

National Safeguarding Team (NHS Wales)

**A Guide for Safeguarding
Children and Adults at Risk in
General Practice**

September 2016 v1

Purpose and Summary of Document

The purpose of this guidance is to clarify the roles and responsibilities of General Practitioners and Practice staff in promoting the safety and well-being of children, young people and adults at risk.

This document modernises and replaces “A Guide for Safeguarding Children and Young People in General Practice” Version 5 issued by Public Health Wales (PHW) 24.02.2015.

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Foreword

There have been significant changes in safeguarding knowledge, priorities, practice and legislation since 'A guide for Safeguarding Children and Vulnerable Adults in General Practice' was first published by the Safeguarding Children Service in 2012. As a consequence safeguarding has evolved. The original guidance was devised mainly for safeguarding children with only some parts looking at adult safeguarding, whereas currently there is a move to safeguarding across all ages.

The biggest changes are due to the [Social Services and Well-being \(Wales\) Act 2014](#) which came into effect in April 2016 (see below for details of the Act with particular respect to safeguarding). This major legislative change will have a significant impact on the safeguarding of children, young people and adults.

Other recent legislative and strategy changes impacting on safeguarding are:

- [Well-being of Future Generations \(Wales\) act 2015](#)
- [Violence against Women, Domestic Abuse and Sexual Violence \(Wales\) Act 2015](#)
- [Safeguarding Children and Young People from Sexual Exploitation: Supplementary guidance to Safeguarding Children: Working Together Under The Children Act 2004](#)
- [Prevent Duty Guidance, 2015](#)
- [Mandatory Reporting of FGM](#)
- [Health and Care Standards \(Wales\) April 2015](#)
- [Talk to Me 2: Suicide and self harm prevention strategy for Wales 2015-2020](#)
- [Response to the Supreme Court Judgment/ Deprivation of Liberty Safeguards 2015](#)
- [The Revised Caldicott Principles.](#)

In safeguarding children and young people the themes of suicide and self harm, child sexual exploitation, female genital mutilation (FGM), domestic abuse and internet and technology based abuse have become much more prominent. The local Safeguarding Children Boards have merged to become

six Regional Safeguarding Children Boards (RSCBs) across Wales. The profile of child abuse has increased not just in the media but within public bodies such as Health, Education and the Police. There is now a National Safeguarding Board set up in April 2016 that looks at safeguarding across Wales, across all ages and across all public service agencies. Health Boards and Trusts have also moved to a safeguarding structure where they have merged many aspects of children's and adult safeguarding.

The safeguarding of Adults at Risk (formerly vulnerable adults) has become a much larger priority, particularly within Health. There are now Adult Safeguarding Boards similar to RSCBs, with the likelihood of children's and adult boards merging in the future. The Social Services and Well-being (Wales) Act 2014 has made it a duty to report all adults at risk, as well as children, to the relevant local authority department. The Mental Capacity Act and deprivation of Liberty Standards are having a huge impact on adults in nursing homes and residential care and hence on Primary Care. As a consequence of this we have undertaken to rewrite the guidance in full.

Social Services and Well-being (Wales) Act 2014

The Social Services and Well-being (Wales) Act 2014 came into effect in April 2016. It sets out what must and should be done to safeguard children and adults. The intention of the Act is to strengthen and build on existing practice. It is important that health professionals and workers are aware of the law, guidance and regulations that apply to their role.

Over Arching Principles and Duties

The Act aims to change the way people's care and support needs are met. The vision of care and support under the Act is one where individuals have a voice in and control over reaching the goals that matter to them and to help them achieve wellbeing.

Central to the Act is the well-being duty. People have a responsibility for their own well-being supported by their families, friends and communities. However, they may also need support from practitioners to ensure that they achieve well-being. A person exercising functions under the Act must seek to promote the well-being of people who need care and support, and

carers who need support. This overarching duty applies to health organisations and their practitioners.

The Act attempts to rebalance the focus of care and support to prevention and earlier intervention, increasing preventative services within the community to minimise the escalation of needs to a critical level.

Collaboration, strong partnership working between organisations and co-production with people needing care and/or support is a key focus of the Act.

Other over arching duties are:

- When exercising functions under the Act, practitioners have to:
 - ascertain and have regard to the individual's views, wishes and feelings (and for under 16s, those with parental responsibility, if practical and consistent with the child's well-being);
 - support them to participate in decisions and to communicate;
 - promote and respect their dignity;
 - have regard to the characteristics, culture and beliefs of the individual;Supporting people to participate includes considering whether advocacy support is necessary.

For adults specifically there is also the duty to:

- a) begin with the presumption that an adult is best placed to judge their own well-being and;
 - b) to have regard to the importance of promoting their independence where possible.
- For children specifically there is also the duty to promote the upbringing of the child by the child's family, in so far as doing so is consistent with the well-being of the child.

In the Act protection from abuse and neglect is one of the aspects of well-being. In relation to a child, well-being also includes their physical, intellectual, emotional, social and behavioural development as well as their

welfare and ensuring that they are kept safe from harm. Safeguarding is part of helping people to live life to the full, not just stopping abuse, neglect and harm.

Other Legislation

Under the Act, you need to have regard to the following;

- [United Nations Principles for Older Persons](#). This includes respect for older people's dignity, beliefs, needs and privacy and for the right to make decisions about their care and the quality of their lives.
- [United Nations Convention on the Rights of the Child](#). This includes the right to life, survival and development, and protection from violence, abuse and neglect.
- [United Nations Convention on the Rights of Disabled People](#) (UNCRDP).

The code of practice for Part 2 of the Act also points out that public authorities must not act in a way that is incompatible with rights under the [European Convention on Human Rights](#). This includes the right not to be subjected to inhuman or degrading treatment and the right to liberty and security.

Safeguarding

Part 7 of the Act (sections 126-142) deals with safeguarding and is underpinned by the overarching duties of the Act. It reiterates that safeguarding is everyone's business and that practitioners in all agencies need to recognise and act when they identify children and adults at risk. It also confirms that safeguarding is much broader than protection from abuse, neglect or harm and that how to help people to keep themselves safe should be something that is always considered.

Other parts of the Act link to the duty to protect people from abuse and neglect, and to protect children from harm are:

- Part 2 links prevention, information and advice to safeguarding;
- Part 3 links assessment to safeguarding;
- Part 4 links meeting needs to safeguarding;

- Part 6, Section 78 says that a local authority looking after any child must safeguard and promote the child's well-being;
- Part 9 says that a local authority must make arrangements to promote co-operation between itself and partners with a view to protecting adults with needs for care and support, or children, who are experiencing, or are at risk of, abuse or neglect;
- Part 10 says that local authorities must arrange, where necessary, for an independent advocate to support and represent an individual in safeguarding processes.

Adults

There is a definition of an Adult at Risk and this phrase replaces the term Vulnerable Adult. The inclusion of at risk enables early intervention to protect an adult at risk.

There is a new duty to report Adults at Risk (Section 128). This is a duty for relevant partners of a local authority including health, probation and the police. If a partner has reasonable cause to suspect that a person is an adult at risk it must inform the local authority of that fact. The decision to act does not require actual abuse or neglect to have taken place. The aim is to protect people who need it and to help them to prevent abuse or neglect.

There is a new duty for a local authority to make enquiries if it has reasonable cause to suspect that a person within its area (whether or not ordinarily resident there) is an adult at risk. Authorities must decide whether any action should be taken and, if so, what and by whom. The timescale is usually 7 days to make the enquiry.

The statutory guidance and regulations, explains the new adult protection and support orders (APSO). An authorised officer may apply to a justice of the peace for an order in relation to an adult living within the local authority's area. APSOs are only to be used in exceptional circumstances where other attempts to speak to the adult considered to be at risk have failed.

Children and Young People Under 18

There is a new definition of a 'Child at Risk'. The old term of 'Child in Need' as under section 17 of the Children Act 1989 is removed.

There is a new duty for relevant partners of a local authority to report children at risk (Section 130). If a partner has reasonable cause to suspect a child is at risk it must inform the local authority of that fact. Again the decision to act does not require actual abuse or neglect to have taken place.

When a child has been reported under Section 130 of the Act the local authority shall make enquiries to enable them to decide whether they should take action to safeguard or promote the child's welfare under section 47 of the Children Act 1989.

This means that practitioners will still need to use the Children Act 1989 section 47 and the All Wales Child Protection Procedures in the same way as they do now when responding to child protection referrals.

Safeguarding Children and Adult Boards Across Wales

The Act establishes six Safeguarding Boards for Children and six for Adults arranged in regions across Wales. There will be representation on Boards from a range of statutory agencies, such as health, probation and the police, not just local authorities. Their aim is to strengthen consistency, ensure good practice and support culture change. Boards have two main roles; prevention and protection. The Act allows for Children and Adult Boards to merge.

Their purpose is to protect or prevent adults or children within their area who are experiencing, or are at risk of abuse, neglect or (for children) other kinds of harm. Their functions include: to scrutinise practice in relevant agencies; raise awareness of policies and procedures; undertake practice reviews and audits; and to disseminate information on best practice or facilitate research into protection, and review training needs.

Boards should ensure that national policies and procedures, aimed at keeping children and adults who have needs for care and support safe from

abuse and neglect, are relevant and fit for purpose. Participation of people who are the recipients of safeguarding services in the work of the Boards will be an expectation and Boards will need to show that they can evidence this.

Each Board must publish a plan each (financial) year setting out what it intends to do and a report on progress and work achieved at the end of that year.

A partner organisation must comply for requests for information from the Board, unless this is incompatible with its duties or will have an adverse effect on its functions.

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1 INTRODUCTION

This document is intended as a guide for practices and practice staff to help them in safeguarding children, young people and adults at risk. It should be used by practices to inform their own practice policies and procedures on safeguarding.

The general practitioner and members of the primary health care team including receptionists and other administrative staff are well placed to recognise when an individual is potentially in need of extra help or services to promote wellbeing, health and development, or is at risk of harm. They are also well placed to recognise when a parent or other adult has problems which may affect their capacity as a parent or carer or which may mean that they pose a risk of harm to a child or adult at risk in their care.

All health professionals have a statutory duty of care to their patients. This duty extends to ensuring safeguarding arrangements are in place to promote the health of and protect the most vulnerable members of society. Furthermore, the Social Care and Wellbeing (Wales) Act 2014 makes it clear that all staff in the public sector have a duty to safeguard the welfare of children and young people and to report to the local authority when they have a reasonable cause to suspect that a person is an adult or a child at risk.

General Practitioners and their support staff are in a key position to become aware of safeguarding concerns at an early stage given their relationship with individual patients, their families and communities. Contacts from surgery consultations, home visits, health clinic attendances, together with information from hospital visits, A & E attendances and consultations with the Out of Hours Service all help to build up a picture of an individual's situation and can alert the team to potential concerns.

Therefore primary care teams should:

- Be alert to the potential indicators of abuse and neglect,
- Be familiar with local procedures for promoting and safeguarding the welfare of children, young people and adults at risk, and
- Understand the principles of patient confidentiality and information sharing.

The Welsh Government Health and Care Standards on Safeguarding Children and Safeguarding Adults at Risk require that Health services promote and protect the welfare and safety of children and adults who become vulnerable or at risk at any time. *(See Appendix 1 for further details).*

This guidance aims to support primary care teams in establishing and maintaining safeguarding arrangements for children, young people and adults at risk that they come into contact with during the course of their work. The emphasis and underlying principles inherent within this guidance are in regard to safeguarding. These support the preventative model of intervention promoted by recent child care legislation, moving the emphasis from abusive incidents on to the wellbeing of people and families.

The General Medical Council's guidance is essential reading.

This includes:

- Good Medical Practice (2013),
- Protecting Children and Young People: Responsibilities of all Doctors,
- 0–18 years: guidance for all doctors,
- Consent,
- Confidentiality.

2 DEFINITIONS

What is a Safeguarding Issue?

Safeguarding means preventing harm and acting to protect children and adults at risk from actual or potential abuse, neglect or exploitation and ensuring they receive proper care that promotes health and welfare.

Safeguarding concerns can arise within almost all areas of practice. It is important that all members of staff have an appropriate level of understanding of the signs and presentations of abuse and neglect and are able to implement the Child Protection or Protection of Vulnerable Adults (POVA) procedures.

Definition of a Child and Young Person

The Social Care and Wellbeing (Wales) Act 2014 defines a child as being any person under 18 years old. The term child includes children and young people. The fact that a child has reached 16 years of age, is living independently, is in further education, is a member of the Armed Forces or is in hospital, prison or a young offender's institution does not change their status or their entitlement to services or protection under the Act.

Definition of an Adult at Risk

The Social Care and Wellbeing (Wales) Act 2014 states "Adult" means a person who is aged 18 or over and an "adult at risk" is an adult who;

- (a) is experiencing or is at risk of abuse or neglect,
- (b) has needs for care and support (whether or not the authority is meeting any of those needs), and
- (c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

In general terms, an adult is classed as at risk when they are receiving one of the following services.

- Continuing health care;
- Relevant personal care;
- Social care work;

- Assistance in relation to general household matters by reason of age, illness or disability;
- Relevant assistance in the conduct of their own affairs; or
- Assistance with communication that may be due to age, illness, disability in some circumstances or where English is not their first language.

People with learning disabilities or mental health problems, older people and disabled people may fall within this definition, particularly when their situation is complicated by additional factors such as physical frailty or chronic illness, sensory impairment, challenging behaviour, social or emotional problems, poverty or homelessness.

Definitions of Abuse and Neglect

Abuse is a violation of an individual's human rights and is a criminal act. It may be a single or repeated incident of neglect or abuse. It may be physical, sexual, psychological, emotional or financial abuse and includes abuse taking place in any setting, whether in a private dwelling, an institution or any other place. It can be an act of neglect or omission to act, or be the unintended result of a person's actions. Self-neglect or self-abuse is a failure to provide for oneself, through inattention or inappropriate diversion of resources¹.

Harm in relation to a child, means abuse or the impairment of

- (a) physical or mental health, or
- (b) physical, intellectual, emotional, social or behavioural development, and where the question of whether harm is significant turns on the child's health or development, the child's health or development is to be compared with that which could reasonably be expected of a similar child¹

Abuse and Neglect of Children and Young People

Abuse is a violation of an individual's human rights. It may be a single or repeated incident of neglect or abuse. It may be physical, verbal, psychological, financial or sexual. It can be an act of neglect or omission to act, or be the unintended result of a person's actions. Self-neglect/self-abuse is a failure to provide for oneself, through inattention or dissipation.

The Local Health Board Lead Nurse for Safeguarding and POVA Lead are available to practice staff to provide guidance for specific concerns about individual cases and for general safeguarding advice. The Designated Doctors and Nurses (Safeguarding Service Public Health Wales) are a further available source of advice and support.

A child is abused or neglected when somebody inflicts harm or fails to act to prevent harm. Abuse may take place within the family or in an institutional or community setting by those known to them or more rarely by a stranger. Signs and symptoms will vary but may be indicated through injury, the child's presentation or the behaviour of parents or carers. Significant factors in parents and carers that lead to safeguarding concerns are Domestic Abuse, Substance and Alcohol Misuse, and Mental Health Problems.

