Policy Title	**Safeguarding Children and Young People**
Policy Number	EDOOP.004
Purpose	To ensure that at all times the protection of children and vulnerable adults from harm Form an integral part of the care and service we deliver. To make sure that all of our staff understand the concepts of safeguarding and the procedure for raising concerns
Author	Dr Aaron Pennell – Clinical Director Dr Anup Mathew – Associate Clinical Director James Callaghan – Safe Guarding Lead/Officer
Responsible officer/s	Dr Anup Mathew – Associate Clinical Director
For use by	All staff working with EDMS
This policy complies with or has been guided by	Safeguarding Children in Whom Illness is Fabricated or Induced. DOH 2002 Sexual Offences Act 2003. Department of Health (2003) National Service Framework for Children, Young People and Maternity Services: Core Standards. Department of Health (2004) Department of Health, London. Responding to Domestic Abuse: A Handbook for Health Professionals. Department of Health (2006a) Department of Health, London. What to do if you're worried a Child Is Being Abused. Department of Health (2006b) Working Together to Safeguard Children. Department of Health (2006c) HMSO
CQC outcome compliant	Outcomes 7
This document supersedes	EDOOP/004/01/12/V1
Approved and ratified by	EDMS Executive Management Team
Implementation date	01 February 2012
Review date	01 February 2017
Version and Document Control	Version 2

Equal Opportunities, Health and Safety, Employment conduct and Professional Liabilities Assessment:

EDMS has ensured given every reasonable means and with the information available at this time that this policy will not discriminate either directly or indirectly in any way against employees, patients or customers on the grounds of race, religion, colour, age, gender or sexual orientation, disability, marital status or culture. EDMS has assessed this policy in terms of current health and safety guidance and has ensured that where requirements have been stipulated these are met. EDMS has ensured that it holds appropriate insurance for this policy to be fully endorsed. EDMS has assessed this policy for any impact it may have on corporate or individual professional requirements and conduct and has ensured any such impact meets with the approval of any professional bodies it may encounter. This policy can be made available in Braille or voice recording and can be translated into other languages

Policy Statement:
This policy document supersedes the previous policy document EDOOP/004/01/12/V1

This Safeguarding documents provides Safeguarding Children and Young People Policy, and contained in appendices to the policy Procedure for Managing Allegations against Staff, Information Sharing Protocol, as well as a range of guidance documents related to safeguarding and abuse.

The policy document outlines the responsibility of EDMS, as well as its staff in safeguarding children and young people who may be vulnerable.

The policy aims to promote a high standard of staff awareness and participation in undertaking their statutory duties in relation to making provision to protect children and adults who may be vulnerable, who they come into contact with during the course of their work.

This document relates to the statutory duties in relation to Children and Young People. Further guidance for safeguarding adults is contained in EDMS' Policy Safeguarding Vulnerable Adults.

This safeguarding of Children and Young People Policy should be read in conjunction with the EDMS Consent to care and treatment.

Introduction
The tragic death of Victoria Climbié on the 25th February 2000 and the subsequent Inquiry conducted by Lord Laming reminds every one of the risks from abuse and the ease whereby many individuals and agencies ignore warning signs.

That Inquiry produced a report which contained over 100 recommendations. The timescales attached to these recommendations were broken down into three bands. The first group were due for implementation in April 2003, with all recommendations implemented within two years. The Laming Inquiry prompted the review of the Children Act 1989, and the recommendations from the inquiry report essentially informed and became the statute of the Children Act 2004.

As a result of the Children Act 2004 widespread changes have been implemented into the whole arena of child protection. Section 11 of the act is key to our activities as a medical provider.

In 2008 following the death of Baby Peter in London, Lord Laming was asked by the Government to urgently review the progress being made since the implementation of the changes brought about by the Children Act 2004 and the statutory guidance contained in *Working Together to Safeguard Children* (WT) *2006*. In March 2009 Laming published his findings in the report, *The Protection of Children in England: A Progress Report.* The Government accepted all of Lord Laming's further recommendations. As a result of this
Working Together has been rewritten and encompasses most of these recommendations in *Working Together to Safeguard Children 2010* (WT2010).

This Policy draws together the elements from WT2010, as well as information from other national and local guidance documents for children and young people and sets out the relevant issues for staff and the procedures which EDMS should be following

Purpose
The purpose of this document is to draw together the requirements and principles related to the protection of children, and young people which includes the important areas of abuse and neglect.

EDMS staff, or those working to provide patient care on behalf of EDMS will ensure that all patients and those members of the community who are considered to be at risk of abuse or neglect when observed or brought to the attention of EDMS employees during a call to a patient or at a consultation, are protected and where appropriate, further action is taken to ensure that they are brought to the attention of the relevant authorities

This Policy replaces all existing clinical instructions and documents related to the protection of children and young people issued by EDMS.

EDMS Responsibilities

Under section 11 of the Children Act 2004

Section 11 of the Children Act 2004 places a duty on key people and bodies to make arrangements to ensure that their functions are discharged with regard to the need to safeguard and promote the welfare of children. As part of its responsibility EDMS has named a Named Doctor for Safeguarding, as well as a safeguarding lead/instructor for Safeguarding. These staff will be assigned our Named Professionals.

The Named Professionals are also the designated senior managers in respect of ensuring allegations against staff are investigated effectively.

EDMS will receive reports either directly or through the online Cause for Concern Form.

Duties

Accountability for child and young people protection is ultimately EDMS' Associate Clinical Director.

All staff have a responsibility to read, understand and to adhere to the requirements of this policy and its appendices, and maintain an up to date knowledge of current practice in both children and young people safeguarding. All staff will be level 2/Group 2 safeguarding children and young persons trained.

In supporting the responsibilities EDMS should, through its safeguarding team, keep itself and all staff up to date by means of both its statutory safeguarding training requirements, as well as the regular dissemination of information as a result of changes in legislation, new practice and recommendations from Serious Case Reviews (SCR's).

All staff must share EDMS' commitment to **protect, safeguard and promote the welfare of children and young people.**

All staff who have access in person to family homes and other locations, or may be involved with individuals at a time of crisis, are in a position to identify initial concerns regarding a child's or young person's welfare.

As well as understanding abuse and the indicators of abuse, it is essential that staff both understand and recognise those children and young people that they come into contact with who are vulnerable. Recognising vulnerability itself is a key element in identifying that a person is being abused or neglected.

All staff in EDMS have specific responsibility to share concerns appropriately, if necessary initially discussing their concerns with a relevant manager in EDMS, and ensuring that they refer any suspected abuse or neglect which is drawn to their attention, or that they become aware of when acting on behalf of EDMS.

Staff may on occasions be required to co-operate further with other agencies with their investigations or enquiries where necessary or appropriate. This might involve making statements and / or being involved in information sharing and strategy meetings, which are a statutory requirement when working with local authorities when there are concerns around safeguarding and/ or protection.

In compiling its safeguarding policy EDMS considers and makes reference to key elements of the policies of the LSCB's within its operational area.

EDMS will make every effort to ensure that its clinicians and staff, when making formal referrals receive feedback from Social Care as appropriate.

Whilst EDMS employs a wide range of people in different roles and with different titles this document, for the sake of simplicity uses the term 'staff' to mean all staff, whether paid or voluntary who undertake duties on behalf of EDMS

General Principles for All EDMS Staff
Emergency Doctors Medical Service is committed to protecting, safeguarding and promoting the welfare of children and young people and there is a considerable amount of legislation and guidance to inform and direct that commitment. .

The safeguarding agenda is a rapidly growing agenda and there are an increasing number of facets which link very closely to the overarching definition and our understanding of abuse. This policy and its appendices identify a range of situations / known facets of abuse that staff may come into contact within their professional duties.

A child is defined as anybody that has not yet reached his or her eighteenth birthday
(Children Act 2004)

Healthcare staff are key to recognising child and young person abuse. Research suggests that awareness generally of child abuse has been poor in the past, approaches to dealing with the problem uncoordinated and many problems underreported. Abuse affects large numbers of people presenting itself in many different ways and the extent of the problem reflects the range of definitions available.

EDMS are required to have in place policies and procedures to effectively respond to known or suspected abuse in both children and young people.

DBS/CRB Checks
EDMS has in place relevant 'safer recruitment' policies, procedures and guidance. All staff who are exempt from the Rehabilitation of Offenders Act, for example those who provide direct services to children, are subject to enhanced Criminal Records Bureau (CRB) checks.

The police (along with Social Care) are the lead statutory agencies coordinating the response to child abuse allegations. They have an important responsibility to work closely with other agencies and organisations and undertake assessments and investigations.

The police have the power to enter property if necessary and also to remove a child into police protection for up to 72 hours if they consider that the child is at risk of 'significant harm'

The key principles underlining the approach and actions to protect those involved are

- *Any vulnerable child or young person can be at risk and has the right to protection from abuse, and*
- *A multi-agency approach is the most effective response.*

The terms *safeguarding* and *protection* are two distinct terms. The multi-agency approach is aimed at preventing abuse (**Safeguarding**) and providing a timely provision of help when it is needed in a proactive sense. **Protection**, as the name suggests is about providing timely protection when abuse has, or is suspected of having taken place.

Different agencies work together to both safeguard vulnerable children and young people and also to share concerns that they may have with other relevant agencies. It is also designed to elicit a swift, effective response from agencies acting together when abuse is suspected.

The prime objective in any investigation of alleged abuse is to secure the best outcome for the vulnerable or abused individual at the centre of the situation. Whilst most cases will be resolved at a local and informal level, on some occasions cases may require to be taken down a more formal route, including potential action through the courts.

Specific Issues relating to Safeguarding
Allegations Against staff
Information in relation to allegations against staff and the process by which they are investigated are contained within EDMS' "Allegations against Staff relating to Safeguarding Children and Vulnerable Adults" Policy. Appendix E, of this document also contains information and the **procedure** to be followed in relation to investigating allegations made against EDMS staff.

People with Learning Disabilities
EDMS recognises that people with learning disabilities can be particularly vulnerable. EDMS has a Lead for Equality, Diversity and Human Rights who work closely with the Named Professionals to ensure that EDMS understands the particular challenges for people with learning disabilities and equally to ensure that the needs of these people are met, particularly in relation to safeguarding and the protection of their welfare.

Children defined as having special needs have particular requirements because of their psychological and / or medical difficulties. For example, deaf or autistic children may demonstrate challenging behaviour, which may or may not be as a result of abuse. Children with special needs are more likely to be abused than children in the general population.

Suspected abuse of children or young people
Any EDMS staff member who suspects abuse MUST follow the procedure and guidance which supplements this policy. These papers clearly outline how EDMS expects staff to recognise possible examples of abuse and what immediate actions staff are to take including reporting concerns to the Safeguarding Teams at the relevant Local Authorities.

Information Sharing and Referring (Reporting) Concerns
Any allegation or suspicion of abuse must be taken seriously and acted on immediately. Any member of EDMS, or voluntary members of the public who help EDMS deliver our service, and who may come into contact with children and young people have a duty to share, and if necessary refer or report concerns regarding suspected abuse or neglect to Social Care.

Local Authorities have a duty to make enquiries to decide whether they should take action to safeguard or promote the welfare of a child who is suffering, or likely to suffer **significant harm.**

The Children Act 1989 introduced the concept of significant harm as 'the threshold that justifies compulsory intervention in family life in the best interests of the child(ren)'.

Failure to act might place the victim at greater risk and they may be discouraged from disclosing the same or further details again as they may feel they were not believed. Failure to report suspected or alleged abuse may also put other people at risk.

If staff have a concern and wish to seek further advice or clarity initially prior to making a formal referral, they should contact one of the following;

- Duty Clinical Director
- Duty Manager
- Named Professional
- Local Safeguarding Children Boards (LSCB)

It is essential that concerns are shared even if no further action is taken following a discussion with one of the above.

Data Protection
Staff should be aware of the Data Protection Act 1998 and Caldicott Guardianship and in particular the six Caldicott Principles in regard to confidentiality, however there are occasions where staff will need to step outside of the requirements of the above in order to fulfil their safeguarding duties.

In respect of this staff should also be aware of the Public Interest Disclosure Act 1998 and the protection it affords professionals in making a referral without consent but where to do so would be defined as being 'in the public interest'.

In accordance with legislative guidelines EDMS will freely share information with other Health, Social Care, police and other Child protection partners, where such information will be in the best interests of the child or young person.

EDMS has in place an **Information Sharing Policy** which sets out clearly what information can be shared, under what circumstances and when this is acceptable. The Information Sharing Policy is contained within the Safeguarding Policy at Appendix F. Staff must be aware of the implications of information sharing when disclosing information in relation to a safeguarding concern.

Policy References

The guidance for this document has been taken from a number of sources:

- ***"Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children";*** HM Government; 2010
- ***Statutory guidance on making arrangements to safeguard and promote the welfare of children under section11 of the Children Act 2004;*** HM Government; 2007
- ***National Service Framework for Children, Young People and Maternity Services - 2004*** (DoH)
- ***Victoria Climbié Inquiry Report*** - Lord Laming, January 2003
- ***The Bichard Inquiry Report*** - Sir Michael Bichard 2004
- ***The Protection of Children in England: A Progress Report*** - Lord Laming March 2009
- ***When to suspect child maltreatment*****; Clinical Guideline July 2009** - NICE (*National Collaborating Centre for Women's and Children's Health)*
- ***Data Protection Act - 1998***
- ***Caldicott Guardian Manual - 2010***
- ***Public Interest Disclosure Act 1998***
- ***Safeguarding Vulnerable Groups Act 2006.***
- ***Relevant Local Safeguarding Children Boards for the East of England*** (reference should be made to individual LSCB Protocols)

  Bedfordshire www.bedfordshirelscb.org.uk
  Hertfordshire www.hertsdirect.org/caresupport/childfam/childprotection/acpc
  Cambridgeshire www.cambslscb.org.uk
  Southend www.southend.gov.uk
  Peterborough www.peterborough.gov.uk/children_and_families/peterborough_safeguarding.aspx
  Norfolk www.lscb.norfolk.gov.uk
  Suffolk
  www.suffolk.gov.uk/CareAndHealth/ChildrenAndFamilies/SuffolkSafeguardingChildrenBoard
  Thurrock www.thurrock-community.org.uk/lsp/safeguard
  Essex www.escb.co.uk
  Luton www.lutonlscb.org

Appendices

Part 1 - Safeguarding Procedures and Protocols

Appendix A	General Information
Appendix B	Child Protection and the Recognition of Abuse
Appendix C	What to do if you have a concern that a child or young person may be being abused or neglected
Appendix D	Referral Flowchart
Appendix E	Allegations of Abuse against a Member of Staff
Appendix F	Information Sharing Protocol

Part 2 - Additional and Supporting Information

Appendix G	Forced Marriage
Appendix H	Domestic Abuse / Violence
Appendix J	Concealed Pregnancy
Appendix K	Female Genital Mutilation
Appendix L	Parental Engagement
Appendix M	Dangerous Dogs
Appendix N	Prevent Strategy and Violent Extremism
Appendix O	References and Internet Links

Part 1 Safeguarding Procedures and Protocols

Appendix A - General Information

This and the other appendices draw together elements from the separate national and local guidance documents for children and young people and sets out the relevant issues for ambulance services and the procedures which EDMS should be following.

