Safeguarding Children
Level 2
Study guide
How to become compliant with level 2 training

Welcome to the safeguarding children training level 2.

Who requires level 2

- Clinical staff below band 5 in paediatric or maternity services and staff working in adult areas (with the exception of in-patient elderly care staff and non-public facing laboratory/pharmacy staff who only require level 1)

- Non-clinical staff who provide interventions to children and contribute to the assessment of children/young people or parent/carers such as some health advocates and administrative staff in community services. If you are a qualified nurse, health visitor, midwife or therapist working in paediatric or maternity services or work in a high-risk adult service you should complete the one day level 3 training course.

Introduction

Children’s rights

Human rights are the basic standards that people need to live in dignity, and exist to make sure that we are treated properly and fairly, and given the freedom to develop to our full potential, and to promote our well being.

In addition to the rights that are available to all people, there are rights that apply only to children. Children need special rights because of their unique needs and because they need additional protection to keep them safe.

The United Nations Convention on the Rights of the Child (1989) is an international document that sets out all of the rights that children have. The United Kingdom Government ratified the Convention in 1991 and ensures that every child has the rights that are listed in it by ensuring, amongst other things, that there is sufficient legislation to keep them safe.
These rights are incorporated into legislation such as The Children Act 1989 and 2003, the Sexual Offences Act 2003, Female Genital Mutilation Act 2003 and the Forced Marriage Act 2007. This key legislation can be found on the safeguarding children training Intranet pages.

Barts Health NHS Trust (BHT) is committed to safeguarding children and young people. It is required to fulfil its statutory duty under Working Together to Safeguard Children 2015 and Section 11 of the Children Act 2004 to safeguard and promote the welfare of children.

The Children Act 1989 defines a child as anyone who has not reached their 18th birthday, including the unborn child and 19th birthday if disabled. The fact that a child has become 16 years of age, is living independently, is in further education, a member of the armed services, is in hospital or in custody in the secure estate for children and young people, does not change his or her status or entitlement to services or protection under the Children Act 1989.

This briefing supports you in understanding what we mean by safeguarding children and child protection, the different ways a child or young person may be abused or neglected and what action you should take if you ever have concerns that a child is being harmed.

All children deserve the opportunity to achieve their full potential.

Effective child protection is essential as part of wider work to safeguard and promote the welfare of children. All employees of Barts Health should aim to proactively safeguard and promote the welfare of children so that the need for action to protect children from harm is reduced.

Safeguarding children: Safeguarding and promoting the welfare of children is defined as:

- Protecting children (including the unborn) up until their 18th birthday or 19th if disabled
- Preventing impairment of children’s health or development
- Ensuring children are growing up in circumstances consistent with the provision of safe and effective care
- Taking action to ensure all children have the best outcomes to promote their well being.

This was historically framed around five outcomes that are key to children and young people’s well being:

- Stay safe
- Be healthy
- Enjoy and achieve
- Make a positive contribution
- Achieve economic well being.

Child protection is a part of safeguarding and promoting welfare. It refers to the activity that is undertaken to protect specific children who are being abused, those who are suffering, or are likely to suffer, significant harm.

A child development chart has been included at the end of this briefing to help you to understand the development stage of children you are working with and whether there are grounds for concern and further investigation. It shows the stages of typical development. However, you will need to consider it alongside the specific circumstances of each child, and will want to consider abilities as well as needs. 

It is also important to note that children do not all develop at the same rate.

Principles of the Children Act 1989 and 2004

Children Act 1989

The Children Act 1989 is the main piece of legislation that underpins our child protection work.

This Act introduced the following principles:

- The welfare and safety of the child are always paramount and the rights of children will always come above the rights of any adult.

Therefore, we must always share appropriate and relevant information relating to children in order to maintain their safety. The Data Protection Act 1998 is not a barrier to sharing this information but a tool to support the process, even if the needs of an adult are such that they are vulnerable themselves.

- It is in children’s best interests to be brought up in their own families wherever possible.

If the parents are unable to meet the needs of the child, the child will be allowed to be cared for by a family member if they are assessed as being suitable.

- Local authorities have a duty to safeguard and promote the welfare of vulnerable children.
The Children Act 1989 gives social services the statutory responsibilities in relation to children.

