referral is required, then the referral should be made without delay. When a child is assessed as in need of protection then while patient, parental or carer consent to share information between agencies remains desirable it is not essential as the safety of the child is considered paramount.

It remains good practice whenever feasible to inform the child/ren and parents or carers if a referral is being considered and to obtain consent, unless to do so would place the child/ren at risk of further harm, see GMC [Protecting Children and Young People](#), and [Seven Golden Rules of Information Sharing](#).

England: The Department for Education issues guidance to local authorities. The current guidance is [Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children \(PDF\)](#) (HM Government, 2013). Local Safeguarding Children Boards (LSCBs) use this guidance to produce their own procedures. GPs need to familiarise themselves with their local policies and procedures for assessment and referral of children and families about whom they are concerned.

Northern Ireland: GPs should refer to guidance on [Understanding the Needs of Children in NI](#) (UNOCINI). This is a regional assessment and referral process broadly based on the triangular assessment model as in England. This referral process is used for both the Child in Need and Child Protection referral. Consent is preferable but in the case of serious risk is not necessary. The UNOCINI assessment is used alongside other particular assessment tools in cases such as [neglect](#) or [domestic violence](#), see also [NSPCC Inform](#).

Scotland: see [THE NATIONAL GUIDANCE FOR CHILD PROTECTION IN SCOTLAND](#) and [GIRFEC](#) which helps practitioners focus on what makes a positive difference for children and young people – and how they can act to deliver these improvements.

Wales: the [Framework for Assessment of Children in Need and their Families \(FFA\)](#) is used by Children's Services for the assessment of all Children in Need, including those in Need of Protection. When considering making a child protection referral GPs may complete a 'pre-referral considerations form'. This form will differ in each Local Authority area across Wales and considers the three domains of the '[Framework for Assessment of Children in Need and their Families](#)' (FFA) (i.e. child's developmental needs, parental capacity to meet those needs and family and environmental factors) and their related dimensions. In addition GPs and primary care teams can refer to [A guide for Safeguarding Children and Vulnerable Adults in General Practice \(2012\)](#) and [All Wales Child Protection Procedures](#).

3.4 What comes after a Child Protection referral?

- Local referral and assessment protocols vary between Local Authorities.
- GPs' Practice areas may span more than one local authority area so it is important to be aware of procedures for each area as these may differ, sometimes significantly.
- All LSCBs or local equivalent and local authorities have websites with details of referral pathways, referral forms, thresholds and eligibility criteria and children's services provision in the areas they cover.

This section can provide only a generic account of what might be expected following a referral as there is significant regional variation in processes. It is important that GPs familiarise themselves with local criteria and processes and check the LSCB or local equivalent and local authority websites regularly to keep abreast of changes.

Children's Social Care are expected to acknowledge and act upon a Child Protection referral within 24 hours of receiving it. Usually Social Care Departments will seek more information by discussion with the referrer, ascertaining the existence of any previous records or referrals for the child and for any other members of their household, checking whether the child is already subject to a child protection plan, checking whether there is a history of a past or current common assessment (e.g. CAF), contacting and referring to other agencies as appropriate (such as the police if an offence has been or is suspected to have been committed or probation services if the child may be at risk of harm from an offender).

The purpose of the assessment is always:

- To gather important information about a child and family.
- To analyse their needs and/or the nature and level of any risk and harm being suffered by the child.
- To decide whether the child is a child in need (section 17) and/or is suffering or likely to suffer significant harm (section 47).
- To provide support to address those needs to improve the child's outcomes to make them safe, ([Working Together to Safeguard Children 2013](#)).

After gathering referral information, the social worker will determine a course of action, usually in conjunction with a senior worker or manager. This may be that no action is required, or by contacting a health visitor or other professional, or for example in England by asking the referrer to initiate a Common Assessment using a [Common Assessment Framework](#) (CAF).

If from available information the social worker believes the child may be a 'child in need' (section 17 of Children Act 1989) the initial assessment will consider the child's developmental needs and family and environmental factors including parenting capacity.

Further referrals may be requested for the parent if under 18 and considered subject to the same risk/s as the child, for other children living in the same household or other children of the family living in different households.

If it is suspected that the child is 'in need of protection' ([section 47 of Children Act 1989](#)) then in some localities a Strategy Discussion might be convened between Children's Social Care, Police and Child Community Health and other agencies including GPs where appropriate. It is possible this could result in a Section 47 enquiry (or similar investigation in other jurisdictions) being carried out, potentially leading to a Child Protection Conference. Professionals involved with the child may be asked to contribute by interview, in writing, or by attending a Child Protection Conference. GPs will receive a request in writing to contribute a report to the Section 47 investigation. If it is decided that the case warrants convening a Child Protection Case Conference, the GP will be invited to contribute a further report and to attend.

If it is felt that a child may be at immediate risk of 'significant harm' urgent protective action maybe required and will be agreed within an emergency Strategy Discussion.

Urgent action could include:

- a Child Protection Medical Assessment by a Specialist Paediatrician;
- the child being temporarily accommodated with the agreement of a parent;
- or possibly by an Emergency Protection Order which may be achieved by the police using their powers of protection or by an interim Court order.

While GP referrers should expect to receive acknowledgement of a referral within 24 hours, this does not always occur and it remains the duty of the referrer to follow up unacknowledged referrals and to continue to monitor the child's welfare during and beyond the referral and assessment process.

[Child abuse reporting requirements for professionals](#) in the four countries of the UK may be found at the NSPCC website which is regularly updated.

England: see [Working Together to Safeguard Children 2013](#).

Wales: after gathering referral information GPs should also refer to the [Framework for Assessment of Children in Need and their Families \(FFA\)](#) to determine a course of action, usually in conjunction with a senior worker or manager.

GPs must be aware of how to use local processes for escalating concerns if they have reason to believe that risk to the child is increasing and it appears that appropriate action is not being taken.

3.5 Report writing in Child Safeguarding and Child Protection

- GPs are perceived as having specific and relevant knowledge relating to the children and families in their care.
- Good record keeping remains an essential component of effective general practice and an important aid to early recognition of parental or carer problems and risks to children.
- Effective report writing requires careful judgment of what constitutes 'significant harm' as well as resolution of possible conflict between consent and confidentiality.

GPs are often asked to provide reports for children in need of extra services, safeguarding or protection. Reports for early help and Child in Need services to be delivered under [Section 17 of the Children Act 1989](#) usually require full parent/carer consent and collaboration with detailed descriptions of care required for any physical or learning disability, medication and/or aids. Refusal to give consent may require a child protection referral.

Reports for statutory Child Protection investigations such as [Section 47 investigations](#) or Child Protection Case Conferences (see specimen report **T7**) may be written without consent if to obtain such consent could increase risk of 'significant harm' to the child. It is however good practice wherever possible to involve the child and family and to ensure they have full access to the report before it is sent. This may be difficult within the short time scale required for a statutory reports.

At Case Conferences families are usually shown all reports prior to the Conference. GPs will be aware that many parents in this situation are themselves vulnerable and may have learning disabilities, mental or physical health problems, be substance abusers or may themselves be legally children (i.e. under the age of 18). GPs may worry about destroying a relationship perceived as therapeutic but a concern to avoid potential distress or disruption of the doctor-patient bond must never be allowed to prevent disclosure of information to relevant agencies in a child's best interest. Such disclosure must however be relevant, proportionate, objective and factual. GPs should confine any views to their professional opinion based upon all relevant facts available.

Such reports should distinguish clearly between facts, such as investigation and examination findings, observations such as relating to demeanour or personal hygiene, and opinion such as those about relationships. Where information is in the nature of an allegation or provided from another source, for example observation of a member of staff, this should be made clear. If a GP has concerns about revealing sensitive information within medical records then advice may be sought from a child protection professional on an anonymised basis but it must be remembered at all times that it is the child's safety which is paramount and central to the process, see GMC [Protecting children and young people: The responsibilities of all doctors](#).

Absence of contact with a child or family may be pertinent to an investigation and should be communicated in the report. Relevant information should be provided on parents, carers and all adults resident within the household, significant adults resident elsewhere, also siblings, half- and step- siblings and other children within or connected with the family.

Northern Ireland: GPs should refer to current [ACPC regional Policies and Procedures](#) which give details of the case conference processes including the GP's responsibility. It outlines timescales for holding meetings and the pathways for various types of child protection investigation.

Scotland: see [National Guidance for Child Protection in Scotland 2010](#).

Wales: see [A guide for Safeguarding Children and Vulnerable Adults in General Practice \(2012\)](#) and [All Wales Child Protection Procedures](#).

3.6 Case conferences and recommendations

The Child Protection Case Conference should focus on the child's circumstances, what they mean for the child's lived experience, what parental/carer behaviours are causing harm or likely to lead to harm, whether the parents understand this and what needs to change.

The Conference provides a forum:

- For professionals from all agencies involved with the family to meet to discuss concerns about the care of an unborn baby, infant, child or children based on information gathered in the course of the Section 47 investigation and strategy meetings.
- To determine whether the unborn baby, infant or child/ren is/are at risk of harm or have already been harmed.
- If it is decided that harm has occurred or the unborn baby, infant or child/ren are at risk of harm, to determine whether the parents or carers have capacity to prevent the harm and to meet the child's emotional, physical and developmental needs.
- The Conference has to agree what can be done to reduce the possibility of further harm and risk and can decide to make the unborn baby, infant or child/ren subject to a Child Protection Plan.

Following a statutory child protection investigation such as a Section 47 investigation, social care may decide that concerns about the unborn baby, infant or child are justified and require an Initial Child Protection Conference.

This should take place within a strict time frame; in England this is within 15 working days from the last strategy discussion (see **Section 5.4**). GPs are usually invited to Child Protection Case Conferences and are expected to produce a report for the Conference. [GMC Child protection Guidance 2012](#) advises that GPs should be involved with this procedure. GPs often find case conference attendance difficult because they are called at short notice and finding cover for busy surgeries becomes problematical.

If attendance is impossible, it is still essential that a comprehensive report be produced and discussed by telephone with the family's social worker and the Conference Chair prior to the conference. It is good practice for this report to also be shared and discussed with the family as well as the child/ren if mature enough, unless to do so would increase risk and/or harm to the child/ren.

Practice Child Safeguarding Policies and Procedures (see specimen in **T2**) should set out processes for ensuring that requests for case conference reports and attendance are handled in a timely and effective way, including contingency plans for emergency surgery cover should a GP be asked to attend a strategy meeting or case conference at limited notice especially if relating to a family about which the Practice has serious concerns. Some local authorities are willing to arrange strategy meetings in GP Surgeries to facilitate GP involvement.

Some GPs request payment for supplying child protection information or attending case conferences – see [GMC Child protection Guidance 2012](#) for advice and consult local guidance but be aware that failure to provide information or to contribute to the child protection process in a timely manner may be construed as professional misconduct.

Case Conference recommendations

The Conference may decide that harm has not occurred and there is no risk of harm, that there are unmet needs which may be addressed through Child in Need measures under [Section 17 of the Children Act 1989](#), or that the unborn baby or child/ren should be placed on a Child Protection (CP) Plan.

The Child Protection Plan should include the following:

- Decisions of the Initial Child Protection Conference (or Review Child Protection Conference);
- Agreed outcomes for the unborn baby or child and family.
- Factors that need to change to achieve the outcomes.
- Assessed needs/risks and priorities of the plan.
- Key people involved, agreed tasks and responsibilities.
- Timescales for action.

- Support and resources required to take the plan forward.
- Process and monitoring of the plan.

The above should be based on improving the child's daily life and aim to address the impact of adverse parent/carer behaviours on the child's development and needs as well long term well-being.

If the unborn baby or child/ren is placed on a CP Plan, a social worker is appointed and a core group usually including the parents or carers to set up to develop a detailed plan to keep the unborn child, infant or child/ren safe. If there are parental or child health needs, the core group might include the GP or other health professionals such as the health visitor. The core group meets regularly to monitor the Plan, and a Review Case Conference is held after 3 months to review progress with further reviews at 6 monthly intervals until it is decided that the baby or child/ren may be safely taken off the CP Plan, stepped down into Section 17 or [Child in Need](#) services or if serious risk remains, taken into care (see **Section 5.7.1**).

In **Scotland** when a child or unborn baby is thought to be at actual harm or potential risk of harm their name will be placed on the Child Protection Register (CPR).

What this means for GPs

GPs will receive a full Case Conference report with details of decisions made and whether the unborn baby or child/ren has been placed on a CP Plan or Register. The full minutes or a summary including the Child Protection Plan should always be stored with the child/ren's medical records, (in the case of an unborn baby with the mother's records), and the Practice Safeguarding Lead will need to ensure that any actions required of the Practice in relation to parental/carer or the child/ren's health are carried out and outcomes communicated to the Review Conference. Parent/care non-compliance with health care plans should be communicated to the social worker as soon as discovered because this may be an important sign of increasing risk to the child.

GP electronic recording systems all have diaries which are useful for keeping track of actions required from CP Plans/Registers and ensuring reports for Review Conferences are sent in time. See also **Section 2.3** for guidance on storing and managing Case Conference Reports and **Tools 2, 3** and **6b**.

England: government guidance for convening Child Protection Case Conferences is contained in the [Working Together to Safeguard Children 2013](#).

Northern Ireland: see [A Short Guide to Child Protection Policy and Procedures](#).

Scotland: see [National Guidance for Child Protection in Scotland 2010](#) 347.

Wales: see 3.14 of the [All Wales child protection procedures \(PDF\) \(2008\)](#).

Sharing Case Conference Reports

These Reports often contain third party references and it is the GP's responsibility to ensure that these are removed when such records are shared. There may also be difficult decisions to be made if an adult patient requests access to medical records containing sensitive information from child protection procedures in infancy and childhood of which they might have no knowledge or recollection. If the GP is concerned about the psychological effect on the patient of such disclosures, advice should be sought from a suitable source such as a medical indemnity organisation on the wisdom and possible consequences of redaction.

3.7 Court Procedures relating to Children

- Court proceedings relating to children are expected to put the child's welfare first.
- A judge or magistrate is expected to make an order only if it is in the child's best interests.

3.7.1 The Child at Risk: Care proceedings

In England, care proceedings usually take place in the Family Proceedings Court cases and are heard by a bench of three magistrates. This court is also responsible for awarding emergency protection orders while more complex cases may be transferred to the county court or high court where the case is heard by judges.

In care proceedings, a Children's Guardian from [Cafcass](#) represents the rights and interests of the child. Usually the GP is not involved at this stage, having already submitted reports for the Section 47 investigation and Case Conference, but in some instances Social Care or parents may request further medical reports especially if the care order is disputed.

The main Orders that can be sought for children by Social Services from the Court are:

- Emergency Protection Order (**EPO**)
- Interim Care Order (**ICO**)
- Care Order (**CO**)
- Supervision Order (**SO**)/Interim Supervision Order (**ISO**)
- Child Assessment Order

Emergency Protection Order

These are made to ensure immediate or short-term safety of the child and can be made by anyone, including local authority or other statutory bodies. The court has to be satisfied that the child will be at risk of significant harm if not removed to a place of safety or not allowed to remain in a place of safety such as a hospital.

An unborn child cannot be made subject to such an order but an emergency protection order may exceptionally be imposed at the moment of birth.

Interim Care Order

Children's social services may ask the Family Proceedings Court to make [interim care orders](#) if a child is considered at risk, while matters are investigated further. The local authority must produce a care plan, specifying where the child will live, arrangements for attending school and access to parents or family members. An interim care order is awarded for eight weeks initially and then must be renewed every four weeks.

Full Care Order

If after further investigation children's services still think a care order is necessary, they will request a [full care order](#) to be made. This gives the local authority parental responsibility for a child. In theory, such parental responsibility is shared with the parents, but in practice, the local authority has the power to determine the extent to which a parent or guardian is involved with their child. To make a care order, the court must be convinced that the threshold criteria set out in [section 31](#) of the Children Act 1989 are met (that the child is suffering, or likely to suffer, significant harm and that the harm is attributable to the parents or carers not providing a reasonable standard of care).

Care Plans

Once a care order is awarded, the care plan for the child will be implemented. Depending on individual circumstances, the child might continue to live at home or be placed in kinship care (with other members of the family), foster care or a residential children's home or school. In circumstances where it would be unsafe for the child to return to live with her/his natural parents or considered not in the child's best interests, the local authority may seek to have the child [adopted](#).

Supervision Order

This may be imposed if the court decides the child can safely continue to live with the parent but that the parent might not necessarily be able or willing to ensure all of the child's needs are met.

The order might for example specify:

- Where a child should live.
- That a supervisor be allowed to visit.
- That the child should go to school.
- That the child should have a physical or mental health examination and/or psychiatric treatment.

Northern Ireland: the court procedures relating to children are broadly similar to those in England for details refer to [Cooperating to Safeguard Children 2003](#).

Scotland: the [Children \(Scotland\) Act 1995](#) provides the main legislative framework for the protection of children in Scotland. Not only does the Act set out the grounds of referral to the Children's Hearing system for those considered in need of compulsory measures of care, it also provides a number of mechanisms allowing for intervention in a child's life when they are considered to be suffering, or at risk of suffering, significant harm.

These mechanisms take the form of court orders, namely:

- Assessment Orders.
- Child Protection Orders.
- Exclusion Orders.

Children may be referred to the [Scottish Children's Reporter](#) (by anyone) in situations where they may require compulsory measures of supervision, either due to concerns about their welfare or in order to assess offending behaviour. A Hearing may decide on a course of action that it believes is in the child's best interest.

Wales: see the [Child Protection System in Wales](#) and [A guide for Safeguarding Children and Vulnerable Adults in General Practice \(2012\)](#).

Police Protection Orders

Note: that the Police have powers under [Section 46 of the Children Act 1989](#) to protect children. A police officer who believes that a child is at risk of suffering significant harm in a particular situation may exercise powers under this Act to remove the child to suitable accommodation or if the child is in hospital or in a place of safety, take steps to ensure the child remains there. A child cannot be kept in police protection for more than 72 hours. Usually the child is immediately referred to the local authority to be placed into foster care. There is no right of appeal against police protection powers being exercised because it is not an Order.

Court Procedures relating to children:

3.7.2 Marriage or Partnership Breakdown

Following the breakdown of a relationship, one or other of the parties may find it necessary to make an application to the Court if unable to come to an agreement regarding any child/ren of the relationship.

Such applications are made under the Children Act 1989 which sets out the concept of [parental responsibility and the private law aspects of the Act](#).

The aim of the Act is to encourage co-operation between parents in respect of the children's welfare needs, underpinned by the basic principle that children should have a continuing relationship with both parents, regardless of parental separation.

Arrangements in the Four Nations for providing support to children in such circumstances are as follows:

- **England:** see Children and Family Court Advisory and Support Service ([Cafcass](#))
- **Northern Ireland:** see [Northern Ireland Guardian Ad Litem Agency](#)
- **Scotland:** see [Children's Hearings department of the Scottish Executive](#), [Scottish Administration's Children's Reporter Website](#)
- **Wales:** see Cafcass Cymru

The GP role

GPs may be asked to provide medical reports in support of applications from one or other parent for access or increased access to the child/ren and must ensure these are written objectively and without bias in accordance with [GMC](#) guidance.

Where [CAFCASS](#) or equivalent organisation has been appointed to write a report to advise a judge in relation to child welfare issues, they may request a medical report relating to the child/ren from a GP. In such an event, it would be usual to seek the patient's (depending on age and capacity) or parent's consent. If this is not possible, and in the absence of a court order, the Practice will need to balance its duty of confidentiality against the need for disclosure without consent, see [GMC Guidance](#) on Consent and Confidentiality.

If no consent is forthcoming and there are Safeguarding or Child Protection concerns, the Practice Child Protection Lead should be consulted and might wish to forward the report to a local Child Protection expert such as the Named Safeguarding GP for further advice.

S4

Recognition, Presentation and Prevention of Child Maltreatment in Primary Care

Click box to
go to section

page

4.1	Presentation of Child Maltreatment in Primary Care	48
4.2	Prevention, Early Recognition and Early Intervention	54

Definitions of abuse used in this Toolkit may be found in [Working Together to Safeguard Children 2013](#) p86.

- Child maltreatment is preventable but prevention depends on early recognition of risk factors and warning signs related to parent and/or carer rather than the child.
- This requires professional curiosity and “[respectful uncertainty](#)” (Laming 2003) to wonder about what is really happening in a family.
- Parental factors such as domestic abuse, substance misuse, mental health problems and lack of parenting skills are important signs that a child might be at risk of maltreatment.
- Family factors include a history of child maltreatment, single parenthood, unemployment and financial stress, history of offending and social isolation.
- Neglectful families tend to have larger numbers of children or people living in a chaotic household often with numerous ‘pets’.
- Child vulnerability is increased in infancy and at any age if they are perceived by parents as having special needs due to physical or learning disability or being in some way ‘different’.
- Adolescent maltreatment may be overlooked because older children are regarded as being able to look after themselves.
- Practice staff may be alerted to a potentially abusive situation by how they themselves are treated by a patient or by observing unusual behaviours on the telephone or in the waiting room.
- Child maltreatment happens in every section of society, crossing all economic, ethnic and cultural lines and may be linked to animal abuse.
- NICE Guidance CG89 [When to suspect child maltreatment](#) covers major alerting features, but signs of child maltreatment may be well hidden, subtle and easily missed in the 10 minute consultation
- Not all abuse is violent or results in physical injury. While neglect and emotional abuse might leave no visible scars, the psychological damage may be severe and lead to life-long damage.

This introduction highlights some of the pitfalls and potential barriers to recognition in general practice.

Barriers to recognition

There are many barriers that individuals often have to overcome before taking appropriate action when faced with a concern about a child's welfare. *Keep me Safe* the RCGP strategy for Child Protection identified the following barriers to recognising and responding to child abuse:

Looking for the wrong thing

Looking for signs of physical abuse as the only markers for child abuse misses behavioural or mood change. Child abuse comes in different forms and it is essential to have understanding of signs and symptoms of distress (see **Section 6**) including how behaviour changes relate to developmental stage and environmental and parental risk factors.

Underestimating the problem

There may be failure to appreciate the danger to a child where there is domestic abuse, parental mental health problems, substance or alcohol abuse (see **Section 5**).

Condoning the problem

For example, neglect is more common where there is deprivation, but deprivation does not cause neglect and should not induce tolerance of maltreatment.

Not seeing the Child

The needs of the child can easily be overshadowed by those of the parents. It is necessary to put the needs of the child above all others and see the child, not just the parents, keeping the child in focus.

Not looking

Child abuse is upsetting. It is easier to ignore the problem or seek other, more comfortable explanations for observations, especially where the child has disabilities. Clinicians themselves may be or have been the victims of abuse or domestic violence so they think it is normal or find it difficult to be involved.

Not knowing what to do next

The practitioner may be unaware of local procedures or contacts. Each practice should make these available to all staff including non-clinical staff, together with clear guidance on how to discuss and communicate concerns. If there are concerns about a child, doing nothing is never an option.

The patchwork or jigsaw nature of Child Protection

Different people hold pieces of information; it is only when individuals and agencies share information together that the picture is complete. This involves effective record keeping and communication internally and between agencies.

The problem is hidden

Parents will bring their child with something other than abuse, such as an 'accident', or not bring their child at all. Parents, especially a non-abusing parent, may be frightened or ashamed. They

may want help, but be unwilling to accept responsibility for their actions. Occasionally a parent may actually induce illness: described as [fabricated and induced illness](#) (previously referred to as Munchausen's Syndrome by Proxy).

Relationships

GPs are often concerned for the relationship with the family. We may assume parents or/and carers will be angry and upset if we appear uneasy about their treatment of a child and we may fear for our professional and personal safety if we raise the issue of child abuse. The family indeed may feel betrayed by us if we express our concerns, so it is crucial to have a non-judgemental attitude and explain what needs to be done; there is evidence that families appreciate this.

Relationships may be fragile anyway or we may feel that the family is doing their best under very difficult circumstances. Our relationship with our patients is founded on trust and mutual respect. Where there are suspicions of child abuse, we may have to adopt a much more assertive approach that will not ultimately cut across this relationship of trust.

Inter-professional relationships

Working effectively in child protection demands an inter-professional approach involving several different agencies such as other health providers, education, social services and the police. This can create problems around confidentiality, consent and data protection. The different languages, cultures and expectations of other agencies and practical difficulties of finding the right professional at the right time and being able to talk to them can add to this feeling of disengagement.

Lack of confidence in the system

Sometimes we feel that the cost of engaging the child and family in the child protection system or the difficulties of working with other agencies outweighs the benefits. It can feel easier to do nothing.

Individual Freedom Versus the Nanny State

Child rearing practices vary; all have a right to a private and family life without undue interference from the State. Judging someone else's child rearing practices may feel awkward. In the Children Act 1989, society has reserved the right to interfere in family life to protect children and [GMC guidance](#) reflects this.

Cultural relativism

This concept describes practitioners' acceptance of different childcare practices as normal and acceptable to the culture of the family and may influence decisions not to intervene. For example, a practitioner may assume that female children are less valued in some cultures, so when a mother seems to value her male above her female children, or arranges a Forced Marriage or Female Genital Mutilation, this is accepted as normal.

It is important to recognise that no culture advocates or condones abuse of children. Over action and inaction have both been shown to be based on misunderstanding and misinterpretation of different cultural patterns, which have led to failure to meet children's needs. Culture, ethnicity, religion or any other diversity issue should not prevent action being taken to safeguard a child.

Sometimes we:

- Find it hard to believe what we are hearing.
- Incorrectly accept hearsay as fact.

- Cannot believe suspicions about someone we know and like.
- Fear 'getting it wrong' for the child and family.
- Worry we may make it worse for the child.
- Believe the services are stigmatising.
- Simply 'don't want to get involved'.
- Do not want to admit we might be wrong even in the face of new or emerging difference to the contrary.
- Do not have the information on what to do and who to contact.
- Fear retribution.
- Have been victims ourselves.

Consent and confidentiality

These issues are often a cause for concern when dealing with possible child maltreatment especially sexual abuse. Guidance is provided in [GMC 0–18](#) and [GMC Protecting Children and Young People](#) while the NSPCC provides a factsheet on [Gillick competency and Fraser guidelines](#).

4.1 Presentation of Child Maltreatment in Primary Care

Practice staff may be alerted to a potentially abusive situation by:

- External communication such as domestic abuse notifications.
- Correspondence from drug and alcohol or mental health services.
- History and/or examination during a consultation.
- Disclosure by a child or parent.
- By how they themselves are treated by a patient.
- Or by observing unusual behaviours on the telephone or in the waiting room.

General indicators

The risk of child maltreatment is recognised as being increased and should be suspected or considered when there is:

- Domestic or inter-familial abuse or marital conflict (see **Section 5.1**).
- Parental or carer drug or alcohol abuse (**Section 5.3**).
- Parental or carer mental health disorders or disability of the mind (**Section 5.2**).
- History of violent offending.
- Previous child maltreatment in members of the family.
- Known maltreatment of animals by the parent or carer (see [Animal abuse and child maltreatment](#)).
- Vulnerable and unsupported parents or carers.
- Pre-existing disability or long-term chronic illness in the child.

This list is by no means exhaustive and children may be vulnerable for many different reasons.

NICE Guidance CG89 uses a further aid to prioritising concerns: **suspecting, considering and excluding** maltreatment using these definitions:

- **Suspect** means a serious level of concern about the possibility of child maltreatment but not proof of it.
- **Consider** means that maltreatment is one possible explanation for the alerting feature and so is included in the differential diagnosis.

■ **Exclude** maltreatment if a suitable explanation is found for the alerting feature, which might be after discussion with colleagues.

Definitions of abuse

All *definitions* of abuse below are taken from [Working Together to Safeguard Children 2013](#) p86. Presentations in general practice are seldom clear cut and well defined, and the different types of abuse often overlap in the same child. Physical signs may be difficult to interpret and may be hard to detect in some types of abuse for examples sexual abuse.

Physical abuse

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 injuries in children

There are a number of injury patterns that cause immediate concern in terms of child protection amongst which are:

- **Any bruising in non-mobile baby** particularly facial bruising, see NSPCC's [All Babies Count](#).
- **Multiple** bruising, with bruising in 'protected' areas or unusual bruises of different ages, see [NSPCC Inform](#).

The alert practitioner may observe unusual signs when the child is brought with an incidental respiratory infection, nappy rash or apparently minor illness and rashes. Many local authority areas now have bruising protocols to be followed if the presentations described above are encountered.

If a child presents with injury it is important to note whether the injuries are consistent with the history provided and the child's developmental stage, see T11 for children under 5, but be aware developmental age is not always related to chronological age.

Think about the following:

- Information regarding areas of bruising that is of concern: face/neck/ear, in infants this is of special significance as it may be a sign of or precursor to more serious injury.
- Any facial/head/neck injury.
- Bruising on buttocks and lower back.
- Bilateral bruising.
- Bruising on upper arms/thighs/small clusters etc or 'protected' areas.
- Inconsistent history.
- Late presentation of injury.
- Injury not consistent with history or age/stage of child – especially important in infants who may not be mobile.
- Unexplained injuries in non-mobile children particularly but all children.
- Presence of other injuries – all presentations but especially those in infants under 12 months even if seemingly minor require full detailed examination.
- Patterns of repeat injuries.

Alerting features may include:

- Abrasions.
- Bites (human).
- Bruises.

- Burns or scalds.
- Cold injuries.
- Cuts.
- Eye injuries.
- Fractures.
- Hypothermia.
- Intra-abdominal injuries.
- Intracranial injuries.
- Intrathoracic injuries.
- Lacerations.
- Ligature marks.
- Oral injuries.
- Petechiae.
- Retinal haemorrhage.
- Scars.
- Spinal injuries.
- Strangulation.
- Subdural haemorrhage.
- Teeth marks.

Note this list is not exhaustive.

Or consider:

- Child with hypothermia due to inadequate clothing.
- or limbs inappropriately covered in hot weather (concealing injury).

See [NSPCC Inform Physical Abuse](#) for more information.

In fabricated or induced illness there may be discrepancy in the clinical picture with one or more of the following:

- Reported signs or symptoms only in the presence of the carer.
- Multiple second opinions being sought or contact with several secondary care specialists in different departments or hospitals.
- Inexplicably poor response to medication or excessive use of aids.
- Biologically unlikely history of events even if the child has a current or past physical or psychological condition.

See also [Statutory Guidance on Safeguarding Children in whom Illness is Fabricated or Induced](#) and NHS Choices [Fabricated or Induced Illness](#).

Emotional Abuse, Behavioural, Interpersonal & Social Functioning

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.

Parental risk factors include:

- Substance misuse.
- Verbal or/and physical aggression.
- Voicing negative thoughts about child, such as dislike or hate.
- Blaming or belittling the child in public.
- Having unrealistic expectations.
- Always assuming the child is at fault.
- Threatening the child.
- Using corporal or emotionally severe punishment.
- Being cold, uncomfortable and unsupportive.

Presentation of emotional abuse in general practice is dependent on the child's age and developmental stage (see **Section 6**) and may be difficult to identify and assess but always accompanies every other type of abuse, see [NSPCC Emotional Abuse](#). *"Belief in witchcraft, spirit possession and other forms of the supernatural can lead to children being blamed for bad luck, and subsequently abused. Fear of the supernatural is also known to be used to make children comply with being trafficked for domestic slavery or sexual exploitation."* "Radicalisation" is now described as a form of emotional abuse; see [Channel Guidance](#) and [Child abuse linked to faith or belief](#).

Alerting features may be observation of harmful parent-child interactions and failure to thrive at any age, physical/mental/emotional developmental delay, as well as:

- Babies: feeding difficulties, irritability.
- Toddler: sleep refusal, food refusal, behavioural difficulties, communication delay.
- School age: low self-esteem, withdrawn or shy, difficulty making friends, secondary enuresis, encopresis, hiding or scavenging food, unexplained change in emotional or behavioural state, school refusal; precocious or coercive sexualised behaviour, self-harm, somatisation – aches, pains.
- Adolescent: self-harming/mutilation, extremes of emotion, aggression or passivity, drug and/or solvent abuse, risk taking, sexual experimentation, homelessness due e.g. to family conflict, running away (note 20% of children who run away have a disability, see [Still Running 3](#)), school refusal, responsibilities which interfere with normal daily activities (such as school) – for example [Young Carers](#).

Young carers as defined in [Working Together to Safeguard Children 2013](#): *Are children and young persons under 18 who provide or intend to provide care assistance or support to another family member. They carry out on a regular basis, significant or substantial caring tasks and assume a level of responsibility, which would usually be associated with an adult. The person receiving care is often a parent but can be a sibling, grandparent or other relative who is disabled, has some chronic illness, mental health problem or other condition connected with a need for care support or supervision.*

Children as young as three years old have been found to be caring for siblings as well as adults. Young carers may be subject to emotional abuse and neglect including deprivation of access to education and normal childhood activities and when discovered require careful assessment and appropriate referral to social care. Services for such children have been set up in many areas; more information is available at [Include Programme](#), [NHS Choices](#) and [Young Carers](#).

Sexual Abuse

Involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. 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 (including via mobile telephones or social media). Sexual abuse is not solely perpetrated by adult males.

Women can also commit acts of sexual abuse, as can other children.

There are often no clear diagnostic signs when a sexually abused child presents in general practice. Identification may depend largely on disclosure of rape or abuse or sexual activity which the child might consider 'normal' because it has been happening from a young age and s/he knows no different.

The GP might have difficulty in deciding if and when to share this information, see **Sections 3.1, 7, 8.1** and **Tool 19**. While the child's wishes must always be taken into account, refusal to consent to sharing or to referral may be due to fear of the abuser, threats and coercion. If in doubt always seek further advice from the local child protection team. Many areas now have police teams dealing specifically with sexual exploitation and officers willing to speak with health professionals concerned about possible criminal activity. See also [NSPCC Sexual Abuse](#).

Diagnostic alerting features include:

- Sexually transmitted infection.
- Hepatitis B or C in under 13s.
- Pregnancy in under 13s or an older child with disability (in which case your local early pregnancy pathway must also be followed, see also NICE Guidance CG110, in addition to child protection procedures).

Physical symptoms may include:

- Persistent unexplained ano-genital symptoms including recurrent or atypical UTIs where there is no underlying physical anomaly.
- Sexually transmitted infection.
- Ano-genital warts (see [CG89](#)).
- Sudden unexplained difficulty in sitting or walking.

Behaviour changes

- Sudden changes in behaviour or routine.
- School refusal or seeming to spend excessive time at school.
- Inappropriate sexual behaviour, disinhibition.
- Secrecy, distrust of familiar adult, anxiety if left alone with particular person.
- Self-harm/mutilation/attempted suicide.
- Concealed pregnancy.
- Relationships with older men-power differential.

In **England** and **Wales** [The Sexual Offences Act 2003](#) applies. It states that "Any sexual intercourse with a child under 13 will be treated as rape. Other non-consensual offences against children under 13 are sexual assault by penetration, sexual assault, and causing or inciting a child to engage in sexual activity. Offences of sexual activity with a child under 16 cover a range of behaviour, involving both physical and non-physical contact. As children and young persons commit sexual crimes on other children, these offences apply also to persons under 18".

However the law goes on to state that children of the same or similar age are highly unlikely to be prosecuted for engaging in sexual activity, where the activity is mutually agreed and there is no abuse or exploitation. See also **Tool 18**, [A Guide to identifying sexual behaviours](#) and **Section 8.1 Sexual Exploitation**.

Northern Ireland: see: [The Sexual Offences \(NI\) Order 2008](#)

Scotland: [The Sexual Offences \(Scotland\) Act 2009](#), Part Four provides for "protective offences" which address predatory sexual behaviour towards children. The Bill maintains the age of consent at 16. It provides that sexual activity of any kind between adults and children under the age of 16 is unlawful. Separate 'protective' offences are provided for in respect of sexual activity with young children (under the age of 13) and older children (from age 13 to age 15). It further provides that sexual intercourse and oral sex between under-16s remains unlawful.

Wales: see also [A guide for Safeguarding Children and Vulnerable Adults in General Practice \(2012\)](#).

Neglect

The persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to:

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

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

Parental risk factors for child neglect

- Domestic abuse.
- Substance misuse.
- Mental Health problems.
- Limited parenting skills, which may be associated with a history of childhood abuse and/or learning difficulties.
- Household stress, such as large numbers of people living in the household, limited finances, poor household management.
- Children left repeatedly without supervision.

Presenting symptoms and signs in the child as with emotional abuse are related to age and developmental stage, but at any age there may be failure to thrive, delayed physical, social and emotional development and communication skills.

Note children with any form of disability or long-term chronic conditions are at increased risk of neglect, see [NSPCC Briefing](#).

Alerting features include:

Health neglect –

- Parents failing to engage appropriately with healthcare, e.g. failure to attend scheduled appointments (practice or wider health professional) but use A&E/Out-of-Hours/ Walk-in services frequently.
- Dental neglect such as untreated tooth decay.
- Treatment for medical problems not being given consistently, poor compliance with medication for chronic long-term conditions.
- Failure to attend for immunisations and other preventative care.

- Repeated apparently accidental injuries suggesting inadequate supervision.

Or consider:

Infants

- Faltering growth (may be due to poor feeding).
- Poor hygiene, poor state of clothing, persistently smelly or dirty, nappy rash.
- Withdrawn, lethargic, depressed.
- Self-stimulation behaviour such as rocking, head-banging.
- Poor attachment to parent/carer.

Early childhood

- Short stature.
- Dirty, unkempt.
- Delay in learning new skills.
- Learning slow and painful.
- Speech and language delay.
- Frequent severe infestations (scabies, head lice).
- Repeated animal bites, insect bites or sunburn.

School age

- Severe educational deficits: learning disabilities, poor problem solving, poor reading, writing and maths.
- Disruptive/overactive in class.
- Desperate for attention.
- Overcompensation.
- Encopresis/enuresis.
- Guilt/self blame.
- Self harming.
- Disturbed eating patterns.
- Low self-esteem.
- Lack of social relationships, difficulty making friends.
- Homelessness.

The GP needs to be aware of chronic presentations where neglect as a causal factor may be easily missed such as developmental delay, failure to thrive, short stature and poor school attendance and performance. It is important to share information early with other professionals such as health visitors and school nurses if neglect is suspected and to follow up missed appointments.

For more guidance see [NSPCC Neglect](#) and **Section 3.3**.

4.2 Prevention, Early Recognition of Child Maltreatment and Early Intervention

- Identifying and managing parental factors risk has been shown to decrease the risk of child maltreatment and improve parental health.
- Discovering abuse early creates better opportunities for timely management of both the child and abuser.
- Early intervention can aid recovery and prevent life-long consequences as well as being of long-term economic and societal benefit.

■ Seeing a warning sign does not necessarily mean that a child is being abused but it is important to have an enquiring mind, to take notice and have a closer look at the family and child's environment.

Preventing abuse requires promoting family well-being and resilience and fostering strong, stable relationships between parents and child. Planning positive intervention involves assessing and addressing parental risk factors preferably before a child is conceived and certainly in early pregnancy, while retaining an awareness that most parents in families with risk factors do not maltreat their children, and some parents in families with no identified risk factors do maltreat their children.

No reliable risk assessment tool has as yet been developed for this purpose but identifying and managing adverse parental factors has been shown to decrease the risk of child maltreatment as well as improving parental health.

Prevention

Infants aged less than one year are known to be at the highest risk of maltreatment and are more at risk of being killed at the hands of another person than any other single year age group in England and Wales. On average, in England and Wales, one baby is killed every 20 days (From: England and Wales: *Office for National Statistics (2013) Focus on: violent crime and sexual offences, 2011/12. [Newport]: Office for National Statistics (ONS)*). 80% of these infants were killed by a parent.

GPs must be especially alert in the ante-natal period to parental risk factors such as domestic abuse, depression and substance abuse and to be vigilant in the post-natal period for signs of parental stress, post-natal depression or other mental illness.

The [six to eight week developmental check](#) is an extremely important opportunity to assess the parent-child relationship and how well parents are managing the transition to new parenthood, see also [NICE CG37](#).

Alerting factors to infant abuse may be:

- Inconsistent history.
- Late presentation of injury.
- Injury not consistent with history or age/stage of child.
- Unexplained injuries in non-mobile children particularly (but applies to all children).
- Presence of other injuries – full examination of infant always indicated.
- Patterns of repeat injuries.

Children who are **physically** or **mentally disabled** or have a **long-term** or **chronic condition** are also at increased risk of abuse and GPs must be alert to such children presenting with failure to thrive, which may be due to maltreatment rather than the underlying condition, or unexplained behaviour change or injuries.

Older children and teenagers 11–17 are a group at increasing risk of abuse and neglect. Young people may be exposed to the stresses of adolescence as well as [bullying](#), [gang activity](#), [cyberabuse](#) and other forms of peer abuse, and various forms of exploitation by adults including [sexual exploitation](#) and [radicalisation](#).

Teenagers who have suffered abuse and/or neglect as infants and children may be especially vulnerable. Risk factors identified in teenage maltreatment include:

- Parental substance abuse and maltreatment history.

- Family problems (including conflict between the young person and parents, family conflict including domestic abuse, inadequate supervision, harsh parenting and poor attachment).
- Breakdown of family structure including reconstituted families.
- Economic hardship.

Adolescents may be perceived as responsible for their misfortunes and provoking their own abuse leading to complaints and symptoms of adolescent maltreatment being ignored by adults. They are often regarded as being able to defend themselves, to be deserving of any punishments they receive and to be able to sustain physical punishment without coming to harm.

Distressed young people may present to General Practice with depression, anxiety, substance abuse, sexually transmitted infections, pregnancy, and behaviour disorders including self-harm, anorexia nervosa, aggression and anti-social behaviour, school problems or school refusal, parental conflict and running away from home. Abused young people may react by developing violent behaviour and be perceived as perpetrators not victims.

It is important to be aware that behaviours described above may be symptoms of maltreatment and requires appropriate assessment including family and environmental factors, intervention and referral in collaboration with other involved agencies. As with all maltreatment, early referral to the right services can aid recovery and help prevent serious life-long mental and physical ill-health.

Identifying vulnerable parents

Identifying vulnerable parents should begin as early in the pregnancy as possible, preferably before conception so that timely support may be offered. Markers of vulnerability may be:

- Extreme youth especially under 16.
- History of being in care.
- History of being abused.
- History of or existing mental health problems.
- Substance abuse.
- Domestic abuse.
- Long-term or chronic physical illness or disability.
- Previous children dying unexpectedly or being taken into care.
- History of offending.
- Homelessness.
- Asylum seekers or uncertain refugee status.
- Learning difficulties.
- Economic and/or employment difficulties.