Any observations or comments that lead to concerns or uncertainty about abuse or neglect should be acted upon by implementing the All Wales Child Protection Procedures (2008) or by seeking advice and guidance.

Where professionals 'consider' child maltreatment they should record their concerns and liaise with other health professionals involved and seek advice.

However when they 'suspect' child maltreatment they should refer the child to social services. In the latter case they should follow the process as laid out in the 'All Wales Child Protection Procedures' (2008).

Guidance from NICE (Clinical Guidelines 89) discusses possible signs of child maltreatment.

Types of Abuse: Children and Young People

In safeguarding children and young people there are four recognised forms of abuse.

Physical Abuse

Physical abuse may involve hitting, 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 or induces illness in a child whom they are looking after.

Physical abuse can lead directly to neurological damage, physical injuries, disability or at the extreme death. Harm may be caused to children both by the abuse itself and by the abuse taking place in a wider family or institutional context of conflict and aggression. Physical abuse has been linked to aggressive behaviour in children, emotional and behavioural problems, and educational difficulties. Violence is pervasive and the physical abuse of children frequently coexists with domestic abuse.

Emotional Abuse

Emotional abuse is the persistent emotional ill-treatment 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. It may feature age or developmentally inappropriate expectations being imposed on children. It may involve 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 ill-treatment of a child, though it may occur alone.

There is increasing evidence of the adverse long-term consequences for children's development where they have been subject to sustained emotional abuse. Emotional abuse has an important impact on a developing child's mental health, behaviour and self-esteem. It can be especially damaging in infancy. Underlying emotional abuse may be as important, if not more so, than other more visible forms of abuse in terms of its impact on the child. Domestic abuse, adult mental health problems and parental substance misuse may be features in families where children are exposed to such abuse.

Sexual Abuse

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

Disturbed behaviour including self-harm, inappropriate sexualised behaviour, depression and a loss of self-esteem, have all been linked to sexual abuse. Its adverse effects may endure into adulthood. The severity of impact on a child is believed to increase the longer abuse continues, the more extensive the abuse, and the older the child. A number of features of sexual abuse have also been linked with severity of impact, including the relationship of the abuser to the child, the extent of premeditation, the degree of threat and coercion, sadism, and unusual elements. A child's ability to cope with the experience of sexual abuse, once recognised or disclosed, is strengthened by the support of a non-abusive adult carer who believes the child, helps the child understand the abuse, and is able to offer help and protection. The reactions of practitioners also have an impact on the child's ability to cope with what has happened, and his or her feelings of self worth.

A proportion of adults who sexually abuse children have themselves been sexually abused as children. They may also have been exposed as children to domestic abuse and discontinuity of care. Sexual abuse on children can have an impact on future relationships and a proportion of children who have been sexually abused may go on to sexually abuse children themselves. However, it would be quite wrong to suggest that most children who are sexually abused will inevitably go on to become abusers themselves.

Neglect

Neglect means a failure to meet a person's basic physical, emotional, social or psychological needs, which is likely to result in an impairment of the person's well-being (for example, an impairment of the person's health or, in the case of a child, an impairment of the child's development).

It may involve a parent or carer failing to provide adequate food, shelter and clothing, failing to protect a child from physical harm or danger, or the failure to ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

The severe neglect of young children has adverse effects on children's ability to form attachments and is associated with major impairment of growth and intellectual development. Persistent neglect can lead to serious

impairment of health and development, and long-term difficulties with social functioning, relationships and educational progress. Neglected children may also experience low self esteem, feelings of being unloved and isolated. Neglect can also result, in extreme cases, in death. The impact of neglect varies depending on how long children have been neglected, the children's age, and the multiplicity of neglectful behaviours children have been experiencing.

Types of Abuse: Adults at Risk

Suspicious of abuse, neglect or exploitation of adults at risk may be triggered by observations of the patients' presentation or by concerns about lack of appropriate care at their home or in a community or residential placement. It may also be reported by the adult themselves. Such reports need to be taken seriously and investigated carefully.

It is also important that caregivers realise that a consensus has emerged identifying 'neglect and acts of omission' as a form of abuse. This includes ignoring medical and physical care needs, failure to provide access to appropriate health services and withholding the necessities of life, such as medication, adequate nutrition and heating.

Practice staff are well placed to identify the risks to general health and well being that are associated with inadequate care, both in the short and long term. The assessment process must identify the factors that may cause problems or impact on the quality of life of the individual patient concerned. To reach such a decision, it is essential that the assessment is approached in a multi-professional way, in collaboration with all those involved in the care of the patient. This will enable appropriate management strategies to be identified and written into care plans.

Seven discrete but related forms of abuse have been identified for adults at risk:

Physical Abuse

Physical abuse can be defined as the non-accidental infliction of physical force that results in bodily injury, pain or impairment. For example, hitting, pushing, pinching, shaking, misusing medication, scalding and the misuse or illegal use of restraint.

Emotional Abuse

Emotional abuse is behaviour or actions that have a harmful effect on the emotional, health and/or development of an adult at risk. This can include threats, deprivation of contact, shouting, ignoring, cruelty, bullying, humiliation, coercion, negating the right of the adult at risk to make choices and undermining self-esteem.

Sexual Abuse

Sexual abuse is the direct or indirect involvement of the adult at risk in sexual activity or relationships, which they:

- Do not want or have not consented to;
- Cannot understand and lack the mental capacity to be able to give consent to;
- Have been coerced into because the other person is in a position of trust, power or authority (for example a care worker).

This includes indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual photography, subjection to pornography or the witnessing sexual acts as well as rape.

Neglect and Acts of Omission

Neglect and acts of omission are the failure of any person, who has responsibility for the charge, care or custody of an adult at risk, to provide the amount and type of care that a reasonable person would be expected to provide. Neglect can be intentional or unintentional. For example, failure to provide for medical, social or educational needs or withholding necessities such as food, drink and warmth and a lack of protection from hazards.

Financial Abuse

Financial abuse is the use of a person's property, assets, income, funds or any resources without their informed consent or authorisation. Financial abuse is a crime.

It includes:

- Theft or fraud;
- Exploitation;
- Undue pressure in connection with wills, property, inheritance or financial transactions;

- The misuse or misappropriation of property, possessions or benefits;
- The misuse of an enduring power of attorney or a lasting power of attorney, or appointeeship.

Discriminatory Abuse

Discriminatory abuse occurs where there is abuse or unfair treatment motivated because by age, gender, sexuality, disability, religion, class, culture, language, and race or ethnic origin.

It can be a feature of any form of abuse of an adult at risk and often occurs when values, beliefs or culture result in a misuse of power that denies opportunity to some groups or individuals e.g. exploiting a person's vulnerability by treating them in a way that excludes them from opportunities they should have as equal citizens, for example, education, health, justice and access to services and protection.

Institutional Abuse

Institutional abuse is the mistreatment, abuse or neglect of an adult at risk by a regime or group of individuals. It takes place in settings and services that adults at risk live in or use. It violates the person's dignity and is a lack of respect for their human rights.

Institutional abuse can occur when the routines, systems and regimes of an institution result in poor or inadequate standards of care and poor practice. It can take the form of an organisation failing to respond to, or address, examples of poor practice brought to their attention. It can take place in day care, care homes, hostels, hospitals, sheltered and supported housing.

It can be difficult to identify the difference between a poor service and institutional abuse.

“A duty of care exists when duties or responsibilities are placed on paid carers” (Ashton & Ward, 2008). It is also important that caregivers realise that the Department of Health publication *No Secrets* (2000) states that a consensus has emerged identifying ‘neglect and acts of omission’ as a form of abuse. This includes ignoring medical and physical care needs, failure to provide access to appropriate health services and withholding the necessities of life, such as medication, adequate nutrition and heating.

Where can abuse happen?

Anywhere, including:

- in a person's own home
- in a residential or nursing home
- in a hospital
- in the workplace
- at a day centre or educational establishment
- in sheltered or supported housing
- in the street.

Who can abuse?

The person responsible for the abuse is often well known to the person being abused, and could be:

- a paid carer in a residential establishment or from a home care service
- a person employed directly by someone in their own home as a carer or a personal assistant
- a social care worker
- a health worker
- a relative, friend, or neighbour
- another resident or person using a service in a shared care setting
- someone providing a support service.

It can also be people who:

- befriend vulnerable people with the intention of exploiting them
- deceive people into believing they are from legitimate businesses, services or utility providers
- intimidate vulnerable people into financial transactions they do not want or cannot understand.

There is often considerable overlap e.g. domestic abuse is often a combination of physical, emotional, financial and sexual abuse.

Wales Interim Policy & Procedures for the Protection of Vulnerable Adults from Abuse (updated January 2013) should be applied when there are suspicions of abuse.

“Safeguarding Vulnerable Adults a Tool Kit for GPs” (BMA 2011) provides valuable information and further guidance to support practice.

3 REPORTING CONCERNS: WHAT TO DO IF YOU IDENTIFY OR SUSPECT ABUSE OR NEGLECT

As a member of Primary Care you have a legal duty to report concerns and take action to safeguard the welfare and safety of a child, young person and/or adult at risk.

Any member of the Primary Care team who detects possible signs of neglect or abuse in a child or adult should take immediate action as below.

Listen and Observe

Note factual signs and symptoms of potential or suspected abuse or neglect without alarming the patient or alerting a possible abuser. If appropriate, listen sympathetically to what a child or adult at risk tells you (as they are often ignored) but do not agree not to tell anyone.

Imminent Danger

Where you are concerned that the child, young person or adult at risk is in immediate danger you **must** contact the appropriate Local Authority Social Services Team straight away. If there are severe injuries requiring further medical treatment a 999 call for police and ambulance should be made **and** then the social services contacted.

Share Concerns

Alert and discuss your concerns with your manager, senior professional or designated staff member depending on your practice procedure. If necessary seek advice from the local Health Board and/or Local Authority Safeguarding Team.

Consider and agree whether it is appropriate to seek agreement to the referral from the child, young person, adult at risk and/or parent/carer, or for them to be informed of the referral. You need to consider whether doing so would place the child, young person or adult at risk at increased risk of suffering significant harm.

Report

If after consideration and discussion you feel that a safeguarding referral is appropriate you should contact the Local Authority Social Services Child or Adult team by phone to report your concerns. Social services teams are available 24 hours a day but may have different contact details out of normal working hours.

This should be followed up within 48 hours with a written report. Social services will usually send a copy of their local referral form by fax/e-mail for completion. These forms can be long and ask for information that is not available to you or your team. You should endeavour to complete those parts for which you are able to provide information.

When reporting information, reports should be restricted to the nature of the injury, suspicious behaviour or concern facts to support the possibility that the injuries or concerns are suspicious. Agree with recipient of referral what the patient and relatives/ carers will be told, by whom and when (and note this).

You should receive confirmation of referral within one working day. If you have not had confirmation within three working days you should contact social services again.

Referral Not Appropriate

You should consider whether the child, young person or adult at risk would still benefit from support or help from social services or another appropriate agency.

If you feel that this is appropriate you should seek consent from the child, young person, adult at risk or their parent/carer to make this referral.

If consent is refused you should contemplate whether this would alter your decision about a safeguarding referral.

Record

You must ensure that all observations, advice sought/received, including from whom and all actions taken are recorded. You should justify any actions you have taken and also give reasons where you have decided not to take any action. These records must be stored confidentially in the patient record.

Review

You should look to review the case and or patient whether you took any action or not. This affords the opportunity to re-evaluate the situation and to confirm that any actions needed have been followed up. There may also be new information available.

If on review or re-evaluation you still have concerns or there are new concerns, you should reconsider your decision about reporting to social services or inform social services of this additional information.

When providing further information it is important to do this by using the same process as for a referral to ensure that this information is incorporated into social services system. Again record and justify any decisions made.

You may then decide to continue to monitor and review the case or to close it.

Appendix 2 provides a Flowchart for actions to be taken when there are safeguarding concerns.

N.B. You should also refer to the [‘All Wales Child Protection Procedures’](#) and the [Wales Interim Policy & Procedures for the Protection of Vulnerable Adults from Abuse](#)

4 PRACTICE ORGANISATION

Safeguarding Practice Lead

It is recommended that each practice should have a Safeguarding Practice Lead (SPL) who must be a general practitioner.

The SPL is not expected to be an expert in safeguarding or deal with all safeguarding issues but a central person who will have oversight of safeguarding matters for the practice. The SPL will enable the other members of the practice to be aware of and access relevant guidance, recognise training needs and appropriate training events and be able to access appropriate support and advice on safeguarding matters.

No individual within a practice should however feel unsupported and good practice organisation will support individuals as well as the whole team in raising concerns and dealing with them appropriately.

Key Tasks of the Safeguarding Practice Lead

The function of the SPL is to maintain an overview of safeguarding practice and will include:

- Ensuring that partners and all staff employed by the practice are aware of their duty to safeguard and are familiar with Safeguarding Children and POVA procedures.
- Ensuring that Practice Safeguarding Children and Adults at risk policies and procedures are developed, implemented and regularly monitored and updated. Also that the Practice meets statutory responsibilities, contractual guidance and national and local regulatory requirements relating to Safeguarding.
- Ensures that the Practice meets medico-legal and regulatory inspection requirements in relation to information sharing and record keeping,
- Ensuring that training needs are determined, they are met and are in line with “Safeguarding children and young people: roles and competences for health care staff” the Intercollegiate Document.
- Ensuring safe recruitment procedures including taking up references and Vetting and Barring checks where indicated.

- Ensures national and local recommendations from statutory Child Protection Case Reviews, Serious Case Reviews and Child Death Reviews are implemented.
- Ensuring that they and all members of their practice are aware of whom to contact locally in the health service, social services and the police in the event of child protection and POVA concerns.
- Providing, within their normal capabilities, practical everyday support and guidance to staff who may have concerns about the welfare and safety of a child or adult at risk including:
 - Assisting them when dealing with child and adult at risk protection matters,
 - Informing them of how sources of safeguarding support and advice can be accessed.
 - Supporting colleagues with making referrals for child and adult protection and reports for Case Conferences
 - Supporting them with participation in statutory and other safeguarding reviews such as Child or Adult Practice reviews, Child Death Reviews and Safeguarding/Protection Audits
- Acting as a focus for external contacts including those from Public Health, Education, Social Care, the Named Safeguarding Professionals, Designated Safeguarding Children Team, regulators and contractors.
- Ensuring that systems are in place to facilitate case discussions by primary health care team about families where there are concerns. Including regular meetings with others in the Primary Healthcare Team such as health visitors, community nurses, then Primary Care Mental Health Team, school nurses, and community children's nurses to discuss particular concerns about vulnerable children, adults and families,
- Maintaining an overview of relevant significant events and complaints against the practice in order to identify any which might have a safeguarding element, and consult with Health Board Named Professionals about complaints where there are safeguarding issues particularly if there is an inferred allegation of professional abuse.
- Will ensure that all staff are aware of the national and local policies relating to professional abuse and raising concerns about professional practice (whistle blowing).