Moved from parental rights to children’s rights therefore introducing the concept of ‘parental responsibility’.

Any adult with parental responsibility (PR) is also legally able to consent to treatment for the child. Adults who have PR are:

- Birth mothers
- Birth fathers who are (or were) married to the child’s mother at the time of the child’s birth
- All fathers (including those who are not married to the mother) of children born on or after 01.12.03 as long as their name is on the birth certificate
- Legal guardians or other adults where this has been awarded in a court order
- The local authority (at the point a child is taken into care).

Please be aware that: Unmarried fathers of children born before 01.12.03 will not automatically have parental responsibility unless they been awarded it in a court order.

Foster carers do not have parental responsibility.

Children who are assessed as being ‘Gillick competent’ using Fraser Guidelines can consent to their own treatment. Further information on Gillick competency can be found on the NSPCC website.

Please note that others (including school teachers in loco parentis or two consultants (where emergency life-saving treatment is required) can also consent if an adult with parental responsibility cannot be contacted.

Further information and guidance can be found in the Barts Health policy for consent to examination and treatment.

Delay is not in the child’s interest and should be avoided.

Barts Health staff must inform the local authority of any child who is at-risk of significant harm on the same day using the multi-agency referral form or portal, depending on the specific borough’s requirements.

The Local Authority have set timescales within which to investigate child in need and child protection referrals.

Children Act 2004

The Children Act 2004 came into force following the death of Victoria Climbie and the follow-on review of child protection by Lord Laming.

This Act introduced the following principles:

- Early help/intervention
- Private fostering.

A private fostering arrangement is defined as: ‘an arrangement between families/households, without the involvement of a local authority, for the care of a child under the age of 16 (under 18 if disabled) by someone other than a parent or close relative (close relatives are parents, step-parents, siblings, siblings of a parent and grandparents) for 28 days or more. (LCPP 2010).

This could be an arrangement by mutual agreement between parents and the carers or a situation where a child has left home against their parent’s wishes and is living with a friend and the friend’s family.

The period for which the child is cared for and accommodated by the private foster carer should be continuous, but that continuity is not broken by the occasional short break.

Privately fostered children are a diverse and sometimes vulnerable group and will include:

- Children sent from abroad to stay with another family, usually to improve their educational opportunities
- Asylum seeking and refugee children
- Teenagers who, having broken ties with their parents, are staying in short-term arrangements with friends or other non-relatives
- Children of prisoners placed with distant relatives
- Language students living with host families.

Private foster carers and those with parental responsibility are required to notify children’s social care of their intention to privately foster, to have a child privately fostered or where a child has been privately fostered in an emergency.

It is likely that children’s social care will have been notified of most private fostering arrangements however Trust staff should refer any children who are identified as being privately fostered to the children’s social care team in the borough in which the child is living, unless it has been confirmed that they are already aware.
Child abuse

Abuse and neglect are forms of maltreatment of a child.

The term child abuse describes a range of ways in which people harm children or young people (unborn-17) knowingly, or by failing to act to prevent harm.

Children may be abused in a family or in an institutional or community setting, by those known to them or, more rarely, by a stranger for example, via the internet. They may be abused by an adult or adults, or another child or children.

Child abuse can be physical, emotional, sexual or neglect. In many cases, children are subjected to a combination of types of abuse eg neglect and emotional abuse.

Some forms of abuse are obvious – for example, when an adult strikes out at a child in anger, but others are much more difficult for outsiders to notice. While some types of abuse are caused by someone doing something that harms the child, others are the result of neglect, of failing to take steps to keep children safe and well.

Definitions of abuse

There are four recognised categories of abuse:

Physical abuse

- Hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating or otherwise causing physical harm to a child
- Fabricated or induced illness (FII) may also be caused when a parent or carer feigns the symptoms of, or deliberately causes ill health, to a child whom they are looking after
- Female genital mutilation (FGM).

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 include not giving the child opportunities to express their views, deliberately silencing them or ‘making fun’ of what they say or how they communicate.
- It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond the child’s developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction.
- It may involve seeing or hearing the ill-treatment of another (domestic abuse).
- It may involve serious bullying (including cyberbullying), causing children frequently to feel frightened or in danger, or the exploitation or corruption of children.

Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.

Emotional abuse can also include the risk of radicalisation or of exploitation by a radical group. For further guidance, please refer to the Prevent strategy which can be found on the Intranet.

Sexual abuse

Forcing or enticing a child to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening.

May involve physical contact:

- Assault by penetration (rape or oral sex)
- Non-penetrative acts such as kissing, masturbation, rubbing and touching child outside of clothing.

May also include non-contact activities:

- Involving children in looking at, or in the production of, sexual images
- Watching sexual activities
- Encouraging a child to behave in sexually inappropriate ways
- Grooming a child in preparation for abuse (including via the internet).
Sexual abuse also includes sexual exploitation. Sexual exploitation of children and young people under 18 involves exploitative situations, contexts and relationships where the young person (or third person/s) receive ‘something’ (eg food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of them performing, and/or another or others performing on them, sexual activities. 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.

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

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

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

Working Together to Safeguard Children 2015.
What are the effects of child abuse?

The effects of cruelty to children are wide-ranging and profound. They vary according to the type of abuse and how long it has been endured but can include:

- Behavioural problems
- Educational problems
- Mental health problems
- Relationship difficulties
- Drug and alcohol problems
- Suicide or other self-harm
- Injury and in extreme cases, death.

Many survivors comment that the emotional consequences are far more severe than the physical effects of abuse.

Fortunately, children who are abused can be helped. What is vital is that everyone who works with children, whether they are paid or volunteers, is equipped to recognise signs of child abuse at the earliest opportunity so that the harm can be stopped and the damage can start to be repaired.

Children/young people and families requiring further support

Each borough has a model that will describe how support within the borough is provided. The general principles are the same and can be described in three tiers:

Tier 1: Universal

The majority of children will reach their full potential, supported by their parents/carers with help from universal services (midwives, health visitors, GPs, A&E, schools, housing services etc.). These children do not have or need a lead professional, the parents/carers successfully take on this role.

Tier 2: Targeted

Children and their families who have additional and/or vulnerable needs that go beyond what is on offer from universal services are supported by targeted services. Examples of this include the specialist midwifery teams, family nurse partnership, therapy services, specialist medical or surgical teams within our hospitals, behaviour support, attendance welfare, youth offending team etc.

Many families will at some time have the need for a targeted service. Some may need a very specific intervention to meet a specific need, delivered by a single service. Others may have complex and interlocking needs which mean they need support from a range of targeted services. In these cases, the Common Assessment Framework (CAF) can act as the key assessment tool before any referral. This is to make sure that we are assessing the needs of families properly and have the whole picture of the services they need and are being offered.

Consent should be received from the young person or their parent/carer before any referral is made. Where a family is receiving a range of targeted services, a lead professional should be identified to help co-ordinate their support and this role can be taken on by any service.

Tier 3: Specialist services

Specialist services are where the needs of the child and their family are so great that intensive or complex intervention is required to keep them safe or to ensure their continued development. Specialist services often have a statutory element to them, meaning that either the child or family are statutorily obliged to engage with the service or that the NHS or local authority are statutorily obliged to provide it, or both.
For example, Children and Adolescent Mental Health Services (CAMHS) provide a specialist service, but a child is only statutorily obliged to engage with the service in cases where the intervention is prescribed under the Mental Health Act.

Examples of specialist services include statutory children’s social care interventions (child in need, child protection or Look After Children Service), statutory youth offending service work, services provided for children and young people as a result of statements of special education need and services provided for children and young people with complex mental health needs and/or substance misuse dependency. In these cases, a person from the service providing the statutory intervention will act as the lead professional.

Children subject to statutory requirements

**Children in need**
A child is defined as being ‘in need’ if:
- He/she is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision of services by a local authority
- Their health or development is likely to be significantly impaired, or further impaired, without the provision for them of such services
- They are disabled.
Children Act 1989 (Sect. 17).

**Children in need of protection**
A child is defined as being in need of protection if ‘there is reasonable cause to suspect that a child is suffering, or is likely to suffer significant harm’ Children Act 1989 (Sect. 47).