Such patients may already be known to services and it is helpful to establish communication with any agencies which may already be involved to work collaboratively and avoid duplication. See also NICE CG110 [Pregnancy and complex social factors](#).

Insufficient parenting ability

Some parents may never have had an opportunity to acquire the skills necessary for good parenting or may lack capacity to do so. Very young parents, for example, might have had a baby because they would like someone to love who will love them in return and may have unrealistic expectations about how much attention and care babies need.

Parents who were themselves victims of child maltreatment may be unaware of the basics of child care such as establishing a routine, feeding, bathing, dental hygiene, appropriate clothing etc.

Parents with learning difficulties may be especially challenging to recognise in primary care, as GPs do not routinely receive information about diagnoses made in educational establishments, and their lack of capacity to look after a baby may not be recognised before the birth.

GPs should familiarise themselves and establish links with local parenting support facilities, such as [SureStart](#) Children's Centres in England, [Parenting NI](#) in Northern Ireland, in Scotland [parenting across scotland](#) and [Flying Start](#) Teams in Wales, which offer groups, classes and outreach work. It is important that even if the father is not registered with the Practice efforts should be made to involve the father in any parenting support and other work with the family.

The role of Public Health Nurses such as Health Visitors is invaluable in this respect as in localities where there are resources to offer a universal service to all parents they may be the first health professionals to recognise when a family is in difficulty.

Early intervention

Research has shown that babies' brains develop most rapidly in the first three years of life and that *'Early Intervention to promote social and emotional development can significantly improve mental and physical health, educational attainment and employment opportunities. Early Intervention can also help to prevent criminal behaviour (especially violent behaviour), drug and alcohol misuse and teenage pregnancy'* (Allen 2011 [Early Intervention: The Next Steps](#) HM Govt).

Early intervention programmes have short and long term objectives. Short term gains may include reducing demands for inappropriate unscheduled medical care, child protection services, care places, special educational provision as well as preventable acute hospital admissions for conditions such as non-accidental injury and untreated medical conditions.

Longer term objectives include improved physical and mental health, improved family relationships, educational attainment and employment prospects, reduced offending and reduced contact with justice systems, probation and prison services.

England: provision of Early Intervention and Early Help services under [Section 10](#) of the Children Act 2004 vary between localities and GPs will find it helpful to familiarise themselves with services available in their area and thresholds for referral. Such services may be described under a variety of terms such as 'Early Help', 'pre-CAF' or 'integrated working' and may include the Family Nurse Partnership, Positive Parenting Programmes, Substance Abuse Treatment Programmes, and psychological therapies such as Cognitive Behaviour Therapy. For more information see Chapter 1 of [Working Together to Safeguard Children 2013](#).

Northern Ireland: see [Early Years 0–6 Strategy](#), [Early Years SureStart](#)

Scotland: see [The Early Years Framework](#)

Wales: see [Building a Brighter Future: The Early Years and Childcare Plan](#)

References

- Asmussen, K., (2010) [Key Facts about Child Maltreatment](#) (NSPCC Research Briefing). London: NSPCC
- Center on the Developing Child at Harvard University, (2012) *The Science of Neglect: The Persistent Absence of Responsive Care Disrupts the Developing Brain: Working Paper 12*. www.developingchild.harvard.edu
- Lazenbatt, A., (2010) [The impact of abuse and neglect on the health and mental health of children and young people](#) (NSPCC Research Briefing) London: NSPCC

S5

Parent, carer and family risk

Click box to
go to section

page

5.1	Exposure of children to domestic violence	60
5.2	Parental mental health problems	62
5.3	Parental or Carer substance misuse	63
5.4	Working with missing, non-engaging or hostile families	65
5.5	Multi-Agency Risk Assessment Conferences (MARAC)	66
5.6	Multi-Agency Public Protection Arrangements (MAPPA)	67
5.7	Domestic Homicide Review	68

■ **Key risk factors for child maltreatment and toxic stress are domestic abuse, parental mental health and substance abuse.**

■ **Early trauma, including physical, sexual, and emotional abuse is associated with increased risk of psychopathology in childhood and adulthood, as well as social and health problems** (Gilbert et al., 2009).

■ **GPs may see such patterns in their consultations and need to be alert to possible consequences** (for more information see [Think Child, Think Parent, Think Family](#)).

Table 3 is taken from a [2012 analysis of Serious Case Reviews](#) of children who have died or been harmed as a result of maltreatment (DfE 2012).

Frequency of occurrence of key factors associated with child abuse and neglect within the family

Risk Factor	Percentage with risk factor
N= 139 cases	
Domestic abuse/violence	63%
Parental mental health problems	58%
Substance misuse	42%
<i>Alcohol</i>	27%
<i>Drugs</i>	29%
None of the above	14%

The analysis shows that it is more common for these features to exist in combination than singly. Parental separation and/or multiple partners is often associated with these factors, as is suicide attempts and self harming behaviour which should prompt thorough assessment of the risk to children. Significant neglect was found in 60% of cases.

These factors are covered in **Sections 5.1, 5.2, 5.3**, while **Sections 5.5 and 5.6** cover **MARAC** and **MAPPA**, systems used in the UK to address risk related to domestic abuse and sexual abuse.

Other important factors to consider are:

- Vulnerable unsupported parents, such as very young parents.
- Parents with learning disability.
- Violent offenders in the home.
- Siblings as carers.
- Siblings as abusers.
- Known maltreatment of animals in the home.
- Deprivation and poverty.
- Gambling.

Shemmings and Shemmings (2011) present evidence to show that many of the above characteristics can result in a maltreatment pathway involving: unresolved loss, parental insensitivity, frightening and frightened parental behaviour and disorganized attachment. This pathway is linked to carer risk factors, genetic factors, disconnected parenting and extremely insensitive parenting.

When working with parents and carers in difficulty, GPs need to take account of the following risks:

- The child may become invisible behind the parental problem.
- The voice of child may not be heard for the same reason.
- In General Practice children in need and children being maltreated may present through parental problems.
- Front line staff, including GP's, may give too much credence to the parental/carers version of events.
- GP consultations dealing with domestic abuse, mental health and substance abuse are challenging and may require more time and several appointments.
- Non attendance of children and adults in the context of these risks is a recurring theme associated with maltreatment and neglect.
- Discovery of maltreatment, especially neglect and child sexual abuse are often pieced together like a jigsaw.
- The GP should seek to record key information in these cases and use a systematic approach to monitoring parental and child risks.
- The GP and other practice staff should communicate and share information within the practice and with key professionals outside the practice as required according to need and risk.
- Vulnerable child and family meetings are valuable because they can be used to monitor and review risk at regular intervals (see **Section 10.1**).

It must be noted that no validated risk assessment tool is as yet available for use in General Practice and child maltreatment may occur in families without any known, apparent or recorded risk factors noted by professionals.

Parental Rights and Responsibility

This is explained and defined at [GOV UK](#). The Medical Protection Society also offers a useful [Factsheet](#).

5.1 Exposure of children to domestic violence

In the UK domestic violence is defined as any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality.

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

- Psychological.
- Physical.
- Sexual.
- Financial.
- Emotional.

Domestic violence is a devastating breach of human rights as well as a major public health and clinical problem. The 2011–12 Crime Survey for England and Wales (CSEW) reports lifetime partner abuse prevalence of 31% for women and 18% for men; 7 and 5% respectively had experienced abuse in the previous 12 months. The CSEW also measures non-partner domestic violence (termed ‘family abuse’), reporting a lifetime prevalence of 9 and 7% for women and men, respectively.

The starkest gender difference in prevalence is for sexual assault (lifetime experience: 20% women and 3% men), and women generally experience more severe, repeated abuse from male partners, with more significant injuries and long term health consequences than men. The prevalence in clinical populations, including general practice, is higher than in the general population: 40% of women patients ever experienced physical abuse in an east London study. This is often invisible to GPs; in the same study less than a 1/5th of survivors had any mention of abuse in their medical record.

Impact of domestic violence on children

Exposure to domestic violence during childhood and adolescence damages health across the lifespan. The impact of domestic violence on children does not require witnessing of violent acts. Exposure also includes hearing or seeing the consequence of the abuse and experiencing depleted parenting.

There is a moderate to strong association between children’s exposure to interpersonal violence and internalising symptoms (e.g. anxiety, depression), externalising behaviours (e.g. aggression) and trauma symptoms. Children exposed to domestic violence are 2–4 times more likely than children from non-violent homes to exhibit clinically significant problems. Children’s exposure to domestic violence also damages social development and academic attainment.

The harmful effects of living with domestic violence accumulate over time for children and this is a strong argument for intervention. There is considerable variation in children’s reactions and adaptation. This is partly explained by the presence or absence of other adversities in children’s lives. For example, children exposed to domestic violence are at increased risk of being maltreated directly or neglected, with higher rates of maladjustment amongst children experiencing this ‘double jeopardy’. The overlap with direct maltreatment ranges from 40 to 60% of children exposed to domestic violence, who may also experience a range of other adversities such as poverty, parental mental ill health, substance misuse and antisocial behaviour. The more adversities a child is exposed to the greater the risk of negative outcomes.

Presentations of children’s domestic violence exposure

The most likely route of disclosure will be via the non-abusing parent’s account of domestic violence but this is unlikely to be a spontaneous disclosure, although mothers may be prompted to seek help because of fears about their children’s safety or well-being.

Disclosure is more likely if the GP asks directly about domestic violence, preferably after training and with knowledge of local domestic violence services. Women may be reluctant to disclose because of fear about children being taken away. By the same token, spontaneous disclosure by a child, particularly in the presence of a parent is rare.

GPs benefit from [training](#) about how to approach this issue, focusing on support to the parent experiencing abuse which does not conflict with prioritising the child's safety.

When should a GP suspect that there is domestic violence in a family? Some of the presentations that should bring the question to mind are the same as those that should raise the suspicion of direct child maltreatment. However, anxiety is a key feature and children may be constantly alert. Anxiety or fear related behaviour includes bed wetting or unexplained illness, running away from home, constant worry about possible danger or safety of family members, and aggression to other children and/or parents.

Resources: [RCGP guidance on practice level response to domestic violence](#)

AVA offers detailed guidance on exposure of children and young people to domestic violence: [Action Against Violence and Abuse](#)

Identifying a child or young person's exposure to domestic violence and immediate response to disclosure

A central feature of good practice is creating opportunity and time to speak to the child or young person on their own in a way that is safe for them and the parent who is experiencing domestic violence, seeking that parent's permission to do so.

Other features of good practice for primary care professionals include:

- being realistic and honest about the limits of confidentiality (but promise to keep the child/parent informed of what is happening);
- helping the child or young person to understand that they are not to blame for the domestic violence and that they are not alone;
- letting them know that domestic violence is never acceptable;
- being careful to acknowledge their experiences, help them understand that it is not their responsibility to protect the non-abusive parent, while validating their concern and any action they may have taken to protect that parent.

Children and young people can find it hard to talk for many reasons, such as shame, guilt, torn loyalties, threats as to what will happen if they tell anyone, not wanting to leave home or split up the family, or simply not having the language to express what is going on. If you are the first person a child has disclosed to, you are a very important person for that child. It is not the GP's role to gather evidence, but you will need to find out enough to determine whether a referral to social services is necessary. Your continuing support to the child is essential whatever you decide about referral.

Further response to disclosure

If a child is at risk of harm, the local safeguarding children board procedures should be followed immediately. The decision to refer to children's social services in the absence of direct maltreatment is a difficult judgment in relation to domestic violence exposure and it hinges on the concept of significant harm: 'any impairment of the child's health or development as a result of witnessing the ill-treatment of another person, such as domestic violence'.

This can include emotional and psychological harm, the form of harm most associated with exposure to domestic violence. Some localities have a policy to refer all children when you suspect

domestic violence, although this is impossible to implement as services would quickly become overwhelmed. Not all children require referral. Discussion with your practice's safeguarding lead is essential and – if you are that person – discussion with your local Named Nurse, Named GP or Doctor for safeguarding will be helpful in reaching a decision about referral.

The common assessment framework has a section on domestic violence within the parenting capacity section that can inform the referral decision by identifying children's level of need. Domestic violence advocacy services, which will be able to support the parent experiencing abuse, also have the expertise to assess children's needs and the need for referral. These services also undertake risk assessment for the parent and their children, a task beyond the capacity of most general practices.

Supporting the parent experiencing domestic violence is crucial to protecting children exposed to that violence. Stopping the violence towards a parent is the most effective way of protecting children and reducing adjustment difficulties associated with exposure. In some localities there are child-focussed services (e.g. run by NSPCC or Barnardos) to which you can make a direct referral in tandem with a referral to a domestic violence services.

Information sharing

Domestic violence is a challenge to safe information sharing. It is crucial to minimise the risk that perpetrators of domestic violence do not receive information about what their victim or children have said about the abuse. Risks to the safety of the non-abusive parent and their children through inappropriate sharing of confidential information must be recognized and prevented.

Information about domestic violence sent to the practice from a 3rd party (such as police, multiagency risk assessment conferences, see **Section 5.5**) should be noted in the medical records of children in the family, but not on the front screen in an easily recognizable form. That information should not be entered in the perpetrator's record unless there is assurance that they are already aware of the allegation.

If children's records are requested by the perpetrating parent, these need to be redacted so as not to endanger the children and the non-abusing parent. The same holds for disclosures by parent experiencing domestic violence: that information should be noted in the children's records in a disguised format and *must not* be entered into the perpetrator's medical record. GPs must guard against discussing disclosure of domestic violence with the perpetrator, as this may endanger the survivor. Police notifications of domestic abuse incidents may be coded using a special code for "Police domestic incident report received" V2 = 9NDJ, V3= Xaaqr.

5.2 Parental mental health problems

- All adults have a one in four chance of experiencing a period of mental illness during their lifetime.
- 90% of people with mental health problems across their lifespan are managed in primary care.
- The GP may be the only professional involved with these families and therefore carries additional safeguarding responsibility towards the children.
- The majority of people with mental health problems do not neglect or harm their children but when significant problems are present it is important to *Think child, think parent, think family* (SCIE 2012).

While GPs should consider the mental health of the patient in every consultation, they should be aware of the dangers of medicalising distress but remain alert to risks to children if the patient is a parent or involved with children in a caring or other capacity.

Issues in parental mental health may include:

- The parent/carer being unable to anticipate needs of child or put child's needs first.
- Parental rejection of the child.
- The child becoming involved in parent's delusional/obsessional behaviour.
- The child/ren becoming carers.
- Periods of separation due to hospitalisation especially of a mother.
- Mental health teams unaware of or not acknowledging their patient's parenting role and discharging a parent still too unwell to look after a child.
- Co-morbidities such as domestic abuse, substance misuse and chronic or long term physical conditions.

Risks will be reduced by good general practice care of people with mental health problems. It is important to recognize risk, working together within the Practice and with other agencies especially health visitors, midwives, school nurses, mental health teams and social care when required. Predicting risk is not easy but even if a particular GP consultation for a child, parent or other family member does not cause concern for immediate child protection action it may contribute to a picture which helps to prevent or define the risk of child maltreatment.

Some **risk factors** to consider:

- Parental suicidal or self harming behaviour raise serious concern, requiring urgent assessment of the children's needs.
- Postnatal depression which occurs in about 10% of women, although research evidence is limited.
- Parental separation especially linked to domestic abuse or multiple new partners can expose the children to physical risk and emotional harm.
- A history of maltreatment in childhood, which may be a causal factor in an adult's mental health problem.
- Children of parent/s with learning disability often have high levels of needs. All agencies, including general practice, should work together to address the needs, and referrals to social care may be required (see **3.3a**).
- Maternal filicide: mothers were invariably reported to have severe mental health problems.
- Paternal filicide: usually linked to violent behaviour, domestic violence, separation, contact issues especially with ongoing court proceedings.

When severe depression, mania or psychosis is present the GP's role in safeguarding the child, parent and family is clearer.

5.3 Parental or Carer substance misuse

- The GP may be the only professional involved with these families and therefore carries additional safeguarding responsibility towards the children.
- Substance misuse can cause serious impact on children in the family; it is important to *Think child, think parent, think family*.
- The risks to children may include direct abuse and neglect as well as long-term emotional effects.
- Where other risk factors are also present (parental mental ill health, domestic violence), the relationship between these factors, a parent's substance misuse and cumulative impact on the children must be taken into account.

'People with drug and alcohol problems are often stigmatized by society and professionals. As a GP you are ideally placed to identify people with drug and alcohol problems and you need to be aware of the consequences of these problems' (RCGP Curriculum 2013)

The GP role in identifying and assessing the impact on children of parental or carer substance abuse and referring for essential support is crucial in ensuring that these children are given opportunities to access normal childhood activities and education.

Men who abuse alcohol are most likely to be implicated when physical abuse toward children occurs in a household and outcomes for children are poorer when living with alcohol abusing parents, especially if violent (see [Bottling It Up](#)).

[Hidden Harm](#) and the [National Treatment Agency](#) provide detailed information and guidance. Many localities now have special services for children of substance abusers, with information available at [Action for Children](#) and local authority websites. In Scotland, guidance may be accessed at [Getting Our Priorities Right](#) – Scottish Government Good Practice Guidance for use by all practitioners working with children, young people and families affected by substance use.

When concerns arise regarding children of substance abusers, a child-focused assessment is necessary. To understand the risks this requires a clear picture of the user's drug and/or alcohol consumption, an analysis of the impact of the user's behaviour on the children and an assessment of parenting capacity.

The GP will have to contribute to this along with other professionals involved, working with the user and other family members or significant adults and sharing information appropriate to need. Risk assessments should be a dynamic rather than a static (one-off) process, which are reviewed in the light of emerging evidence. The GPs knowledge and records can contribute to this process.

The NSPCC in reviewing serious cases noted the following associations with parental substance misuse:

- Sudden infant death.
- Accidental ingestion of drugs.
- Accidents.
- Parents deliberately giving drugs to children.
- Neglect including neglect of nutrition and health.

Increased risks may be caused by:

- New partner.
- Non family visitors in the home.
- Missed appointments with any agency.
- Non-compliance with treatment programmes.
- Criminal activity.
- Moving home.
- Financial and other stresses including debt.

Engaging and consulting with patients with substance misuse problems in primary care can be challenging, and it is important to be aware of a history of maltreatment in childhood which may be a causal factor in the misuse.

Becoming a parent may be an incentive for a user to seek treatment, and stop abusing substances. For the children, having a parent who is actively trying to stop using substances is a protective factor.

5.4 Working with missing, non-engaging or hostile families

Missing children and families

Children subject to a statutory Child Protection investigation such as Section 47 Enquiry under the Children Act 1989 or on a Child Protection Plan (including unborn children, i.e. pregnant mothers) are usually deemed to be 'missing' if there has been no contact with an involved professional for 10 days, although local authority protocols for dealing with missing children vary slightly between areas.

If a GP or member of the Practice Team becomes aware that the patient has been removed from the Practice List or appointments are being missed, it is necessary to inform the child's or family's social worker immediately usually by telephone but always follow up in writing (see **T9**), and also inform any other health professionals who might be involved with the child and/or family such as the midwife, paediatrician, therapists etc. Practice safeguarding children procedures and protocols (**T2**) should contain guidance on managing missed appointments with a process for ensuring urgent action if the child is within the child protection system or there are particular concerns about a family.

The local authority as a statutory agency has overall responsibility for taking emergency measures to locate the child and/or family usually by involving the police and using protection or recovery orders.

Non-engaging families

In such circumstances, the GP's interest will relate to the child/ren's health and well-being. If it appears that there is non-compliance or lack of co-operation by a parent or carer relating to prophylactic health care, treatment of known conditions, administration of medication or attendance at appointments, GPs must consider if the health concerns have been fully and clearly explained, taking into account issues of language, culture, learning difficulties, disability, expectations etc and that parents or carers fully understand the concerns and the risks of non-compliance.

There is a special issue in the UK where prophylactic immunisation is not mandatory and parents have the right to refuse to have their children immunised. This requires careful assessment to determine if parental neglect applies only to refusal to have the child protected against infectious disease or whether such neglect extends to other areas of child care, and if there are any parental risk factors such as domestic abuse, substance misuse or mental health issues which might indicate increased of child maltreatment.

If non-engagement continues, it will be necessary to involve other health professionals such as health visitors or school nurses depending on the child's age, and consider whether a CAF process or social care referral might be beneficial. An assessment of parental capacity to understand the child's needs and to make the necessary changes might be required at which stage social care has to become involved, initially at an Early Help (**Section 3.3a** or Child in Need level **Section 3.3b**) but if it becomes apparent that the child may be at risk of significant harm, a Child Protection referral (**Section 3.3c**) should be made using local procedures.

Case history:

Carly is a 17 year old with moderate learning difficulty. She became pregnant accidentally after a single contact and has not seen the baby's father since. She gave birth to a 2.3 kg baby boy after an uneventful pregnancy, but the baby became unwell shortly after birth and had special investigations which revealed a congenital metabolic condition. On being told the diagnosis Carly immediately left the post-natal ward, taking her baby and failed to respond to attempts to contact her. She also did not attend three urgent out-patient appointments. Eventually she was located by the police and brought back to the hospital. When asked by the paediatrician why she had left, she said she did not want her baby taken away. The paediatrician explained to her very carefully that there was no reason to take away her baby but that her baby was ill and required special feeds. Carly immediately burst into tears and hugged the paediatrician. She said no one had explained it her and she was not aware that she could be harming her baby by giving ordinary feeds. She also said no one had ever been so kind to her before.

Hostile families

GP surgeries all have policies for dealing with issues of staff safety on verbal and physical intimidation, aggression and violence towards staff. These policies should be also followed when working with hostile and/or aggressive families. Fear of aggression and violence inevitably affects how staff react to certain patients and may adversely influence their behaviour, judgement, professional relationship with the family and willingness to intervene. A natural reluctance to engage with such patients must be carefully balanced against consequences for patient safety and increased medico-legal risk.

Where there are children in the family, consideration must be given on the impact of such behaviour on them, especially if there are already safeguarding concerns or they are in the Child Protection system and the Practice has a duty to ensure that the relationship with the parents or carers does not deteriorate to a point where medical care of the child/ren is jeopardised.

In circumstances where removal of parents or carers from the Practice List becomes inevitable, other professionals involved with their children must be informed in a timely manner to ensure that there is continuing availability of medical care and that a responsible adult is available to accompany the children whenever they require health care, with due consideration to issues of parental responsibility, consent and confidentiality. **Removing children from a Practice List without making arrangements for ongoing care is not acceptable.**

Increasing parental/carers aggression could indicate increased risk to the child/ren and requirement for escalation of the child protection process, so it might be helpful at this stage to discuss concerns with the Practice Safeguarding Lead and local safeguarding team and to consider whether a child protection referral is indicated.

See also GMC [Ending your professional relationship with a patient \(2013\)](#) and British Medical Association – General Practitioners Committee (GPC) [Removal of patients from GP lists](#).

5.5 Multi-Agency Risk Assessment Conferences (MARAC)

[Multi-Agency Risk Assessment Conferences](#) (MARACs) are regular local meetings where information about high risk domestic abuse victims (those at risk of murder or serious harm) is shared between local agencies. By bringing all agencies together at a MARAC, and ensuring that whenever possible the voice of the victim is represented by the Independent Domestic Victim Advisors, a risk focused, co-ordinated safety plan can be drawn up to support the victim. There are

currently over 260 MARACs are operating across England, Wales and Northern Ireland managing over 57,000 cases a year. The MARAC model is also followed in Scotland.

GPs may need to refer victims of domestic abuse to MARACs and should familiarise themselves with local and national procedures (see MARAC Toolkit). They should also ensure that their contact details are known to the local MARAC coordinator to facilitate a two-way flow of information about victims and their care plans.

'Striking the Balance' offers Practical Guidance on the application of Caldicott Guardian Information Sharing Principles to Domestic Violence and MARACs.

More information available within MARAC Toolkit, see **Tool Number 17**.

5.6 Multi-Agency Public Protection Arrangements (MAPPA)

The Criminal Justice Act 2003 provides for the establishment of Multi-Agency Public Protection Arrangements (MAPPA) in each of the 42 criminal justice areas in England and Wales. A similar process applies to Scotland and Northern Ireland. These are designed to protect the public, including previous victims of crime, from serious harm by sexual and violent offenders. They require the local criminal justice agencies and other bodies dealing with offenders to work together in partnership in dealing with these offenders. The police, probation and prison services working together are the Responsible Authority (RA). Other agencies which have a duty to co-operate (DTC) include health service providers.

The Multi-Agency Risk Assessment Conference (MARAC see **Section 5.5**), has developed in response to the many victims who have suffered domestic abuse and who are at risk of further abuse. MARAC has links to MAPPA, without being a formal part of it. A key link between children's services departments and MAPPA is in the area of child protection and safeguarding children.

In **Northern Ireland**, multi-agency public protection arrangements are called PPANI and operate in a broadly similar way to those in England.

What the duty to cooperate means for GPs

Many MAPPA cases will involve offenders with a history of mental disorder but some may also suffer from long-term chronic physical conditions. A GP may be asked to do the following:

- Provide health information to contribute to an up-to-date risk assessment and other information to ensure that the offender is managed effectively.
- Provide general advice about their role and the type of services provided (including advice about how services can be accessed, such as opening times, appointment systems, out of hours' services etc).
- Coordinate health promotion and health management activities in a way which complements work of other agencies such as mental health trusts, for example ensuring provision of prescriptions for necessary medication, regular necessary health checks, monitoring compliance with drug therapies and attendance at scheduled appointments for medical care.

GPs may want to refer to the MAPPA Guidance [Data Sharing Code of Practice](#), available within Chapter 9.

Children and young people subject to MAPPA

The age of criminal responsibility in England and Wales is 10 years so any person aged 10 or over, including children and young persons, may be convicted in the courts of any offence. For serious offences, the child or young person may receive a custodial sentence and may be required to notify the police of his or her details under the Sexual Offences Act 2003.

A child or young person who is convicted of a serious sexual or violent offence (as set out in Schedule 15 to the Criminal Justice Act 2003) will be a MAPPA offender. The law also requires his

or her needs as a child to be considered by MAPPA agencies. "Children who are encountered as offenders, or alleged offenders, are entitled to the same safeguards and protection as any other child and due regard should be given to their welfare at all times." (*Working Together 2013*).

MAPPA is therefore expected to take a different approach when managing children and young persons. When identifying the risk of potential harm to others that the child or young person poses, any risks to the child or young person must also be taken into account including attention to their health and well-being as set out in Intercollegiate Guidance '*Healthcare of Children and Young People in Secure Settings*'.

More information on MAPPA including MAPPA in Scotland and Northern Ireland may be found at [Criminal casework – Multi agency public protection arrangements \(MAPPA\)](#).

5.7 Domestic Homicide Review

The purpose of a [Domestic Homicide Review](#) is to prevent domestic violence and homicide by improving service responses for all domestic violence victims and their children through improved intra and inter-agency working.

[Domestic abuse](#) is the main precursor of domestic homicide. According to the [Office for National Statistics](#), some 7% of women and 5% of men were estimated to have experienced domestic abuse in 2011/2012, equivalent to an estimated 1.2 million female and 800,000 male victims. GPs may become aware of these attacks by victims making disclosures or by asking the right questions during the consultation and are expected to have policies and procedures in place to ensure victims are offered appropriate advice and support.

In 2011/12, 367 homicide victims (all causes) were male and 172 were female. Approximately half of the women in the year reviewed were killed by a partner or former partner.

[Domestic Homicide Reviews](#) (DHRs) were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act (2004) and came into force in England and Wales on 13th April 2011. (N.B. This process is currently under consideration in Northern Ireland but not yet implemented, see Tackling Domestic and Sexual Violence and Abuse [Action Plan](#).)

The Review is conducted in a similar way to Serious Case Reviews in that individual Independent Management Reviews are carried out for each involved agency. Relevant records from all involved agencies, including health records, are scrutinised to establish a chronology and chain of events which can then be analysed to understand where and how agencies and services could have worked together better to prevent the tragedy.

GPs will be asked to share information, in the public interest, from medical records of the victim and partner and sometimes those relating to the children and other household members.

Resources and references

[AVA Detailed guidance on exposure of children and young people to domestic violence](#)

[RCGP guidance on practice level response to domestic violence](#)

[NSPCC Family Environment: Drug Using Parents \(FEDUP\)](#)

[RCGP e-learning course for GPs to help patients with substance misuse problems](#)

[RCGP Substance misuse resources](#)

[RCGP Mental Health Tools](#)

[Social Care Institute for Excellence \(2012\) *Think child, think parent, think family*.](#)

S6

Communication with children and families

Click box to
go to section

page

6.1	Facilitating communication with children	70
6.2	How to manage disclosure	74
6.3	Barriers to disclosure and intervention	74
6.4	The role of the GP in managing disclosures of abuse	75
6.5	Working with parents	77

■ Research on the prevalence of abuse suggests that what is detected is only the very tip of the iceberg.

■ Many children are left hidden from view, suffering alone in abusive situations for many years.

■ Studies show that only 30% of mothers to whom disclosures are made take positive action to stop the abuse.

■ Disclosure to professionals is rarely a sudden or one off event. Young people describe it as more like going on a journey, with trust and confidence in the process growing over time.

No one noticed no one heard (Allnock & Miller 2013), recent research from the NSPCC, suggests that contrary to popular belief 80% of abused children attempted to disclose before they were 18 years, however in 90% of cases this was a negative experience. In many cases the disclosure was not 'heard' or acted upon.

In 10% of cases disclosure was a positive experience; these cases contained the following 3 elements – all were believed, action was taken that protected the child from ongoing abuse and they received emotional support.

Children disclosed abuse through their behaviour as well as verbally. Most received help and support from friends, who recognised worrying changes in behaviour; some were met with disbelief and a few were turned on, teased and bullied.

Teachers were found to be the professionals children most often turn to. Those who took action immediately were viewed as helpful and positive. Many children were already in contact with professionals (social workers, doctors and police) and believed they should have been asked more questions to uncover the abuse responsible for their self-harm and depression.

Disclosure was made a lot easier when professionals took notice of their injuries or distress and asked about it. Providing a safe confidential space with time to talk was important.

Positive experiences occurred when the child was involved in planning, kept informed of actions and progress with the investigation and their views and opinion sought at each stage in age appropriate language.

6.1 Facilitating communication with children

Babies and preschool children

Brain growth is most rapid in the first 2 years of life with the majority of neurons already formed pre birth. The quality of the antenatal environment and exposure to maternal diet, stress, drugs and alcohol has a significant long lasting impact. Premature birth, poor intrauterine growth and neonatal complications such as sepsis and substance withdrawal all can be indicative of a poor antenatal environment.

'Toxic stress' ([CDC Harvard University](#)) relates to early adverse experiences sustained over a long period of time which can actually change how a child's brain develops. *"Prolonged exposure to stress hormones can impact the brain and impair functioning in a number of ways". For example:*

- Toxic stress can impair the linking of brain circuits leading to the development of a smaller brain.
- Children can develop a low threshold to stressful events, becoming over-reactive to adverse experiences throughout their lives.
- High levels of stress hormones can suppress the body's immune response, leading to chronic and long-term conditions such as hypertension, diabetes mellitus and cardio-vascular disease.
- Sustained high levels of certain stress hormones can damage areas of the brain essential for learning and memory.

The quality of the relationship between babies with their primary care giver in the early years is a key indicator as to subsequent development of the nervous and hormonal system through attachment. Severe early abuse and neglect stunts brain and body growth and development.

Babies learn to regulate their emotions through the attachment relationship ([Mary Ainsworth 1973](#)). The early attachment relationship has an impact on future cognitive development, but even more significantly on the development of impulse control and trust. It influences all future relationships forming the basis of social, emotional and behavioural development.

The stress response stabilises in the first 6 months. Frightened or frightening care giving in the early weeks and months of life can result in disorganised attachment (D. and [Y. Shemming](#)). Up to 80% of abused or neglected babies develop a disorganised attachment. The foundation for understanding and expression of language develops in the first 2 years. With an average child from a professional family being exposed to 45 million words compared to 13 million in a average family on welfare, there is a 30 million word gap by age 3 years ([The Early Catastrophe](#) Betty Hart & Todd Risley). Social behavioural observations at 3 years may be predictive of antisocial behaviour, substance misuse and mental health problems in adulthood ([Dunedin Study](#)).

The 6–8 week check

In the UK this is the only routine developmental check carried out by a doctor and provides a unique opportunity to assess not just the infant's physical development but also the quality of the parent-child interaction and parental well-being.

- Was the baby wanted and accepted?
- Is the baby thriving and growing?
- Is the baby abnormally tense / distressed or floppy / withdrawn?

- How irritable and/or 'colicky' is this baby and how is the parent coping?
- How do the parents interact with the baby, hold and talk to the baby, dress and undress it, calm the baby down?
- Are they confident and relaxed, tense and anxious, tired or ill?
- What level of support do they have?

It is useful to ask the parent what the baby might be thinking. This can give clues as to their ability to 'mentalise' and how they keep their baby in mind in relation to their own feelings about the baby. Incongruities can indicate the presence of unresolved traumatic parental loss. Experiences of past insensitive care received as children can lie behind frightened and frightening parenting and the development of a disorganised unhealthy attachment pattern, see <http://www.youtube.com/watch?v=zovtRq4e2E8> (Dr Dan Siegel)

Other scheduled and unscheduled appointments

Babies and pre-school children communicate largely in a non-verbal manner. We can notice how they are dressed and presented. Does the skin and hair have a healthy glow? How does the baby interact and respond when spoken to and examined? Do they turn readily to the parent for comfort and reassurance?

The GP surgery is often the site where childhood immunisations are given. The baby relies on the confidence of the adults in the room to contain their emotions after this uncomfortable procedure and how quickly they produce an atmosphere of calm to resolve distress.

Is this family able to negotiate the appointment system and attend in an appropriate timely manner? Is there an overuse of walk in or A&E facilities? Are scheduled appointments kept or forgotten? Is medication used appropriately? In this way parents communicate their own ability for impulse control and executive functioning.

As the child becomes older The 'Still Face Experiment' can be observed & documented to record how well the baby & parent are interacting socially together. (Dr. Edward Tronick <http://www.youtube.com/watch?v=apzXGEbZht0>)

Elements of *The Strange Situation Experiment* devised by Mary Ainsworth can also be observed in the GP surgery with a child between 9–18 months if the familiar adult leaves the room and is then reunited with the child. Warning signs are finding the child is more at ease with a stranger (e.g. the GP) and showing signs of being reluctant to leave the consulting room. Another warning sign is if a child approaches a caregiver showing signs of fear and wariness as they do so. <http://www.youtube.com/watch?v=s608077NtNI>

Concerns about the quality of parenting in this age group can be discussed and collated with the health visitor or wider practice team. Where possible, consent to do so should be obtained from the parent, unless doing so is thought to bring or increase risk to the child.

If concerned, the child's development can be assessed to see if s/he is reaching expected milestones and receiving adequate stimulation. If language and behaviour has too great adult sexual content this can be another marker of exposure to abuse.

The Primary School Child

By this age the child is becoming more able to communicate verbally, this can be facilitated through drawing and play. The child is often less self-conscious and more at ease communicating indirectly, being asked how a friend/toy might act or think rather than being questioned directly about their own feelings/sensations. Drawing the household can be far more informative than asking a child directly who they live with.

It is important to use developmentally appropriate language and check understanding

At quite a young age children can be introduced to the concept of consent and helped to feel in control of some aspects of the consultation and examination, therefore less likely to be frightened by it. They are often the expert in their own experience; it is important to explore their views of the situation and fears about disclosure.

It is important to respect a child's right to confidentiality, although it is usually helpful to encourage them to involve their parents in their problems unless it is felt unsafe to do so.

Questions should be asked in a manner that puts the child at their ease and builds rapport over time. Do they have an adult who they trust and confide in? What makes them happy? Is there anything worrying them or making them sad or unhappy? If they think of something make it clear that a doctor is someone they can visit to talk to in confidence.

The primary school child will often communicate their distress with their environment through their behaviour; witnessing any of the behaviours listed below could indicate a need for a more in depth assessment and/or discussion with the school.

When there are concerns about a child's behaviour it is important to try to interview the child alone if possible, in order to establish what is really troubling the child; most parents are usually willing for this to happen.

Some members of the practice team maybe more at ease than others talking to children. Further consultations can be arranged either with the same doctor in order to build up a rapport or with someone with more experienced and confident in dealing with children.

Note that self-harm at this age can take the form of head banging, shutting fingers in doors, running in front of cars and other risk taking behaviours.

Ask:

- What is a typical day in the life of this child like?
- What are their eating and sleeping patterns? Do they suffer from nightmares, flashbacks or sleepwalking?
- What is the level of self-care; washing, dressing ability, dental and body hygiene?
- Is there a history of wetting, soiling or smearing?
- Are they enjoying school? Do they get invited to other children's houses or parties?
- Do they seem unduly isolated at home or in the playground?
- How much time do they spend in a virtual world absorbed in TV or video games?
- Do they appear unduly anxious, jumpy on edge? Or frozen, shut down, watchful and wary?
- Is this child unusually independent or very dependent on adults for their age?
- Are they overly shy or fearful or overly friendly and attention seeking with strange adults?
- Are they overly compliant or defiant? Do they accept boundaries?
- Is this child overly controlled or acts impulsively without thinking?
- Are they restless, hyperactive or less active than usual?
- How do they respond when hurt or distressed? How do they express their feelings? Are they able to verbalise how they feel?
- Is this child able to get on well and play happily with their peers? Are they bossy or easily led? Are they a bully or a victim?
- Does this child have any unusual routines or obsessions?
- Do they display concerning behaviour through play or in trying to meet everyday needs; such as searching in bins for food or theft of other children's belongings etc?
- Is this child safe to leave unsupervised with other children?
- Are they destructive to other people's property or their own?

- Does the child ever go into a dazed or trance like state? Teachers can report excessive daydreaming.
- Does the child ever demonstrate a marked variation in their level of skills, or regressive behaviour, display sexualised behaviour, conduct disorder, ADHD/ hyperactivity, withdrawal and lack of interest, signs of autism/Asperger's syndrome?

Adolescents

In the research paper *No one noticed no one heard, a study of disclosure of abuse*, young people said they wanted someone to notice that something was wrong; they wanted to be asked direct questions; they wanted professionals to investigate sensitively but thoroughly; and they wanted to be kept informed about what was happening.

It is important to advertise the Practice confidentiality policy on posters in the waiting room and website to reassure young people that what they say in a consultation will remain confidential; the consultation room is a safe space, where any information will be shared in a planned way.

Receptionists and practice staff provide the first impression as to whether the practice is a safe friendly caring place. All staff should be aware that doctors are happy to see young people alone and facilitate them negotiating the appointments system. The Practice should consider adopting 'You're welcome' criteria for young people friendly services.

The waiting room should have facilities, such as Wi-Fi, leaflets, posters and information relevant to children and young people as well as adults, helping all to feel welcome.

Abuse survivors are often very hypersensitive to body language cues and will be assessing whether you have the emotional capacity to handle the situation. They are more likely to disclose if you are sensitive, compassionate, interested and able to remain calm and not unduly alarmed by their information. Ask questions directly and confidently, as if you deal with this situation routinely. It is important not to feel rushed; the 10-minute consultation is limited. If abuse is suspected then make arrangements to see the young person again to explore your concerns further.

Know your local services, referral pathways and what support they can offer.

By this age group mental health problems start to emerge. These are far more common in looked after children or in those with abusive relationships. Relationships need to be explored and young people risk assessed for abuse when the following behaviour patterns are seen:

- Anorexia, bulimia & obesity.
- Anxiety & depression.
- Conduct disorders, antisocial behaviour and criminality.
- Risk taking behaviour.
- Poor self esteem.
- Easily distracted / can't concentrate.
- Loss of interest, Withdrawn, spending excessive time on the Internet.
- Body modification.
- Self harm & suicidal behaviour.
- Substance misuse.
- Sexual promiscuity/phobia.
- Obsessive behaviour.
- Excessive washing / poor hygiene.
- Wetting & soiling.
- Medically unexplained symptoms.
- Back & joint pain.
- Headaches.

- Abdominal, pelvic or testicular pain.
- Recurrent STIs.
- Numb, disorientated, amnesic.
- Running away or going missing.
- Hearing voices.

Doctors need to ask what is going on in these adolescent's lives to result in such types of behaviours.

6.2 How to manage disclosure

Abuse has usually been going on for some considerable time before disclosure. When suspected it is usually worth taking time to talk to the child and gather as much information as possible, seek advice from your safeguarding lead or a designated or named professional and then plan with the child and non-abusing parent(if there is one) what to do next.

Find out which adults the child trusts and who in their family or among friends is able to offer ongoing support. If the abuse meets local thresholds then refer to social services; if it does not it is important to know where the child can access ongoing therapy, and parents or carers can obtain help and support to meet the child's needs.

Other children in the family should always be considered for assessment when abuse of one child is uncovered.

'This research (No one noticed no one heard) has highlighted the need for greater awareness about the signs of abuse, that children do disclose but we don't hear those disclosures. The research has emphasised the need for professionals to ask young people about abuse in a direct and developmentally appropriate manner, while ensuring they are safely able to disclose. Children and young people need to be provided with better knowledge about boundaries, their rights to protection and safety, and healthy relationships, and information about where and how to seek help. The research has also highlighted the important role of other adults in noticing the signs of abuse and hearing disclosures in all of their forms.'

6.3 Barriers to disclosure and intervention

Negative experiences recounted in the [research](#) included numerous missed opportunities by professionals to detect and act, lack of emotional support, lack of protection from on-going abuse, including being made to meet with professionals, the perpetrator and or the parent complicit in the abuse, which led to them recanting their disclosure and allowing abuse to continue.

Lack of trust in adults in authority, fear of police, of being taken to the doctor, psychiatrists and psychologists reinforced the child's belief that there was something wrong with them, rather than with what is happening to them.

Many children stated they had no one to turn to.

These children live in families with parents suffering from substance misuse and with parents caught up in abusive relationships such as domestic violence themselves, so do not recognise that what they are experiencing is abusive. Some have little experience of supportive healthy relationships. Some are victims of a number of perpetrators.

The younger the age that abuse starts the harder it is for children to recognise it as abuse and disclose. This applies in particular if there is abuse within the family or in intimate relationships when it is harder for the child to recognise it as abuse especially when it is these adults on whom the child depends to meet their everyday needs.

Some lack the language or ability to verbally express what has happened. This applies especially to disabled children and those with learning difficulty.

Some are anxious about the consequences of disclosure because of threats and intimidation by perpetrators. Some feel ashamed, embarrassed and are afraid of being accused of lying.