Provision of a Safe and appropriate Environment and Health Promotion

Within the Practice there is a need to ensure that the facilities are appropriate and staff are appropriately trained and qualified for the examination and treatment of children, young people and adults at risk.

Practices should provide a safe and welcoming environment. This is particularly important where children are concerned.

There is an opportunity for practices to be a valuable resource for public information and to promote the rights of patients.

- Posters and leaflets should be clearly visible and available and cover such topics as: drug and alcohol abuse, domestic violence, sexual and reproductive health clinics and young people clinics.
- Clear information about confidential helplines should be visible and available within the waiting area, for example the contact numbers for Childline, NSPCC helplines, MEIC, Domestic Abuse helpline and any locally available advocacy services for children, young people and adults at risk.
- Information should be available and accessible for young people who may also attend without their parents and carers.
- Any practice policy or procedure relating to young people for example, on confidentiality, should be made readily available.
- Information should be displayed to advise patients/public how to make a complaint and what response they should expect.

Parents/carers should be encouraged to remain with their child or the patient that they are accompanying at all times. Where this is not possible, or a young person or vulnerable adult wishes to attend alone, then a second member of the team should be present to act as a chaperone for the patient and to support the staff member. If either the doctor or patient does not wish a chaperone to be present the fact should be recorded. Also if an offer for a chaperone was made and declined. This provides staff with security against false allegations, however it would not be acceptable for a practice to refuse to see an unaccompanied minor if they insisted on a private consultation.

Such safe practice should apply to any care environment including residential homes and the patients' own home.

Safe Recruitment Practice

As employers, the practice must ensure all staff working with children and adults at risk are suitable for the post.

Prior to employment all staff with access to children and adults at risk, including staff with access to patient records should have a Disclosure and Barring Service (DBS) check carried out as set out in the policy of the Health Board and in line with current legislation.

If temporary staff are recruited from an agency then the practice should be assured that appropriate checks have been made by the agency.

Doctors in training should have been checked by the Post Graduate Deanery.

Advice must be sought from Safeguarding advisors following notice of a relevant criminal conviction for a member of the practice staff.

Appointment Process

Employers must ensure that all staff engaged to work with children, young people and adults at risk are suitable to do so. All reasonable steps must be taken in the employment process including:

- Availability of a full employment history with satisfactory explanations for any gaps in employment history.
- Qualifications and professional registration are checked.
- Proof of identity is checked (birth certificate and passport).
- References are properly validated. At least two references should be requested, one of which would be from the present employer – if not this should be explored.
- The referee should be clearly informed of the nature of the post. The referee should also be asked if they would be willing to employ the applicant again and whether they had any issues or concerns in the behaviour of the candidate.
- Wherever possible references should be available at/before the interview, but if this is not possible they must be available before appointment and taking up post. Unconditional offers of employment must not be made until references have been checked. It is recommended that the referee should be contacted directly. Telephone contact should be made when clarification of details given in

references is required and a written record of the contact kept. This information must be made available to those responsible for making the appointment.

- A disclosure and barring check where appropriate depending on access to children and adults at risk.
- The candidate should be clear that failure to disclose previous and any new convictions is a disciplinary issue.
- It is now a criminal offence to appoint a person who is unsuitable to work with children by virtue of a previous relevant conviction. (This offence carries a prison sentence). Not knowing is not considered a defence if you did not undertake suitable pre-employment checks and suitable checks thereafter.
- If any practice requires clarification whether their recruitment policy is robust, this can be sought from the Named Professionals within the Health Board or the Designated Professionals, Safeguarding Children Service, Public Health Wales.

The appointment should be subject to all the above being in place. If the checks are not fully completed the appointing officer will need to make a decision on the appointment date and whether it is suitable for the appointee to begin work but with no unsupervised contact with children or adult at risks. No employee should be given unsupervised access to children or adult at risks without all satisfactory recruitment checks having been made.

Under the Rehabilitation of Offenders Act 1974 (Exceptions) Order 1975 and the Rehabilitation of Offenders Act 1974 (Exclusions and Exceptions) (Scotland) Order 2003, healthcare professionals are exempt from the provisions of Section 4(2) of the Rehabilitation of Offenders Act 1974. Therefore primary care professionals are not entitled to withhold information about convictions which for other purposes are spent under the provisions of the Act and failure to disclose such convictions could result in disciplinary action.

A Disclosure and Barring (DBS) check may be needed for certain jobs relating to healthcare and where required they must be carried out in line with current legislation. It is a criminal offence for an employer to knowingly allow a barred person to work in regulated activity.

Healthcare professionals are required to disclose to the GMC/GNC if they have been barred from regulated activity. The Home Office provides further details about regulated activity, disclosure and barring, and the duty to refer to the DBS.

If temporary staff are recruited from an agency then the practice should be assured that appropriate checks have been made.

Clarification on recruitment policy in relation to safeguarding can be sought from the Named Professionals for Safeguarding within health boards in Wales. Advice may also be sought from your medical protection organisation or equivalent body and from the safeguarding advisors e.g. if unsure about how to proceed following notice of a criminal conviction for a member of the practice staff.

Safe Working Practice

Practice staff do not expect allegations of abuse to be made against them, but it is important that they acknowledge that such a possibility exists. For this reason it is in the interest of the practice to develop strategies, which protect both patients from harm and professionals from false accusations.

It is important that all staff in contact with any patient always act in a professional manner and in ways in which their behaviour cannot be misinterpreted or lead any reasonable person to question their suitability to work with children, young people or adults at risk.

The practice should develop a policy, which considers the chaperoning of children and adults at risk undergoing physical examination and those who either attend or wish to be seen for consultations alone.

Children and young people wishing to consult without the presence of their parents could be encouraged to attend with a friend or a same sex member of staff could be present as chaperone.

Whether you work with children directly or indirectly as part of your job, or meet them as members of the public you have the same duty to ensure that they are protected from harm. You must ensure that your own behaviour does not cause a child distress and neither can it give rise to misinterpretation

Staff should also be aware that behaviour in their personal lives and actions of their partner (or other family members) drawn to the attention of other agencies, may raise questions about their suitability to work with children, young people and adults at risk e.g. domestic violence or their own children being entered on the Child Protection Register.

Allegations of Professional Abuse

All allegations of abuse of children or adults at risk by an employed member of staff or partner should be taken seriously and managed in accordance with the All Wales Child Protection Procedures (2008) or the Wales Interim Policy & Procedures for the Protection of Vulnerable Adults from Abuse (2013).

Practices must consider carefully how they empower staff and partners to raise concerns about the personal or professional behaviour of colleagues which lead to safeguarding concerns (whistle blowing).

Allegations against Employed Staff

Allegations or concerns about the behaviour of an employed member of staff should not be investigated internally and advice should be sought from the LHB, medical defence organisations or the BMA, if you are uncertain about what action to take.

A referral made under the All Wales Child Protection Procedures or POVA procedures may result in a multiagency strategy meeting being convened to consider and evaluate all risks and plan the next steps to be taken. If the individual concerned is an employee of the practice then it will be necessary for the practice to be represented. This should be the SPL or other partner.

The Health Board Named Professionals for Safeguarding/POVA should be contacted for advice and support regarding concerns of professional abuse.

In the event of an individual employee being dismissed or moved to another position as a result of safeguarding enquiries and/or a criminal investigation, the investigation outcome meeting or final strategy meeting should advise the employer of the duty to submit their details to the Disclosure and Barring Service (DBS). This is a requirement of the Safeguarding Vulnerable Groups Act 2008. The DBS will consider whether any further action needs to be taken in respect of barring the individual from further employment with vulnerable groups.

Allegations against a Practice Partner or Salaried GP

The Medical Director of the Local Health Board should attend or be represented at the Strategy meeting to consider the allegations of professional abuse. A member of the Primary Medical Care Advisory Team should be invited to attend the Strategy meeting in order to give help and professional advice. If a concern raised is about a

doctor the strategy meeting is a confidential exchange of information which is preliminary to deciding whether there are safeguarding concerns present regarding that individual. Information about the individual would be shared confidentially from all sources possible. It is in that context that the presence of PMCAT can provide important information about the practitioner even including such things as rudeness to staff and colleagues, inappropriate decision making and indeed poor clinical practice.

If a safeguarding enquiry leads to disciplinary action being taken for a practitioner either the Medical Director of the LHB or the Chair of the Performance Panel should refer the case to the General Medical Council and the DBS.

Children Not Brought to Appointments

Missing appointments for some children may be an indicator that they are at an increased risk of abuse and neglect. There are many innocent reasons why children miss appointments but numerous studies have shown that missing healthcare appointments is a feature in many serious case reviews including those into child deaths.

Within Health there is now a move towards the concept of Was Not Brought (WNB) rather than Did Not Attend (DNA) for children and young people. It is rarely the child's fault that they miss appointments. The National Service Framework for Children (2004) states that: Children or young people failing to attend clinic appointments "may trigger concern, given that they are reliant on their parent or carer to take them to the appointment. Failure to attend can be indicator of a family's vulnerability, potentially placing the child's welfare in jeopardy". Not addressing missed appointments may disadvantage the child involved.

All Health Boards and Trusts have DNA or WNB policies that include informing Primary Care. Many children are also not brought to appointments in Primary and Community healthcare.

CEMACH in their 2008 report into Serious Case Reviews noted how frequently children who died had previously been identified as recurrent non-attendees, including hospital and community appointments. They also commented on the deleterious consequences for children who had failed to attend out-patient appointments on one or more occasions and were not followed up.

Recommendations from CEMACH include:

- Health Services, including Child and Adolescent Mental Health Services should proactively follow up children who do not attend appointments.
- When a child or young person doesn't attend an appointment with any health service, they should be contacted and the appointment should be rearranged.
- Children with chronic illnesses who do not attend hospital appointments should be followed up in primary care to discuss reasons for non-attendance.

The Care Quality Commission (CQC) review of safeguarding children arrangements in the NHS, July 2009, identified that there should be a process in place for following up children who fail to attend appointments.

The RCGP/NSPCC Toolkit 2014 makes the recommendations that practices have in place:

- Procedures for identifying and following children who do not attend scheduled appointments within the Practice or with other Agencies such as therapies, secondary or community care;
- Procedures to identify and follow up children with more than expected unscheduled appointments at the Practice, OOHs, A&E Departments, Walk-in Centres.

It should be remembered that parents have the right to make decisions in respect of their child's health. The concept of Parental Responsibility gives a legal definition to the rights and responsibilities of a person with parental responsibility. Parental responsibility allows a parent or carer to accept or decline a health service or treatment on behalf of their child. However if by declining a health service or treatment this may be detrimental to the child or young person's health, growth or development, an assessment should be made of the risk this poses to the child or young person.

The United Nations Convention on the Rights of the Child recognises the right of the child to enjoy the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. It requires that organisations strive to ensure that no child is deprived of his or her right of access to such health care services.

It is therefore important that Primary Care has processes in place to deal with children and young people who are not brought to appointments both in Secondary and Primary care.

Children Not Attending Appointments with Other Health Professionals

Health Board Was Not Brought/Did Not Attend policies state that when children miss appointments the referring clinician is notified. It is recognised that missing appointments can be an indicator of neglect.

In Primary Care there should be a process in place to:

- Identify WNB/DNA notifications for children.
- Review the reason for referral and assess if any further action is required to manage the clinical problem that prompted the referral.
- Note if there have been any other episodes of missing appointments in any setting including Primary Care.
- Consider whether there are any safeguarding concerns and if there are take any appropriate action.
- Consider contacting the family about children not being brought for appointments especially if there are multiple instances.
- Document this process including any subsequent actions taken as a result.

Children Not Attending Appointments in Primary Care

It is clear that a lot of missed appointments in Primary Care are due to the transient nature of many conditions and do not give rise to concerns. However if we do not have a process in place we cannot recognise when vulnerable children are not brought or there are multiple missed appointments.

Therefore Primary Care Practices need to have a Was Not Brought policy for children that should include:

- Identifying when children are not brought for appointments.
- If the appointment is known to be as a consequence of a referral/recommendation of other Healthcare Professionals, notifying them of the failure to attend.
- If the reason for the appointment is known, consideration as to whether there are any clinical consequences and if any actions are required.
- Consideration of any safeguarding concerns, especially when there are multiple episodes of WNB in Primary Care or other settings.
- Appropriate action if there are clinical or safeguarding concerns.
- Consideration of contacting the family about children not being brought for appointments especially if there are multiple instances.
- Documenting this process including any actions taken as a result.

Documentation

Accurate record keeping is an essential part of the accountability for and effectiveness of child safeguarding and protection of adults at risk. It is an extremely important element to ensure effective inter-agency working. Documentation within practices should accurately reflect not only the care provided but also any concerns in respect of a child, young person or adult at risk.

Concerns may be raised by the presentation or disclosures of a child or adult at risk. They may also arise from how a parent/carer relates to or behaves towards a child or adult at risk in their care. These concerns, observations or comments should be recorded in the relevant child and parent/carer's records, along with the actions taken including the seeking of advice and the advice given.

It is important that a record is made of:

- What the concerns are and why you have them
- Who your concerns were shared with
- What if any actions were taken and by whom

It may be relevant to record concerns about the observations, presentation or comments of anyone accompanying the patient in the patient records. A record should always be made of who accompanied the young person in a consultation.

Recent cases have also demonstrated the importance of tracking children about whom there are concerns as closely as possible. Practices may have knowledge as to where such children are living and with whom. In order that a practice has discharged its responsibilities it is recommended that consideration is given to the following:

- Formulation of a system to ensure that the following categories of children can be easily identified:-
 1. Children on the Child Protection Register.
 2. Children "looked after" by the Local Authority.
 3. Children at risk as defined by the Social Services and Well-being (Wales) Act

It is important that all general practices have a system in place to "flag" manual and computer records, which contain such information. There are a number of Read Codes available to assist in this process, see chapter 17.

- Where a child who is the subject of concern is known to have moved and the whereabouts are known it is good practice for the GP to telephone the new GP to alert them to any known concerns. Where there is social work involvement then the key worker should also be informed. If the new GP is not known, the Shared Service Partnership (previously known as Business Services) should be asked to trace the child through the NHS database.
- There may be times that a child's record needs to be "fast tracked" to or from a general practice. This is especially important in the case of children for whom there are child protection concerns or for children who are looked after. Those responsible for the transfer of records must be aware of these procedures.

Child and Adult Protection Documentation

For those children subject to a Child Protection Case Conference and adults subject to a Protection of Vulnerable Adult investigation, documentation will be produced and sent to the practice by the Local Authority. This usually includes the minutes of meetings, including any outcomes such as whether a child's name has been placed on the child protection register and the outline of the safeguarding plans. This information is necessary in order for the practice to understand the child or adult's circumstances, level of risk and welfare concerns and to maintain a safeguarding role. The documentation is also likely to contain individual reports from the agencies involved, including the social services and other health agencies.