The definition of significant harm was amended under the Child Adoption Act 2002 to include:
‘impairment suffered from seeing or hearing the ill-treatment of another’ Adoption and Children Act 2002 (Sect. 120).

There are no absolute criteria for identifying significant harm and it will depend on the:
- Degree and extent of physical harm
- Duration and frequency of the abuse or neglect
- Extent of premeditation
- Degree of threat and coercion.

If you are unsure whether this threshold has been met, speak to your safeguarding lead or the Safeguarding Children Team.

**Making a referral to children’s social care**
If a child is considered to be a ‘child in need’ or a ‘child in need of protection as defined by the Children Act 1989, a referral should be made to children’s social care.

Parental consent or the consent of the child if Gillick competent is required for child in need referrals.

Further information on Gillick competency can be found on the NSPCC website.

Any child who will be in hospital for more than three months must be referred, under section 85 of the Children Act 1989, to that hospital’s children’s social care team. The referral should be made as soon as it is anticipated that the child will be in hospital long-term.

If you suspect that a child or young person is in need of protection, you must refer using either the multi-agency referral form or via the electronic portal depending on the specific borough’s requirements.

If you work in a non-clinical area, contact the Safeguarding Children Team for further advice and support.

If you suspect the abuse is being carried out by a member of Barts Health staff, you must inform your line manager and the Safeguarding Children Team.

There must be no delay in making the referral and it should be made before the end of your shift/working day. In an emergency, the referral can be made over the telephone but must then be confirmed in writing on the inter-agency referral form within 48 hours.

Referral processes with each borough are different and therefore the borough specific guidance as described on the safeguarding children Intranet site should be followed.

Where the child is an in patient if there are concerns about the safety and welfare of a child/young person who is currently an in-patient or who has presented at the Emergency Department (ED), they must not be discharged until the consultant paediatrician, whose care they are under is assured that there is an agreed plan in place that will safeguard the child’s welfare.
If you have reason to believe that a child is in imminent danger of harm the police should be called using the 999 emergency services number.

**Completing the referral**
- Be concise, avoiding long explanations.
- Try to use bullet points to clearly state your concerns.
- Fully complete all professionals contact details.
- Ask about siblings and the schools they attend.
- Ask who has parental responsibility.

**What happens once a referral has been made?**
The flow chart above details the full range of processes that could take place. In some circumstances, for example, alternative action will need to be taken, such as the child being placed in foster care.

**What next?**
- **Hopefully:**
  - Co-operation by family with child protection plan
  - Desired change in family ie ‘good enough’ parenting
  - Case is closed by children's social care.

**If things get worse or no change:**

**Looked after children**
Some children who have been victims of abuse or neglect are taken into care by the Local Authority and become ‘looked after children’. This happens when assessment by Children’s Social Care indicates that it is not possible for the birth family to care for the child safely, or to protect the child from further abuse.

**Legal definition of looked after children:**
- ‘Looked After’ – a provision made under the Children’s Act 1989 in England and Wales whereby a local authority has obligations to provide for, or share, the care of a child or young person under 16 years of age where parent(s) or guardian(s) for whatever reason are prevented from providing them with a suitable accommodation or care.

- Care leaver: a person who has been looked after for at least 13 weeks since the age of 14, and who was in care on their 16th birthday.
Children may be taken into care as an emergency, or after a period of time of statutory agencies working with the birth family. Some children are only looked after for a short period and then return home. However, some go on to be adopted or will remain looked after until they reach adulthood.

**Physical illness in LAC: a cross sectional study (2014)**
Study of 1,253 LACs & 10,438 children in their own homes.

**Previously known facts**
- LAC have high prevalence of physical illness
- They have frequent changes in placement, making continuity difficult
- Association with low socio-economic class

**New Findings**
- Increased reported incidence of cerebral palsy, epilepsy and cystic fibrosis, but reduced incidence of atopic conditions
- Increased risk of unmet needs if health professionals and carers fail to identify chronic conditions

There is a legal framework in England and Wales which defines who are looked after children. Children who are victims of neglect or abuse form the majority of looked after children. Children could however, also be accommodated for other reasons:
- At the request of parents due to parental ill health or parental inability to manage challenging behaviour
- Under 18 year olds who arrive in the UK unaccompanied
- Young offenders on remand. Those in custody or a community based alternative eg intensive foster placements or supervision and surveillance.