Introduction

The tragic death of Victoria Climbié on the 25th February 2000 and the subsequent Inquiry conducted by Lord Laming reminds everyone of us of the risks of abuse and the ease whereby many individuals and agencies ignore warning signs.

That Inquiry produced a report which contained over 100 recommendations. The timescales attached to these recommendations were broken down into three bands. The first group were due for implementation in April 2003, with all recommendations implemented within two years. The Laming Inquiry prompted the review of the Children Act 1989, and the recommendations from the inquiry report essentially informed and became the statute of the Children Act 2004.

As a result of the Children Act 2004 widespread changes have been implemented into the whole arena of child protection. Section 11 of the act is key to our activities as an ambulance trust.

In 2008 following the death of Baby Peter in London Lord Laming was asked by the Government to urgently review the progress being made since the implementation of the changes brought about by the Children Act 2004 and the statutory guidance contained in Working Together to Safeguard Children (WT) 2006. In March 2009 Laming published his findings in the report, The Protection of Children in England: A Progress Report. The Government accepted all of Lord Laming's further recommendations. As a result of this Working Together has been rewritten and encompasses most of these recommendations in
Working Together to Safeguard Children 2010 (WT2010)

General Principles

A child is defined as anybody that has not yet reached their eighteenth birthday.

Healthcare staff are key to recognising child abuse. Research suggests that awareness generally of child abuse has been poor in the past, approaches to dealing with the problem uncoordinated and many problems underreported. Abuse affects large numbers of people presenting itself in many different ways and the extent of the problem reflects the range of definitions available.

EDMS are required to have in place policies and procedures to effectively respond to known or suspected abuse in children and young people.

Definition of Abuse

'Abuse' is a violation of an individual's human and civil rights by any other person or persons and can take many different forms. It can relate to a single act or repeated acts.

Types of Abuse

It should be noted that in many situations different types of abuse can be inextricably linked, an example of this being Internet and Sexual abuse. Likewise some forms of abuse, for example Financial or Discriminatory tend to be confined to one specific group, in this case to vulnerable adults.

There are the more familiar (historical) types of abuse as listed below, as well as abuse patterns and types which have developed in specific areas, or in recent years. All types of abuse are described in greater detail below, and with specific reference in following appendices. The more 'familiar', or historical types of abuse are;

- Physical abuse and Fabricated Induced Illness
- Emotional or Psychological abuse
- Sexual abuse
- Neglect and acts of omission
- Discriminatory Abuse (linked, Hate Crime)

As mentioned above there are emerging types and facets of abuse. Whilst the above give a general view of the commonly recognised 'types' of abuse, a number of specific concerns are addresses in following appendices. These include;

- Migrant Abuse and Human Trafficking

- Internet Abuse
- Forced Marriage
- Domestic Abuse / Violence
- Concealed Pregnancy
- Female Genital Mutilation
- Prevent Strategy and Violent Extremism

Specific types of abuse are detailed, and where there are specific facets to a particular type of abuse, these are covered in the relevant appendices, Appendix B covers specific facets in relation to child and young person abuse.

Physical abuse and Fabricated Induced Illness: Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, suffocating or otherwise causing physical harm.
Fabricated Induced Illness: Physical harm may also be caused when a parent or carers feigns the symptoms of, or deliberately causes ill-health, to a vulnerable person they are looking after. Common description terms used are Fabricated or Induced Illness (FII), 'factitious illness by proxy' or 'Munchausen's syndrome by proxy'.
The following list is of behaviours exhibited by carers which can be associated with fabricating or inducing illness in a child. This list is not exhaustive and should be interpreted with an awareness of cultural behaviours and practices which can be mistakenly construed as abnormal behaviours:

- Deliberately inducing symptoms in children by administering medication or other substances, by means of intentional transient airways obstruction or by interfering with the child's body so as to cause physical signs.
- Interfering with treatments by over dosing with medication, not administering them or interfering with medical equipment such as infusion lines;
- Claiming the child has symptoms which are unverifiable unless observed directly, such as pain, frequency of passing urine, vomiting or fits. These claims result in unnecessary investigations and treatments which may cause secondary physical problems;
- Exaggerating symptoms which are unverifiable unless observed directly, causing professionals to undertake investigations and treatments which may be invasive, are unnecessary and therefore are harmful and possibly dangerous;
- Obtaining specialist treatments or equipment for children who do not require them;
- Alleging psychological illness in a child.

Concerns may arise about possible fabricated or induced illness when:

- Reported symptoms and signs found on examination are not explained by any medical condition from which the child may be suffering; or
- Physical examination and results of medical investigations do not explain reported symptoms and signs; or
- There is an inexplicably poor response to prescribed medication and other treatment; or
- New symptoms are reported on resolution of previous ones; or
- Reported symptoms and found signs are not seen to begin in the absence of the carer; or
- Over time the child is repeatedly presented with a range of signs and symptoms; or
- The child's normal, daily life activities are being curtailed, for example school attendance,
- Beyond that which might be expected for any medical disorder from which the child is known to suffer

***Emotional or Psychological abuse*:** Emotional / psychological abuse is the persistent emotional ill-treatment of a child or young person such as to cause severe and persistent adverse effects on their emotional development or wellbeing. It may involve conveying to them that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may feature age or developmentally inappropriate expectations being imposed on children. It may involve causing the person frequently to feel frightened or in danger, or the exploitation or corruption of the child or young person.

***Sexual abuse*:** Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, whether or not the person is aware of what is happening. The activities may involve physical contact, including penetrative or non-penetrative acts. They may include non-contact activities, such as involving the child or young person looking at, or in the production of pornographic material or watching sexual activities, or encouraging them to behave in inappropriate ways.

***Neglect and acts of omission*:** Neglect is the persistent failure to meet a child or young person's basic physical and/or psychological needs, likely to result in the serious impairment of their health or development. It may involve a parent or carer failing to provide adequate food, shelter and clothing, failing to protect the person from physical harm or

danger, or the failure to ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to a child or young person's basic emotional needs.

Migrant Abuse and Human Trafficking: Each year a number of migrants enter the UK quite legally to work in agriculture and other areas. Whilst visas are granted to allow this to happen, and regulations in relation to 'gang master' activity is more stringent than ever, they are particularly open to abuse, specifically around accommodation, pay, terms and conditions and their health needs. Every effort should be made to support these people to ensure they are not abused.

More complex are the migrants who enter the country illegally, or those who are overstayers, quite often people (and children) who are outside of the authorities radars. Quite often these people enter not just the UK, but also into a life of abuse and in particular abuse centered around the sex trade and drugs.

There are more people enslaved worldwide today than there were 200 years ago. The modern day slave trade is the fastest growing form of international crime with an estimated 600,000-800,000 people trafficked across international borders each year. The number of people trafficked internally is currently unknown. People are bought and sold into the sex industry, forced labour, domestic servitude and forced organ donation to name a few. This affects children, young people and adults. Given promises of better prospects and living opportunities by their abusers, they are exploited and held in poor conditions often suffering extreme violence, harassment and threats. Often unable to speak English these individuals are unable to speak out about their suffering.

The most classic case of our time of migrant abuse was that of Victoria Climbė, she was given the opportunity to have better prospects, but was systematically abused from the time she left Africa. The numbers of migrant children has increased in recent years they are of increased vulnerability. They may be being moved illegally or against their will often on an undisclosed pretext.

In the case of children, they are children first and we should not lose sight of that. They face legal and cultural complexities. Migrant children should be assumed as children in need or in need of referral.

Internet Abuse: Sadly, Internet abuse is now a widespread problem, the Internet providing a useful medium for those wishing to exploit young people, and children particularly. At the same time other information communication technology (ICT) methodologies are increasingly being used by perpetrators to prey on their victims. For example using webcams, texting and other mobile phone technologies.

Internet chat rooms, discussion forums and bulletin boards are known to be used by perpetrators as a means of contacting children or young people as a way of establishing deceptive relationships with them. They then 'groom' the victims, either psychologically on the Internet itself, or by arranging to actually meet with them. Often victims believe that they are actually chatting to genuine people on-line. Alternatively, the perpetrators may ask the victim to transmit pornographic images of themselves, or to perform sexual acts live in front of a webcam.

The perpetrators are very adept at manipulating their victims and particularly in the case of children it is a known fact that girls are more at risk than boys

Institutional abuse: Involves the collective failure of an organisation to provide an appropriate and professional service to vulnerable people. It can be seen or detected in processes, attitudes and behaviour that amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and stereotyping. It includes a failure to ensure the necessary safeguards are in place to protect children and young people and maintain good standards of care in accordance with individual needs, including training of staff, supervision and management, record keeping and liaising with other providers of care. In these cases the Police should be notified to ensure that a criminal investigation is undertaken.

As mentioned above there are emerging types and facets of abuse. Whilst the above give a general view of the commonly recognised 'types' of abuse, a number of specific concerns are addresses in following appendices. These include;

- Forced Marriage
- Domestic Abuse / Domestic Violence
- Concealed Pregnancy
- Female Genital Mutilation
- Prevent Strategy and Violent Extremism

How and where abuse occurs:
Abuse also falls into different patterns:
Long-term - for instance, an ongoing family situation such as domestic violence between spouses or generations or misuse of benefits

Opportunistic - such as theft occurring because money has been left around; sexual abuse can also be opportunistic

Serial - in which the perpetrator seeks out and grooms vulnerable individuals, one after another, for personal gain or exploitation. Sexual abuse usually falls into this pattern as do some forms of financial abuse situational - comes from external circumstances; it could arise, for instance, because unrelated pressures have built up or because of challenging behaviour

Abusive acts can take place anywhere - there is no such thing as "an assumed safe place" - and any individual may be an abuser.

Staff Responsibilities
All staff in EDMS have specific responsibilities to share any concerns they may have, and if necessary report or refer suspected abuse which is drawn to their attention or that they become aware of when acting on behalf of EDMS to Social Care.

The key principles underlining the approach and actions to protect those involved are

- A*ny child or young person can be at risk and has the right to protection from a*bu*se*
- *A multi-agency approach is the most effective response.*

. ***It is your role:***

- to listen to the person telling you about the abuse
- to ensure their safety and your own safety to share concerns with appropriate managers within EDMS, and if necessary
- to report or refer concerns or suspicions regarding to Social Care via the appropriate channels
- to keep a detailed record of your observations and / or what you have been told

If someone tells you they have been abused

- Move them to a private place if possible. Let them tell you what happened in their own words. Reassure them that they have done the right thing in telling you about the abuse. Do not ask leading questions as this might affect a subsequent police enquiry.
- Never promise to keep a secret. Tell them as soon as possible that you will have to report to at least one other person, as it is your duty to do this. (This will give them the chance to stop talking if they are not happy for this to happen.)
- Do not talk to anyone who does not need to know about the allegation or suspicion of abuse, not even the witnesses if there were any. By inadvertently telling the alleged abuser for example, you may be later accused of "corrupting evidence" or "alerting."

Information Sharing and Referring (Reporting) Concerns
Any allegation or suspicion of abuse must be taken seriously and acted on immediately. Any staff member of EDMS, or voluntary members of the public who help the EDMS deliver our service, and who may come into contact with children and young people have a duty to share, and if necessary refer or report concerns regarding suspected abuse or neglect.

Failure to act might place the victim at greater risk and they may be discouraged from disclosing the same or further details again as they may feel they were not believed. Failure to report suspected or alleged abuse may also put other people at risk.

Abuse of EDMS patients
EDMS and its staff come into contact with a large number of potentially vulnerable people on a daily basis, whilst going about its work. Whilst it is unlikely, there is always the chance that a member of staff could witness a colleague abusing a child or young person.

Because abuse is a sensitive and difficult area we can be tempted not to take action when we think it has happened or is occurring within our own environment. This may be particularly true when the abuser is a member of staff.

However, ignoring our concerns or keeping them "in house" can risk:

- reinforcing abusive behaviour and perhaps putting others at risk
- no action, including support and protection, for all those in the situation
- further misery because distress is not being fully acknowledged
- vulnerable victims seen as not needing or entitled to care, treatment, support or justice

EDMS has in force a 'Whistleblowing Policy' which sets out the policy, roles and responsibilities of staff and processes involved. The policy is available on EDMS staff page on the website.

If in any doubt at all about a situation you are involved in or know about, seek advice.

Appendix B - Child Protection and the Recognition of Abuse

Introduction

All children deserve the opportunity to achieve their full potential. They should be enabled to

- be as physically and mentally healthy as possible
- receive maximum benefit from educational opportunities
- live in a safe environment
- experience emotional well-being
- feel loved and valued
- become competent in looking after themselves
- have a positive image of themselves
- have opportunities to develop good interpersonal skills and confidence.

Section 10(2) of the Children Act 2004 underpins these ideals and additionally sets out five outcomes for improving the wellbeing of children, namely

- Physical and mental health and emotional wellbeing (stay safe)
- Protection from harm and neglect (be healthy)
- Education, training and recreation (enjoy and achieve)
- Making a positive contribution to society; and
- Social and economic wellbeing

Significant Harm

The Children Act (1989) introduced the concept of significant harm as the threshold that justifies compulsory intervention in family life in the best interests of the children. The local authority is under a duty to make enquiries, or cause enquiries to be made, where it has reasonable cause to suspect that a child is suffering, or likely to suffer, significant harm *(section 47; Children Act 1989).*

There is no absolute criteria on which to rely when judging what constitutes significant harm. Consideration of the severity of ill-treatment may include the degree and the extent of physical harm, the duration and frequency and abuse and neglect, the extent of premeditation and the degree of threat and/or coercion.

Some children may be suffering, or at risk of suffering, significant harm, either as a result of a deliberate act, or a failure on the part of the parent or carer to act or to provide proper care of the child being beyond parental control, or all of these factors. These children need to be made safe from harm as well as their other needs being met. Children may be abused in a family or in an institutional or community setting; by those known to them or more rarely, by a stranger.

Who is vulnerable to abuse?

Although any child can potentially be a victim of abuse, there are some groups of children who may be particularly vulnerable. These include children with learning disabilities, severe physical illness or sensory impairments. Sources of stress within families may have a negative impact on a child's health, development or well-being, either directly or because they affect the capacity of parents to respond to their child's needs. Sources of stress may include social exclusion, domestic violence, and the unstable mental illness of parent or carer, or drug and alcohol misuse. Parents who appear over-anxious about their child when there are signs of illness or injury may be displaying signs of an inability to cope.

