General Practice

Child Safeguarding

Supporting Development at

Level 3

GP Child Safeguarding Competencies

Published: October 2015
In March 2014 the Royal College of GPs put its name to a new competency framework for NHS staff ‘Safeguarding children and young people: roles and competencies for healthcare staff’, which sets out minimum training requirements for GPs. All GPs should now be trained to level 3 within the guidance.

The competencies are broken down into four categories: knowledge, clinical knowledge, skills, and attitudes and values.

For those individuals moving into a permanent senior level post such as substantive career grade or GP who has yet not attained the relevant knowledge, skills and competence required at level 3, it is expected that within a year of appointment additional education will be completed equivalent to a minimum of 8 hours of education and learning related to safeguarding/child protection.

Over a three-year period, professionals should receive refresher training equivalent to a minimum of 6 hours for those at Level 3 core (this equates to a minimum of 2 hours per annum) and a minimum of 12-16 hours for those at Level 3 requiring specialist knowledge and skill.

Training, education and learning opportunities should be multi-disciplinary and inter-agency, and delivered internally and externally. It should include personal reflection and scenario-based discussion, drawing on case studies, serious case reviews, lessons from research and audit, as well as communicating with children about their issues.

This should be appropriate to the speciality and roles of the participants. At level 3 this could also, for example, include attendance at a multi-agency workshop on feedback from serious case reviews or a Local Safeguarding Children Board (LSCB) launch of a policy (e.g. of the Levels of Need) where appropriate. GPs should consider encompassing safeguarding/child protection learning within regular multi-professional and/or multi-agency staff meetings, vulnerable child and family meetings, clinical updating, clinical audit, reviews of critical incidents and significant unexpected events, and peer discussions (it will also support the multi-agency requirements for safeguarding competencies).

The document that follows is an aide memoire for GPs to support them in reaching some of the competencies at level 3.

For more Information see The RCGP/NSPCC Safeguarding Children Toolkit for General Practice

1 https://www.rcn.org.uk/__data/assets/pdf_file/0008/474587/Safeguarding_Children_Roles_and_Competences_for_Healthcare_Staff_02_0....pdf
## Contents

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Useful Contacts</td>
<td>4</td>
</tr>
<tr>
<td>When to Suspect Child Maltreatment - Quick Reference Guide</td>
<td>5</td>
</tr>
<tr>
<td>What is Child Protection</td>
<td>6</td>
</tr>
<tr>
<td>What is the Difference between Child Protection and Safeguarding</td>
<td>6</td>
</tr>
<tr>
<td>Child’s Voice</td>
<td>6</td>
</tr>
<tr>
<td>MASH</td>
<td>6</td>
</tr>
<tr>
<td>Children’s Wellbeing Directorate</td>
<td>6</td>
</tr>
<tr>
<td>MARAC</td>
<td>6</td>
</tr>
<tr>
<td>MAPPA</td>
<td>7</td>
</tr>
<tr>
<td>SARC</td>
<td>7</td>
</tr>
<tr>
<td>Shropshire Safeguarding Children Board</td>
<td>7</td>
</tr>
<tr>
<td>Child Death Overview Panel (CDOP)</td>
<td>8</td>
</tr>
<tr>
<td>Legislation</td>
<td>9</td>
</tr>
<tr>
<td>Threshold for Referral to Social Care</td>
<td>20</td>
</tr>
<tr>
<td>Mental Capacity Act</td>
<td>20</td>
</tr>
<tr>
<td>Early Help</td>
<td>22</td>
</tr>
<tr>
<td>Compass</td>
<td>22</td>
</tr>
<tr>
<td>Children in Need</td>
<td>24</td>
</tr>
<tr>
<td>Think Family</td>
<td>25</td>
</tr>
<tr>
<td>The GP Consultation</td>
<td>25</td>
</tr>
<tr>
<td>Fabricated and Induced Illness</td>
<td>26</td>
</tr>
<tr>
<td>Domestic Abuse</td>
<td>28</td>
</tr>
<tr>
<td>Disclosure of Abuse</td>
<td>29</td>
</tr>
<tr>
<td>Information Sharing</td>
<td>29</td>
</tr>
<tr>
<td>Making a Referral to Social Care</td>
<td>31</td>
</tr>
<tr>
<td>Advice for GPs re Interactions with a Social Worker</td>
<td>32</td>
</tr>
<tr>
<td>Resolving Professional Differences</td>
<td>35</td>
</tr>
<tr>
<td>Children with Disabilities</td>
<td>35</td>
</tr>
<tr>
<td>Privately Fostered Children</td>
<td>35</td>
</tr>
<tr>
<td>Home Educated Children</td>
<td>36</td>
</tr>
<tr>
<td>Children who go Missing</td>
<td>36</td>
</tr>
<tr>
<td>Child Sexual Exploitation</td>
<td>37</td>
</tr>
<tr>
<td>Trafficked Children</td>
<td>37</td>
</tr>
<tr>
<td>Unaccompanied Asylum Seekers</td>
<td>37</td>
</tr>
<tr>
<td>Female Genital Mutilation</td>
<td>37</td>
</tr>
<tr>
<td>Forced Marriage</td>
<td>38</td>
</tr>
<tr>
<td>The Unseen Child</td>
<td>38</td>
</tr>
<tr>
<td>Child Protection Case Conferences</td>
<td>39</td>
</tr>
<tr>
<td>Categories of abuse</td>
<td>40</td>
</tr>
<tr>
<td>Working with Sexually Active Young People</td>
<td>42</td>
</tr>
<tr>
<td>Managing an Accusation against a Member of Staff</td>
<td>46</td>
</tr>
<tr>
<td>Other Useful Advice and Information</td>
<td>46</td>
</tr>
<tr>
<td>Appendix 1 - Sample assessment of under 16 year olds sexual activity</td>
<td>48</td>
</tr>
</tbody>
</table>
## Useful Contacts

<table>
<thead>
<tr>
<th>Name</th>
<th>Designation</th>
<th>Organisation</th>
<th>Contact details</th>
</tr>
</thead>
<tbody>
<tr>
<td>David Coan</td>
<td>Designated nurse for safeguarding</td>
<td>Shropshire CCG</td>
<td>01743 277500 ex 2089 Mob 07794 255801</td>
</tr>
<tr>
<td>Dr M Ganesh</td>
<td>Designated doctor for safeguarding</td>
<td>Shropshire CCG</td>
<td>01952 567308</td>
</tr>
<tr>
<td>Julie Harris</td>
<td>Named nurse for safeguarding children</td>
<td>Shropshire Community Health NHS Trust (HV/school nurse/CAMHS)</td>
<td>01952 385656 Mob 07794 238303</td>
</tr>
<tr>
<td>Alison Wood</td>
<td>Lead nurse for child death overview panel</td>
<td>Shropshire Community Health NHS Trust</td>
<td>01952385838 Mob 07770347632</td>
</tr>
<tr>
<td>Ellie Johnson</td>
<td>Looked after children designated nurse</td>
<td>Shropshire CCG</td>
<td>01743 250124</td>
</tr>
<tr>
<td>Dr Jessica Sokolov</td>
<td>GP Board Member, Clinical Director Women's and Children's Service</td>
<td>Shropshire CCG</td>
<td>01743 277500</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th><strong>Initial contact team/compass/Family connect (Monday to Friday)</strong></th>
<th>Shropshire</th>
<th>Telford</th>
</tr>
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<tr>
<td>0345 678 9021</td>
<td>0345 678 9021</td>
<td>01952 385385</td>
</tr>
<tr>
<td>01952 385385</td>
<td>01952 676500</td>
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<tr>
<th><strong>Emergency out of hours</strong></th>
<th>Shropshire</th>
<th>Telford</th>
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<tr>
<td>0345 678 9040</td>
<td>0345 678 9040</td>
<td>01952 676500</td>
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</tbody>
</table>
WHEN TO SUSPECT CHILD MALTREATMENT - QUICK REFERENCE GUIDE

Using this guidance - Flowchart

Listen and Observe
Take into account the whole picture of the child or young person.
Sources of information that help to do this include:
- symptom
- physical sign
- result of an investigation
- interaction between the parent or carer and child or young person
- any history that is given
- report of maltreatment, or disclosure from a child or young person or third party
- child's appearance, demeanour or behaviour

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

An unsuitable explanation is one that is:
- implausible, inadequate or inconsistent:
  - with the child or young person's presentation, normal activities, medical condition (if one exists), age or developmental stage, or account compared with that given by parent and carers
  - between parents or carers
  - between accounts over time
- based on cultural practice, because this should not justify hurting a child or young person.

