Safeguarding Children

Level 2 – Clinical and non-clinical staff who have contact with children and young people

Core Skills Reader

Adapted by James Paget University Hospitals NHS Foundation Trust from the Core Skills for the North West Health Sector
Introduction to the Core Skills

The Core Skills standardises the training for 10 subjects commonly delivered as part of statutory and mandatory training requirements for health and social care organisations.

For each subject a set of learning of outcomes has been agreed nationally and is set out in the UK Core Skills and Training Framework (a copy of the framework is available on the Skills for Health website: www.skillsforhealth.org.uk/).

The learning outcomes specify what needs to be covered in the training for each Core Skills subject. This ensures a quality standard is set and provides clear guidance for organisations to deliver against these requirements as well as recognise the equivalent training delivered externally. This allows for Core Skills training to be portable between organisations and prevents the needless waste and duplication of statutory and mandatory training where is not required.

To aid organisations in the delivery of the Core Skills subjects, these education resources have been developed to be aligned to the learning outcomes in the UK training framework. Organisations have the flexibility to deliver these resources in a variety of formats as well as adapting them to add localised content alongside the Core Skills Materials.

If you require any further information about the Core Skills, in the first instance please contact the Learning and Development Lead in your organisation.
Introduction to Safeguarding Children Level 2

This reader covers the Core Skills learning outcomes for Safeguarding Children Level 2. It can be used either as a standalone document or as supporting material alongside the Safeguarding Children presentation or eLearning package (the relevant slide numbers and eLearning pages are given with each sub-heading). Whichever way the reader is used, it is recommended that the Safeguarding Children Assessment is completed afterwards to allow the learner to demonstrate they have retained the knowledge and learning required to support best practice.

This resource has been designed to cover induction level training and addresses the key principles in Safeguarding Children. It covers the general information about Safeguarding Children that all employees should be aware of. It is mapped against the learning outcomes in the UK Core Skills Training Framework.

The training covered here is likely to be a minimum requirement for all staff working in a health setting and specific staff groups may require additional training dependent upon their role.

It is anticipated that it will take you approximately 20-30 minutes to complete this reader. Current national guidelines recommend that the subject of Safeguarding Children is repeated a minimum of every three years.

Safeguarding Children is an emotive subject; therefore if you need any support or advice after completing this programme please contact your organisation's safeguarding team or lead.

Please be aware that there will be graphics and / or images which some users may find distressing. Some of the photographs used in this programme are posed by models.
What you will learn in this Reader

1. Understand the importance of being an effective advocate for the child or young person at risk of maltreatment Common terminology in child safeguarding.
2. Understand the normal development of children and young people and how maltreatment may affect this. The nature, types and range of child abuse.
3. Understand the scale and health impact of child maltreatment.
4. Know the potential child and parental vulnerability factors that may lead to child maltreatment or neglect. The risks associated with the internet and online social networking.
5. Understand the potential increased needs of ‘Looked-after Children’ and risk of further maltreatment.
6. Understand the legal, professional, and ethical principles and responsibilities guiding information sharing Potential consequences of failing to raise concerns.
7. Understand your own role and the key roles and responsibilities of other key colleagues in contributing to effective safeguarding. The importance of maintaining a child and young person focus.
8. Know when and where further support is needed to undertake the required action to ensure effective safeguarding.
9. Be able to document safeguarding/child protection concerns and maintain appropriate record keeping.
10. Know how, appropriate to their role and within context of agreed local arrangements, how to make a referral to social services (now Children's Social Care), if a safeguarding issue is identified.
11. Be able to share appropriate and relevant information in a variety of forms between teams and relevant agencies.
12. Know the sources of evidence and processes that can be helpful in learning lessons, including the findings and implications from Serious Case Reviews, and reviewing the effectiveness of safeguarding arrangements.
13. Understand the paramount importance of the child or young person’s best interests as reflected in legislation and key statutory and non-statutory guidance.
14. Be able to recognise how their own beliefs, experience and attitudes might influence their response and involvement in safeguarding activity.
Safeguarding is everyone’s business

Staff working in the health sector, across a wide variety of settings, play an essential part in ensuring that children, young people and their families receive the care, support and services that they need. You may be the first person to be aware that families are experiencing difficulties.

All registered professionals are bound by their code of conduct to act in the patient’s best interests and are responsible for their acts and failure to act.

Safeguarding is a range of activities that are aimed at upholding an individual's fundamental right to be safe, with a particular emphasis on those who are unable to keep themselves safe.

YOU have a responsibility to act in the best interests of the child when you think that they are at risk, or likely to be at risk, of suffering significant harm.