It is now recognised that children develop the ability to dissociate and fragment away from events if they become neurologically overwhelmed during abuse episodes. When this occurs, the child is detached from the reality of the abuse. It feels like the abuse happened to someone else or not at all i.e. in posttraumatic amnesia. They then lose the ability to process this experience into a narrative memory with a sense of past, present and future; instead the memory is implicit in nature and can result in posttraumatic symptoms such as flashbacks, body memories or powerful relived emotions. These symptoms can be triggered by talking about abusive events leading to a phobia of disclosure itself.

The disclosure journey to recovery, processing memories and symptoms of abuse is not easy and requires an extensive network of open ended, consistent support, able to contain the emotions released. In many areas therapy is time restricted, which may limit the child's ability to fully recover.

6.4 The role of the GP in managing disclosures of abuse

The GP consultation

"You should make it clear that you are available to see children and young people on their own if that is what they want. You should avoid giving the impression (whether directly, through reception staff or in any other way) that they cannot access services without a parent. You should think carefully about the effect the presence of a chaperone can have. Their presence can deter young people from being frank and from asking for help." (GMC 0-18)

Strengths

The general practitioner is in a unique position amongst health care medical professionals in possessing generalist skills. Our records span the lifetime of the patient and frequently that of family members. Ideally they contain some information regarding every physical, mental health and social care contact that occurs throughout the health care system.

The doctor's consulting room is one of society's few spaces where patients understand it is safe to confide innermost fears to a trusted professional, who will respect their confidentiality unless there is an overriding need to share that information with others in order to ensure patient safety. GPs are still largely trusted by patients to be acting in their best interests and are therefore more likely than other professionals to receive confidential information.

We are sometimes asked into patients' homes in times of crises and therefore have a chance to see conditions that children live and sleep in at testing as well as prearranged times. We can observe parenting skills in difficult circumstances. The surgery represents a relatively strange environment for the child. Children are often ill and distressed when they visit us. They may have been kept waiting or have to endure unpleasant procedures such as immunisations.

We frequently see other members of a child's household and know about their physical and mental health problems and life stresses. We have the opportunity to consider what significance and implications this has on the lives of children living with adults who have difficulty coping. Acting proactively in seeking support for families is more effective than waiting for a crisis to develop.

Difficulties

Training emphasises trust of parents' accounts, the parent usually knows his or her child better than anybody. However, this is not always the case. The GP also needs to assess whether parents have the capacity to keep their child, or indeed anyone else, in mind. A more investigatory professional curiosity is useful to assess whether the history matches the presentation. The doctor needs to take heed of any uncomfortable feelings he may have about the parent child interaction, or young person's behaviour and learn to interpret what that might signify.

Our training is a largely 'illness' based. We are trained from early on in our career to make a 'diagnosis' and treat it. There is less emphasis in recognising social and emotional causes of illness and distress, which are harder to know how to manage. In general practice we have to learn to live with uncertainty and how to manage those situations in a safe enough way, acknowledging that this involves a certain element of risk.

Sometimes it feels safer just to 'medicalise' the problem i.e.: diagnosing a 'conduct disorder' rather than asking why the child appears so sad and angry.

Thresholds for social care are often high, leaving us uncertain how to proceed when a need is revealed.

The 10-minute consultation is not long enough in itself to allow for disclosure and onward planning. Fortunately disclosure is rarely a one off event, but something that happens over time, starting with a trusting doctor-patient relationship.

In these circumstances we need to work with non-medical colleagues, whose professional culture, language and ways of working are different and unfamiliar. The GP can feel a loss of control and concern about how multiagency involvement will benefit and improve the child's situation.

Multiple professions and agencies work to different commissioned priorities and targets, and deploy different theoretical models and practices to the same families/young people.

Tensions can arise between professionals when dealing with these complex cases. It is important to anticipate difficulties and avoid voicing disappointment, irritation and sniping at other professionals involved, thereby mimicking the 'parents at war' that so many children and young people experience with adults involved in their care.

Families and children can evoke additional effort and care from new workers by criticising earlier workers/agencies, so as professionals we may be subject to biased negative feedback about each other. It is important to be aware of such manoeuvres and avoid attempts to play professionals off against each other while keeping the child's interests paramount.

6.5 Working with parents

- Most parents when faced with pregnancy, birth and a new baby are apprehensive and keen to do their best.
- While very few parents wilfully set out to harm their children, behaviour towards others is largely rooted in their own past experience and relationships.
- Modern society and fragmentation of family life has resulted in providing fewer opportunities to handle babies before having your own.

When looking after expectant parents, it is helpful to consider the following during the consultation as parents' ability to act in the best interests of their child can be observed even pre-conception.

- Has the pregnancy and/or baby been planned for?
- Are finances adequate?
- How good is parental self-care?
- During the antenatal period was the mother able to stop smoking and using alcohol and drugs, eat adequately and achieve a good balance between activity and rest? And what about the father's lifestyle?
- What experience and feelings do the parents have towards children and young people?
- Are expectations developmentally appropriate?

When the baby arrives powerful experiences of one's own childhood are evoked. If this was traumatic or neglectful then parenting can reawaken unresolved powerful emotions impeding that parent's ability to enjoy and bond with their child.

If a risk of maltreatment is suspected it is worth exploring parent's own experience of being parented and whether supportive relationships exist.

- What was school life like?
- Were childhood experiences pleasant or difficult?
- How did the parent cope with difficult early childhood experiences?
- Are the parents able to keep the baby in mind or are they too busy concentrating on their own survival needs?
- Is parenting ability being impaired by alcohol, learning disability or dissociation.
- How do they regulate their own emotions?

If the doctor is alarmed and frightened by aggressive domineering behaviour or finds it difficult to engage with a withdrawn parent, what is the child experiencing?

The impact of frightened or frightening parenting on the child

The child develops a sense of trust, identity and mastery of the world around them through receiving responsive, good enough parenting. When a young child seeks attachment and acceptance from its caregiver which is unavailable the child is unable to find resolution following frightening situations.

Children and adults brought up in frightening environments where caregivers are unpredictable and inconsistent develop heightened awareness of the slightest hint of danger in others. Here acceptance and survival during early childhood can depend on being able to react instantaneously to parental cues.

During adolescence this ability to read environmental cues is heightened further at least 2 years ahead of cortical regulatory mechanisms. The adolescent vents this emotion towards their main caregiver, who in turn needs the ability to stay calm and cope with the situation. If a caregiver is unable to cope and regulate the adolescent's emotions, behaviours are externalised or internalised or both.

Peter Fonagy and others have recognised the importance of 'mentalisation', which is the imaginative ability to try to make sense of oneself and others' behaviour through our beliefs, fears, desires and hopes. It recognises that this is difficult and that there are various ways to interpret the same behaviour in others. It develops throughout childhood.

If during childhood a nurturing attuned adult is not around to help the child 'mentalise' and reflect back their experiences, dissociation is more likely to occur. The child who does not have sufficient experience of being soothed and understood fails to develop the ability to self-soothe.

Dissociation describes the range of behaviours by which we can distance or detach ourselves from what is actually happening around us. It is the mechanism by which we cope with situations that are overwhelming to the nervous system, which can be manifested for example as post traumatic amnesia following severe physical injury.

Dissociation helps individuals survive that moment, however prevents resolution, processing and making sense of the situation. Ideally mentalisation and processing can occur later with the help of empathic others who help make sense of the situation.

When this does not happen, posttraumatic stress symptoms and other mental health problems can develop.

Families in difficulty

Parents are the experts in their own experience and have usually spent far more time considering how to cope and manage the situation in which they find themselves than we have. This is often a good starting place when considering how our systems can empower parents to help themselves to parent better.

If as a GP your past experience tells you that relationships are inherently unsafe then trying to establish a therapeutic relationship with the family can feel threatening and trigger survival responses of fight, flight, freeze and submit. It is useful to recognise and explore this reaction, if possible, when it occurs.

When considering how best to help these families, find out what local provision there is in your area. Interventions are far more effective when problems are detected early before a crisis has occurred. Strengths based approaches are usually more successful than those focused on problem behaviour, although it is important to establish consistent boundaries across agencies involved as to what is acceptable parenting behaviour and what is not.

Often these families have many agencies involved in their care. Social services, nursing services, housing, police, probation, psychiatrists, psychologists, parenting services, drug and alcohol services, paediatricians and voluntary sectors as well as the GP. All these agencies have different cultures, languages and interventions and find it difficult to work in a co-ordinated way.

Families can evoke extra effort from new workers by emphasising the inadequacies of others who have tried to help, so subjecting professionals to negative bias about each other's ways of working.

When agencies fail to appreciate each other's ways of working sufficiently, families can be caught in the middle, left to make sense of different approaches, and frequently end up playing agencies off against each other.

Effective therapeutic interventions are increasingly based on improving [mentalisation](#) and reflective ability to try to calm emotions for all concerned.

The important question is: **can the parents improve sufficiently to make necessary progress within the time frame for this child?**

Reference

Fonagy, P., (2001) *Attachment Theory and Psychoanalysis* New York: Other Press, 2001.

S7

Looked After Children (LAC)

Click box to go to section

page

7.1	Improving the Health of Looked After Children and Young People Leaving Care	80
7.2	Private Fostering	82

- GPs play a vital role in improving health, well-being and life course for this group of children.
- About 90,000 children are looked after in the UK at any given time; health services in conjunction with local authorities hold a 'corporate parenting responsibility' for these children.
- Approximately 2/3 of these children have been taken into care because of abuse and/or neglect.
- Having a single parent is the greatest risk factor for placement in care.
- A disproportionate number of looked-after children and young people are from black and minority ethnic backgrounds, or have physical or learning disabilities.

The term 'looked after children and young people' usually means those looked after by the state, under applicable national legislation which differs between England, Northern Ireland, Scotland and Wales. However the term also includes those who subject to a care order or temporarily looked after for short breaks or respite care and can also used to describe 'accommodated' children and young people who are looked after on a voluntary basis at the request of, or by agreement with, their parents.

NICE has published [Quality Standards QS31](#) which defines best practice for health and wellbeing and describes areas for quality improvement in care of looked-after children and young people from birth to 18 years and care leavers (including young people planning to leave care or under leaving care provisions).

7.1 Improving the health of Looked After Children and Young People Leaving Care

- In 2013 there were 92,000 Looked After Children in the UK. They are more likely than their peers to experience difficulties including speech and language problems, bedwetting, co-ordination difficulties and eye or sight problems.
- About half of all looked after children have problems relating to emotional health or behaviour ([Mental Health of Looked After Children 2000](#)).
- Almost half of young women leaving care became pregnant within 18 to 24 months.
- Care leavers are at increased risk of substance misuse, mental health problems and offending with 23% of the adult prison population having been in care.

- Over 40% have other health problems such as asthma and allergy.
- About a quarter of young people leaving care have some sort of disability.

[Statutory Guidance](#) states that every child who enters care should have a holistic health assessment within 28 days of entering care. The initial health assessment should ideally be conducted by a registered medical practitioner and should lead to the production of a comprehensive health care plan. A review health assessment should take place at six-monthly intervals for children under five, and annually for children over five.

In some areas the initial health assessment is carried out by General Practitioners who are expected to have Level 3 skills and competences in the care of vulnerable children as laid down in [Looked after children: Knowledge, skills and competences of health care staff \(INTERCOLLEGIATE ROLE FRAMEWORK 2012\)](#). Health professionals should carry out the assessment in consideration of physical health, sexual, emotional and mental health well-being and health promotion. GPs doing this work should have consistent access to appropriate training, educational opportunities, and peer support, as well as regular contact and communication with the Looked After Children Team in their locality.

Health care plans

GPs not directly involved with health assessments still need to be aware of the special vulnerabilities and health needs of any looked after children and care leavers who may be registered at their Practice and should ensure medical records are obtained, summarised and coded as soon as the child registers, care plans are fully documented and recommended actions such as specialist referrals happen and are regularly reviewed.

On the basis of the health assessment, a child is given a health care plan integrated into their overall care plan. Health care plans may cover:

- Administration of missing immunisations.
- Assessment and management of conditions newly diagnosed during the assessment process.
- Treatments for known conditions including congenital abnormalities, maternal factors such as drug and alcohol usage in pregnancy which could have on-going effects on development and behaviour, prescribed medication, review and follow-up arrangements.
- Referrals made to specialist services (such as secondary care, CAMHS, child development centres and community services, such as speech therapy) with arrangements to monitor whether appointments are kept.
- arrangements for health promotion, lifestyle advice and dental care including by whom.
- Provision of any aids and adaptations required by disabled children.

Care plans must include contact details of other professionals involved with the child such as members of the Looked After Children Team and Social Worker. Progress and effectiveness of care plans should be monitored at regular intervals and could take place within the context of a Vulnerable Child and Family Meeting, to which professionals involved with LACs are invited.

Regular monitoring allows early recognition of difficulties, of non-compliance or ineffectiveness of treatments, and early intervention with specialist referral where indicated to prevent or mitigate the consequences. Disabled children in the care system may be especially disadvantaged by repeated relocation and it is the responsibility of the GP to ensure they are not lost to follow-up by therapies and other specialist services.

Children under 5 should have review health assessments every 6 months while children 5–18 have annual reviews. This is an opportunity to assess the child's physical and mental health status, review the health care plan and provide health promotion advice, information and counselling. Adolescents will need advice on lifestyle choices, drugs, alcohol, and sexual health and should be offered Chlamydia screening.

Research studies by the psychologist [John Bowlby](#) and others has demonstrated that the quality of the relationship formed by children with their early caregivers has enormous impact which influences patterns of behaviour, emotions and expectations for the rest of the child's life and future relationships. Disruption of early parenting for any reason, for example maternal physical or mental illness, addiction or experience of domestic abuse may all affect the mother's ability to create an environment in which her child forms a secure attachment. This leaves many looked-after children with '[attachment disorder](#)' and already vulnerable, in need of extra support and susceptible to mental health problems by the time they enter local authority care.

The [Care Leavers Strategy](#) sets out responsibilities of health services, among other agencies, for their ongoing care including transition to adulthood. The health and well-being of care leavers has generally been found to be poorer than that of young people who have never been in care, and to deteriorate in the year following leaving care, with higher levels of teenage pregnancy, drug and alcohol abuse and mental as well as physical health problems. Care leavers who become pregnant have generally poorer outcomes with three times the expected incidence of post-natal depression, 25% of their babies of low birth weight and perinatal mortality 60% higher than the national average. These young people may have high geographical mobility due to being moved between foster placements, children's homes and schools, and may have difficulty being accepted for GP registration or remaining registered with a GP, and with management and follow-up of long-term or chronic conditions. Studies have also shown high levels of unemployment, homelessness and encounters with the criminal justice system.

[NICE Guidance PH28](#) emphasises the importance of involving children and young people in decisions about their health as soon as they are mature enough, ensuring they are fully informed about their health needs and learn how to navigate their way through the health care system. New legislation [Children and Families Act 2014](#) should provide more support and protection to vulnerable children. **The role of the GP is to ensure care leavers have timely access to universal and specialist health services, appropriate to their physical and mental health needs.**

Case history

In December 2013 a Serious Case Review was carried out in England following serious and prolonged sexual exploitation of adolescent girls in the care of a local authority, at the hands of a number of men who subsequently received criminal convictions.

Issues identified include: frequent incidences of young people missing from home; recurrent attendances at A&E; professionals including GPs aware of the girls' high risk behaviour but seemingly unresponsive to their vulnerability. See **Section 8.1** and **Tools 18** and **19**.

7.2 Private Fostering

Private fostering is an arrangement whereby a child under the age of 16 (under 18 if disabled) is cared for by someone who is not their parent or a 'close relative' for 28 days or more. Close relatives are defined as step-parents, grandparents, brothers, sisters, uncles or aunts (whether of full blood, half blood or marriage).

Private fostering arrangements are legally regulated, in England under [the Children \(Private Arrangements for Fostering\) Regulations 2005](#), with similar regulations in the other jurisdictions.

GPs may discover such arrangements incidentally when new patients register, or by disclosure from the foster parent and are obliged to ensure the local authority is aware of the arrangement.

The local authority has a duty to check on the suitability of the private foster carer and a social worker should visit the child regularly to ensure that the child is being well looked after. A local authority may remove a child from a private foster carer at any time if they believe that the child is suffering, or is at risk of suffering significant harm.

In private fostering, the child's parent or person holding parental responsibility retains overall responsibility, so while the GP has to ensure that while the child receives necessary health care, examinations and procedures should be carried out with informed consent of the child, if judged to have capacity, as well as the person holding parental responsibility. This may be difficult if the private fosterer has no documentation conferring parental responsibility, the parent is far away and the child does not have capacity to give consent.

Signs that a child might be privately fostered

- A patient who has attended the surgery with a new child or series of different children of differing ages.
- A child previously unknown to you seen on a home visit.
- The carer is vague about the child's medical history, routines or needs.
- The child mentions that they are no longer living at home.
- It is unclear with whom the child is living and what the relationship of the carer is to the child.
- The child is from overseas but the purpose of the visit is unclear.

If a GP has concerns about the child's health, health care requests made by the foster carer, consent and confidentiality or is worried the child might be an unaccompanied asylum seeker or have been trafficked, it is advisable to seek advice from the local safeguarding children team or the local authority department with responsibility for private fostering. For more information see also **Section 9.3** and [Somebody Else's Child](#).

Signs that a child might be trafficked

- Malnourished or with an eating disorder.
- Not registered with a GP or attending school.
- Signs of substance misuse.
- Signs of physical or sexual abuse.
- Signs of self-harm or history of overdosing.
- Well-dressed and with a mobile phone but no money.

For more guidance see the [NSPCC Child Trafficking Advice Centre](#), which produces a range of leaflets for professionals. Any professional, including GPs can consult CTAC by ringing 0808 800 5000 or accessing the website. CTAC covers the whole of the UK.

S8

Sexual Violence Against Children and Young People

Click box to
go to section

page

8.1	Child Sexual Exploitation	85
8.2	Female Genital Mutilation (FGM)	89
8.3	Forced Marriage	91

NSPCC studies show that:

- 1 in 20 children have been sexually abused.
- 1 in five of these is male; the majority of assaults occur against female children.
- Over 90% of children, who have experienced sexual abuse, were abused by someone they knew.
- 18,915 sexual crimes against children under 16 were recorded in England and Wales in 2012/13.

Sexual violence is a hidden crime, one of the least reported for many reasons which may include shame, being made to feel responsible for the abuse, fear of the abuser with anxiety about repercussions and effects of disclosure on the family. Many incidents of child sexual abuse may go unreported or disclosed very late in adult life. A history of abuse may be disclosed to a GP at the time of first pregnancy, during routine cervical screening or pelvic examination, during serious or terminal illness or near the time of death.

Children may respond to such abuse by becoming anxious, depressed and withdrawn but may also develop problem behaviours such as sexualised behaviour, aggression and truanting related to their feelings of confusion, frustration, anger, grief and general inadequacy to control their situation.

Longer term issues may be recurring depression and anxiety, persisting poor self-esteem, limited social skills low educational attainment, poor employment skills, difficulty with intimate relationships and inadequate parenting capacity.

The UK Government has set up a [National Group](#) to consider and disseminate learning emerging from reviews of historical child sexual abuse cases and recent child sexual exploitation cases currently within the public domain.

Consent and Confidentiality

These issues are often a cause for concern when dealing with possible child maltreatment especially sexual abuse. Guidance is provided in [GMC 0–18](#) and [GMC Protecting Children and Young People](#) while the NSPCC provides a factsheet on [Gillick competency and Fraser guidelines](#).

8.1 Child Sexual Exploitation

Working Together to Safeguard Children 2013 defines a child as anyone who has not yet reached their 18th birthday. This definition is used throughout this Toolkit and in this section.

- Sexual exploitation of children and young people under 18 involves exploitative situations, contexts and relationships where the young person (or third person/s) receive 'something' (eg, food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of them performing, and/or another or others performing on them, sexual activities.
- Child sexual exploitation can occur through the use of technology without the child's immediate recognition; for example being persuaded to post sexual images on the internet/mobile phones without immediate payment or gain.
- Violence, coercion and intimidation are common.
- Involvement in exploitative relationships is characterised by the child's or young person's limited availability of choice resulting from their social, economic or emotional vulnerability.

From *Safeguarding Children and Young People from Sexual Exploitation (2009)* DCSF

Sexually exploited children are children in need of services under the Children Acts 1989 and 2004. They are also children in need of immediate protection but a common feature of Child Sexual Exploitation (CSE) is that the child or young person does not recognise the coercive nature of the relationship or see themselves as victims of exploitation.

Role of the GP in recognition and management

Children & Adolescents are regular users of primary care, with 11–15 year olds visiting their GPs twice a year and 16–25 year olds up to five times a year (*Key data on Adolescence AYPH*).

GPs are therefore in an ideal position to notice early signs of childhood sexual exploitation when children present in their surgeries, if alert to possible indicators (see also **Section 4, Tools 18 and 19**, for N Ireland guidance see *SBNI Sexual Exploitation*).

Sudden changes in appearance, behaviour, mood, educational attainment, drug and alcohol use, sexual activity and general health and wellbeing may be indicators of involvement in abusive relationships and consideration should be given to carrying out a risk assessment for CSE, see **Tool 19** BASSH Proforma also available at [Spotting the Signs](#).

When considering the possibility of CSE, take account of the **risk factors** as some children have increased vulnerability to sexual exploitation:

- Children in care due to their "distance" both emotional and physical from the parent/guardian/carer, see **Section 7**.
- Children with disability, additional needs, poor social skills, or very low self-esteem may be open to approaches by exploitative adults, peers or older young persons.
- Children involved in the Youth Justice system.
- Children who are neglected and/or unsupervised by their parents or carers or who have been recently bereaved.

Possible presentations to general practice may include:

- Early onset of sexual activity and / or pregnancy.
- Sexually transmitted infections and/or multiple partners.
- Mood swings and changes in behaviour.
- Aggressive outbursts, withdrawal, loss of interest.
- Self-harm.

- Alcohol/substance misuse.
- Medically unexplained symptoms such as chronic pains including headaches, abdominal, joint and back, pelvic and testicular pain.
- Sudden deterioration in control of long-term or chronic conditions such as diabetes, epilepsy, eczema or asthma.
- Hyperactivity, risk taking behaviour and/ or lethargy, lack of energy.
- Unexplained injuries.
- Low self esteem, leading to a change in personal appearance.
- Enuresis and soiling.

Parents and/or carers may express concern about:

- The child or young person repeatedly going missing, particularly overnight.
- Going to lots of 'parties'.
- Coming home with unaccounted gifts, e.g. clothes, money, food, jewellery and drugs, (common one being a mobile phone).
- Having a relationship with an older partner with whom there may be concerns.
- Excessive and secret use of internet and/or mobile (potential grooming?).
- Having several SIM cards, frequent mobile phone top ups.
- Losing contact with family and friends of their own age and associating with an older age group.
- Unrecognised cars arriving at the home, particularly at unusual times.
- Hair or body modification.
- Excessive washing or bathing particularly when returning from 'missing' episodes, or poor hygiene.
- Being unusually secretive (where have they been, who are their friends).

How to proceed

Discuss your concerns with family/carer of child, **but only where appropriate**.

- Talk to the young person alone; however be aware that they may not recognise that they are in an abusive relationship, because of the nature of sexual exploitation.
- Consider parent or carer concerns if child is spending disproportionate amounts of time away from home and/or seems guarded in front of parents or carer.
- As soon as possible, discuss with your Practice Child Safeguarding Lead who might wish to seek further advice from the local Named Safeguarding GP or Child Protection Team.
- Check/understand/apply your organisational and local safeguarding children procedures.

Case History:

Mum is worried about Katie aged 15yrs, she is binge drinking and staying out late at night with friends. Their relationship has deteriorated and Katie is occasionally violent and aggressive towards her younger siblings. She has a new boyfriend aged 18yrs, who buys her gifts including a brand new smart phone. When she attends for sexual health advice Chlamydia screening tested positive.

Discussion points

- A change in Katie's behaviour.
- STI under the age of 16yrs & in receipt of gifts and a new mobile phone since meeting this new boyfriend; consideration should be given to childhood sexual exploitation.

A risk assessment for childhood sexual exploitation should be carried out preferably by talking to Katie alone ensuring that her mobile device is switched off during the interview to stop the conversation being recorded. If the risk assessment or professional judgement suggests that Katie is at risk of sexual exploitation a referral to Social Service should be made preferably with her consent. Should she refuse consent her fears about information sharing should be explored and advice sought from a designated or named professional on how to proceed.

Multi-Agency response to the sexual exploitation of children

A Multi-agency network or planning meeting/discussion should take place for all children considered at risk of sexual exploitation. Child Protection Procedures should always be followed as appropriate to findings in relation to the risk assessment. Some areas are developing MASE (Multiagency Sexual Exploitation Panel) Panels led by Children's Social care and the police. Guidance for professionals working across the 4 nations of the UK may be found at [NSPCC Inform](#).

Principles underpinning MASE Panels include:

Sexually exploited children should be treated as victims of abuse, not as offenders.

Authorities have previously referred to child victims as 'promiscuous' or 'prostitutes'.

- Children do not make informed choices to enter or remain in sexual exploitation, but do so from coercion, enticement, manipulation or desperation.
- Children who are, or at risk of, being sexually exploited will have varying levels of needs. They may have multiple vulnerabilities and therefore an appropriate multiagency response and good coordination is essential.
- Law enforcement must direct resources against the coercers and sex abusers, who are often adults, but could also be the child's peers while recognising that these peers may also be victims themselves.

Recognised models of Child Sexual Exploitation:

Model 1

Inappropriate relationships:

Usually involves just one abuser who has inappropriate power – physical, emotional or financial – or control over a young person. The young person may believe they have a genuine friendship or loving relationship with their abuser

Model 2

Boyfriend:

Abuser grooms victim by striking up a normal relationship with them, giving them gifts and meeting in cafés or shopping centres. A seemingly consensual sexual relationship develops but later turns abusive. Victims are required to attend parties and sleep with multiple men and threatened with violence if they try to seek help.

Model 3

Organised exploitation and trafficking:

Victims are trafficked through criminal networks – often between towns and cities – and forced or coerced into sex with multiple men. They may also be used to recruit new victims. This serious organized activity can involve the buying and selling of young people.

The [NSPCC Child Trafficking Advice Centre](#) produces a range of leaflets for professionals. Any professional, including GPs can consult CTAC by ringing 0808 800 5000. Information about the CTAC is available on the NSPCC website. CTAC covers the whole of the UK.

See also NHS Choices [How to spot child sexual exploitation](#) and Lucy Faithfull Foundation [Services for Professionals](#).

Child Sexual Exploitation

Case History

Mum brings Ryan aged 13yrs to surgery. Education welfare are involved as his school attendance has started to drop off recently. Previously Ryan was doing well and enjoyed school but he is now reluctant to go. When he manages to get to school he appears more anxious than previously and on occasion has to leave the classroom looking pale and feeling faint. He complains of back and abdominal pain, further questioning reveals that he is not sleeping well and has had a couple of episodes of faecal incontinence.

Discussion points

- School refusal and marked sudden change in behaviour
- Assessing multiple symptoms and new onset faecal incontinence.

If after thorough physical examination and investigation Ryan's symptoms remain unexplained, consideration needs to be given to sexual abuse and a risk assessment carried out preferably by talking to Ryan alone (this could be done by referring him to whoever in the practice who has expertise in this area). Referral to Social Services for further investigation should occur if a risk assessment confirms risk of abuse or if professional judgement suggests that this is the most likely explanation of his symptoms. Ryan's consent for referral should be sought and if refused the reasons for his refusal explored. Young people may have been groomed and threatened with serious injury or death to their families or themselves if they disclose abuse. They are often aware of the dangers of disclosure and this need to be taken into account to ensure information is shared in a safe contained way. If worried that a child is being abused always seek advice from a designated or named professional.

References

CEOP (2011) [Out of Mind, Out of Sight Making every child matter ... everywhere](#)
EXECUTIVE SUMMARY CEOP thematic assessment
Breaking down the barriers to understanding child sexual exploitation
Department for Education (2012) [What to do if you suspect a child is being sexually exploited](#)
Department of Health (2014) [Child sexual exploitation: health working group report](#)
Gray, D. and Watt, P. (2013) [Giving Victims a Voice](#) Joint report into sexual allegations made against Jimmy Savile
[NWG Network: Stop Child Abuse through Sexual Exploitation](#)
Office of the Children's Commissioner (2013) Inquiry into Child Sexual Exploitation in Gangs and Groups (2013) [If Only Someone had Listened](#)
The Derby Safeguarding Children Board (2013) [Operation Kern Learning Review Summary Document](#)

8.2 Female Genital Mutilation (FGM)

- FGM is illegal, is a form of child abuse and a violation of the rights of the child.
- It reflects a culture of gender-based violence although the mutilation is usually arranged by the child's mother.
- It is not countenanced by any religion.
- The major risk factor for a female child is coming from a practising community particularly if FGM has already occurred in the family.

FGM is practised in many African countries as well as the Middle East and Asia. *"FGM involves procedures that include the partial or total removal of the external female genital organs for cultural or other non-therapeutic reasons. The practice is medically unnecessary, extremely painful and has serious health consequences, both at the time when the mutilation is carried out and in later life."* (Definition from [Multi-Agency Guidelines](#) England and Wales) It is illegal in the UK to subject a girl or woman to FGM or to assist a non-UK person to carry out FGM overseas.

What to do in General Practice if worried a child may be subject to FGM or have been a victim of FGM

If in doubt, children presenting with perplexing genital symptoms and signs should be urgently referred to a specialist paediatrician. GPs or Practice Nurses worried that a child may be at risk of FGM should always seek advice from their Practice Safeguarding Lead. When there is a suspicion or concern that significant harm will be experienced, professionals have a legal duty to report and refer cases, document responses, and share information between agencies under [Section 47](#) of The Children Act (1989) and should make a referral to Social Care following local Child Protection procedures.

If the child is considered to be at immediate risk, for example by being taken to a foreign country, an Emergency Protection Order can be sought by Social Care so that the child may be removed to a place of safety. If it is suspected or confirmed that FGM has already occurred, a referral should still be made to allow a strategy meeting to take place, further management planned and Police involvement considered.

Usually the child will require specialist examination to ascertain that mutilation has taken place. If this is confirmed she will require testing for blood born viruses, offer of immunisation for tetanus and hepatitis B, diagnosis and management of intercurrent conditions or complications, and referral to Child and Adolescent Psychiatry services. Even if examination and testing is refused such children should be offered ongoing psychological and social support.

How FGM might present in General Practice

GPs should be aware of the health needs of their practice population including prevalence and likelihood of certain conditions such as FGM. Offering patients a holistic assessment at time of registration creates an opportunity to assess individual as well as wider family health needs and to enquire about FGM if indicated.

The consequences of FGM are directly related to the magnitude of the mutilation, with most serious long-term effects related to extensive tissue removal and severe narrowing of the vaginal orifice. The procedure is traditionally carried out by lay practitioners using unsterile instruments in unhygienic conditions, but approximately 18% are said to be performed by health professionals.

Immediately following the procedure a child may be presented with immediate physical effects range from severe pain, post-operative infections including tetanus, blood borne viruses, shock, blood loss, damage to other organs, inability to pass urine and death. Later presentations may

occur with chronic wound sepsis, recurrent urinary tract infections, urinary frequency noted at home or school, sudden deterioration in mood or behaviour following a holiday abroad, gait disturbance or avoidance of sporting activities.

Long term physical problems include chronic pelvic infection, infertility, recurrent urinary tract infections with potential for renal damage, dyspareunia and loss of libido and sexual pleasure for the woman as well as major problems with child birth and increased risk to the baby of intra-partum and neonatal death. In terms of psychological complications the majority (80%) suffer mood and or anxiety disorders and post traumatic stress disorder is as frequent as in other forms of early child abuse.

The mutilation may be inflicted at any stage in the child's life from birth to the first pregnancy, but the majority of cases are said to occur between 5–8 years and this should be considered the age of highest risk.

Routine procedures such as cervical cytology and ante-natal booking questionnaires may identify adults who have already been mutilated and whose children may therefore be at risk but such women are often only identified when giving birth and good communication between midwives, obstetric units and GPs is essential to ensure the diagnosis is documented and appropriate action taken to protect the new baby and existing children. This must include a risk assessment and appropriate coding and flagging of records so that any GP or Practice Nurse in contact with the child/ren is made aware of the risk and can provide support and education to help prevent FGM in her offspring.

Long holidays back to the mother's country of origin are often used to achieve FGM e.g. over the summer holidays. Practice nurses need to be aware of potential risk to young girls presenting for travel advice, anti-malarials and immunisations for travel to certain countries, especially if their mothers have been flagged as FGM victims.

Recording FGM: Read Codes v2

Family History of Female Genital Mutilation	12b..
History of Female Genital Mutilation	15K..
Female Genital Mutilation Type 1	K5780
Female Genital Mutilation Type 2	K5781
Female Genital Mutilation Type 3	K5782
Female Genital Mutilation Type 4	K5783
Deinfibulation of vulva	7D045
Deinfibulation of vulva to facilitate delivery	7F1B5

References and Resources

0800 028 3550 FGM Helpline

NHS Choices [Female Genital Mutilation](#)

RCM, RCN, RCOG, Equality Now, UNITE (2013) *Tackling FGM in the UK: Intercollegiate Recommendations for identifying, recording, and reporting*. London: Royal College of Midwives.

Scottish Government: [Female Genital Mutilation](#)

Northern Ireland Executive www.dhsspsni.gov.uk/domestic_violence

WHO (2013) [Female Genital Mutilation Factsheet](#)

8.3 Forced Marriage

- Forcing someone to marry is a serious abuse of human rights and where children are involved, it is child abuse.
- A [forced marriage](#) almost always involves rape which may be repeated until pregnancy results.

In 2004 the UK government's definition of Domestic Violence was extended to include acts perpetrated by extended family members as well as intimate partners. Consequently, acts such as Forced Marriage and so-called 'Honour' crimes, which can include abduction and homicide, are now embraced. These are largely hidden problems and the true incidence is unknown but considered to be widespread among certain communities.

Victims may also experience violence from their own family as well as the spouse and spouse's family. In the most serious cases, the victim has been murdered after trying to refuse the marriage or attempt escape – a so-called 'honour' killing.

The UK definition of forced marriage is "a marriage conducted without the valid consent of both parties, where duress is a factor". Such coercion can include physical violence, emotional abuse and psychological pressure such as the concept of bringing 'shame' on the family.

A forced marriage must be distinguished from an arranged marriage, where both parties are in full agreement and freely consent to the marriage, although their families may play a significant role in the choice of partner.

Many forced marriages involve children still at school. Friends, teachers and school nurses may be initial recipients of disclosures and might contact the Practice requesting advice and help. As with Female Genital Mutilation, travel plans may be an indication of a looming problem for a child, male or female. Practice Nurses should be aware of the possibility especially if the child attending for travel immunisations or advice appears unhappy or distressed about the impending 'holiday' and should alert the Practice Child Protection Lead if suspicions are aroused. If a Practice is concerned, a useful contact is the [Forced Marriage Unit \(FMU\)](#) which will help to **stop a forced marriage** or help individuals leave a forced marriage **Telephone: 020 7008 0151**.

The FMU has developed a SmartPhone app which can be downloaded for free from [Freedom Charity](#). It provides advice for young people and professionals on how to spot the signs of a forced marriage and where they can go for help. More information at:

[Gov UK Forced Marriage Guidelines](#)

Scottish Government Responding to **Forced Marriage**: Multi-Agency Practice **Guidelines**

SecEd Spotting the Signs of Forced Marriage

S9

Children in Special Circumstances

Click box to
go to section

page

9.1	Children and Social Media	92
9.2	Gang abuse	93
9.3	Trafficking	94
9.4	Radicalisation as a form of abuse	95
9.5	Hidden Children	95

- These children have been defined as being at risk of poorer outcomes than their peers, this group includes young carers, homeless children, asylum seekers and children in custody.
- They may include children subject to newer forms of abuse such as through electronic devices and media.
- They also include victims of abuse which appear to be increasing in the UK such as gang abuse, trafficking and radicalisation.

Identification of these children requires a multi-agency approach with effective communication, collaboration and information sharing not just between providers of children's services but also between adult and children's services.

The aim of assessment of these often complex problems is to establish the child's needs then develop and implement a realistic management plan to improve the child's health and well-being and improve long-term life-course outcomes. This plan could include assessment of parenting capacity, provision of parenting support, working with the child to improve resilience and mental health or intervention to remove the child to a place of safety.

Ways in which such children might present to primary care are set out briefly in the following sections.

9.1 Children and Social Media

The internet while bringing many advantages for entertainment, communication and education has created opportunities for children and young people to be exposed to situations for which they are emotionally and psychologically unprepared such as images of abuse, pornography or violence including child abuse and sexual violence, as well as communication with individuals or groups intending harm.

Children and young people may present to GPs with low mood, sleep disturbance, behavioural disorders, self harm or suicidal ideation as a reaction to abuse including cyberbullying or sexual

exploitation. Such abuse may be coming from strangers met online or people known to them using social media to intensify bullying. NSPCC research shows that 38% of young people have been affected by cyberbullying and that it can lead to depression, isolation, self-harm and in severe cases suicide.

It is important as part of routine history taking in a distressed or disturbed child to ask about online activities, including those provided by mobile telephones, as well as parental knowledge, supervision and control of what the child does when online.

The internet can be used to befriend and groom children as a preliminary to sexual exploitation. 'Sexting' as defined by the NSPCC is "the exchange of self-generated sexually explicit images, through mobile picture messages or webcams over the internet". Children as young as 8 have been discovered taking and sending images of themselves through this medium. They may be unaware that this practice is illegal and that images once placed on the internet are difficult to remove. They are also potentially exposed to exploitation, bullying and further harm.

If reported to a GP the first consideration is to support and reassure the child and parent and encourage them to [take steps](#) to prevent further harm. The second is a responsibility to ensure that the child is kept safe and this will necessitate obtaining more information from the child and family if possible, obtaining their consent to share information and taking advice from child protection professionals on any further action which might be indicated.

[The Child Exploitation and Online Protection Centre \(CEOP\)](#) provides useful advice for parents as does the [NSPCC](#).

9.2 Gang abuse

- Evidence has been found of sexual, physical and emotional abuse of children by gangs and groups.
- Some children's experiences of familial abuse increases their vulnerability to exploitation.
- Use of weapons is associated with gangs.
- Mobile phones, social networking sites and other forms of technology are used as channels through which perpetrators groom, bully and pursue victims.
- Both victims and professionals are confused about what constitutes consent to sexual activity.

In December 2012, the Office of the Children's Commissioner published a report '[If only someone had listened](#)' into child sexual exploitation in gangs and groups. About 2,500 children per year are confirmed as victims of gang exploitation while 16,500 are identified as being at high risk of sexual exploitation (NSPCC figures). Violence is used to keep victims controlled, as is oral and anal rape as a form of humiliation and subjugation.

Victims have been identified as being between the ages of 4–19, with the majority being girls aged 15, 28% being from black or ethnic minorities. In studies these young people felt it unlikely that they would directly report their experiences to a health or other professional.

However they may present in general practice with sexually transmitted infections, pregnancy, unexplained injuries, depression and other mental health conditions, self harm and substance misuse. It is important not to make assumptions that the child has willingly consented to sexual activity or is voluntarily promiscuous. Self-harm or aggressive behaviour may be the result of despair or self-loathing rather than anti-social tendencies. It is important to take a careful, sensitively structured history and to examine the child fully if s/he consents. Warning signs of sexual exploitation are described fully at [NHS Choices](#) and summarised in **Section 8.1**, see also **Tools 18** and **19**.

Children living in residential care are known to be especially vulnerable especially if placements have broken down or the child has a record of running away, but children from stable homes who are apparently doing well at school may also be drawn unwittingly into exploitation and/or gang activity.

9.3 Trafficking

- The National Crime Agency has identified an increase in numbers of UK born children being trafficked, with the number trafficked for sexual exploitation doubling in 2013.
- Numbers identified represent just a small proportion of these children.
- The most common nationality or country of origin for child victims of trafficking (not just for sexual abuse) was Vietnam, followed by the UK then Albania.
- Such children may be subjected to physical, emotional and sexual abuse as well as neglect.

These children may be hidden, not allowed access to healthcare, education or leisure and unknown to general practice unless they are British born in which case they may be returned home each night and may well have been registered with the same GP from birth and have presented for routine care in infancy.

They may be seen in primary care because of injuries or impairments typical of certain jobs, injuries from control measures or assault including forms of sexual violence, and may appear frightened or anxious and unwilling to give a history. They may also present with recurrent urinary tract infections, sexually transmitted diseases and pregnancy.

If a GP or a staff member is worried about a child, the usual child protection referral mechanism comes into play but there is also national guidance to be followed if there is a special concern that the child has been trafficked.

National guidance on Trafficking

NSPCC's [Child Trafficking Advice Centre \(CTAC\)](#) is a specialist service providing information and advice to any professional working with children or young people who may have been trafficked into the UK.

The four nations in the United Kingdom, in addition to international organisations such as the United Nations all publish guidance to help professionals identify a child who may have been trafficked.

England: the guidance *HM Government (2011) [Safeguarding children who may have been trafficked: practice guidance \(PDF\)](#)* lists possible indicators that a child may have been trafficked into the UK or is under the control of a trafficker or receiving adult.

Northern Ireland: the guidance *[Working arrangements for the welfare and safeguarding of child victims of human trafficking](#)* refers professionals to the *United Nations Office on Drugs and Crime (UNODC) ([2008]) [Human trafficking indicators \(PDF\)](#)*. [Geneva]: United Nations Office on Drugs and Crime (UNODC).

Scotland: the Scottish Government has adapted England's guidance for application in Scotland and the list of indicators covers similar points: See Scottish Government ([2009]) *[Safeguarding children in Scotland who may have been trafficked \(PDF\)](#)*. [Edinburgh]: Scottish Government.

Wales: the All Wales Child Protection Procedures Review Group, on behalf of the Welsh Government, has published: All Wales Child Protection Procedures Review Group (2011) *[All Wales practice guidance for safeguarding children who may have been trafficked \(PDF\)](#)*.

International: the *United Nations Office on Drugs and Crime (UNODC) ([2008]) [Human trafficking indicators \(PDF\)](#)* provides lists of general indicators and more specific indicators for children, domestic servitude, sexual exploitation, labour exploitation and begging and petty crime.

9.4 Radicalisation as a form of abuse

- Radicalisation is defined as causing someone to become an advocate of radical political or social reform by supporting terrorism and violent extremism.
- Radicalisation of children and young people may include encouraging them to undertake violent activities on the grounds of religious belief.
- This may include attacks on others including suicide attacks.