On receipt of this documentation it is important to note the content of the minutes and update the electronic record for those concerned including any parents and/or carers also registered at the practice.

It is recommended to scan the minutes of the meetings into the electronic record for all family members concerned and who are registered at the practice. The front sheet of the conference minutes will state who these are. These will then constitute part of the lifelong patient medical record and should not subsequently be removed. The records do not need to be redacted prior to scanning.

Conference reports generated by health professionals in respect of individual family members should also be scanned onto the record of the patient to whom this applies. Other reports may be destroyed as a summary of each will be contained within the conference minutes.

If the full minutes of the conference have been scanned onto the electronic record, along with any relevant health reports then the hard paper copies can be destroyed.

Any minutes or health reports that have not been fully scanned should be safely stored inside the full paper GP patient record as a constituent part of the individual patient record and reference made on the electronic record that these copies exist. Case Conference and other safeguarding meeting minutes should not be filed separately but should remain part of the clinical record as they will contain information that may be relevant to the provision of future health and social care and assist in a better understanding of the needs and circumstances of family members.

Practitioners should consider carefully whether it is appropriate to disclose the content to third parties not directly involved in the case conference or in the provision of health care. If disclosure is considered necessary redaction of third party information would be required prior to their release in these circumstances.

Non-disclosure would also apply to any party, where doing so may place the victim or other family members at risk e.g. where the current address should not be disclosed.

There should also not be release of the records to parents or carers where there is not parental responsibility for all of the children named in the conference minutes. In these circumstances advice should be sought from Health Board Named Professionals.

As with all records, careful consideration should be given to the management and sharing of sensitive information with the patient who may wish to access their own records. If it is felt that the information would distress or be harmful to the patient it can be removed e.g. graphic descriptions of circumstances in child protection case conference minutes.

Transfer of Records

When a child moves, swift transfer of the electronic record will alert the new GP to the child's child protection status and the name of their Social Worker (as on the front page of the minutes). However this should not deter a telephone call to the receiving GP if this is required and a record kept of this conversation. The same would apply to the records of an adult at risk subject to an Adult protection and support order.

Any un-scanned records and reports held by the practice should be gathered together and secured. These should be placed in a sealed envelope and labelled with the child's name and NHS number with the request to forward to the new GP. This should be placed in the 'blue bag' and sent to the regional Shared Services partnership (formerly BSC).

Perpetrators

It is necessary for safeguarding to identify perpetrators of abuse. Where children or adults are subject to a safeguarding plan following a Child Protection or Adult at Risk investigation this should also be noted in the records of their parents or carer. Any adult convicted of the abuse of a child, young person or adult at risk should have this noted in their records

Any adult subject to Multi agency public protection arrangements 'MAPPA' or Multi-agency risk assessment conference 'MARAC' in relation to their behaviour that results in a public protection plan should have that noted within their record.

Case Audit and Review

All relevant health records must be made available to those undertaking a case review on behalf of the Local Safeguarding Children Board. This will usually be the Designated or Health Board Named Professionals safeguarding.

5 STAFF TRAINING

GMC guidance states that all Doctors must be competent in safeguarding children. The requirements for this are stated in, Safeguarding Children and Young People: Roles and Competences for Health Care Staff, Intercollegiate Document, March 2014 ([ICD](#)).

NHS Wales also requires all healthcare staff to satisfy, to the appropriate level, the competences in this document.

All health staff have to receive basic safeguarding training as part of their induction programme.

There is currently no GMC requirement nor is there an ICD equivalent for training regarding safeguarding adults at risk. However it is a requirement of Statutory and Mandatory training that healthcare staff have adult safeguarding training every three years.

The ICD Competence levels for Safeguarding Children and Young People are as follows:

Level 1

Non-clinical staff working in health care settings, including receptionists and administrative staff.

Level 2

Minimum level required for clinical staff who have some degree of contact with children and young people and/or parents/carers, including Practice Nurses, Health Care Assistants and Phlebotomists.

Level 3

Clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns, including GPs and Nurse Practitioners.

Level 3

Additional Specialist Competences: are also required by all GPs

The Level 3 competences for GPs as well as the knowledge, skills and attitudes that relate to these competences can be found in the [ICD](#).

N.B. Those requiring competences at Levels 2 and 3 should also possess the competences at each of the preceding levels but only need to update the highest level they achieve.

All of the ICD levels are different to the levels that have previously been used

Statutory and Mandatory Training for Safeguarding Adults at Risk has 2 levels. Level 1 is part of the induction programme and Level 2 is required for all staff.

Access to Training

Level 1 and 2 E-learning, compliant with the ICD competences, is now available free for all NHS staff. See below for details of how to find information and help to access this resource.

Level 1 and 2 Adult E-learning is also available free to health staff via their local Health Board.

For level 3 safeguarding children and young people competences there is no set way to demonstrate attainment of the required competences. Rather the emphasis of any training should be on the importance of a multiplicity of approaches to learning to acquire and maintain knowledge and skills.

For instance:

- completing an e-learning module
- attending a training session in or out of the practice
- reading appropriate local guidelines
- case reviews and SEAs
- drawing upon lessons from research, case studies and child practice reviews
- the importance of effective transfer of learning to the workplace
- demonstrating positive change in practice to improve outcomes.

Some Useful Resources

- The Safeguarding Children Service website has details of learning events and the NHS Wales e-learning as well as a dedicated GP section with useful links and documents*.
- LHBs put on level 3 training events and the Safeguarding Teams also provide regular training sessions.
- Local Safeguarding Children's Boards run many training courses that are appropriate for level 3. Details are available on their websites.
- The RCGP in conjunction with NSPCC has developed a toolkit aimed at training for Primary Care. [Toolkit](#)
- Training sessions are regularly put on by Charities and Voluntary Organisations across Wales. e.g. [NSPCC](#), [Children in Wales](#).
- There are numerous e-learning modules readily available to doctors through

sources such as the [BMA](#), [NSPCC](#) and [RCGP](#).

The ICD and E-learning details are available on the Safeguarding Children Service (SCS) Web pages under Training and Events. There are other useful learning resources here.

[SCS Training and Events Intranet Page](#)

[SCS Training and Events Internet Page](#)

There is also a GP Guidance page

[SCS GP Guidance Intranet Page](#)

[SCS GP Guidance Internet Page](#)

In addition to the level of training above, the Safeguarding Practice Lead (SPL) should ensure that they keep up to date with safeguarding developments through relevant bulletins and access to appropriate websites. The Practice should have in place a system to record whether the staff have received safeguarding training relating to children, young people and adults at risk.

6 CONFIDENTIALITY, CONSENT, INFORMATION SHARING AND CAPACITY

Confidentiality and Information Sharing

Healthcare professionals and their support staff have a legal duty to share concerns and take action to safeguard the welfare and safety of children, young people and adults at risk.

Fears about sharing information cannot be allowed to stand in the way of the need to safeguard.

The most important consideration is whether sharing information is likely to safeguard

The revised Caldicott Principle 7 states that “the duty to share information can be as important as the duty to protect patient confidentiality”.

Sharing of information between practitioners and organisations is essential for effective identification, assessment, risk management and service provision. Many Serious Case Reviews into serious harm or death in children cite information sharing concerns as a contributory factor. Legislation and professional guidance concerned with confidentiality protects individual patients, but they are not intended to prevent exchange of information between the professionals and agencies that have a responsibility for ensuring the protection of children, young people and adults at risk.

In cases where there are safeguarding concerns, there is a duty to share all relevant information with the professionals and agencies that need to know. This may include disclosing information to other professionals who need access to that information for the purposes of safeguarding with or without the permission of the child, young person, adult at risk, parents or carers. You do not need to be certain that a person is at risk of significant harm to take this step. If a child, young person or adult is at risk of, or is suffering, abuse or neglect, the possible consequences of not sharing relevant information will, in the overwhelming majority of cases, outweigh any harm that sharing your concerns with an appropriate agency might cause.

In sharing concerns about possible abuse or neglect, you are not making the final decision about how best to protect a person. That is the role of the local authority

and, ultimately, the courts. Even if it turns out that the person is not at risk of, or suffering, abuse or neglect, sharing information will be justified as long as your concerns are honestly held and reasonable, you share the information with the appropriate agency, and you only share relevant information.

Whilst the Data Protection Act 1998 places duties on organisations and individuals to process personal information fairly and lawfully, it is not a barrier to sharing information where the failure to do so would result in a child or vulnerable adult being placed at risk of harm. It does not prohibit the collection and sharing of personal information but provides a framework to ensure that personal information about an individual is shared appropriately. Similarly the common law duty of confidence and human rights concerns, such as respecting the right to a private and family life, would not prevent sharing where there are real safeguarding concerns.

Confidentiality is an important duty, but it is not absolute. There are circumstances when it may be appropriate to disclose confidential patient information. These are:

- when you have the patient's consent, or
- when the law says you must, or
- when it is in the public interest to do so.

Adults at risk and children are entitled to the same duty of confidence as any other person provided that they have the ability to understand their choices and the consequences of any actions.

A complete record of what has been shared should always be kept.

Note See Appendix 3 – The Seven Golden Rules to Information Sharing

Consent

Seeking a patient's consent to disclosure of information shows respect, and is part of good communication. Wherever possible, you should seek consent and be open and honest with the individual (and/or where appropriate, their family or carers) from the outset as to why, what, how and with whom, their information will be shared.

In safeguarding the child, young person or adult at risk may not have the capacity to give consent (see below for details about capacity). If you believe that a patient may be a victim of neglect or physical, sexual or emotional abuse, that they lack capacity to consent to disclosure and where you believe that the disclosure is in the patient's best interests or necessary to protect others from a risk of serious harm, you must give information promptly to an appropriate responsible person and the local

authority. The responsible person may be the patient's parent, family, carer or an advocate. If, for any reason, you believe that disclosure of information is not in the best interests of a neglected or abused patient, you should discuss the issues with an experienced colleague. If you decide not to disclose information, you should document in the patient's record your discussions and the reasons for deciding not to disclose. You should be prepared to justify your decision.

You do not necessarily need the consent of the patient or their parent/carer to share their personal information. It is still possible to share personal information if it is necessary in order to carry out your role, or to protect the vital interests of the individual.

Working in partnership with families is essential to promoting the welfare of children and vulnerable adults. When making a safeguarding referral, it is good practice to inform the parents or carers. There may be occasions when it is believed that informing the parents or carers may place the individual at further or additional risk. In such circumstances consent should not be sought and the parent or carer should not be informed of the referral. The professional is charged with the protection of the child, young person or adult at risk not with the protection of the parent or carers.

If consent is withheld by a parent or carer to share information, a risk assessment of the child, young person or adult at risk's concerns should be undertaken and further advice sought, as the refusal to consent may increase concerns.

You would also not need to seek consent if it was unsafe to do so because of a risk of harm to you or your staff. In the process of any subsequent investigations by the police and social services it should be expected that the referral and its source will be made known to parents or carers. Therefore any concerns about the impact of this on healthcare professionals and/or their support staff should be shared with the police or social services departments at the time of referral.

The Carlile review: *Too serious a thing: review of safeguards for children and young people treated and cared for by the NHS in Wales*, stated

"There is nothing within the Caldicott Report, the Data Protection Act 1998, or the Human Rights Act 1998, which should prevent the justifiable and lawful exchange of information for the protection of children or prevention of serious crime".

Therefore while consent is desirable it is not necessary for safeguarding referrals.

Safeguarding is dependent on raising concerns and on sharing information appropriately. However, healthcare professionals are frequently uncertain as to whether their concerns reach a threshold for action. In these circumstances advice

should be sought from a professional with expertise in safeguarding. Contact details of local Safeguarding Children and Adult teams within health and social care should be readily available locally.

Professionals must also be aware of their governing bodies' guidance on consent.

See appendix 4 for a flowchart on actions to be taken when sharing information

Capacity

Every adult and young person aged 16-17 is presumed to have the capacity to make their own decisions and to give consent unless there is enough evidence to suggest otherwise.

For consent to be valid the patient must:

- have the capacity to give consent
- be acting voluntarily – they must not be under any undue pressure from you or anyone else to make a decision
- have sufficient, balanced information to allow them to make an informed decision
- be capable of using and weighing up the information provided.

You must **not** assume that a patient lacks capacity based just upon their age, disability, beliefs, condition and behaviour or because they make a decision you disagree with. You must base an assessment of capacity on an individual basis taking into account the patient's ability to make a specific decision at the time it needs to be made, as well as the complexity and importance of that decision. At any time a person may be capable of making some decisions but not others.

In the case of adults at risk reference should be made to the Mental Capacity Act 2005 and its Code of Practice. (See also Appendix 5)

Children under 16 are not presumed to have the capacity to consent, they must demonstrate their competence. A child can give consent if you are satisfied that the treatment or action is in their best interests and that they have the maturity and ability to fully understand the information given and what they are consenting to.

The Mental Capacity Act 2005 does not apply to children under 16. However the principles of assessing capacity are the same. The Fraser Guidelines are often used to assess capacity in children under 16 years of age though they were originally intended for the prescribing of contraception to this group. Consideration should always be given to getting consent from a child under 16 years of age where they

are felt to be competent. In this case you do not also need consent from a person with parental responsibility.

When making decisions about whether to disclose information about a patient who lacks capacity, you must:

- (a) make the care of the patient your first concern
- (b) respect the patient's dignity and privacy, and
- (c) support and encourage the patient to be involved, as far as they want
- (d) and are able, in decisions about disclosure of their personal information.

Deprivation of Liberty

Article 5 of the Human Rights Act states that; "everyone has the right to liberty and security of person. No one shall be deprived of his or her liberty [unless] in accordance with a procedure prescribed in law".

The [Deprivation of Liberty Safeguards](#) (DoLS) is the procedure prescribed in law, as part of the [Mental Capacity Act 2005](#) (MCA), when it is necessary for a resident or patient **who lacks capacity** to consent to their care and treatment, to be deprived of their liberty in order to keep them safe from harm.

Summary of Deprivation of Liberty Safeguards

- The Deprivation of Liberty Safeguards is an amendment to the Mental Capacity Act 2005. They apply in England and Wales only.
- The Mental Capacity Act allows restraint and restrictions to be used, but only if they are in a person's best interests.
- Extra safeguards are needed if the restrictions and restraint used will deprive a person of their liberty. These are called the Deprivation of Liberty Safeguards.
- The Deprivation of Liberty Safeguards can only be used if the person will be deprived of their liberty in a care home or hospital. In other settings the Court of Protection can authorise a deprivation of liberty.
- Care homes or hospitals must ask a local authority if they can deprive a person of their liberty. This is called requesting a standard authorisation.
- There are six assessments which have to take place before a standard authorisation can be given.
- If a standard authorisation is given, one key safeguard is that the person has someone appointed with legal powers to represent them. This is called the relevant person's representative and will usually be a family member or friend. Where a person is unbefriended then they must be appointed an Independent Mental Capacity Advocate (IMCA).

- Other safeguards include rights to challenge authorisations in the Court of Protection, and mandatory review at least yearly.