Children with learning difficulties and / or special needs have particular needs because of a psychological or medical difficulty. For example, deaf or autistic children may demonstrate challenging behaviour, which may or may not be as a result of abuse. Children with special needs are more likely to be abused that children in the general population

Recognition of Child Abuse

Non-accidental injury

For an injury to be accidental it should have a clear, credible and acceptable history and the findings should be consistent with the history and with the development and abilities of the child. When looking at injuries in children, you should be aware of the possibility of the injury being non-accidental and consider it in every case, even if you promptly dismiss the idea.

- Examples of abuse indicators may be: any injury in a non-mobile baby
- frequent accidents in unlikely places e.g. the buttocks, trunk and inner thighs
- soft tissue injuries under clothing
- bruises of the same age on both sides of the body or of varying ages

- small deep burns in unlikely places or repeated burns and scalds, or 'glove and stocking' burns
- poor state of clothing, cleanliness and/or nutrition
- late reporting of the injury or delay in seeking help.

When assessing an injured child, you should use your judgement regarding what level of accidental injury would be appropriate for their state of development. Although stages of development vary (e.g. children may crawl or walk at different ages), injuries can broadly be divided between mobile and non-mobile children.

Non-mobile babies
Any injury in a non-mobile baby must be considered carefully and have a credible explanation if it is to be considered accidental.

Healthy babies do not bruise or break their bones easily. They do not bruise themselves with their fists or toys, bruise themselves by lying against the bars of a cot, or acquire bruises on their feet when they are held for a nappy change.

Bruising on the ears, face, neck, trunk and buttocks is particularly suspect. Petechial spots (tiny blood spots under the skin) which disappear very rapidly may indicate attempted smothering. A torn frenulum (behind the upper lip) is rarely accidental in babies, and bleeding from the mouth of a baby should always be regarded as suspicious.

Fractures
Fractures in babies are seldom caused by 'rough handling' or putting their legs through the bars of the cot. Babies rarely fracture their skull after a fall from a bed or a chair. After a difficult delivery, the clavicle (collar bone), humerus or femur may be broken and not noticed until a lump appears about 2-3 weeks later. In this case, the baby would require paediatric assessment to confirm any suspicions of non-accidental injury.

Shaking injuries
When small babies are shaken violently their head and limb movements cannot be controlled, and this can result in severe brain damage from haemorrhage inside the skull. It may also cause metaphyseal fractures of the limbs as a result of the rotary movement. Finger bruising on the chest may indicate that a baby has been held tightly and shaken.

Burns and scalds
Accidental burns and scalds are fairly common in older babies (over six months). Burns from grabbing hot objects (e.g. hair tongs, irons etc) are found on the palms of the hands and not on the back of the hands. Scalds caused by pulling hot liquids are usually on the front of the face, neck, chest and legs with multiple splash marks.

Mobile babies and toddlers
A torn frenulum at this age may occur when the child falls flat on a carpet while running, but there are usually friction burns of the nose and chin at the same time. Non-accidental fractures are uncommon after the age of two years. Once the child can talk, he/she is more able to tell how the injury was sustained.

Bruising
Bruises are collections of blood under the skin or in the tissues. They are a bluish-red in the beginning, then turn purple and brown, and finally to yellow. The exact dating of bruising is difficult as it depends on the individual, the depth of the bruise and the tissues affected.

It is normal for toddlers to have accidental bruises on the shins, elbows and forehead. They usually fall forward, so bruises on the back or buttocks are suspect. They do not bruise both sides of the body at the same time, and the bruise cannot be round a curved surface.

Two black eyes may appear 2-3 days after on accidental blow in the middle of the forehead when the bruise begins to resolve. This sign is significant however if it occurs without forehead swelling.

Bruising caused by a hand slap leaves a characteristic pattern of 'stripes' representing the imprint of fingers. Forceful gripping leaves small round bruises corresponding to the position of the fingertips. 'Tramline' bruising is caused by a belt or stick and shows as lines of bruising with a white patch in between. Bites result in small bruises forming part or all of a circle.

Burns and scalds
Burns are caused by the application to the skin of dry heat and the depth of the burn will depend on the temperature of the object and the length of time it is in contact with the skin.

Abusive burns are frequently small and deep, and may show the outline of the object, whereas accidental burns rarely do so because the child will pull away. For example, a burn reflecting the shape of the soleplate of an iron cannot be accidentally caused.

Flame burns are usually less deep, have a less defined outline and may be fan-shaped. Friction burns may look similar to a flame burn and are usually seen on the prominent areas of the body such as the nose and chin, the heels or the shoulders.

Cigarette burns are not common. They are round, deep and have a red flare round a flat brown crust. The burns usually leave a scar and should not be confused with chickenpox scabs or impetigo.

Scalds are caused by steam or hot liquids. Accidental scalds may be extensive but show splash marks, unlike the sharp edges of damage done when the child is dunked in hot water (although splash marks may also feature in a non-accidental burn, indicating that the child had tried to escape hot water). The head, face, neck, shoulders and front of the chest are the areas affected when a child pulls over a kettle. If the child turns on the hot water in the bath, the soles of the feet are in contact with the bath and will be less affected that the top of the feet.

Fractures
Children's bones bend and splinter rather than break, and require considerable force to be damaged. There are various kinds of fractures, depending on the direction and strength of the force which caused the injury.

Greenstick - The bones bend rather than break. This is a very common accidental injury in children.

Transverse - The break goes across the bone and occurs when there is a direct blow or a direct force on the end of the bone, e.g. a fall on the hand will break the forearm bones or the lower end of the humerus.

Spiral or Oblique - A fracture line which goes right around the bone or obliquely across it is due to a twisting force, which is often a feature in non-accidental injuries.

Metaphyseal - Occur at the extreme ends of the bone and are not seen accidentally. Caused by a strong twisting force.

Skull fractures - These must be consistent with the history and explanation given, as babies and small children do not fracture their skulls from falls of only a few feet. Complex (branched), depressed or fractures at the back of the skull are suspect.

Rib fractures - These do not occur accidentally, except in a severe crushing injury. Any other cause is highly suspicious of non-accidental injury.

Deliberate poisoning and attempted suffocation
These are very difficult to assess and may need a period of close observation in hospital. Deliberate poisoning, such as might be found in a case of a child in whom **Fabricated or Induced Illness (FII)** is induced by carers with parenting responsibilities (formally known as Munchausen syndrome by proxy), may be suspected when a child has repeated puzzling illnesses, usually of sudden onset. The signs include unusual drowsiness, apnoeic attacks, vomiting, diarrhoea and fits.

Older children and adolescents
If the injury is accidental, older children will give a very clear and detailed account of how it happened. The detail will be missing if they have been told what to say.

Overdosing and other self-harm injuries must be taken seriously in this age-group, as they may indicate sexual or other abuse (such as exploitation).

Neglect
Neglect is more difficult to recognise and define than physical abuse, but its effects can be life-long. When a child is neglected this means his or her basic needs are not met. Neglect comprises both lack of physical care and

supervision and a failure to encourage the child in terms of their emotional, physical and educational development. Impairment of growth, intelligence, physical ability and life-expectancy are only a few of the effects of neglect in childhood.

A neglected or abused infant may show signs of poor attachment. They may lack the sense of security to explore, and appear unhappy and whining. There may be little sign of attachment behaviour, and the child may move aimlessly round a room or creep quietly into corners

In pre-school and school-age children, indicators of neglect include poor attention span, aggressive behaviour and poor co-operative play. Indiscriminate friendly behaviour to unknown adults is often a feature of children who are deprived of emotional affection. Other signs include repetitive rocking or other self-stimulating behaviour. Personal hygiene may be poor because of physical neglect, and this may lead to rejection by peers.

Emotional Abuse
Emotional damage occurs as a result of all forms of abuse, but emotional abuse alone can be difficult to recognise as a child may be physically well cared-for and the home in good condition. Some factors which may indicate emotional abuse are:

If the child

- is constantly denigrated before others
- is constantly given the impression that the parents are disappointed in them
- is blamed for things that go wrong or is told that they may be unloved/sent away
- is either bullying others or being bullied him/himself

If the parent

- does not offer any love or attention, e.g. leaves them alone for a long time - is obsessive about cleanliness, tidiness etc.
- has unrealistic expectations of the child, e.g. educational achievement/toilet training

Children can be at risk of emotional abuse because of the circumstances of adults in their immediate surroundings, e.g. if there is an atmosphere of domestic violence, adults with mental health problems or a history of drug or alcohol abuse. It cannot be assumed that a child is safe in a care setting, as children in this environment can be subject to exploitation e.g. for prostitution.

Sexual Abuse
Although some children are abused by strangers, most are abused by someone known to them. Some are abused by other children including siblings, who may also be at risk of abuse. The majority of abusers are male, although occasionally women abuse children sexually or co-operate with men in the abusing behavior

Both girls and boys of all age groups are at risk. The sexual abuse of a child is often planned and chronic. A large proportion of sexually abused children have no physical signs, and it is therefore necessary to be alerted to behavioural and emotional factors that may indicate abuse.

Allegation of abuse by the child
Any allegation of abuse by a child is an important indicator and should always be taken seriously. It is important to note that children may only tell a small part of their experience initially. Adult responses can influence how able a child feels about revealing the full extent of the abuse. If abuse is alleged, the adult being told about the abuse must be careful not to ask leading questions.

Physical signs and symptoms
The following symptoms should give cause for concern and further assessment:

- soreness, discharge or unexplained bleeding in the genital area
- chronic urinary and vaginal infections
- bruising, grazes or bites to the genital or breast area
- sexually transmitted diseases
- pregnancy, especially when the identity of the father is vague a
- change in bowel habit, such as soiling or constipation

Behavioural and emotional indicators

- inappropriate sexual knowledge for the child's age - overt sexual approaches to other children or adults
- fear of particular people or situations e.g. bath time or bedtime
- drug and alcohol abuse (older children)
- suicide attempts and self-injury
- running away and fire-setting
- environmental factors and situation of parents (e.g. domestic violence, drug or alcohol abuse, learning disabilities).

EDMS Procedures

In the reporting of a suspected case of abuse, the emphasis must be on shared professional responsibility and immediate communication. Attempts must be made to meet the needs of the vulnerable child.

There are a number of ways in which staff may receive information or make observations which suggest that a vulnerable child has been abused or is at risk of harm. Staff may often be the first professional on scene and their actions and recording of information may be crucial to subsequent enquiries. **It is particularly important that other people who may be present should not be informed of a staff member's concerns in circumstances when this may result in a refusal for the child to attend hospital or in any situation where a vulnerable child may be placed at further risk.**

Clinical staff should follow the normal history-taking routine, taking particular note of any inconsistency in history and any delay in calling for assistance. If necessary, staff should ask appropriate questions of those present to clarify what patients, relatives, friends or carers are saying or meaning to say.

Staff should be aware that a child who is frightened may be reluctant to say what may be the cause of their injury, especially if the person responsible for the abuse is present. It may be helpful to make a note of the child's body language. It is important to stop questioning when suspicions are clarified, avoiding any unnecessary questioning, as this may affect the credibility of subsequent evidence.

Remember: It is neither your role, nor that of EDMS to investigate suspicions. The task for EDMS staff is to ensure that any suspicion or concern is passed to the appropriate agency, i.e. the police or the appropriate local Social Care. This should be achieved by following the guidelines below. It is also important to ensure that those to whom care is handed over are also aware, for example A&E Staff

Actions to be taken by All Staff regardless of setting

This should be read in conjunction with the general information in the section at appendix A,
'Guidance on what to do if you are concerned a person is being abused or neglected' and the flowchart at appendix D.

If staff come into contact with a child about whom they have a concern in relation to the child being, or having been abused:

If there is another person present and member of staff is concerned that he or she may be the abuser, the staff member should not let that person know they are suspicious. If the child is conveyed to hospital, staff should inform the Clinical Director and if told to do so also inform a senior member of the A&E staff of their concerns about possible abuse. They should detail only factual information on the Patient Report Form (PRF), and the cause for concern form ensuring that

If conveying to hospital the yellow copy of the PRF is handed over to the A&E staff. They should be careful not to do this in a way that would alert the alleged abuser or place the vulnerable child at risk of further abuse or intimidation. It should also be remembered that a patient or carer may request access to any clinical record. Staff should therefore be aware of the following;

- The Freedom of Information Act 2000
- Data Protection Act 1998
- The possible legal requirements to produce records in court or a statement of evidence

While the wishes of the child, parents, relatives or guardian should be taken into account, if the level of suspicion is high then wherever possible the child should be taken to hospital.

If the child needs to be conveyed to hospital and another person tries to prevent this, staff may need to consider

whether to involve the police. Staff should inform the Clinical Director about the situation seeking their guidance.

If the child is not conveyed to hospital, a Patient Report Form will be completed recording the facts only. Factual information can include details about the environment as well as the clinical record of the patient. The record should not contain any comment about suspicions, opinion the staff may have had, or conjecture.

EDMS staff, should contact the Clinical Director *by telephone* and inform them of their concerns. The staff should discuss the situation with the duty manager, or duty director. Advice can also be sought as described above. A decision should be taken at this time whether to inform Social Care, although it is likely in the vast majority of cases that where there is a genuine concern that such a referral MUST happen.

Staff working in non clinical settings may also have concerns about a child's safety. This may for example be as a result of things they hear or see out and about doing their normal duties. Staff in these situations also have a duty to refer any concerns they might have.

Information Sharing
Sharing sensitive information is a difficult area for many people who care for others. Some circumstances over-ride the duty of confidentiality and the requirements of Data protection Act and Caldicott Principles and also the wishes of the person being abused. The Public Interest Disclosure Act (1998) supports all workers' rights to disclose evidence under a range of important circumstances. Appendix F provides comprehensive information on information sharing.

It is important not to promise confidentiality when someone discloses information about possible abuse and you might want to have a form of words ready for such an eventuality, for instance: "I can't promise to keep what you're telling me to myself because of the risk to you or others."

Concerns over people other than patients
It is quite possible that while caring for a patient that staff become aware of possible abuse against a child in the family. This is perhaps a more difficult situation to manage.

While the patient is the most important focus of the staff's attention, once the duty of care to the patient has been discharged the clinician must act upon their suspicions and report their concerns about the child to Social Care

In both of the situations described above it is imperative that staff fulfil their statutory duty as described in WT2010 if they have a concern about a child who may be being abused or neglected. Where the child is considered to be at imminent danger the police should be requested to attend. In less serious situations it is the responsibility of the concerned staff to make contact with the Clinical Director for further advice and then the relevant children's Social Care

Sudden Unexpected Death In Childhood (SUDIC)
In January 2003 *The Royal College of Pathologists* and *The Royal College of Paediatrics and Child Health* established an intercollegiate group to review how sudden unexpected deaths in infancy should be investigated. The result was the report '*Sudden unexpected death in infancy*', compiled by a working group chaired by The Baroness Helena Kennedy QC, now known as 'The Kennedy Report'. As a result of the report and its recommendations many changes have been made into the way that deaths in infancy and childhood are managed and investigated.

