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SAFEGUARDING CHILDREN WHAT YOU SHOULD KNOW

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Aims:

- To understand what safeguarding means and how concerns might present
- To understand the GP and their staff's statutory role in keeping children safe
- To consider how to respond to concerns about a child
- To have an awareness of the impact of COVID 19 on children
- To consider the importance of sharing information accurately and appropriately

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Presentation Plan

- What is safeguarding? – guidance
- Assessment of and risk factors for abuse
- Impact of COVID 19

Break

- Looked After Children
- Adverse Childhood Experiences (ACEs)
- Cases to discuss

Break

- Significant harm and statutory processes
- Any questions???

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What Does Safeguarding Mean?

- **All agencies working with children and young people and their families take all reasonable measures to ensure that the risk of harm to children's welfare is minimised.**
- **That where there are concerns about children and young people's welfare, all agencies take appropriate action to address those concerns working to agreed local policies and procedures in full partnership with other agencies**

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NICE Guidance July 2009 (reviewed 2017)

Alerting features to detect child maltreatment:

- CONSIDER maltreatment
  - Maltreatment is one possible explanation for the alerting feature or is included in the differential diagnosis
- SUSPECT maltreatment
  - Serious level of concern about the possibility of child maltreatment but not proof

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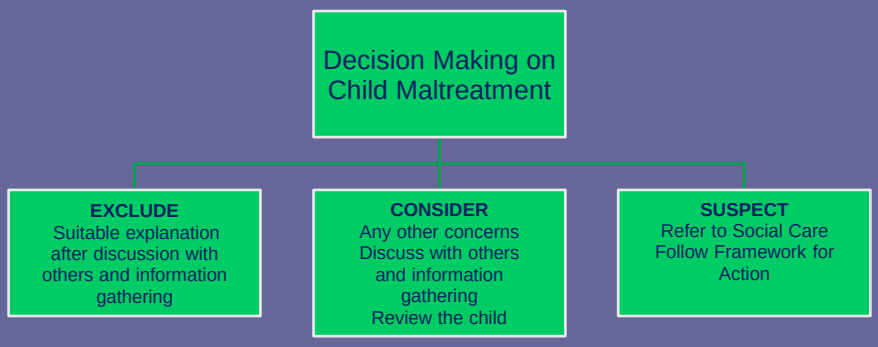
NICE Guidance – When to Suspect Child Maltreatment



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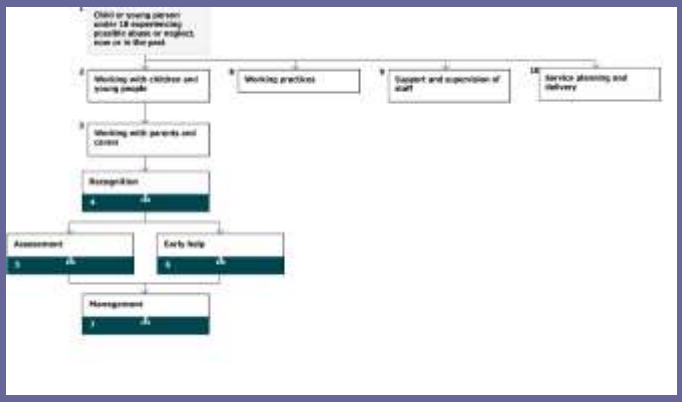
NICE Guidance – on Abuse and Neglect October 2017



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Consider abuse in the four categories:

Physical

Emotional

Sexual

Neglect

Remember: Actual and At Risk of

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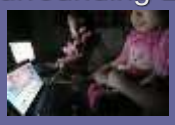
When considering a child at risk…..

Think about the

- ✓ Child's needs

- ✓ Parental or Carer's capacity to meet those needs

- ✓ The Surrounding Environment/ Context



The 3 aspects above make up
"an early help assessment" to identify and address needs

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Risk factors for Child Abuse

- Drug/alcohol misuse
- Mental health problems
- Domestic abuse or history of violent offending

The Toxic Trio
Identified repeatedly as high risk combination for harm to children in serious case reviews/safeguarding practice reviews

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Other Risk Factors

- Previous child maltreatment in members of the family or parental experience
- Known maltreatment of animals by parents
- Vulnerable and unsupported parents
- Child disability
- Social Stressors e.g. Poor housing/low educational attainment/unemployment/ financial difficulties/ criminality
- Isolation / unseen e.g. not in education

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Breakout Groups

- Please take ten minutes to discuss with your colleagues how COVID 19 may have impacted on children and if your consultations with children have changed – if so why?