Good safeguarding can be directly related to our Trust values;

- Putting patients first
- Aiming to get it right
- Recognising that everybody counts
- Doing everything openly and honestly

Who is a child

The Children Act 1989 defines a child as:

‘Anyone who has not yet reached their 18th birthday’

The fact that they may:

- Live independently
- Are a parent themselves
- Are in custody
- Or are a member of the armed forces

Does not change their entitlement to protection under the Children Act 1989.

Looked After Children is the term used to describe children and young people that are looked after by the local Authority.
**Children Act 1989**

The key elements from the Children Act 1989 are:

- The overriding purpose of the Act is to promote and safeguard the welfare of children
- Parents have responsibilities; children have rights
- Children are best cared for in their own homes
- **All staff** dealing with children have a responsibility towards children who may have been abused
- Concerns **must** be shared with colleagues and other agencies when confronted with possible abuse

Two sections of the Act have specific meaning.

**Section 17 enquires (child in need)**

A child is in need if:

- He / she is unlikely to achieve and maintain, or to have an opportunity of achieving or maintaining, a reasonable standard of health or development without the provision of services by the local authority (LA)
- Health or development is to be significantly impaired, or further impaired without the provision of such services
- He / she is disabled

**Section 47 enquires (child protection)**

- Where there is reasonable cause to suspect that a child is suffering or is likely to suffer significant harm
- This can include harm or likelihood of harm which is attributable to a lack of adequate parental care or control
What makes children vulnerable?

- They depend on adults for their basic needs
- They believe what adults tell them
- They believe what is happening to them happens to other children
- They do not have a voice in society
- They are not always listened to by adults
- They cannot always express concerns
- They may have learning disabilities

Children looked after by the Local Authority (Looked After Children - LAC) may be more vulnerable.

What is Child Abuse?

On average, every week in England and Wales at least one child is killed at the hands of another person
(Home Office 2011)

The term "child abuse" is used to describe a range of ways in which people, usually adults, harm children although other children can also harm children.

A child is anyone under the age of 18

Often the adult is a person who is known and trusted by the child.

Child abuse can take place in the home, at school, ANYWHERE where children spend time.
Why do we need to safeguard children?

In 2000, an 8 year old girl called Victoria Adjo Climbié was abused and murdered by her guardians. After her death there were major changes in England's child protection policies. To view more information please click here (PDF opens in a new window).

In 2007, a 17 month old boy named Peter Connolly (Baby P) died after suffering more than 50 injuries over an eight-month period, during which he was repeatedly seen by Haringey Children’s Services and NHS health professionals. To view more information please click here (PDF opens in a new window).

Serious Case Reviews

The point at which concerns are first raised about a child is critical in achieving an appropriate response and a positive outcome. All those working with children should be able to identify children at risk of significant harm or those who are in need because of their vulnerability. Below are the lessons have been learnt:

- Issues around domestic abuse, mental health and failure to attend appointments/repeated cancellations
- Recognition and response to safeguarding children
- Documentation and record keeping
- Communication and information sharing
- Child focus

Child development

- Children are not ‘little adults’
- All children develop at different rates, however there are milestones which give practitioners an idea of what a child should be able to achieve
- There are differences in the way a child grows and develops, which need to be understood when assessing injuries in a child
- Consideration should be given to children with learning difficulties
**Framework for the assessment of children in need and their families 2000**

The framework is used by all children's services to assess a child's needs. It is often shown as a triangle or pyramid (see below) to highlight the key areas, which are the child's development, parents/carers and their environment. Notice how the child's welfare is at the centre.

![Framework Diagram]

**Information sharing or child protection?**

When assessing a child using the Framework for the assessment of children in need and their families it is important that if the child needs help that they are referred to the correct people. A child can either be an information sharing case or in need of child protection. Look at the following scenarios and decide what type of referral they are.

Whilst an inpatient on a ward, the staff notice that a 10 month old child is given only milk by her mother. When the mother is asked what food her daughter would like she replies "she will not eat any solid food, she just spits it out". Select if you feel that this is an information sharing or a child protection issue.
Information sharing or child protection?

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Types of Abuse

The four main types of child abuse are listed below. We will look at each type in more depth throughout the programme.

- Physical
- Emotional
- Sexual
- Neglect

To view a copy of Working Together to Safeguard Children from the Department of Children, Schools and Families, please click here.

Physical Abuse

Physical abuse may involve:

- Hitting or Shaking
- Throwing
- Poisoning
- Burning or scalding
- Drowning
- Suffocating
- Or otherwise causing physical harm to a child

Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces, illness in a child.
Physical Indicators

There are many indicators to physical abuse. Click the buttons below to see more information.