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

CONSIDER child maltreatment
If an alerting feature prompts you to consider child maltreatment:
- look for other alerting features of maltreatment in the child or young person's history, presentation or parent – or carer – child interactions now or in the past.
And do one or more of the following:
- Discuss your concerns with a more experienced colleague, a community paediatrician, child and adolescent mental health service colleague, or a named or designated professional for safeguarding children.
- Gather collateral information from other agencies and health disciplines.
- Ensure review of the child or young person at a date appropriate to the concern, looking out for repeated presentations of this or any other alerting features.

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

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

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

Record
Record all actions taken and the outcome.
**What is child protection?**

All children have a right to protection against abuse, neglect, exploitation and violence and many organisations have a statutory duty to safeguard and promote the welfare of children and young people. A successful approach requires multi-agency collaboration and a recognition of child wellbeing at the heart of your organisation.

**What is the difference between child protection and safeguarding?**

Safeguarding, and promoting the welfare of children, is a broader term than child protection. It encompasses protecting children from maltreatment, preventing impairment of children's health or development, and ensures children grow up in safe circumstances.

Child protection is part of this definition and refers to activities undertaken to prevent children suffering, or likely to suffer, significant harm.

**Child’s voice**

Young people need a voice. It is important for many young people to feel they have a say in what they want to happen without feeling the weight of responsibility. It is therefore important, where possible and dependent on the young person’s age, to speak directly to the young person, to ascertain their wishes and explain the actions you, as a professional, take. However, don’t forget even competent young people are children until the age of 18 years and we have a duty of care to safeguard their welfare. This may mean that, on occasions, a young person may either refuse consent or make a decision that we feel may put them at risk. In that case we have a duty of care and, whilst we note their viewpoint, we will safeguard them.

**What is...?**

**The MASH:** This is the Multi Agency Safeguarding Hub. This team is largely based upon three common principles: information sharing, joint decision making and coordinated intervention. Agencies represented within the MASH are the ‘front door’ of children’s social care, education, the police and health. Shropshire MASH is known as COMPASS

**Children’s Wellbeing Directorate:** This is the Local Authority’s children services including social care.

**MARAC:** Multi Agency Risk Assessment Conference which improves responses to victims of domestic abuse. The Health Visitor and School Nurse will have representation at MARAC and can provide information if requested.
**MAPPA:** Multi Agency Public Protection Arrangements are in place to ensure the management of violent and sexual offenders who pose a serious risk of harm to the public. There are 3 levels of MAPPA meetings where level 3 is held for the most serious offenders. The CCG safeguarding team can support this contact if needed.

**SARC:** Sexual Assault Referral Centre. SARC is specialist medical and forensic services for anyone who has been raped or sexually assaulted. The SARC that covers Shrewsbury is the Glade: [http://www.theglade.org.uk](http://www.theglade.org.uk)

Professionals enquiry number: 01886 833555
or Mountain Healthcare 0330 223 0099 (available 24hrs)

SARC provides a one-stop service, including medical care, forensic examination and emotional support following assault/rape.

Should an adult/teenage child not wish to report the assault to the police they can still access the SARC services and can then choose whether they would like to inform the police at a later stage and have their samples stored whilst they are considering what to do next. It is hoped that through this option service users can take back some control over what is happening whilst allowing more time to make such an important decision.

In order to preserve any evidence that may be present it is vital that help from the SARC is accessed *as immediately as possible* after an assault.

NOTE For children about whom there are concerns of a sexual nature, a referral to children’s social care must be made. Shropshire Services team/initial contact team 0345 678 9021.

**Shropshire’s Safeguarding Children Board (SSCB)**
[http://www.safeguardingshropshireschildren.org.uk/scb/](http://www.safeguardingshropshireschildren.org.uk/scb/)

Local Safeguarding Children Boards (LSCBs) were established by the Children Act 2004 (see below) which gives a statutory responsibility to each Local Authority to have this mechanism in place. LSCBs are now the key system in every locality of the country for organisations to come together to agree on how they will cooperate with one another to safeguard and promote the welfare of children. The purpose of this partnership working is to hold each other to account and to ensure safeguarding children remains high on the agenda across their region.
Child Death Overview Panel

GPs and other NHS professionals have a legal obligation (Children Act 2004) to share information with the Child Death Overview Panel (CDOP).

Through a comprehensive and multidisciplinary review of child deaths, CDOP aims to better understand how and why children in Telford and Shropshire die and to use these findings to take action to prevent child deaths and improve the health and safety of our children and young people. All deaths of children and young people under the age of 18 years will be reviewed by CDOP.

Under the legislation the CDOP should be informed of the deaths of all children normally resident in their geographical area. Should a GP be made aware that a child in their practice has died they need to inform the CDOP Administrator/Secretary to Designated and Named Nurses, Shropshire Community Health NHS Trust.

Address: 30 West Road, Wellington, Telford, Shropshire, TF1 2BB
Tel: 01952 385684 – Fax: 01952 223920
Email: cdop@shropcom.nhs.uk

Following the notification of a child’s death, CDOP will send a form B to the child’s (or mother’s for a neonate) GP. Again under the legislation the GP has a duty to cooperate and complete the form in a timely manner.
Legislation

There are two different paths of law: criminal, which involves crime, and civil/public law. Children's safeguarding legislation falls under public law.

Differing standards of proof
More evidence is needed to find the accused at fault in criminal cases than to find the defendant at fault in civil ones. To convict someone of a crime, the prosecution must show there is proof beyond a reasonable doubt that the person committed the crime and, in most cases, that they intended to commit it. Civil cases, in contrast, must be proven on a balance of probabilities - if it is more likely than not that the defendant caused harm or loss, a court can uphold a civil claim.

The long history of children's welfare legislation had given rise to numerous uncoordinated official powers and functions. The Children Act 1989 brought together the myriad of legislation under one Act. Following the death of Victoria Climbie this was expanded with the publication of the Children Act 2004.

The Children Act 1989/2004
The Children Act 1989 revised 2004 introduced comprehensive changes to legislation in England and Wales affecting the welfare of children. It gave every child the right to protection from abuse and exploitation and the right to inquiries to safeguard their welfare.

The Act:

- Reinforced the autonomy of families through definition of parental responsibility
- Provided for support from local authorities, in particular for families whose children are in need
- Legislated to protect children who may be suffering or are likely to suffer significant harm.

Safeguarding & Promoting Welfare
Provides a balance:
Underpinning values of Children Act 1989:

Child-Focused
- welfare of the child is paramount

Minimum Intervention
- whenever possible children are best brought up within their own families

Partnership with Families
- child welfare and safety should be promoted through working with parents and children

Partnership between Agencies
- positive collaboration between agencies rather than one agency acting on behalf of or in competition with others

Non-discriminatory Practice
- recognition and valuing difference

Key Concepts of the Act
- Paramountcy (child always has paramountcy over adults)
- Parental Responsibility
- Prevention
- Partnership
- Preferences of the Child
- No Order principle (the Court would prefer not to become involved unless there are no alternatives)

Parental Responsibility

What is parental responsibility?

All mothers and most fathers have legal rights and responsibilities as a parent - known as ‘parental responsibility’.

If you have parental responsibility, your most important roles are to:

- provide a home for the child
- protect and maintain the child
If you have parental responsibility for a child you don’t live with, you don’t necessarily have a right to contact with them - but the other parent still needs to keep you updated about their well-being and progress.

You’re also responsible for:

- disciplining the child
- choosing and providing for the child’s education
- agreeing to the child’s medical treatment
- naming the child and agreeing to any change of name
- looking after the child’s property

Parents have to ensure that their child is supported financially, whether they have parental responsibility or not.

Who has parental responsibility?

A mother automatically has parental responsibility for her child from birth.

A father usually has parental responsibility if he’s:

- married to the child’s mother
- listed on the birth certificate (after a certain date, depending on which part of the UK the child was born in)

A person can apply for parental responsibility if they don’t automatically have it.

Births registered in England and Wales

If the parents of a child are married when the child is born, or if they’ve jointly adopted a child, both have parental responsibility.

They both keep parental responsibility if they later divorce.

Unmarried parents

An unmarried father can only get legal responsibility for his child in one of three ways:

- jointly registering the birth of the child with the mother (from 1 December 2003)
- getting a parental responsibility agreement with the mother
- getting a parental responsibility order from a court
Same Sex Civil partners

Same-sex partners who were civil partners at the time of the treatment will both have parental responsibility.

Non-civil partners

For same-sex partners who aren’t civil partners, the second parent can get parental responsibility by either:

- applying for parental responsibility if a parental agreement was made
- becoming a civil partner of the other parent and making a parental responsibility agreement or jointly registering the birth

Applying for parental responsibility (see HM Courts and Tribunals website[^3] for forms etc.)

If an individual has agreement of the mother, they can apply to court to get parental responsibility.

They need to be connected to the child, e.g. as their father, step-parent or second female parent.

More than two people can have parental responsibility for the same child.