Depending on the legal status of the looked after child, the Local Authority may or may not have parental responsibilities, and this determines who can give consent for medical treatment. Parental
responsibility means the legal rights, duties, powers, responsibilities and authority a parent has for a child and their property. A person who has parental responsibility for a child has the right to make decisions about their care (including consent to medical treatment) and upbringing:

- Subject of a care order: Local Authority has parental responsibility (PR)
  - Section 31 (Care order)
  - Section 44 (Emergency protection order)
  - Under supervision order, court bail, in remand, secure accommodation order etc (other specific Sections of 1989 Act)
- Accommodated (Section 20): Local authority does not have PR. Birth parents retain PR
- Unaccompanied asylum seeking children: Local Authority has PR

Health needs of Looked After Children

Looked after children (LAC) are amongst the most vulnerable children in our society. Many have suffered prolonged neglect and abuse. They are known to be at significantly increased risk of having mental health and behavioural problems (5 to 10 times of general childhood population) and developmental or learning problems (8 times). Such problems can persist for years after they have been taken into care.

Risk factors for ill-health amongst Looked After Children

The following are factors predisposing Looked After Children to having health and developmental problems:

- Maternal health during pregnancy
  - Drug and alcohol abuse: neonatal abstinence syndrome, foetal alcohol syndrome
  - Congenital infections due to substance abuse and maternal lifestyle: Hep B & C, HIV, Congenital syphilis
  - Mental health conditions
  - Less than optimal antenatal care
- Family history of developmental and psychiatric conditions (>50% with positive family history)
  - Learning difficulties
  - Attention Deficit Hyperactivity Disorder (ADHD)
  - Autism Spectrum Disorder
  - Anxiety and depression
- Increased incidence of hereditary conditions
- Child’s own experience of abuse, neglect, domestic violence, crime and deprivation.

Recognition of health problems and approach to management

Therefore, when providing care for looked after children, it is important to bear in mind the increased likelihood of mental health, behavioural, developmental and learning problems. Such factors could affect the approach to understanding the presenting conditions and the subsequent management plan. Good knowledge of child development is also important.

Just like any other children, LAC are still vulnerable and at risk of abuse and neglect. As a group, they are known to be at increased risk of child sexual exploitation. Therefore, if there are such concerns, advice must be sought and referrals must be made along the usual channels.

Health service for LAC

There are statutory requirements in relation to meeting the health needs of looked after children and Barts Health is commissioned to provide health assessments for Tower Hamlets looked after children and to provide advice to the London Borough of Tower Hamlets. For Newham and Waltham Forest, similar services are provided by East London Foundation Trust, and North East London Foundation Trust.

After coming into care, a looked after child is offered a statutory initial health assessment by a medically qualified practitioner. Subsequently, LAC under 5 years will have 6 monthly statutory health reviews, which includes developmental checks. Schedule of Growing Skills 2 is used by the Barts Health LAC Team for developmental checks. Those between 5 to 18 years will have yearly reviews. Review health assessments can be undertaken either by a nurse or by a doctor. In Tower Hamlets,
Young people aged 17 are given a health passport prior to leaving care, that contains as much of their health history that is known.

Health and developmental issues identified at these assessments are highlighted to the Local Authority in the form of a health care plan that feeds into their 6 monthly LAC Review by Social Care. The LAC health team does not provide hands-on management, but provides advice to carers, young people and the Local Authority, and makes referrals to other health care providers as necessary. In addition, there is a dedicated child and adolescent mental health service pathway commissioned for LAC under Tower Hamlets.

Contact numbers
Tower Hamlets Looked After Children’s health team: 020 8980 3510
Tower Hamlets Looked After Children’s Social Care Team: 020 7364 5006
Newham: Please refer to ELFT and London Borough of Newham websites
Waltham Forest: Please refer to NELFT and London Borough of Tower Hamlets websites

Child protection flagging system
Children attending any service within the borough in which they reside must be checked on the hospital/services electronic record keeping system to see if they are subject to a child protection plan. Each site has local arrangements as to how this information can be accessed and this can be found on the Intranet.