A sudden unexpected death in childhood is defined as 'a death of a child that was not anticipated as a significant possibility 24 hours before the death - or where there was a similarly unexpected collapse leading to, or precipitating the events that led to the death' *(Working Together to Safeguard Children 2010).*

Subsequently, and as a result of the report, it was agreed that as well as infancy, that the new procedures would also be extended to include all 'children' up to the age of 18 years. Therefore these procedures now apply equally to all infants and children up to their eighteenth birthday.

Each county or unitary authority now has in place a 'rapid response procedure' for every unexplained child or infant death.

In some case where we may be acting as an Ambulance services we may obviously be involved in the process, as we may often be the first professionals to arrive at the scene where a child has died or is in cardiac arrest. The first priority is clearly preserving life wherever possible and making every possible effort to resuscitate the child.

Equally, staff can offer a considerable amount of information in relation to the events surrounding the child's death. There is a danger that we become so focussed on what we are doing to preserve life that there is the potential to miss things that we are being told, or to miss vital signs of additional injury, vital information or even note the surroundings.

The gathering of information is part of building the picture of why the child or infant died.
Whilst at the time it may be difficult given the circumstances to relate to any information other than that directly relating to the cardiac arrest or life threatening injury / illness, and it's management, as professionals we are likely to be the only people who observe the scene with the child or infant along with parents / carers still present. Needless to say we have the potential to gather a range of vital information that other agencies cannot. Here are some examples of the information that can be useful in such a tragic event, in addition to a good clinical history;

- What position was the child in when you arrived?
- Do the parents / carers know what position they found the child or infant in?
- What were they wearing when you arrived?
- What was the temperature of the room (obviously the question is, was it 'overly' hot or 'overly' cold.
- Particularly note and report any obvious 'old' injuries
- Particularly note any inconsistencies in the history
- Be aware of the potential importance of preserving the scene / do not disturb the scene unnecessarily

Whilst much of the above relates to the medical and social history surrounding the event, consideration of the above may lead staff to considering concerns about abuse in some situations. Whilst the process of investigation that follows a child's death would look very closely at events leading up to that point, staff should refer their concerns to Social Care in the normal way.

Likewise, consideration should be given as to whether there are other children at the location who may be at risk, and if this is the case Social Care should be contacted without delay.

Appendix C - What to do if you have a concern that a child or young person may be being abused or neglected

It is important to understand that failing to Act is not an option

If you have a concern or you suspect a child or young person is being abused you should initially assess whether or not it is safe or appropriate to remain in the situation, or whether to move to a place of safety.

You also need to assess whether it safe or appropriate to discuss your concerns with either the person or their carers. The most ideal situation is, of course, is one where you have the consent of the person(s) concerned to take things further.

However, there will be many occasions when because of the nature of the call, and/or the situation/circumstances existing at the time it is not appropriate to raise your concerns openly. This will be the situation particularly when children are the focus of your concerns.

Staff should be aware of the Data Protection Act 1998 and Caldicott Principles in regard to confidentiality, however there are occasions where staff will need to step outside of the requirements of the above in order to fulfil their safeguarding duties.

In these situations it is still essential to raise your concerns (if necessary without consent), and the decision to share information would be considered to be 'in the public interest' (Public Interest Disclosure Act (1998).

If it is obvious that the child or young person concerned wishes to discuss their situation with you, or starts to divulge information that raises your suspicions, that staff listen carefully to what they have to say. It is imperative that the situation remains safe for staff and other professional colleagues, as well as the person divulging the information.

Listen carefully to what they are telling you. If it is appropriate make contemporaneous notes, but remember that you must only document fact (e.g. What, Where, When, Why, How).

- Document what you see and hear
- Do not document opinion or conjecture
- Do not make accusations, either verbally or on paper
- Do not ask any leading questions
- Do not make promises not to take things any further - particularly where children are involved. Staff must make it clear that you might need to share your concerns with other people.

It is important to note that suspicions and concerns do not always relate to the patient that staff have been called to at that time. There are many examples of where concerns have actually been raised about partners, siblings, carers or others at the location.

Remember - if you consider that the child or young person you have a concern about is in imminent danger the police should be called immediately. This applies equally to staff who are concerned that they may also be in danger. In these situations it might also be prudent to withdraw from the situation).

There will be other times when staff may feel it more appropriate to discuss concerns with the Clinical Director or the Named Professionals in the first instance for guidance**.**

However in all cases where staff suspect a child or young person has been or is at risk of abuse the case MUST be referred to the relevant Social Care after discussion with the Clinical Director.

EDMS procedure for making a referral to Social Care, and for formally recording details of the referral within EDMS must be followed in all cases.

There are various sources of information and advice available in EDMS when staff have a concern or suspicion that somebody is being abused or neglected. If you still require further advice or guidance, during normal working hours (or out of hours in the unlikely situation that all other attempts to seek advice have failed) one of the Named Professionals should be contacted, by calling the office number which is monitored 24/7

There are 24/7 telephone numbers for Social Care emergency duty teams (EDT's) for every area.

(Remember: Failing to act is not an option).

If you are making a formal referral to Social Care, telephone the duty team initially and discuss your concerns with the duty social worker.

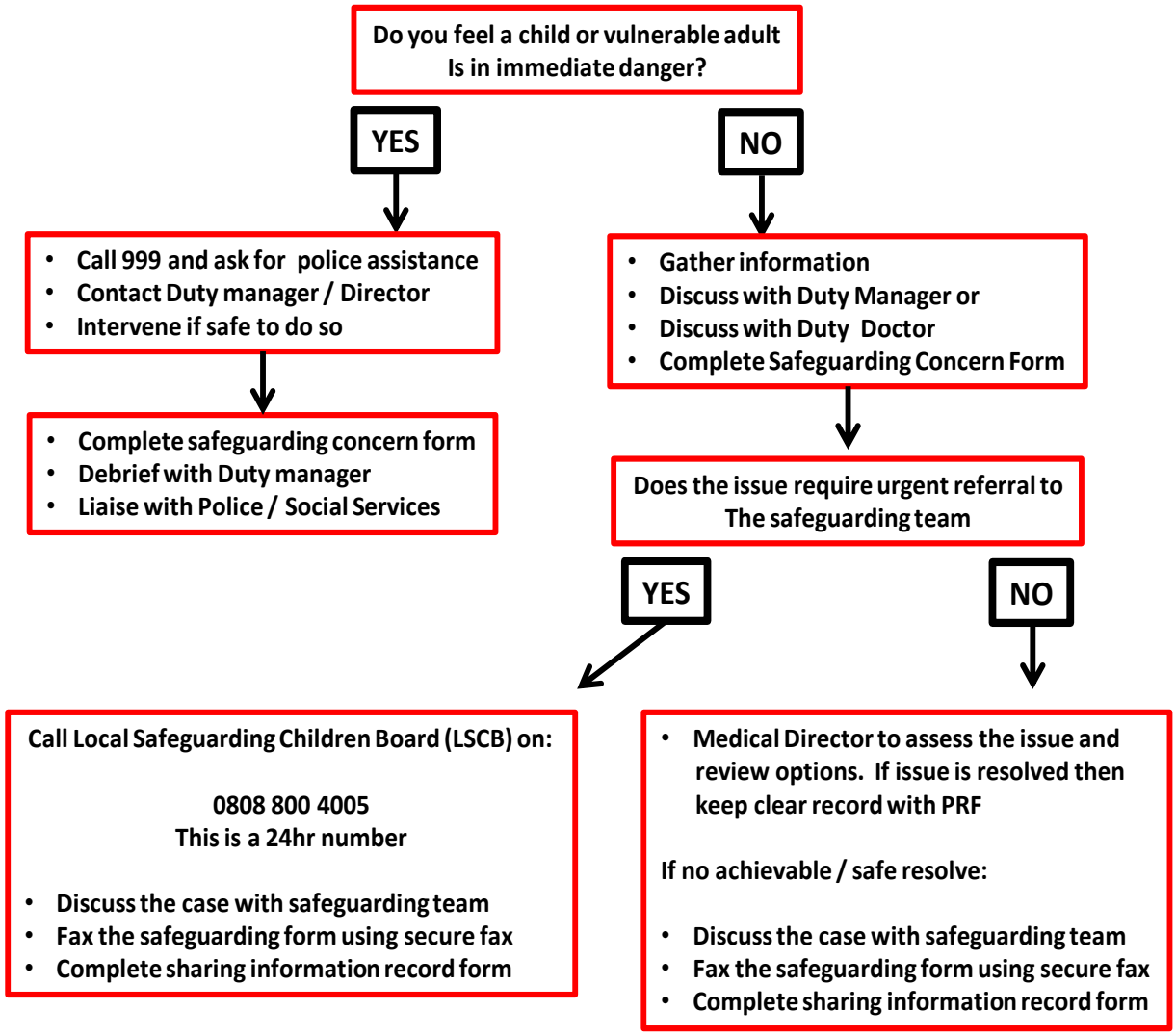
Even if you have conveyed the child or young person with whom you have a concern to hospital, it is still imperative that you telephone Social Care to make a referral. *(There has been know anecdotally that there have been situations where staff have expressed concerns to hospital staff and no further action has been taken).*

Having spoken to the relevant Child Social Care team you then need to formally record your referral with EDMS. To do this telephone the Clinical Director and inform directly.

Appendix D
What to do if you are concerned that a child or young person is being abused or neglected

Emergency Doctors Medical Service

SAFEGUARDING CONCERN ALGORITHM



- At any point you can discuss the case with the safeguarding team
- DO NOT hesitate to escalate if you feel it is the safest thing to do
- NEVER ignore or dismiss a potential safeguarding issue

www.emergency-doctors.org

Appendix E - Allegations of Abuse Against a Member of Staff

Procedure for Responding to an Allegation of Abuse or Neglect against a Child or Young Person made against a member of staff working for or on behalf of EDMS

The procedure contained within this appendix sets out the role EDMS and its responsibilities when there is an allegation against a member of staff and also the role of Local Area Designated Officer (LADO), for Suffolk this is:

Southern Area
County Safeguarding Manager
Landmark House, 4 Egerton Road, Ipswich IP1 5PF
01473 263128

Introduction

Working Together to Safeguard Children (2010) Chapter 6 (6.32) says that;
'Children can be subjected abuse by those who work with them in any and every setting. All allegations of abuse or maltreatment of children by a professional, staff member, foster carer or volunteer must therefore be taken seriously and treated in accordance with consistent procedures. LSCB's (Local Safeguarding Children Board's) have responsibility for ensuring that there are effective inter-agency procedures in place for dealing with allegations against people who work with children, and for the monitoring and evaluating the effectiveness of those procedures'

The guidance goes on to say that, 'The scope of inter-agency procedures in this area is not limited to allegations involving significant harm, to a child'.

In clarifying the above point it is also given to apply in situations where an individual is deemed to have;

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

Working Together also makes clear that the framework above applies to a wider range of allegations than direct abuse of a child. It also means that the process has to be followed where there is an allegation that might indicate that the alleged perpetrator is unsuitable to work with children in his or her present position, or in any capacity.

Local Area Designated Officer (LADO)

Each county, and where relevant each unitary authority has to have a Local Area Designated Officer (LADO). Usually two or three cover each area. They are employed by the County Council or Unitary Authority, and will normally come from either a social care or educational background**.**

Their overarching role is to see that cases and their progress are monitored effectively and to ensure that they are dealt with in a timely fashion, and that the process is fair, consistent and thorough.

What does this mean for EDMS?

EDMS takes any allegations against staff that are brought to its attention very seriously. EDMS as healthcare professionals has a statutory responsibility to safeguard and promote the welfare of children, young people and vulnerable adults**.**

As mentioned above, Working Together makes clear that the framework above applies to a wider range of allegations than direct abuse of a child. It also means that the process has to be followed where there is an allegation that might indicate that the alleged perpetrator is unsuitable to work with children in his or her present position, or in any capacity.

It must be remembered that there could be a number of strands to an investigation. These might include;

- A police investigation of a possible criminal offence
- EDMS internal disciplinary investigation
- Enquiries and assessment by Children's Social Care about whether a child is in need of protection or in need of services
- Parallel investigations by other agencies

In practice there are a range of situations outside of obvious and direct abuse whereby procedures need to be instigated. This might include, for example where information comes to light that an individual is or has been investigated by the police in relation to accessing inappropriate websites (involving children), and/or downloading inappropriate images or materials, or where that information comes to light from other sources, for example through whistleblowing.

It is also given to mean situations where, as an individual's employer we become aware that the individual may be implicated, or that there may be an allegation against the individual, in a situation - as listed above - outside of their employment with EDMS which may bring into question the individual's suitability to work with children.

Manager Responsibilities
Upon receipt of information regarding an allegation against an individual, action will initiated as per EDMS' Disciplinary Policy. If the allegation / investigation is in relation to any of the points mentioned above, The Clinical Director should be should be contacted and advised, if contacting the Clinical director is not appropriate, the Associate Clinical Director, should be informed and advised.

If you are not sure if the allegation is relevant to safeguarding then please contact one of the Named Professionals for advice.

EDMS has responsibility for the welfare of any staff member against whom an allegation is made. In all such instances, the individual member of staff should be offered support.

Named Professionals
The Clinical director and company directors are given the responsibility for ensuring that allegations against staff are investigated, specifically in relation to the protection of children as per WT2010.

They also provides the link between EDMS - LADO and other relevant organisations to the investigation with whom we are required to liaise.

EDMS' directors will be able to provide advice on the specific processes involved in investigating an allegation against a member of staff, particularly in relation to the interaction with the relevant LADO.

EDMS normally through one of the Clinical Directors should inform the relevant LADO - as per WT2010 - within 24 hours of initial notification. (The duty LADO can be accessed via the relevant children's services out of hours).

The Clinical Director deals with the responsibility for allegations against staff will normally attend the initial strategy meeting and any subsequent strategy meetings convened by the LADO.

The Clinical Director will liaise between the following agencies and key people;

- The police
- Local Area Designated Officer
- Company Directors
- Other relevant agencies - as appropriate

Action to be taken
The Procedure for Responding to an Allegation of Abuse or Neglect against a Child or Young Person made against a member of staff working with Children or Young People is based on the framework for dealing with allegations of abuse made against a person who works with children, as detailed Working Together 2010.

The term 'works' includes anybody that works for, either on a paid or voluntary basis, is observing, or whose services are commissioned by EDMS.

This procedure should be applied when an allegation or concern has been made against any member of staff who works with, or might come into contact with children or young people, and in doing so may have;

- Behaved in a way that has harmed, or may have harmed a child or young person
- Possibly committed a criminal offence against or related to a child or young person
- Behaved in a way that indicates that they may be unsuitable to work or have contact with children or young people

However, the scope of this procedure is not just limited to allegations involving significant harm, or risk of significant harm to a child or young person. It should also be followed in other situations, as laid out below, all of which should be seen to be followed up in an objective manner. It should be noted that the situations detailed below are not exhaustive.

The following behaviours should be considered within the scope of abuse and/or neglect. Specific elements of abuse might include physical, sexual, emotional/psychological, financial and neglect.