Children may be exposed to messages about terrorism through a family member or friend, a religious school or group, or through social media and the internet. This creates risk of a child or young person being drawn into criminal activity and exposure to significant harm.

There is a cross-Government strategy to stop people becoming terrorists, known as '[Prevent](#)'. One of 'Prevent's' foremost objectives is to support individuals who might be vulnerable to recruitment or who have already been recruited by violent extremists, and [guidance](#) is available for healthcare workers.

All local authorities should have an agreed process in place to safeguard children and young people from violent extremism. All staff should be aware of the nature of risk in the area in which they work and should know what to do if worried about a child. Information should be available on the local authority's website and from the children's services department. Risk and level of preparedness varies across the country and if no information is readily available and you are worried about a child, contact your local safeguarding children team for further advice.

9.5 Hidden Children

Most children in the UK are registered with a general practitioner.

- When children who are not known to the Practice are seen, health professionals should take the opportunity to assess them for signs of abuse described elsewhere in this document.
- The same applies to children who are registered with the Practice but rarely seen.

Children in both the above categories may be at risk of abuse and neglect and may also present medico-legal risk to the practice especially if they suffer from medical conditions which are not being treated adequately. GPs have a responsibility to provide urgent and immediately necessary care for all children presenting to the Practice, regardless of registration or immigration status, while being conscious that carers of such children may seek to avoid attention of the authorities by providing assumed names and false addresses.

Some GP surgeries adopt a policy of not seeing children unless a main carer is already registered with the Surgery. In such situations the GP nevertheless has a responsibility to ensure that appropriate alternative arrangements are made in a timely manner for the child to receive necessary health care.

1. Children who are registered with a practice but are never or rarely seen

Children may not be brought for screening or immunisations appointments or not presented for care of acute conditions at the practice. It should be noted that infants and young children depend on adults for provision of care and failure to make and keep such appointments might be considered a feature of neglect. It should be considered good practice on the part of health professionals to follow up failure to attend for prophylactic care or care of chronic or long-term conditions and to persuade reluctant parents to present children for such care.

Such children may be frequently presented to Out of Hours Services and A&E departments for care of acute conditions, yet fail to attend routine Out-Patients appointments. These are known indicators of risk (CEMACH 2008). Practices might wish to develop routine searches and flagging to identify such children, see **T2** and **ChildSafe Trigger T13**.

Other children who may be registered but hidden from view include home-schooled children. Regulations applying to home schooling may be found at <https://www.gov.uk/home-education>. The county council has to be told if a child is being taken out of school but thereafter has no mandate to check on the child's well-being.

2. Children presented for immediately necessary treatment or temporary registration.

These may be:

- Children already registered with another UK GP who are on holiday or visiting relatives.
- Children who are looked after by the local authority, either placed with foster carers or in a children's home.
- Recent immigrants not yet registered.
- [Asylum seekers](#).
- Illegal immigrants.
- [Trafficked children](#).

In most cases seeing children as temporary residents is a straightforward procedure. GPs practising in resort towns with a regular influx of tourists every summer will be used to seeing a number of children with minor and straightforward ailments which do not cause great concern and this may also apply to children staying temporarily with relatives known to the practice.

Treatment of these children within general practice is already funded within most NHS contracts. The GP's duty is to provide any immediately necessary medical treatment to the child regardless of place of origin or right to UK residence. Detailed guidance may be found at [GMC 0–18](#), [Information for visitors](#) to England, in [Scotland Overseas Visitors liability](#).

Note that regulations for primary care differ from those for secondary care.

An essential aspect of the duty of care to the child is that careful, detailed, contemporaneous records are maintained and accurate contact details be obtained in the event that follow-up for a medical condition is required or concern about the child's well-being has been aroused. The child's full name, permanent address and telephone number, name of carer, name of usual GP and school if of school age, should be ascertained, in addition to the temporary address and telephone contact details.

If in the course of seeing such children the GP feels there is a possibility that the child may be at risk, it might be helpful to telephone the child's usual GP or school to obtain more information. If no information is forthcoming about the usual GP or school and the GP remains concerned, then local safeguarding procedures should be followed.

Children in the care of the local authority (see **Section 7**) should be registered permanently. Concerns around the length of the placement and possible changes of GP should be discussed with their social worker and if they are moved to another carer, every effort must be made to ensure that their records are transferred to the next GP in a timely and appropriate manner.

However, it is necessary to maintain continuing awareness of the existence of children who are rarely seen because they are neglected, may have been trafficked, are in this country illegally or are children of failed asylum seekers (see [Immigration rules](#) and **Sections 9.3** and **9.5**).

S10

Case Reviews

Click box to
go to section

page

10.1	The Vulnerable Child and Family Meeting	99
10.2	Serious Incident Reviews and Root Cause Analysis	100
10.3	The Child Protection Review	100
10.4	The Child Death Review	101

- **Case based reviews are a useful method for learning about improving patient safety.**
- **Most adverse events involve a series of incidents, several agencies and multiple contributory factors some of which may be complex.**
- **The case review methodology is used widely in child protection practice when children come to serious harm to determine what has gone wrong in the system and to make recommendations to improve practice.**
- **In General Practice, Case Reviews are supplemented by other strands of [clinical governance](#) such as clinical audit, risk assessment, staff education, training and commitment and effective patient participation.**

Case Reviews are intended to allow an honest, objective and comprehensive analysis of 'near-misses' and adverse events in a 'safe' environment while building a culture of trust and supported learning within an organisation. Such analyses go beyond assessing fault and allocating blame and may be applied to events which went well such as successful early intervention to protect a child from harm.

Human error is common and normal but patients suffering harm as a result of healthcare rarely do so because of human error alone. *"The fundamental causes of adverse events usually lie in a variety of systemic features operating at the level of the task, the team, the work environment and the wider organisational context"* (Rogers 2001).

Accounts of an incident may be taken from written records including correspondence from external agencies such as secondary or social care, written reports from staff members, or interviews with staff. It should then be possible from these written and verbal accounts to develop a chronology of events. This chronology, or narrative if preferred, may then be used to guide a structured analysis and permit a team reflection on the incident without focus on the immediate incident or blaming an individual, the aim being to identify what needs to change or be improved within organisational systems and processes in order to improve outcomes for patients. [Seven Steps to Patient Safety in General Practice](#) offers a framework for Practices to work through to improve patient safety.

This may be adapted to a child protection case, by considering patient registration practices, record keeping, identification of parental factors including substance abuse, domestic abuse and mental health and assessment of impact of parental health on the child. Reflective notes from such discussions which document change in practice and outcomes improvement may be used by GPs as evidence for Appraisal and Revalidation (see Tools **T1**, **T2**, **T3**, **T4**, **T5**, **T6**, **T8**, and **T9**).

10.1 The Vulnerable Child and Family Meeting

Health professionals working in Primary Care find it advantageous to meet on a regular basis for:

- Case-based discussion about vulnerable children and families under their care.
- To share information about assessments and plans for children in need, children at risk or children within child protection services.
- To monitor the progress of care plans.

These meetings also provide opportunities for professionals to share success and good practice as well as support each other through stressful challenging situations.

Such meetings will usually be attended by GPs, Public Health nurses (e.g. Health Visitors and School Nurses) and Community Children's Nurses and Midwives. Depending on the patients being discussed it may be beneficial to invite involved practitioners from other Agencies such as Social Care, Children's Centres or the Voluntary Sector. It is helpful for a Practice administrator or manager to attend and for minutes to be taken as a record of the meeting.

While there is currently no universal framework for managing pre-conceptual well-being, the issues which can contribute to poor maternal and child health and vulnerability are well recognised. These may include pre-existing maternal physical and/or mental issues including disability, domestic abuse, a history of childhood abuse or being a looked-after child, drug and/or alcohol abuse, obesity, poverty, recent immigrants, asylum seekers or refugees, communication difficulties including speaking or understanding English, poor nutrition and smoking.

The presence of one or more of these factors identified opportunistically at a routine GP appointment, perhaps for contraception or minor illness, can act as a trigger for further action to initiate active assessment of those who might need extra help, support and management to reduce identified risks before a vulnerable woman becomes pregnant.

When she becomes pregnant the midwife and health visitor can be fully informed of her needs at an early stage so that an appropriate care plan be developed in collaboration with the patient and her family and implemented in the early ante-natal period. Increasing concerns during the pregnancy may indicate a need for referral for a [pre-birth assessment](#). The care plan is usually refreshed in the post-natal period and the family's needs reassessed at intervals thereafter, taking into account that family circumstances may change over time.

Regular communication between involved professionals ensures vital information is shared early and appropriately so that action can be taken rapidly if a child is perceived to be at risk or additional risk of abuse or neglect. To aid this process alerts can be set up in GP recording systems to detect non-attendance for routine care such as ante-natal care, the 6-8 week check and immunisations and excessive attendances for unscheduled care, including attendances for injury.

References and usseful Websites

England: [Giving all children a healthy start in life, Healthy Child Programme: Pregnancy and the first five years of life](#)

Northern Ireland: [Families Matter: Supporting Families in Northern Ireland](#)

Scotland: [A Pathway of Care for Vulnerable Families, Early Years Framework; Scottish Government 2008](#)

Wales: [Children and Young People, Building a Brighter Future: Early Years and Childcare Plan](#)

10.2 Serious Incident Reviews and Root Cause Analysis

- In this context, a serious incident requiring investigation is defined as an incident that occurred in relation to NHS-funded services and care, including General Practice.
- The list of incidents includes abuse, described as a violation of an individual's human and civil rights by any other person or persons, and failure to prevent such abuse.

In 2010, the National Patient Safety Agency (NPSA) developed a national framework for the notification, management and learning from serious incidents in the NHS – [National framework for reporting and learning from serious incidents requiring investigation](#). This document sets out in detail definitions of serious incidents as well as processes for reporting, investigation and learning from such incidents.

Root Cause Analysis

[Root Cause Analysis](#) is a type of cause and effect analysis which aids thorough analysis of a problem including possible root causes. Being able to discover the main problem rather than the effect of a problem allows identification, clarification and investigation of major causes and can lead to development of more permanent solutions. The [NHS Patient Safety Agency](#) has developed a series of tools, available online, to identify how and why patient safety incidents happen. These tools are also useful in investigating child protection incidents.

10.3 The Child Protection Review

- Child Protection Reviews, described as in England [Serious Case Reviews \(SCRs\)](#) are commissioned by Local Safeguarding Boards (LSCBs) when a child dies or sustains significant harm, and abuse or neglect are known or suspected to have been a factor or the child has committed suicide. In Northern Ireland a similar function is carried out by [Case Management Reviews](#), in Scotland [Significant Case Reviews](#) while in Wales they have been replaced by [Child Practice Reviews](#).
- Child Protection Case Reviews are intended as vehicles for learning how professionals and agencies work individually and together to safeguard and promote the welfare of children, and to ensure that interagency working is improved as a result.
- Recommendations from such reviews are circulated to relevant organisations and those for General Practice will usually be applicable to all UK Practices.

Serious Case Reviews in England are fully described in [Working Together to Safeguard Children](#) Chapter 4. For lessons to be learnt when a child has died or been seriously injured, the LSCB requires information about how relevant organisations including health services and professionals have each dealt with the child and their family. This information is often collected in a standardised format called an 'Individual Management Review' (IMR), although other methodologies are in use (such as ['systems' models](#)).

The IMR writer for General Practice is usually a health professional such as a Named Safeguarding GP with no previous knowledge of the child or family and who is familiar with reading GP records. The IMR writer will expect to be given full access to the victim's GP records as well as records of siblings and/or other children living in the household, parents and/or carers. Such access is mandated under Part 1 Section 8 of the [Children's Schools and Families Act 2010](#).

The IMR writer will produce a chronology of GP contact with the family which will be used as a basis for analysis of the sequence of events leading up to the serious injury or death.

GPs and their Practice Teams will find it useful to be actively involved in this process by making it the focus of a Critical Incident Meeting or Sudden Unexpected Incident Meeting (see **Tool 6i**) to which the IMR writer is invited and at which contacts with the child and family can be considered, explored and used as a basis for developing change leading to improvement in practice. Reflective notes from such meetings may be produced as evidence for GP Appraisal and Revalidation.

The purpose of the Child Protection Review is not to allocate blame to individuals or agencies, but to identify where improvements in practice should be made in order to limit the risks to other children and young people. An overview report is produced by an independent writer employed by the LSCB or equivalent. This brings together information gathered in the individual IMRs, from the child death review process (if the child has died), and from any reports or contributions requested from other sources. The overview report analyses all information submitted and sets out conclusions and recommendations for each organisation involved with the child.

These recommendations will be circulated to relevant organisations and those for General Practice will usually be applicable to all UK Practices.

For more information see:

England: [Serious Case Reviews](#)

Northern Ireland: [Case Management Reviews](#)

Scotland: [Significant Case Reviews](#)

Wales: [Child Practice Reviews](#).

10.4 The Child Death Review

- All child deaths are tragic and the purpose of the English [Child Death Review](#), or in Wales the [PRUDiC](#) process, is to learn as much as possible from them, to try to prevent future deaths, and to support families.
- It is important that child deaths be accurately coded and documented in GP records of parents and siblings, that appropriate and timely bereavement support is offered and that the possible impact on any subsequent pregnancies and offspring is taken into account.

The Child Death Review process in England is fully described in Chapter 5 of [Working Together to Safeguard Children 2013](#). There are two interrelated processes for reviewing child deaths (either of which can trigger a [Serious Case Review](#)):

1. A rapid response by a group of key professionals (sometimes known as a rapid response team) who come together for the purpose of enquiring into and evaluating each unexpected death of a child;
2. An overview of all child deaths (under 18 years) in the local safeguarding children board (LSCB) area(s), undertaken by a panel ([Child Death Overview Panel](#) in England, [National Child Death Review Team](#) in Wales).

[N.B. In **Northern Ireland** the Child Death Review process has not yet been introduced, for current arrangements see [Guidance to the Safeguarding Board for Northern Ireland](#).]

GPs are expected to contribute by supporting the family and meeting with one or more members of the rapid response team which usually includes a Designated Paediatrician for Child Deaths

and a Safeguarding Nurse Specialist to plan next actions and share relevant information including medical records of the child and where appropriate those of parents, siblings and carers. This information sharing is mandated under Part 1 Section 8 of the [Children's Schools and Families Act 2010](#).

When initial information has been collated including if available post-mortem examination results, the Designated Paediatrician convenes one or more multi-agency case discussions, usually including all professionals who knew the family such as the GP as well as those involved in investigating the child's death. These meetings review further available information, including any that may raise concerns about safeguarding issues and lead to recommendation that a [Serious Case Review](#) or similar Child Protection Review be undertaken or surviving siblings be referred to children's social care.

When detailed information about the child's death becomes available decisions have to be made on sharing information with the family and any other relevant agencies about the cause of death or factors that may have contributed to the death and planning future care of the family including on-going support.

These issues may be considered at a Sudden Unexpected Death Meeting (see **Tool 6i**) involving the whole Practice Team and/or other involved health professionals such as the Health Visitor, School Nurse, Community Children's Nurse, where information may be shared, contacts with the family scrutinised and analysed, changes in practice agreed if indicated, and a plan for future care of the family developed.

Child Death review processes in Scotland and Northern Ireland are explained in [Royal College of Paediatrics and Child Health guidance on Child Death Review Processes](#), although Scotland has recently agreed to introduce a national Child Death Review System.

S11

Commissioning Child Safeguarding in the NHS

Click box to
go to section

page

11.1	Safeguarding Children (and Adults): Responsibilities of NHS Commissioning Organisations	104
11.2	Case History: A Clinical Network	105
11.3	The role of the Named Safeguarding Children GP	106

■ **The role of the named GP is not defined in statutory guidance, but they have proved invaluable at supporting general practice and improving the experience of vulnerable children and families. NHS England has indicated that it will support continuation of this role.**

■ **It remains the responsibility of every NHS funded organisation and healthcare professional including General Practice and GPs to ensure that people in vulnerable circumstances are not only safe but also receive the highest possible standard of care.**

■ **GP practices should have a lead for safeguarding, who should work closely with named GPs and designated professionals.**

How the NHS commissions child and adult safeguarding in England from April 2013 is described in [Safeguarding Vulnerable People in the Reformed NHS Accountability and Assurance Framework](#). This framework is intended to support NHS organisations to fulfil their statutory safeguarding duties as set out in

■ [Working Together to Safeguard Children](#).

■ [Statutory Guidance on Promoting the Health and Well-being of Looked After Children](#).

■ and in any future legislation regarding the safeguarding of adults (guidance is currently based on [No Secrets](#)).

NHS England is responsible for ensuring that General Practices from which they commission services provide a safe system that safeguards children and adults at risk of abuse or neglect. This takes account of specific responsibilities for looked after children and for supporting the Child Death Overview process, to include sudden unexpected death in childhood. There is an expectation that GPs will contribute fully to Serious Case Reviews (SCRs) which are commissioned by LSCBs/SABs and also, where appropriate, to individual management reviews or other local audit and review processes. GPs are expected to carefully consider all requests from an LSCB to share information for child safeguarding purposes.

New NHS commissioning bodies are in the process of developing organisational structures and processes which will support delivery of their statutory obligations to safeguard children under the Children Acts 1989 and 2004. This will include working with other agencies such as Local Safeguarding Children Boards, and Social Care as well as Public Health who are now responsible

for commissioning a range of services for children and young people such as the 5–19 Healthy Child Programme (0–19 from 2015), school health services, drugs and alcohol services and sexual health services. NHS England is also working with Health Education England, the Care Quality Commission and the Revalidation Support Team to ensure that training, regulatory and revalidation requirements for GPs relating to child safeguarding are consistent and aligned.

11.1 Safeguarding Children (and Adults): Responsibilities of NHS Commissioning Organisations

In England:

NHS England (formerly the NHS Commissioning Board)

NHS England has a wide-ranging role in safeguarding children, with statutory responsibilities for all directly commissioned services including primary care, as well as working with CCGs, Local Authorities, local Health and Well-being Boards and Local Safeguarding Children and Safeguarding Adult Boards to engage with local assurance and accountability processes.

Each area team has a Director of Nursing with lead responsibility for safeguarding for both children and adults, and who acts as the main agent for advice and support to the area team as well as the wider system. This includes responsibility for commissioning any reviews or enquiries of independent contractor services such as General Practices. In this role they may be supported by local 'Safeguarding Forums', which are being set up as a source of wider expertise and advice and include Designated and Named professionals.

Clinical Commissioning Groups

CCGs as the main commissioners of local health services are expected to assure themselves that the organisations from which they commission services such as hospitals and community services have effective safeguarding arrangements in place.

They are required to demonstrate there are appropriate systems in place for discharging these responsibilities including:

- Training their staff to recognise and report safeguarding issues.
- Governance arrangements which include a clear line of accountability for safeguarding.
- Arrangements to co-operate with local authorities in the operation of LSCBs, SABs and health and wellbeing boards.
- Ensuring effective arrangements for information sharing.
- The expertise of designated doctors and nurses for safeguarding children and for looked after children.
- A designated paediatrician for unexpected deaths in childhood.
- Having a safeguarding adults' lead and a lead for the Mental Capacity Act.

Health Safeguarding Systems

There is concern that with health reforms and budgetary pressures health safeguarding systems could become fragmented. This has resulted in increasing interest in development of Clinical Networks in which clinicians work in a collegiate way to share expertise and provide mutual professional support, and multi-agency safeguarding teams. The latter are usually designed to be a single point of contact to gather multi-agency information prior to referrals to Children's Social Care.

They enable professionals from a number of different agencies such as health, social care, police and education to work collaboratively and share information securely to enable consistent high quality risk assessments. If cases do not meet the threshold for social care, workers within the hub will, if indicated refer to the appropriate agency or professional to ensure that necessary support is provided to the family.

Northern Ireland: see [Health and Social Care in Northern Ireland, Guidance to agencies: public protection arrangements \(PDF\)](#) (2008).

Scotland: see [National Guidance for Child Protection in Scotland 2010](#)

Wales: [Health Boards](#) deliver and commission services and they are responsible for ensuring that General Practices from which they commission services provide a safe system that safeguards children and adults at risk of abuse or neglect.

11.2 Case History: A Clinical Network

Greater Essex Safeguarding Children Clinical Network author Dr Siobhan Barnes

A Managed Clinical Network for Safeguarding Children and Looked After Children was developed in the geographical county of Essex in 2011. The network initially comprised 5 Primary Care Trusts (later becoming 7 Clinical Commissioning groups) and is co-terminous with 1 Local Authority and 2 Unitary Authorities.

The architects for this change were the Designated Nurses in post at the time who recognised and proactively responded to:

- A CQC inspection report recommending that Designated Doctor and Nurse function across the 5 PCTs was too depleted to be effective.
- The changing NHS landscape leading to increasing complexity of the Health System with the inherent potential for negatively affecting the partnership working essential to Safeguarding Children.
- The desire to protect Safeguarding capacity particularly the role of Named GP and Named Nurse for Primary Care.

Following extensive consultation within Health and with partner agencies the Managed Clinical Network was developed. The particular model was chosen to:

- Ensure continued local availability of advice and expertise with PCT aligned Designated and Named Professionals remaining in their localities.
- Provide access to Strategic guidance and expert advice for Health and its partner agencies through the creation of a Hub of Lead Professionals.
- Allow distribution of responsibilities across the Network so reducing the duplication of effort and the burden on individual Designated Professionals and also facilitating specialism.
- Facilitate sharing of staff resources across Southend Essex and Thurrock.

Since inception the Network has driven improvement within Primary care including:

- Creation of a new Level 3 training package with greater emphasis on small group case based discussion and risk assessment.
- Rates for GPs trained to Level 3 have increased from under 20 to over 80%.
- A single Child/Young Person's Registration form designed by the Named GPs, in line with Laming's original recommendation and endorsed by Essex LMC, now in use across the 7 CCGs.

- An Information Sharing Form designed by the Named GPs is now used by all 3 Authorities for any requests for information from Primary Care.
- Development of a Looked After Children Primary Care Resource pack.
- An amended Section 11 style audit of all practices in the 7 CCGs, results being used to target support at a practice level and inform training provision at a CCG level.

Network staff, NHS England and partner agencies are very supportive of the Network which is currently under review. There are proposed changes to the management structure in keeping with the roles and responsibilities of NHS England both in directly commissioning Primary Care and its' oversight of CCGs.

See also the Home Office Report 2013 [Multi-Agency Working and Information Sharing Project Early Findings](#) and [Devon multi-agency safeguarding hub: case study report](#).

11.3 The role of the Named Safeguarding Children GP

The role

- Named Safeguarding GPs in England deliver education, improve child protection processes, disseminate evidence based practice and guide General Practices to deliver statutory functions.
- There are as yet no Named Safeguarding GPs in N Ireland, Scotland and Wales, where other mechanisms are in place to support GPs.

Over the last decade Named Safeguarding GPs have evolved into GPs with a Special Interest who have been active in engaging and motivating GPs, supporting them in managing sensitive, challenging and disturbing situations. They have also worked collaboratively with the Local Safeguarding Children Boards and other Agencies such as Social Care, the Police and Education in writing Independent Management Reviews and Serious Case Reviews and in development and implementation of Action Plans resulting from these Reviews. More recently Named GPs have been involved in supporting GPs to contribute to Section 11 Multi-Agency Audits and to prepare for regulatory Safeguarding and Looked After Children inspections.

Current policy

Working Together to Safeguard Children 2013 states that "GP practices should have a lead and deputy lead for safeguarding, who should work closely with named GPs. Named professionals have a key role in promoting good professional practice within their organisation, providing advice and expertise for fellow professionals, and ensuring safeguarding training is in place."

Within *Safeguarding Vulnerable People in the Reformed NHS: Accountability and Assurance Framework*, the role of the Named GP has been clarified, strengthened and described as critical. A minimum of 2 sessions per week per population of all ages of 220,000 is recommended. The guidance acknowledges that "Named GPs have proved invaluable at supporting general practice and improving the experience of vulnerable children and families", and in 2014 NHS England decided that Named GPs will be employed by Area Teams to support them in discharging their statutory safeguarding obligations.

General practice has an important place in the early identification and joint management of child maltreatment. This has been increasingly recognised since the report on the death of [Victoria Climbié](#) in 2003 and clearly defined by the [General Medical Council](#) in 2012. The long term health, social and economic consequences of child maltreatment will be recognised by individual GPs and shown by recent research (for example that carried out by [PreVail](#)).

Primary care contractors as the gatekeepers of the NHS will often be the first professionals to be alerted to problems within a family but this aspect of General Practice remains a challenge to individual GPs, Practice Teams and the NHS generally especially in times of economic austerity, organisational change and increasing pressure on Practices.

Historically the Named GP role arose from recommendations in the [Children's NSF 2004](#) as a means of supporting Primary Care commissioning organisations in discharging their statutory duties under [Section 11 of the Children Act 2004](#). Organisations which employed Named GPs benefited from an improved awareness of safeguarding issues within primary care and discovered that peer led clinical leadership delivered widespread improvements in GPs' approach to safeguarding children.

Named Safeguarding GPs today play a role in:

- Providing specific expertise in children's health and development and in care of families in difficulty as well as children who have been abused or neglected.
- Providing supervision, expert advice and support to GPs and other staff in child protection issues.
- Offering advice on local arrangements with provider organisations for safeguarding children.
- Promoting, influencing and developing relevant training for staff especially GPs and their teams.
- Providing input as a skilled professional to child safeguarding processes, in line with the procedures of local safeguarding children boards.
- Taking a lead in writing the General Practice components of serious case reviews, independent management reviews, [Section 11 Multi-Agency Audits](#).
- Supporting processes required by regulators' unannounced single and multi-agency inspections.

Named Safeguarding Children GPs remain an essential part of current and future NHS structure in England see **T10** for a detailed role description.

Information on support for GPs working in jurisdictions other than England

Northern Ireland: [Cooperating to Safeguard Children Roles and Responsibilities](#) and [Safeguarding Board for Northern Ireland](#)

Scotland: [Child Protection Guidance for Health Professionals](#)

Wales: [Safeguarding in General Practice, A Guide for Safeguarding Children and Vulnerable Adults in General Practice](#)

S12

Adult Survivors and Disclosures of Historical Abuse

Some adults who survive maltreatment and neglect in childhood are able to overcome childhood trauma to live happy, rewarding lives, while others may present in general practice with a wide spectrum of symptoms, signs and conditions including:

- Relationship difficulties.
- Problems adjusting to pregnancy or parenthood.
- Depression.
- Other mental health issues including anorexia nervosa and self-harm.
- Substance misuse.
- Physical symptoms such as chronic pains and fatigue which remain unexplained by investigations and examination.
- Poor physical health including chronic and long-term conditions.

They may still be in contact with their abuser or live in the same neighbourhood and sightings of the abuser might cause 'flashbacks', panic attacks and nightmares as well as recurrence and persistence of unpleasant memories. They might worry that their abuser is continuing to abuse others.

Knowing and understanding a patient's history is key to providing appropriate support and management but many patients find it hard to disclose a history of abuse and GPs may become frustrated by a seeming inability to help a patient attending frequently with apparently inexplicable symptoms or unsolvable problems. This is a difficult and sensitive area of practice where GPs may have to work hard to build the patient's trust by being welcoming, supportive and non-threatening and finding the right moment to ask difficult questions. Gently raising the possibility without asking direct questions might help patients talk about the issues.

Disclosure of historical abuse

If a patient discloses abuse, it is essential to respond calmly, compassionately and in a non-judgmental way, which imply belief in the patient's narrative. This initial response is a vital component of the healing process as the patient who feels believed and listened to is more likely to take further steps to confront the issue.

The patient's immediate physical, psychological, social and safety concerns can then be addressed in concordance with the patient's wishes and with the patient's consent. The GP will need to take time at this stage to ascertain the patient's priorities, to listen, to provide information, and where required to make necessary referrals, but patients should not be pressurised into accepting referrals or taking action. Disclosing abuse for the first time may bring a sense of relief and empower the patient to take further action but talking to the GP might be all they would like to do at this stage and patience is required to allow them to do this in their own way and at their own pace.

When a disclosure indicates others might still be at risk, then it becomes necessary to inform statutory agencies such as social care and the police as soon as feasible. This should be discussed as far as possible with the patient and consent obtained to share information.

If the patient refuses consent to share information the GP might have to act without patient consent, in the public interest, see [GMC Confidentiality guidance](#). If in doubt, it is always wise to take advice from local safeguarding children and/or adult services or the police child protection unit. In most circumstances this can be done without initially revealing the patient's identity.

The most vulnerable children will inevitably grow into vulnerable adults, but adults also become vulnerable due to acquired disability, illness, frailty and age. Resources to help safeguard adults are listed below.

Resources for survivors

[Victim Support](#)

[National Association for People Abused in Childhood](#)

[NSPCC Adults abused in childhood](#)

References

[MPS/NSPCC \(2013\) Gray, D., Watt, P., Giving Victims a Voice](#)

[NAPAC \(2014\) Kelly, S. Bird, J., Recovering from Childhood Abuse](#)

[RACGP \(2008\) Abuse and violence: working with our patients in general practice](#)

Resources for Safeguarding Adults

[ADASS Safeguarding Adults](#)

[DH Protecting Patients from avoidable harm](#)

[GOV.UK Adult Safeguarding](#)

S13

References

Ainsworth, M.D.S., et al, (1978) *Patterns of Attachment: A Psychological Study of the Strange Situation* Hillsdale, NJ. Lawrence Erlbaum

Bayley N., (2006) *Bayley Scales of Infant and Toddler Development*. 3rd edn. Pearson Education, Inc., San Antonio, TX.

Bowlby, J., (1988) *A Secure Base: Parent-Child Attachment and Healthy Human Development* New York: Basic Books

Brandon, M., et al, (2012), *New learning from serious case reviews: a two year report for 2009–2011* London: Department of Education

CQC [Safeguarding Protocol](#)

CQC [Safeguarding Children Review](#)

Dodds J.B. (1968) *The Denver Developmental Screening Test-Manual*. University of Colorado Press, Denver.

Duggan, A., et al, (2007) Impact of statewide home visiting program to prevent child abuse. *Child Abuse and Neglect*, 31(8), 801–827. doi: 10.1016/j.chiabu.2006.06.011

Gardner, R., (2008) *Developing an effective response to neglect and emotional harm to children* available online at http://www.nspcc.org.uk/Inform/research/nspccresearch/completedresearch/DevelopingAnEffectiveResponseToNeglectPDF_wdf56700.pdf

Gilbert, R., et al, (2009) Recognising and responding to child maltreatment. *The Lancet* 2009 Jan 10; 373(9658): 167–80.

Gilbert, R., et al, (2009) Burden and consequences of child maltreatment in high income-countries *The Lancet* 393(9657): 68–81

Gov.UK (2012) [Children and Young People's Health Outcomes Forum: Recommendations to improve children and young people's health results](#)

Griffiths, R., (1967) *The Abilities of Babies*. University of London Press, London.

Horwath, J., (2007) Tackling Child Neglect in *Community Care* March 28, 2007 http://www.communitycare.co.uk/2007/03/28/tackling-child-neglect-jan-horwath-considers-factors-around-referring-neglect-cases/#.UysqA_I_uSo

Horwath, J., (2007) *Child Neglect: Identification and Assessment* Palgrave

Horwath, J., ed (2009) *The Child's World: the Comprehensive Guide to Assessing Children in Need* Jessica Kingsley Publishers

- Laming, Lord H., (2003) *The Victoria Climbié Inquiry*
<http://webarchive.nationalarchives.gov.uk/20130401151715/https://www.education.gov.uk/publications/eOrderingDownload/CM-5730PDF.pdf>
- MacMillan, H., et al, (2009) Interventions to prevent maltreatment and associated impairment, *The Lancet* 373(9659): 250–266
- NCB Early Support (2013) [Early Years Developmental Journal](#). Frankenburg
- NHS Commissioning Board (2013) *Safeguarding Vulnerable People in the Reformed NHS Accountability and Assurance Framework*
<http://www.england.nhs.uk/wp-content/uploads/2013/03/safeguarding-vulnerable-people.pdf>
- NSPCC Inform [Case Reviews Published in 2013](#)
- NSPCC [Safe Network](#)
- Ofsted (2011), *Ages of concern: learning lessons from serious case reviews*. Manchester: Ofsted
- Rogers S. Risk management in general practice. In: Vincent CA, editor. *Clinical risk management, Enhancing patient safety*. London: BMJ Publications; 2001. pp. 241–59.
- Parliament UK (2012) *Children first: the child protection system in England* – Education Committee
<http://www.publications.parliament.uk/pa/cm201213/cmselect/cmeduc/137/13708.htm>
- Sanderson, C., (2013) *Counselling Skills for Working with Trauma* Jessica Kingsley Publishers
- Seifert, K., (2003) *Attachment, Family Violence and disorders of childhood and adolescence*.
- Paridigm. Available online at: <http://www.drkathyseifert.com/attachment.pdf>
- Shemmings D. & Shemmings Y., (2011) *Understanding Disorganised Attachment*. Jessica Kingsley, London
- Sheridan, M.D., (2008) *From Birth to Five Years: Children's developmental progress*. Routledge, London.
- Simpson, J., et al, (2012) Female Genital Mutilation: the role of health professionals in prevention, assessment and management *BMJ* 2012;344 e1360 pp37–41
- Stoltenborgh, M.I., et al, (2011) A global perspective on child sexual abuse: meta-analysis of prevalence around the world. *Child Maltreat.* 2011 May; 16(2): 79–101. doi: 10.1177/1077559511403920.Epub2011Apr21.
- Thoburn, J., (2013) Services for vulnerable and maltreated children in Wolfe, I., and McKee, M., Ed *European Child Health Services and Systems Lessons without borders* McGrawHill Open University Press
- Tompsett, H., et al, (2009) *The child, the family and the GP: tensions and conflicts of interest for GPs in safeguarding children* DCSF Research Brief RBX-09-05
- WHO (2014) ed Sethi, D. et al, *European report on preventing child maltreatment*
The UN Convention on Rights of the Child 1989

Wilson, P., Mullin, A., (2010) Child Neglect: What does it have to do with General Practice?
Br J Gen Pract. Jan 1, 2010; 60(570): 5–7.

Woodman, J., *et al*, (2012) A simple approach to improve recording of concerns about child maltreatment in primary care records: developing a quality improvement intervention *British Journal of General Practice*, 1 July 2012, vol. 62, no. 600, pp. e478-e486(9)
<http://bjgp.org/content/62/600/e478.figures-only?related-rls=yes&legid=bjgp;62/600/e478>

Woodman, J. *et al*, (2014) The GP's role in responding to child maltreatment: time for a rethink?
<http://www.rcgp.org.uk/news/2014/july/~media/Files/CIRC/Safeguarding-Children/RCGP-GP-Role-responding-to-child-maltreatment-July-2014.ashx>

Tool
1

Top Tips: for Writing Practice Policies and Procedures

Aims and objectives

This should include a sentence about safeguarding being everyone's duty and the principles of safeguarding from the Practice's perspective as an integral component of Child Health provision.

Responsible leads

The Practice should include the names and contact details for the clinical lead (preferably a GP) and deputy, and the administrative lead for safeguarding in the practice.

Safe staff recruitment

The Practice decision re security checks on new and existing staff should be clarified along with the recruitment procedure to minimise risk. The new staff induction pack should include details of how new staff are to receive training and should ensure the Practice protocol is read. Consideration should be given to induction and training needs of nursing and medical students as well as temporary volunteer and locum staff.

Raising concerns about children

- The protocol should make reference to guidance about when and how to raise concerns e.g. 'What to do if you think a child is being abused.'
- Use of NICE guidance on when to suspect child maltreatment.
- Details of access to your local safeguarding children board – LSCB – website (if the practice area crosses local authority area boundaries there may be more than one LSCB involved).

The protocol should include:

- How to do a referral to Social Care when there is a concern about the child experiencing significant harm.
- Reference to the CAF (common assessment framework) and how to access the CAF form.
- Details of the child death process.
- Reference to the use of body charts for describing injuries and refer to where to find body charts to use.

Raising concerns about staff

The Practice must have a safe 'whistle-blowing' procedure and information on contacting the Local Authority Designated Officer(LADO)

Sharing information and record keeping

The protocol should include a plan for managing, acting upon and filing requests for:

- Section 47 information.
- Section 17 information.
- Reports for Case Conferences.
- Reports for Review Conferences.
- How to produce such reports using a standard template.
- The storage, scanning and management of child protection documents and case conference reports.
- The Practice plan for managing newly registered child patients.
- Questions to ask newly registering child patients as per Laming guidance.
- The correct Read codes to use for vulnerable children and families, children subject to a protection plan and those for family members of children with a protection plan, who is going to be responsible for adding the codes and how records are to be flagged when there are safeguarding concerns.
- A plan for managing domestic violence reports received from Health Visitors and other sources.
- Dealing with requests to share information for Serious Case Reviews, Child Death Review, Domestic Homicide Reviews.

Training and education

The protocol should include a plan:

- For regular training of all staff both clinical and non-clinical which should include at least one joint training session each year.
- To keep a record of training activity in the Practice and expectations for induction and training when new staff are recruited.
- Which shows that clinical staff are progressing through to Level 3 training.

Audit and review

The protocol should include a review date and a plan to audit its effectiveness on a regular basis.

Reference to other useful documents such as

- Local Safeguarding Board Policies and Protocols.
- Local contact telephone numbers for Named Safeguarding GP, Designated Doctor, Social Services Advice and Referral Line, Police Child Protection Unit.
- Report proformas.
- Referral forms for Common Assessment Framework and Child Protection.
- Body Maps for recording injuries.
- ['GMC 0–18 years Guidance for all doctors.'](#)
- [GMC 2012 Child Protection Guidance.](#)
- Lord Laming(2003) *The Victoria Climbié Inquiry* p290.
- [NSPCC help for professionals.](#)
- [RCGP Safeguarding Children Toolkit.](#)
- [BMA Child Protection Toolkit.](#)
- [NICE guidelines 'When to suspect child maltreatment'](#) July 2009.
- [Working Together to Safeguard Children 2013.](#)
- [Young Person's Guide to Keeping Children Safe 2013.](#)

Tool

2

Specimen Child Safeguarding Policy for General Practice

[!\[\]\(c3d993ca47bfe2a953c700506ce31fa0_img.jpg\) Back to main contents](#)

Liquorice Allsorts Medical Centre

Dr F Marshallow
Dr H Éclair

Tel: _____
Fax: _____

Child Safeguarding and Child Protection Policy

Contents

Policy statement
Basic principles
Responsibilities
Child protection: sources of advice and support
Immediate actions
What to do with allegations of abuse from a child
Confidentiality
Physical examination of a child or young person
Attitudes of parents or carers
Training – in house
Record keeping
Information on child abuse available at safenetwork
<http://www.safenetwork.org.uk/Pages/default.aspx>

Policy statement

Under the 1989 and the 2004 Children Acts a child or young person is anyone under the age of 18 years.

Safeguarding children is the action we take to promote the welfare of all children and protect them from harm.

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

The Practice recognises that all children have a right to protection from abuse and neglect and the Practice accepts its responsibility to safeguard the welfare of all children with whom staff may come into contact.

We intend to:

Respond quickly and appropriately where information requests relating to child protection are made, abuse is suspected or allegations are made.

Provide children and parents with the chance to raise concerns over their own care or the care of others.

Have a system for dealing with, escalating and reviewing concerns.

Remain aware of child protection procedures and maintain links with other bodies, especially the commissioning body's appointed contacts.

The Practice will ensure that all staff are trained to a level appropriate to their role, and that this is repeated on an annual refresher basis. New members of staff will receive induction training within x months of start date(preferably less than 6 months).

Basic principles

- The welfare of the child is paramount.
- It is the responsibility of all adults to safeguard and promote the welfare of children and young people. This responsibility extends to a duty of care for those adults employed, commissioned or contracted to work with children and young people.
- The Practice must have safe recruitment practices including appropriate use of The disclosure and barring service <https://www.gov.uk/government/organisations/disclosure-and-barring-service/about> and safe whistle blowing processes.
- Staff who work with children are responsible for their own actions and behaviour and should avoid any conduct which would lead any reasonable person to question their motivation and intentions.
- Staff should work and be seen to work, in an open and transparent way.
- The same professional standards should always be applied regardless of culture, disability, gender, age, language, racial origin, religious belief and/or sexual identity.
- Staff should continually monitor and review their practice and ensure they follow the guidance contained in this document and elsewhere.
- The Practice will ensure regular meetings are held to discuss vulnerable children and families and that such meetings include other Agencies such as Midwives and Public Health Nurses to ensure early recognition of circumstances leading to abuse and neglect and early intervention to help prevent abuse and neglect.
- The Practice will ensure children and their families are able to share concerns and complaints and that there are mechanisms in place to ensure these are heard and acted upon.

Responsibilities

Dr Marshmallow is the appointed Clinical Safeguarding Lead within the practice.

Dr Éclair is the appointed Clinical Safeguarding Deputy Lead within the practice.

Mrs Macaroon is the Administrative Safeguarding Lead.

The Clinical Safeguarding Lead and Clinical Safeguarding Deputy Lead are responsible for all aspects of the implementation and review of the children's safeguarding procedure in this practice.

Child protection: sources of advice and support

Contact information

Practice Clinical Safeguarding Children Lead	Dr Marshmallow
Practice Clinical Safeguarding Children Deputy Lead	Dr Eclair
Practice Administrative Lead	Mrs Macaroon
Named GP for Safeguarding Children	Dr Coconutice Telephone Number:
For further contacts	Designated Doctor: Social Care: Police Child Abuse Investigation Unit: NSPCC Child Line 0800 1111
Useful websites	RCGP/NSPCC Safeguarding Children Toolkit Local Safeguarding Children's Board

Common presentations and situations in which child abuse may be suspected include:

- Disclosure by a child or young person.
- Physical signs and symptoms giving rise to suspicion of any category of abuse and/or inconsistent with the history provided.
- A history which is inconsistent or changes over time.
- A delay in seeking medical help.
- Extreme or worrying behaviour of a child, taking account of the developmental age of the child.
- Self-harm.
- Accumulation of minor incidents giving rise to a level of concern, including frequent A&E attendances.

Some other situations which need careful consideration are:

- Repeated attendance of young baby under 12 months of age.
- Any bruising or injury in child under 24 months of age.
- Very young girls or girls with learning difficulties or disability requesting contraception, especially emergency contraception.
- Girls under 16 presenting with pregnancy or sexually transmitted disease, especially those with learning difficulties, chronic long term illness, complex needs or disability.
- Situations where parental factors such as mental health problems, alcohol, drug or substance misuse, learning difficulties, domestic abuse may impact on children and family life.
- Unexplained or suspicious injuries such as bruising, bites or burns, particularly if situated unusually on the body.
- The child says that she or he is being abused, or another person reports this.