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Arthur and Star

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Impact of COVID 19

- Social isolation and reduced educational opportunity including inequitable access to IT (reported to be a 20% increase in children electively home educated post COVID)
- Reduced access to routine child healthcare
- Evidence of increase in infant non accidental head trauma
- Increase in domestic abuse and reduce parenting capacity
- Financial implications on families
- Increased stress and mental health issues
- Anecdotally in Bolton increase in children moved into care under police powers e.g. extreme neglect/exposure to illicit activity in the home
- **Benefits include** more time spent with the family where this is a positive, reduced educational expectations, reduced social anxiety and women seen alone for antenatal care has allowed DAV disclosure

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Remote consultations with children

- Children are entitled to safe and confidential consultations
- Continue to assess capacity using Gillick and encourage involvement of parents
- Before the consultation check for flags indicating safeguarding risk
- Have a low threshold for converting to face to face if concerns raised
- Ask to speak to (or at least see) the child
- What does the background look like –
  are there signs of neglect / coercion

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Intimate images in consultations/training

- Criminal acquisition and misuse of such images must be recognised as a risk.
- The law considers the following:
  - whether the image is 'indecent' and
  - whether there is the defence of a 'legitimate reason' or;
  - whether there is a 'lack of awareness' of the nature and content of the image and how this image is handled by the clinician, for example, if a patient sends an unsolicited intimate image
- Ensure you have informed consent and document appropriate clinical judgements when obtaining and storing intimate images of children

IF NECESSARY SEEK SAFEGUARDING OR MEDICAL DEFENCE ADVICE

NHSE&NHSI Guidance - Key principles for intimate clinical assessments undertaken remotely in response to COVID 19 July 2020

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Looked After Children - Definitions

- **A looked after child** is provided with accommodation for a continuous period of more than 24 hours by the local authority.
- **A care leaver** has been in the care of the local authority for a period of 13 weeks or more spanning their 16th birthday. Children may however remain in care until 18 years .
- **Private fostering** applies to a child under the age of 16 (18 if disabled) and is a private arrangement with no Local Authority involvement. It involves someone other than a parent, grandparent, sibling, aunt or uncle with an intention that it should last for 28 days or more
- **Parental Responsibility (PR)** All mothers and most fathers have legal rights and responsibilities as a parent - known as 'parental responsibilities'. With PR your most important roles are to: provide a home for the child and protect and maintain the child. PR can be lost through court order e.g. special guardianship/adoption/full care order

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Legal Status

Lawful removal of children takes place in these ways:

- By the Police (PPO) under section 46 of the Children Act (72 hrs max);
- Application to the court for an order:
  - Emergency Protection Order (EPO) under section 44 of the Children Act 1989 which can last from 7-15 days maximum;
  - Interim Care Order (ICO) under section 38 of the Children Act 1989 (8 weeks and renewed every 4 weeks)
- Application may be made to the courts for a full care order (Section 31)
- Some children are accommodated by voluntary agreement with their parents (Section 20) and the parents retain PR
- Children receiving a total of 75 days or more short break care will be classed as looked after child (and parents retain PR)
- Foster carers will have some delegated responsibility for routine health care but do not hold PR

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Data

As of 31 March 2020, there are 80,080 looked-after children and young people in England, with the total number of children being looked after increasing yearly since 2010.

In Bolton Sept 2021

- 685 Looked After Children in previous 6 months for whom Bolton Local Authority has responsibility which is 96 per 10,000. (nationally 58 per 10,000 children)
- 224 Care Leavers

Children may live in foster care, residential care, with kinship carers, in pre –adoptive placements or with birth parents.

Just because a child is in care
doesn't necessarily mean they are safe

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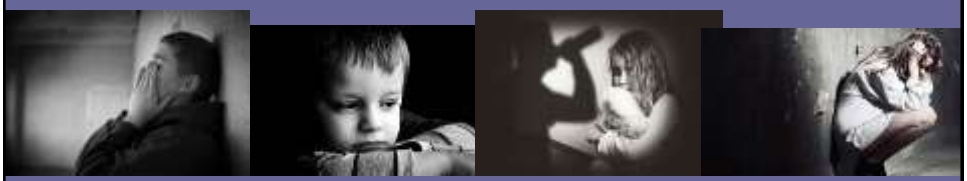
Why do children come into care?

Most children are in care because of abuse and neglect



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Common outcomes

Adverse childhood experiences (ACES) are a complex set of related childhood experiences that directly affect a child before the age of 18

Studies into adverse childhood experiences (ACEs) have shown that the effects of abuse, neglect and dysfunctional home environments are linked to harmful behaviours i.e. smoking, harmful alcohol use, risky behaviour and also chronic health issues throughout life.