Sign a parental responsibility agreement

If a father wants parental responsibility and the mother agrees, they need to fill in a parental responsibility agreement.

There’s a different agreement form for step parents.

They then take the agreement to their local county court or family proceedings court, where it can be signed and witnessed.

They need to also take the child’s birth certificate and proof of identity, like a passport or driving license.

Send two copies of the form to the address below:

Principal Registry of the Family Division
First Avenue House
42-49 High Holborn

Apply for a court order

If an adult wants parental responsibility but can’t agree on arrangements with the mother, they can apply for a court order.

A court order costs £215. A form can be downloaded from HM Courts and Tribunals.

If a couple use a surrogate to have a child, they need to apply for a parental order.

Relevant Sections of the Act

Section s3

A person who -

(a) Does not have parental responsibility

but

(b) has care of the child

“may do what is reasonable in all the circumstances of the case for the purpose of safeguarding the child’s welfare” - (subject to the provisions of the Act).

Section s8 Orders

Under the Act all efforts should be made to resolve problems voluntarily and court orders should only be sought if they will be of positive benefit to the child (Local Authorities cannot apply for or be granted Section 8 Orders; they are private law Orders that would normally be used in family disputes, often used by couples following acrimonious breakdown of relationship).

Deals with:

Residence: May be made by the Court because there has been a dispute about the child’s residence, or because there has been a question about the child’s welfare, which has required an Order to be made.

Anyone named in a Residence Order as living with the child and caring for them, obtains parental responsibility for them with the making of the Order (Section 12) but they lose it once the Order ends.

Contact: It should be noted that it is the child’s right to have contact with their parents and not the parents’ right. Contact Orders define the arrangements for a child having contact
with the person named on the Order. Although usually a parent, contact can also be granted to grandparents or siblings.

**Specific Issue:** resolve particular areas of disagreement relating to the exercise of parental responsibility.

**Prohibited Steps:** restrict parental responsibility. Prohibited Steps Orders prevent the taking of an action that would otherwise be quite reasonably exercised by someone with parental responsibility. For example, if the parent who has the care of a child is concerned that the other parent may seek to abduct or harm the child they may obtain one of these Orders to prohibit the 'absent' parent from having any contact with the child except by prior arrangement and under supervision.

**Section s17 Child In Need**

Section 17 defines a child as being in need in law if:

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

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

Having a disability is defined as a person who is blind, deaf, dumb, suffering from a mental disorder, substantially and permanently handicapped by illness, or congenital deformity or from suffering from some other disability as may be prescribed.

The definition will include any child or young person under the age of 18.

The service can also be provided to the child’s family or any member of his or her family so long as the aim is to safeguard and promote the child’s welfare. Support can include providing cash assistance to a family.

A Local Authority can provide accommodation to a child in need away from his family under Section 20 of the Children Act 1989. The Courts have also decided that whilst a Local Authority may provide residential accommodation for children in need to live with their parents, it has no duty to do so.
General Duty to Children in Need

Local Authorities are under a general duty to safeguard and promote the welfare of all children in need in their area. Local Authorities must do whatever possible to ensure sufficient services and measures are in place to promote a child being raised within its own family, if it is safe to do so.

Section s31 Care Orders

A Care Order (under Section 31(1)(a) of the Children Act) places the child in the care of the Local Authority, with parental responsibility being shared between the parents and the Local Authority.

The Court will expect to be informed by the Local Authority of what plans there are for a child and be satisfied that the Care Order is in the child's best interests.

A Care Order can last until a young person is 18 years old, or until an Adoption, Supervision, Special Guardianship or Residence Order is made, or until the Court decides that the Order is no longer necessary. The Local Authority, or persons with parental responsibility for the child, can apply for the discharge of the Order.

Interim Care Orders

This is an Order that is made at the first hearing after Care Proceedings have been issued. This Order can last for up to 8 weeks and can be renewed every 4 weeks after that. The Order can only be granted if the Court feels there is good reason to believe that a child may be at serious risk of harm.

When the Local Authority applies for an Interim Care Order, they have to have prepared an Interim Care Plan which sets out where the child should live until the final hearing. This will include contact arrangements between the parent and the child. The Local Authority must show the Care Plan to the parent(s) and should ensure that the plan suits the child's cultural, religious and racial heritage.

The Interim Care Order, like a Care Order, grants the Local Authority Parental Responsibility (although the parents do not lose their parental responsibility) which means they are able to make decisions about the child's living arrangements and do not need the parents’ permission to do so.

The Court can also grant other orders at the same time as the Interim Care Order such as an Exclusion Order which forces an adult who is believed to be dangerous to a child out of the child's home.

Section s35 Supervision Order

This places a child or young person under the supervision of the Local Authority or a Probation Officer, who are required to advise, help and befriend the child.
The Order can only be for one year in the first instance, but the Supervisor can apply for this to be extended although it must not be for more than three years in all, and not after the person is 18 years old.

A Supervision Order may have conditions. For example, that the child should have medical or psychiatric examination or treatment (although there would need to be consent). It may also say that the child should take part in particular activities at specified times.

The Order can be stopped if any interested parties apply to the Court and the Court agrees, or if a Care Order is made.

**Section s20 Voluntary Care**

Some children are looked after by the Local Authority by agreement with, or at the request of, their parents. The parents retain parental responsibility (the Local Authority have no parental responsibility). Under Section 20 of the Children Act, it is the duty of all Local Authorities to make accommodation available for such children in need. Children may be accommodated (in residential or foster care) for a short or longer period. No court proceedings are involved, and the parents retain full parental responsibility.

**Section s43 Child Assessment Order**

A Child Assessment Order is available for the Local Authorities to apply when leading an investigation into the welfare, health and development of a child. Usually used when either a Local Authority or the NHS cannot gain access to a child.

When a Local Authority or an authorised person makes an application for an order to be made under this section with regards to the welfare of the child in question, the court may make an order, if, and only if, it is satisfied that:

- The applicant has reasonable cause to suspect that the child is currently suffering or likely to suffer significant harm
- An assessment of the child’s welfare, health and development and treatment they receive day-to-day, is needed to allow the applicant to make a decision as to whether or not the child in question is suffering or likely to suffer any harm in the future

It is very unlikely that a Child Assessment Order will be requested without the application for a further order by the court.

The Child Assessment Order is most commonly used and most appropriate where the harm suffered by the child is long term and collective rather than harm that is sudden and severe.

**Effects of a Child Assessment Order**

Where a Child Assessment Order has been granted by the courts and then becomes the duty of the person in a position to produce the child, named in the order and to comply with
such directions relating to the assessment of the child as the court believes is appropriate to specifically name in the Child Assessment Order.

A Child Assessment Order authorizes any person carrying out the child assessment, or any specific part of the assessment order, to do so in accordance with the terms and conditions of the order.

If the child who is subject to the Child Assessment Order is of sufficient understanding to make an appropriate informed decision he may refuse to submit to a medical or psychiatric examination or any other assessment.

This appears to give the child absolute refusal and control over their treatment. However, this does not rule out the court’s ability to override a child’s decision not to consent to treatment, if they feel it is necessary for the child’s welfare for the appropriate tests to be carried out.

Duration of a Child Assessment Order

The maximum duration of a Child Assessment Order is seven days from the date specified in the order with no power of extension.

This gives the local authorities very little time to make their enquiries and so must be very well prepared before the commencing date in order to obtain all the appropriate correct information.

No further application for a child assessment may be made within six months of the disposal of the previous Child Assessment Order without the leave of the court.

Section s44 Emergency Protection

The reason for an Emergency Protection Order is to enable a child in a genuine emergency to be removed from where he is, or be kept where he is, depending on the given circumstances in order to provide short-term protection.

The Emergency Protection Order is an extremely serious step which should not be taken lightly or regarded as a routine step in family law proceedings for the protection of children.

Where any person applies to the court for an Emergency Protection Order to be made under this section, with respect to a child, the court may make the order if and only if they are satisfied that that:

- There is reasonable cause to believe that the child is likely to suffer significant harm if not removed and taken to new accommodation provided by or on behalf of the
applicant, or if he does not remain in the accommodation where he is being provided
treatment.

• Or where an application is made by a local authority or for instance NSPCC, and there
are enquiries being made with regards to the child’s welfare and these enquiries are
being aggravated by access to the child being unreasonable refused to the authorized
person who is conducting the enquiries and that this person believes that the access to
the child is a matter of urgency.