- The child has an injury for which the explanation seems inconsistent, delayed presentation, or which has not been adequately treated or followed up.
- The child's behaviour changes, either over time or quite suddenly, and he or she becomes quiet and withdrawn, or aggressive.
- Refusal to remove clothing for normal activities or keeping covered up in warm weather.
- The child appears not to trust particular adults, perhaps a parent or relative or other adult in regular contact.
- An inability to make close friends.
- Inappropriate sexual awareness or behaviour for the child's age.
- Fear of going home or parents being contacted.
- Disclosure by an adult of abusive activities, including activities related to internet and social media use.
- Reluctance to accept medical help.
- Fear of changing for PE or school activities.

Immediate actions

- Concerns should immediately be reported to the Lead clinician within the Practice or his / her deputy (above).
- Concerns should be discussed internally and an action plan decided.
- In the absence of one of the nominated persons, the matter should be brought to the attention of the local Safeguarding Team, or, if it is an emergency, and the Designated persons cannot be contacted, then the most senior clinician will make a decision whether to report the matter directly to Social Services or the Police.
- If the suspicions relate to a member of staff there should be internal discussion with the Practice Safeguarding Lead or deputy, and a plan of action decided, the local Safeguarding Children team and / or social services should be contacted directly. Consideration should be made to involving the LADO.
- Suspicions should not be raised or discussed with third parties other than those named above.
- Any individual staff member must know how to make direct referrals to the child protection agencies and should be encouraged to do so if they have directly witnessed an abuse action; however, staff are encouraged to use the route described here where possible. In the event that the reporting staff member feels that the action taken is inadequate, untimely or inappropriate they should report the matter directly. Staff members taking this action in good faith will not be penalised.
- Where emergency medical attention is necessary it should be given. If necessary as ascertained by clinical judgement the child should be admitted to the care of the emergency Paediatric service and a social services referral made. Any suspicious circumstances or evidence of abuse should be reported to the designated clinical Lead.
- If a Social Services referral is being made without the parent's knowledge and urgent medical treatment is required, social services should be informed of this need. Otherwise, if it is decided that the child is not at risk, suggest to the parent or carer that medical attention be sought immediately for the child.
- If appropriate the parent/carers should be encouraged to seek help from the Social Services Department prior to a referral being made. If parents do not consent to medical care or to a social care referral and they fail to do so in situations of real concern the safeguarding Lead will contact social services directly for advice.
- Where sexual abuse is suspected the Practice Lead or Deputy will contact the Social Services or Police Child Protection Team directly. The Lead will not speak to the parents if to do so might place the child at increased risk.

■ Neither the Practice Safeguarding Lead or any other Practice team member should carry out any investigation into the allegations or suspicions of sexual abuse in any circumstances. The Practice Safeguarding Lead will collect exact details of the allegations or suspicion and provide this information to statutory child protection agencies: Social Care, the police or NSPCC, who have powers to investigate the matter under the Children Act 1989.

What to do with allegations of abuse from a child

Keep calm

- Reassure the child that they were right to tell you, and that they are not to blame and take what the child says seriously.
- Be careful not to lead the child or put words into the child's mouth – ask questions sensitively
- Do not promise confidentiality.
- Fully document the conversation on a word by word basis immediately following the conversation while the memory is fresh.
- Fully record dates and times of the events and when the record was made, and ensure that all notes are kept securely.
- Inform the child/ young person what you will do next.
- Refer to the Practice Safeguarding Lead clinician or Deputy.
- Decide if it is safe for a child to return home to a potentially abusive situation. It might be necessary to immediately refer the matter to social services and/or the police to ensure the child's safety.

Confidentiality

Staff are required to have access to confidential information about children and young people in order to do their jobs, and this may be highly sensitive information. These details must be kept confidential at all times and only shared when it is in the interests of the child to do so, and this may also apply to restriction of the information within the clinical team. Care must be taken to ensure that the child is not humiliated or embarrassed in any way.

If an adult who works with children is in any doubt about whether to share information or keep it confidential he or she should seek guidance from the practice clinical Safeguarding Children Lead. Any actions should be in line with locally agreed information sharing protocols, and whilst the Data Protection Act applies it does not prevent sharing of safeguarding information. Whilst adults need to be aware of the need to listen and support children and young people, they must also understand the importance of not promising to keep secrets. Neither should they request this of a child or young person under any circumstances.

Additionally, concerns and allegations about adults should be treated as confidential and passed to the practice safeguarding lead or appointed person or agency without delay.

Responding to requests for safeguarding/child protection information

All requests for information relating to a child protection investigation or report for Case Conference will be passed to the Child Safeguarding Lead or Deputy on the day received. A response will be made in a timely manner, preferably within 48 hours, and if this is not possible the Agency requesting information will be informed and a reason given.

Physical examination of a child or young person

A parent or carer should be present at all times, or a chaperone offered. Children should only be touched under supervision and in ways which are appropriate to, and essential for clinical care.

Permission should always be sought from a child or young person before physical contact is made and an explanation of the reason should be given, clearly explaining the procedure in advance. Where the child is very young, there should be a discussion with the parent or carer about what physical contact is required. Routine physical examination of an individual child or young person is normally part of an agreed treatment procedure and/or plan and should be understood and agreed by all concerned, justified in terms of the child's needs, consistently applied and open to scrutiny.

Physical contact should never be secretive or hidden. Where an action could be misinterpreted a chaperone should be used or a parent fully briefed beforehand, and present at the time. Where a child seeks or initiates inappropriate physical contact with an adult, the situation should be handled sensitively and a colleague alerted.

Attitude of parents or carers

Parental attitude may indicate cause for concern:

- Unexpected delay in seeking treatment.
- Reluctance to have child immunised.
- Failure to take child for dental care.
- Failure to attend scheduled appointment with GP or other healthcare providers.
- Denial of injury, pain or ill-health.
- Incompatible explanations, different explanations or the child is said to have acted in a way that is inappropriate to his/her age and development.
- Reluctance to give information or failure to mention other known relevant injuries.
- Unrealistic expectations or constant complaints about the child.
- Alcohol misuse or drug/substance misuse.
- Domestic Abuse or Violence between adults in the household.
- Appearance or symptoms displayed by siblings or other household members.

Training – in house

Safeguarding Children Updates are given regularly by Lead Safeguarding GP at Team meetings. The Practice Safeguarding Children Lead is responsible for ensuring training records are kept and maintained and will liaise with the Practice Appraisal Lead to ensure training is aligned with identified staff development needs. An annual Update and Refresher is given by a member of the Local Safeguarding Children Team, such as the Named GP.

Record keeping

All information received regarding children from the Safeguarding Children Team and any other associated Services should be regarded as strictly confidential.

This information should be handled by the designated member of staff who will deal with such paperwork in the following way.

Designated member of staff for record keeping: Mrs Macaroon.

Child Protection Reports are as important as records of serious physical illness and should be recorded in the same way and with the same degree of permanence.

Case Conference Reports should be ideally be scanned into that individual child's electronic General Practice records. If necessary third party references must be blanked out or anonymised before scanning or sharing with appropriate agencies.

Appropriate coding and templates should be used in Active and Past Problem Lists and priority lists

Child's records should be linked in some way to parents even if not living at the same address, siblings and others in household by use of appropriate templates and codes.

Read codes expressing that a child is on a Child Protection Plan should be entered into notes of all individuals living at same address.

It is vital that when a child who is or has been on a Child Protection Plan moves to another area that the full clinical record including Case Conference Reports be sent to the next GP. Therefore they must **NOT be kept separate or isolated from the child's written or computer records**. Tragedies have resulted from Case Conference Records not being passed on to the child's current GP. (Pass on welfare concerns even if the child is not subject to a protection plan.)

Important

Case conference records must never be destroyed e.g. by deleting electronic records or shredding hard copies.

Therefore:

- All reports will be scanned onto the relevant child's records.
- These reports will be vetted to remove any 3rd party information especially if external agencies request these medical records.
- All reports/correspondence will be seen and summarised by a GP.
- All contacts with any parties regarding any safeguarding children issues should be recorded on the patient's medical records and any necessary action taken immediately.

Tool
3

Recommended Codes

 [Back to main contents](#)

Recommendations for recording concerns about Child Maltreatment in Primary Care

Level 1

We recommend that GPs flag whenever maltreatment is considered using the code:

'Child is cause for concern'. (Read version 2 term: 13If Read 3: **XaMzr**)

Level 2

Basic consistent coding of child maltreatment:

We propose the following six codes are used:

Term	Read v2	Read v3
1 Child is cause for concern ¹	13If	XaMzr
2 <i>Child no longer vulnerable</i> ²	13IW	XaLqv
3 Family is cause for concern	13lp	Ub1Go
4 <i>Social worker involved</i>	13G4	13G4.
5 <i>Child in care</i>	13IB	13IB.
6 <i>Health visitor visits</i>	13G2	13G2.

¹ Use as standard "Red flag" about concerns

² Use when concerns cease

Recommendations for recording concerns about Child Maltreatment in Primary Care

Level 3

Consensus coding of child maltreatment

We recommend where more detail is needed the following codes are used:

1. What is the cause for concern?		Read v2	Read v3	Notes
Non-specific	Child is cause for concern *1*	13If	XaMzr	
	<i>Child no longer vulnerable</i> *2*	13IW	XaLqv	1 ALWAYS CODE to flag concern in all children in whom maltreatment is 'considered' (as defined in NICE guidance). This is the minimum coding we recommend for any child with concerns.
	Suspected child abuse	13Ip	Ub1Go	
	History of abuse	13G4	XaEFq	2 Use 'Child is no longer vulnerable' to indicate the end of a period of professional concern
Specific	At risk of neglect	13ZV	XaKbS	
	At risk of emotional abuse	13ZR	XaKbP	3. Use 'a/n care social risk' to indicate any child who was identified as a cause for concern before birth, including maternal drugs/alcohol use, domestic violence or child protection concerns during pregnancy
	History of emotional abuse	14X2	XaEFt	
	At risk of physical abuse	13VF	XaKbR	4. Use for children assessed by CSC as needing extra service to meet full potential and avoid impairment (section 17, Children Act 1989).
	History of physical abuse	14X0	XaEFr	
	At risk of sexual abuse	13ZW	XaKbT	5. Use no longer in need when appropriate
	History of sexual abuse	14X1	XaEFs	
	a/n care: social risk *3*	625	6252	Copies available from: www.clininf.eu/maltreatment/
2. Is the family a cause for concern?		Read v2	Read v3	
Family	Family is cause for concern	13Ip	Ub1Go	This coding list is recommended by RCGP, Institute of Child Health & University of Surrey Multisite Audit Group
<i>Cause for concern?</i>	<i>Family member no longer subject of a child protection plan</i>	13Iz	XaPkG	
	Paternal drug misuse	12X2	XaPDT	
	Maternal drug misuse	63C6	63C6	
	Both parents misuse drugs	12X1	XaPDU	
	Maternal alcohol abuse	63C7	63C7	
	Alcoholic in family	1282	XM1Jq	
	At risk violence in the home	13VF	13VF	
	History of domestic violence	14X3	XaJhe3	
3. Child protection / Children's Social Care Services involved?		Read v2	Read v3	
Protection procedures	Child protection procedure	64c	Ub0ex	
	<i>No longer on child protection plan</i>	13Iw	XaOtl	
	Child protection investigation	Z352	Ub0ez	
	Social services case conference	3875	3875	
	Child subject of a child protection plan	13Iv	XaOnX	
	Family member subject to a child protection plan	13Iy	XaPkF	
Contact with social services	Social worker involved	13G4	13G4	
	Refer to social worker	8HHB	XaBva	
	Report received from social services	9NDA	XE2NS	
	Child in Need *4*	13IS	XaEFq	
	<i>Child no longer in need</i> *5*	13IT	Xa1087	
Looked after	Child in care	13IB	13IB	
	Foster care	8GE7	8GE7	
	Fostering medical examination	6982	6982	
	Child lives with another relative	13Ic	XaMFL	
	Child lives with unrelated adult	13Iu	Xa0in4	
4. What other professionals are involved?		Read v2	Read v3	
Healthcare or other professional involved	Health visitor visits	13G2	13G2	
	Under care of paediatrician	9NNG	XaAPa	
	Seen by community paediatrician (v2=seen in paed' clinic)	9N1V	XaASU	
	Seen by child and adolescent psychiatric services	9No0	XaAXM	
	Under care of school nurse	9NNP	XaAQs	
	Police record	13JN	XE0pj	

Tool
4

Record Keeping

Exercise for clinicians

This may be discussed at a clinicians' meeting and carried out on the records of any child registered at the Practice but might be especially useful if the child is known to the Child Protection system and has been seen within the previous twelve months. Look at the records and based on what is recorded, consider the following questions:

- If the family becomes unhappy with the Practice and decides to sue is the Practice legally vulnerable on any account?
- How confident in the record keeping would the Practice be if a child protection case requires a court hearing and a court report is requested?
- Would the Practice be confident in the record keeping if the child is seriously injured or killed and the case becomes a Child Protection case review or Child Death Review?
- How does Practice feel about a Named Safeguarding GP or Nurse, NHS Trust, Local Authority solicitors and the Courts seeing the records?
- How vulnerable would the Practice be if a child's family and their solicitors ask to see the records?
- If the GP/s and/or Practice Nurses feel uneasy about their record keeping – why?
- If the GPs or Practice Nurses have to defend their practice on the basis of their record keeping, will they be able to do so?

For children known to be in need or at risk:

- Do the records accurately describe measures the Practice has put in place to minimise impact of parental (or carer) physical or mental illness or substance abuse on the child?
- If the child is on a Child Protection Plan, is this accurately coded in the records, do the records demonstrate a clear understanding of the GP role in the Plan and show regular monitoring of any GP actions required?
- If the child is Looked After does the record demonstrate that health assessments are carried out in a timely manner, the GP role is understood and the GP contributes to implementation and monitoring of the Care Plan?
- If the child is a care-leaver, i.e. has been in the care of the Local Authority, is this accurately documented and coded in the records?
- Is there a system in place to alert health professionals seeing a care-leaver that there may be increased vulnerability because of the child's history?
- Do the records clearly show that the Practice is actively taking measures to improve health and well-being of a child known to be vulnerable?

For all of the above: **if not why not?**

Tool
5

Safeguarding Children Self-Assessment Tool

For use in General Practices

This Tool has been adapted from the Bournemouth Audit Tool originally developed by the Bournemouth Safeguarding Children Team.

1. Introduction

This is a tool for audit of general practice systems and processes relating to safeguarding children and young people determine whether Practices are currently up to date with requirements. This is designed to be completed as a group exercise by the Primary Health Care Team and might usefully form part of a Safeguarding Children/Child Protection training session or Primary Care Team Meeting Agenda.

It is possible to become overwhelmed by the range of tasks described. Some practices will already be well advanced, others just beginning. The 11 steps listed below will assist you in prioritising tasks based on audit and/or risk assessment. An alternative checklist is available from [NSPCC Safe Network](#).

The 11 steps are:

1. Be aware of, understand and recognise child abuse.
2. Develop and maintain a culture of openness and awareness.
3. Identify and manage the risks and dangers to children and young people in your practice and activities.
4. Develop a child protection policy.
5. Create clear boundaries for example with the limits to confidentiality.
6. Follow safe recruitment practice including obtaining references for all team members.
7. Support and supervise staff and volunteers.
8. Ensure there is a clear procedure for addressing concerns.
9. Know your legal responsibilities.
10. Have a practice policy which welcomes and encourages children and young people to participate in your practice.
11. Provide safeguarding education and training to all members of the team.

Serious Case Reviews undertaken in UK have highlighted a number of recommendations regarding systems and procedures undertaken in general practices, particularly in relation to record keeping including flagging vulnerability, 'child at risk'/'families at risk', families in which there is domestic abuse as well as other medically held information that could have informed multi-agency working if shared appropriately.

Section 11 of the Children's Act (2004) along with 'Working Together to Safeguard Children' (2013) set out the statutory responsibilities of all services, including General Practice, in relation to safeguarding of children and young people. Addressing domestic abuse is an integral part of this agenda.

2. Audit of General Practice systems and procedures

The audit uses the following RAG (Red Amber Green) scoring definitions

Red not yet achieved or little action taken to date

Amber some action undertaken but further work needed to complete

Green completed, procedures in place, monitored and updated on a regular basis

This tool helps practices to consolidate and improve practice, and should be part of ongoing organisational development and risk assessment. It is anticipated that for most Practices there will be further action to be taken on some sections.

As well as summarising action already taken, include any action underway or planned along with anticipated completion dates in the Progress Notes column.

Practices may find it helpful to consider how these recommendations relate to the needs of their specific Practice populations, what barriers might arise to implementing the suggested Plan, and how these might be overcome. They will also need to consider their current systems in relation to GMC Child Protection Guidance and regulator, such as CQC, requirements as well as contractual obligations as laid down by Primary Care Commissioners.

Policies and procedures

Desired outcome	Task(s)	Progress notes	Red Amber Green
		Summary of measures taken by the practice and any further action planned/underway.	
1. The practice has a clearly defined and understood policy in place regarding safeguarding children, young people and vulnerable adults that also addresses issues of domestic abuse and elder abuse. This Policy includes appointment of a Practice Child Safeguarding Lead (who could also be the Practice Child Health Lead) and Deputy.	Develop a Practice safeguarding policy, (which could be a component of the Practice Child Health Policy or the Practice Patient Safeguarding Policy), which is regularly reviewed, monitored for fitness of purpose, updated as necessary and accessible to all staff. The Practice appoints a Child Safeguarding Lead and Deputy.		

2. This policy is known to all members of the Primary Care Team, who are aware of where in the Practice premises or within the IT System the Policy and all supporting documents are stored, and can access these documents whenever required.	Ensure Staff are made aware of the policy and its content at time of induction for new staff and then reminded of the policy and their role in safeguarding at regular updates.		
3. The Practice has a Domestic Abuse Policy and Procedures. Action is taken immediately a domestic abuse issue arises and processes are in place for ensuring this is followed up in the longer-term.	Put in place Domestic Abuse Policy and Procedures and system for following up domestic abuse issues in both the short, and longer-term. Ensure that this Policy and Procedures are understood and used by all GPs and practice staff.		
4. Safeguarding issues, vulnerable families, and domestic violence concerns and reports are regularly addressed in practice meetings including meetings for non-clinical staff and temporary staff.	<p>a) The Practice holds regular Primary Care meetings attended by both clinical and non-clinical staff.</p> <p>b) The Agenda includes safeguarding issues, vulnerable families, and domestic violence concerns and reports as regular agenda items in practice meetings.</p> <p>c) The Practice puts systems in place to ensure temporary staff such as locum GPs are aware of concerns raised at such meetings.</p>		
5. The Practice has regular vulnerable child/ren and family meetings attended by health visitor/s. school nurse/s and social workers where appropriate, at which vulnerable children and families are discussed, information shared, child in need and child protection plans monitored and reviewed.	The Practice communicates effectively with health visitors, school nurses and the local social care team, organises regular vulnerable child/ren and family meetings and ensures proceedings are carefully documented and care plans followed up.		

<p>6. The Practice has a system in place to ensure requests for Child in Need and Child at Risk Reports are identified and dealt with in a timely appropriate way when received.</p>	<p>Administrative staff are able to recognise such requests as urgent and forward them to the GPs as soon as received. There is a system in place to record dates of receipt and response. Should it be decided not to respond (for example if it is discovered that the child is not registered with the Practice), social care is immediately informed, with reasons provided and documented.</p>		
<p>7. The Practice has a system in place for dealing with invitations to attend Case Conferences, and for providing reports for Review Conferences</p>	<p>a) Practice policies and procedures set out how such requests are handled, such as how surgeries will be covered so that the family's GP or the Practice Lead Safeguarding GP can attend. b) A system is put in place to enable GPs to be given protected time to ensure a comprehensive report can be written for Conference especially if they cannot attend in person. c) There is a diary alert system put in place to ensure Review reports are completed and sent in a timely manner especially if the GP is unable to attend the Conference.</p>		
<p>8. The Practice has a system in place to ensure that any hospital or other healthcare provider communications to GPs raising potential concerns about children subject to a Child Protection Plan should be followed up urgently rather than routinely.</p>	<p>Ensure that all communications to the practice about children subject to a Child Protection Plan are recognised by administrative staff and followed up urgently.</p>		
<p>9. The Practice has a system in place for addressing Critical and Sudden Unexpected Incidents including Child Protection Incidents.</p>	<p>The Practice puts in place regular Significant Event Meetings and Audits to assess what could have been done differently, if the incident could have been prevented and how lessons learned can be used to improve quality of practice and care.</p>		

Patient registration and de-registration

Desired outcome	Task(s)	Progress notes	Red Amber Green
		Summary of measures taken by the practice and any further action planned/underway.	
10. At time of registration with a GP all children are seen by a clinician and receive a holistic assessment to include, in addition to usual health and immunisation history, ascertaining relationship to main carer and who has parental responsibility, details of natural parents and siblings, first language, whether at school if of school age, housing circumstances.	The Practice sets up a system to ensure all new child patients receive a base-line assessment of health and social needs at time of registration.		
11. When a vulnerable child leaves the Practice this information is passed on to all involved professionals.	The Practice has a system in place to ensure that when informed of a child leaving the list who is known to be vulnerable, the health visitor and other involved professionals such as paediatrician and social worker are immediately informed.		
12. In the event that a GP practice has either direct or indirect consultations relating to an infant or child who has not yet been registered with the practice, a temporary file should be made. Any direct or indirect discussion/consultation relating to that individual should be documented in this temporary file. If the child does not then register with the surgery these notes should be forwarded on to the registered GP.	<p>The Practice has a system in place for setting up a temporary file for any child not yet registered with the practice and this is used to record any direct/indirect consultations regarding that child. If the child does not then register with the surgery, the temporary notes are forwarded on to the registered GP.</p> <p>The Practice has a facility for flagging a 'child at risk' in electronic patient records is in place and regular checks to that this is consistently used even for temporary residents.</p>		

Record keeping, summarising, coding and filing			
Desired outcome	Task(s)	Progress notes	Red Amber Green
		Summary of measures taken by the practice and any further action planned/underway.	
13.Children's records are summarised in the same way as adults' records and any concerns coded appropriately.	The Practice puts an system of audit in place to examine a sample of children's records annually to check the quality of summarising and coding.		
14.Whenever a child is seen the name of the accompanying adult is noted with detail of relationship to the child.	The GP seeing the child ensures this information is recorded.		
15.Whenever a child is seen a history is taken, including from the child if able to communicate, and the child is examined appropriately if indicated. This is documented.	The Practice puts an system of audit in place to examine a sample of children's records annually to check the quality of record keeping associated with GP and Practice Nurse consultations with children, including recording who accompanies the child.		
16.Children reported as not attending routine hospital or practice appointments should be followed up even if not subject to a CP Plan.	The Practice must have system in place to 'flag-up' children who default from attendance at routine appointments.		
17.Children with more than expected unscheduled attendances at the Practice or other healthcare providers are monitored and followed up.	The Practice has a system in place for monitoring unscheduled child attendances.		

<p>18. Ante-Natal Care: When a woman whose existing children are subject, or have in the past been subject to a Child Protection Plan becomes pregnant GPs notify other relevant professionals (e.g. health visitors and social workers). <i>This also applies to situations where a woman's existing children have been taken into care.</i></p>	<p>The Practice must have a system in place to ensure ante-natal booking referrals contain relevant Child Protection information and also ensure that other involved professionals such as health visitors and social workers are notified when a woman becomes pregnant if her existing children are or have been subject to a Child Protection Plan or have been taken into care.</p>		
<p>19. The practice member of staff responsible for a particular family in recognised challenging circumstances (a vulnerable family) follows up the family when a member(s) misses appointments.</p>	<p>Identify a lead practice member of staff as responsible for each family which is in recognised challenging circumstances (a vulnerable family).</p> <p>This staff member will contact such families when a family member misses an appointment.</p>		
<p>20. Reports received by GP practices from other health providers regarding vulnerable child/ren or families are carefully examined to check if any further action is required to protect the child/ren, such as sharing further information.</p>	<p>Risk assessment process in place to consider the need to share information with other agencies where indicated. Record made of actions taken by the GP practice and reasons why taken including reasons not to share information.</p>		
<p>21. In the event that a GP practice has either direct or indirect consultations relating to an infant or child who has not yet been registered with the practice, a temporary file should be made. Any direct or indirect discussion/consultation relating to that individual should be documented in this temporary file. If the child does not then register with the surgery these notes should be forwarded on to the registered GP.</p>	<p>Set up temporary file for any child not yet registered with the practice and use to record any direct/ indirect consultations regarding that child. If the child does not then register with the surgery, forward the temporary notes on to the registered GP.</p> <p>Ensure that a facility for flagging a 'child at risk' in electronic patient records is in place and ensure that this is consistently used even for temporary residents.</p>		

<p>22. The Practice actively tries to link family members from vulnerable families in medical records, especially if they have different surnames or live at different addresses so they can be flagged. For example if includes drug dependent parents have children subject to a Child Protection Plan, their parents and others living at the same address have their records flagged to note this fact. (This is more complicated if the others are registered at different general practices. Health visitors can often assist with making the links when this is the case).</p>	<p>There is a system in place to ensure family members' medical records are flagged to indicate links, especially if they have different surnames and live at different addresses. This is essential if children are vulnerable or subject to a Child Protection Plan. Known gaps in information are also recorded for example if a parent is registered with another Practice.</p>		
<p>23. Whenever there is a disclosure of a domestic abuse incident this is recorded using appropriate Read codes in the children's medical records as well as the adults' medical records. A note is made for further discussion with the Health Visitor.</p>	<p>Put in place a procedure to ensure that domestic abuse disclosures by adults are also recorded in children's medical records using appropriate Read Codes. Ensure that this procedure is understood and used by all GPs and practice staff.</p> <p>NB Care must be taken with terminology used to record such information in the records of alleged perpetrators, and this should not be recorded as fact unless there is a known conviction for the offence.</p>		
<p>24. When a child become subject to a Child in Need Plan or Child Protection Plan this is recorded in the child's medical record with the associated documentation (e.g. Case Conference Records or Common Assessment Framework) scanned into the child's medical record.</p>	<p>Ensure a record is made when documents are received and all documentation such as Section 17 requests and reports, Section 47 requests and reports, Common Assessment Framework and Case Conference reports, is scanned into each individual child's medical records even where there are a number of children in a family subject to a Child in Need Plan or Child Protection Plan.</p> <p>The Practice develops a policy to deal with information sharing when there are third party references within these reports.</p>		

Tool 6

Reflective Tools

A series of reflective exercises for GPs and their Practice Teams

These are intended to be worked through over a period of time and are for use in professional and organisational development and as a starting point for internal audits and quality improvement projects which may be presented as evidence for GP appraisal and revalidation.

Most of these exercises may be carried out in stages and used as a basis for clinician or practice team meetings.

Tool 6a Reflective Tool: Registration procedure for child patients

Practice Protocol

Are new child patients seen by a clinician at the time of registration?

If not what are the reasons?

What does that mean for the Practice? For example if new patients are not seen because of lack of resources, how does this affect other services on offer?

Is there a risk to the Practice in not seeing new patients at registration?

Is there a risk to patients?

Registration Documentation

Is the following documented at the time of registration?

- Name of main carer and relationship to child.
- Child's first language.
- Name of school if of school age.

New patient assessment (this applies to patients of all ages)

If new patients are seen at the time of registration, is a holistic assessment of their needs carried out, to include:

- Birth history, past and present medical history.
- Family history.
- Medication history, including non-prescription drugs.

- Information on any chronic long-term conditions and care plans.
- Social history to include housing and history of maltreatment or being in care.
- a baseline medical assessment of height, weight, blood pressure.

Consider the records of a child patient registered within the last 5 years who is or has been within the child protection system: Would holistic assessment at the time of registration have resulted in the child being managed differently?

Tool 6b Record keeping, identification, coding, flagging and risk assessment of vulnerable children and families

Coding (to be used in conjunction with Tool 3)

Is there a system in place for coding vulnerabilities? For example is the following coded?

- Child in care.
- Informal fostering arrangements.
- Care leavers.
- Children living in a household where there is domestic abuse.
- Children living in a household where there is substance abuse.
- Children on a Child Protection Plan.
- Children removed from a Child Protection Plan.
- Children with Section 17 provision.
- Children with Early Help provision.

Consider the records of a child who is either in or has been within the child protection system: were any of the codes above recorded? Was the child recognised as being vulnerable?

Alerting and flagging

- Is there a flagging system in place for vulnerable children and families?
- Does the Practice have procedures in place to alert staff to vulnerable families and children who might be at risk?
- Does the system work?
- Does the Practice regularly assess the effectiveness of such systems? For example if an appointment is requested for a child known to be vulnerable, does the Practice offer a same day appointment and is the clinician seeing the child alerted?
- How could the Practice check if the system is working?

Record keeping

Consider the records of a family with children within or who have been in the child protection system.

- Is there any difference between parent and child in how contacts have been documented?
- Looking at the child/ren's records, is there any record of the child, if mature enough, being involved in the consultation and decision making process regarding management of the presenting condition?
- Is there any record of the child's view or opinion?

Storage and sharing of Child Protection Records

- How does the Practice store Child Protection Records such as Case Conference Reports?
- Are they stored separately from the child's records?
- If so, what are the benefits to the Practice?
- What are the benefits to the child?
- What are the risks to the Practice?
- What are the risks to the child?
- How does the Practice address the issue of third party information within such reports?
- What is Practice Procedure for dealing with requests to share records which might contain third party information?
- Who is accountable if third party information is inadvertently shared?

Risk assessment and risk management

- How does the Practice assess risk to children and families?
- What Tools are used?
- Are they effective? This could be assessed by looking at the records of a child/ren who have been in the child protection system to see if vulnerabilities were identified at consultations or within correspondence and recorded using appropriate codes.
- How does the Practice assess risk in relation to infants where there may be underestimation of vulnerability and frailty?
- How does the Practice assess risk relating to sexually active children under 13 or vulnerable young people under 18?
- How does the Practice assess risk in children who self-harm?
- Does the Practice keep an organisational Risk Register?
- How often is it updated?
- Does it highlight any child safeguarding risks specific to your organisation?

Tool 6c Information Sharing for Child Safeguarding

GPs and their staff take patient confidentiality and protection of patient records from unauthorised access very seriously. This Tool may be used during in-house Practice training for both clinical and non-clinical staff to consider situations in which information may be shared without patient consent to aid child safeguarding and child protection. There are a series of questions which may be used as a basis for further discussion and to consider whether staff view current practice procedures as satisfactory or if there might be room for improvement.

Requests from external Agencies to share information

- How does the Practice handle requests by telephone, fax, email or letter to share information? Are these handled differently depending on the medium?
- Is this process described within Practice Policies and Procedures?
- Are all staff aware of the agreed process?
- Usually such requests are for information to be shared urgently, within a set time frame. Is there any risk of such requests 'getting lost' in the system? Is there a system in place to monitor how long it takes for the Practice to respond?
- Are patients informed when such requests are received?
- Do you think they should be informed; what are the risks, what are the benefits?

Sharing Information internally

- Is there a Practice protocol for sharing information internally?
- Does this protocol consider information sharing to safeguard children?
- Does it describe what actually happens in the Practice?
- Why would you want to share information internally and under what circumstances would internal information sharing be considered essential?

Sharing information with consent

- What is the Practice procedure for sharing information with consent?
- How is the child and/or parent informed and involved?
- Who within the Practice is responsible for this process?
- Who is responsible for recording and documenting that consent has been given?

Sharing information without consent

- What is Practice policy if patients are asked for consent to share information but refuse?
- What would you do next?
- What worries staff most about information sharing without consent?
- Is everyone in the Practice agreed on the circumstances in which information can be shared without patient consent?
- Where would staff members turn for advice if there is not agreement?

Case histories

Ask members of staff to think of a child safeguarding situation which has worried them in the last 12 months.

- Was information shared with other agencies about the child and/or family? This information sharing could have been for example an informal discussion with a health visitor, telephone advice from the local safeguarding team or a formal referral to social care.
- Was information shared with or without consent?
- Was the information shared documented?
- Were reasons for sharing given and documented in the patient's records?
- What was the outcome for the child and/or family?
- What was the outcome for the involved clinician?
- What do staff feel about this incident? Does it make them feel satisfied that everything possible was done to protect the child or does it make them feel unsafe or uncomfortable?

Tool 6d Date Sharing Checklist from Information Commissioners Office 2013

Data sharing checklist – one off requests

Scenario:

You are asked to share personal data relating to an individual in 'one off' circumstances. Is the sharing justified?

Key points to consider:

- Do you think you should share this information?
- Have you assessed the potential benefits and risks to individuals and/or society of sharing or not sharing?
- Do you have concerns that an individual is or might in the future be at risk of serious harm?
- Do you need to consider an exemption in the DPA to share?

Do you have the power to share?

Key points to consider:

- The type of organisation you work for.
- Any relevant functions or powers of your organisation.
- The nature of the information you have been asked to share (for example was it given in confidence?).
- Any legal obligation to share information (for example a statutory requirement or a court order).

If you decide to share

Key points to consider:

- What information do you need to share?
 - ☐ Only share what is necessary.
 - ☐ Distinguish fact from opinion.
- How should the information be shared?
 - ☐ Information must be shared securely.
 - ☐ Ensure you are giving information to the right person.
- Consider whether it is appropriate/safe to inform the individual that you have shared their information.

Record your data sharing decision and your reasoning – whether or not you shared the information.

If you share information you should record:

- What information was shared and for what purpose.
- Who it was shared with.
- When it was shared.
- Your justification for sharing.
- Whether the information was shared with or without consent

Tool 6e Sample Section 11 Audit (see Section 4.5 The Role of Regulators in England in inspecting General Practice Safeguarding Children arrangements)

A generic example of such an audit, compiled using examples from several localities, is given below, and may be used as a self-assessment tool for Practice Development.

Most audits consider eight key areas of work covering safeguarding leadership, safe staff recruitment and selection, Practice Policies and Procedures, staff training and development, information sharing, working with other agencies, learning from reviews and effective working with children and families.

This audit may also be adapted to assess Practice safeguarding adult procedures. The key areas are set out below with reasons for their importance.

1. Safeguarding Leadership: *the Practice has in place arrangements which demonstrate the importance of safeguarding and promoting the welfare of children*

- The Practice has a Safeguarding Lead GP and Deputy
- There is also an administrative Lead with responsibility to ensure all staff work to Practice Policies and Procedures

Evidence:

- Documentation of the Lead's work such as dealing with staff enquiries and concerns, referrals to statutory agencies, follow-up of referrals, staff supervision and support, training records.
- Minutes are kept of case review meetings attended by all staff, with agreed actions.
- Record of monitoring of agreed actions.
- Details of access to Policies and Procedures and audit trail to demonstrate how often staff use them.

2. Child Safeguarding Policies and Procedures are in place to support effective working: *Clear, reasonable policies help staff do their job more effectively by setting out their individual responsibilities in relation to safeguarding children.*

Procedures explain the steps to be taken in specific circumstances e.g. if a child makes a disclosure. Policies should be regularly reviewed in collaboration with the workforce and be easily accessible to staff.

- The organisation has Safeguarding Children Policies and Procedures. This policy is updated regularly and at least every 3 years.
- The policies are readily available either in hard copy or on the Practice intranet or website, are easily accessed by all staff, and provide clear, uncomplicated guidance on how to recognise and respond to possible abuse or neglect.
- There is an organisational whistle-blowing policy which encourages staff to report concerns without fear of retribution, underpinned by written procedures for dealing with situations where allegations of abuse are made against someone working in the Practice.
- Safeguarding incidents and allegations of abuse are recorded, monitored and accessible to external assessors.
- Allegations concerning individuals who work with children are referred to the Local Authority Designated Officer as appropriate.

Evidence:

- Details of how staff access Practice Safeguarding Children Policies and Procedures.
- Details of how often they are reviewed and review log.
- Record of failures to comply and reasons.
- Records of responses to complaints, actions taken, how they are monitored.

3. Safe Staff recruitment: *Practices must have in place recruitment and selection procedures which support identification of the right people to work with children and families who may be ill and/or vulnerable.*

Safe recruitment practices ensure the proper selection of staff who will have regular contact with children or vulnerable adults. These practices include:

- Policies clarifying when criminal records checks are necessary.
- Interviews conducted face to face.
- Checks on identity, qualifications and previous employment history.
- Taking up references.
- Checking for unusual features in the application form and CV.
- Referral to the Disclosure and Barring Service if found to be a safeguarding risk to children (or adults).

Evidence:

- Details of safer recruitment policy / practices e.g taking up references.
- Details of Disclosure and Barring Policy and any referrals made.
- Records of any allegations against staff and actions taken.
- Records of any referrals to the LADO.

4. Staff and Practice Development: *Employers in the NHS are responsible for ensuring that their staff are competent to carry out their responsibilities for safeguarding children within their respective roles in accordance with Inter Collegiate Training Guidance.*

- Safeguarding awareness training is required on induction for all NHS staff regardless of degree of contact with children and families. This induction should cover child protection responsibilities dependent on their role within the Practice, how to recognise and respond to possible abuse or neglect, how to use Practice Safeguarding Children Policies and Procedures.
- Additional training plans are in place for those staff members with daily contact with children and families.
- While clinicians are responsible for their own professional development, the Practice has clear training expectations in relation to child safeguarding.
- Training records are kept and regularly reviewed and monitored/ audited.
- Appropriate supervision and support is available for staff working with children and families.
- There is a named Practice lead for Safeguarding Children always available for staff support and advice when dealing with safeguarding issues. Staff are made aware who they should contact for advice on safeguarding issues.

Evidence:

- Description of the induction process and training for new staff including information on safeguarding content.
- Staff training record including for clinical staff;
- Details of training offered and available to staff, including regular updates and multi agency training;
- Details of training pathways and how monitored;
- Evidence that Practice Safeguarding Children Lead provides advice, support and supervision e.g. minutes of supervision meetings.

5. Working Effectively with Children and Families: *'Safeguarding is everyone's business' and staff need to understand how to work together in the Practice as well as with different organisations to ensure children are protected from abuse and neglect. Staff must learn to be confident about responding to safeguarding concerns and knowing what to do if worried about a child.*

- Identification of need: staff members can recognise the abuse or neglect of children and know how to discuss and refer concerns internally;
- Staff know how to make referrals to statutory agencies as appropriate.
- There are processes in place for documenting incidents, concerns and referrals in relation to children. This includes recording the action that results.
- All staff understand the importance of intervening early to prevent problems escalating.
- Depending on their role within the Practice, staff regularly participate in multi-agency meetings and assessments to safeguard children and families.
- Staff are aware of local safeguarding board policies and procedures and know how to access them.
- The wishes and feelings of patients of all ages including children and young people are taken into account when Practices services are designed and delivered
- Wherever possible, children and young people are fully involved in plans to safeguard their welfare, and individual case decisions are informed by the wishes, feelings and experiences of children and young people. (If there are concerns about a child's capacity to consent, there is an assessment of their capacity and in circumstances where the child or young person is deemed to lack capacity a best interest decision is taken).
- Information on how to provide feedback or to complain is readily available for children, young people and families. All feedback and complaints are monitored and reviewed.
- Services available for children and young people ensure equality of access.
- Internal audits are carried out of safeguarding practice.

Evidence:

- Clinicians and senior administrative staff working with children and families attend and keep records of internal review meetings such as critical incident reviews relating to safeguarding or child protection, vulnerable child and family meetings, attendance at external meetings such as with the Named Safeguarding GP, education and training record, evidence of good safeguarding coding and record keeping, evidence of timely response to child protection enquiries, record of reports to Case Conferences and attendance at Strategy Meetings and Case Conferences.
- Children and families are regularly invited to provide feedback on services.
- Records are kept of how complaints are handled and monitored.
- Evidence that services are accessible to children and families especially the most vulnerable.

6. Sharing and storing information: *Where there are concerns about safeguarding children, relevant information should be shared with safeguarding specialists and/or statutory agencies such as social care without delay.*

- Practice Policies and Procedures set out clearly the processes for sharing information with other professionals where this is necessary to protect children from harm.
- Details of these arrangements are covered at staff induction.
- Training and guidance on information governance and Practice record keeping policies is available for staff.
- Child Protection Records are stored securely and safely and there are clear processes in place to ensure that Child Protection records are accessible to all Practice clinicians and made available for Case Reviews such as Serious Case Reviews.

Evidence:

- Details of the guidance used in the organisation e.g. Caldicott.
- How guidance and training, on information sharing, is made available to staff (both on induction for new starters and for existing staff).
- Child Protection concerns are appropriately coded and recorded.
- When information is shared this is documented in patient records showing when, to whom, and why and what information was shared.
- If a decision is taken not to share information, this is clearly documented giving reasons.

7. Learning from Incidents and Reviews: *Professionals and organisations need to reflect on the quality of their services to children and families to learn from their own practice and that of others. Good practice may be shared to increase understanding of what works well. When things go wrong then a scrupulous, objective analysis of events to understand what happened and why, can lead to service improvement to reduce the future risk of harm.*

This Review process is covered in **Section 10**.

Evidence:

- Records of reviews to which the Practice has contributed and resulting actions.
- Records of internal reviews and resulting change in practice, including how this is monitored and audited.

Tool 6f Exercise to consider the impact of adverse parental factors such as Domestic Abuse, Drug and Alcohol Abuse, Mental Health issues, on parenting ability

1. What do we do as a Practice to decrease impact of parental problems on the children?
2. Examine a selection of records of parents or carers with these issues, then look at their children's records to see if the issue is clearly coded and documented so that all practitioners seeing the patient is made aware of the issues.

3. Then consider the children's records to see if there is any coding or documentation related to parental problems or any record of actions to mitigate the impact of parental problems on the child/ren, for example, discussion with other involved professionals such as Health Visitors, School nurses, Teachers, use of local Early Help schemes or Common Assessment Framework, referrals to Children's Centres, Playgroups, etc.

4. Considering specific families, the following could be considered:

- What else could we have done?
- What went well for the children?
- What could have been better?
- Were any of the children referred to social care?
- If not should any have been referred?
- Were any subject to Section 17 or 47 investigations?
- Was a Case Conference called on any of the children?
- Are any of the children on a Child protection Plan?
- Have any been taken into Care?
- Have any been referred to CAMHs?