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Toxic Stress

- Severe and chronic trauma causes toxic stress in children
- Toxic Stress damages children's brains
- When trauma launches children into flight, fight or fright mode, they cannot learn - **It is physiologically impossible**

Always prepared to fight or flee
Anxious
Disengaged
Poor learner

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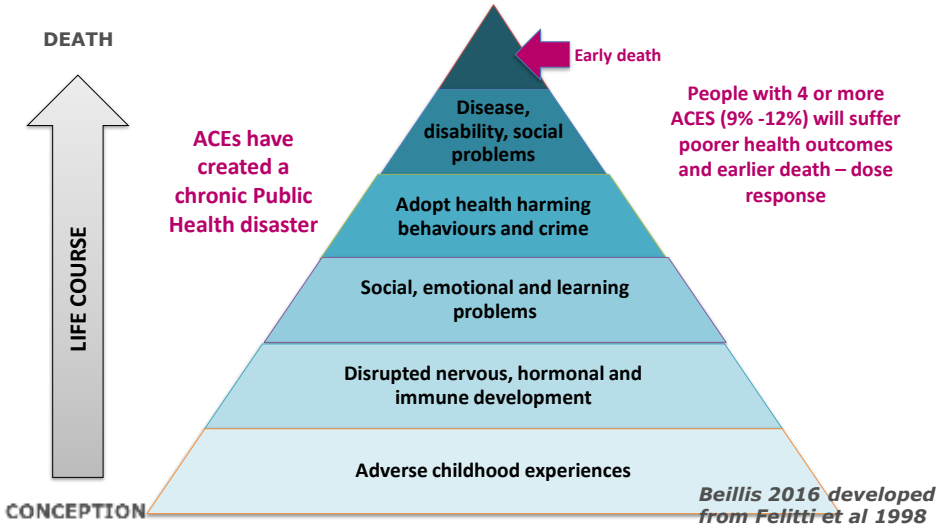
ACES the Life Course



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Common outcomes continued

Put your guesses in the chat box……

Children in care and care leavers account for less than 1% of the population:

- How many of the adult prison population have been in care?
- **25%**
- How many girls aged 15-18 in the youth justice system have spent time in care?
- **61%**
- How many homeless people have spent time in care?
- **25%**
- In 2019, 14.9 % of all children had a special educational need compared with how many of looked-after children
- **55.9%**
- In 2019, around 12% of all young people aged 19 to 21 years were not in education, employment or training, what is the rate for Care Leavers?
- **39%**
- The rate of mental health disorders in the general population aged 5 to 15 is 10%. What is the rate for those who are looked after?
- **it is 45% (and 79% for those in residential care)**

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Statutory care

Statutory care plan and reviews	Statutory health plan	Statutory personal education plan	Many children have a EHC Plan also
Every child in care has a care plan. There is an initial statutory review at 20 days, then at 3 months and then at least 6 monthly thereafter. Information from health and education feeds into this overall care plan	Initial health assessment within 20 days of becoming looked after Review health assessments twice yearly up to 5 years and annual thereafter until 18 years. All these result in a health care plan. If there is a plan for permanence an adoption medical is required	Twice yearly personal education plan (PEP) for those children in school and in pre – school settings	EHC plans identify educational, health and social needs and set out the additional support to meet those needs. They are for children/ young people up to 25 years who need more support than is available through special educational needs support.

Looked-after children and young people NICE guideline Published: 20 October 2021
www.nice.org.uk/guidance/ng205

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So……..

What would you do?

Cases to consider in your breakout rooms……

We will have a short break at the end before reconvening as a full group to take questions and discussion points

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The Concept of "Significant Harm"

Children Act 1989 states that "significant harm" is the threshold that justifies compulsory intervention in family life in the best interests of children

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

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The Concept of "Significant Harm"

There is no absolute criteria for what constitutes significant harm however 'harm' means *"ill-treatment or the impairment of health or development, including, for example, impairment suffered from seeing or hearing the ill-treatment of another"*

It is rarely a "black or white" decision and may lie on a continuum.
Agencies, where possible working with families, should aim to predict and prevent harm by early intervention

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Information sharing

Information shared should be:

✓Necessary

✓Proportionate

✓Relevant

✓Accurate

✓Timely

and

✓Secure

Best practice states consent to share information should be obtained, however, it is not necessary in order to protect a child

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2018 GMC Guidance – Protecting Children and Young People The Responsibilities of all Doctors

- Principles:
- All children and young people have a right to be protected from abuse and neglect – all doctors have a duty to act on any concerns they have about the safety or welfare of a child or young person.
- All doctors must consider the needs and well-being of children and young people who are individuals with rights
- Children and young people have a right to be involved in their own care
- Decisions made about children and young people must be made in their **best interests**

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GMC Guidance continued...