Effects of an Emergency Protection Order

• While an Emergency Protection Order is in place it operates as a direction/ order to any
person who is in a position to do so to comply with any requests to produce the child to
the person in authority.
• The Emergency Protection Order authorises the removal of the child at any time to
accommodation that is provided by or on behalf of the applicant and the child must be
kept there.
• The order also authorises the prevention of the child’s removal from any hospital or
place the child may be receiving treatment.
• An Emergency Protection Order also gives the applicant parental responsibility for the
child concerned.
• The applicant who receives parental responsibility through the use of an Emergency
Protection Order must only exercise their parental responsibilities as so far as it is for
the protection of the child’s welfare.
• Where the person holding parental responsibility is required to return the child, he shall
do so either to the person from whose care the child was removed or if that is not
reasonably practical they must return him to the care of his parents, any person who
may not be a parent but holds parental responsibility, or such persons the courts
consider appropriate.

Duration of an Emergency Protection Order

• The maximum duration of an Emergency Protection Order is eight days. Where the
person who applied for the Emergency Protection Order is the local authority or the
NSPCC, a limited extension for a further seven days may be granted. Only one extension
is permitted.
• There may be an application made for the discharge of the Emergency Protection order.
This application for discharge may be brought by the child, the parents, persons with
parental responsibility and any person whom the child was living with immediately prior
to the execution of the Emergency Protection Order.
• This discharge cannot be applied for within the first 72 hours following the
establishment of the order.
Can the Alleged Abuser be Removed Instead?

Originally, The Children’s Act 1989 did not provide any provisions for the removal of the alleged abuser instead of the child and many local authorities tried to bring actions of this nature, all of which were unsuccessful.

The Family Law Act 1996 amended the Children’s act 1989 to include the exclusion requirement within the Emergency Protection Order.

An exclusion requirement is any one of the following:

- A provision requiring the relevant person to leave the dwelling house in which they live with the child who is subject to the Emergency Protection Order.
- A provision prohibiting the relevant person from entering a dwelling house in which the child who is subject to the Emergency Protection Order lives.
- A provision excluding the relevant persons from a specified area in which the dwelling house of the person subject to the Emergency Protection Order is located.

Section s46 Police Protection

If a police constable believes that a child is at risk of suffering significant harm in a particular situation then he may exercise powers under this Act to remove the child to suitable accommodation or if the child is in hospital or in a place of safety, take steps to keep the child there. A child cannot be kept in police protection for more than 72 hours.

There is no right of appeal against police protection powers being exercised. It is not an Order. Parents have to be informed of where the child is placed.

This is seen as Draconian action that should only be used in exceptional circumstances where there has been insufficient time in which to seek an Emergency Protection Order.

Section s47 Duty to Protect (investigate child protection)

Where a Local Authority have reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer significant harm, the Authority shall make, or cause to have made, such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child’s welfare.

Under the legislation the NHS have a ‘duty to cooperate’ with the Local Authority when they are conducting s47 enquiries by sharing relevant information in a timely fashion. This relates to information regarding the child and information that may be held in respect of an adult which may mean that a child is at risk from that adult.
Threshold for a Referral to Social Care

Please refer to the ‘Multi-agency Guidance on Threshold Criteria to help support Children, Young People and their Families in Shropshire’ and the Shropshire’s Safeguarding Children Board (SSCB) website:
http://westmerciaconsortium.proceduresonline.com/pdfs/shrop_thresh_crit.pdf

http://www.safeguardingshopshireschildren.org.uk/scb/index.html

Mental Capacity Act 2005

This Act provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they may lack capacity in the future. It sets out who can take decisions, in which situations, and how they should go about this. The Act covers young people from the age of 16 years through adulthood.

What is mental capacity?
Mental capacity is the ability to make a decision.

• This includes the ability to make a decision that affects daily life – such as when to get up, what to wear or whether to go to the doctor when feeling ill – as well as more serious or significant decisions.
• It also refers to a person’s ability to make a decision that may have legal consequences – for them or others. Examples include agreeing to have medical treatment, buying goods or making a will.

The starting point must always be to assume that a person has the capacity to make a specific decision. Some people may need help to be able to make or communicate a decision, but this does not necessarily mean that they lack capacity to do so. What matters is their ability to carry out the processes involved in making the decision – and not the outcome.

What does the Act mean by ‘lack of capacity’?
Section 2(1) of the Act states:
‘For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.’

This means that a person lacks capacity if:

• they have an impairment or disturbance (for example, a disability, condition or trauma) that affects the way their mind or brain works, and
• the impairment or disturbance means that they are unable to make a specific decision at the time it needs to be made.
An assessment of a person’s capacity must be based on their ability to make a specific decision at the time it needs to be made, and not their ability to make decisions in general. Section 3 of the Act defines what it means to be unable to make a decision.

Section 2(2) states that the impairment or disturbance does not have to be permanent. A person can lack capacity to make a decision at the time it needs to be made even if:

- the loss of capacity is partial
- the loss of capacity is temporary
- their capacity changes over time.

A person may also lack capacity to make a decision about one issue but not about others.

**Assessing Capacity**

Anyone assessing someone’s capacity to make a decision for themselves should use the two-stage test of capacity:

- Does the person have an impairment of the mind or brain, or is there some sort of disturbance affecting the way their mind or brain works? (It doesn’t matter whether the impairment or disturbance is temporary or permanent.)
- If so, does that impairment or disturbance mean that the person is unable to make the decision in question at the time it needs to be made?

A person is unable to make a decision if they cannot:

1. understand information about the decision to be made (the Act calls this ‘relevant information’)
2. retain that information in their mind
3. use or weigh that information as part of the decision-making process, or
4. communicate their decision (by talking, using sign language or any other means)

**Assessing an Individual’s Ability to Make a Decision**

- Does the person have a general understanding of what decision they need to make and why they need to make it?
- Does the person have a general understanding of the likely consequences of making, or not making, this decision?
- Is the person able to understand, retain, use and weigh up the information relevant to this decision?
- Can the person communicate their decision (by talking, using sign language or any other means)? Would the services of a professional (such as a speech and language therapist) be helpful?
Early Help

(www.shropshire.gov.uk/early-help/early-help-forms/)

Providing early help is more effective in promoting the welfare of children than reacting later.

- Early help means providing support as soon as a problem emerges, at any point in a child’s life, from the mother’s pregnancy (help for the unborn child) through to the teenage years.
- Early sharing of information is the key to providing effective early help.

Clinical commissioning groups and the NHS are subject to Section 10 of the Children Act 2004, hence so are GPs who have an important role in identifying families where issues are emerging and ensuring that they are given the support within primary care if possible or encouraged to access help – this could be through the Health Visitor, School Nurse or local services such as Children’s Centres.

Alerting Factors

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

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

Effective early help relies upon local agencies working together to:

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

COMPASS

This is the single point of coordination into Shropshire Children’s Services at an Early Help level. Compass helps to coordinate existing Early Help pathways. It does not replace them. Compass is working collaboratively with Shropshire Clinical Commissioning Group and
Shropshire Community Health NHS Trust to design and deliver a new single point of coordination into Shropshire Children Services. The aim is to make accessing support from children’s services simple, easy and clear. Compass will also provide a single point of contact for professionals to obtain advice and support.

Compass uses an integrated team approach with CAMHS senior primary mental health practitioners, Early Help social workers, Early Help targeted youth workers and the Family Information Service co-located to triage cases on a daily basis to progress support.

Professionals can call Compass on 0345 678 9021 for:

• information and guidance (including support with the Early Help process and how to access Early Help tools, resources and training)
• finding out if anyone has recorded that they have done an assessment and provided Early Help to a child/young person
• seeking a consultation with an Early Help social worker or primary mental health worker

All professionals completing Early Help forms are required to provide copies to Compass so that the information can be recorded and shared as appropriate. Forms that need to be recorded (with consent) are:

• Early Help Webstar assessment - at start and end of an early help episode
• Early Help assessment (EHAF) (or other appropriate assessment when making a referral for targeted early help agencies)
• Early Help review plan
• Early Help closure form
• Early Help referral form
• outcome evaluation of positive family life

Professionals can make requests for targeted Early Help support by sending a completed Early Help referral form to us at the address below.

All referrals must be accompanied by evidence of need that cannot be met by universal services (e.g. Early Help Webstar, self-harm risk assessment, Early Help assessment EHAF, SPECTRA) or programmes.

Requests relating to child and adolescent mental health that would have previously been referred to CAMHS will now be coordinated at Compass. Use the Early Help referral form to access Tier 2 CAMHS.
Compass will help to ensure that children and young people in Shropshire with a range of needs, including mental health issues, receive appropriate and timely support, suitable to their level of need.

Please note: The process for making safeguarding referrals and obtaining emergency help for children and young people experiencing mental ill health is unchanged.

If you have any queries regarding Compass, please contact earlyhelp@shropshire.gov.uk

Compass
Shropshire Council
Mount McKinley
Anchorage Avenue
Shrewsbury Business Park
Shrewsbury
SY2 6FG

**Child in Need**

Section 17 of the Children Act 1989 (see legislation section) defines a child as being in need in law if:

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

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

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

**The GP Role in Helping the Child in Need**

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

GPs are able to identify and refer children in need of more than one service using Compass and will be expected if required to contribute to the child in need referral process by
supplying medical information about the child and if relevant the parents or carers; and participating in the team around the child and/or family where there are health needs requiring Primary Care input. See also Working Together to Safeguard Children 2015.