Concerns/allegations relating to inappropriate behaviour between a member of staff and a child or young person might include for example:

- Allegation of physical punishment or abuse of a child/young person whilst carrying out their duties
- An abuse of trust - involving a sexual relationship where a professional relationship of trust exists
- Grooming - developing a relationship with a child or young person or with the intention of perpetrating sexual harm
- Any offence which might suggest that a person poses a risk of harm to a child or young person.

Notification and Initial Response

Allegations arise from a number of sources, both internally and externally. Information regarding a concern may come to light by way of another member of staff or by whistleblowing. EDMS may be made aware of a concern or allegation by the police or the local authority, in the latter case normally the Local Area Designated Officer (LADO).

In the case of an allegation being notified to EDMS by the Police or LADO, the first point of contact will normally be the Clinical Director or Named Professionals.

When an allegation is received from an internal source it is essential that the information received is shared with the Directors.

At the same time if EDMS is made aware of an allegation internally one of the Named Professionals in their capacityshould be notified immediately, along with a representative from Human Resources. Depending on the seriousness of the allegation either the police (if not already done so) or relevant LADO should be notified as soon as possible.

In the initial stages it is important that staff or managers do not undertake any enquiries or seek to determine whether the allegation may be true or not. It should be remembered that the likelihood is that the police and/or local authority may well have primacy in terms of any initial investigation.

There may however be situations where the allegation or concern is such that immediate action needs to be taken to ensure the safety of a child or young person. Such action should be taken in line with EDMS' Safeguarding and/or Disciplinary Policies. Action might include a decision to suspend the member of staff as per EDMS' disciplinary policy and/ actions to preserve potential sources of evidence (for example mobile phones or computers).

Where it is considered that there is an immediate risk to a child, young person, or others the police should be notified immediately.

In the event that a member of staff is made aware of an allegation against a person from another organisation, advice should be sought from the Clinical Director or Named Professionals. Where necessary, this information will be reported to the relevant area LADO or police depending on its severity.

Documentation is a fundamental element of recording the details of an allegation or concern. It is imperative that any manager or member of staff receiving details of an allegation documents as much detail as possible. The information documented must be factual in relation to what has been said or heard, and should as a minimum record when the allegation was made, to whom the allegation was made and where possible be contemporaneous. It should be signed by the person receiving the allegation, timed and dated. Where the allegation is made face-to-face, the record should similarly be signed by the person making/relaying the allegation. Where this isn't the case, written verification should be requested. Any such records should be securely held for future reference.

All relevant documentation in relation to the allegation should be collated by the Clinical Director or Named Professional or manager receiving the allegation and stored securely. They will be able to provide advice on documenting information as appropriate. If it is not appropriate for the person receiving the allegation to obtain this information, it will then fall to another Director to do so prior to contacting the LADO.

The relevant LADO MUST be informed of any allegation within one working day of it being received. Each area operates an 'on call' system for its LADO's, the numbers of which are held by the Named Professionals.

Where the staff member concerned is not aware of the allegation against them, and subject to the seriousness and potential need for immediate action by EDMS, no contact should be made with them until there has been an initial consultation with the LADO.

Where it is decided that a multi-agency strategy meeting is to be held the EDMS will take advice from, and agree with the LADO what action, if any, needs to be taken in respect to the staff member(s) concerned at that time.

In some circumstances it may be appropriate that no action is taken until such time that the multi-agency strategy meeting has been held. There will be other times when it is deemed necessary to take immediate action, for example to safeguard a vulnerable child

Consideration of suspension must be in line with EDMS Disciplinary Policy.

The Named Professional overseeing the process is responsible for ensuring that the following people have been informed:

- Clinical Director
- Associate Director
- Company Directors
- Senior member of Human Resources (HR)

Timing of the notification above will vary depending on where the information has originated, and upon the severity of the allegation.

The relevant Named Professional, should initiate a log / chronology to ensure that all information and their actions are recorded in a timely fashion

There may be situations where in addition to the initial actions documented above it is appropriate to make a formal referral to Children Social Care. EDMS will be responsible for ensuring that this takes place, and that the information is also forwarded to EDMS's Safeguarding Incidents folder.

Consideration should be given at an early stage as to whether the Health and Care Professions Council (HCPC) or any other professional body needs to be informed.

Allegations or concerns of the nature being outlined can give rise to anxieties for staff member concerned and the person(s) that are the alleged victims. Confidentiality is key and should only be shared with those who have a legitimate right to know about the allegation.

All managers actively involved in EDMS response to an allegation against a member of staff should maintain an up to date chronology of events in relation to their own activity in the case.

Strategy Meetings

In the majority of cases an initial multi-agency strategy meeting will be called. Essentially, this is an 'information sharing' meeting and is convened by the Local Authority (LA) and will be attended by representatives from the staff member's employer, the Police, Social Care and the Local Authority, including the LADO. It is normally chaired by a member of the LA or the LADO.

Other relevant agencies may also be invited to attend. All agencies will share the information they have at that stage about the allegation, known chronology of events, the known background and employment history of the person who is the subject of the allegation, as well as information known about the alleged victim.

In instances where the allegations give rise to a police interview, wherever possible, the police will be asked to request from the individuals concerned to share the statements and evidence they obtain with the employer and/ or regulatory body (Working Together 2010 Appendix 5, paragraph 25). It is important that this is achieved at an early stage in order that the police and Crown Prosecution Service (CPS) can share relevant information without delay at the end of the investigation or court case. It is important to appreciate that there may be occasions where such information is disclosed without consent subject to a decision by the police information officer.

The multi agency strategy meeting will provide a means on which EDMS can consider what actions may or may not be required at any particular time. It may therefore be that as a result of this meeting that a decision is made to suspend or temporarily redeploy a member of staff to a role that is closely supervised, and that does not involve working directly with the public. It is however important to stress that the decision on what action needs to be taken lies wholly with EDMS. The multi-agency strategy meeting can only provide advice on what action they would consider appropriate in the circumstances.

If there is to be a police investigation it is likely that further strategy meetings will be planned. WT2010 recommends this happens on a four weekly basis.

EDMS will be mindful of advice from the multi agency strategy meeting and/or police in making a decision regarding the undertaking of an internal investigation. EDMS would not normally undertake its own disciplinary investigation when advised that this could hinder any potential police investigation and/or potential prosecution.

The police have a responsibility to inform the LADO and employer as soon as they have completed their investigation. This informs EDMS that either the person(s) have been charged, that no prosecution is being pursued, or that they have decided to close the investigation. When no further criminal proceedings are being taken the LADO will discuss with EDMS in liaison with its Human Resources Department whether any further action is appropriate, and if so how to proceed. Information provided by the police and Social Care should assist in this process.

At the conclusion of external investigation a final multi agency strategy meeting should take place to review the case. At this point the allegation will also be categorised and any further actions planned. The Local Safeguarding Children Board should be made aware of the case at an early stage and at this point the conclusion and any issues raised should be shared with the LSCB. It is also an opportunity for EDMS to consider any lessons learnt in respect to the management of the case, risk management and, for example, any training needs the case may have identified.

Media interest can be generated when these situations become public knowledge. Following LADO liaison with EDMS's Communication lead, agreement should be reached at the multi-agency strategy meeting as to whether or not a joint media strategy / briefing paper should be prepared in case there is media interest

EDMS Investigation and Outcomes
EDMS will be mindful of advice from the multi agency strategy meeting and/or police in making a decision regarding the timing of the undertaking of an internal investigation. EDMS would not normally undertake its own disciplinary investigation until a later point in time when advised that commencing the investigation earlier could hinder any potential police investigation and/or potential prosecution. Any such internal investigation would be undertaken in accordance with EDMS's Disciplinary Policy.

EDMS should keep in contact with the police so they can monitor progress of any external investigation and subsequent action including any convictions.

On conclusion of the disciplinary process the LADO should be informed of the outcome. In situations where the individual has harmed a child, or is considered to pose a risk of harm to children, a referral to the Independent Safeguarding Authority and/or any regulatory body is required. If this is the case the referral should be made within one month (Working Together 2010).

Further Information

Further information on our responsibilities can be found in the publication Working Together to Safeguard Children; A guide to inter-agency working to safeguard and promote the welfare of children; HM Government 2010.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4007781

Other references:

Guidance for safer working practice for adults who work with children and young people; Department for Education and Skills (2009)
Website: www.dcsf.gov.uk/everychildmatters/resources-and-practice

Appendix F – Information Sharing Policy

Introduction

It is essential that all agencies work together and share information, using an agreed protocol, to strengthen the processes for safeguarding and promoting the welfare of vulnerable groups from abuse. It is only when all agencies share the information they hold that a full picture emerges upon which to reach decisions and determine a plan of action to minimise the risk of harm to vulnerable groups from abuse.

Vulnerable groups and their parents/carers have a right to expect that agencies will overcome barriers to sharing confidential information in a responsible way to ensure that the safety and well-being of children and young people remains paramount.

It has to be clearly understood that the term 'consent' is used in two distinct contexts in safeguarding and in this policy. Other areas of the policy set out consent in relation to a person's 'capacity to consent' in relation to the Mental Capacity Act. More specific information on this can be found in EDMS document, Capacity to Consent Policy.

Consent in the context of information sharing as described in the protocol contained in this appendix relates to the service user's consent for EDMS staff to divulge information where a concern is raised about neglect or abuse. Contained within this policy defines the different aspects of consent in this context and define when consent may or may not be required in relation to protecting a vulnerable person.

Safeguarding and promoting the welfare of children and young people must always be the primary consideration. It should over-ride any perceived risk of damaging the relationship between professional and their client/patient.

Information sharing is vital to safeguarding and promoting the welfare of children and young people from abuse. A **key factor in many serious case reviews has been a failure to record information, to share it, to understand the significance of the information shared, and to take appropriate action in relation to known or suspected abuse or neglect.**

We know that staff recognise the importance of information sharing and that there is much good practice. We are also aware that staff, in some situations feel constrained from sharing information by their uncertainty about when they can do so lawfully. This guidance aims to provide clarity on that issue. It is important that staff:

- are supported by EDMS in working through these issues;
- understand what information is and is not confidential, and the need in some circumstances to make a judgment about whether confidential information can be shared, in the public interest, without consent;
- understand and apply good practice in sharing information at an early stage as part of preventative work;
- are clear that information can normally be shared where you judge that a child or young person is at risk of significant harm or that an adult is at risk of serious harm.

Purpose and Principles

The purpose of this protocol is to clarify the principles behind, and the arrangements for, sharing sensitive personal information between EDMS and other agencies in order to safeguard and promote the welfare of children and young people from abuse.

A basic principle of the Data Protection Act 1998 is that there has to be a 'legitimate basis' for disclosing sensitive personal data. Research and experience have shown repeatedly that keeping children and young people safe from harm requires professionals and others to share information:

- About a child's health and development and exposure to possible harm
- About a parent/carer who may not be able to care for a child adequately or safely without help
- About those who may pose a risk of harm to a child.

In cases of domestic abuse:

- Where there are children under the age of 18 years resident in the household.
- Where a victim is pregnant.

In broad terms, therefore, sharing sensitive personal information can be legitimate because often it is only when information from a number of sources has been shared and put together that it becomes clear that a child or young person is at risk of or is suffering harm. It is worth bearing in mind those enquiries following child deaths, domestic abuse homicides and other situations where practice has been called into question have repeatedly identified the failure to share information as a contributory factor.

EDMS subscribes to the over-riding principle that the needs and rights of children and young people come first.

It is critical that where there is reasonable cause to believe that a child or young person **may be suffering or may be at risk of suffering significant harm**, **concerns should be referred to Social Care or the police, in line with EDMS Safeguarding Policy**.

In some situations there may be a concern that a child or young person may be suffering, or at risk of suffering significant harm, or of causing significant harm to another child or serious harm to an adult.

However, **if there is uncertainty as to whether what has given rise to the concern constitutes 'a reasonable cause to believe', in these situations, the concern must not be ignored.** Staff should always talk to someone to help them decide what to do - a Named Professional or Named Doctor, or duty manager.

Ultimately, EDMS Medical Director as Caldicott Guardian is responsible for what information EDMS releases.

Where you have concerns that the actions of some may place children at risk of significant harm, it may be possible to justify sharing information with or without consent for the purposes of identifying people for whom preventative interventions are appropriate. Significant harm to children and young people is not restricted to cases of extreme physical violence. For example, the cumulative effect of repeated abuse or threatening behaviour may well constitute a risk of serious harm to child.

EDMS strongly supports the principle of working in partnership with vulnerable groups and their parents/carers and other family members.

This means among other things seeking the consent of these individuals wherever it is possible and consistent with the vulnerable person's best interests. This should include, wherever possible, seeking clear, explicit and informed consent from the individual(s) concerned for information about them to be shared with **specified** other individuals or agencies. Where such consent can be freely obtained, this is clearly the best way of resolving any potential conflict of interest.

However, it is recognised that frequently such consent cannot be obtained, either because it is refused, the individual concerned cannot be contacted within a reasonable time to give consent or seeking the consent would place the vulnerable person at greater risk of harm. Data protection principles relate to all situations.

Seven golden rules for information sharing
EDMS supports the 7 golden rules for information sharing outlined in the Information sharing: Practitioners' guide Every Child Matters website Practice Guidance www.ecm.gov.uk/informationsharing:

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 judgment, that lack of consent can be overridden in the public interest. You will need to base your judgment 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.

Practice Guidance
If you are asked, or wish, to share information, you must use your professional judgment to decide whether to share or not and what information it is appropriate to share, unless there is a statutory duty or a court order to share.

To inform your decision making this section sets out further information in the form of seven key questions about information sharing:

- Is there a clear and legitimate purpose for you or EDMS to share the information?
- Does the information enable a living person to be identified?
- Is the information confidential?
- If the information is confidential, do you have consent to share?

- If consent is refused, or there are good reasons not to seek consent to share confidential information, is there a sufficient public interest to share the information?
- If the decision is to share, are you sharing information appropriately and securely?
- Have you properly recorded your information sharing decision?

Question 1: Is there a clear and legitimate purpose for sharing information?
If you are asked, or wish, to share information about a person you need to have a good reason or a clear and legitimate purpose to do so. This will be relevant to whether the sharing is lawful in a number of ways.

Working for a statutory organisation the sharing of information is within the functions and powers of that statutory body.

Any sharing of information must comply with the law relating to confidentiality, data protection and human rights. Establishing a legitimate purpose for sharing information is an important part of meeting those requirements. There is more information about the legal framework for sharing information in the document Information Sharing: Further guidance on legal issues.

Sharing information where you have a statutory duty or a court order
There are some situations where there is a requirement by law to share information, for example, in the NHS where a person has a specific disease about which environmental health services must be notified. There will also be times when a court will make an order for certain information or case files to be brought before the court.

In such situations, you must share the information, even if it is confidential and consent has not been given, unless in the case of a court order, EDMS is prepared to challenge it and is likely to seek legal advice.

Consent from the individual is not required in these situations and should not be sought because of the potential consequences of refusal.