Deprivation of Liberty Safeguards

There are many people in different settings who are deprived of their liberty by virtue of the type of care or treatment that they are receiving, or the level of restrictive practices that they are subject to, but they cannot consent to it because they lack the mental capacity to do so. In most cases, the care and treatment is necessary and is being delivered in their best interests even though it amounts to a deprivation of liberty. The Deprivation of Liberty Safeguards ('DOLS') were brought into force in April 2009 to ensure that professionals applied checks and balances when they had to deprive people lacking capacity of their liberty.

A Supreme Court judgement in March 2014 made reference to the 'Acid Test' to see whether a person who lacks capacity is being deprived of their liberty, which consisted of two questions:

- Is the person subject to continuous supervision and control? *And*
- Is the person free to leave? (with the focus being not on whether a person seems to be wanting to leave, but on how those who support them would react if they did want to leave)

If the following features are present, it would make sense to consider a deprivation of liberty application:

- frequent use of sedation/medication to control behaviour
- regular use of physical restraint to control behaviour
- the person concerned objects verbally or physically to the restriction and/or restraint
- objections from family and/or friends to the restriction or restraint
- the person is confined to a particular part of the establishment in which they are being cared for
- the placement is potentially unstable
- possible challenge to the restriction and restraint being proposed to the Court of Protection or the Ombudsman, or a letter of complaint or a solicitor's letter
- the person is already subject to a deprivation of liberty authorisation which is about to expire.

Restraint and Restrictions

The majority of patients who lack capacity to make decisions about their care and treatment and admission to or discharge from hospital can be treated in their best interests under Section 5 of the Mental Capacity Act 2005. Restraint may be used provided that the person using them reasonably believes that it is necessary to restrain the patient in order to prevent harm to the patient, and that the act is a proportionate response to the likelihood of the patient suffering harm, and the seriousness of the harm. Restraint does not merely mean the use of force, but can include the threat of the use of force or restriction of the individual's liberty, whether or not they resist. The difficult issue to identify is the point at which the level and intensity of the restraint and restrictions used amounts to a deprivation of liberty.

Restrictions and restraint can include:

- using locks or key pads which stop a person going out or into different areas of a building
- the use of some medication, for example, to calm a person
- close supervision in the home, or the use of isolation
- requiring a person to be supervised when out
- restricting contact with friends, family and acquaintances, including if they could cause the person harm
- physically stopping a person from doing something which could cause them harm
- removing items from a person which could cause them harm
- holding a person so that they can be given care, support or treatment
- bedrails, wheelchair straps, restraints in a vehicle, and splints
- the person having to stay somewhere against their wishes or the wishes of a family member
- repeatedly saying to a person they will be restrained if they persist in a certain behaviour.

Such restraint can take away a person's freedom and so deprive them of their liberty. They should be borne in mind when considering whether the support offered to a person is the least restrictive way of providing that support.

Health and Care providers don't have to be experts about what is and is not a deprivation of liberty. They just need to know when a person might be deprived of their liberty and take action.

Final decisions about what amounts to a deprivation of liberty are made by courts. The Code of Practice for the Deprivation of Liberty Safeguards gives examples of where courts have found people being and not being deprived of their liberty.

Emergency life-sustaining interventions and the provision of emergency care to a patient lacking consent to such treatment should always be given as clinically required and there should never be any delay for prior deprivation of liberty authorisation to be sought. This means that there may be situations in which the question of whether a person is deprived of their liberty (and if so, how that deprivation of liberty is to be authorised) cannot be resolved prior to the administration of such treatment.

It is likely that the immediate provision of life-sustaining treatment to an incapacitated patient in a true emergency situation will not be considered to be a deprivation of liberty. But as the patient transitions from the initial emergency treatment to on-going care the risk of deprivation of liberty increases with the increasing duration of treatment.

Authorisation of a Deprivation of Liberty under DoLS

The Deprivation of Liberty Safeguards (DoLS) can only apply to people who are in a care home or hospital. This includes where there are plans to move a person to a care home or hospital where they may be deprived of their liberty.

Where a care home or hospital thinks it needs to deprive someone of their liberty they have to ask for this to be authorised by a Supervisory Body which is the local authority where the person is usually resident. They can do this up to 28 days in advance of when they plan to deprive the person of their liberty.

The supervisory body appoints assessors to see if the conditions are met to allow the person to be deprived of their liberty under the safeguards.

The conditions that need to be met to allow a person to be deprived of their liberty under the safeguards include:

- The person is 18 or over (different safeguards apply for children).
- The person is suffering from a mental disorder (as per MCA 2005).
- The person lacks capacity to decide for themselves about the restrictions which are proposed so they can receive the necessary care and treatment.
- The restrictions would deprive the person of their liberty.
- The proposed restrictions would be in the person's best interests.

- Whether the person should instead be considered for detention under the Mental Health Act.
- There is no valid advance decision to refuse treatment or against the wishes of a Lasting Power of Attorney for Health and Welfare or Court Appointed Deputy.

If all conditions are met, the supervisory body must authorise the deprivation of liberty and inform the person and the care home or hospital in writing. It can be authorised for up to one year and may include conditions such as the person must be escorted to recreational activities off the premises. The person does not have to be deprived of their liberty for the duration of the authorisation. The restrictions should stop as soon as they are no longer required. If it is felt that a person still needs to be deprived of their liberty at the end of an authorisation, the managing authority must request another standard authorisation.

The assessment process for a standard authorisation acts as a safeguard for this process. This involves at least two independent assessors who must have received training for their role. There will always be one mental health assessor and one best interests assessor who will stop deprivation of liberty being authorised if they do not think all the conditions are met.

Family, friends and paid carers who know the person well should be consulted as part of the assessment process. They may have suggestions about how the person can be supported without having to deprive them of their liberty. Those people who don't have family or friends who can represent them have a right to the support of an Independent Mental Capacity Advocate (IMCA) during the assessment process. And at all times, the fifth principle of the Mental Capacity Act, that any decision made in a person's best interests must be the least restrictive of their rights and freedoms, should be borne in mind.

When DoLS Cannot Be Used

The Deprivation of Liberty Safeguards can only be used if a person is in hospital or a care home. If a person is living in another setting, including in supported living or their own home, it is still possible to deprive the person of their liberty in their best interests, via an application to the Court of Protection.

If a person is in hospital they should not be subject to the Deprivation of Liberty Safeguards if they meet the criteria for detention under the Mental Health Act.

The Deprivation of Liberty Safeguards should not be used if the main reason is to restrict contact with individuals who may cause the person harm. If it is believed to be in a person's best interests to limit contact an application should be made to the Court of Protection.

If there is a dispute about where a person should stay, an authorisation does not resolve the dispute. The Code of Practice of the Mental Capacity Act says that unresolved disputes about residence, including the person themselves disagreeing, should be referred to the Court of Protection.

Court of Protection

The Court of Protection may make a similar order to a DOLS authorising deprivation of liberty in a domestic setting (outside hospitals and care homes) in relation to personal welfare. This could include a placement in a supported living arrangement.

Death Certification and DoLS

The Chief Coroner opinions, on the law as it now stands, is that the death of a person subject to a DoLS should be the subject of a coroner investigation because that person was in state detention within the meaning of the Coroners and Justice Act 2009.

Please see; [Chief Coroners guidance](#) to actions when a person dies whilst detained under a DOLS

It is important to understand that the grant of authority to deprive an individual of their liberty under the MCA 2005 (whether by way of a DOLS authorisation or an order of the Court of Protection) does not require the individual to be deprived of their liberty. In other words, it is not an order that the person must be detained. Rather, it means that a person or body can rely upon that authority to deprive the individual of their liberty secure in the knowledge that they are acting lawfully.

7 SEXUALLY ACTIVE YOUNG PEOPLE AND ADULTS AT RISK

Sexually Active Young People

Most children and young people under the age of 18 will have a healthy interest in sex and sexual relationships. Those working with children and young people need to be able to identify where those relationships may be abusive and the young people may need the provision of protection and additional services. The primary concern of anyone working with sexually active children and young people under the age of 18 years must be to safeguard and promote their welfare.

Doctors have a responsibility to provide a confidential sexual health service in which young people have trust but also have a duty to act to safeguard children. A confidential sexual health service is essential for the welfare of children and young people. Concern about confidentiality is the biggest deterrent to young people asking for sexual health advice. That in turn presents dangers to young people's own health and to that of the community, particularly other young people. Striking a balance between what on the surface appears to be conflicting needs can cause significant dilemmas to professional staff.

Young people, including those under 13, will present with specific health needs ranging from advice on contraception and pregnancy, through to the treatment of sexual transmitted disease. It is the prime responsibility of the health professional to deal with these issues without delay.

It is illegal to pay for the sexual services of a young person under 18 years of age.

Children Under the Age of 13

The All Wales Child Protection Procedures in section 5.4.6.1 states that Under the Sexual Offences Act 2003, children under the age of 13 are of insufficient age to give consent to sexual activity.

In all cases where the sexually active young person is under the age of 13, a full assessment must be undertaken by the agency involved. Each case must be assessed individually and consideration must be given to making a child protection referral to social services. In order for this to be meaningful, the young person will need to be identified, as will their sexual partner if details are known.

The GMC states: “You should usually share information about sexual activity involving children under 13, who are considered in law to be unable to consent. You should discuss a decision not to disclose with a named or designated doctor for child protection and record your decision and the reasons for it.”

A decision not to refer to social services can only be made following a discussion of the case, with the Designated / Named lead for child protection within the LHB. When a referral is not made, the professionals and agency concerned are fully accountable for the decision and the reasons for the decision must be clearly recorded.

When a girl under the age of 13 is found to be pregnant, a referral must be made to social services where an initial assessment will be completed and an All Wales Child Protection Procedures 2008 strategy meeting/discussion will take place, which will include representatives from health and education.

The Bichard Inquiry Report’s recommendation 12 stated that the Government should reaffirm the guidance that the police are notified as soon as possible when a criminal offence has been committed, or is suspected of having been committed, against a child – unless there are exceptional reasons not to do so. The Welsh Assembly Government reaffirmed this recommendation in the guidance Safeguarding Children: Working Together Under the Children Act 2004 in Chapter 8, paragraph 8.29”.

Any offence under the Sexual Offences Act 2003 involving a child under 13 years is very serious and should be taken to indicate a risk of significant harm. However, although the legislation is clear in respect of under 13s this group of children are still entitled to the right of confidential advice on contraception, condoms, pregnancy and abortion.

Professionals’ assessment in this age group needs to be more in depth and their thresholds for referral much lower. This assessment should be undertaken every time the child is seen or information is received which escalates potential risk to the child. In all cases professionals should discuss with the safeguarding practice lead and seek advice from the named or designated professionals. If following that discussion a decision not to make a referral is arrived at the professionals must be prepared to fully justify, record and make available for review if necessary, any decision not to make a referral to Social Services and the Police.

Children Aged 13 to 16

The Sexual Offences Act 2003 reinforces that, whilst mutually agreed, non-exploitative sexual activity between teenagers does take place and that often no harm comes of it, the age of consent should still remain at 16. This acknowledges that this group of young people can still be vulnerable, even when they do not view themselves as such. For children between 13 and 16 years the child's own views on their best interests are also a factor, which should be given a weight dependent on their maturity and understanding.

Providing advice and treatment to young people under 16 years of age can be given under the Fraser guidelines without parental consent providing that the young person understands the advice being given and cannot be persuaded to inform or seek support from their parents. All decisions must be made within the best interest of the child balanced against the need to protect the rights and freedom of others. This could pose a major dilemma for health professionals in that the Sexual Offences Act 2003 states that sexual activity under the age of 16 is illegal.

It is not in the best interests of the child or young person to have an automatic referral made to Police or Social Services when knowledge about their sexual activity becomes known to a health professional. Once information has been shared with authorities it may remain on databases even if no convictions occur.

The purpose of the act is to safeguard the welfare of the young person in circumstances where the sexual activity suggests that that they are being exploited. The law is not intended to prosecute mutually agreed sexual activity between two young people of similar age.

For children aged 13 to 16 the decision not to refer can be made by the health professional alone if they are satisfied that the activity is acceptable. It is essential that the reasoning behind the decision and the decision taken is recorded clearly by the practitioner in the young persons' medical record.

In all situations decisions would clearly be influenced by knowledge of power or age imbalances between the partners, suggestions of abuse of trust or the use of sexual favours. Possible power imbalances within a relationship can result from differences in size, age, material wealth and/or psychological, social and physical development. In addition gender, sexuality, race and any other diversity issues where levels of sexual knowledge can be used to exert power. Where a power imbalance results in coercion, manipulation and/or bribery and seduction, these pressures can be applied to a young person by one or two individuals, or through peer pressure (i.e. group bullying).

Particular sensitivity must be employed when considering the needs of young people with learning disabilities, mental disorders or communication difficulties. Confidentiality cannot be absolute in these circumstances and sharing information without consent might be necessary in the above circumstances.

Action will also need to be taken when the young person's own behaviour places them at risk including vulnerability due to the abuse of drugs and alcohol or denial or minimising concerns regarding their activity.

Any girl under the age of 16, who is pregnant, must be offered specialist support and guidance by the relevant services. Any child protection concerns must be discussed with the safeguarding children lead in the local Health board

Young People aged 17 to 18

Although sexual activity in itself is no longer an offence over the age of 16, young people under the age of 18 are still offered the protection of Child Protection Procedures. Consideration still needs to be given to issues of sexual exploitation through abuse of power or trust. Young people, of course, can still be subject to offences of rape and assault and the circumstances of an incident may need to be explored with a young person. It is an offence for a person to have a sexual relationship with a 16 or 17 year old if they are an adult in a position of trust or authority in relation to them or a family member as defined by the Sexual Offences Act 2003.

Sexual Activity in Adults at Risk

The Sexual Offences Act 2003 does not intend to criminalise all sexual activity that someone with what they term a mental disorder i.e. an adult at risk, might engage in. It is also not intended to restrict the right of a person to engage in sexual relationships. It does however seek to protect vulnerable people when this sexual activity is founded on exploitation and abuse.

The sexual offences act splits into three categories the offences against those with a mental disorder. These are:

1. *Offences against a person with a mental disorder impeding choice. This covers individuals whose mental functioning is so impaired at the time of the sexual activity that they are unable to refuse.*

2. *Offences against those who have the capacity to consent to sexual activity but have a mental disorder which makes them vulnerable to inducement, threat or deception.*

3. *Offences by care workers against those with a mental disorder.*

Sexual activity with adults who lack capacity is always illegal, as they can never legally give their consent. There should always be contact with the Police and a Referral made under the Safeguarding Adults Procedures in these circumstances.

For adults at risk there may be inducement, threat or deception similar to grooming and exploitation seen in child sexual abuse. This may lead to the appearance of a victim having 'agreed' to the activity but the reality is that any apparent agreement will have been obtained by exploitation. There is a very difficult balancing act when dealing with adults at risk who may have capacity to consent to sexual relationships. On the one hand to protect them against the consequences of potentially harmful and exploitative relationships and on the other to protect the right that every adult should enjoy to respect for the most intimate and private parts of their lives.