This is used to develop an action plan and coordinate service delivery. If health needs are identified the GP will be expected to be part of the Team Around the Child or Team Around the Family and to review and monitor progress at regular intervals to ensure management of health conditions is effective and responsive to the child’s changing needs as s/he grows and matures. Effective communication and collaboration with the child, family and other service providers is essential, as is preparation for transition to adult services and support during the process.

**Think Family**

Families have a range of needs and from time to time will require support or services to help meet them. Difficulties that impact on one family member will inevitably have a knock on effect on other family members.

For this reason all practitioners should ‘Think Family’. In a system that ‘thinks family’ both adults and children’s services should:

- Have no ‘wrong door’.
- Look at the whole family.
- Build on family strengths.
- Provide support tailored to need.

Individual practitioners working with either children or adults or both should:

- Ensure you know who has parental responsibility.
- Know who is living with the child/children.
- Consider the involvement, potential contribution and (when appropriate) the risks associated with all the adults who have a significant influence on a family, even if they are not living in the same house, or are not formally a family member.
- Have ready access to information to enable practitioners to consider impact of parents’/carers’ condition, behaviour, family functioning and parenting capacity.
- Identify and provide responsive services for families that are family focussed.

**Always prioritise the safety and welfare of children within a family.**

**The GP Consultation**

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

Training emphases trust of parents’ accounts, the parent usually knows his or her child better than anybody. However, this is not always the case.

The GP also needs to assess whether parents have the capacity to keep their child, or indeed anyone else, in mind. A more investigatory professional curiosity is useful to assess whether the history matches the presentation. The doctor needs to take heed of any uncomfortable feelings he may have about the parent child interaction, or young person’s behaviour and learn to interpret what that might signify.

If a child discloses listen to the child, letting them explain what happened in his or her own words. Don’t stop your child in the middle of the story to go get someone or do something else. Limit questioning to only the following four questions if the child has not already provided you with the information:
• What happened?
• When did it happen?
• Where did it happen?
• Who did it?
• How do you know them? (If the relationship of the abuser is unclear)

It is be helpful to write down exact quotes of what the child said for the benefit of Court appearances.

If the abuse meets the threshold document (see below) then refer to social services; if it does not it is important to know where the child can access ongoing therapy, and parents or carers can obtain help and support to meet the child’s needs.

http://westmerciaconsortium.proceduresonline.com/pdfs/shrop_thresh_crit.pdf

Fabricated and Induced Illness (FII)

NB Parents will have a prepared story.

Understanding Fabricated or Induced Illness; the defining characteristics of fabricated or induced illness are:
• Illness in a child which is fabricated or induced by a parent or a carer
• A child is presented for medical assessment and care usually persistently often resulting in multiple medical procedures
• The perpetrator often denies the aetiology (explanation of the cause ) of the child’s illness
• Acute symptoms and signs cease when the child is separated from the perpetrator. It is important to be aware that FII is only one manifestation on the spectrum of child abuse. Risk factors for abuse may be indicators of FII as much as any other forms of abuse.

The methods of inducing illness are:
• Minor injury to the child to produce falsified specimens
• Poisoning with a range of prescribed or non-prescribed substances. Included in this is excessive manipulation of prescribed drugs (both under and over administrations) such that harm to the child occurs
• A direct injury to the child, including administration of substances through portals of entry to the body such as intravenous cannulae
• Suffocation.

Category

Warning Signs of Fabricated or Induced Illness
• Reported symptoms and signs found on examination are not explained by any medical condition from which the child may be suffering.
• Physical examination and results of medical investigations do not explain reported symptoms and signs.
• There is an inexplicably poor response to prescribed medication and other treatment.
• New symptoms are reported on resolution of previous ones.
• Reported symptoms and found signs are not seen to begin in the absence of the carer.
• The child’s normal, daily life activities are being curtailed beyond that which might be expected for any medical disorder from which the child is known to suffer.
• Over time the child is repeatedly presented with a range of signs and symptoms.
• History of explained illnesses or deaths or multiple surgery in parents or siblings of the family.
• Once the perpetrator’s access to the child is restricted, signs and symptoms fade and eventually disappear (similar to category 5 above).
• Exaggerated catastrophes or fabricated bereavements and other extended family problems are reported.
• Incongruity between the seriousness of the story and the actions of the parents.
• Erroneous or misleading information provided by parent.

Should a practice have concerns that a child is being subjected to FII, a referral to Children’s Social Care must be made.
Domestic Abuse

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

This can encompass, but is not limited to, the following types of abuse:
• psychological
• physical
• sexual
• financial
• emotional

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

‘Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.’

Children may be at risk of suffering long-term psychological and emotional damage as a result of witnessing the abuse, experiencing the stress and tensions of living in an environment where the likelihood of abuse is ever present or becoming actual victims of violence and abuse.

Witnessing abuse may have the effect of teaching children that abuse is a legitimate response to problems, and a means of maintaining control over other people in intimate or family relationships. Abuse often continues after a couple have separated, especially at times of contact arrangements with the parent with whom the children do not live. Healthcare professionals need to be alert to the symptoms of domestic abuse and women should be given the opportunity to disclose domestic abuse in an environment in which they feel secure. (NICE 2003).

All members of staff need to be aware of the frequent inter-relationship between domestic violence and the abuse and neglect of children. Where there is evidence of domestic violence, the implications for any children living in the household should be considered, including the possibility that the children may themselves be subject to violence or other harm. Children and young people need to be safe physically and emotionally. In all cases of domestic abuse consideration must be given to need to make a referral to Compass
Disclosure of Abuse

In 2013 the NSPCC conducted research (‘No one noticed, no one heard’) describing the childhood experience of abuse of young men and women and how they disclosed this abuse and sought help.

Researchers interviewed 60 young adults (aged 18-24 years) who had experienced high levels of different types of abuse and violence during childhood. The young adults were asked whether they had tried to tell anyone about what was happening to them, and what had happened as a result of their disclosures, over 80% had tried to tell someone about the abuse.

Types of Disclosure: Disclosures can be direct or indirect. Most likely a disclosure will be indirect, which can mean the child does not share the details of the abuse without being prompted, or does so in a round-about way. An example of this is, “Sometimes my step-dad keeps me up at night.” A disclosure can also be disguised, for example: “I have a cousin who is being abused.” In other cases the disclosure can be through hints or gestures, or even through another child “My friend told me...” The child is hoping that a caring parent or caregiver will get the ‘hint’ they are offering.

Recognize the Clues: It is important to recognize the possible clues so that further questions are asked. Most children who disclose want the abuse to stop. When the disclosure is ‘missed’ they may continue with additional hints, or not.

Information Sharing

GPs have a responsibility for raising concerns, sharing information, and working together with statutory agencies to contribute to the ‘early help’, ‘child protection’ and ‘child in need’ processes.

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

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

It is critical that where you have reasonable cause to believe that a child or young person may be suffering or may be at risk of suffering significant harm, you should always refer your concerns to Children’s Wellbeing (social care within the MASH) or the West Mercia Police.

4 http://www.nspcc.org.uk/services-and-resources/research-and-resources/no-one-noticed-no-one-heard/
The Department of Health ‘Information Sharing’ (2015) provides advice on sharing information:

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

NB Don’t forget a child’s safety is always paramount under the law. If you receive information from an adult patient which you think may put a child’s welfare at risk, the child’s safety overshadows the adult’s rights to confidentiality.

7 Golden Rules for Information Sharing

1. Remember that the Data Protection Act is not a barrier to sharing information but provides a framework to ensure that personal information about living persons is shared appropriately.

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

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

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

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

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

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

If in doubt pick up the phone and ask.

**What to do if a Request for Information is Received**

As a general rule in safeguarding children, **consent is not required for Section 47 referrals** where a child is considered at risk or is thought to have suffered significant harm. Nevertheless if undertaking a referral to social services, consent should be sought unless to do so would increase harm to the child. If social services request information then this should be provided for all section 47 and section 17 referrals.

Section 17 referrals are usually made with parent/carer consent **but consent is not required** in cases where failure to share information could result in the situation deteriorating. However for Early Help, **consent would be required** unless failure to provide early help would result in risk or harm to child.

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

- Confirm the identity of the requestor and *bona fide* nature of the information requested. This should usually be in writing and should include some information on why the request is being made.
- Confirm whether you hold any information on the patient.
- Consult the ‘Seven Golden Rules of Information Sharing’.

**Referral to Social Care: the Child at Risk of Significant Harm and the Child in need of protection**

Clinicians need to have courage.