If a child is found to have a child protection plan, whether or not their attendance is deemed to be linked to any child protection issues the appropriate social care and health agencies supporting the family must be informed.

Unexpected Child Death Process
The death of any child is a tragedy and must be thoroughly and sensitively investigated. If a child dies unexpectedly in one of our hospitals, a Datix incident form and SI proforma must be completed. Additionally there is a child death process that must be followed in all cases. Please refer to the SUDIC policy for further guidance.

Within each borough there is a Child Death Overview Panel (CDOP) to which all child deaths must be reported. The purpose of the panel is to review the deaths of all children who reside in the borough and identify themes and trends to determine whether there were modifiable or non-modifiable factors that resulted in the child’s death. If necessary, CDOP will refer the case to the Serious Case Review Panel to consider whether a case review or serious case review is required. For further information in relation to this please refer to Chapter 4 of Working Together to Safeguard Children (2015) which can be found on the safeguarding children section of the Intranet.

Harmful traditional practices

What are harmful traditional practices?

Harmful Traditional Practices – what health workers need to know

Harmful traditional practices are forms of violence which have been committed primarily against women and girls in certain communities and societies for so long that they are considered, or presented by perpetrators, as part of accepted cultural practice.

The most common are:

- **Forced or early marriage**
  Can be defined as ‘a marriage in which one or both spouses do not (or, in the case of some adults with learning or physical disabilities, cannot) consent to the marriage and duress is involved’.

- **So-called ‘honour’-based violence**
  Any type of physical or psychological violence committed in the name of ‘honour’ predominantly against women for actual or perceived immoral behaviour, which is deemed to have shamed their family or community.

- **Female genital mutilation or cutting (FGM)**
  Refers to procedures that intentionally alter or injure female genital organs for non-medical reasons.

- **Witchcraft/Spirit possession**
  The term ‘belief in spirit possession’ can be defined as the belief that an evil force has entered a child and is controlling him or her. Sometimes the term ‘witch’ is used and is defined as the belief that a child is able to use an evil force to harm others.
Victims of forced marriage and “honour” based violence often experience abuse within the relationship. Rape, physical, emotional and psychological violence, forced pregnancy and restrictions on freedom of dress, behaviour and lifestyle are common. Some women are virtually under house arrest, and may only be allowed out if accompanied by family members.

Who is at risk?
The key risk factor for experiencing forced marriage and ‘honour’-based violence is being female. Younger women are the main victims although men are also sometimes affected. The majority of those seeking advice for forced marriage are Asian women and tend to be aged between 18 and 23. FGM is most frequently carried out on young girls between infancy and the age of 15.

Health impact
Harmful traditional practices encompasses a range of abuse which results in physical and psychological harm, disability and even death for significant numbers of women. Patients may present with physical, sexual and mental health issues. Some of the signs to look out for include:

- Issues consistent with domestic abuse
- Anxiety and depression
- Substance misuse
- Eating disorders
- Early and unwanted pregnancy
- Self-harm, suicidal

Women may present to health professionals with many of the same problems evident in women experiencing domestic abuse. Other potential indicators are:

- Family history of older siblings marrying early
- Withdrawal from education, or for women with physical or learning disabilities, withdrawal from their social networks or day care
- A young woman being taken to the doctor to be examined to see if she is a virgin

Possible presentation of symptoms associated with poisoning
- Less commonly, a woman’s hair may have been cut or shaved as punishment

Remember – a woman may be a virtual prisoner at home, so seeing health staff may be a rare opportunity for her to tell someone about what is happening.

Your role as a health worker
As a health worker you are in a unique position to respond to any form of harmful traditional practice by treating the patient with respect and dignity and by:

- Being aware of the possibility of such abuse
- Understanding the cultural context
- Recognizing signs and symptoms
- Initiating discussion
- Assessing safety
- Documenting your findings (not in hand-held notes)
- Giving correct information
- Be sensitive to different needs and ensure all patients can access services equally, for example by providing professional interpreting services

Further information on what to look for and what you can do to help can be found in the guidance. The presence of domestic abuse may also mean that dependent children are at risk of serious harm. If you suspect this, you should follow local child protection procedures and seek a multi-agency response to increasing safety for those affected.
Safeguarding children and domestic abuse

Domestic violence is defined as:

Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over, who are, or have been, intimate partners or family members, regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse:

- Psychological
- Physical
- Sexual
- Financial
- Emotional.