Injuries that can't be explained

There may not be any explanation given. If the reason is given it could be unconvincing, or parents may give differing accounts.

The child may also cover their injuries so they don't need to explain them. Children may do this by wearing long sleeves, even when hot, or being reluctant to get changed in front of anyone.

Injuries that haven't been treated

An abused child may not have proper, or any, medical attention for certain injuries, which therefore means they may not heal properly.

Multiple bruises

Bruising to the hands, face, ears, back, body, arms or buttocks. Bruising that looks like an imprint. Bruising that is in a cluster or a uniform shape.

- Slap
- Buckle
- Pinch

Bite marks

Need to consider the child's and possibly the child's playmates' developmental age and also the size of the bite mark.

Bruising on a baby

Bruising on a baby or a child that is not yet mobile, especially on the face and buttocks, should be treated as suspicious. Injuries in older children's upper arms, body, thighs, ears, face, neck, stomach, genitalia and buttocks are also likely to be indicators of abuse.
Burns
Intentional burns are usually multiple, with clear edges and on unusual parts of the body, such as buttocks or back.
  ▪ Cigarette burns
  ▪ Carpet burns (neglect)

Torn frenulum
A torn frenulum (membrane that connects the lips with the gums and attaches the tongue to the floor of the mouth, it is also the sensitive skin on the underside of the penis) on its own is not enough evidence of physical abuse as there have been fewer than 50 cases of torn frenulum in physically abused children.

Poisoning
This can sometimes be that the parents have given their child too much of an unsuitable substance, such as salt.

Bi-lateral black eyes
Sometimes children can get two black eyes from a playground accident so this needs to be looked at in the context of the whole situation.

Scalds
Accidental scalds are usually caused by the child knocking a hot drink over themselves, which will typically affect the upper half of the child's body.

Deliberate immersion scalds leave rings around the child's body, arms or legs and the scald is a uniform depth on the skin.

Shaking injuries
Signs that a baby has been shaken could include;
  ▪ Ligature marks,
  ▪ Internal injuries,
  ▪ Head turned to one side or unable to lift/turn their head,
  ▪ Blood pooling in the eyes,
  ▪ Breathing difficulties,
  ▪ Unresponsive pupils or seizures.

The baby may not display all of these signs but even if they have one, they need medical attention immediately.
Fractures

Any fractures to a child under 18 months old, or fractures which are inconsistent with the child's developmental age, can be interpreted as physical abuse. Many fractures may not be obvious unless the bone is x-rayed and some fractures, such as rib fractures, do not always have bruising to the skin.

The NICE guidelines state that physical abuse can also be suspected "if a child has one or more fractures in the absence of a medical condition that predisposes to fragile bones or if the explanation is absent or unsuitable".

Sexual Abuse

Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not a child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example rape or oral sex) or non-penetrative acts such as:

- Masturbation
- Kissing
- Rubbing
- Touching outside of clothing

They may also include non-contact activities, such as involving children looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet).

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

(Working Together to Safeguard Children 2013)
Signs

The following physical signs may indicate sexual abuse in the absence of a reasonable alternative explanation.

- Discharge, bleeding, pain on passing urine or repeated urinary tract infections
- Injuries to the genital area
- Itching, soreness in the genital or anal areas
- Rectal bleeding
- Sexually Transmitted Diseases (STDs)
- Persistent abdominal pain or headaches without apparent cause
- Fingertip bruising on the inside of the thigh
- Teenage pregnancy/termination of pregnancy

No signs do not mean no abuse!

Other signs

- Pregnancy in a girl under the age of 16 should raise the question of abuse, especially when the identity of the father is vague or a secret
- Withdrawal and introversion
- Sleep disturbance, nightmares or refusing to sleep alone
- Eating problems
- Self-harm
- Sudden onset of wetting or soiling, by day or night
- Hinting at sexual activity through words, play or drawing
- Running away, sleeping out, attempting suicide, abusing drugs or alcohol
- Display of sexual knowledge or behaviour beyond the child's years
Neglect

Neglect is the persistent failure to meet a child’s basic physical and/or psychological needs, likely to result in the serious impairment of the child’s health or development. Neglect may occur during pregnancy as a result of maternal substance abuse.