Question 2: Does the information enable a living person to be identified?
In most cases the information covered by this guidance will be about an identifiable living individual. It may also identify others, such as other vulnerable person(s), partner, parent or carer. If the information is anonymised, it can be shared. However, if the information is about an identifiable individual or could enable a living person to be identified when considered with other information, it is personal information and is subject to data protection and other laws. The remainder of this section provides further information to inform your decision about sharing personal information.

Wherever possible, you should be open about what personal information you might need to share and why. In some situations, it may not be appropriate to inform a person that information is being shared or seek consent to this sharing, for example, if it is likely to hamper the prevention or investigation of a serious crime or put a child at risk of significant harm or an adult at risk of serious harm.

Question 3: Is the information confidential?
Confidential information is:
- personal information of a private or sensitive nature; and
- information that is not already lawfully in the public domain or readily available from another public source; and
- information that has been shared in circumstances where the person giving the information could reasonably expect that it would not be shared with others.

This is a complex area and you should seek advice if you are unsure.

Sometimes people may not specifically ask you to keep information confidential when they discuss their own issues or pass on information about others, but may assume that personal information will be treated as confidential. In these situations you should check with the individual whether the information is or is not confidential, the limits around confidentiality and under what circumstances information may or may not be shared with others

> *There are different types of circumstances that are relevant to confidentiality. One is where a formal confidential relationship exists, as between a doctor and patient, or between a social worker, counsellor or lawyer and their client. Here it is generally accepted that information is provided in confidence. In these circumstances all information provided by the individual needs to be treated as confidential. This is regardless of whether or not the information is directly relevant to the medical, social care or personal matter that is the main reason for the relationship.*
>
> *Another circumstance is, for example, in an informal conversation, where a pupil may tell a teacher a whole range of information but only asks the teacher to treat some specific information confidentially. In this circumstance, only the information specific to the pupil's request would be considered to be confidential.*

There are also circumstances where information not generally regarded as confidential (such as name and address) may be provided in the expectation of confidentiality and therefore should be considered to be confidential information.

Confidence is only breached where the sharing of confidential information is not authorised by the person who provided it or, if about another person, by the person to whom it relates. If the information was provided on the understanding that it would be shared with a limited range of people or for limited purposes, then sharing in accordance with that understanding will not be a breach of confidence. Similarly, there will not be a breach of confidence where there is consent to the sharing.

Information about an individual or family is confidential to EDMS as a whole, and not to individual members of staff. However staff do have a responsibility to maintain the confidentiality of the information. They should only share confidential information with other staff in EDMS for genuine purposes, for example, to seek advice on a particular case.

Public bodies that hold information of a private or sensitive nature about individuals for the purposes of carrying out their functions (for example Children's Social Care, young people's health) may also owe a duty of confidentiality, as people have provided information on the understanding that it will be used for those purposes. In some cases agencies may have a statutory obligation to maintain confidentiality, for example, in relation to the case files of looked after children.

Individuals have a right to access their medical records and any records held by professional agencies including EDMS. Requests to access medical records held by EDMS will be made via the Clinical Director. Where information is recorded in the persons file which has been supplied by a third party for example a statement from another professional that information may only be shared with the patient if permission is granted for sharing

Question 4: Do you have consent to share?
Consent issues can be complex and a lack of clarity about them can sometimes lead staff to assume incorrectly that no information can be shared. This section gives further information to help you understand and address the issues.

It covers:

- what constitutes consent;
- whose consent should be sought; and
- when consent should not be sought.

What constitutes consent?
Consent must be 'informed'. This means that the person giving consent needs to understand why information needs to be shared, what will be shared, who will see their information, the purpose to which it will be put and the implications of sharing that information.

Consent can be 'explicit' or 'implicit'. Obtaining explicit consent for information sharing is best practice and ideally should be obtained at the start of the involvement, when working with the individual or family to agree what support is required. It can be expressed either verbally or in writing, although written consent is preferable since that reduces the scope for subsequent dispute. Implicit consent can also be valid in many circumstances. Consent can legitimately be implied if the context is such that information sharing is intrinsic to the activity or service, and especially if that has been explained or agreed at the outset.

An example of implicit consent is where a GP refers a patient to a hospital specialist and the patient agrees to the referral. In this situation the GP can assume the patient has given implicit consent to share information with the hospital specialist. However, explicit consent would be required to share information outside the bounds of the original service or setting, for example, for a different type of referral.

In a multi-agency service, explicit consent for information sharing is usually obtained at the start of the involvement and covers all of the agencies within the service. This would provide implicit consent to share information within the multi-agency service but there would be a need to seek additional explicit consent for sharing with practitioners or agencies outside of the service.

Consent must not be secured through coercion or inferred from a lack of response to a request for consent.

If there is a significant change in the use to which the information will be put compared to that which had previously been explained, or a change in the relationship between the agency and the individual, consent should be sought again. Individuals have the right to withdraw consent at any time.

Whose consent should be sought - children and young people
You may also need to consider whose consent should be sought. Where there is a duty of confidence, it is owed to the person who has provided the information on the understanding it is to be kept confidential. It is also owed to the person to whom the information relates, if different from the information provider. A child or young person, who has the capacity to understand and make their own decisions, may give (or refuse) consent to sharing.

Children aged 12 or over may generally be expected to have sufficient understanding.
Younger children may also have sufficient understanding. As explained, this is presumed in law for young people aged 16 and older. When assessing a child's understanding you should explain the issues to the child in a way that is suitable for their age, language, learning disability or other disability and likely understanding. Where applicable, you should use their preferred mode of communication.

The following criteria should be considered in assessing whether a particular child or young person on a particular occasion has sufficient understanding to consent, or to refuse consent, to sharing of information about them:

Can the child or young person understand the question being asked of them?

Do they have a reasonable understanding of:

- What information might be shared;
- The main reason or reasons for sharing the information; and
- The implications of sharing that information, and of not sharing it?

Can they:

- Appreciate and consider the alternative courses of action open to them;
- Weigh up one aspect of the situation against another;
- Express a clear personal view on the matter, as distinct from repeating what someone else thinks they should do; and
- Be reasonably consistent in their view on the matter, or are they constantly changing their mind?

Considerations about whether a child has sufficient understanding are often referred to as Fraser guidelines, although these were formulated with reference to contraception and contain specific considerations not included above.

In most cases, where a child cannot consent or where you have judged that they are not competent to consent, a person with parental responsibility should be asked to consent on behalf of the child. If a child or young person is judged not to have the capacity to make decisions, their views should still be sought as far as possible.

Whose consent should be sought - adults
It is good practice to seek consent of an adult where possible. All people aged 16 and over are presumed, in law, to have the capacity to give or withhold their consent to sharing of confidential information, unless there is evidence to the contrary.

The *Mental Capacity Act 2005 Code of Practice* defines the term 'a person who lacks capacity' as a person who lacks capacity to make a particular decision or take a particular action for themselves, at the time the decision or action needs to be taken.

When consent should not be sought
There will be some circumstances where you should not seek consent from the individual or their family, or inform them that the information will be shared. For example, if doing so would:

- Place a person (the individual, family member, yourself or a third party) at increased risk of significant harm if a child, or serious harm if an adult; or
- Prejudice the prevention, detection or prosecution of a serious crime; or
- Lead to an unjustified delay in making enquiries about allegations of significant harm to a child, or serious harm to an adult.

You should not seek consent when you are required by law to share information through a statutory duty or court order.

Question 5: Is there sufficient public interest to share the information?
Even where you do not have consent to share confidential information, you may lawfully share it if this can be justified in the public interest. Seeking consent should be the first option. However, where consent cannot be obtained or is refused, or where seeking it is inappropriate or unsafe, the question of whether there is a sufficient public interest must be judged by the practitioner on the facts of each case. **Therefore, where you have a concern about a child or young person, you should not regard refusal of consent as necessarily precluding the sharing of confidential information.**

A public interest can arise in a wide range of circumstances, for example, to protect children and young people from significant harm, promote the welfare of children or prevent crime and disorder. There are also public interests, which in some circumstances may weigh against sharing, including the public interest in maintaining public confidence in the confidentiality of certain services.

The key factors in deciding whether or not to share confidential information are necessity and proportionality, i.e. whether the proposed sharing is likely to make an effective contribution to preventing the risk and whether the public interest in sharing

information overrides the interest in maintaining confidentiality. In making the decision you must weigh up what might happen if the information is shared against what might happen if it is not and make a decision based on professional judgement. The nature of the information to be shared is a factor in this decision making, particularly if it is sensitive information where the implications of sharing may be especially significant for the individual or for their relationship with the practitioner and the service.

It is not possible to give guidance to cover every circumstance in which sharing of confidential information without consent will be justified. You must make a judgement on the facts of the individual case. Where there is a clear risk of significant harm to a child or young person, the public interest test will almost certainly be satisfied. There will be other cases where you will be justified in sharing limited confidential information in order to make decisions on sharing further information or taking action - the information shared should be necessary for the purpose and be proportionate.

There are some circumstances in which sharing confidential information without consent will normally be justified in the public interest. These are:

- When there is evidence or reasonable cause to believe that a child is suffering, or is at risk of suffering, significant harm; or
- When there is evidence or reasonable cause to believe that a young person is suffering, or is at risk of suffering, serious harm; or
- To prevent significant harm to a child or young person, including through the prevention, detection and prosecution of serious crime.

If you are unsure whether the public interest justifies disclosing confidential information without consent, you should be able to seek advice from the Clinical Director. Where possible you should not disclose the identity of the person concerned. Other sources of advice include The Caldicott Guardian, Information Commissioner's Office (ICO), named professionals within EDMS and your Local Safeguarding Children Board.

EDMS has two Named Professionals who undertake a lead role for safeguarding vulnerable groups. If the concern is about possible abuse or neglect of a child or young person, you should discuss your concerns with your manager or one of the Named Professionals. If you still have concerns, you should refer your concerns to children's Social Care and/or the police in line with EDMS's Safeguarding Policy.

You should discuss any concerns with the family and, where possible, seek their agreement to making referrals to Children's Social Care **only where such discussion and agreement- seeking will not place a child at increased risk of significant harm, or any other individual at increased risk of serious harm, or lead to interference with any potential investigation.** The child's safety and well-being must be the overriding consideration in making any such decisions.

If you decide to share confidential information without consent, you should explain to the person that you intend to share the information and why, unless it is inappropriate or unsafe to do so.

Question 6: Are you sharing information appropriately and securely?

If you decide to share information, you should share it in a proper and timely way, act in accordance with the principles of the Data Protection Act 1998 and Caldicott Guardianship Principles. In relation to sharing information, you will need to ensure that you:

- Share only the information necessary for the purpose for which it is being shared;
- Understand the limits of any consent given, especially if the information has been provided by a third party;
- Distinguish clearly between fact and opinion;
- Share the information only with the person or people who need to know;
- Check that the information is accurate and up-to-date;
- Share it in a secure way, for example, confirm the identity of the person you are talking to; ensure that a conversation or phone call cannot be overheard; use secure email; ensure that the intended person will be on hand to receive a fax;
- Establish with the recipient whether they intend to pass it on to other people, and ensure they understand the limits of any consent that has been given; and
- Inform the person to whom the information relates and, if different, any other person who provided the information, if you have not done so already and it is safe to do so.

In deciding what information to share, you also need to consider the safety of other parties, such as yourself, other professionals and members of the public. If the information you want to share allows another party to be identified, for example, from details in the information itself or as the only possible source of the information, you need to consider if sharing the information would be reasonable in all circumstances. Could your purpose be met by only sharing information that would not put that person's safety at risk?

Question 7: Have you properly recorded your information sharing decision?
You should record your decision and the reasons for it, whether or not you decide to share information. If the decision is to share, you should record what information was shared and with whom.

GMC Guidance
The General Medical Council (GMC) has produced guidance entitled Confidentiality (2009) and 0-19 year's guidance for all doctors (2007). These are available to be downloaded from www.gmc-uk.org It emphasises the importance in most circumstances of obtaining a patient's consent to the disclosure of personal information, but makes clear that information may be released to third parties - if necessary without consent - in certain circumstances. Those circumstances include the following.

Disclosures when a patient may be a victim of neglect or abuse
If you believe that a patient may be a victim of neglect or physical, sexual or emotional abuse, and that they lack capacity to consent to disclosure, you must give information promptly to an appropriate responsible person or authority, if you believe that the disclosure is in the patient's best interests or necessary to protect others from a risk of serious harm. If, for any reason, you believe that disclosure of information is not in the best interests of a neglected or abused patient, you should discuss the issues with an experienced colleague.

Principles of confidentiality
Respecting patient confidentiality is an essential part of good care; this applies when the patient is a child or young person as well as when the patient is an adult. Without the trust that confidentiality brings children and young people might not seek medical care and advice, or they might not tell you all the facts needed to provide good care.

Sharing information with the consent of the child or young person
Sharing information with the right people can help to protect children, young people and vulnerable adults from harm and ensure that they get the help they need. It can also reduce the number of times they are asked the same questions by different professionals. By asking for their consent to share relevant information, you are showing them respect and involving them in decisions about their care.

If children and young people are able to take part in decision-making, you should explain why you need to share information, and ask for their consent. They will usually be happy for you to talk to their parents and others involved in their care or treatment.

Sharing information without consent
If a child or a young person does not agree to disclosure there are still circumstances in which you should disclose information:

- When there is an overriding public interest in the disclosure
- When you judge that the disclosure is in the best interests of the child or young person who does not have the maturity, mental capacity or understanding to make a decision about disclosure
- When disclosure is required by law

Public interest
You can disclose, without consent, information that identifies the child or young person, in the public interest. A disclosure is in the public interest is if the benefits which are likely to arise from the release of information outweigh both the child and young person's interest in keeping the information confidential and society's interest in maintaining trust between Health Care Professionals and patients. You must make this judgement case by case, by weighing up the various interests involved.

When considering whether disclosure would be justified you should:

- Tell the child or young person what you propose to disclose and why, unless that would undermine the purpose or place the child or young person at increased risk of harm
- Ask for consent to the disclosure, if you judge the child or young person to be competent to make the decision, unless it is not practical to do so.

If a child or young person refuse to give consent, or if it is not practical to ask for consent, you should consider the benefits and possible harms that may arise from disclosure. You should consider any views given by the child or young person on why you should not disclose the information. But you should disclose information if this is necessary to protect the child or young person or someone else, from risk of death or serious harm. Such cases may arise, for example, if:

- A child or young person is at risk of neglect or sexual, physical or emotional abuse
- The information would help in the prevention, detection or prosecution of serious crime, usually crime against the person
- A child or young people or is involved in behaviour that might put them or others at risk of serious harm, such as serious addiction, self harm or joy-riding

If you judge that disclosure is justified, you should disclose the information promptly to an appropriate person or authority and record your discussions and reasons. If you judge that disclosure is not justified, you should record your reasons for not disclosing.