- Children, young people and their families have a right to receive confidential medical care and advice – but this must not prevent doctors from sharing information if this is necessary to protect children and young people from abuse or neglect.
- Decisions about child protection are best made with others – consulting with colleagues and other agencies that have appropriate expertise will protect and promote the best interests of children and young people.
- Doctors must be competent and work within their competence to deal with child protection issues

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Multiple high profile cases where children have been harmed or killed

Common themes can be identified (through serious case reviews etc..):

•Over optimism and a willingness to believe things will change
•Adult problems over-ride the child's
•The importance of seeing the child frequently, watching for trends, seeing them alone and asking them about their views and feelings
•Listening to adults (e.g. other relatives, professionals) when they try to speak on behalf of the child
•See life through the eyes of the child
•Being alert to parents and carers who try to prevent access to their child including frequent DNA's
•Information gathering and sharing- the need for fresh eyes

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Recent Changes

- Children and Social Work Act 2017
  - LSCBs ceased to exist
  - 3 equal partners to lead on safeguarding arrangements via statutory Partnerships
- Working Together republished 2018
- Child Death Review processes guidance 2018
  - SUDC (Joint agency response)
    - GM rota
  - Multiagency mortality meetings (CDRM)
  - Designated doctor for Child deaths (CCG)

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Child Death Overview Panel

- Reviews all deaths of children 0-18 years
- Currently Bolton, Wigan and Salford
- Looking for themes/trends
- Aims to implement changes to reduce further deaths e.g.

Co-sleeping identified as highest risk factor for preventable death in the region. Resulted in ongoing publicity campaigns and routine professional enquiry

Suicide in young people has resulted in a thematic review in 2017 to inform future service provision including all age RAID

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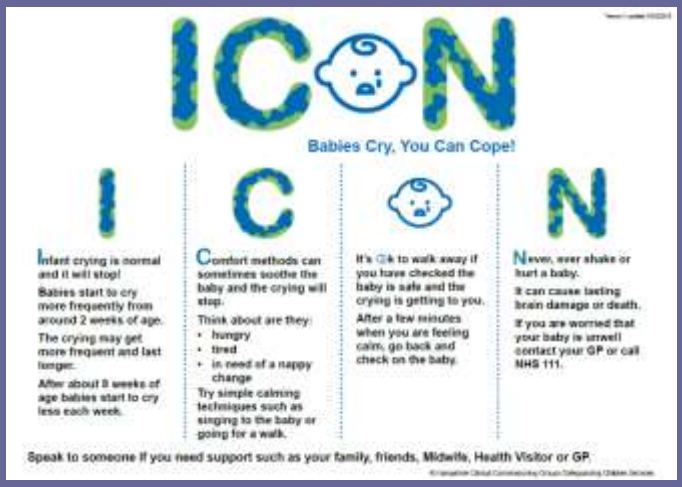
What is ICON?



https://iconcope.org/for-professionals/

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Other considerations

Our work, and that of our multiagency colleagues, is inspected and reviewed

- Serious Case Reviews – now renamed as Safeguarding Practice Reviews
  - Oversight from National Panel
- Domestic Homicide Reviews
- Independent Management/ Learning Reviews
- CQC

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Training

- Aligns to appraisal – evidence life long, continuous learning and reflection
- GPs should be trained to “Level 3” competencies as detailed in ***Safeguarding children and young people: roles and competences for health care staff – Fourth edition: 2019***
- Minimum of 12- 16 hours every 3 years
- Use a variety of ways to keep up to date, e.g. completing an elearning module, attending a training session, case based discussions or reading appropriate guidelines and reflecting
- No one course / session can deliver this

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In Summary:
Children need you to keep them safe

- Consider or suspect abuse as an explanation for a child's condition/situation
- Gather Information and discuss your concerns with your colleagues who know the child
- Gain consent from the parents or child, where possible and safe to do so, but this is not essential
- Refer onto appropriate agency for support or protection
- Record your concerns and actions accurately

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Safeguarding Children is Yours and Everyone's Responsibility

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Any Questions?

"When I approach a child, he inspires me in two sentiments: tenderness for what he is: and respect for what he may become" – Louis Pasteur

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- If you want a copy of this presentation please email:

  Charlotte.Mackinnon@nhs.net

  For more information and resources please go to:

  www.boltonsafeguardingchildren.org.uk

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