It is therefore important to consider what arrangements can be put in place to support decision making by adults who do have capacity to make decisions about sexual relationships but who would nonetheless be vulnerable to exploitation and abuse. We should not require people whose capacity has been questioned to demonstrate that they will approach decisions about sex with a greater level of reflection and rational analysis than other adults. Many adults make decisions about sex which others would think rash or ill-advised and there is in reality often little or no rational analysis when adults of unquestioned mental capacity make decisions about sex.

Where the sexual relationship is considered consensual and not abusive, health care workers should ensure that the Adult at Risk receives appropriate advice regarding sexual health and contraception.

8 DOMESTIC ABUSE

Domestic abuse has a profound effect on all those who experience it, resulting in short and long term consequences for the individual's mental health and wellbeing, an increased risk of physical injury and in some cases, death. The consequences of abuse can lead to homelessness, isolation and long term social exclusion.

GPs should make a record of domestic abuse incidents in the records of victims, perpetrators and any children, using the appropriate Read codes (see Chapter 17).

Health Professionals are often well placed to raise issues leading to disclosure of abuse and violence and best placed to direct victims to appropriate support such as: The [All Wales Domestic Abuse and Sexual Violence helpline](#): tel 0808 80 10 800
The Welsh Government [Live Fear Free](#) website.

The definition of domestic abuse has recently been changed so that it now includes 'coercive control'. The British Crime Survey 2009/10 found that 16-19-year-olds were the group most likely to suffer abuse from a partner and this has also informed the change in the definition.

The Definition of Domestic Abuse

“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”.

Where:

- 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 is not a legal definition but is used by government departments for the purposes of, for example, targeting support services (Home Office, 2015).

The abuse experienced can vary from emotional abuse, to physical, sexual, financial, psychological abuse and neglect. Many victims will often experience a combination of these behaviours. Domestic abuse has the highest rate of repeat victimisation of all violent crimes.

Domestic abuse, like child abuse is often referred to as a 'hidden' harm because victims of abuse are often afraid to report the abuse for fear of repercussions by the abuser. Perpetrators of abuse will attempt to reassert their control over the victim if they sense a change in behaviour. Victims often stay in a relationship because they are afraid of what the perpetrator may do to them or other family members should they attempt to leave. Many victims of abuse also feel a sense of relief during the times where the abuse stops and hope that their circumstances will improve and the pattern of abuse will stop. The risk of death peaks at the point victims try to leave the abuser and for a period after separation.

The prevalence of physical assaults from a partner or adult family member is higher among heterosexual women than among men. Heterosexual women experience more repeated physical violence, more severe violence, more sexual violence, more coercive control, more injuries and more fear of their partner (NICE, 2014).

However it is important to remember that violence and abuse which meets the definition of domestic abuse are also experienced by other adults, within family settings and relationships. This includes in same sex relationships, in the elderly between partners and from their children, between other family members and by men who are abused by women. Recognising, responding and supporting victims should be about an inclusive approach for all potential victims, providing effective responses to all.

There is under-reporting of domestic abuse and sexual violence from Black and Minority Ethnic and Lesbian, Gay, Bisexual and Transgender communities.

Domestic Abuse and children and young people

Domestic abuse and family violence has a profound effect on children and young people who experience it within their family. Research shows that children experiencing domestic abuse can be affected in every aspect of their functioning; safety, health, school attendance, educational achievement, economic well-being and emotional and social development. In the most extreme cases children are at risk of serious injury or death.

It is a major factor in Child Protection cases and one of the commonly recurring features in Serious Case/Child Practice Reviews. Children are put at risk of experiencing physical harm from the perpetrator or by being caught up or trying to

intervene in arguments and fighting between family members. Children are hugely affected by the fear of abuse as well as seeing and hearing abuse within their family.

The link between domestic abuse and child abuse is so strong that it is usual practice to always make a referral to Social Services in cases where there are children dependent on the perpetrator or victim.

This is true even where the adult victim has capacity and declines referral for themselves. The children do not have to be present at the time of the incident triggering concern; the nature of domestic abuse is such that there has often been a long period of abuse before there is a disclosure or revelation. In these circumstances the professional making the referral is acting as an advocate for the child who normally cannot make an informed choice about reporting the abuse they are suffering.

Adolescent to parent violence and abuse (APVA)

APVA has been recognised as a challenge facing Healthcare professionals by NICE (National Institute of Clinical Excellence). Research by Against Violence and Abuse (AVA) and Families, Drugs and Alcohol (ADFam) with parents who had experienced APVA clearly showed that GPs were a common first port-of-call for parents looking for help. As such, it is crucial that staff fully understand this complex area of abuse. It is encompassed by the definition of domestic abuse and this applies to those aged 16 or above. However APVA can also involve children under 16.

It is important that a young person using abusive behaviour against a parent receives a safeguarding response and is referred to social services as a child at risk.

Practitioners should also consider whether to report the parent to social services as an adult at risk.

Given the complicated nature of these situations interventions should focus on treating and supporting the family including the perpetrator.

APVA is widely recognised by practitioners who work with families across a range of support services but it is not usually officially documented and therefore does not currently appear in any public records or figures. All forms of domestic violence and abuse are under-reported and parents are, understandably, particularly reluctant to disclose or report violence from their child. Parents report feelings of isolation, guilt and shame surrounding their child's violence towards them, and fear that their parenting skills may be questioned and that they will be blamed or disbelieved by those to whom they disclose the violence. Many parents worry that their

victimisation will not be taken seriously or, if they are taken seriously, that they will be held to account and that their child may be taken away from them and/or criminalised.

APVA can include physical violence from an adolescent towards a parent and a number of different types of abusive behaviours, including damage to property, emotional abuse, and economic/financial abuse. Violence and abuse can occur together or separately. Abusive behaviours can encompass, but are not limited to, humiliating language and threats, belittling a parent, damage to property and stealing from a parent and heightened sexualised behaviours. Patterns of coercive control are often seen in cases of APVA

It is also important to understand the pattern of behaviour in the family unit; siblings may also be abused or be abusive. There may also be a history of domestic abuse, or current domestic abuse occurring between the parents of the young person. It is important to recognise the effects APVA may have on both the parent and the young person and to establish trust and support for both.

There is no single explanation for APVA and the pathways appear to be complex. Some families experiencing APVA have a history of domestic violence and abuse. In other cases the violence is contextualised with other behavioural problems, substance abuse, mental health problems, learning difficulties, or self-harm. In some cases there are no apparent explanations for the violence and some parents find it difficult to understand why one child is aggressive towards them when their other children do not display such behaviour.

APVA is a complex problem and the boundaries between 'victim' and 'perpetrator' can be unclear. The violence is often (although not always) contextualised within existing family problems and many 'perpetrators' of violence towards their parents are, or have been victims or secondary victims of domestic violence and abuse or child abuse. It is often difficult to observe or assign labels of 'perpetrator' and 'victim' and there are numerous concerns about criminalising a young person for their behaviour, and the negative impact that this may have on their future life chances. Professionals working with children and young people and parents should seek to identify risk factors early and work together with the family to provide early support to avoid crisis situations.

Abuse from a child or young person, as with other forms of domestic abuse, can also cause health and wellbeing issues such as anxiety, depression, stress and physical injury. It may result in parents self-medicating with drugs and alcohol as a coping mechanism. Those who experience APVA often suffer a great deal before seeking

support. This is often linked to feelings of failure in the parenting role, and the shame and stigma of having an abusive child.

Domestic Abuse and Older People (60+)

Research suggests that older people's experiences of domestic abuse may be different from younger people.

The experience of domestic abuse amongst older people varies. For some they will have experienced abuse at the hands of their partner for many years, for others the abuse may be a characteristic of a new relationship started in later life. They may be being abused by a family member and for some the abuse may have started as they've reached older age and/or become frail or cognitively impaired. Up to a third of abuse experienced by older people is perpetrated by family members other than partners or ex partners.

As with other forms of domestic abuse, violence and abuse experienced by older people can and often does involve coercive control. However whilst some perpetrators may be coercive and deliberately premeditated in their actions, others may be reacting in circumstances where they are unable to cope with the level of care their partner or parent requires, or perhaps there is a clinical causality – as a result of dementia/Alzheimer's disease. The use of coercive control techniques may feature less prominently where abusive behaviour is a consequence of unintentional neglect or the emotional situational stress experienced by the carer. Unintentional abuse may cause harm through action or inaction. It can have a serious impact on an Adult at Risk and should not be ignored. A referral to the Adult safeguarding procedures can be a useful way of bringing professionals together on a multi-agency basis to ensure the person at risk is safe and their needs and the carer's needs are being addressed.

An older person may not experience abuse directly but be exposed to it in their family environment, for example older people living in the family home where another family member is the primary victim, or when targeted by a perpetrator who is abusing a member of their family. It is important to recognise that such exposure to abuse can still present serious short and long-term harm or even death. It is also an important reminder that a holistic, whole family approach is optimum for professionals in order to address the needs of all members, including those with care needs.

Whilst loss of independence and low self-esteem affects many older people who suffer domestic abuse, people with care and support needs who are coerced and controlled by carers or family members may have more difficulties in recognising their experience as abuse. They are more likely to blame themselves or their needs

for the abuse. They may also fear losing hard won independence; or fear loss of pride and fear of failure to manage their condition.

Fear that disclosure will exacerbate the abuse is a general barrier for all victims of abuse, older people are often more emotionally, financially and physical dependent on the abuser(s) than their younger counterparts because of age related health issues. A consequence of this dependency means that older people are reluctant to report abuse because there is a fear that they will be institutionalised and placed in a care home. This may also influence how much they disclose about their experience and their likelihood of minimisation.

Older people, more so than their young counterparts do not want to involve agencies in their private affairs because of the shame associated with abuse by a family member and a perceived lack of entitlement to receive help.

When assessing an older person's risk of harm and need it may be necessary to assess their capacity to make a particular decision. Assessing capacity can be particularly challenging in cases involving domestic abuse and sexual violence. It may be the case that the person is cared for by, or lives with, a family member or intimate partner and the person makes decisions relating to these relationships which appear to place them in danger. In such cases it will be necessary to seek to understand whether these decisions are 'unwise decisions' which the person has capacity and freedom to make, or decisions not made freely, due to coercion and control, and therefore part of the abuse.

Physical and sexual assault in older victims is more likely to result in serious injury than with other age groups because of physiological changes in the body.

Disability and sensory impairment related to ageing is common. Disability can result from domestic abuse and in those who are frail a marked decline in physical and mental function can result from apparently low-level incidents. Disability is also known to increase the likelihood of a person experiencing abuse. Disabled women are twice as likely to experience violence and sexual abuse as non-disabled women.

Older people with dementia are more likely to experience abuse than older people who do not have this condition. They are at higher risk of abuse due their impaired ability to seek help, advocate for themselves or remove themselves from potentially abusive situations. The likelihood is so significant that this should be seen as a risk factor linked to the likelihood of abuse.

Due to the incidence of age related illness and disability, many older people who are experiencing domestic abuse have health or social care needs and may fit the definition of an Adult at Risk under The Social Services and Well-being (Wales) Act 2014. Where a person is identified as an “adult at risk” under the Act, the Local Authority will have a responsibility to make, or cause to be made, whatever enquiries it considers necessary to enable it to decide whether any action should be taken and, if so, what and by whom.

Stalking

Stalking is not legally defined but the amendments include a list of example behaviours which are following, contacting/attempting to contact, publishing statements or material about the victim, monitoring the victim (including online), loitering in a public or private place, interfering with property, watching or spying. This is a non exhaustive list which means that behaviour which is not described above may also be seen as stalking. Stalkers will often use multiple and differing methods to harass their victims. Stalking can consist of any type of behaviour such as regularly sending flowers or gifts, making unwanted or malicious communication, damaging property and physical or sexual assault. If the behaviour is persistent and clearly unwanted causing fear, harassment or anxiety then it is stalking.

The absence of violence in a stalking case doesn't mean the victim is unaffected. Stalking can cause severe psychological distress to a victim. Depression, anxiety, sleep disturbance, paranoia, agoraphobia and post-traumatic stress disorder are all common side effects of stalking.

As of 25th November 2012 two new amendments to the Protection from Harassment Act were made that makes stalking a specific offence in England and Wales.

- To prove a section 2A it needs to be shown that a perpetrator pursued a course of conduct on two or more occasions which amounts to harassment and that the particular harassment can be described as stalking behaviour.
- Section 4A is stalking involving fear of violence or serious alarm of distress. Again serious alarm and distress is not defined but can include behaviour which causes the victim to suffer emotional or psychological trauma or have to change the way they live their life.

Sections 2 and 4 of the Protection from Harassment Act can also still be used to prosecute harassment. Harassment is described in the Act as a course of conduct which (a) amounts to harassment of another and, (b) which they know or ought to know amounts to harassment of another.

Health Professionals should

- make it easy for the victim to talk about their experiences;
- be supportive, reassuring and non-judgemental;
- never assume that someone else will take care of domestic violence and abuse issues – you may be the victim’s first and only contact;
- always be prepared to work in partnership with other organisations that have been set up to ensure a victim’s safety;
- always adhere to local and national domestic abuse policies.

Ask and Act

Following the Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015 it is now the role of the entire Public Service to provide an effective response to those experiencing violence against women, domestic abuse and sexual violence.

Ask and Act is a process of targeted enquiry that recognises that there are indicators of potential violence against women. These should be used as a prompt for professionals to ask patients whether they have been affected by any of these issues. The implementation of ‘Ask and Act’ should acknowledge that women disproportionately experience domestic abuse, sexual violence and other abuse, such as forced marriage and female genital mutilation.

The aims of “Ask and Act”

- increase identification of those experiencing violence against women, domestic abuse and sexual violence;
- offer referrals and interventions for those identified which provide specialist support based on the risk and need of the client;
- begin to create a culture across the Public Service where the experience of violence against women, domestic abuse and sexual violence is an accepted area of business and where disclosure is supported, accepted and facilitated;
- improve the response to those who experience violence against women, domestic abuse and sexual violence with other complex needs such as substance misuse and mental health;

- pro-actively engage with those who are vulnerable and hidden, at the earliest opportunity, rather than only re-actively engaging with those who are in crisis or at imminent risk of serious harm.

Violence against women, domestic abuse and sexual violence require a Public Service response. Professional confidence to identify these issues, to ask about them and to respond effectively is fundamental for good clinical and social care practice.

Primary Care is expected to implement Ask and Act. There is a programme of training for this that is being rolled out across health boards.

Indicators of Potential Domestic Abuse

There are various indicators for domestic abuse that suggest an Ask and Act targeted enquiry is appropriate.