Tool 6g Domestic Abuse

An exercise for whole practice training to include non-clinical staff, based on evidence that providing abuse victims with full information about their legal rights and helping victims and children to obtain protection from violence with relevant practical and other assistance can improve outcomes for such families (see **Section 3.3**).

Domestic Abuse Protocols and Procedures

- Are there Practice Domestic Abuse Protocols and Procedures?
- If the answer is yes, when was it last reviewed?
- Are all staff aware of it?
- Do all staff work to it?
- Where is patient information about domestic abuse support displayed and/or stored?
- Are all staff aware of this information?
- Is it regularly updated?
- When did a member of staff last access this advice?
- Does everyone in the Practice know what to do if worried about a victim of domestic abuse or the children in the family?

Relationship between Child and domestic abuse

- When a child protection enquiry is received by the Practice, are checks automatically made on the parent/carer records for domestic abuse?

Considering **domestic abuse notifications** from the health visitor or child safeguarding team:

- What does the Practice do with these notifications?
- Who is responsible for recording and disseminating this information?
- What happens next after a notification is received?
- Are all staff made aware of these notifications?

- Why should all staff be made aware?
- What else should happen when a notification is received?
- Are these notifications discussed at the vulnerable child and family meetings?

Support for families and victims

- What does the Practice do to assess impact of the abuse on the victim?
- What does the Practice do to assess impact of the abuse on the victim's children?
- Is any support offered to the victim or victim's children when notification of an incident is received? For example are any children referred for counselling or CAMHs?
- Do clinicians maintain a policy of encouraging adults in an abusive situation to be seen separately and develop relationships with different GPs so that each might speak freely without fear of retribution?

Next steps

- Is everyone agreed that everything that could be done to support and help victims of domestic abuse and their children registered with the Practice is being done?
- If not, what should be put in place?

Tool 6h Serious Domestic Incident Meeting: When domestic abuse results in serious injury or death

After a patient's sudden death or serious injury, health professionals and others involved in the family's care are expected to support the family but may struggle to deal with their own shock and emotional response. GPs and their Practice Teams might find it a mutually beneficial exercise to consider such incidents at a Sudden Unexpected Incident Meeting using a chronology of contacts with the Practice as the basis for discussion of the following:

- Does the surgery have policies and procedures in place for dealing with concerns about domestic violence and abuse?
- Is everyone in the Surgery aware of domestic violence and abuse protocols agreed with other agencies, including any information-sharing protocols?
- Were GPs and Practice Nurses seeing the victim responsive to the needs of the victim and the perpetrator?
- Are they knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if there are concerns about a victim or perpetrator?
- Is it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations? Is a need for further training indicated?
- Was the victim informed of options/choices to make informed decisions?
- Were they signposted to other agencies?
- Are GPs and the Team aware of standard risk assessment tools, procedures and policies?
- Are there standardised procedures for recording domestic abuse disclosures and notifications?
- Was the victim subject to a [MARAC](#)?

Next steps: what can the Practice Team do differently following this discussion, who will be responsible for developing and implementing an action plan, how will the plan be monitored and when will it be reviewed?

Tool 6i **Template for recording reflective Practice meetings on Child Protection Adverse Events** such as Critical Incident Reviews, Serious Case Reviews and Sudden Unexpected Death

Definitions:

Adverse event	An incident that did lead to harm e.g. unexpected death or serious injury
Near miss	An incident that did not lead to harm
Safeguarding incidents	This term covers everything that could have or did cause harm to a child/ren or family

Meeting Record

Date of Meeting	Attendance List
-----------------	-----------------

What is the event on which you are reflecting:

Brief description of event:

Issues raised by the event:

What went well?

What did not go well?

As a result of the discussion, have any gaps or risks in clinical or administrative practice been identified?

Should any changes be made and what are they?

Are there any staff training and/or other performance management needs?

Should any of your learning from this incident be shared externally, for example with the Named Safeguarding GP? Should it be shared anonymously?
Consider how this could be done.

Adapted from Source: Luce R Safeguarding Children: Legal Framework for Nurses, Midwifery and Community Practitioners.
Publishers: John Wiley & Blackwell.
[Evidence into Practice](#)

Tool

7

Specimen report for Section 47 Reports and Case Conferences

 [Back to main contents](#)

When completing this report remember it will be read by social workers who may be unfamiliar with medical terminology. Use clear comprehensible language and be careful to distinguish objective factual information from concerns or intuition.

Specimen GP Report to a Section 47 Enquiry and Initial Child Protection Conference Report

Please complete this form for use as a response to Section 47 enquiries and as an initial Child Protection Conference report.

Use additional sheets as necessary or attach computer printouts or a supporting letter where relevant.

Child's NAME	DOB	Address

Main Carer/s NAME	Relationship to child	DOB	Address

If main carer not a parent, details of parents if known:

Father's NAME	DOB	Address

Mother's NAME	DOB	Address

Name and DOB	Relationship	Relationship

Name	Relationship or connection

RECORDED CONSULTATIONS over last 12 months	Number	DNAs
GP		
Nurse, Nurse practitioner, PHCT		
OOH service		

IMMUNISATIONS:

Contact with other NHS Services and other Agencies	NO	YES
Paediatrician		
A&E		
GP OOHs/Urgent Care of Walk-in Centres		
Other Hospital IP/OPD		
SALT/other therapies		
CAHMS		
Ed Psych		

MEDICAL and SOCIAL HISTORY

Birth and neonatal		
Developmental		
Physical		
Emotional/psychological		
Any known significant social issues e.g. running away from home, involvement with gangs		
Prescribed Medication		

FAMILY OR HOUSEHOLD ISSUES

From your records, are there any concerns about:

DOMESTIC VIOLENCE within the household, extended family or likely carers?

If YES please give details.

SUBSTANCE/ALCOHOL MISUSE within the household, extended family or likely carers?

If YES please give details.

LEARNING DISABILITY, MENTAL OR PHYSICAL ILLNESS in the carers which may impinge on their ability to care for and protect the child adequately? If YES please give details.

DO YOU HAVE ANY CURRENT CONCERNS ABOUT THE CHILD including unexplained/suspicious injuries, neglect social, behavioural or psychological issues? If YES please give details.

INFORMATION SHARING

Have you shared this report with the child/parents/carers?

Do you have any reason/s for NOT sharing this report? If so please state reason/s.

Are there any sensitive issues which should be discussed in confidence and/or not shared with the child/parent or carer?

Comments:

I confirm that I have reviewed the child's medical record and the records of all relevant family/household members in compiling this report.

Name/address/contact details of GP

Date form completed

Signature of GP

If this is a report for Cased Conference, will you be attending this conference?

NO

YES

Tool
8

Specimen Form for Child Registration



 [Back to main contents](#)

New Patient questionnaire

Under 16 year olds

Personal details

Surname	Date of birth
Forename/s	Male/Female
Address	
Postcode	
NHS No	Nationality
Place of birth	
Full name of Main Carer	Main Carer's
Home tel number	Work/mob tel number
Relationship to Child	Ethnicity (please tick)
First language of Child	White <input type="checkbox"/>
First language of Carer	Black <input type="checkbox"/>
Birth Weight and any problems at birth	Asian <input type="checkbox"/>
Any developmental problems?	Chinese <input type="checkbox"/>
Name of Previous GP	Eastern European <input type="checkbox"/>
Name of Practice	South American <input type="checkbox"/>
Name of School if applicable	Mixed Race <input type="checkbox"/>
Your previous address	
Postcode	

Past medical history

Please list any illnesses/operations
(There is additional space on the back of this form if required)

Are you allergic to medication

☐ Yes

☐ No

If Yes, which type of medication

Do you have any allergies

☐ Yes

☐ No

If Yes, which are you allergic to

Do you suffer from (please tick if you do)

☐ Asthma

☐ Diabetes

☐ Thyroid disease

☐ High blood pressure

☐ Epilepsy

☐ Heart disease

Family history

Are any of your closest family members affected by any of these conditions (please tick)

<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Blindness	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Heart disease
<input type="checkbox"/> Infectious diseases	<input type="checkbox"/> Others (please specify) _____	
<input type="checkbox"/> Cancer Type of cancer (if known) _____		

Immunisations Please give date when these vaccinations were given

1st DTP/Polio	2nd DTP/Polio
3rd DTP/Polio1st Hib	1st Hib
2nd Hib	3rd Hib
1st Men C	2nd Men C
3rd Men C	Booster Hib
MMR	Pre School
Booster MMR	Others

Next of Kin (Full Name) _____

Relationship to you _____

Address _____

Postcode _____ Tel No _____

Extra space for additional information

(Please add any other relevant information you think the Doctor should be aware of)

This image shows a single sheet of white paper with horizontal blue ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

To be completed by Practice staff

Date of appointment for health check with Practice Nurse

Tool
9

Specimen form for vulnerable child leaving Practice >

[< Back to main contents](#)

[Today's Date..]

Notification of Vulnerable Child leaving GP List

Dear Colleague

Name:

DOB:

NHS number:

Address:

Next of kin:

School (if known):

We would like to advise you that the patient detailed above was registered at Liquorice Health Centre and is currently subject to a Section 47 Enquiry or Child Protection Plan

The patient left the Practice list on:

Date:

I T Team
Liquorice Health Centre

Copies to:

Health Visiting Team
Social Worker named in Case Conference Minutes
Children's Services or area equivalent
Child Health record system

Tool
10

For commissioners: Named Safeguarding Children GP Skills, Competences and Role Description

The Named Safeguarding Children GP should

1. Be an experienced GP of good professional standing with extended knowledge and skills in the care of children and young people as evidenced by a higher qualification in Child Health such as DCH or MSc, and/ or experience working in delivery of child health services within community paediatrics, schools or secondary care. GPs may also have developed expertise through a range of other activities, including education, research, involvement with service development and management.

- Experience (current or previous) of working in relevant departments and professional specialties, such as attachment to a community paediatric unit under the supervision of a specialist practitioner;
- Self-directed learning with evidence of the completion of individual tasks.
- Attendance at recognised meetings / lectures / tutorials on specific relevant topics.
- As a trainee or other non-consultant career grade post under the supervision of a specialist or consultant in safeguarding children and young people in the secondary care service.
- Under supervision of a specialist clinician to include experience of seeing cases, attendance at Local Safeguarding Children Board meetings, Child Protection Case Conferences and multi-agency training and educational meetings.
- As part of a vocational training programme.
- During the Foundation Year 2 post.
- As a clinical placement agreed locally.
- As part of a recognised university course.
- Delivery of training to relevant safeguarding special interest professional groups.
- Successful completion of a diploma or equivalent.
- Participation in recognised training by an appropriate medical Royal College, eg, RCPCH Level 2 training.
- RCGP Master classes.
- An educational role within the community supporting the development of safeguarding in local primary care.
- Evidence of working under direct supervision with a specialist clinician in relevant clinical areas. [The number of sessions should be sufficient to ensure that the GP is able to meet the competences of the service requirements].

2. Be a member of the RCGP.

3. Possess key skills areas

- Effective communication and engagement with children, young people and families.
- Child and young person development.
- Safeguarding and promoting the welfare of the child.
- Supporting transitions.
- Multi-agency working.
- Sharing information.

4. Be developing or already be acknowledged to have safeguarding/child protection expertise.

5. Have a higher qualification related to the nature of the post, for example: a GP trainer accreditation or similar level qualification for a post with mostly educational activities; or membership of the Faculty of Forensic and Legal Medicine (FFLM) for posts involving forensic work.

Job description for all named professionals

1. Support all activities necessary to ensure that the organisation meets its responsibilities to safeguard/protect children and young people.

2. Be responsible to and accountable within the managerial framework of the employing organisation.

3. At all times and in relation to the roles and responsibilities listed, work as a member of the organisation's safeguarding/child protection team.

4. Inter-agency responsibilities

- a) Participate in the health group and other subcommittees of the LSCB /the safeguarding panel of the health and social care trust/the child protection committee.
- b) Advise local police, children's social care and other statutory and voluntary agencies on health matters with regard to safeguarding/child protection.

5. Leadership and advisory role

- a) Support and advise the board of the health care organisation about safeguarding/child protection.
- b) Contribute to the planning and strategic organisation of safeguarding/child protection services.
- c) Work with other specialist safeguarding/child protection professionals on planning and developing a strategy for safeguarding/child protection services.
- d) Ensure advice is available to the full range of specialties within the organisation on the day-to-day management of children and families where there are safeguarding/child protection concerns.
- e) Provide advice (direct and indirect) to colleagues on the assessment, treatment and clinical services for all forms of child maltreatment including neglect, emotional and physical abuse, Fabricated or Induced Illness (FII), child sexual abuse, honour-based violence, child trafficking, sexual exploitation and detention.

6. Clinical role (where relevant)

- a) Support and advise colleagues in the clinical assessment and care of children and young people where there are safeguarding/child protection concerns, as part of own clinical role, whilst being clear about others personal clinical professional accountability;
- b) Support and advise other professionals on the management of all forms of child maltreatment, including relevant legal frameworks and documentation;
- c) Assess and evaluate evidence, write reports and present information to child protection conferences and related meetings;
- d) Provide advice and signposting to other professionals about legal processes, key research and policy documents ;

7. Co-ordination and communication

- a) Work closely with other specialist safeguarding/child protection professionals across the health community;
- b) Ensure the outcomes of health advisory group discussions at an organisational level are communicated to the safeguarding/child protection team and other staff, as appropriate;
- c) Work closely with the board-level executive lead for safeguarding/child protection within the health care organisation;
- d) Liaise with professional leads from other agencies, such as Education and Children's Social Care.

8. Governance: policies and procedures

- a) Ensure that the health care organisation has safeguarding/child protection policies and procedures in line with legislation, national guidance, and the guidance of the LSCB/the safeguarding panel of the health and social care trust/the child protection committee;
- b) Contribute to the dissemination and implementation of organisational policies and procedures;
- c) Encourage case discussion, reflective practice, and the monitoring of significant events at a local level.

9. Training

- a) Work with specialist safeguarding/child protection professionals across the health community and with the training sub-groups of the LSCB/ the safeguarding panel of the health and social care trust/the child protection committee to agree and promote training needs and priorities;
- b) Ensure that every site of the health organisation has a training strategy in line with national and local expectations;
- c) Contribute to the delivery of training for health staff and inter-agency training;
- d) Evaluate training and adapt provision according to feedback from participants;
- e) Tailor provision to meet the learning needs of participants.

10. Monitoring

- a) Advise employers on the implementation of effective systems of audit;
- b) Contribute to monitoring the quality and effectiveness of services, including monitoring performance against indicators and standards;
- c) Contribute, as clinically appropriate, to serious case reviews/case management reviews/significant case reviews, and individual management reviews/ individual agency reviews/internal management reviews;
- e) Disseminate lessons learnt from serious case reviews/case management reviews/significant case reviews, and advise on the implementation of recommendations.

11. Supervision

- a) Provide/ensure provision of effective safeguarding/child protection appraisal, support and supervision for colleagues in the organisation;
- b) Contribute to safeguarding/child protection case supervision.

12. Personal development

- a) Meet the organisation's requirements for training attendance;
- b) Attend relevant local, regional, and national continuing professional development activities to maintain competences;
- c) Receive regular safeguarding/child protection supervision and undertake reflective practice;
- d) Recognise the potential personal impact of working in safeguarding/child protection on self and others, and seek support and help when necessary.

13. Appraisal

Receive annual appraisal from a professional with specialist knowledge of safeguarding/child protection and with knowledge of the individual's professional context and framework.

14. Accountability

- a) Be accountable to the chief executive of the employing body;
- b) Report to the medical director, nurse director or board lead with primary responsibility for children's services and safeguarding within the organisation;

15. Authority

The Named Doctor should have the authority to carry out all of the above duties on behalf of the employing body and should be supported in so doing by the organisation and by colleagues.

16. Resources required for the post

Professionals' roles should be explicitly defined in job descriptions, and sufficient time and funding must be allowed to fulfil their child safeguarding responsibilities effectively.

- a) The time required to undertake the tasks outlined in this Job Description will depend on the size and needs of the population, the number of staff, the number and type of directorates/operational units covered by the health care organisation, and the level of development of local safeguarding/child protection structures, process and function.
 - b) The health care organisation should supply dedicated and effective secretarial and administrative support.
 - d) The employing body should ensure that during a serious case review/case management review/significant case review the professional is relieved of some of their other duties. The employing body should delegate these appropriately to ensure that the work of the specialist safeguarding/child protection professional is still carried out effectively.
 - e) The health care organisation should supply additional support when the professional is undertaking an individual management review/individual agency review/internal management review, as part of a serious case review/case management review/significant case review
 - f) Given the stressful nature of the work, the health care organisation should provide safeguarding/child protection focused support and supervision for the specialist professional.
- This outline is based on the duties and responsibilities of the named professional in England.

References

1. Carpenter, J., *et al*, (2009) Organisation, outcomes and costs of inter-agency training for safeguarding and promoting the welfare of children DSCF Nov 2009.
2. Dept for Education and Skills (2004) Common Core Skills and Knowledge for the Children's Workforce 2004 www.cwdcouncil.org.uk/commoncore
3. HM Gov Working Together to Safeguard Children 2013
4. Laming, H., (2009) The Protection of Children in England: A Progress Report March 2009 www.publications.everychildmatter.gov.uk
5. RCGP GUIDANCE AND COMPETENCES FOR THE PROVISION OF SERVICES USING PRACTITIONERS WITH SPECIAL INTERESTS (PWSIs) SAFEGUARDING CHILDREN AND YOUNG PEOPLE http://www.rcgp.org.uk/clinical-and-research/clinical-resources/~/_media/FA0C58A739964D009E21757D77923B0F.ashx
6. Royal College of Paediatrics and Child Health (2012) Model Job Description Named Doctor for Child Protection <http://www.rcpch.ac.uk/child-health/standards-care/child-protection/child-protection>

Tool
11a

Early Years Child Development

A general knowledge of the key milestones in the early years of a child's life will help with assessing developmental needs, taking a history and carrying out an examination when a child presents with illness, failure to thrive or injury.

Important Milestones in Child Development, a Poster provided courtesy of the charity Contact a Family, and devised by Dr John Oates and Dr Silvana Mengoni of the Open University, illustrates the ages by which most children will have gained certain skills. This poster links with the [Personal Child Health Record](#) and the [Statutory Early Years Foundation Framework](#). The [Early Years Journal](#) is particularly useful if you know or suspect that a child you are seeing is unlikely to progress in the same way as other children whether or not a particular factor or learning difficulty has been identified and given a name.

If more detailed resource is required regarding particular milestones, refer to the [Development Matters](#) document on the early foundation years' website.

Training videos on monitoring child development may be found at the [Newborn and Infant Screening](#) website

References

Bayley, N., (2006) *Bayley Scales of Infant and Toddler Development*. 3rd edn. Pearson Education, Inc., San Antonio, TX.

Early Support (2013) *Early Years Developmental Journal*.
www.ncb.org.uk/media/894183/early_years_developmental_journal2013.pdf

Frankenburg, W.K., Dodds, J.B. (1968) *The Denver Developmental Screening Test-Manual*. University of Colorado Press, Denver.

Griffiths, R. (1967) *The Abilities of Babies*. University of London Press, London.

Sheridan, M.D. (2008) *From Birth to Five Years: Children's developmental progress*. Routledge, London.

Tool

11

Poster Guide to Child Development

Important milestones in child development

The table below lists the ages by which most children will have gained certain skills. If your child has not reached these milestones by these ages, it is advisable to talk your health visitor or GP.

	PERSONAL, SOCIAL AND EMOTIONAL	COMMUNICATION	PHYSICAL	THINKING
6 MONTHS 	<ul style="list-style-type: none"> Holds eye contact briefly (5 seconds or more) Recognises and is most responsive to main carer; face brightens, activity increases when familiar carer appears Shows emotional responses to other people's emotions – for example, smiles when smiled at and becomes distressed if hears another child crying 	<ul style="list-style-type: none"> Turns eyes and/or head towards you when you speak Reacts by smiling, looking and moving when you interact Vocalises back when talked to (making own sounds) especially to familiar adult and when a smiling face is used 	<ul style="list-style-type: none"> Makes smooth movements with arms and legs, which gradually become more controlled Explores hands and fingers – for example, watches them, presses hands together, clasps and unclasps hands Picks up and explores objects – for example, by holding to mouth 	<ul style="list-style-type: none"> Shows interest in new experiences – for example, when you show a new toy Repeats actions that have an effect – for example, kicking or batting a mobile to create movement including actions to make a sound again, for example, shaking a rattle Shows anticipation and enjoyment of familiar caring routines and simple games – for example, sucks or licks lips in response to sounds of preparation for feeding or gets excited upon seeing spoon or familiar toy
12 MONTHS 	<ul style="list-style-type: none"> Shows attachment to special people – for example, by being distressed when they are separated, staying close and showing affection Follows with gaze when an adult directs attention to an object by looking and pointing – for example, when an adult points to a bus and says "Look at the bus" and your child looks at the bus 	<ul style="list-style-type: none"> Begins to babble by repeating a series of the same sounds – for example, 'ba-ba-ba', 'ma-ma-ma' Points to objects and people, using index finger 	<ul style="list-style-type: none"> When sitting, can lean forward to pick up small toys Actively cooperates with nappy changing – for example, lies still, helps hold legs up 	<ul style="list-style-type: none"> Watches toy being hidden and tries to find it Struggles to get objects that are out of reach and pulls a mat towards them to make a toy or object come closer
18 MONTHS 	<ul style="list-style-type: none"> Uses other person to help achieve a goal – for example, to get an object that's out of reach or activate a wind-up toy Is aware of other people's feelings – for example, looks concerned if hears crying, or looks excited if hears a familiar happy voice 	<ul style="list-style-type: none"> Uses approximately five different words without any help Recognises and will identify many objects and pictures (by pointing) when asked questions – for example, "Where's the ball?" 	<ul style="list-style-type: none"> Takes first few steps; feet wide apart, uneven steps, arms raised for balance Signals wet or soiled nappy or pants 	<ul style="list-style-type: none"> Engages in simple pretend play with soft toys – for example, hugs and kisses teddy or pretends to be asleep by covering self with a blanket and closing eyes Matches shape of piece to hole – for example in a shape sorter
2½ YEARS 	<ul style="list-style-type: none"> Uses a familiar adult as a secure base from which to explore independently in new environments – for example, goes away to play and interact with others, but returns for a cuddle if becomes anxious Demonstrates sense of self as an individual – for example, wants to do things independently, says "No" to adult, and so on Shows understanding of some rules and routines 	<ul style="list-style-type: none"> Says two words together – for example teddy sleeping, more juice Recognises and joins in with songs and actions – for example, 'The Wheels on the Bus' Says three words together – for example, 'go park today', 'big red bus' 	<ul style="list-style-type: none"> Starts to help with dress and hygiene routines Holds pencil between thumb and two fingers no longer using whole hand grasp Shows control in holding and using hammers, books and mark-making tools 	<ul style="list-style-type: none"> Can organise and categorise objects – for example, putting all red things and all blue things in separate piles Operates mechanical toys – for example, turns the knob on a wind-up toy, pulls back on a friction car, pushes button to open flap Completes simple puzzle board
3½ YEARS 	<ul style="list-style-type: none"> Recognises self in mirror or photo – for example, if looks in mirror and sees dirt or food on face, tries to wipe it off, or points to self in photo when asked Shows independence in selecting and carrying out activities 	<ul style="list-style-type: none"> Listens eagerly to short stories, is able to talk about particular parts of them and requests favourites over and over again Uses a range of tenses – for example, 'play', 'playing', 'will play' and 'played' 	<ul style="list-style-type: none"> Catches a large ball Washes and dries hands 	<ul style="list-style-type: none"> Is more organised, gathering together the toys they want to play with before starting play – for example, getting the doll and the tea set before starting to play tea-parties or getting the train and tracks and setting them out before playing trains Draws person with head and one or two other features or parts
5 YEARS 	<ul style="list-style-type: none"> Is curious about others and can adapt behaviour to fit in with different events and social situations – for example, removing shoes and socks before going on slide after seeing others doing this Works as part of a group or class, taking turns and sharing fairly, understanding that there need to be agreed values and codes of behaviour for groups of people, including adults and children, to work together harmoniously 	<ul style="list-style-type: none"> Uses longer sentences to link more than one idea, for example "We walked to the park and we watched the ducks" Can pick out the first sound in a word 	<ul style="list-style-type: none"> Reliably dry and clean during the day Dresses and undresses independently 	<ul style="list-style-type: none"> Concentrates and listens for more than ten minutes in adult-led activities that they enjoy Shows flexibility in trying different ways of tackling problems

Tool
12

Information Sharing Poster



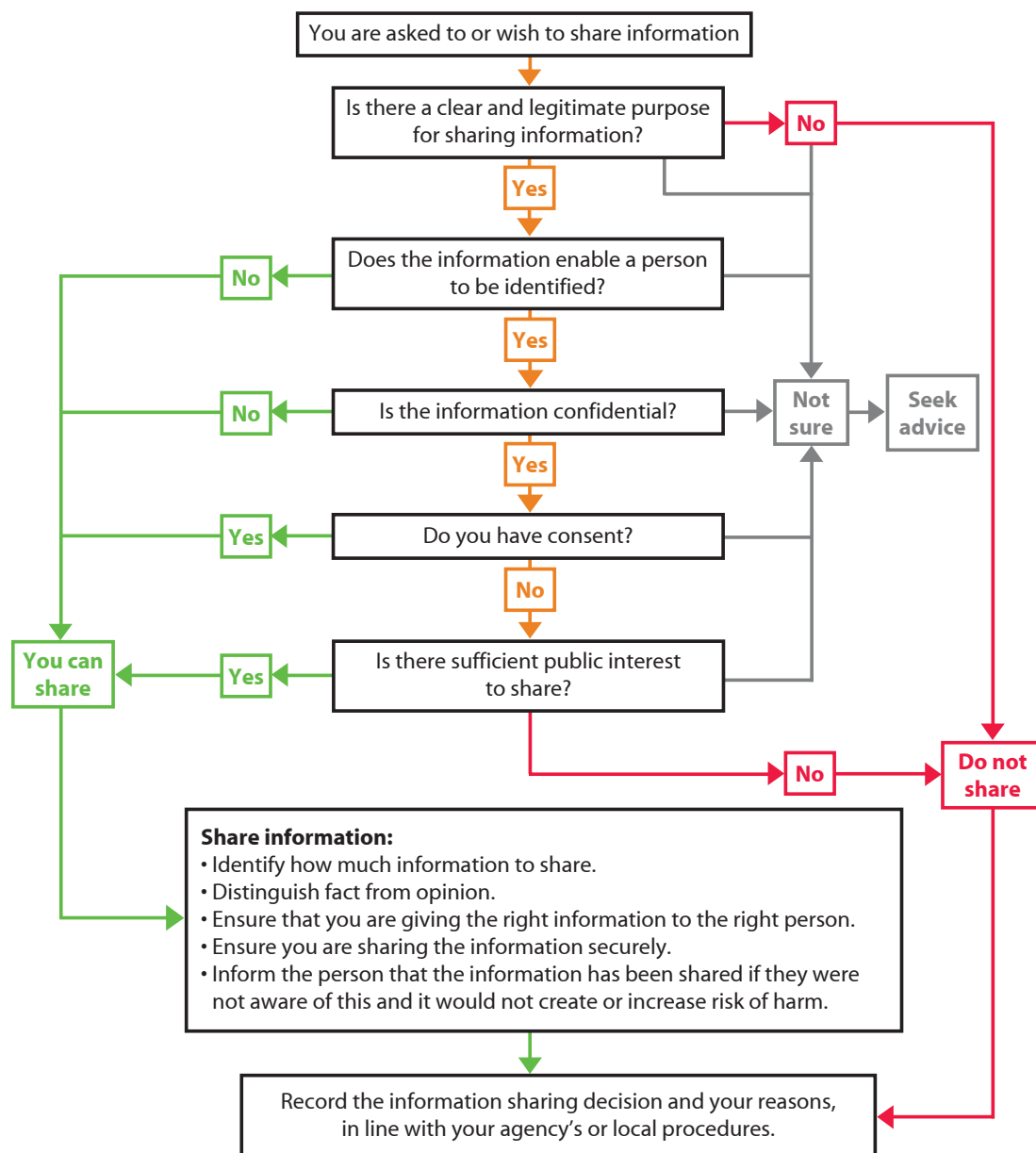
[!\[\]\(6605b201d6f14d9b3bcb8ab5f274d107_img.jpg\) Back to main contents](#)

Seven **golden rules** for information sharing

1. **Remember that the Data Protection Act is not a barrier to sharing information** but provides a framework to ensure that personal information about living persons is shared appropriately.
2. **Be open and honest** with the person (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so.
3. **Seek advice** if you are in any doubt, without disclosing the identity of the person where possible.
4. **Share with consent where appropriate** and, where possible, respect the wishes of those who do not consent to share confidential information. You may still share information without consent if, in your judgement, that lack of consent can be overridden in the public interest. You will need to base your judgement on the facts of the case.
5. **Consider safety and well-being:** Base your information sharing decisions on considerations of the safety and well-being of the person and others who may be affected by their actions.
6. **Necessary, proportionate, relevant, accurate, timely and secure:** Ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those people who need to have it, is accurate and up-to-date, is shared in a timely fashion, and is shared securely.
7. **Keep a record** of your decision and the reasons for it – whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose.

Local contacts

Flowchart of key questions for information sharing



If there are concerns that a child may be at risk of significant harm or an adult may be at risk of serious harm, then follow the relevant procedures without delay.

Seek advice if you are not sure what to do at any stage and ensure that the outcome of the discussion is recorded.

Local contacts

Tool
13

ChildSafe Trigger Tool

 [Back to main contents](#)

ChildSafe Trigger Tool

‘Safeguarding our children from harm’

Guidelines for use in general practice

Purpose

The purpose of the ChildSafe Trigger Tool is to help GP practices assess information received from Emergency Department/ Out of Hours/Urgent Care/Walk-in Centres about child attendances in order to identify and act on potential safeguarding concerns.

Context for change

The ChildSafe Trigger Tool has been developed in response to a learning lessons review (LLR) undertaken by Durham Local Safeguarding Children Board (LSCB). This review identified that incoming information on the children involved was treated by the practice as ‘isolated events’; leading to a lack of recognition of the frequency of the children’s injuries. A recommendation was made that a ‘tool’ be developed to assist practices process communications from other parts of the health system in order to help reduce the risks of similar situations reoccurring.

Structure of the Childsafe Trigger Tool

The ChildSafe Tool consists of 9 potential factors that *may* indicate a child is vulnerable. They relate to the vulnerability factors that have been identified within the Biennial Analyses (Ofsted, (2011); Brandon *et al*, (2012)) of national serious case reviews.

Although these factors are known to be of significance, it is not possible to weight the individual factors directly to the vulnerability of any child. It is a combination of these factors and professional judgment that will assess the information along with local knowledge for each individual child and identify potential risk.

The ChildSafe Tool is intended for use with any communication, including letters and communications (paper or electronic) which indicates that the child has attended parts of the health system because of incurring a physical trauma.

The ChildSafe Tool can also be used for non-trauma should there be a reason for any concern.

Supporting definitions

The following definitions are being used in the context of the ChildSafe Trigger Tool:

- A **'Child'** is defined as being under 18 years of age.
- **'Trauma'** is intended to include all injuries, including self-harm and overdose

Process: roles and responsibilities (See flow chart)

It is the responsibility of the practice safeguarding children leads to ensure a robust system is communicated and operates effectively in their practice.

1. Practice receives health information regarding a child's attendance at urgent care, out of hours, walk in or Emergency Department centre.
2. Communication relates to a child trauma.
3. Child demographic entered onto Childsafe Trigger Tool.
4. Information gathered against the Childsafe categories.
5. Assessment of harm against Childsafe Trigger tool undertaken by a clinician.
6. Outcome and actions taken forward following the assessment to be coded (when available) and recorded as part of the child's health record.

If a clinician finds an alerting feature it is recommended that they follow the actions in the "Consider maltreatment" box in the NICE guidance flowchart.

At any point the clinician can discuss their concerns with the Names Nurse, Named GP, Designated nurse, Designated Doctor, police or local authority colleagues.

Name of child

NHS number

EMIS number



North Durham

Clinical Commissioning Group

ChildSafe Trigger Tool

Safeguarding children from harm

Standard: For use against all child information relating to trauma received from urgent care, out of hours and emergency departments

Process: On receipt of clinical information review the child's records against the ChildSafe Trigger Tool

Clinical advice: Practice Safeguarding Lead, Named GP for safeguarding children or Designated Doctor Safeguarding Children

	Assessment of information		Yes	No
C	Child	Child has child protection plan or is a children in need or is looked after by the local authority		
H	House moves – if available	More than two moves in the last year/registered in the last 6 months		
I	Injury events	More than 3 ED/OOH/UC attendances in the last 6 months		
L	Learning and other Disabilities	Either the parents or child		
D	Domestic violence or other injuries in household	Including parents, partners and siblings		
S	Substance abuse documented, including Alcohol	Any substance abuse documented, including drugs and alcohol		
A	Age of child	Note, if under 1year		
F	Family members	Other issues in household including frequent DNAs, diagnosed mental health illness, a number of different partners		
E	External agencies	Involvement from wider external agencies e.g. social care, probation		

© North Durham Clinical Commissioning Group 2013

Updated 29/09/13

Name of child

NHS number

EMIS number

Actions taken

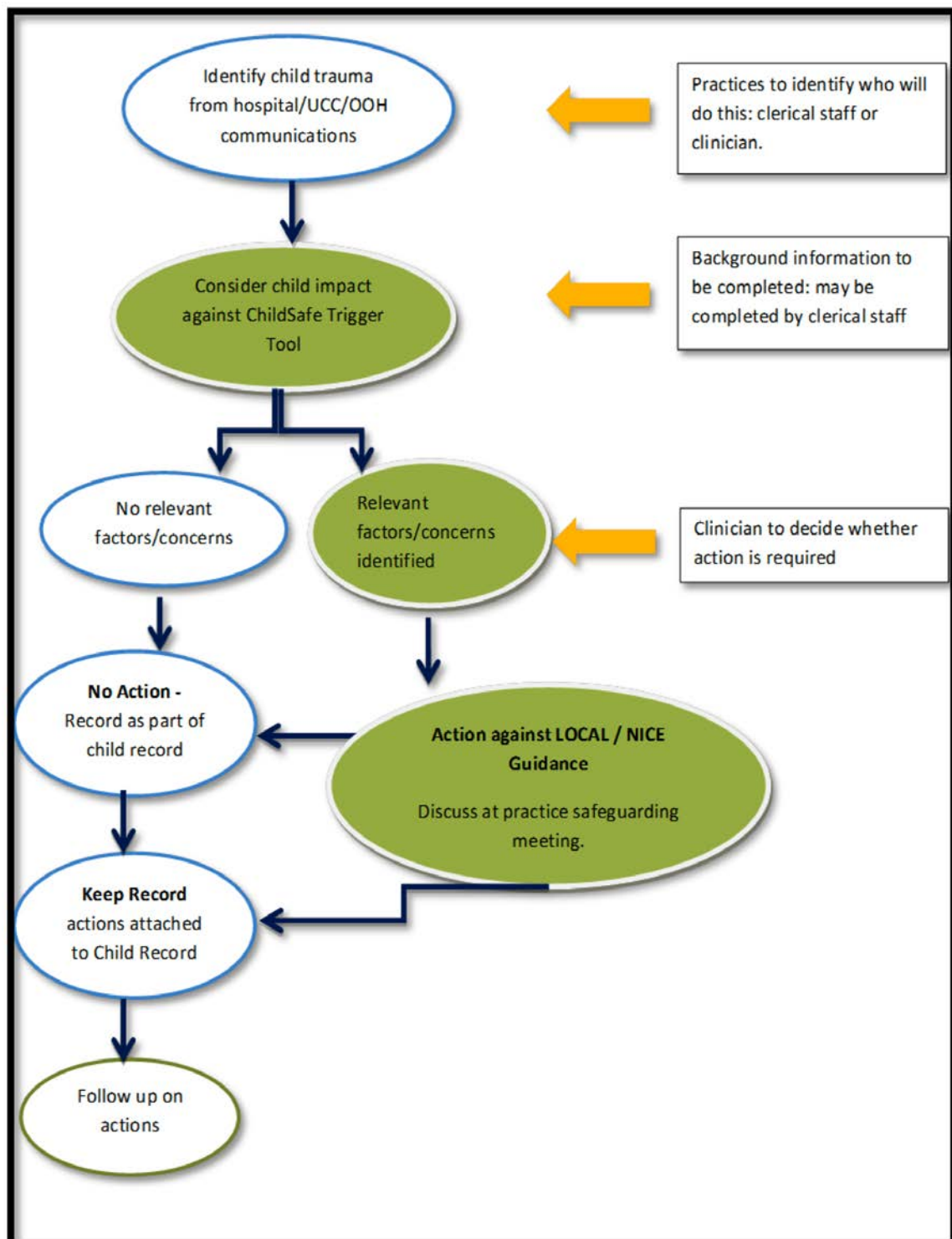
No Actions
Needed

Assessment undertaken by: _____ (print name)

Signed:

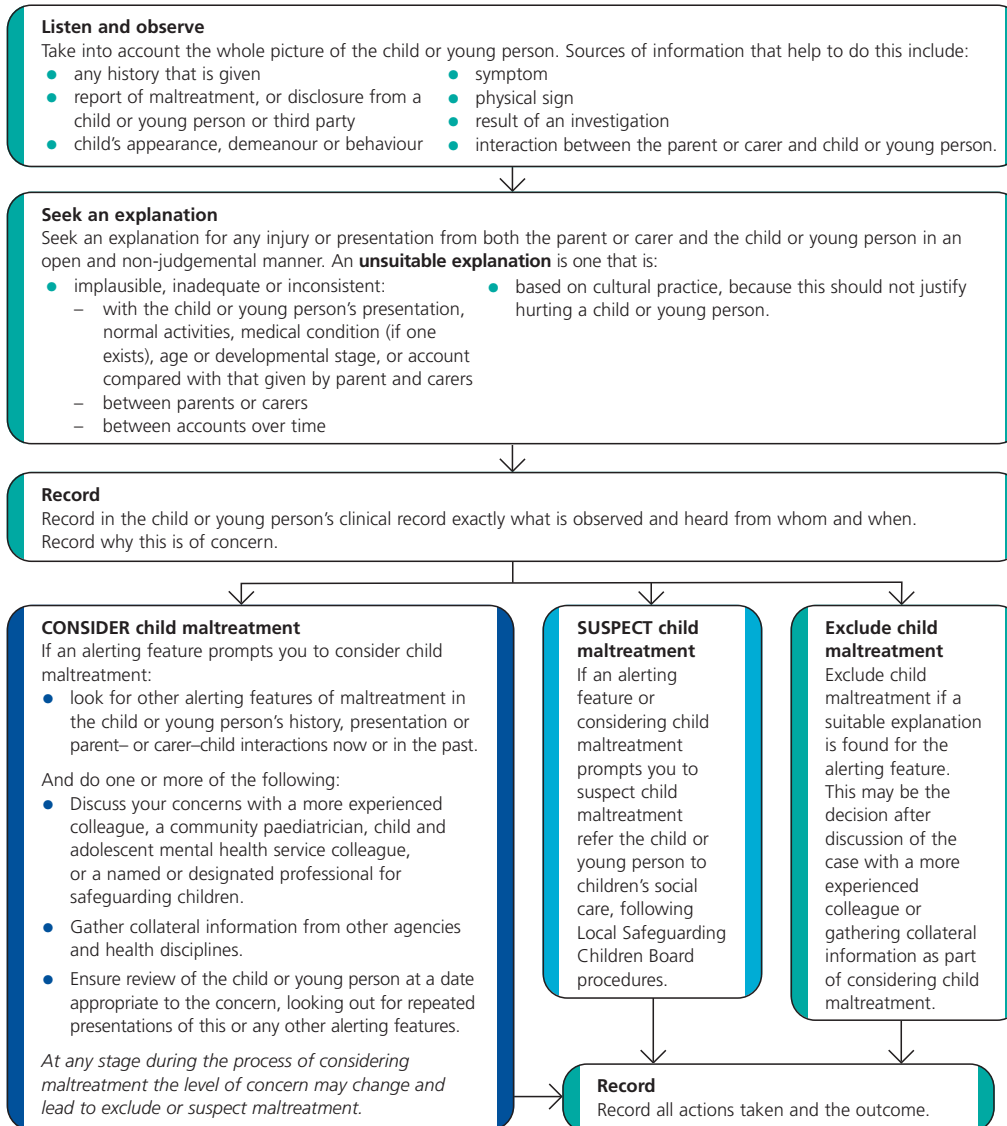
Date of assessment:

ChildSafe Trigger Tool Flow chart



NICE (2009) Clinical guideline 89 – When to suspect child maltreatment.

If you encounter an alerting feature described in this guidance it is good practice to follow the process outlined below.



References

Ofsted (2011), *Ages of concern: learning lessons from serious case reviews*. Manchester: Ofsted

Brandon, M *et al* (2012), *New learning from serious case reviews: a two year report for 2009-2011* London: Department of Education

Tool

14

Health Visitor

SAFER Tool



 [Back to main contents](#)



SAFER communication guidelines

These are guidelines for communications between health visitors and local authority children's social care teams using the SAFER process when a child may be suffering or is likely to suffer significant harm*.

All verbal communications can be carried out using the SAFER process. It can also be used for 'no name consultations'. The use of SAFER will ensure a uniform approach to communicating the level of risk to a child/children.

Section A:

Prior to referral ask yourself these questions:

Assessment

- Have I assessed the child and family and documented my findings? If not what is the source of my information?

Evidence

- What is happening, or not, which is causing concern/or impacting on the safety of the child?
- Is there any evidence of mental illness, substance abuse, domestic abuse, a chaotic lifestyle or missed appointments?

Actions

- Have I consulted my Local Safeguarding Children's Board (LSCB) interagency procedures?
- How do the child's needs meet the local threshold for referral (Working together, 2013 p.14)
- Is a Common Assessment Framework (CAF) in existence for this child/ren?
- Have I documented all existing risk factors or issues?
- Has the situation/referral been discussed with the child's parent(s)/carers, or would this put the child at greater risk?
- Who else lives in/regularly visits the household? Can I provide their personal details and relationships to the child/children?
- Has the situation been discussed with the child's general practitioner and other relevant health professionals, e.g. adult mental health?
- Have I updated myself on the child and family's recent health history?
- Do I have knowledge of any siblings? May they be at risk of harm too?
- Is there a social worker already allocated? Have I discussed the referral with that social worker?
- Has the situation been discussed with a named nurse/senior colleague for safeguarding?