Part 2 Additional and Supporting Information

Appendices to - Additional and Supporting Information, Glossary and References

As mentioned above the safeguarding agenda is a rapidly growing agenda and there are an increasing number of facets which link very closely to the overarching definition and our understanding of abuse. Part 2 of these appendices identifies a range of situations / known facets of abuse that staff may come into contact within their professional duties.

Appendices H,J,K,L M and have prominent governmental initiatives and themes supporting them, and a greater awareness in these areas is being raised.

Above all, and regardless of race, gender, culture or ethnicity they are all facets which represent, or contribute to abuse. Equally, as abuse they are not acceptable in any form or interpretation. As time goes on further policy and / or guidance may be developed and disseminated in relation to this.

Appendix G - Forced Marriage

Introduction

A marriage must be entered into with the full and free consent of **both** people. Everyone involved should feel that they have a choice. An arranged marriage is not the same as a forced marriage. In arranged marriages the families take a leading role in choosing the marriage partner. The marriage is entered into freely by both people.

However, in some cases, one or both people are **forced** into a marriage their families want. A forced marriage is a marriage conducted without the valid consent of both people, where pressure or abuse is used. The victims are put under both physical pressure (harm / injury may be threatened or inflicted), or emotional pressure (they may be made to feel that they are bringing shame on their family) to get married.

Hundreds of young people (particularly girls and young women) are forced into marriage each year. Some are taken overseas to marry whilst others may be married in the UK. Forced marriage can involve child abuse, including abduction, violence, rape, enforced pregnancy and enforced abortion. Refusing to marry can place a young person at risk of murder, sometimes also known as "honour killing".

A forced marriage is not sanctioned within any culture or religion.

The majority of cases reported in the UK involve South Asian families, but also families from East Asia, the Middle East, Europe and Africa.

In some cases people are taken abroad without knowing they are to be married. Children and young adults may only be aware they are going on holiday or to learn their cultural / ethnic culture. When they arrive in the country their passports may be taken by their family to stop them from returning home.

Forced marriage is an abuse of human rights, and a form of domestic violence, hate / discriminatory crime, honour crime, sexual assault / rape, migrant / human trafficking and child abuse.

Children as young as 7 or 8 can be victims of forced marriage.

There are many cases that don't get reported, but of those that do it is known that around 85% of cases involve women and 15% involve men.

Reasons for Forced Marriage

There are well documented reasons for forced marriages which include;

- Controlling unwanted behaviour and sexuality (including perceived promiscuity, or being gay, lesbian, bisexual or transgender) - and particularly the behaviour and sexuality of women.
- Protecting 'family honour'
- Responding to peer group or family pressure
- Attempting to strengthen family links
- Ensuring land, property and wealth remain within the family
- Protecting perceived cultural ideals
- Protecting perceived religious ideals which are misguided
- Preventing 'unsuitable' relationships e.g. outside the ethnic, cultural, religious or caste group
- Assisting claims for residence and citizenship
- Long-standing family commitments
- Arrangements for the marriage can be made very early on in the child's life, including pre-birth

General Information

A forced marriage will be valid unless and until it is set aside by a divorce or annulment in a civil court. Women forced to marry may find it very difficult to initiate any action to bring the marriage to an end and may be subjected to repeated rape (sometimes until they become pregnant) and ongoing domestic abuse within the marriage.

Women under threat of forced marriage may appear anxious, depressed and emotionally withdrawn with low self-esteem. They may come to the attention of health professionals for a variety of reasons such as unexplained injuries or mental health, self harming, eating disorders or challenging behaviour disorders but they are unlikely to disclose forced marriage. Others may come to the attention of health professionals, for example through pregnancy.

Other warning signs may include a family history of older siblings marrying early. In these cases their parents may feel that it is their duty to ensure that children are married soon after puberty in order to protect them from sex outside marriage.

Women with physical or learning disabilities may be withdrawn from their social networks or day care and kept at home. However,

there have been occasions when women have presented with less common warning signs such as cutting or shaving of a woman's hair as a form of punishment for disobeying or perhaps 'dishonouring' her family.

In some cases a girl may report that she has been taken to the doctors to be examined to see if she is a virgin. There have been reports of women presenting with symptoms associated with poisoning, or burning themselves by setting light to their hair.

Some people may feel that running away is their only option. For many people, especially women from ethnic minority communities, leaving their family can be especially hard. They may have no experience of life outside the family. In addition, leaving their family (or accusing them of a crime or simply approaching statutory agencies for help) may be seen as bringing shame on their honour and on the honour of their family in the eyes of the community. This may lead to social ostracism and harassment from the family and community. For many, this is simply not a price they are prepared to pay.

For people with mental and physical disabilities, their impairment and care needs may prevent them from leaving and make them completely reliant on the family.

Those who do leave often live in fear of their own families who will go to considerable lengths to find them and ensure their return. Families may solicit the help of others to find their runaways, or involve the police by reporting them missing or falsely accusing the woman of a crime.

Some families have traced women through medical and dental records, bounty hunters, private investigators, local taxi drivers, members of the community and shopkeepers or through National Insurance numbers, benefit records, school and college records. Sometimes having traced them, the family may murder them (so-called "honour killing").

Health professionals
Health professionals should be alert to potential warning signs and consider that forced marriage could be the reason. However, they should be careful not to assume that forced marriage is an issue simply on the basis that a women presents with any of these problems. Of course, some of these warning signs could be indicative of other forms of abuse or neglect.

Forced marriage is recognised in the UK as a form of domestic abuse and as serious abuse of human rights. The Department of Health has joined forces with the Forced Marriage Unit to raise awareness of the problem.

Further reading:

www.forcedmarriage.net

www.bia.homeoffice.gov.uk/partnersandfamilies/forcedmarriage

Appendix H - Domestic Abuse / Violence

Introduction

Domestic Violence has sadly is becoming a bigger and bigger issue in today's society. Clinicians' and ambulance staff are - as always - in the front line and come into increasing contact with domestic violence and both its victims and perpetrators.

There is a considerable government push to both raise the awareness of, and also to reduce the incidence of domestic violence and domestic abuse. Any form of violence or threat is abuse and domestic violence includes threatening behaviour, physical, psychological, sexual, financial or emotional abuse. WT2010 defines domestic violence occurring between, '*adults or young people, who are or have been intimate partners, family members or extended family members, regardless of gender or sexuality'.*

This includes issues of concern to black and minority ethnic (BME) communities such as so called 'honour based violence', female genital mutilation (FGM) and forced marriage.

Incidence of Domestic Abuse / Violence

It is estimated that on average two women are killed each week as a result of domestic violence. However, it is not 'gender neutral' - 1 in 4 women and 1 in 6 men will experience DV in their lifetime.

Domestic violence occurs across society, regardless of age, gender, race, sexuality, wealth, and geography. It can be part of a larger spectrum of relationship violence, which also includes sexual assault, child and elder abuse, animal abuse and neglect. Also, drug and alcohol misuse is also known to be a factor in many situations.

All EDMS staff clearly have a duty to protect anybody from abuse, which in the case of domestic abuse may be adults and / or children. Domestic Abuse and Violence can have a profound and long term effect on children in particular and staff should be aware of this at all times.

As mentioned domestic abuse can a manifestation of any one or more known categories of abuse emotional abuse is a major factor in many domestic abuse cases, and the victim may exhibit one or more of the following;

- Psychological / emotional abuse: intimidation and threats (e.g. To kill or maim, to report victims to agencies, to remove or hurt children or family pets)
- Social isolation
- Verbal abuse
- Humiliation
- Constant criticism
- Enforced trivial routines
- Over intrusiveness
- False allegations

Awareness

Staff need to be aware of the inter-relationship between domestic violence and the abuse and neglect of children.

There may be serious and long term effects on children who witness domestic violence, which in its own right can produce behavioural problems in the child, including low esteem, depression, absenteeism, ill health, bullying and many more.
Children can be harmed by overhearing or witnessing violence within their family setting.

Staff may be in a unique position to witness or hear about first hand, abusive situations in family settings. By nature of our work we often have access to locations where other professionals would not be welcome.

Responsibilities

As is already well documented, as professionals we have both a statutory and moral duty to share concerns that we may have in relation to a child or vulnerable adult that may be being abused or neglected. That duty extends to reporting concerns about the possibility of domestic violence or abuse having happened.

Additionally, staff should consider very carefully the position of children caught up in, or witnessing situations of domestic abuse. Domestic abuse is often a long term situation and it is well known that long term exposure to domestic abuse can have a profound a effect on the development of a child.

Not only is it essential that we do all in our power to protect the victims of abuse, but it is equally important to take in a bigger picture and recognise that there may be more than one victim in the long term.

In line with the above, staff should therefore consider very carefully in situations where children are caught up in, or witness, domestic violence whether it is in their best interest that they be referred to the relevant Children's Social Care.

When acting as Ambulance staff, amongst many other professionals can find themselves in a unique position whereby they have the real ability to save a child from a lifetime of abuse, and in doing so potentially promote their long term development and help towards securing a better future into adulthood for them.

Sharing Information or Referring

By definition there will be many occasions when we are at a location where domestic abuse and / or violence may have taken place alongside other professional colleagues. It is important in these situations that we act unilaterally in referring any concerns that we may have to the relevant Children's Social Care department. Relying on each other to take the initiative can, and has lead in the past to nothing happening.

Likewise, and in keeping with making referrals in general the same applies when taking victims of domestic abuse to an A&E Department. Regardless of whether the hospital staff make their own referral staff should still follow the referral pathway (see flowchart at Appendix D).

Domestic abuse is no different to any other form of abuse in that it is totally unacceptable. If staff have a concern that domestic abuse has occurred they should follow the normal EDMS pathways as set out in Appendices D and E.

Further Reading

WT2010; Chapter 11; 11.79 to 11.92

www.hiddenhurt.co.uk

Appendix J - Concealed Pregnancy
Challenges of Concealed pregnancy
The concealment of pregnancy represents a real challenge for professionals in safeguarding the welfare and the wellbeing of the foetus and the mother. While concealment by its nature limits the scope of professional help, experience shows that better outcomes can be achieved by co-ordinating an effective inter-agency approach once the fact of the pregnancy is established.

This will also apply to future pregnancies where there has been a previous concealed pregnancy. In some cases, pregnancies may be concealed until or after delivery, when particular attention should be given to safeguarding the child's welfare, and indeed to the well being of the mother.

A concealed pregnancy is;

- When a woman knows she is pregnant but does not tell anyone or those who are told conceal the fact from all caring and health agencies.
- Where a woman appears genuinely not aware she is pregnant. Concealment may be an active act or a form of denial where support from appropriate carers and health professionals is not sought.
- Concealment of pregnancy may be revealed late in pregnancy, in labour or following delivery.

The birth may be unassisted whereby there are additional risks to the child and mother's welfare and long-term outcomes.

Child protection issues may arise where a pregnancy is disclosed late as the focus will always be on the child regardless of whether unborn or born, and so where there would normally be concerns about an unborn child, child protection procedures would be likely to be initiated early in the pregnancy.

There is no national agreed definition of what constitutes a concealed pregnancy however there have been many studies carried out. The Crisis Pregnancy Agency (CPA) revealed that the main reasons for concealing or denying a pregnancy are fear of the social stigma of becoming pregnant in unconventional circumstances and fear of the family's reaction.

The report "Concealed Pregnancy, A Case Study in an Irish Setting" looked at 51women who concealed their pregnancies between July 2003 and December 2004. The most striking aspect of the study was that the sample of women used including women of all ages, and of all social backgrounds, both married and single.

Concealment Definitions
Conscious Denial*;* when the woman recognises that she is pregnant but denies this to herself and others. Her denial is a coping strategy invoked because the reality of the pregnancy is unimaginable and threatening to her.

Concealment of Pregnancy*;* When a woman acknowledges the pregnancy to herself but hides it from others, because external stresses make it difficult for her to reveal the pregnancy or because she wants to retain control over the outcome. An additional sub group here relates to women who are not aware of being pregnant because of significant unusual features in the pregnancy cause her to deny it or makes diagnosis difficult.

Crisis Pregnancy; Defined as a "pregnancy which is neither planned nor desired by the woman concerned", and which represents a personal crisis for her. This can be the case in some forced marriages.

Late Booker; For the purpose of this document, late booking is defined as presenting for maternity services after 24 weeks of pregnancy.

Reasons are mixed but may include the woman who wants a baby against the wishes of others, or to serve a purpose known only to herself.

Un-booked women presenting in labour must be regarded as high risk as their medical, obstetric and antenatal histories will not be known. As such, they should be taken to the nearest Hospital without exception, either before or after the birth.

Reasons for concealment
There is limited research into concealed pregnancy and even less into the link between this and child abuse. The reality is that women may have a variety of reasons for their behaviour.

A Review of forty Serious Case Reviews (DH 2002) identified one death was significant to concealment of pregnancy. Earl (2000), Friedman et al (2005), Vallone & Hoffman, highlight that there is a well-established link between neonatacide - infanticide in the 24 hours following birth - and concealed pregnancy.

Studies have shown that late commencement of antenatal care may be a feature of teenage pregnancy, for a variety of reasons. These include not fully understanding the consequences and complications of risk factors in pregnancy, poor motivation to keep appointments and concealment or denial of pregnancy.

In some cases the woman or young girl may be truly unaware that she is pregnant until very late into the pregnancy. For example a young woman with a learning disability may not understand why her body is changing. Denial may persist as a result of thinking that the problem will go away if it is ignored. Due to stigma, shame or fear, concealment may be a deliberate means of coping with the pregnancy without informing anyone.

A woman or girl may conceal their pregnancy if it occurred as the result of sexual abuse, either within or outside the family, due to her fear of the consequences of disclosing that abuse.

A woman who has had a previous child removed from her may be reluctant to inform the authorities that she is pregnant. There have been cases where the mother not only conceals the pregnancy and birth, but also the baby's body, should the baby die.

Concealed birth (including concealed still birth) represents a criminal offence, though enquiries into these circumstances should be conducted sensitively and with due regard to the context in which this takes place.

A pregnancy may be concealed in situations of domestic violence. Domestic abuse is more likely to begin or escalate during pregnancy.

In some religions and cultures, a pregnancy outside of marriage may have life threatening consequences for the woman involved. In these instances, women have been known to conceal their pregnancy or 'disappear' to avoid bringing shame to the family.

General Information
Although there is minimal evidence available, staff should remain alert to a future pattern of concealed pregnancies once one has been identified. To assess the longer-term prognosis for the child it is important to gain some understanding of what outcome the mother intended for the child i.e. did she hope it would survive?

There are also concerns in relation to the age of the mother. The Sexual Offences Act 2003 note that sexual activity with a child under the age of 13 is not acceptable and that regardless of the circumstances, children of this age can never legally give their consent and penetrative sex with a child under the age of 13 is classed as rape regardless of the age of the perpetrator/s and must be referred to Social Care/Police as a child protection issue.

Sexual activity with a child under 16 is also an offence, but where the child is between 13 and 16 consideration must be given to discussion with other agencies.