Once a child is born, neglect may involve a parent or carer failing to:

- Provide adequate food,
- Clothing and shelter,
- Ensure adequate supervision (including the use of inadequate care-givers),
- Ensure access to appropriate medical care or treatment

Indicators of Neglect

- Impairment of growth
- Mottled hands and feet, which may be swollen
- Unhygienic home conditions affecting health and development
- Abnormally excessive appetite
- Frozen watchfulness
- Failure to attend school
- Pot belly and thin hands
- Inappropriate clothing and neglected appearance
- Severe nappy rash
- Failure to seek medical advice and care
- Impairment of development
- Lack of stimulation and supervision
Emotional Abuse

Emotional abuse is the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child’s emotional development. It may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. (Working Together to Safeguard Children 2013)

Signs of Emotional Abuse

Information taken from NICE guidelines “When to suspect child maltreatment”. Displays a sudden change of behaviour or emotional state that is not usual for their age:

- Recurrent nightmares containing similar themes
- Extreme distress
- Oppositional behaviour
- Withdrawal of communication
- Becoming withdrawn

Behaviour or emotional state is not consistent with their age or cannot be explained by medical causes, neurodevelopment disorders or other stressful situations:

- Fearful, withdrawn, low self-esteem
- Aggressive, oppositional
- Habitual body rocking
- Indiscriminate contact or affection seeking
- Over-friendliness to strangers including healthcare professionals
- Excessive clingingness
- Persistently resorting to gaining attention
- Demonstrating excessively ‘good’ behaviour to prevent parental or carer disapproval
- Failing to seek or accept appropriate comfort/affection from an appropriate person when significantly distressed
- Coercive controlling behaviour towards parents or carers
- Very young children showing excessive comforting behaviour when witnessing parental or carer distress
Responds to a health examination or assessment in an unusual way:
- Extreme passivity
- Resistance or refusal

Regularly has responsibilities that interfere with essential normal daily activities:
- School attendance

Shows dissociation that is not explained by a known traumatic. Transient episodes of detachment that are outside the child's control and that are distinguished from daydreaming, seizures or deliberate avoidance of interaction.

Shows repeated, extreme or sustained emotional responses that are out of proportion to a situation and are not expected for the child’s age or explained by a medical cause:
- Anger or frustration expressed as a temper tantrum in a school-aged child
- Frequent rages as minor provocation
- Distress expressed as inconsolable crying

**Sexual exploitation**

Sexual exploitation of children and young people under 18 involves exploitative situations, contexts and relationships where young people (or a third person or persons) receive ‘something’ (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of them performing, and/or another or others performing on them, sexual activities.

Child sexual exploitation can occur through the use of technology without the child’s immediate recognition; for example being persuaded to post sexual images on the Internet/mobile phones without immediate payment or gain.

In all cases, those exploiting the child/young person have power over them by virtue of their age, gender, intellect, physical strength and/or economic or other resources. Violence, coercion and intimidation are common, involvement in exploitative relationships being characterised in the main by the child or young person’s limited availability of choice resulting from their social/economic and/or emotional vulnerability.

*(National Working Group for Sexually Exploited Children and Young People 2008)*
Children have been moved into and around the UK with a purpose of sexually abusing them.

Adults have pretended to be a child and befriended the child through online chat rooms, social networking sites and gained their trust and emailed and messaged them.

Children have been stalked through their online activities. Do parents or carers actually know who their child is talking to online and which sites they are accessing? Think of the dangers if children agree to meet up with the “child” they believe they were talking to.

**Domestic Abuse**

Domestic violence and abuse is ‘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 and emotional (Department of Health).

**What to do if there are children involved:**

- Any incident of domestic violence within the home where there is a child or unborn child needs a direct referral to children’s social care
- Analysis of serious case reviews found evidence of past or current domestic violence present in 53% of cases
- Domestic violence can have a serious impact on children’s safety despite the efforts of parents to protect them
- Child protection agencies now have an obligation to consider the impact of hearing or witnessing domestic violence on a child’s emotional and psychological well-being
Increased risk

The risks of harm are increased where there is one or more of the following factors:

- Domestic violence and abuse
- Substance abuse (including alcohol)
- Mental ill health

These factors are known collectively as the 'toxic trio'.

The risks of harm are increased where there is one or more of the following factors:

How to respond if a child confides in you

It takes a great deal of courage for a child to confide in someone. Therefore it is important that you respond in the correct way.

- Remain calm, accessible and receptive
- Listen carefully without interrupting
- Be aware of your own non-verbal messages
- Make it clear that you are taking them seriously
- Use the child's actual words whenever possible
- Make a note of what is said and who is present
- Acknowledge their courage and reassure them they are right to tell
- Reassure them that they should not guilty, and that you are sorry that this has happened to them
- Let them know you are going to do everything you can to help them, and what may happen as a result
- DO NOT show expressions of shock / horror
Female Genital Mutilation (FGM)

FGM (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.