Prior to making a call, have the following available:

- the child's health record
- a chronology of significant and recent events
- the evidence triggering your concern

Section B:

Aide-memoir to support efficient and appropriate telephone referrals of children who may be suffering, or are likely to suffer significant harm

S	<p>Situation</p> <ul style="list-style-type: none"> • This is the health visitor (give name) for (give your area). I am calling about...(child's/children's names, address and date of birth). • To whom am I speaking? (Ensure you log the main role of the person taking the referral). • I am calling because I believe this/these child/ren may be at risk of significant harm. • The parents are/aren't aware of the referral.
A	<p>Assessment and Actions</p> <ul style="list-style-type: none"> • I have assessed the child personally and the specific concerns are..... (provide specific factual evidence, ensuring the points in Section A are covered). • Or: I fear for the child's safety because...(provide specific facts – what you have seen, heard and/or been told, and when you last saw the child and parents). • A CAF has/hasn't been followed. • This is a change since I last saw him/her (give number of) days/weeks/months ago. • The child is now.....(describe current condition and whereabouts). • I have not been able to assess the child/children but I am concerned because..... • I have.....(actions taken to make child safe).
F	<p>Family factors</p> <ul style="list-style-type: none"> • Specific family factors making this child at risk of significant harm are:(based on the Assessment of Need Framework and covering specific points in section A). • Additional factors creating vulnerability are..... • Although not enough to make this child/ren safe now, the strengths in the family situation are.....
E	<p>Expected response</p> <ul style="list-style-type: none"> • In line with Working Together to Safeguard Children, NICE guidance and Section 17 and/or Section 47 of the Children Act I recommend that a specialist social care assessment is undertaken (urgently?). • Other recommendations? • Ask: Do you need me to do anything now?
R	<p>Referral and recording</p> <ul style="list-style-type: none"> • I will follow up with a written referral and would appreciate it if you would get back to me as soon as you have decided your course of action. When might I expect to hear from you? • Exchange names and contact details with person taking the referral. • Now refer in writing as per local procedures (LSCB) and record details, time and outcomes of telephone referral. • If the referral is not accepted /actioned, consult the escalation policy/process and discuss this with the named nurse.

(NB: The intention is to make reasons for referral factual and informative to assist the duty team in taking appropriate action.)

If a child is at risk of immediate, significant harm, the priority is to move them to a place of safety. The police have the powers to remove a child to a place of safety without parental consent

*The Children's Act (1989) defined harm as 'ill treatment or the impairment of health or development'. To decide whether harm is significant the potential/current health and development of the child in question should be considered compared to that of a similar child

References

- Brandon et al (2012) New learning from serious case reviews a two year report for 2009-2011. Department for Education Research Report. DfE-RR226.
- HM Government (2013) Working Together to Safeguard Children. <http://www.workingtogethernonline.co.uk/resources.html>
- Your local safeguarding policy and procedures.
- Framework for the Assessment of Children in Need and their Families. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4003256.
- NICE (2009) When to suspect child maltreatment. NICE Clinical Guideline 89.
- Children Act (1989) HMSO.
- DCSF.(2006) What to do if you are worried a child has been abused.
- Pocket information sharing guide (2008) HM Government.

The SAFER tool was developed from another SBAR which originated from the US Navy and was adapted for use in healthcare by Dr M Leonard and colleagues from Kaiser Permanente, Colorado, USA

Tool
15

Responding to Domestic Abuse, Guidance for General Practices



 [Back to main contents](#)

Responding to domestic abuse:

Guidance for general practices



Royal College of
General Practitioners



IRIS
Identification & Referral
to Improve Safety



This document provides guidance to general practices to help them respond effectively to patients experiencing domestic abuse,¹ a Department of Health strategic priority:

www.dh.gov.uk/en/PublicHealth/ViolenceagainstWomenandChildren/index.htm

This guidance includes key principles to help you develop your domestic abuse policy.²

1. The role of management

A senior person within the practice should be identified to clarify the practice's response to domestic abuse by:

- Finding out what **existing domestic violence services** are available (a list of national organisations is on page 4).
- **Engaging** with local domestic abuse services – and the Domestic Violence Co-ordinator – to develop an effective working partnership.
- Commissioning **training** for the practice team.
- Establishing a **simple care pathway** for patients disclosing domestic abuse by identifying a local **designated person** who will be responsible for the initial assessment of victims.
- Ensuring that the practice's response to disclosure always adheres to its **information sharing** protocols.

Identifying the designated person

The practice's designated person can either be:

- An external specialist domestic abuse service practitioner who undertakes the initial assessment on behalf of the practice and liaises with the GP. Specific evidence based training and support programmes for general practice are available: www.irisdomeesticviolence.org.uk
- An internal practice nurse or other health professional who is trained to carry out this work.

2. Establishing a domestic abuse care pathway

The primary healthcare team's role

- Recognise patients whose symptoms mean they might be more likely to be experiencing domestic abuse.
- Enquire sensitively and provide a safe and empathetic first response.
- Understand the practice's process for responding to disclosure, and know what to do when there is immediate risk of harm to patients and their children.
- Know who the designated person is for their practice.
- Understand the process for arranging the patient's initial assessment with the designated person.
- Document domestic abuse within patient records safely and keep records for evidence purposes.
- Share information appropriately. Information will be shared **only with the consent** of the patient, subject to practice policy on child protection and adult safeguarding. In exceptional circumstances information may be shared without the patient's consent. Some cases considered at MARAC³ meetings are likely to constitute exceptional circumstances because MARACs discuss the most serious cases of alleged or suspected domestic abuse.

1. For the Home Office's definition of domestic abuse visit: www.homeoffice.gov.uk/crime/violence-against-women-girls/domestic-violence/

2. For more information about the guidance contact iris@nextlinkhousing.co.uk or info@caada.org.uk

3. Multi-Agency Risk Assessment Conference – where information is shared and a coordinated safety plan implemented to protect the highest risk victims of domestic abuse: www.caada.org.uk/aboutus/faqs.html For guidance about the application of Caldicott Guardian Principles to domestic abuse and MARACs visit: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_133589

The designated person's role

When undertaking an initial assessment of the patient, the designated person will:

- Conduct a risk assessment. http://www.caada.org.uk/marac/RIC_with_guidance.pdf
- Advise the patient about the services available according to the risk level. This may result in:
 - The patient becoming part of the designated person's own case load, if they are a specialist domestic abuse practitioner themselves.
 - Referral to an appropriate local specialist domestic abuse service, if the patient consents.
 - Signposting to domestic abuse resources and provision of a basic safety plan if the patient is unwilling to engage with services at this time.
- Ensure that child protection and adult safeguarding procedures are initiated where required, especially where there is immediate risk of harm to patients and their children.

3. Training requirements for the practice team

The whole GP practice team – clinical and non-clinical – should be trained in how to recognise the signs of domestic abuse, how to enquire sensitively and safely, the importance of confidentiality and the practice's process for responding to disclosure. Initial education about domestic abuse can be accessed through the RCGP e-learning module: <http://elearning.rcgp.org.uk/course/view.php?id=88> This should be complemented by practice-based training delivered by a local specialist domestic abuse service.

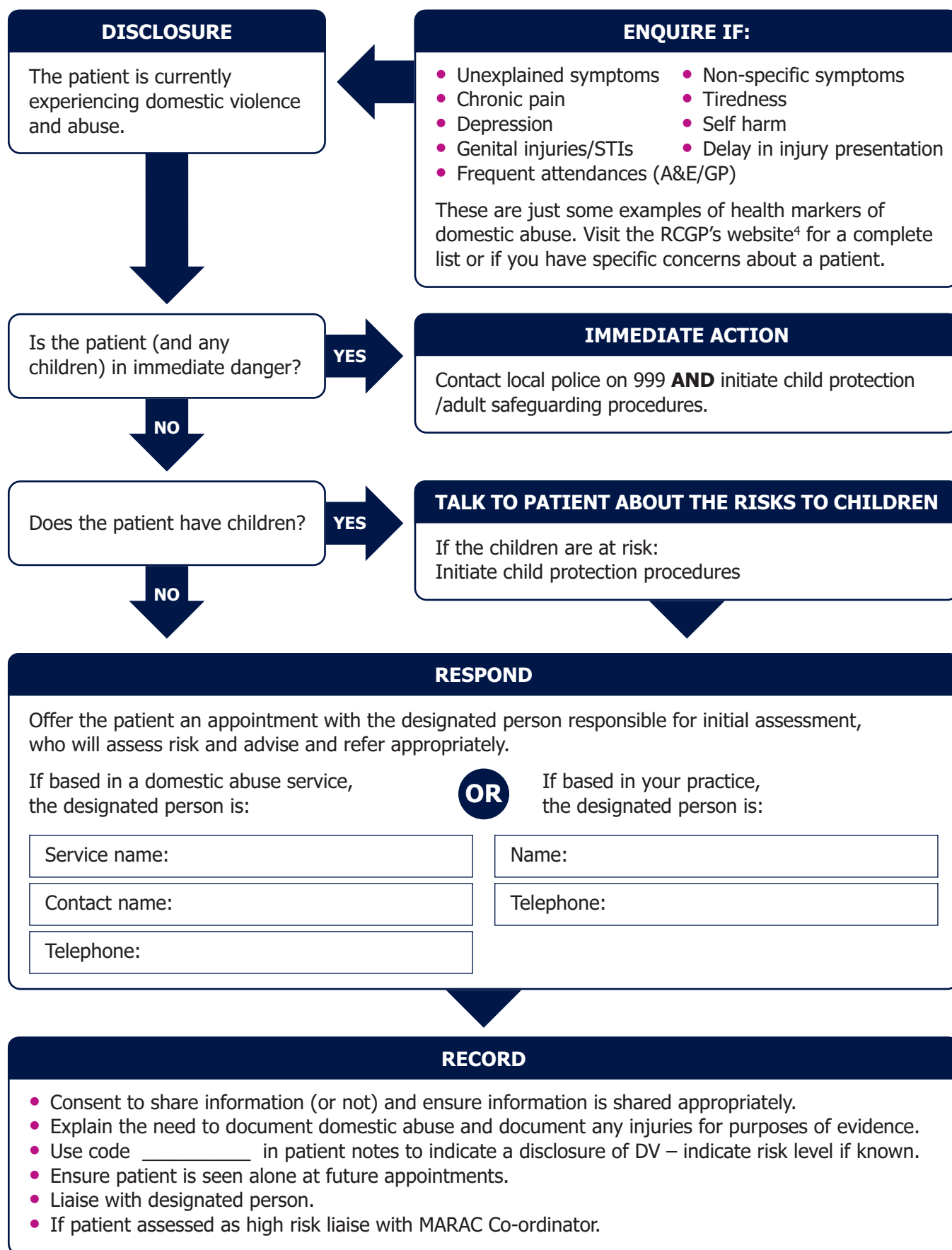
Training should cover:

- The **health markers** of domestic abuse. For example, when patients present with depression, anxiety, tiredness, chronic pain or non-specific symptoms.
www.rcgp.org.uk/policy/position_statements/domestic_violence-the_gps_role/consider_the_possibility.aspx
- How to '**ask the question**' sensitively and safely.
www.rcgp.org.uk/policy/position_statements/domestic_violence-the_gps_role/ask_the_question.aspx
- The implications of domestic abuse for both **child protection and adult safeguarding**.
www.rcgp.org.uk/default.aspx?page=2260
www.education.gov.uk/publications/standard/publicationdetail/page1/DCSF-00305-2010
- How to respond in cases of **immediate and significant risk** (i.e. where it may not be safe to go home).
- How to document domestic abuse and manage **patient notes** safely.
www.rcgp.org.uk/policy/position_statements/domestic_violence-the_gps_role/document.aspx
- The protocols of **information sharing, consent and confidentiality**.
- Local domestic abuse **response pathways** for all levels of **risk**.
- The practice's process for responding to disclosure of domestic abuse. A one page flow chart can be useful – an example is on page 3.
- What to do when a **perpetrator** discloses or is also registered with the GP.

4. Implementation at a clinical commissioning level

These issues also need to be addressed by the strategic lead for the clinical commissioning group who coordinates commissioning of services for domestic abuse victims across the local health economy. This could include, for example, A&E, mental health, drug and alcohol and maternity services, as well as general practice. This may well be the same person with strategic responsibility for child protection and/or adult safeguarding.

Resource: Process for responding to domestic abuse



4. www.rcgp.org.uk/policy/position_statements/domestic_violence-the_gps_role/consider_the_possibility.aspx

Resource: Domestic abuse services directory

Service	Description	Name	Contact
DIRECT SUPPORT FOR VICTIMS AND PERPETRATORS			
National service			
24-hour National Domestic Violence Helpline Freephone	A service for women experiencing domestic violence, their family, friends, colleagues and others calling on their behalf. It is run in partnership between Women's Aid and Refuge. Callers may first of all hear an answerphone message before speaking to a person.	n/a	0808 2000 247 www.nationaldomesticviolencehelpline.org.uk
Men's Advice Line Freephone	A confidential helpline for all men experiencing domestic violence by a current or ex-partner. This includes all men – in heterosexual or same-sex relationships. Offers emotional support, practical advice and information on a wide range of services for further help and support.	n/a	0808 801 0327 Days and times of phone support vary. www.mensadvice.org.uk/mens_advice.php
Respect Phoneline Freephone	A confidential helpline for people who are abusive and/or violent towards their partners. Offers information and advice to support perpetrators to stop their violence and change their abusive behaviours. The main focus is to increase the safety of those experiencing domestic violence.	n/a	0808 802 4040 Days and times of phone support vary. www.respectphoneline.org.uk
Local services			
MARAC Co-ordinator	Your MARAC Co-ordinator may contact you for information about cases being seen at MARAC.	Please complete	Please complete
Domestic Violence Co-ordinator	Professional who co-ordinates the local response to domestic abuse.	Please complete	Please complete
Please complete	May include provision of independent support to victims and children experiencing domestic abuse in the community and in refuge.	Please complete	Please complete
Please complete	May provide support to perpetrators of domestic abuse and their partners.	Please complete	Please complete
SUPPORT FOR PROFESSIONALS			
National commissioning model			
IRIS	A commissionable model providing specific domestic abuse training, support, referral and recording for general practice. The whole practice team receives in-house training and ongoing support from a specialist domestic abuse advocate and a clinical lead. The domestic abuse advocate provides a direct referral route for patient referrals and care pathways are provided for female survivors, male survivors and perpetrators.	Annie Howell E: ahowell@niaendingviolence.org.uk Medina Johnson E: medina.johnson@nextlinkhousing.co.uk	www.irisdomesticviolence.org
National training provider			
Co-ordinated Action Against Domestic Abuse (CAADA)	A national charity supporting a strong multi-agency response to domestic abuse. CAADA provides practical help to support professionals and organisations working with domestic abuse victims. General training on domestic abuse, risk and multi-agency work is available.	training@caada.org.uk	0117 317 8750 www.caada.org.uk


Responding to domestic abuse: Guidance for general practices

© 2012 CAADA and IRIS. Please acknowledge CAADA and IRIS when reprinting.

CAADA – registered charity number 1106864. www.caada.org.uk www.irisdomesticviolence.org

Tool
16

Domestic Abuse Risk Assessment Tool for Named Safeguarding GPs



 [Back to main contents](#)

CAADA Risk Identification Checklist (RIC) & Quick Start Guidance for Domestic Abuse, Stalking and 'Honour'-Based Violence

You may be looking at this checklist because you are working in a professional capacity with a victim of domestic abuse. These notes are to help you understand the significance of the questions on the checklist. Domestic abuse can take many forms but it is usually perpetrated by men towards women in an intimate relationship such as boyfriend/girlfriend, husband/wife. This checklist can also be used for lesbian, gay, bisexual relationships and for situations of 'honour'-based violence or family violence. Domestic abuse can include physical, emotional, mental, sexual or financial abuse as well as stalking and harassment. They might be experiencing one or all types of abuse; each situation is unique. It is the combination of behaviours that can be so intimidating. It can occur both during a relationship or after it has ended.

- ✓ The purpose of the RIC is to give a consistent and simple tool for practitioners who work with adult victims of domestic abuse in order to help them identify those who are at high risk of harm and whose cases should be referred to a MARAC meeting in order to manage their risk. If you are concerned about risk to a child or children, you should make a referral to ensure that a full assessment of their safety and welfare is made.
- ✓ The RIC should be introduced to the victim within the framework of your agency's:
 - Confidentiality Policy
 - Information Sharing Policy and Protocols
 - MARAC Referral Policies and Protocols
- ✓ Before you begin to ask the questions in the RIC:
 - Establish how much time the victim has to talk to you? Is it safe to talk now? What are safe contact details?
 - Establish the whereabouts of the perpetrator and children;
 - Explain why you are asking these questions and how it relates to the MARAC
- ✓ Whilst you are asking the questions in the RIC:
 - Identify early on who the victim is frightened of – ex-partner/partner/family member
 - Use gender neutral terms such as partner/ex-partner. By creating a safe, accessible environment LGBT victims accessing the service will feel able to disclose both domestic abuse and their sexual orientation or gender identity.
- ✓ Revealing the results of the RIC to the victim: Telling someone that they are at high risk of serious harm or homicide may be frightening and overwhelming for them to hear. It is important that you state what your concerns are by using the answers they gave to you and your professional judgement. It is then important that you follow your area's protocols when referring to MARAC and Children's Services. Equally, identifying that someone is not currently high risk needs to be managed carefully to ensure that the person doesn't feel that their situation is being minimised and that they don't feel embarrassed about asking for help. Explain that these factors are linked to homicide and serious harm and that if s/he experiences any of them in future, that they should get back in touch with your service or with the emergency services on 999 in an immediate crisis.
- ✓ Please pay particular attention to a practitioner's professional judgement in all cases. The results from a checklist are not a definitive assessment of risk. They should provide you with a structure to inform your judgement and act as prompts to further questioning, analysis and risk management whether via a MARAC or in another way.

The responsibility for identifying your local referral threshold rests with your local MARAC.

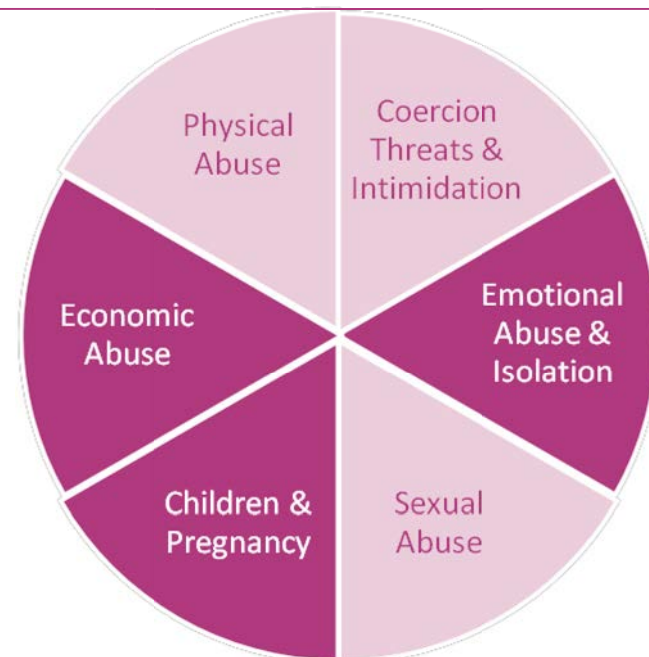
- ✓ **Resources:** Be sure that you have an awareness of the safety planning measures you can offer, both within your own agency and other agencies. Be familiar with local and national resources to refer the victim to, including specialist services. The following websites and contact details may be useful to you:
- ✓ National Domestic Violence Helpline - 0808 2000 247 - For assistance with refuge accommodation and advice
- ✓ 'Honour' Helpline - 0800 5999247 - For advice on forced marriage and 'honour' based violence
- ✓ Sexual Assault Referral Centres - <http://www.rapecrisis.org.uk/Referralcentres2.php>
- ✓ Broken Rainbow - 08452 604460 – www.broken-rainbow.org.uk for advice for LGBT victims

We ask about **PHYSICAL ABUSE** in questions 1, 10, 11, 13, 15, 18, 19 & 23

- ✓ Physical abuse can take many forms from a push or shove to a punch, use of weapons, choking or strangulation.
- ✓ You should try and establish if the abuse is getting worse, or happening more often, or the incidents themselves are more serious. If your client is not sure, ask them to document how many incidents there have been in the last year and what took place. They should also consider keeping a diary marking when physical and other incidents take place.
- ✓ Try and get a picture of the range of physical abuse that has taken place. The incident that is currently being disclosed may not be the worst thing to have happened.
- ✓ The abuse might also be happening to other people in their household, such as their children or siblings or elderly relatives.
- ✓ Sometimes violence will be used against a family pet.
- ✓ If an incident has just occurred the victim should call 999 for assistance from the police. If the victim has injuries they should try and get them seen and documented by a health professional such as GP or A&E Nurse.

We ask about whether the victim is experiencing any form of **SEXUAL ABUSE** in question 16

- ✓ Sexual abuse can include the use of threats, force or intimidation to obtain sex, deliberately inflicting pain during sex, or combining sex and violence and using weapons.
- ✓ If the victim has suffered sexual abuse you should encourage them to get medical attention and to report this to the police. See above for advice on finding a Sexual Assault Referral Centre which can assist with medical and legal investigations.

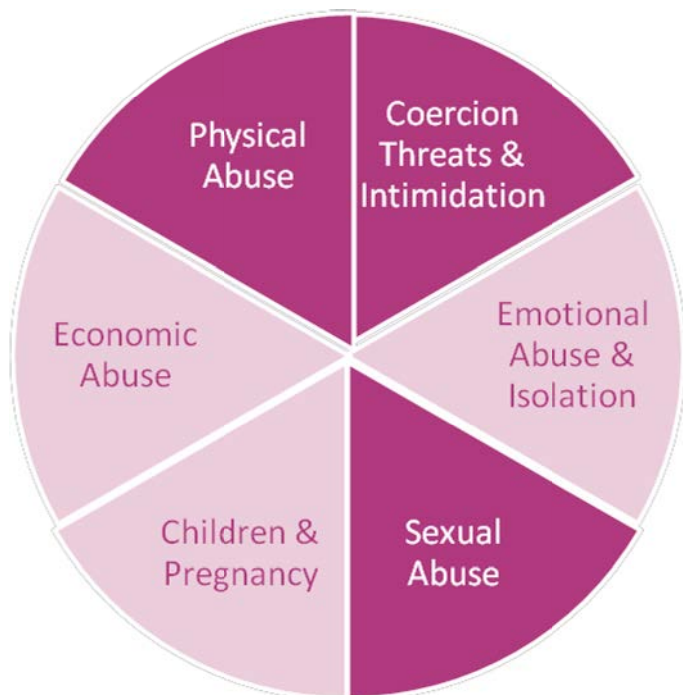


COERCION, THREATS AND INTIMIDATION is covered in questions 2, 3, 6, 8, 14, 17, 18, 19, 23 & 24.

- ✓ It is important to understand and establish: the fears of the victim/victims in relation to what the perpetrator/s may do; who they are frightened of and who they are frightened for (i.e. children/siblings). Victims usually know the abusers behaviour better than anyone else which is why this question is significant.
- ✓ In cases of 'Honour' Based Violence there may be more than one abuser living in the home or belonging to the wider family and community. This could also include female relatives.
- ✓ Stalking and harassment becomes more significant when the abuser is also making threats to harm themselves, the victim or others. They might use phrases such as "If I can't have you no one else can..."
- ✓ Other examples of behaviour that can indicate future harm include obsessive phone calls, texts or emails, uninvited visits to the victim's home, workplace etc, loitering and destroyed or vandalised property.
- ✓ Advise the victim to keep a diary of these threats, when and where they happen, if anyone else was with them and if the threats made them feel frightened.
- ✓ Separation is a dangerous time: establish if the victim has tried to separate from the abuser or has been threatened about the consequences of leaving. Being pursued after separation can be particularly dangerous.
- ✓ Victims of domestic abuse sometimes tell us that the perpetrators harm pets, damage furniture and this alone makes them frightened without the perpetrator needing to physically hurt them. This kind of intimidation is common and often used as a way to control and frighten.
- ✓ Some perpetrators of domestic abuse do not follow court orders or contact arrangements with children. Previous violations may be associated with an increase in risk of future violence.
- ✓ Some victims feel frightened and intimidated by the criminal history of their partner/ex-partner. It is important to remember that offenders with a history of violence are at increased risk of harming their partner, even if the past violence was not directed towards intimate partners or family members, except for 'honour'-based violence, where the perpetrator(s) will commonly have no other recorded criminal history.

ECONOMIC ABUSE – Question 20

- ✓ Victims of domestic abuse often tell us that they are financially controlled by their partners/ex-partners. Consider how the financial control impacts on the safety options available to them. For example, they may rely on their partner/ex-partner for an income or do not have access to benefits in their own right. The victim might feel like the situation has become worse since their partner/ex-partner lost their job.
- ✓ The Citizens Advice Bureau or the local specialist domestic abuse support service will be able to outline to the victim the options relating to their current financial situation and how they might be able to access funds in their own right.



CHILDREN & PREGNANCY – Questions 7, 9 & 18 refer to being pregnant and children and whether there is conflict over child contact.

- ✓ The presence of children including step children can increase the risk of domestic abuse for the mother. They too can get caught up in the violence and suffer directly.
- ✓ Physical violence can occur for the first time or get worse during pregnancy or for the first few years of the child's life. There are usually lots of professionals involved during this time, such as health visitors or midwives, who need to be aware of the risks to the victim and children, including an unborn child.
- ✓ The perpetrator may use the children to have access to the victim, abusive incidents may occur during child contact visits or there may be a lot of fear and anxiety that the children may be harmed.
- ✓ Please follow your local Child Protection Procedures and Guidelines for identifying and making referrals to Children's Services.

We ask about **EMOTIONAL ABUSE** and **ISOLATION** in questions 4, 5 & 12. This can be experienced at the same time as the other types of abuse. It may be present on its own or it may have started long before any physical violence began. The result of this abuse is that victims can blame themselves and, in order to live with what is happening, minimise and deny how serious it is. As a professional you can assist the victim in beginning to consider the risks the victim and any children may be facing.

- ✓ The victim may be being prevented from seeing family or friends, from creating any support networks or prevented from having access to any money.
- ✓ Victims of 'honour' based violence talk about extreme levels of isolation and being 'policed' in the home. This is a significant indicator of future harm and should be taken seriously.
- ✓ Due to the abuse and isolation being suffered victims feel like they have no choice but to continue living with the abuser and fear what may happen if they try and leave. This can often have an impact on the victim's mental health and they might feel depressed or even suicidal.
- ✓ Equally the risk to the victim is greater if their partner/ex-partner has mental health problems such as depression and if they abuse drugs or alcohol. This can increase the level of isolation as victims can feel like agencies won't understand and will judge them. They may feel frightened that revealing this information will get them and their partner into trouble and, if they have children, they may worry that they will be removed. These risks are addressed in questions 21 & 22.

If you are a professional working with domestic abuse and would like to know more about the Risk Identification Checklist you can find the following publications on our website:

- ✓ **CAADA-DASH MARAC Risk Identification Checklist (RIC) 2009 for the identification of high risk cases of domestic abuse, stalking and honour based violence**
http://www.caada.org.uk/dvservices/RIC_and_severity_of_abuse_grid_and_IDVA_practice_guidance.pdf
This is a helpful guide for IDVAs or practitioners new to the RIC and who want to become more familiar and confident in managing the process. It takes you through the process of completing the RIC with your client and provides detail on why and how to ask each question. This guide also provides supplementary questions to gather additional detail about each risk factor and provides general safety planning advice. It includes the Severity of Abuse Grid (SAG). The SAG gives practitioners the chance to profile the domestic abuse in more detail and identify significant concerns which may be relevant to include in a safety plan or share at a MARAC.
- ✓ **CAADA-DASH Risk Identification Checklist – without guidance**
http://www.caada.org.uk/marac/RIC_without_guidance.doc
This is a basic version of the RIC to download and use in everyday practice.
- ✓ **CAADA-DASH Risk Identification Checklist – Frequently Asked Questions**
http://www.caada.org.uk/marac/RIC_FAQs.pdf
This addresses a number of practical questions relating to the use of the checklist.
- ✓ **We also have a library of resources and information about training for frontline practitioners at**
http://www.caada.org.uk/marac/Information_about_MARACs.html

Other MARAC toolkits and resources

If you or someone from your agency attends the MARAC meeting, you can download a **MARAC Representative's Toolkit** here: <http://www.caada.org.uk/marac/Toolkit-MARAC-representative.pdf>. This essential document troubleshoots practical issues around the whole MARAC process.

Other **frontline Practitioner Toolkits** are also available from http://www.caada.org.uk/marac/Resources_for_people_who_refer_to_MARAC.html. These offer a practical introduction to MARAC within the context of a professional role. Please feel free to signpost colleagues and other agency staff to these toolkits where relevant:

A&E	LGBT Services
Ambulance Service	MARAC Chair
BAMER Services	MARAC Coordinator
Children and Young People's Services	Mental Health Services for Adults
Drug and Alcohol	Police Officer
Education	Probation
Fire and Rescue Services	Social Care Services for Adults
Family Intervention Projects	Sexual Violence Services
Health Visitors, School Nurses & Community Midwives	Specialist Domestic Violence Services
Housing	Victim Support
Independent Domestic Violence Advisors	Women's Safety Officer

For additional information and materials on Multi Agency Risk Assessment Conferences (MARACs), please see the http://www.caada.org.uk/marac/10_Principles_Oct_2011_full.doc. This provides guidance on the MARAC process and forms the basis of the MARAC Quality Assurance process and national standards for MARAC.

CAADA-DASH Risk Identification Checklist (RIC)

Aim of the form:

- To help front line practitioners identify high risk cases of domestic abuse, stalking and 'honour'-based violence.
- To decide which cases should be referred to MARAC and what other support might be required. A completed form becomes an active record that can be referred to in future for case management.
- To offer a common tool to agencies that are part of the MARAC¹ process and provide a shared understanding of risk in relation to domestic abuse, stalking and 'honour'-based violence.
- To enable agencies to make defensible decisions based on the evidence from extensive research of cases, including domestic homicides and 'near misses', which underpins most recognised models of risk assessment.

How to use the form:

Before completing the form for the first time we recommend that you read the full practice guidance and Frequently Asked Questions and Answers². These can be downloaded from http://www.caada.org.uk/marac/RIC_for_MARAC.html. Risk is dynamic and can change very quickly. It is good practice to review the checklist after a new incident.

Recommended Referral Criteria to MARAC

1. **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 particular 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.*** This 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.
2. **'Visible High Risk':** the number of 'ticks' on this checklist. If you have ticked 14 or more 'yes' boxes the case would normally meet the MARAC referral criteria.
3. **Potential Escalation:** the number of police callouts to the victim as a result 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. It is common practice to start with 3 or more police callouts in a 12 month period but this will need to be reviewed depending on your local volume and your level of police reporting.

Please pay particular attention to a practitioner's professional judgement in all cases. The results from a checklist are not a definitive assessment of risk. They should provide you with a structure to inform your judgement and act as prompts to further questioning, analysis and risk management whether via a MARAC or in another way.

The responsibility for identifying your local referral threshold rests with your local MARAC.

What this form is not:

This form will provide valuable information about the risks that children are living with but it is not a full risk assessment for children. The presence of children increases the wider risks of domestic violence and step children are particularly at risk. If risk towards children is highlighted you should consider what referral you need to make to obtain a full assessment of the children's situation.

¹ For further information about MARAC please refer to the 10 Principles of an Effective MARAC:

http://www.caada.org.uk/marac/10_Principles_Oct_2011_full.doc

² For enquiries about training in the use of the form, please email training@caada.org.uk or call 0117 317 8750.

Name of victim:

Date:

Restricted when complete

CAADA-DASH Risk Identification Checklist for use by IDVAs and other non-police agencies³ for identification of risks when domestic abuse, 'honour'-based violence and/or stalking are disclosed.

<p>Please explain that the purpose of asking these questions is for the safety and protection of the individual concerned.</p> <p>Tick the box if the factor is present <input checked="" type="checkbox"/>. Please use the comment box at the end of the form to expand on any answer.</p> <p>It is assumed that your main source of information is the victim. If this is <u>not the case</u> please indicate in the right hand column</p>	Yes (tick)	No	Don't Know	State source of info if not the victim e.g. police officer
1. Has the current incident resulted in injury? (Please state what and whether this is the first injury.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2. Are you very frightened? Comment:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3. What are you afraid of? Is it further injury or violence? (Please give an indication of what you think (name of abuser(s)...) might do and to whom, including children). Comment:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4. Do you feel isolated from family/friends i.e. does (name of abuser(s)) try to stop you from seeing friends/family/doctor or others? Comment:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5. Are you feeling depressed or having suicidal thoughts?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6. Have you separated or tried to separate from (name of abuser(s)....) within the past year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7. Is there conflict over child contact?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8. Does (.....) constantly text, call, contact, follow, stalk or harass you? (Please expand to identify what and whether you believe that this is done deliberately to intimidate you? Consider the context and behaviour of what is being done.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9. Are you pregnant or have you recently had a baby (within the last 18 months)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10. Is the abuse happening more often?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
11. Is the abuse getting worse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
12. Does (.....) try to control everything you do and/or are they excessively jealous? (In terms of relationships, who you see, being 'policed at home', telling you what to wear for example. Consider 'honour'-based violence and specify behaviour.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
13. Has (.....) ever used weapons or objects to hurt you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

³ Note: This checklist is consistent with the ACPO endorsed risk assessment model DASH 2009 for the police service.

Name of victim:**Date:****Restricted when complete**

Tick box if factor is present. Please use the comment box at the end of the form to expand on any answer.	Yes (tick)	No	Don't Know	State source of info if not the victim
14. Has (.....) ever threatened to kill you or someone else and you believed them? (If yes, tick who.) You <input type="checkbox"/> Children <input type="checkbox"/> Other (please specify) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
15. Has (.....) ever attempted to strangle/choke/suffocate/drown you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
16. Does (.....) do or say things of a sexual nature that make you feel bad or that physically hurt you or someone else? (If someone else, specify who.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
17. Is there any other person who has threatened you or who you are afraid of? (If yes, please specify whom and why. Consider extended family if HBV.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18. Do you know if (.....) has hurt anyone else? (Please specify whom including the children, siblings or elderly relatives. Consider HBV.) Children <input type="checkbox"/> Another family member <input type="checkbox"/> Someone from a previous relationship <input type="checkbox"/> Other (please specify) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19. Has (.....) ever mistreated an animal or the family pet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20. Are there any financial issues? For example, are you dependent on (.....) for money/have they recently lost their job/other financial issues?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21. Has (.....) had problems in the past year with drugs (prescription or other), alcohol or mental health leading to problems in leading a normal life? (If yes, please specify which and give relevant details if known.) Drugs <input type="checkbox"/> Alcohol <input type="checkbox"/> Mental Health <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22. Has (.....) ever threatened or attempted suicide?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
23. Has (.....) ever broken bail/an injunction and/or formal agreement for when they can see you and/or the children? (You may wish to consider this in relation to an ex-partner of the perpetrator if relevant.) Bail conditions <input type="checkbox"/> Non Molestation/Occupation Order <input type="checkbox"/> Child Contact arrangements <input type="checkbox"/> Forced Marriage Protection Order <input type="checkbox"/> Other <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
24. Do you know if (.....) has ever been in trouble with the police or has a criminal history? (If yes, please specify.) DV <input type="checkbox"/> Sexual violence <input type="checkbox"/> Other violence <input type="checkbox"/> Other <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Total 'yes' responses				

Name of victim:

Date:

Restricted when complete

For consideration by professional: Is there any other relevant information (from victim or professional) which may increase risk levels? Consider victim's situation in relation to disability, substance misuse, mental health issues, cultural/language barriers, 'honour'- based systems and minimisation. Are they willing to engage with your service? Describe:

Consider abuser's occupation/interests - could this give them unique access to weapons? Describe:

What are the victim's greatest priorities to address their safety?

Do you believe that there are reasonable grounds for referring this case to MARAC? Yes / No

If yes, have you made a referral? Yes/No

Signed:

Date:

Do you believe that there are risks facing the children in the family? Yes / No

If yes, please confirm if you have made a referral to safeguard the children: Yes / No

Date referral made

Signed:

Date:

Name:

Practitioner's Notes

This checklist reflects work undertaken by CAADA in partnership with Laura Richards, Consultant Violence Adviser to ACPO. We would like to thank Advance, Blackburn with Darwen Women's Aid and Berkshire East Family Safety Unit and all the partners of the Blackpool MARAC for their contribution in piloting the revised checklist without which we could not have amended the original CAADA risk identification checklist. We are very grateful to Elizabeth Hall of Cafcass and Neil Blacklock of Respect for their advice and encouragement and for the expert input we received from Jan Pickles, Dr Amanda Robinson, James Rowlands and Jasvinder Sanghera.

Tool
17

MARAC Toolkit



[!\[\]\(e78f798d4ea5c530c9db49e7d26e6b95_img.jpg\) Back to main contents](#)

Children and Young People's Services – Toolkit for MARAC

Contents:

1. Frequently asked questions
2. Flowcharts: Steps to the MARAC process; tracking the research and referral processes for MARAC
3. Forms from CAADA: Risk Identification Checklist (RIC), referral and research forms

What is a Multi-Agency Risk Assessment Conference (MARAC)?

A MARAC is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, probation, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors. After sharing all relevant information they have about a victim, the representatives discuss options for increasing the safety of the victim and turn these into a co-ordinated action plan. The primary focus of the MARAC is to safeguard the adult victim. The MARAC will also make links with other fora to safeguard children and manage the behaviour of the perpetrator. At the heart of a MARAC is the working assumption that no single agency or individual can see the complete picture of the life of a victim, but all may have insights that are crucial to their safety. The victim does not attend the meeting but is represented by an IDVA who speaks on their behalf.

MARACs and Children and Young People

The MARAC will help you link up efforts to safeguard the abused parent and efforts to safeguard the child, helping you to intervene in vulnerable families before children are placed at significant risk. The MARAC will also help you to work with clients that are not engaging with you or need more support by involving other agencies, such as the IDVA service or specialist domestic violence services, to work with the victim.

'We are often at a loss as to how to progress if Mum says "nothing's happened and the children are fine". The MARAC gives us a way to get beyond that position.' *Safeguarding Officer, Liverpool*

1. Frequently asked questions

Why does a representative from my agency attend?

The risk to children from domestic abuse is clearly understood. You will receive information from a variety of agencies at MARAC about what is going on in the family, whether or not your agency is already involved in the case. This will allow you to make better decisions on how to progress referrals where resources permit and to assess the risks to the family, and therefore keep children safer at home.

What cases are discussed?

The highest risk cases of domestic abuse are discussed in your MARAC. These will have been identified by a practitioner from any agency using an evidence based risk assessment tool (see page 11 for the CAADA recommended Risk Identification Checklist). It is recommended that the MARAC should initially see the top 10% of cases in your area in terms of risk profile.

What information should my agency bring?

The Children's Services representative at MARAC (normally someone with managerial responsibilities) should bring any relevant information regarding the family that might help to assess the risk to the victim and children or inform a safety plan. This might include whether or not the case is known to children's services, whether the child is on the child protection register, level of any current intervention, any assessments and the outcomes of those assessments.

What actions can we offer?

The actions volunteered by Children's Services usually focus on increasing the safety of the children and working with other agencies to make sure that current support offered is safe for the victim involved. Specific actions for Children's Services might include agreeing to assess the children, referring the case to other services, or going on joint visits with the police or the IDVA. Given the risk posed to the children, we would suggest that a standard

action should be to carry out an initial assessment if one has not already been done. Further, you may wish to confirm that your local safeguarding board has a system in place for monitoring the safety of the children identified at MARAC.

Can we refer a case to MARAC?

Any agency that has signed the MARAC Operating Protocol can refer a case to the meeting. You will need to identify the adult victim as being at high risk of harm, either by using the CAADA Risk Identification Checklist or by using your professional judgement. If you need any support in this area, your local IDVA team will be happy to advise you.

What are the legal grounds for sharing information where consent is not given?

Disclosures to MARAC are made under the Data Protection Act and the Human Rights Act. Information can be shared when it is necessary to prevent a crime, protect the health and/or safety of the victim and/or the rights and freedoms of those who are victims of violence and/or their children. It must be proportionate to the level of risk of harm to a named individual or known household. For further information see the FAQs on disclosure of information at MARAC available at http://www.caada.org.uk/marac/Disclosure_of_Info_at_MARAC_FAQs.pdf

Does the victim need to know they are being discussed at MARAC?

Whether you discuss the MARAC with your client will depend on whether you referred the case to MARAC.

IF YOU ARE THE REFERRING AGENCY: It is good practice to discuss the referral with the victim if it is safe to do so. You will need to use your professional judgement to decide whether it is safe.

IF YOU ARE NOT THE REFERRING AGENCY: You should check with the referring agency before contacting your client to gather relevant information to ensure it is safe to do so.

There is a grid at the end of this toolkit where you can enter details of your local MARAC representatives.