Remember the child is at risk at all times during the pregnancy through to the birth. If you are aware the mother has not yet engaged with Maternity services you need to ensure this is highlighted to Social Care, ensure the mother is taken to the Hospital.

Further reading

www.forwarduk.org.uk

Appendix K - Female Genital Mutilation

Female Genital Mutilation or FGM is a collective term for procedures which include the removal of part or all of the external female genitalia for cultural or other non-therapeutic reasons (WT2010).

In the UK FGM is a criminal offence (Prohibition of Female Circumcision Act 2003) and equally the act makes it an offence for UK residents or nationals to carry it out, or knowingly allow it to happen abroad - even in countries where it is legal.

FGM has potentially serious health implications, is unnecessary and can be extremely painful, both at the time and later on in life. It is typically carried out between the ages of 4 and 13. It remains relatively common across the world. In the UK alone it is estimated that up to 24,000 girls under the age of 15 are at risk of FGM.

As well as being illegal FGM is clearly abuse and not acceptable. Staff should be aware of the signs that a girl may be being prepared for, or may have recently undergone FGM.

Further reading

The Female Genital Mutilation Act 2003
Website: www.opsi.gov.uk/acts/acts2003/ukpga_20030031_en_1

WT2010; Chapter 6; 6.14 to 6.19
www.forwarduk.org.uk

Appendix L - Parental Engagement

Parent- or carer-child interactions alerting features that should prompt you to child maltreatment:

Consider - or carer-child interactions may be harmful. Examples include:

- Negativity or hostility towards a child or young person.
- Rejection or scapegoating of a child or young person.
- Developmentally inappropriate expectations of or interactions with a child, including inappropriate threats or methods of disciplining
- Exposure to frightening or traumatic experiences, including domestic abuse
- Using the child for the fulfilment of the adult's needs (for example, children being used in marital disputes).
- Failure to promote the child's appropriate socialisation (for example, involving children in unlawful activities, isolation, not providing stimulation or education).
- Suspect emotional abuse when persistent harmful parent- or carer-child interactions are observed or reported.

Consider child maltreatment if parents or carers are seen or reported to punish a child for wetting despite professional advice that the symptom is involuntary.

Consider emotional neglect if there is emotional unavailability and unresponsiveness from the parent or carer towards a child and in particular towards an infant.

Suspect emotional neglect if there is persistent emotional unavailability and unresponsiveness from the parent or carer towards a child and in particular towards an infant.

Consider child maltreatment if a parent or carer refuses to allow a child or young person to speak to a healthcare professional on their own when it is necessary for the assessment of the child or young person.

Emotional, behavioural, interpersonal and social functioning alerting features that should prompt you to CONSIDER child maltreatment:

Any behaviour or emotional state in a child if it is inconsistent with their age and developmental stage or there is no medical explanation (including a neurodevelopmental disorder, for example, ADHD or autism spectrum disorders) or other stressful situation unrelated to maltreatment (for example, bereavement or parental separation). Behaviour or emotional states that may fit this description include:

- Fearful or withdrawn emotional state
- Low self-esteem
- Aggressive or oppositional behaviour
- Habitual body rocking
- Indiscriminate contact or affection-seeking
- Over-friendliness to strangers
- Excessive clinginess
- Persistently resorting to gaining attention
- Demonstrating excessively 'good' behaviour to prevent parental or carer disapproval
- Failing to seek or accept appropriate comfort or affection from an appropriate person when significantly distressed
- Coercive controlling behaviour towards parents or carers
- Very young children showing excessive comforting behaviours when witnessing parental or carer distress
- Child or young person regularly has responsibilities that interfere with essential normal daily activities (for example, school attendance).
- Marked change in behaviour or emotional state not expected for the child or young person's age and developmental stage (for example, recurrent nightmares with similar themes, extreme distress, becoming withdrawn, markedly oppositional behaviour or withdrawal of communication) in the absence of a medical explanation or known stressful situation unrelated to maltreatment.
- Repeated, extreme or sustained emotional responses shown by a child that are out of proportion to a situation and are not expected for the child's age and developmental stage (for example, frequent rages at minor provocation, anger or frustration expressed as a temper tantrum in a school-aged child or distress expressed as inconsolable crying) in the absence of a medical explanation, neurodevelopmental disorder (for example, ADHD or autism spectrum disorders) or bipolar disorder when the effects of any known past maltreatment have been explored.
- Dissociation (transient episodes of detachment that are outside the child's control and that are different from daydreaming, seizures or deliberate avoidance of interaction) displayed by a child, not explained by a known traumatic event that is unrelated to maltreatment.

Further Reading:

NICE guidance on when to suspect child maltreatment: http://guidance.nice.org.uk/CG89

Appendix M - Prevent Strategy and Violent Extremism

In May 2008 the government launched its Prevent Strategy with the objective of stopping people becoming terrorists or supporting violent extremism. In the Ministerial Foreword it says, 'This country, like many others, faces a challenge from terrorism and violent extremism. A very small minority seek to harm innocent people in the name of an ideology which causes division, hatred and violence. It is the role of government to take the tough security measures needed to keep people safe. But a security response alone is not enough; as with so many other challenges, a response led and driven by the community is also vital'.

Prevent is just one strand of a larger strategy known as CONTEST. This anti-terrorism strategy promotes collaboration and co-operation between public service organisations. The Health Service has a key role to play in the Prevent strategy by recognising and stopping people - many of whom are vulnerable - becoming terrorists or supporting violent extremism.

One of its primary objectives is to support individuals who are vulnerable to recruitment or have already been recruited by violent extremists. As a result all local authorities should have in place a process for safeguarding vulnerable children, young people and adults susceptible to violent extremism.

Working Together 2010 says, 'Experience suggests that young people from their teenage years onwards can be particularly vulnerable to getting involved with radical groups through direct contact with members, or increasingly, through the internet. This can put a young person at risk of being drawn into criminal activity and has the potential to cause significant harm'.

It is an important assumption that the intention is not to put through the criminal justice system those who are vulnerable to, or are being drawn into, violent extremism unless they have clearly committed an offence. It is vital that individuals and communities understand this and have the confidence to use the support structures.

As health professionals' staff should be aware of the potential risks in their area. Staff should be aware that if they have a concern that a child or vulnerable person is potentially involved with activities or acts in a way that is of concern to the professional in relation to violent extremism, that they should share that information as appropriate.

Further Reading:

WT2010; Chapter 11; 11.74 to 11.78

The Prevent Strategy: A Guide for Local Partners in England; Stopping people becoming or supporting terrorists and violent extremists; HM Government 2008

Building Partnerships, Staying Safe; the prevention of violent extremism - pilot programme: guidance for healthcare workers; Department of health 2009

Appendix N - Dangerous Dogs and safeguarding children

The NSPCC document, **Understanding the links; Information for professionals; child abuse, animal abuse and domestic violence** says, *'There is increasing research and clinical evidence which suggests that there are sometimes inter-relationships, commonly referred to as 'links', between the abuse of children, vulnerable adults and animals. A better understanding of these links can help to protect victims, both human and animal, and promote their welfare'*.

There have been a number of profile attacks on young children in the last few years which have resulted in serious injury and even deaths of children. Some known dangerous dogs are banned in the UK but many are kept covertly and often trained in connection with dog fighting which has been illegal in this country since 1835.

Dangerous dogs can be considered in two contexts, firstly dogs that come under the Dangerous Dogs Act 1991 and are a banned dog as per the act. These are;

- Pit Bull Terrier
- Japanese Tosa
- Dogo Argentino
- Fila Braziliero
- Cross bred pit bulls

The second group relates to dogs that are dangerous, or perceived to be. When you attend an incident or come into contact with family that has a dog you need to consider whether or not the dog poses any threat to the child's health, development or safety. This could be any dog of any breed. Considerations might be for example:

- Is it a large dog in a small flat?
- Is the dog left alone with the child?
- Is the dog looked after properly (does it look healthy)?
- Is the dog being maltreated or abused by anybody there?
- Does it appear that more money is spent on the dog compared to the child?

It is obvious that very few people would be able to recognize dogs in the first group as defined by the Dangerous Dogs Act 1991, and this document does not require that staff become canine experts. Many professionals have difficulty in recognizing dangerous dogs, particularly the 'pit bull' family of dogs.

Remember that dogs are often protective towards their home and family members, particularly when strangers are invited into the home. A sensible approach should be adopted as often dogs will act to protect that environment and the people well known to them.

Remember equally that dogs can become jealous of children and babies, and particularly when babies are newly introduced into the family and are small and immobile.

In the context of safeguarding in the event that you are not sure about the dog you should, if appropriate share your concerns with the family. In the event that you feel unable to do this you should discuss the issue, in the first place, with your manager.

If you believe there is a safeguarding risk to children in the house you should make a referral to Social Care using EDMS referral pathway.

In extreme circumstances, or when you suspect that the dog is one of the breeds mentioned above or is a serious risk to the child, you should contact the police immediately.

Further Reading:

Understanding the links; Information for professionals; child abuse, animal abuse and domestic violence. NSPCC
www.nspcc.org.uk/inform

Dangerous Dogs Law; Guidance for Enforcers; Department for Environment Food and rural Affairs (defra); March 2009
www.defra.gov.uk

Appendix O- References and Internet Links

Government / National References

Bichard Inquiry Report - Sir Michael Bichard 2004
Website: www.bichardinquiry.org.uk/report/

Caldicott Guardian Manual - 2010
Website: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_114509

Care Standards Act 2000
Website: www.opsi.gov.uk/acts/acts2000/ukpga_20000014_en_1

Children Act 2004
Website: www.opsi.gov.uk/acts/acts2004/ukpga_20040031_en_1

Confidentiality: NHS Code of Practice (DH, 2003)
Website: www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf

Data Protection Act 1998
Website: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_4010391

Data Protection and Sharing - Guidance for Emergency Planners and Responders (HMG, 2007)
Website:www.ukresilience.gov.uk/~/media/assets/www.ukresilience.info/dataprotection%20pdf.ashx

Equality Act 2010
Website: http://www.equalities.gov.uk/equality_act_2010.aspx

Every Child Matters (TSO, 2003)
Website: www.everychildmatters.gov.uk/aims/background/

Fraser Guidelines
Website: www.nspcc.org.uk/inform/research/questions/gillick_wda61289.html

Freedom of Information Act 2000
Website: www.opsi.gov.uk/acts/acts2000/ukpga_20000036_en_1

Guidance for safer working practice for adults who work with children and young people; Department for Education and Skills (2009)
Website: www.dcsf.gov.uk/everychildmatters/resources-and-practice

HM Government Information sharing vision statement (HMG, 2006)
Website: www.justice.gov.uk/publications/informationsharingvision.htm

Human Rights Act 1998
Website: www.opsi.gov.uk/acts/acts1998/ukpga_19980042_en_1

Information Sharing: Guidance for practitioners and managers (HMG, 2008)
Website: www.ecm.gov.uk/informationsharing

Information sharing practitioners' guide: Cross-Government guidance to improve practice by giving practitioners across children's services clearer guidance on when and how they can share information legally and professionally
Website: www.ecm.gov.uk/informationsharing

Kennedy Report; Sudden unexpected death in infancy. Baroness Helena Kennedy QC 2004
Website: www.rcpath/resources/pdf/SUDI%20report%20for%20web.pdf

Making Arrangements to Safeguard and Promote the Welfare of Children
Website: www.everychildmatters.gov.uk/resources-and-practice/IG00042/

MAPPA (Multi Agency Public Protection Arrangements) guidance (2007)
Website: www.probation.homeoffice.gov.uk/output/page30.asp

Emergency Doctors Medical Services – Safeguarding

MARAC (Multi-Agency Risk Assessment Conference) toolkits.
Website: www.caada.org.uk/index.html

National Health Service Act 2006.
Website: www.dh.gov.uk/en/Publicationsandstatistics/Legislation/Actsandbills/DH_064103

National Service Framework for Children, Young People and Maternity Services - 2004 (DoH)
Website: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4089101

NHS Information Governance (DH, 2007)
Website: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_079616

Our Health, Our Care, Our Say (DH, 2006)
Website: www.dh.gov.uk/en/Healthcare/Ourhealthourcareoursay/index.htm

Public Interest Disclosure Act 1998
Website: www.opsi.gov.uk/acts/acts1998/ukpga_19980023_en_1

Safeguarding Children and Young People from Sexual Exploitation
Website: www.dcsf.gov.uk/everychildmatters/_download/?id=6021

Safeguarding Children in whom illness is fabricated or induced
Website: www.dcsf.gov.uk/everychildmatters/_download/?id=3161

Statutory guidance on making arrangements to safeguard and promote the welfare of children under section11 of the Children Act 2004; HM Government; 2007
Website: www.everychildmatters.gov.uk/resources-and-practice/IG00042/

The Common Core of Skills and Knowledge for the Children's Workforce
Website:www.dcsf.uk/everychildmatters/strategy/deliveringservices1/commoncore/commoncoreofskillsandknowledge/

The Female Genital Mutilation Act 2003
Website: www.opsi.gov.uk/acts/acts2003/ukpga_20030031_en_1

The Prevent Strategy: A Guide for Local Partners in England; Stopping people becoming or supporting terrorists and violent extremists; HM Government 2008

The Protection of Children in England: A Progress Report - Lord Laming March 2009
Website: http://publications.dcsf.gov.uk/

The Right to Choose: Multi-agency statutory guidance for dealing with forced marriage
Website: www.fco.gov.uk/resources/en/pdf/3849543/forced-marriage-right-to-choose

When to suspect child maltreatment; Clinical Guideline July 2009 - NICE (National Collaborating Centre for Women's and Children's Health)
Website: http://guidance.nice.org.uk/CG89

Victoria Climbié Inquiry Report - Lord Laming, January 2003 - DoH
Website: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008654

When to suspect child maltreatment (NICE)
Website: www.nice.org.uk/nicemedia/pdf/cg89fullguidance.pdf

"Who Decides: making decisions on behalf of mentally incapacitated adults"; Lord Chancellor's Department (1997)

"Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children"; HM Government; 2010
Website: www.ecm.gov.uk/safeguarding

Working Together to Safeguard Children and What to do if you are worried a child is being abused (HMG, 2010).
Website: www.ecm.gov.uk/safeguarding

Local Safeguarding Children Boards

Bedfordshire
www.bedfordshirelscb.org.uk

Cambridgeshire
www.cambslscb.org.uk

Essex
www.escb.co.uk

Hertfordshire
www.hertsdirect.org/caresupport/childfam/childprotection/acpc

Luton
www.lutonlscb.org

Norfolk
www.lscb.norfolk.gov.uk

Peterborough
www.peterborough.gov.uk/children_and_families/peterborough_safeguarding.aspx

Southend
www.southend.gov.uk

Suffolk
www.suffolk.gov.uk/CareAndHealth/ChildrenAndFamilies/SuffolkSafeguardingChildrenBoard

Thurrock
www.thurrock-community.org.uk/lsp/safeguard