Signs

The potential outward and physical signs of someone who is experiencing violence against women, domestic abuse and sexual violence will be both physical and linked to the demeanour and behaviour of the client. They may include attitudinal change:

- Changes in attitude or behaviour: becoming very quiet, anxious, frightened, tearful, aggressive, distracted, depressed etc.
- Constant accompaniment by partner, even where this seems supportive and attentive
- Partner exerting unusual amount of control or demands over interactions with service, including constant accompaniment
- Reliance on partner for decision making-lack of free will and independence
- Obsession with timekeeping
- Secretive regarding home life
- Worried about leaving children at home with partner or family
- Partner or ex-partner exerting unusual amount of control or demands over clients schedule
- Social isolation from family/friends
- Unexplained injuries
- Change in the pattern or amount of make-up used
- Change in the manner of dress: for example, clothes which do not suit the climate which may be used to hide injuries
- Substance use/misuse
- Fatigue/sleep disorders.

Symptoms

As the term would indicate it is expected the identification and subsequent enquiry based on symptoms will be rooted within clinical and medical practice. Symptoms which should trigger an enquiry include (this list is not exhaustive):

- Depression
- Anxiety
- Medically unexplained chronic pain
- Tiredness
- Alcohol or other substance use
- Self harm
- Suicide attempts
- Eating disorders
- Medically unexplained chronic gastrointestinal symptoms
- Medically unexplained reproductive symptoms, including pelvic pain, sexual dysfunction
- Adverse reproductive outcomes, including multiple unintended pregnancies and/or terminations, delayed pregnancy care, adverse birth outcomes
- Gynaecological problems
- Medically unexplained genitourinary symptoms, including frequent bladder or kidney infections or other
- Repeated vaginal bleeding and sexually transmitted infections
- Problems with the central nervous system – headaches, cognitive problems, hearing loss
- Repeated health consultations with no clear diagnosis or medically unexplained symptoms
- Intrusive or controlling partner in Consultations

Cues

A cue describes either a piece of information or pattern of behaviour which merits enquiry. This could include taking an overview of a client's engagement with services over time and querying the reasons behind sporadic or crisis based engagement. It might also include information provided by a partner agency, based on referral or shared via use of local Information Sharing Protocols which indicates concern, suspicion or unsubstantiated intelligence the client might be experiencing violence against women, domestic abuse and sexual violence.

To "Ask and Act" is not to interrogate, but where a cue is observed or received a professional should make appropriate enquiry.

Settings

There is evidence which suggests in some settings routine enquiry is appropriate as the reason for the patient's engagement within the setting is also a trigger for enquiry in relation to violence against women, domestic abuse and sexual violence. Professionals working in the following settings should routinely ask all clients whether they are experiencing violence against women, domestic abuse and sexual violence due to the known co-occurrence of domestic abuse with the core purpose of the service they provide (mental health issues, pregnancy, child maltreatment):

Mental Health

The risk of developing depression, post-traumatic stress disorder (PTSD), substance use issues or becoming suicidal is 3 to 5 times higher for women who have experienced violence in their relationships compared to those who have not. Acknowledging mental health settings as an indicator for "Ask and Act" offers practitioners an opportunity to address these links pro-actively and offer care which addresses the co-occurring issues.

Maternal and Post Partum Settings

30% of domestic violence starts in pregnancy and is associated with low birth weight and pregnancy complications including miscarriage and still-birth. A process of "Ask and Act", with additional training will further strengthen the existing maternity care pathway which uses an evidence based approach to asking all women about domestic abuse in the antenatal period.

Concerns about Child Maltreatment

Nearly three quarters of children on the child protection register live in households where domestic violence occurs and 52% of child protection cases involve domestic violence. 62% of children exposed to domestic abuse are also directly harmed. There are missed opportunities to identify violence against women, domestic abuse and sexual violence and to identify risks to children.

Multi Agency Risk Assessment Conference (MARAC)

Working in a multi-agency partnership is the most effective way to approach domestic abuse at both an operational and strategic level. The MARAC is a process to address the safety and protection of those most at risk from serious assault or murder as a result of domestic abuse.

In many high risk situations, victims may adopt an increasingly passive stance and an acceptance of their situation without the possibility of change, leading to them being unlikely to seek help. The MARAC is a vital tool in addressing their safety and

is a way of moving the responsibility for addressing domestic abuse from the victim to a broad group of agencies.

Effective protection of victims and their children is a multi agency responsibility. This meeting combines up to date risk information with a comprehensive assessment of a victim's needs linking those directly involved to the provision of appropriate services for the victim, children and perpetrator.

Health professionals may be asked to attend, or provide information for, the MARAC. The duty of responsibility to co-operate with this process is the same as for Child Protection Case Conferences.

The aims of the MARAC are to

- share information to enhance the safety, health and well being of victims, adults and their children;
- raise awareness of the impact of domestic abuse on children;
- agree and implement a risk management plan;
- reduce repeat victimisation;
- determine whether the perpetrator poses a significant risk to any particular individual or to the general community;
- reduce domestic homicide and abuse;
- prevent child abuse;
- ensure agency accountability;
- provide support for staff members and professionals involved in high risk domestic abuse cases.

The MARAC may recommend a referral to social services. Similarly at any point in a social service assessment process a MARAC may be recommended and arrangements must be in place to share information between the 2 processes.

MARAC partner agencies recognise the overlap between domestic abuse and the abuse of children. The legal definition of harm to children has been extended to include those living in households where domestic abuse is taking place. Amendment, *Section 120, Adoption & Children Act 2002*.

Please see chapter 17 for a list of Read codes recommended for use in primary care in the victim, family and perpetrator records.

9 SUBSTANCE AND ALCOHOL MISUSE

The Welsh Government's ten year substance misuse strategy, [Working Together to Reduce Harm, 2008 – 2018](#), has prioritised supporting substance misusers to reduce harm to themselves and their families by the provision of advice, brief intervention and recovery based services. Adult and child services need to continue working together, aiming for effective treatment and support for the adult, leading to major benefits, and improved outcomes for the child.

Adults at Risk: Using Substances and/or Alcohol

Substance and alcohol misuse in adults could mean that they prioritise obtaining and using drugs and / or alcohol above all other things in their lives. Such life styles and priorities can often lead people to be particularly vulnerable to abuse.

Where adults and young people with co-existing mental health needs use substances or alcohol there is a potential for self neglect. This may mean there is a decline in the way they manage their health, mismanage or omit prescribed medications and fail to attend appointments. Communities, friends and families may notice changes in friendship groups as well as concerns about living conditions and who the adult is spending time with.

Approximately one third of UK mental health service users, half of the people seen by substance misuse services, and seven out of ten prisoners will experience co-existing substance misuse and mental health problems at some point in their lives. In order to deliver effective services to this client group, services have to be co-ordinated and have clear treatment protocols and care pathways in place.

The [National Treatment Agency for Substance Misuse](#) has identified key principles in terms of ensuring appropriate care of drug misusers:

- Drug misusers have the same entitlement as other patients to the services provided by the National Health Service.
- The focus for the clinician treating a drug misuser is on patients themselves. However, the impact of their drug misuse on other individuals – especially dependent children – and on communities should be taken into consideration.

Substance/Alcohol use: Impact on Parenting or Caring

Parental drug and alcohol misuse can cause serious and significant harm to children of all ages, from conception to adulthood. The adverse consequences for children are typically multiple and cumulative and will vary according to the child's stage of development. They include failure to thrive; blood-borne virus infections; incomplete immunisation and otherwise inadequate health care; a wide range of emotional, cognitive, behavioural and other psychological problems; early substance misuse and offending behaviour; and poor educational attainment.

It is estimated that between 2–3% of children under 16 in England and Wales have one or both parents dealing with a serious drug problem.

The complexity of substance and alcohol misuse significantly affects children and families. Safeguarding and protecting vulnerable children and is a key theme of the Social Services and Well being Act (2014) recognising that children and young people are likely to be at greater risk of harm through their own substance misuse or parental substance misuse.

In order to make a comprehensive assessment of drug using parents, National Treatment Agency guidelines outline the following:

- Effect of drug misuse on functioning, for example, intoxication, agitation;
- Effect of drug seeking behaviour, for example, leaving children unsupervised, contact with unsuitable characters;
- Impact of parent's physical and mental health on parenting;
- How drug use is funded, for example, sex working, diversion of family income;
- Emotional availability to children;
- Effects on family routines, for example, getting children to school on time;
- Other support networks, for example, family support;
- Ability to access professional support;
- Storage of illicit drugs, prescribed medication and drug-using paraphernalia.

It is also helpful to consider what it is that a parent is not doing for their child (age appropriate expectations) that you would be reasonably expecting a parent to do. In addition to the above information the following examples of concerns or behaviours would hopefully lead to discussion about whether support is in place or if a specific intervention is needed for a family or an individual.

- Failing to attend appointments, not bringing a child to an appointment;
- A child or young person not attending school or college;
- Noticing apparent neglect issues, examples such as lack of self care in an adult or young person or neglectful care of a child;
- Parents associating with unsuitable or inappropriate adults impacts on children having chaotic and potentially unsafe lives;
- Where income may be being spent on drugs or alcohol, there is a lack of money for food, clothes and essential amenities for the children.

Support and Services

For children, young people, families and adults it is important to consider what (if any) services are currently involved giving support. It may be that asking appropriate questions is enough to open a discussion about supporting needs and current agency support.

Integrated Family Support Services are able to complete a specific and intensive planned intervention working with the most vulnerable children and families in Wales, specifically where substance misuse is impacting on parenting and child welfare.

Information about specific substances and the potential health risks to an individual is available from the NHS Choices website: [NHS Choices - livewell/drugs](#) . As well as the confidential drugs advice site: ['Talk to Frank'](#) .

10 CHILD SEXUAL EXPLOITATION (CSE)

The Welsh Government and the All Wales Child Protection procedures definition of Child sexual exploitation is the coercion or manipulation of children and young people into taking part in sexual activities. It is a form of sexual abuse involving an exchange of some form of payment which can include money, mobile phones and other items, drugs, alcohol, a place to stay, 'protection' or affection. The vulnerability of the young person and grooming process employed by perpetrators renders them powerless to recognise the exploitative nature of relationships and unable to give informed consent.

Those exploiting the child hold power over the child or young person (by virtue of age, gender, intellect, physical strength, money and / or other resources). CSE involves exploitative relationships as well as violence, intimidation and coercion and prays on the child's emotional or social or economic vulnerability

In contrast to other forms of sexual abuse, children and young people who are sexually exploited may not recognise that they are being abused as they perceive the perpetrator as giving them something they need or want. This may change over time as the perpetrator's behaviour becomes more coercive, but fear of consequences may stop them from disclosing.

Sexual exploitation results in children and young people suffering harm, and causes significant damage to their physical and mental health. Some young people may be supported to recover whilst others may suffer serious life-long impairments which may, on occasion, lead to their death, for example through suicide or murder.

There are different ways in which sexual exploitation may take place such as:

- An inappropriate relationship often characterised by a significant age difference - the perpetrator exercises power over the young person through giving them something they need in exchange for sexual activity.
- The 'boyfriend' model - the young person is groomed to view the person as a boyfriend but is then forced into performing sexual behaviours for others.
- Peer-on-peer exploitation - the young person is drawn into sexual activities by their peers e.g. as part of the ritual of belonging to a gang.

It should not be assumed that children aged 16 and 17 years are safe from CSE. A young person who has been subject to a complex pattern of life experiences including sophisticated grooming and priming processes that have brought them to a point where they are at risk of or are abused through CSE, are often not able to recognise the exploitative relationships and situations they are in. They may even present as being in control.

Health services have a role and responsibility in relation to prevention and recognition of CSE. Staff working across agencies need to be familiar with risk indicators, assessment procedures and the contents of the *All Wales Protocol*. Information sharing and multi-agency working is central to safeguarding and promoting the welfare of children and young people vulnerable to, at risk of and abused through child sexual exploitation.

Vulnerability Factors for CSE

Disclosure of this form of abuse is rare and there is a perception that CSE is a hidden form of abuse that takes place out of sight. However as quoted by a young victim of CSE to researchers from the University of Bedfordshire “It’s not hidden, you just aren’t looking”.

Almost all children and young people come into contact with Primary Care and it is possible to reduce the risks associated with CSE at all levels of risk. Vulnerability and risk indicators of CSE are well established. So there is an opportunity to recognise those at risk and to involve other agencies in preventing abuse. Early identification and a timely response are central to effective safeguarding practice.

Whilst generally more females than males suffer from CSE and the average age when concerns are first identified is 13-15 years old, no one is immune.

Particular life experiences associated with increased risk of CSE are:

- Family dysfunction
- Prior (sexual) abuse or neglect
- Going missing / running away
- Substance misuse
- Disengagement from education
- Social isolation
- Low self esteem
- Socio-economic disadvantage
- Learning difficulties / disabilities

- Peers who are sexually exploited
- Gang-association
- Attachment issues
- Homelessness
- Being in care.

Possible warning signs of CSE (drawn from CCSEGG interim report, 2012)

- Missing from home or care
- Physical injuries
- Drug or alcohol misuse
- Involvement in offending
- Repeated STIs, pregnancies and termination
- Absent from school
- Change in physical appearance
- Evidence of sexual bullying/vulnerability through the internet and/or social networking sites
- Estranged from their family
- Receipt of gifts from unknown sources
- Recruiting others into exploitative situations
- Poor mental health
- Self-harm or thoughts of or attempts at suicide

In Wales the Barnardo's Sexual Exploitation and Risk Assessment Form (SERAF) is the recommended tool to identify those at risk from CSE. Some research done in South Wales on the questions used in the SERAF has identified four questions that are the most important to ask. The wording used in these questions has been established in consultation with young people.

They are:

- Have you ever stayed out overnight or longer without permission from your parent(s) or guardian?
- How old is your partner or the person(s) you have sex with? (Is the age difference 4 or more years?)
- Does your partner stop you from doing things you want to do?
- Thinking about where you go to hang out, or to have sex. Do you feel unsafe there or are your parent(s) or guardian worried about your safety?

11 LOOKED AFTER CHILDREN

Children and young people who are looked after are historically amongst the most socially excluded groups in England and Wales. Prior to entering care, they may have profoundly increased health needs in comparison with other children and young people from similar socio-economic backgrounds. Due to their poor educational, health and social outcomes they are very vulnerable.

Their high levels of health need are often related to their experiences prior to coming into care. These can include neglect, abandonment, and abuse - physical, mental or sexual.

- In 2014 just 12% of Looked After Children attain 5 GCSE grades A* to C including English and Maths compared to 52% of young people who are not in the care system.
- Studies have shown that young people moving on to independent living are at an increased risk of homelessness relatively soon after leaving care.
- The prevalence of mental disorders is 40% for children in the looked after system compared with 12% in children from the private household survey.

This means that they have specific needs and should be treated in an empathic and responsive manner by Primary Care.

The Local Authority must ensure that all Looked After children are promptly registered with a GP. There needs to be clear guidance for all primary care staff on how to deal with a young person wishing to register or access their services with or without involving a parent or carer.