GPs have a responsibility to refer a child to Children’s Social Care under Section 47 of the Children Act 1989 when it is believed or suspected that a child has suffered *significant harm* and /or is likely to suffer *significant harm*. 
Commonly encountered parental risk factors for child maltreatment are domestic abuse, substance misuse, and mental health problems.

If there is risk that the parent or carer might refuse to permit treatment or abscond with the child, the Police will have to be notified.

If a child is found to be suffering from an apparently serious injury or illness, a referral must be made immediately to both social service and Police. Also an acute paediatric service may be called; normally this would be Princess Royal Hospital, Telford (see flow chart below)

For all referrals a follow up must be made to ensure the child/ren have arrived safety at the medical review. In some cases Police will be called to escort the child/ren and family to the medical to ensure this occurs.

Note: Infants under 12 months old are at increased risk of non-accidental injury – remember when examining an infant that “those who can’t cruise rarely bruise” and a small apparently insignificant bruise in a baby might be a marker for serious life-threatening injury. Note if the Child is at a GP surgery consideration to ringing the police to ensure the child’s safety is maintained must also be considered.

Advice for GPs for Child Protection Interactions with a Social Worker

This guidance has been produced to help structure the interactions that occur when a Social Worker rings a GP for information about a child or family. It has been produced after consulting the GMC booklet entitled ‘0-18 Years: Guidance for all doctors’\(^5\) (paragraphs 56-63). The MDU has helped in its creation to provide support its members on this topic. The RCGP Child Safeguarding Group has also contributed to its content. Below are the points that should be covered in any interaction.

1. What is the information that has led to the Social Worker involvement and exactly what is the Social Worker asking you to divulge? The GP needs to know this to give them enough information to decide whether release of information without consent is justifiable.

2. Is the Social Worker conducting an initial assessment investigation which is a general enquiry, or a Section 47 investigation which is based upon a significant safeguarding concern in which case share information and document in records?

\(^5\) http://www.gmc-uk.org/guidance/ethical_guidance/children_guidance_index.asp
3. Can the Social Worker provide written consent of either the adult whose records are being requested, or a person with parental responsibility, where a child’s records are requested? Has any Child under 16, who may have maturity to give consent, provided consent for sharing of their records?

4. What is the name and job title of the person you are releasing the information to and have you taken reasonable steps to confirm that they are the person that they say they are?

5. Does gaining consent put the child at risk, or risk gathering evidence for the investigation?

6. When no consent has been provided, have you shared proportionately and relevantly to the concern explained to you, justifying why you should not gain consent first?

7. Will release of the information change the actions of the social worker?

8. In the event consent is refused by the subject, or carer of the child, but you feel information needs to be shared to protect a child, have they been advised what information has been released and why?

9. What will happen now and how will you be notified of the outcome of the investigation?

10. Have you reviewed all the notes of individuals in the family home?

11. As an issue for your practice, does this case need to be reviewed in the GP-HV safeguarding meeting or with other members of the team?

We have received some feedback from Compass regarding the quality of referrals into Social Care. As you are aware from the recent safeguarding forums the number of referrals into Social Services has escalated and as such they have asked all agencies to ensure that referrals are filled out correctly.

<table>
<thead>
<tr>
<th>Issue</th>
<th>Remedy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incorrect referral forms being used.</td>
<td>New form being devised to allow for electronic referral and in multi-agency training</td>
</tr>
<tr>
<td>Important personal information not always included</td>
<td>Next of kin family dynamic and actual concern of a child safety for example not taking medication and this will lead to…. Or Family have a chaotic lifestyle take drugs and child has poor attendance at school and fails to turn up for immunisations and has poor</td>
</tr>
</tbody>
</table>
The reason for the referral, concerns and risks not being articulated clearly. | See above
---|---
The child/young person’s protective factors not identified | Please indicate any protective factors you think appropriate e.g.
Is in nursery at “xxxxxxx”
Is at school and attends xxxxxx primary/secondary school

Safeguarding and other agency concerns not included with referral information. | Please include any information discussed at Muilt agency meeting or team meetings or with a child’s teacher/adult’s mental health team etc.

Telephone calls not received in a timely manner or not called back | New form designed but can still use telephone agree time to ring back if concerned, for example I am in clinic until xxx so can a social worker ring between .......

Action Following Referral

- Lateral checks – Multi Agency Safeguarding Hub are carried out
- GPs may be contacted during these enquiries, please cooperate
- Strategy Discussion may be instigated and GPs asked to attend or provide information. Note: HV or School Nurse would normally attend and GPs can liaise with these services to ensure right information is present
- GPs can sometimes request for phone conference or video conference to attend if required
- Medical Examination if required
- Investigation may be a S17 or S47
- Referrals can be down-graded or upgraded depending on the information gathered
- Child Protection Conference – outcome child could be subject to a child protection plan – first review within three months then six monthly if they remain on a plan. Regular Core Groups to make sure the plan is improving the child’s life, if not either alter the plan or if case drifting re-call case conference.
Resolving Professional Differences

Occasionally situations arise when workers within one agency/professional feels that the decision made by a worker from another agency on a child protection or child in need case is not a safe decision. The safety of individual children is the paramount consideration in any professional disagreement and any unresolved issues should be addressed with due consideration to the risks that might exist for the child.

All professionals should feel able to challenge decision-making and to see this as their right and responsibility in order to promote the best multi-agency safeguarding practice. The procedure can be accessed under:
http://westmerciaconsortium.proceduresonline.com/chapters/p_res_prof_dis.html

These Steps to Safeguarding provides a means to raise concerns about decisions made by other professionals or agencies by:

a) Avoiding professional disputes that put children at risk or obscure the focus on the child
b) Resolving the difficulties within and between agencies quickly and openly
c) Effective working together depends on an open approach and honest relationships between agencies. Problem resolution is an integral part of professional co-operation and joint working to safeguard children.

Vulnerable Groups of Children

Children with Disabilities
The available UK evidence suggests that disabled children are at increased risk of abuse, and that the presence of multiple disabilities appears to increase the risk of both abuse and neglect.

Disabled children may be especially vulnerable to abuse for a number of reasons:
- Increased risk of being socially isolated with fewer outside contacts than non-disabled children
- Their dependency on parents and carers for practical assistance in daily living, including intimate personal care, increases their risk of exposure to abusive behaviour
- They have an impaired capacity to resist or avoid abuse.

Safeguards for disabled children are essentially the same as for non-disabled children.

Privately Fostered Children
Privately fostering is when a child under the age of 16 (18 if disabled) is looked after by somebody who is not their parent or a close relative. This is a private agreement between
the parent and carer which extends for 28 days or more. Close relative is a grandparent, step parent, brother, sister, aunt or uncle.

Parents and private foster carers are legally required to notify their local authority of each instance of private fostering.

Professionals who incidentally become aware of private fostering arrangements have a duty to report this to the Local Authority so that the child’s circumstances can be investigated and their safety and well-being assured.

When a healthcare professional is aware that a child is privately fostered they should:

- Inform the parents of their duty to notify the receiving authority’s children’s social care team (and notify Compass).
- Encourage the parents to share information (regarding foster carer’s address) prior to any move.
- Advise parents to transfer the child’s red book, NHS card and relevant health information to new carer.
- Ensure that any private foster carer is aware of their responsibility to notify Compass of the arrangements.

Children who are Home-Educated
Many families prefer to educate their children at home and it is their right under UK law to do so. Home educating families do not have to follow the National Curriculum and are not subject to regulation or inspection in the same way as schools.

While most home-educated children live happy fulfilled lives, some are socially isolated and ‘hidden’ from view.

GPs and their teams may be the only professionals with whom such children may have contact and therefore should be vigilant when they are seen and be alert for signs of abuse and/or neglect.

Children who go missing from Home/Care
The terms ‘young runaway’ and ‘missing’ in this context refer to children and young people up to the age of 18 years who have run away from their home or care placement, have been forced to leave, or whose whereabouts are unknown.

Children who decide to run away are unhappy, vulnerable and in danger.

As well as short term risks to their immediate safety there are longer term implications as well with children and young people who run away being less likely to fulfil their potential and live happy, healthy and economically productive lives as adults.
Children at risk of Sexual Exploitation (see page 42 for more information)
Children and young people who are sexually exploited are the victims of child sexual abuse, and their needs require careful assessment. This group may include children who have been sexually abused through the misuse of technology, coerced into sexual activity by criminal gangs or the victim of trafficking. The strong links that have been identified between different forms of sexual exploitation, running away from home, gang activity, child trafficking and substance misuse should be borne in mind especially when seeing unaccompanied children, temporary residents or those new to the Practice.

Trafficked Children
Children and young people can be trafficked for various reasons, including sexual exploitation, forced labour, domestic servitude, criminal activities, benefit fraud, organ harvesting or illegal adoption.