Other MARAC toolkits and resources

If you or someone from your agency attends the MARAC meeting, you can download a **MARAC Representative's Toolkit** <http://www.caada.org.uk/marac/Toolkit-MARAC-representative.pdf>. This essential document troubleshoots practical issues around the whole MARAC process. Other **frontline Practitioner Toolkits** are also available from http://www.caada.org.uk/marac/Resources_for_people_who_refer_to_MARAC.html. These offer a practical introduction to MARAC within the context of a professional role. Please feel free to signpost colleagues and other agency staff to these toolkits where relevant:

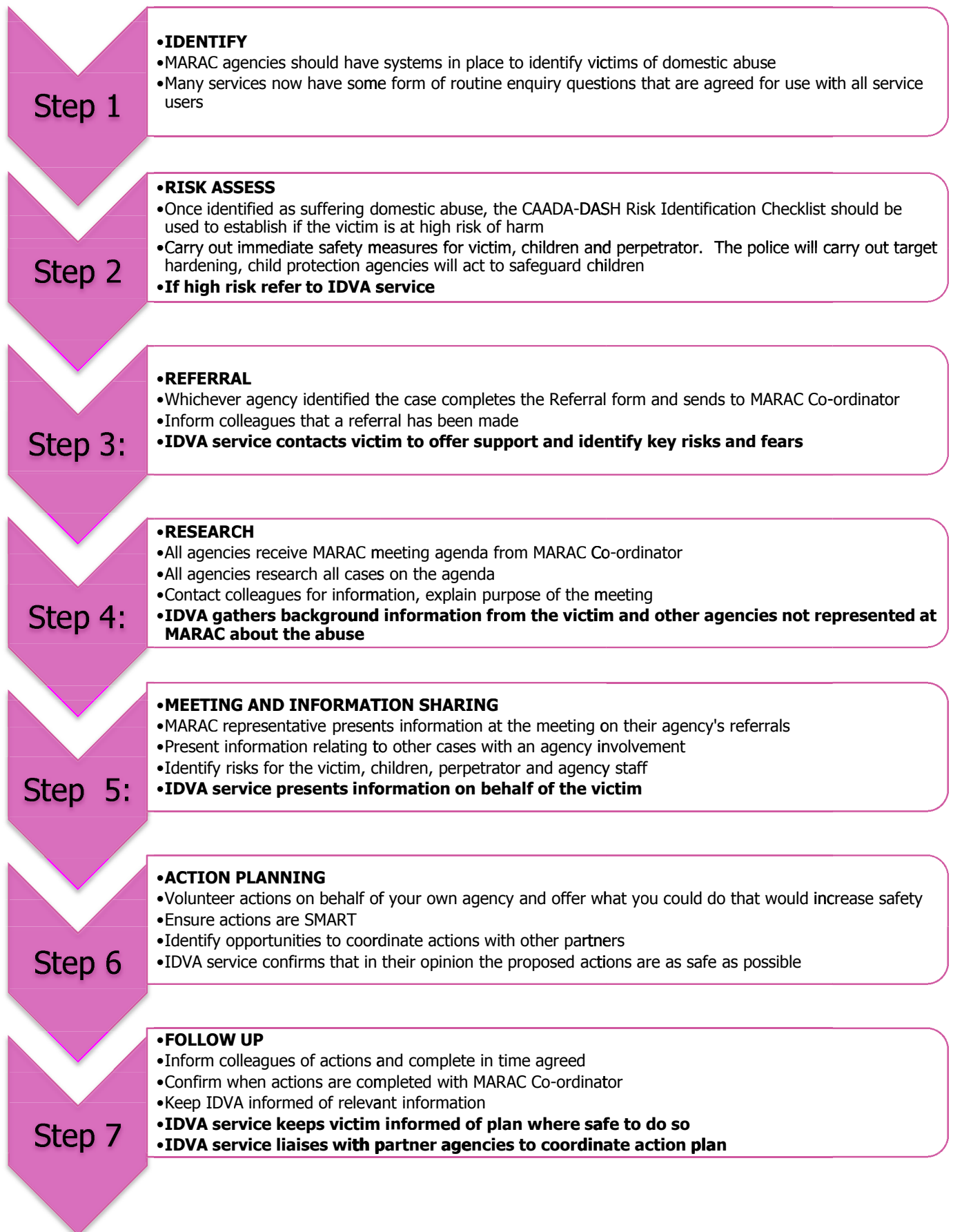
A&E	LGBT Services
Ambulance Service	MARAC Chair
BAMER Services	MARAC Coordinator
Children and Young People's Services	Mental Health Services for Adults
Drug and Alcohol	Police Officer
Education	Probation
Fire and Rescue Services	Social Care Services for Adults
Family Intervention Projects	Sexual Violence Services
Health Visitors, School Nurses & Community Midwives	Specialist Domestic Violence Services
Housing	Victim Support
Independent Domestic Violence Advisors	Women's Safety Officer

For more guidance on the MARAC process see the 10 Principles of an Effective MARAC:

http://www.caada.org.uk/marac/10_Principles_Oct_2011_full.doc. This forms the basis of the MARAC Quality Assurance process and national standards for MARAC.

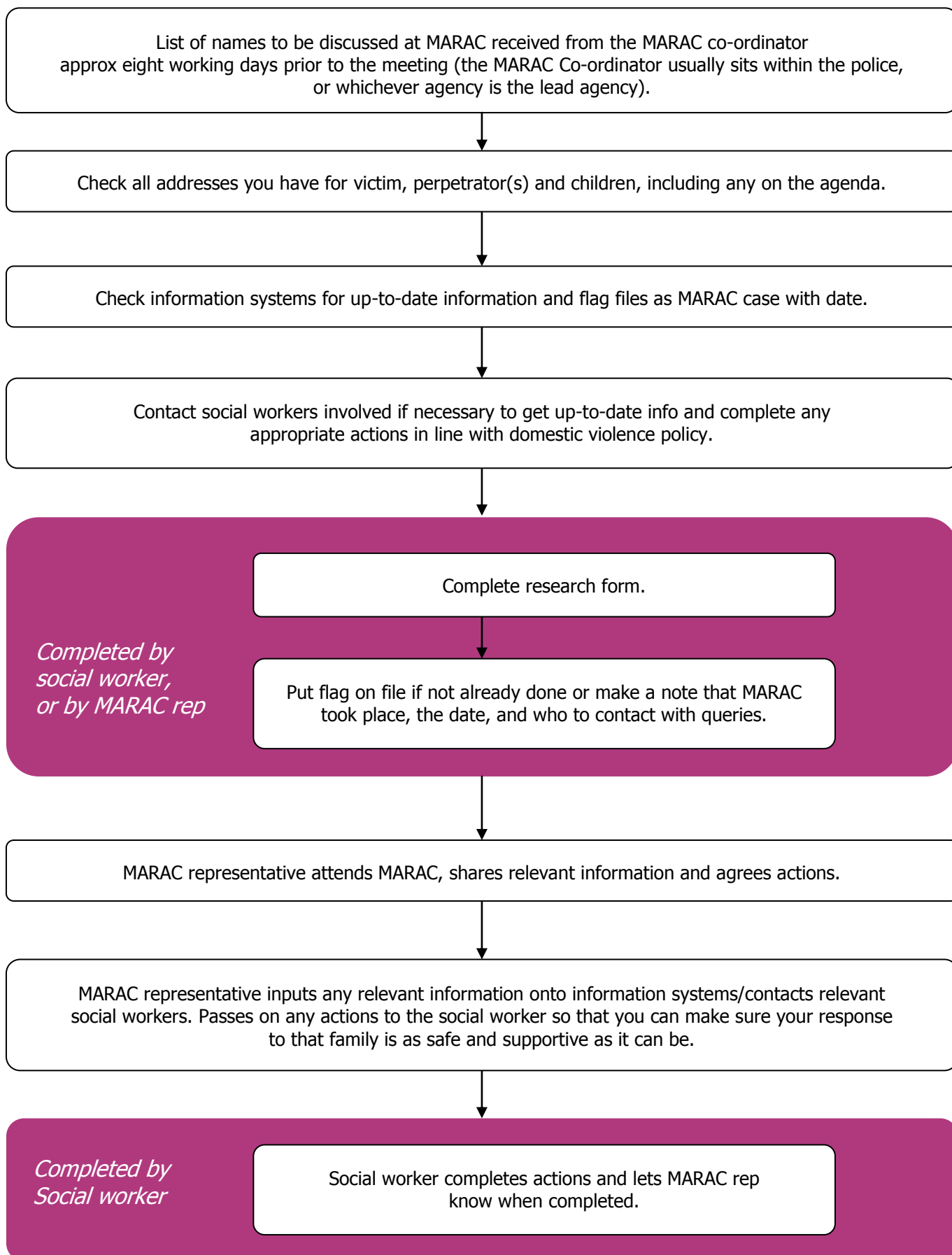
2. Flowcharts

Steps to the MARAC Process



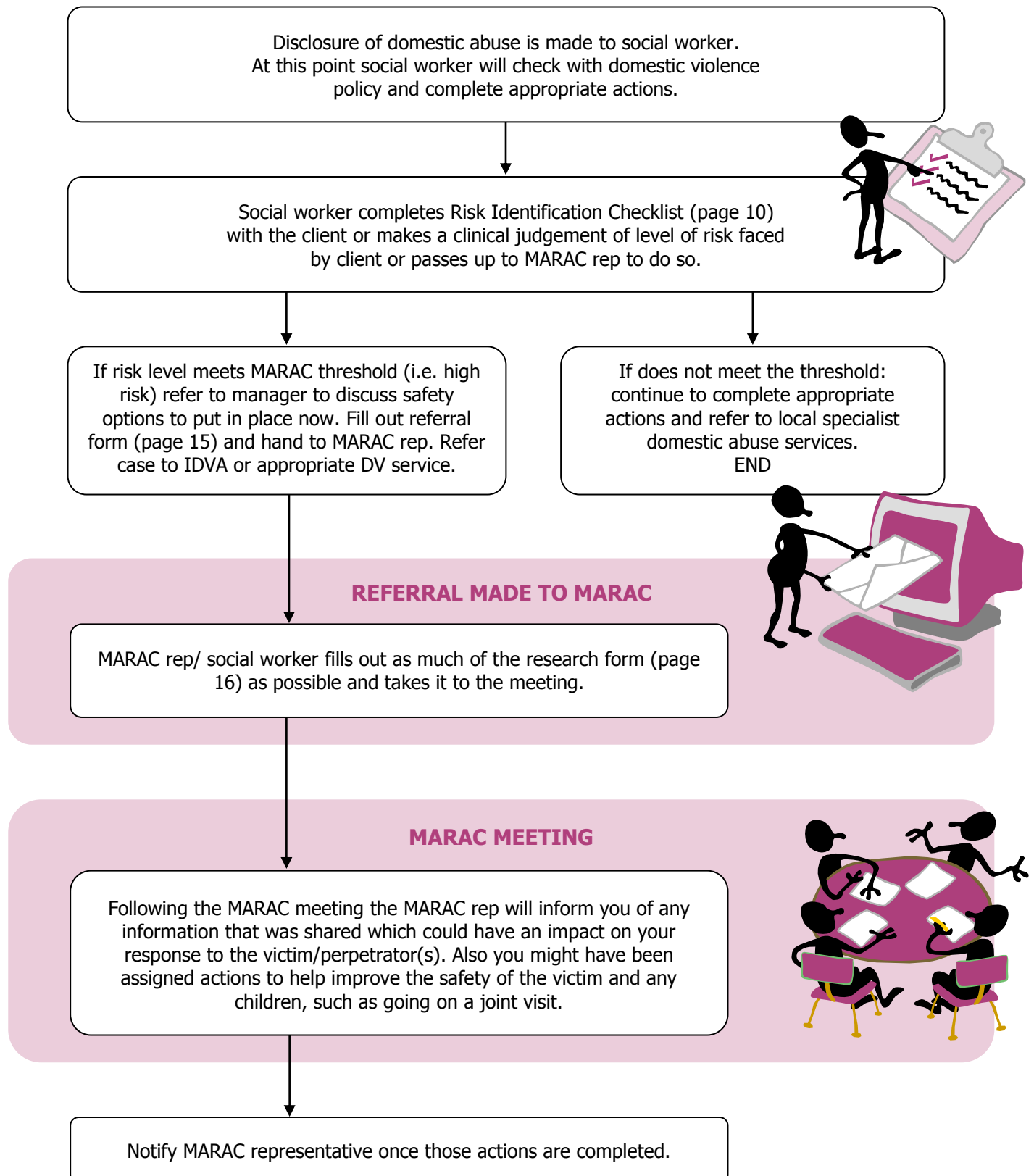
Researching for the MARAC

Practice in your agency will differ according to local policy and organisational structure, but below is an outline of the research process for MARAC. All the cells in white should be completed by your MARAC representative.



Referring a case to the MARAC

Policies on referring to your particular MARAC will be available locally but here is an outline of the process.



3. Risk Identification Checklist (RIC) guidance

CAADA Quick Start Guidance for the Risk Identification Checklist (RIC) for Domestic Abuse, Stalking and 'Honour'-Based Violence

You may be looking at this checklist because you are working in a professional capacity with a victim of domestic abuse. These notes are to help you understand the significance of the questions on the checklist. Domestic abuse can take many forms but it is usually perpetrated by men towards women in an intimate relationship such as boyfriend/girlfriend, husband/wife. This checklist can also be used for lesbian, gay, bisexual relationships and for situations of 'honour'-based violence or family violence. Domestic abuse can include physical, emotional, mental, sexual or financial abuse as well as stalking and harassment. They might be experiencing one or all types of abuse; each situation is unique. It is the combination of behaviours that can be so intimidating. It can occur both during a relationship or after it has ended.

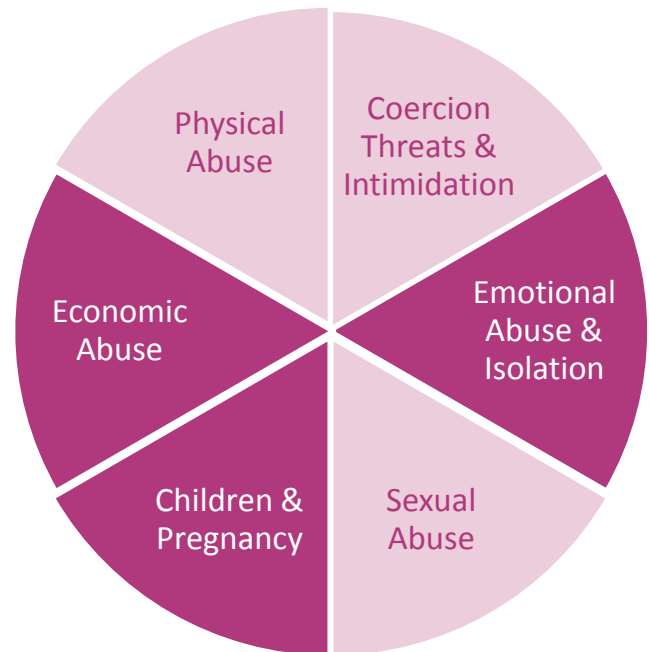
- ✓ The purpose of the RIC is to give a consistent and simple tool for practitioners who work with adult victims of domestic abuse in order to help them identify those who are at high risk of harm and whose cases should be referred to a MARAC meeting in order to manage their risk. If you are concerned about risk to a child or children, you should make a referral to ensure that a full assessment of their safety and welfare is made.
- ✓ The RIC should be introduced to the victim within the framework of your agency's:
 - Confidentiality Policy
 - Information Sharing Policy and Protocols
 - MARAC Referral Policies and Protocols
- ✓ Before you begin to ask the questions in the RIC:
 - Establish how much time the victim has to talk to you? Is it safe to talk now? What are safe contact details?
 - Establish the whereabouts of the perpetrator and children;
 - Explain why you are asking these questions and how it relates to the MARAC
- ✓ Whilst you are asking the questions in the RIC:
 - Identify early on who the victim is frightened of – ex-partner/partner/family member
 - Use gender neutral terms such as partner/ex-partner. By creating a safe, accessible environment LGBT victims accessing the service will feel able to disclose both domestic abuse and their sexual orientation or gender identity.
- ✓ Revealing the results of the RIC to the victim: Telling someone that they are at high risk of serious harm or homicide may be frightening and overwhelming for them to hear. It is important that you state what your concerns are by using the answers they gave to you and your professional judgement. It is then important that you follow your area's protocols when referring to MARAC and Children's Services. Equally, identifying that someone is not currently high risk needs to be managed carefully to ensure that the person doesn't feel that their situation is being minimised and that they don't feel embarrassed about asking for help. Explain that these factors are linked to homicide and serious harm and that if s/he experiences any of them in future, that they should get back in touch with your service or with the emergency services on 999 in an immediate crisis.
- ✓ Please pay particular attention to a practitioner's professional judgement in all cases. The results from a checklist are not a definitive assessment of risk. They should provide you with a structure to inform your judgement and act as prompts to further questioning, analysis and risk management whether via a MARAC or in another way.
The responsibility for identifying your local referral threshold rests with your local MARAC.
- ✓ **Resources:** Be sure that you have an awareness of the safety planning measures you can offer, both within your own agency and other agencies. Be familiar with local and national resources to refer the victim to, including specialist services. The following websites and contact details may be useful to you:
 - ✓ National Domestic Violence Helpline - 0808 2000 247 - For assistance with refuge accommodation and advice
 - ✓ 'Honour' Helpline - 0800 5999247 - For advice on forced marriage and 'honour' based violence
 - ✓ Sexual Assault Referral Centres - <http://www.rapecrisis.org.uk/Referralcentres2.php>
 - ✓ Broken Rainbow - 08452 604460 – www.broken-rainbow.org.uk for advice for LGBT victims

We ask about **PHYSICAL ABUSE** in questions 1, 10, 11, 13, 15, 18, 19 & 23

- ✓ Physical abuse can take many forms from a push or shove to a punch, use of weapons, choking or strangulation.
- ✓ You should try and establish if the abuse is getting worse, or happening more often, or the incidents themselves are more serious. If your client is not sure, ask them to document how many incidents there have been in the last year and what took place. They should also consider keeping a diary marking when physical and other incidents take place.
- ✓ Try and get a picture of the range of physical abuse that has taken place. The incident that is currently being disclosed may not be the worst thing to have happened.
- ✓ The abuse might also be happening to other people in their household, such as their children or siblings or elderly relatives.
- ✓ Sometimes violence will be used against a family pet.
- ✓ If an incident has just occurred the victim should call 999 for assistance from the police. If the victim has injuries they should try and get them seen and documented by a health professional such as GP or A&E Nurse.

We ask about whether the victim is experiencing any form of **SEXUAL ABUSE** in question 16

- ✓ Sexual abuse can include the use of threats, force or intimidation to obtain sex, deliberately inflicting pain during sex, or combining sex and violence and using weapons.
- ✓ If the victim has suffered sexual abuse you should encourage them to get medical attention and to report this to the police. See above for advice on finding a Sexual Assault Referral Centre which can assist with medical and legal investigations.

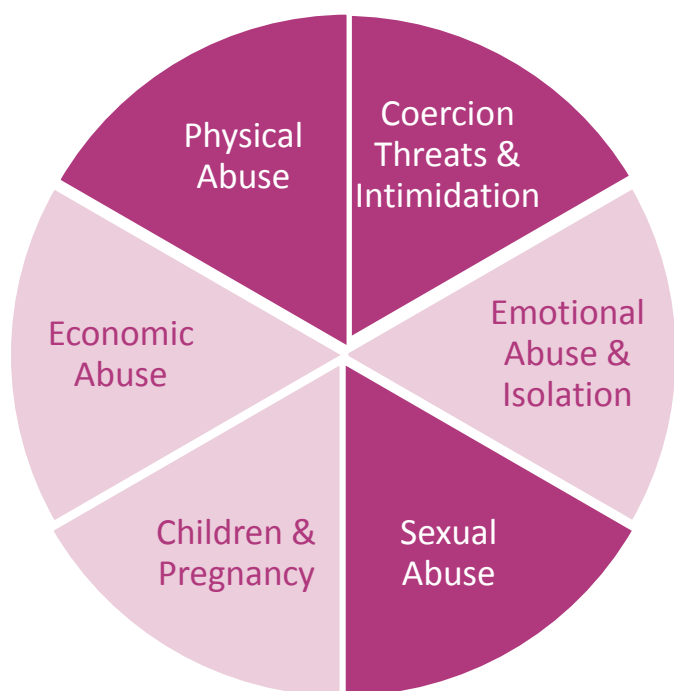


COERCION, THREATS AND INTIMIDATION is covered in questions 2, 3, 6, 8, 14, 17, 18, 19, 23 & 24.

- ✓ It is important to understand and establish: the fears of the victim/victims in relation to what the perpetrator/s may do; who they are frightened of and who they are frightened for (i.e. children/siblings). Victims usually know the abuser's behaviour better than anyone else which is why this question is significant.
- ✓ In cases of 'Honour' Based Violence there may be more than one abuser living in the home or belonging to the wider family and community. This could also include female relatives.
- ✓ Stalking and harassment becomes more significant when the abuser is also making threats to harm themselves, the victim or others. They might use phrases such as "If I can't have you no one else can..."
- ✓ Other examples of behaviour that can indicate future harm include obsessive phone calls, texts or emails, uninvited visits to the victim's home, workplace etc, loitering and destroyed or vandalised property.
- ✓ Advise the victim to keep a diary of these threats, when and where they happen, if anyone else was with them and if the threats made them feel frightened.
- ✓ Separation is a dangerous time: establish if the victim has tried to separate from the abuser or has been threatened about the consequences of leaving. Being pursued after separation can be particularly dangerous.
- ✓ Victims of domestic abuse sometimes tell us that the perpetrators harm pets, damage furniture and this alone makes them frightened without the perpetrator needing to physically hurt them. This kind of intimidation is common and often used as a way to control and frighten.
- ✓ Some perpetrators of domestic abuse do not follow court orders or contact arrangements with children. Previous violations may be associated with an increase in risk of future violence.
- ✓ Some victims feel frightened and intimidated by the criminal history of their partner/ex-partner. It is important to remember that offenders with a history of violence are at increased risk of harming their partner, even if the past violence was not directed towards intimate partners or family members, except for 'honour'-based violence, where the perpetrator(s) will commonly have no other recorded criminal history.

ECONOMIC ABUSE – Question 20

- ✓ Victims of domestic abuse often tell us that they are financially controlled by their partners/ex-partners. Consider how the financial control impacts on the safety options available to them. For example, they may rely on their partner/ex-partner for an income or do not have access to benefits in their own right. The victim might feel like the situation has become worse since their partner/ex-partner lost their job.
- ✓ The Citizens Advice Bureau or the local specialist domestic abuse support service will be able to outline to the victim the options relating to their current financial situation and how they might be able to access funds in their own right.



CHILDREN & PREGNANCY – Questions 7, 9 & 18 refer to being pregnant and children and whether there is conflict over child contact.

- ✓ The presence of children including step children can increase the risk of domestic abuse for the mother. They too can get caught up in the violence and suffer directly.
- ✓ Physical violence can occur for the first time or get worse during pregnancy or for the first few years of the child's life. There are usually lots of professionals involved during this time, such as health visitors or midwives, who need to be aware of the risks to the victim and children, including an unborn child.
- ✓ The perpetrator may use the children to have access to the victim, abusive incidents may occur during child contact visits or there may be a lot of fear and anxiety that the children may be harmed.
- ✓ Please follow your local Child Protection Procedures and Guidelines for identifying and making referrals to Children's Services.

We ask about **EMOTIONAL ABUSE** and **ISOLATION** in questions 4, 5 & 12. This can be experienced at the same time as the other types of abuse. It may be present on its own or it may have started long before any physical violence began. The result of this abuse is that victims can blame themselves and, in order to live with what is happening, minimise and deny how serious it is. As a professional you can assist the victim in beginning to consider the risks the victim and any children may be facing.

- ✓ The victim may be being prevented from seeing family or friends, from creating any support networks or prevented from having access to any money.
- ✓ Victims of 'honour' based violence talk about extreme levels of isolation and being 'policed' in the home. This is a significant indicator of future harm and should be taken seriously.
- ✓ Due to the abuse and isolation being suffered victims feel like they have no choice but to continue living with the abuser and fear what may happen if they try and leave. This can often have an impact on the victim's mental health and they might feel depressed or even suicidal.
- ✓ Equally the risk to the victim is greater if their partner/ex-partner has mental health problems such as depression and if they abuse drugs or alcohol. This can increase the level of isolation as victims can feel like agencies won't understand and will judge them. They may feel frightened that revealing this information will get them and their partner into trouble and, if they have children, they may worry that they will be removed. These risks are addressed in questions 21 & 22.

If you are a professional working with domestic abuse and would like to know more about the Risk Identification Checklist you can find the following publications on our website:

- ✓ **CAADA-DASH MARAC Risk Identification Checklist (RIC) 2009 for the identification of high risk cases of domestic abuse, stalking and honour based violence**
http://www.caada.org.uk/dvservices/RIC_and_severity_of_abuse_grid_and_IDVA_practice_guidance.pdf
This is a helpful guide for IDVAs or practitioners new to the RIC and who want to become more familiar and confident in managing the process. It takes you through the process of completing the RIC with your client and provides detail on why and how to ask each question. This guide also provides supplementary questions to gather additional detail about each risk factor and provides general safety planning advice. It includes the Severity of Abuse Grid (SAG). The SAG gives practitioners the chance to profile the domestic abuse in more detail and identify significant concerns which may be relevant to include in a safety plan or share at a MARAC.
- ✓ **CAADA-DASH Risk Identification Checklist – without guidance**
http://www.caada.org.uk/marac/RIC_without_guidance.doc
This is a basic version of the RIC to download and use in everyday practice.
- ✓ **CAADA-DASH Risk Identification Checklist – Frequently Asked Questions**
http://www.caada.org.uk/marac/RIC_FAQs.pdf
This addresses a number of practical questions relating to the use of the checklist.
- ✓ **We also have a library of resources and information about training for frontline practitioners at**
http://www.caada.org.uk/marac/Information_about_MARACs.html

4. CAADA-DASH Risk Identification Checklist (RIC)

Aim of the form:

- To help front line practitioners identify high risk cases of domestic abuse, stalking and 'honour'-based violence.
- To decide which cases should be referred to MARAC and what other support might be required. A completed form becomes an active record that can be referred to in future for case management.
- To offer a common tool to agencies that are part of the MARAC¹ process and provide a shared understanding of risk in relation to domestic abuse, stalking and 'honour'-based violence.
- To enable agencies to make defensible decisions based on the evidence from extensive research of cases, including domestic homicides and 'near misses', which underpins most recognised models of risk assessment.

How to use the form:

Before completing the form for the first time we recommend that you read the Quick Start Guidance for Domestic Abuse, Stalking and 'Honour'-Based Violence on page six of this Toolkit. Full practice guidance and Frequently Asked Questions and Answers can also be downloaded http://www.caada.org.uk/marac/RIC_for_MARAC.html. Risk is dynamic and can change very quickly. It is good practice to review the checklist after a new incident.

Recommended Referral Criteria to MARAC

1. **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 particular 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.*** This 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.
2. **'Visible High Risk':** the number of 'ticks' on this checklist. If you have ticked 14 or more 'yes' boxes the case would normally meet the MARAC referral criteria.
3. **Potential Escalation:** the number of police callouts to the victim as a result 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. It is common practice to start with 3 or more police callouts in a 12 month period but this will need to be reviewed depending on your local volume and your level of police reporting.

Please pay particular attention to a practitioner's professional judgement in all cases. The results from a checklist are not a definitive assessment of risk. They should provide you with a structure to inform your judgement and act as prompts to further questioning, analysis and risk management whether via a MARAC or in another way.

The responsibility for identifying your local referral threshold rests with your local MARAC.

What this form is not:

This form will provide valuable information about the risks that children are living with but it is not a full risk assessment for children. The presence of children increases the wider risks of domestic violence and step children are particularly at risk. If risk towards children is highlighted you should consider what referral you need to make to obtain a full assessment of the children's situation.

¹ For further information about MARAC please refer to the 10 Principles of an Effective MARAC http://www.caada.org.uk/marac/10_Principles_Oct_2011_full.doc

CAADA-DASH Risk Identification Checklist for use by IDVAs and other non-police agencies² for risk identification when domestic abuse, 'honour'- based violence and/or stalking are disclosed.

<p>Please explain that the purpose of asking these questions is for the safety and protection of the individual concerned.</p> <p>Tick the box if the factor is present <input checked="" type="checkbox"/>. Please use the comment box at the end of the form to expand on any answer.</p> <p>It is assumed that your main source of information is the victim. If this is <u>not the case</u> please indicate in the right hand column</p>	Yes (tick)	No	Don't Know	State source of info if not the victim e.g. police officer
1. Has the current incident resulted in injury? (Please state what and whether this is the first injury.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2. Are you very frightened? Comment:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3. What are you afraid of? Is it further injury or violence? (Please give an indication of what you think (name of abuser(s)...) might do and to whom, including children). Comment:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4. Do you feel isolated from family/friends i.e. does (name of abuser(s)) try to stop you from seeing friends/family/doctor or others? Comment:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5. Are you feeling depressed or having suicidal thoughts?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6. Have you separated or tried to separate from (name of abuser(s)....) within the past year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7. Is there conflict over child contact?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8. Does (.....) constantly text, call, contact, follow, stalk or harass you? (Please expand to identify what and whether you believe that this is done deliberately to intimidate you? Consider the context and behaviour of what is being done.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9. Are you pregnant or have you recently had a baby (within the last 18 months)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10. Is the abuse happening more often?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
11. Is the abuse getting worse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
12. Does (.....) try to control everything you do and/or are they excessively jealous? (In terms of relationships, who you see, being 'policed at home', telling you what to wear for example. Consider 'honour'-based violence and specify behaviour.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

² Note: This checklist is consistent with the ACPO endorsed risk assessment model DASH 2009 for the police service.

Name of victim:**Date:****Restricted when completed**

Tick box if factor is present. Please use the comment box at the end of the form to expand on any answer.	Yes (tick)	No	Don't Know	State source of info if not the victim
13. Has (.....) ever used weapons or objects to hurt you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
14. Has (.....) ever threatened to kill you or someone else and you believed them? (If yes, tick who.) You <input type="checkbox"/> Children <input type="checkbox"/> Other (please specify) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
15. Has (.....) ever attempted to strangle/choke/suffocate/drown you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
16. Does (.....) do or say things of a sexual nature that make you feel bad or that physically hurt you or someone else? (If someone else, specify who.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
17. Is there any other person who has threatened you or who you are afraid of? (If yes, please specify whom and why. Consider extended family if HBV.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18. Do you know if (.....) has hurt anyone else? (Please specify whom including the children, siblings or elderly relatives. Consider HBV.) Children <input type="checkbox"/> Another family member <input type="checkbox"/> Someone from a previous relationship <input type="checkbox"/> Other (please specify) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19. Has (.....) ever mistreated an animal or the family pet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20. Are there any financial issues? For example, are you dependent on (.....) for money/have they recently lost their job/other financial issues?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21. Has (.....) had problems in the past year with drugs (prescription or other), alcohol or mental health leading to problems in leading a normal life? (If yes, please specify which and give relevant details if known.) Drugs <input type="checkbox"/> Alcohol <input type="checkbox"/> Mental Health <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22. Has (.....) ever threatened or attempted suicide?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
23. Has (.....) ever broken bail/an injunction and/or formal agreement for when they can see you and/or the children? (You may wish to consider this in relation to an ex-partner of the perpetrator if relevant.) Bail conditions <input type="checkbox"/> Non Molestation/Occupation Order <input type="checkbox"/> Child Contact arrangements <input type="checkbox"/> Forced Marriage Protection Order <input type="checkbox"/> Other <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
24. Do you know if (.....) has ever been in trouble with the police or has a criminal history? (If yes, please specify.) DV <input type="checkbox"/> Sexual violence <input type="checkbox"/> Other violence <input type="checkbox"/> Other <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Total 'yes' responses				

Name of victim:

Date:

Restricted when completed

For consideration by professional: Is there any other relevant information (from victim or professional) which may increase risk levels? Consider victim's situation in relation to disability, substance misuse, mental health issues, cultural/language barriers, 'honour'- based systems, geographic isolation and minimisation. Are they willing to engage with your service? Describe:

Consider abuser's occupation/interests - could this give them unique access to weapons? Describe:

What are the victim's greatest priorities to address their safety?

Do you believe that there are reasonable grounds for referring this case to MARAC? Yes / No

If yes, have you made a referral? Yes/No

Signed:

Date:

Do you believe that there are risks facing the children in the family? Yes / No

If yes, please confirm if you have made a referral to safeguard the children: Yes / No

Date referral made

Signed:

Date:

Name:

Practitioner's Notes

--

RESTRICTED WHEN COMPLETED

5. MARAC REFERRAL FORM

*MARAC referrals should be sent by **secure email or other secure method**.*

Referring agency						
Contact name(s)						
Telephone / Email						
Date						
Victim name				Victim DOB		
Address				Diversity Data (if known) B&ME <input type="checkbox"/> Disabled <input type="checkbox"/> LGBT <input type="checkbox"/> Gender M / F		
Telephone number				Is this number safe to call?	Y / N	
Please insert any relevant contact information e.g. times to call						
Perpetrator(s) name				Perpetrator(s) DOB		
Perpetrator(s) address				Relationship to victim		
Children (please add extra rows if necessary)	DOB	Relationship to victim	Relationship to perpetrator	Address	School (If known)	

Reason for Referral / Additional Information

Professional judgement	Y / N	Visible high risk (<i>14 ticks or more on CAADA - DASH RIC</i>)	Y / N
Potential escalation (<i>3 or more incidents reported to the Police in the past 12 months</i>)	Y / N	MARAC repeat (further incident identified within twelve months from the date of the last referral)	Y / N
If Yes, please provide the date listed / case number (if known)			
Is the victim aware of MARAC referral?	Y / N	If no, why not?	
Has consent been given?	Y / N		
Who is the victim afraid of? (to include all potential threats, and not just primary perpetrator)			
Who does the victim believe it safe to talk to?			
Who does the victim believe it not safe to talk to?			
Has the victim been referred to any other MARAC previously?	Y / N	If yes where / when?	

RESTRICTED WHEN COMPLETED

6. RESEARCH FORM FOR MARAC

Name & Agency	
Telephone / Email	
Date	

Victim name		Victim DOB	
Victim name and DOB			
Victim address			
MARAC case number (from agenda)			

Please insert any changes / errors / other information (e.g. aliases or nicknames) below

Are the victim details on the MARAC list accurate?	<i>Y / N</i>	
Are the children(s) details on the MARAC list accurate?	<i>Y / N</i>	
Are the perpetrator details on the MARAC list accurate?	<i>Y / N</i>	

Note records of last sightings, meetings or phone calls.	
Note recent attitude, behaviour and demeanour, including changes.	
Highlight any relevant information that relates to any of the risk indicators on the checklist (<i>e.g. the pattern of abuse, isolation, escalation, victim's greatest fear etc.</i>).	
Other information (<i>e.g. actions already taken by agency to address victim's safety</i>).	
What are the victim's greatest priorities to address their safety?	
Who is the victim afraid of? <i>To include all potential threats, and not just primary perpetrator.</i>	
Who does the victim believe it safe to talk to?	
Who does the victim believe it not safe to talk to?	

7. Contact details for MARAC representatives

[illegible]

Tool
18

Brook Traffic Light Tool

 [Back to main contents](#)

This 'Traffic Light Tool' forms part of a resource designed to help professionals who work with children and young people to identify, assess and respond appropriately to sexual behaviours.

By identifying sexual behaviours as **GREEN**, **AMBER** or **RED**, professionals across different agencies can work to the same criteria when making decisions and protect children and young people with a unified approach. The normative list aims to increase understanding of healthy sexual development and distinguish it from harmful behaviour.

This tool must be used within the context of the guidance provided at www.brook.org.uk/traffic-lights and should not be used in isolation.

What is a Green behaviour?

Green behaviours reflect safe and healthy sexual development. They are:

- displayed between children or young people of similar age or developmental ability
- reflective of natural curiosity, experimentation, consensual activities and positive choices

Expressing sexuality through sexual behaviour is natural, healthy and a part of growing up.

Green behaviours provide an opportunity to positively reinforce appropriate behaviour, and to provide further information and support.

Green behaviours

- holding or playing with own genitals
- attempting to touch or curiosity about other children's genitals
- games e.g. mummies and daddies, doctors and nurses
- enjoying nakedness
- interest in body parts and what they do
- curiosity about the differences between boys and girls
- feeling and touching own genitals
- curiosity about other children's genitals
- curiosity about sex and relationships, e.g. differences between boys and girls, how sex happens, where babies come from, same-sex relationships
- sense of privacy about bodies
- telling stories or asking questions using swear and slang words for parts of the body
- solitary masturbation
- use of sexual language including swear and slang words
- having girl/boyfriends who are of the same or opposite gender
- interest in popular culture, e.g. fashion, music, media, online games, chatting online
- need for privacy
- consensual kissing, hugging, holding hands with peers

Age 9 – 13

Age 13 – 17

- solitary masturbation
- sexually explicit conversations with peers
- obscenities and jokes within the current cultural norm
- interest in erotica /pornography
- use of internet / e-media to chat online
- having sexual or non-sexual relationships
- sexual activity including hugging, kissing, holding hands
- consenting oral and /or penetrative sex with others of the same or opposite gender who are of similar age and developmental ability
- choosing not to be sexually active

What is a Red behaviour?

Red behaviours are outside of safe and healthy behaviour. They may be:

- excessive, secretive, compulsive, coercive, degrading, or threatening
- involving significant age, developmental, or power differences
- of concern due to the activity type, frequency, duration, or the context in which they occur

Red behaviours indicate a need for immediate intervention and action, though it is important to consider actions carefully.

Please refer to internal guidance or safeguarding frameworks to decide on the next steps to take or talk to a designated safeguarding lead.

Red behaviours

- persistently touching the genitals of other children
- persistent attempts to touch the genitals of adults
- simulation of sexual activity in play
- sexual behaviour between young children involving penetration with objects
- forcing other children to engage in sexual play
- frequent masturbation in front of others
- sexual behaviour engaging significantly younger or less able children
- forcing other children to take part in sexual activities
- simulation of oral or penetrative sex
- sourcing pornographic material online
- exposing genitals or masturbating in public
- distributing naked or sexually provocative images of self or others
- sexually explicit talk with younger children
- sexual harassment
- arranging to meet with an online acquaintance in secret
- genital injury to self or others
- forcing other children of same age, younger or less able to take part in sexual activities
- sexual activity e.g. oral sex or intercourse
- presence of sexually transmitted infection (STI)
- evidence of pregnancy
- exposing genitals or masturbating in public
- preoccupation with sex, which interferes with daily function
- sexual degradation/humiliation of self or others
- attempting/forcing others to expose genitals
- sexually aggressive/exploitative behaviour
- sexually explicit talk with younger children
- sexual harassment
- non-consensual sexual activity
- use of/acceptance of power and control in sexual relationships
- genital injury to self or others
- sexual contact with others where there is a big difference in age or ability
- sexual activity with someone in authority and in a position of trust
- sexual activity with family members
- involvement in sexual exploitation and/or trafficking
- sexual contact with animals
- receipt of gifts or money in exchange for sex

Tool
19

Spotting the Signs of Sexual Exploitation: The BASHH proforma



[!\[\]\(9dfdaff1d86ba3c1f8353b4d1b61b8c5_img.jpg\) Back to main contents](#)

[!\[\]\(83f22ed94ec5517769dd76d702c6bfd8_img.jpg\) Back to main contents](#)

Identifying Child Sexual Exploitation: A proforma to aid sexual health care providers

This Child Sexual Exploitation proforma has been developed as a tool for sexual health services to aid in the assessment of young people who are at risk of, or experiencing, sexual exploitation.

Focus group work has shown that young people prefer to be asked sensitive questions in a professional but conversational manner which is effective for both you and them. You may need to rephrase questions to suit individuals, and avoid using language that may be unfamiliar to young people, such as medical jargon.

If a young person is considered to be at risk from replies they give when you are using the tool, you must add the relevant information to your services under age proforma, and follow your own children and young people safeguarding policy by discussing / informing the safeguarding lead within your service.

If a young person does not want to answer any of the questions please make a note of this on the CSE proforma but do not push them.

When asking questions about whom the young person is having sex with, find out what term the young person feels comfortable using, as they may not perceive that person as a partner.

Please note that a young person may perceive their situation as consensual when in fact they are being groomed.

Confidentiality

Make sure the young person is aware of confidentiality before you start your consultation:

"Confidentiality means that we won't tell anyone what you and I talk about unless we feel that we need to protect you or someone else from harm - and even then we'll try and discuss it with you first."

Definition of sexual activity

When in consultation with young people, please make it explicitly clear that sexual activity may include vaginal, oral and/or anal sex.

Identifying Child Sexual Exploitation: A proforma to aid sexual health care providers

Visit Number:

Confidentiality discussed and understood:			
Age:		Gender:	
Ethnicity:			
Education			
Do you attend School / Education other than school / Pupil Referral Unit / College/ Training / Employment?	Do you attend regularly?	Do you enjoy it?	Is there anyone there who you can talk to?
Family Relationships			
Who do you live with?	How are things at home?	Do you feel like you can talk to someone at home about sex / relationships?	Young carer: Looked after child: Homeless: Runaway: Family bereavement: Learning or physical disability:
Are you involved with any other agencies or professionals e.g. social workers, mental health services? If so, would you be happy for us to contact them if we feel we need to?			
Friendships			
Do you have friends your own age who you can talk to?		Do your friends like and know the person you have sex with (if you are involved with or having sex with anyone)?	
Relationships			
Are you having sexual contact with anyone? (If no) When was the last time you did?	Are you happy in your current circumstance, i.e. with the person you're going out with/with the person you have sex with?	How old is the person you are having sex with?	How many people have you had sexual contact with in the past 3 months? In the past 12 months?

Identifying Child Sexual Exploitation: A proforma to aid sexual health care providers

Where do you spend time together?		Where did you meet the person you have sex with?
Consent		
Have you ever been made to feel scared or uncomfortable by the person/s you have been having sexual contact with with?	Have you ever been made to do something sexual that you did not want to do / been intimidated?	Do you feel you could say no to sex?
Has anyone ever given you something like gifts, money, drugs, alcohol or protection for sex?	Where do you have sex?	Who else is / was there when you have sex (any other form of sexual contact)?
Sexual Health		
What contraception do you use?	Do you feel like you can talk to the person you have sex with about using condoms / other forms of contraception?	
Have you ever had an STI test?	Have you ever had an STI? If yes, which, and how many times?	
Do you ever use drugs and/or alcohol?		
Do you often drink / take drugs before having sex?		
Do you suffer from feeling down / depression?	Have you ever tried to hurt yourself or self-harm?	Have you ever been involved in sending or receiving messages of a sexual nature, does anyone have pictures of you of a sexual nature?
Professional analysis		
Is there evidence of any of these within their relationship? Coercion: Overt aggression (physical or verbal): Suspicion of sexual exploitation / grooming: Sexual abuse: Power imbalance: Other vulnerabilities (please give details):		
If you have identified risks or concerns please discuss with CSE / Safeguarding Lead by (date) and follow your own child protection policy and procedure.		

Identifying Child Sexual Exploitation: A proforma to aid sexual health care providers

Any additional information:						
Signed:	Printed:	Date:				
Fraser Guidelines		<table border="1"> <thead> <tr> <th>Yes</th> <th>No</th> </tr> </thead> <tbody> <tr> <td></td> <td></td> </tr> </tbody> </table>	Yes	No		
Yes	No					
<p>The young person understands the health professional's advice.</p> <p>The young person is aware that the health professional cannot inform her/his parents that he/she is seeking sexual health advice without consent, nor persuade the young person to inform his /her parents.</p> <p>The young person is very likely to begin having, or continue to have, intercourse with or without contraceptive / sexual health treatment.</p> <p>Unless he/she receives contraceptive advice or treatment the young person's physical or mental health, or both, are likely to suffer.</p> <p>The young person's best interests require the health professional to give contraceptive advice, treatment, or both without parental consent.</p>						