The legal situation

FGM is practiced in some cultures but it is illegal in the UK. It is also illegal to arrange for a child to be taken abroad for FGM. If caught, offenders face a large fine and a prison sentence of up to 14 years.

What you can do

If you are worried about someone who is at risk of FGM, or has had FGM, ALL STAFF have the responsibility and duty to report this. The Trust’s Safeguarding Leads are responsible for acting as a resource of information and support for staff. See Trust FGM Reporting and Safeguarding Policy available on the intranet and follow flowchart using attached risk assessments.

The Police and Social Care will then have the responsibility to investigate and protect any girls or women involved.

Local Authority Designated Officer (LADO)

Raising concerns

Should you have concerns about a colleague that may present a risk to children, raise immediately to your line manager and/or the Trust’s Safeguarding Leads.

All allegations against people that work with children must be reported to the Local Authority Designated Officer (LADO); Managing Complaints Against Staff Who May Present a Risk to Children (LADO) Policy available on the intranet.

The Trust’s Safeguarding Leads are responsible for acting as a source of information and support for staff in relation to the LADO process in conjunction with the Human Resources Department.
Child confidentiality

Everyone has a duty to consider when disclosure of information is appropriate and if unsure to seek advice.

There are some circumstances in which disclosure may be made despite the absence of consent. These include disclosure which is:

- Required by court order.
- To safeguard children / child protection

For more information please see the Information Sharing: Guidance for Practitioners and Managers - HM Government Oct 2008.

Information must be shared on a ‘need to know’ basis which is in the best interest of the service user.

Confidentiality must not be confused with secrecy. Valid consent must be obtained prior to all exchanges. (In exceptional cases, information may be shared without valid consent, if it is in the patient's best interests).

Any exchanges of information must be in line with the Caldicott principles and the Data Protection Act 1998.

Please seek advice on sharing information as it is important that you do not breach patient confidentiality unnecessarily.
Dignity in the healthcare setting

It is important to remember that each patient is an individual and has the right to make decisions regarding their care and how they are treated. To ensure we uphold this, patients should be asked at every opportunity to contribute information and be consulted and involved in any decision making.

Caring responsibilities

When staff are taking history from patients we must ask ‘do you have any caring responsibilities?’ This should be asked of everybody aged 12 years old and above. Children could be young carers or even be parents themselves. People living alone may have caring responsibilities for relatives, neighbours or pets.

How to report abuse

The Trust's Safeguarding Leads are responsible for acting as a source of information and support for staff when they have concerns about safeguarding children. There is a JPUH Safeguarding Children Strategy and Safeguarding Team intranet webpage where information can be found about how to make a referral. If a referral is needed this will go to either the Norfolk or Suffolk MASH (Multi-Agency Safeguarding Hub). The MASH is made up of professionals from Children’s Social Care, Police and Health who will collectively decide what the next steps may be.

If you witness or hear about abuse, follow the Trust’s MASH referral flowchart process overleaf;
SAFEGUARDING CHILDREN, YOUNG PERSON OR ADULT

Safety / Welfare Concerns Flowchart

This flowchart informs you of the process you must follow should you have concerns regarding the safety or welfare of a child, young person or adult.

if you have any safety or welfare concerns for a child, young person or adult.

TELEPHONE

Norfolk Multi-Agency Safeguarding Hub (MASH) 0344 800 8020

Suffolk Multi-Agency Safeguarding Hub (MASH) 0808 800 4005

Discuss your concerns with the Safeguarding Team including any outcome of your MASH telephone consultation.

(01493) 45-3964 (child)  (01493) 45-2231 (adult)

Complete relevant referral form as a follow up to the telephone consultation. All referral forms can be found on the Safeguarding Team Intranet Page

Children
Following the telephone consultation to MASH;
- Complete form
- Email to MASH@ipaget.nhs.uk

Adults
Following the telephone consultation to MASH;
- Complete and fax the form(s)
- Send original form to the Safeguarding Team

* This includes unborn.

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How to access policies, procedures and guidelines

All the policies, procedures and guidelines that relate to Safeguarding issues and concerns can be found on the Trust's intranet page. Please ensure you are aware of your organisation’s safeguarding policies and procedures.

Conclusion

- Safeguarding is EVERYONE’S business and EVERYONE’S responsibility
- Recognise it
- Record it
- Discuss it
- Refer it
- Follow it up – NEVER ASSUME someone else is dealing with it