Unaccompanied Asylum Seeking Children (UASC)
These are ‘children who are under 18 years of age who have been separated from their parents and who are not being cared for by an adult who by law or custom has the responsibility to do so’ (UNHCR, 1994).

In June 2003 guidance was issued that stated where children seeking asylum are alone the ‘presumption should be that they fall into Section 20 of the Children Act’ (DH, 2003).

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

Female Genital Mutilation
Female genital mutilation (sometimes referred to as female circumcision) refers to procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons. The practice is illegal in the UK. If you are worried about someone who is at risk of FGM or has had FGM, you must share this information with social care or the police. New measures aimed at bringing an end to female genital mutilation (FGM) in the UK were announced in February 2015. These new measures included new mandatory recording requirements for GPs and mental health trusts, requiring them to record FGM incidence by October 2015.

Collection and submission of the new dataset became mandatory for all acute trusts from 1 June 2015, and all GPs and mental health trusts from 1 October 2015.
GPs, acute and mental health trusts in England can register to participate by completing the User Registration Form found under User Documents to the right of the page at www.hscic.gov.uk/fgm

Forced Marriage
A forced marriage is where one or both people do not (or in cases of people with learning disabilities, cannot) consent to the marriage and pressure or abuse is used. The Anti-social Behaviour, Crime and Policing Act 2014 makes it a criminal offence to force someone to marry.

No Access, Child not brought to Appointments and/ or The Unseen Child
All children and young people have the right to good health care and the opportunity to maximise their well-being. General practice therefore needs to ensure that every child and their carer are made aware of the range of services that they may need or are entitled to access. This right to good health care needs to be balanced with the wishes and feelings of the parents or carers and their right to choose to take up health services.

General practice has a duty to safeguard and promote the welfare of children and young people. This policy provides a framework to assess, identify and action any concerns, which may feature either when health professionals cannot gain access to the child/children in the home or the child/children fails to attend healthcare appointments.

Essentials Aspects of Decision Making / Risk Assessments
The health professional should consider the following questions when assessing risk:

- Does the no access visit / to the child raise concern for their safety or welfare?
- Has the child/young person a long term condition which may mean heightened risks due to missed appointments
- Have previous concerns been identified by agencies which involved the family receiving a support package?
- Is the child currently on the child protection register? (in which case inform the social worker of all missed appointments)
- Has the child been recently removed from the child protection register?
- Have there been any concerns regarding violence between family members?
Consider whether the child/young person may be at risk of significant harm and if so, refer to Compass.

Child Protection Conferences

The aim of a case conference is to enable those professionals most involved with the child and family, and the family themselves, to assess all relevant information and plan how to safeguard the child and promote his or her welfare.

There are three strands to a case conference; to:

- Bring together and analyse in an inter-agency setting the information which has been obtained about the child’s health, development and functioning, and the parents’ or carers’ capacity to ensure the child’s safety and promote the child’s health and development within the context of their wider family and environment.
- Consider the evidence presented to the conference, make judgments about the likelihood of a child suffering significant harm in future, and decide whether the child is at continuing risk of significant harm; and
- Decide what action is needed to safeguard the child and promote his or her welfare, how that action will be taken forward, and with what intended outcomes.

Adequate time should be taken by staff to prepare for any conference and ensure an up to date knowledge of child protection procedures in relation to their role. Staff should identify any gaps in their information and liaise with appropriate colleagues prior to the conference to ensure their knowledge is up to date.

It is expected practice to provide a written report to the conference. The report should be submitted to the chair of the conference at least 3 working days prior to the conference. The author of the report should ensure that the parents/carers (and child dependent on age) read the report prior to submission.

Please be aware that any reports may be used in future court action.

The conference should consider if the child is at continuing risk of significant harm, safeguarding the child will therefore require inter-agency help and intervention, delivered through a formal child protection plan. If a child protection plan is deemed necessary it is the role of the conference to formulation the plan, in as much detail as possible.

The test for determining significant harm should be that either:

- The child can be shown to have suffered ill-treatment or impairment of health or development as a result of physical, emotional, or sexual abuse or neglect, and professional judgement is that further ill-treatment or impairment are likely; or
- Professional judgement, substantiated by findings of enquiries in this individual case or by research evidence, is that the child is likely to suffer ill-treatment or the impairment of health or development as a result of physical, emotional, or sexual abuse or neglect.

**Categories of Abuse**

**Physical Abuse**

- Hitting, Shaking, Throwing, Biting,
- Burning, Scalding
- Poisoning, Drowning, Suffocating.
- Causing physical harm to a child.
- **Bruising/injury in < 6months or non mobile child must always be regarded as suspicious.**

Accidental Injuries occur on bony parts of the body

- Knees, shins, elbows and forehead
Sexual Abuse

- Non-contact activities e.g. looking at or involvement in the production of pornographic material.
- Forcing or enticing a child to take part in sexual activities even if not aware of what is happening, grooming.
- Encouraging children to behave in sexually inappropriate ways.
- Non-penetrative, as well as penetrative acts.

- Is the presenting behaviour consensual for all children or young people involved?
- Is the behaviour reflective of natural curiosity or experimentation?
- Is the behaviour unusual for the child or young person?
- Does the behaviour involve children or young people of a similar age or developmental ability?
- Is the behaviour occurring in a public or private space? How does this affect the colour categorisation?
- Is the behaviour excessive, coercive, degrading or threatening?
- Are other children or young people showing signs of alarm or distress as a result of the behaviour?

Use the Brook Traffic Light system toolkit to help support your decision.

Neglect

- Persistent failure to meet child’s basic physical and/or psychological needs.
• Likely to result in serious impairment of health or development.
• Failure to provide adequate food, shelter and clothing or protection from physical harm or danger.
• Failure to access medical care or treatment.

Emotional Abuse

• Persistent emotional ill-treatment of a child.
• Child made to feel unloved, inadequate, worthless or rejected.
• Involves conveying to a child that they are loved only insofar as they meet the needs of another person.
• Child made to feel frightened or in danger.
• Developmentally – inappropriate expectations (carers).

Working with Sexually Active Young People under the Age of 16 years (including Child Sexual Exploitation CSE)

This is designed to assist Primary Care Professionals understand CSE and to identify where young people are being exploited in a sexual manner and the young person may need the provision of extra support or protection. This is based on the principle enshrined in the Children Act 1989 that the welfare of the child is paramount and it emphasises the need to be robust in assessing the likelihood of significant harm when a young person is engaged in a sexual relationship.

Account must be taken of the recommendation in the Bichard Inquiry Report (HMSO 2004) that all suspected criminal activities should be reported to the Police and the Sexual Offences Act 2003 (children under the age of 13 are not considered competent to give
consent to sexual activity, sexual activity involving a child under the age of 13 years constitutes a ‘serious arrestable offence’).

The initial assessment of a young person involved in or at risk of sexual abuse should focus upon the effects upon the young person’s emotional, physical and sexual health, their educational needs, their relationship with their parents/carers and any relationship with the sexual partners.

Age is but one factor, which Primary Care need to consider in the assessment process.

The purpose of the assessment is to:
- Establish what needs the young person may have (including the need for protection),
- Establish whether the young person is engaged in an exploitative relationship,
- Record any disclosed information to support any future Police action

In determining whether a relationship presents a risk of harm to a young person, the following factors should be considered:
- The age of the young person and whether they are deemed competent to consent to the sexual act (see below consideration for making a referral to another agency).
- What are the young person’s living conditions?
- Is the young person attending school?
- Is the young person involved in a sexual relationship where there is an age/power imbalance? (see below)
- Is there any information regarding either partner that would lead you to have concerns that they were involved in a sexual relationship with a young person, e.g. a history of previous offences of a sexual nature or a history of sexual exploitation?
- Does the relationship mean that the young person is spending increasing amounts of time away from their home/carers?
- Has the relationship become more important than family, friends, school and other interests?
- Is there a concern that the young person is engaging in sexual activity for reward, which could take the form of money, clothes, jewellery or drugs?
- Have concerns been expressed that the young person is in possession of sums of money that cannot be accounted for?
- Have concerns been expressed that different older men/women are contacting the young person either in person or by calling on the home land line or mobile phone?
- Is the young person staying out regularly until the early hours of the morning/ going missing from home without the parents/carers knowing of their whereabouts?
- Is there any attempt to secure secrecy by the sexual partner beyond what would be considered usual in a teenage relationship?
• Is the young person’s own behaviour, for example through the use of alcohol or drugs, putting them at risk due to the inability to making informed choices?

Power Imbalances
Sexual abuse and the exploitation of a child or young person always involve an imbalance of power. The assessment should seek to identify possible power imbalances within a relationship, these can result from differences in size, age, material wealth and/or psychological, social and physical development. In addition gender, sexuality, sexuality, race and levels of sexual knowledge can be used to exert power.