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.

This definition, which is not a legal definition, includes so called ‘honour’ based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group. (Home Office 2013).

Risk and impact domestic abuse has on children

Children living with domestic abuse (DA) and abuse can be adversely affected and the impact is usually on every aspect of a child’s life. The impact of domestic violence and abuse on an individual child will vary according to the child’s resilience and the strengths and weaknesses of their particular circumstances.

RISK

- 90 percent of cases with children in same/next room.
- About half the children in DA families have themselves been badly hit or beaten.
- 75 percent of children subject to a child protection plan live in households with DV.
- 90 percent of child deaths through abuse feature domestic violence.

IMPACT

- Children may get caught in the ‘cross-fire’ protecting their mother or father and sustain physical injuries.
- Girls often seek to protect siblings during episodes of violence.
- Depression, anxiety, guilt, fear, insecurity, sleeping and eating disorders, nightmares, shame, self-harming.
- Difficulties with concentration, heightened aggression, violence as ‘normal’, early sexual and/or drug activity, disobedience/anti-social behaviour.

Referral process

Child:

If there are children in the household then a referral to children’s social care may need to be completed if at risk of significant harm. All cases should be discussed with the Safeguarding Children Team (consent not needed) if unsure.
As a minimum, the information will need to be shared with all health professionals working with the child as an early help assessment (eg Common Assessment Framework CAF) will need to be undertaken.

**Adult:**

There are a range of support services available for people affected by domestic abuse. Whilst the referral processes for each of the boroughs that we work with differs slightly, the support the victim receives will be similar. In all cases the victim must consent to the referral being made. Details of the services can be found on the services and support page and on the risk assessment and referral page of the domestic abuse site on the Barts Health Intranet: http://bartshealthintranet/About-Us/Corporate-Directorates/Nursing-and-Governance/Safeguarding/Domestic-abuse/Index.aspx

In all cases some level of risk assessment must be undertaken based on the information available, irrespective of whether referral to support services has been agreed. The referral form / DV1 and DASH (domestic abuse, stalking and honour based violence) risk assessment form can be used to guide this assessment. Cases of high risk must be referred to MARAC (multi-agency risk assessment conference). Although consent should be sought, referral to MARAC must be made if the risks have been identified, even if consent is not given.

Staff unsure about undertaking a risk assessment must inform a senior practitioner or their line manager and contact the safeguarding children or safeguarding adults team to identify who can support them with this if there is no one within the department that can do so. Further information is available within the domestic abuse level 2 briefing.

Borough specific guidelines for safeguarding children and adults must be followed in all cases where domestic abuse is identified.

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**National/local safeguarding children guidance**

There is a range of national and local safeguarding guidance, policies and procedures to support us in our work which is available on the safeguarding children Intranet page.

Thank you for reading this briefing. Further safeguarding children information and the teams contact details are available on the safeguarding children Intranet page which can be accessed via the ‘I want to’ drop-down on the trust Intranet homepage.

**Acute staff:**

**Newham:**

Monday – Friday 9 – 5: Tel: 0207 363 9147 / 9368 or via Newham Hospital switchboard.

Outside of office hours, an on-call Named Nurse for Safeguarding Children can be contacted via the hospital switchboard or bleep 123.

**Tower Hamlets:**

Monday – Friday 9 – 5: advice can be sought from a member of the Safeguarding Children Team on:

- **Acute Services:** 0203 594 6003
- **Community Services:** 0208 223 8879

Outside of office hours, the on-call Named Nurse for Safeguarding Children can be contacted via The Royal London Hospital switchboard on 0207 377 7000.

**Whipps Cross:**

Monday – Friday 9 – 5: Tel: 0208 535 6855, Mobile: 07572 160538 or via Whipps Cross Hospital switchboard or bleep 518.

Outside of office hours, the on-call Named Nurse for Safeguarding Children can be contacted via the hospital switchboard.