Support by a group of peers can exert a tremendous pressure on a female to engage in a sexual activity. The opposite is also true where a group of females can exert such power over a male. A power imbalance may also occur where one partner holds in a position of trust over the other individual (e.g. a 16 year old young person and a 23 year old teacher).

Care needs to be exercised when assessing the risks posed to a young person with a disability. The disability may mean that the young person is vulnerable due to physical dependency, the need for intimate care and a language or learning disability may mean that it is not easy to communicate their wishes to another person. However, respect needs to be given to the disabled young person’s wishes to engage in a sexual relationship if the relationship is not deemed to be of a concerning nature.

Consent and Confidentiality
Any competent young person in the United Kingdom can consent to medical, surgical or nursing treatment, including contraception and sexual/reproductive health.

A young person is said to be competent if they are capable of fully understanding the nature and possible consequences of the treatment. Consent from parents/carers is not legally necessary, although the involvement of parents is encouraged.

Young people (aged 13 plus as legally young people under the age of 13 years are unable to consent) are owed the same duties of care and confidentiality as adults. However, confidentiality may be broken when the health, safety or welfare of the young person, or others, would otherwise be at risk.

The first duty of every professional is to safeguard and promote the welfare of the child and young person and young people who may be involved in the sexual relationship. It must always be made clear to young people at the earliest opportunity and throughout any working relationship that the duty of confidence is not absolute, and that there may be some circumstances where the needs of the client/service user or other young people can only be safeguarded by sharing information with other agencies on a need to know basis.
Decisions to share information with parents will require staff to use their professional judgment. Decisions not to share information should be informed by the young person(s):

- Understanding professional advice and sufficient maturity to understand what is involved
- Inability to be persuaded to inform his/her parents, or allow the health professional to do so
- Likelihood to have intercourse without contraception
- Physical and/or mental health being likely to suffer without advice and support
- Best interests in requiring advice and support without parental consent

**Fraser Guidelines 1980**

Any decision to break confidentiality should be discussed with the young person prior to the sharing of any information. All decisions either to share or not to share information must be backed up with robust record keeping.

Due regard should be given to the Sexual Offences Act 2003 that a young person under the age of 13 years is deemed as incapable of consenting and in such cases there should be a presumption that the case will be reported to Compass.

In the unlikely situation where a referral to the Police/Social Services is deemed not to be in the best interests of a child under the age of 13 years, the professional involved must fully document the reasoning behind why such a decision was made and should be aware that they may need to defend their position in a Court of Law.

Where a professional is aware that a young person aged 13 or over is sexually active but the professional’s assessment does not raise concerns that the young person’s sexual relationship is abusive, then Primary Care should continue to make arrangements for the young person to receive a confidential service and support from the appropriate professional.

In any case, if a member of Primary Care believes a child is at imminent risk (including a risk that the young person is involved in prostitution) a referral must be made to Compass and/or the Police immediately and the guidance contained in the Shropshire Safeguarding Children Board interagency child protection procedures for safeguarding children must be followed ([http://westmerciaconsortium.proceduresonline.com](http://westmerciaconsortium.proceduresonline.com)). For support in making decisions regarding the assessment of young people under the age of 16 please see appendix 1 below.
Managing Allegations against Staff

Despite all efforts to recruit safely there will be occasions when allegations of abuse against children are raised. The allegations may relate to the person’s behaviour at work, at home or in another setting.

All allegations of abuse of children by those who work with children must be taken seriously.

Allegations against people who work with children, whether in a paid or unpaid capacity, cover a wide range of circumstances. If you are aware of a person who works with children and has:

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

All such allegations made against adults working with children must be referred to the Local Authority Designated Officer (LADO), who provides advice and guidance to employers and voluntary organisations, liaises with the police and other agencies and monitors the progress of cases to ensure that they are dealt with as quickly as possible consistent with a thorough and fair process.

Contact: LADO & Risk Manager Independent Review Unit, Mt. McKinley Building, Anchorage Avenue, Shrewsbury Business Park, Shrewsbury SY2 6FG.
Tel: (01743)250009 Email: ellie.jones@shropshire.gov.uk Web: www.shropshire.gov.uk

Other useful advice and information

Information sharing advice for safeguarding practitioners, Department for Education, March 2015
https://www.gov.uk/government/publications/safeguarding-practitioners-information-sharing-advice

What to do if you are worried a child is being abused, Department for Education, March 2015

Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children, Department for Education, March 2015

http://www.core-info.cardiff.ac.uk/publications
The systematic review findings in the articles on this website (topics listed below) are only accurate up to the date of their publication:

Dental neglect
Early years neglect / emotional abuse
Parent-child interaction
School aged neglect / emotional abuse
Teenage neglect / emotional abuse
Bites
Bruising
Burns
Fractures
Neurological injuries
Oral injuries
Retinal findings
Spinal injuries
Visceral injuries etc.
## Appendix 1  
Sample assessment of under 16 year olds sexual activity

<table>
<thead>
<tr>
<th>Age of Client</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Age of Partner</td>
<td></td>
</tr>
<tr>
<td>Who did patient attend with?</td>
<td></td>
</tr>
<tr>
<td>Have you encouraged patient to talk to parents?</td>
<td></td>
</tr>
<tr>
<td>Have you discussed confidentiality?</td>
<td></td>
</tr>
<tr>
<td>Any suggestion of any coercion/pressure to have sex?</td>
<td></td>
</tr>
<tr>
<td>She is a willing participant?</td>
<td></td>
</tr>
<tr>
<td>If the male partner did not use a condom, why not?</td>
<td></td>
</tr>
<tr>
<td>Did she feel she could have said no to having sex at any time?</td>
<td></td>
</tr>
<tr>
<td>Has she been offered any rewards to have sex or threats if she doesn’t?</td>
<td></td>
</tr>
<tr>
<td>Any features suggesting an imbalance of power in the relationship?</td>
<td></td>
</tr>
<tr>
<td>Does the partner hold a position of trust (e.g. teacher, friend of the family etc.?)</td>
<td></td>
</tr>
<tr>
<td>Are they ever asked to keep the relationship secret or to lie about their whereabouts with family or friends?</td>
<td></td>
</tr>
<tr>
<td>Does the partner ever stop them from seeing their friends?</td>
<td></td>
</tr>
<tr>
<td>Living arrangements?</td>
<td></td>
</tr>
<tr>
<td>Who do they live with?</td>
<td></td>
</tr>
<tr>
<td>How is home life?</td>
<td></td>
</tr>
<tr>
<td>Parent/Carer knowledge</td>
<td></td>
</tr>
<tr>
<td>Is the parent/carer aware of the relationship?</td>
<td></td>
</tr>
<tr>
<td>Aware that they are having sex?</td>
<td></td>
</tr>
<tr>
<td>Aware that they are attending clinic?</td>
<td></td>
</tr>
<tr>
<td>Vulnerability</td>
<td></td>
</tr>
<tr>
<td>Alcohol and/or drug use?</td>
<td></td>
</tr>
<tr>
<td>Are they attending school?</td>
<td></td>
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<tr>
<td>Are there any problems at school? (e.g. bullying)</td>
<td></td>
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<tr>
<td>Eating disorders?</td>
<td></td>
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<tr>
<td>Self harming?</td>
<td></td>
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<tr>
<td>Do they seem depressed/anxious/withdrawn?</td>
<td></td>
</tr>
<tr>
<td>Mental health problems?</td>
<td></td>
</tr>
<tr>
<td>The young person understands the advice given?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>The young person is aware that the health professional cannot inform her/his parents that he/she is seeking sexual health advice without consent, nor persuade the young person to inform his/her parents.</td>
<td></td>
</tr>
<tr>
<td>The young person is very likely to begin having, or continue to have, intercourse with or without contraceptive / sexual health treatment.</td>
<td></td>
</tr>
<tr>
<td>Unless he/she receives contraceptive advice or treatment the young Person’s mental and or physical health is likely to suffer.</td>
<td></td>
</tr>
<tr>
<td>The young person’s best interests requires the health professional to give contraceptive advice, treatment, or both without parental consent.</td>
<td></td>
</tr>
<tr>
<td>The patient demonstrates competency?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>If we need to share any of this information with safeguarding children agencies, have we discussed this with the young person?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Action Taken:</td>
<td></td>
</tr>
</tbody>
</table>
I have tried to persuade this patient to inform his/her parents/guardian or allow us to do so on his/her behalf.

It is my assessment that this patient has the ability to understand the medical advice being given, the procedures of the clinic and the implications of tests and treatment and is capable of giving informed consent. I believe that it is in his/her best interest to be seen in our clinic without/with possible parent/guardian’s knowledge.

Health Adviser’s Signature: ..........................................................