The nature of their care means that they are highly mobile and this can impact on the continuity and hence quality of their care. To deliver the best possible medical care to the child or young person General Practice needs to have the best possible access to the relevant medical records. Treating a patient as a temporary resident is not ideal as the medical record is not available to the treating practitioner and any new information may not be added to the health record. In circumstances where children are seen without their medical records it is suggested that the treating practitioner will normally wish to talk to the child or young person's registered practitioner to avoid treating the patient "blind".

Each looked after child should be regularly assessed by a Community paediatrician or specialist nurse for Looked After Children and a copy of the care plan sent to the GP. The GP clinical record is unique and can integrate all known information about health and health events during the life of any child or young person. This enables an overview of health priorities and to know whether health care decisions have

been planned and implemented. The community record follows the child. The Personal Child Health Record (Red book) should also follow the child. The GP record also provides continuity and is an important ongoing record for Looked after Children and Young People.

Primary Care Teams are expected to ensure that:

- Looked after children are registered with the carer's GP within 10 working days of the date of placement.
- The registration status of looked after children becomes permanent no later than 4 weeks following the date of placement.
- GP records of a child who is looked after are requested and transferred using the 'Fast Tracking' system.
- GP records make the "looked after" status of the child or young person clear, so that their particular needs can be acknowledged.
- Details of the carer and social worker or personal advisor should be recorded.
- There is timely, sensitive access to a GP or other appropriate health professional when a child or young person who is looked after requires a consultation.
- Young people requesting medical help without a carer to assist or register them should initially be seen assessed and any medical needs dealt with. It is important to note that they are entitled to confidential appointments with the doctor without involving their foster carer or social worker if they are Fraser competent.
- Healthcare professionals are able to assess the competence of young people.
- Young people who are capable are able to register without any involvement of carers or parents. This is particularly important as physical and mental health problems can increase after a young person leaves care.
- Young people are entitled to attend any GP surgery for sexual health issues, emergency contraception and other urgent problems including preventative care e.g. immunisations, without necessarily being registered there.
- Referrals made to specialist services are timely, taking into account the needs and high mobility of many children and young people who are looked after.
- GP services, when requested, provide summaries of the health history of a child or young person who is looked after, including their family history and ensure that this information is passed promptly to health professionals undertaking health assessments, subject to appropriate consents.
- They maintain a record of the health assessment and contribute to any necessary action within the health plan.

- Copies of any existing health reports and any subsequent reports are forwarded to the existing GP and any GP with whom the child will be registered following placement, so that the GP record remains a comprehensive health record for the child.

12 FEMALE GENITAL MUTILATION (FGM)

Female genital mutilation (sometimes referred to as female circumcision or 'cutting') refers to procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons. FGM comprises all procedures involving partial or total removal of the external female genitalia for non-medical reasons. The practice is illegal in the UK under the FGM Act 2003.

FGM is a form of child abuse and violence against women. The health implications of FGM can be severe to fatal depending on the type of FGM carried out. Professionals need to be aware of the possibility of FGM.

For children the All Wales Child Protection Procedures have specific guidance on [FGM](#). For Adults there is an All Wales FGM Pathway (see appendix 6).

The FGM Line is available on 0800 0283 550 or fgmhelp@nspcc.org.uk

There are no health benefits to FGM. Removing and damaging healthy and normal female genital tissue interferes with the natural functions of girls' and women's bodies, causing both short and long term physical, emotional and psychological health problems. Simple descriptors and information about of FGM can be found on [NHS Choices-FGM](#).

FGM is carried out on girls aged anywhere from infancy to late teenage years, and seems to be more common before puberty. Girls may be taken to the family country of origin over the school holiday periods, where FGM takes place on the child. Increasingly, girls may have FGM performed in the UK.

Indicators of FGM

However this is not an exhaustive list and professionals should be vigilant at all times.

Indications that FGM may be about to take place include:

- The family comes from a community that is known to practice FGM e.g., Somalia, Sudan and other African countries. It may be possible that they will practice FGM if a female family elder is around.
- Parents state that they or a relative will take a girl out of the country for a prolonged period.
- A girl may talk about a long holiday to her country of origin or another country where the practice is prevalent, including African countries and the Middle East.

- A girl may confide to a professional that she is to have a 'special procedure' or to attend a special occasion.
- A professional hears reference to FGM in conversation, for example a girl may tell other children about it.
- A girl may request help from a teacher or another adult.
- Any girl born to a woman who has been subjected to FGM must be considered to be at risk, as must other female children in the extended family.
- Any girl who has a sister who has already have undergone FGM must be considered to be at risk, as must other female children in the extended family.

Indications that FGM may have already taken place include:

- A girl may spend long periods of time away from the classroom during the day with bladder or menstrual problems if she has undergone Type 3 FGM
- There may be prolonged absences from school if she has undergone Type 3 FGM
- A prolonged absence from school with noticeable behaviour changes on the girl's return could be an indication that a girl has recently undergone FGM
- Professionals also need to be vigilant to the emotional and psychological needs of children who may/are suffering the adverse consequences of the practice e.g. withdrawal, depression etc
- A girl requiring to be excused from physical exercise lessons without the support of her GP
- A girl may ask for help.

FGM: Mandatory Reporting

There is a 'Duty to Report' FGM as part of the FGM Act 2003; section 5B of the Act (inserted under section 74 of the Serious Crime Act 2015).

The legislation applies to all registered health professionals in England and Wales. It requires them to make a report to the police where, in the course of their professional duties, they either:

- Are informed by a girl under 18 that an act of FGM has been carried out on her; or
- Observe physical signs which appear to show that an act of FGM has been carried out on a girl under 18 and they have no reason to believe that the act was necessary for the girl's physical or mental health or for purposes connected with labour or birth.

For the purposes of the duty, the relevant age is the girl's age at the time of the disclosure/identification of FGM (i.e. it does not apply where a woman aged 18 or over discloses she had FGM when she was under 18).

Complying with the duty does not breach any confidentiality requirement or other restriction on disclosure which might otherwise apply. The duty is a personal duty which requires the individual professional who becomes aware of the case to make a report; the responsibility cannot be transferred. The only exception to this is if you know that another individual from your profession has already made a report then there is no requirement to make a second referral.

The duty does not apply in relation to at risk or suspected cases or in cases where the woman is over 18. In these cases, you should follow local safeguarding procedures as stated above.

Where there is a risk to life or likelihood of serious immediate harm, professionals should report the case immediately to police, including dialling 999 if appropriate.'

Further information regarding procedural information can be sourced by following this link to the Home Office guidance: [Mandatory Reporting of FGM - Procedural Information](#)

Recording FGM in the Patient Healthcare Record

As of 1 April 2014, the 'ISB 1610 Female Genital Mutilation Prevalence Dataset' was published. Within it are rules for healthcare professionals. This includes General Practitioners and other primary healthcare staff.

All clinical staff **must** record in patient healthcare records when it is identified that a patient has had FGM. If it can be determined what type of FGM the patient has, according to the WHO classifications (outlined below) this **must** be recorded. Where it is not possible to determine the type of FGM, then 'Female Genital Mutilation' **must** still be recorded within the clinical notes.

WHO Classification of FGM

- Type 1** Partial or total removal of the clitoris and/or the prepuce (clitoridectomy)
- Type 2** Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision)
- Type 3** Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation)

Type 4 All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization

The recommended Read codes can be found in chapter 17.

13 HONOUR BASED VIOLENCE

Honour-based violence (HBV) is the term used to refer to a collection of practices used predominantly to control the behaviour of women and girls within families or other social groups in order to protect supposed cultural and religious beliefs, values and social norms in the name of 'honour'. HBV incidents and crimes include specific types of offence, such as forced marriage and female genital mutilation (FGM), and acts which have long been criminalised, such as assault, rape and murder. HBV is used to refer to the full range of incidents and crimes which perpetrators carry out under the guise of maintaining or protecting perceived 'honour'.

It should be noted that HBV does not stand alone but is linked with established domestic abuse, child protection, and protection of adult at risk procedures which should always be used in these cases.

HBV is normally associated with cultures and communities from Asia, the Middle East, Africa, Gypsy, and traveller communities. In reality HBV impacts across cultures, nationalities, faith groups and communities and transcends international boundaries.

Honour has many interpretations, for the purpose of this guidance it relates to the concept that the reputation and social status of an individual, a family or community is based on the behaviour and morality of its members.

It is important to consider the part honour can play in an individual's life to assist you in understanding the mindset of a perpetrator and the risk posed to a victim. Some perpetrators will go to great lengths when they have been dishonoured by a victim's behaviour. The following are issues which could be considered as effecting honour:

- Defying parental authority
- Dress, behaviour, and attitude
- Sexual relationships / behaviour before marriage
- Use of drugs or alcohol
- Gossip and rumour (which may damage reputation).

The consequences to a person who is considered to have damaged their honour or that of their family / community can be extreme and may include:

- Ostracism by family and community
- Economic disadvantage

- Political consequences (community leaders may lose support)
- Loss of social status
- Abuse and violence
- Suicide as a result of the control and abuse
- Murder
- Forced marriage
- Dowry abuse (known as bride burning when a dowry paid for a bride is not considered sufficient by her new family which results in abuse and possibly the physical burning of the bride)
- Pressure to go abroad
- House arrest
- Excessive restrictions e.g. removed from education, prohibited from working, not allowed use of phone, banned from seeing friends.

It is important for practitioners to be aware of triggers and warning signs which maybe apparent in HBV cases, these can include:

- Truancy
- Decline in performance or punctuality
- Withdrawal from education
- Not authorised to attend extracurricular activities
- Self harm / attempted suicide
- Eating disorders
- Depression
- Isolation
- Substance misuse
- Family disputes
- Running away
- Female genital mutilation
- Lack of money – financial control.

A victim of HBV will have overcome immense cultural beliefs to have reported HBV to an agency / a friend who has made the report. Alternatively a friend or professional may have raised concerns about HBV. It is therefore vital that agencies respond immediately and appropriately to ensure the victims safety. The need for positive action is fundamental to an effective and timely response.

Reassure the victim, take the threats to their safety seriously and offer support. It is imperative that all victims are treated professionally and with sensitivity. Ensure you speak to the victim alone and discover who is 'safe' to speak in front of.

Do not make any assumptions based upon culture; many cultures have extensive differences in small areas.

Forced Marriage

Forced marriage is a marriage in which one or both spouses do not (or in the case of some adults with learning disabilities or physical disabilities cannot) consent to the marriage and duress is involved. Duress can include physical, psychological, financial, sexual and/or emotional pressure.

An arranged marriage is very different to a forced marriage and the two should not be confused. An arranged marriage is an established tradition where a spouse is suggested by the families of the prospective bride and / or groom. However the choice to go ahead with the marriage remains with the bride and groom.

Advice and support can be accessed through The [All Wales Domestic Abuse and Sexual Violence Helpline](#) on **0808 8010 800**
and
The Welsh Government [Live Fear Free](#) website.

14 MODERN DAY SLAVERY

Modern Day Slavery (or formerly Human Trafficking) is the second most profitable crime in the world, second only to drugs. It is also a growing crime in the UK with victims exploited in four main ways;

Someone is in slavery if they are:

- forced to work - through mental or physical threat
- owned or controlled by an 'employer', usually through mental or physical abuse or the threat of abuse
- dehumanised, treated as a commodity or bought and sold as 'property'
- physically constrained or has restrictions placed on his/her freedom of movement.

Advice and Support is available on the [Modern Slavery Helpline](#) and on 0800 0121 700

The term Modern Slavery captures a whole range of types of exploitation, many of which occur together. These include but are not limited to:

- forced or bonded labour
- sex trafficking
- forced migrant labour
- domestic servitude
- forced child labour
- child soldiers
- children exploited for commercial sex (including child sex tourism)
- other forms of exploitation – organ removal, forced begging, forced benefit fraud, forced marriage and illegal adoption.

Modern slavery affects people of all ages, gender and races. However those that are socially excluded, a minority group or vulnerable tend to be targeted the most. It is important to note that people may be moved across national boundaries however this is a practice also happens within the UK to adults and children who may or may not be UK citizens.

Those who traffic people may do so by force, through coercion or by using fraudulent payment and promises of non-existent legitimate employment.

What to look for

Modern Day Slavery (MDS) is often referred to as a 'hidden crime' because victims either do not perceive themselves as such or because they are unwilling to talk to police due to:

- A fear of retribution/reprisals from their traffickers (either against themselves or their families)
- Fear and suspicion of the authorities, and a lack of awareness that these people are in a position to help.
- Fear resulting from Juju or witchcraft rituals.
- Fear that their traffickers will accuse them of being complicit in their trafficked situation.
- Toleration of their situation as it is more favourable than their home circumstances.
- Being in a relationship with their traffickers.
- Stockholm syndrome, where due to unequal power victims create a false emotional or psychological attachment to their controller.
- Fear of discrimination from their community and families.

It is not uncommon for traffickers to provide stories for victims to tell if they are approached by the authorities - errors or lack of reality in these stories may be because they have been composed by others and learnt.

Signs

This is not an exhaustive or definitive list

- People living and working at the same address
- People collected very early in the morning and/or returned late at night on a regular basis
- Being driven between premises rather than arriving or leaving on foot
- Signs of injury, malnourishment and a general unkempt appearance
- Isolation from the rest of the community/limited social contact
- Being escorted to appointments by people who do not appear to be friends or family
- Not being allowed to answer questions themselves at medical appointments
- Not registered with a G.P.
- Not sure of their personal information e.g. home address, place of work

Information from the community, no matter how small or insignificant it seems, can play a crucial role in tackling Modern Day Slavery.

15 ABUSE AND NEW TECHNOLOGIES

Advances in the internet and wider information and communications technology are now firmly embedded within the everyday lives of UK adults and children. Online activity features prominently in entertainment, education and social lives. It is often now seen as an essential tool for offline lives and for children in particular this can lead to blurred edges. It has also led to new ways in which abuse can be perpetrated.

The abuse may be part of abuse that is taking place in the real world for example grooming. Or it may be that the abuse only happens online such as persuading children to post sexual images. Children can be at risk of online abuse from people they know, as well as from strangers.

Children can feel like there is no escape from these forms of abuse as abusers can contact them at any time of the day or night, the abuse can come into safe places like their bedrooms, and images and videos can be stored and shared with other people.

The main forms of this abuse are:

- Indecent images of children (IIOC)
- Online child sexual exploitation (OCSE)
- Sexual Abuse On-Line
- Cyber bullying.

Indecent Images of Children

IIOC continue to proliferate across the internet via Webmail, social networking and file hosting, file sharing peer to peer, the hidden internet, the commercial production and distribution of IIOC and live video streaming.

Those who view IIOC online pose a risk to any children to whom they have access. However the greatest composite risk is assessed as coming from those involved in the production images of a higher Sentencing Council classification as the production of such images will inevitably involve more serious contact sexual offending.

CEOP estimated that there were around 50,000 individuals in the UK involved in downloading and sharing IIOC during 2012.

Online Child Sexual Exploitation (OCSE)

The term online child sexual exploitation (OCSE) is used to describe a genre of internet offending which includes, but is not defined by, traditional notions of online grooming. Use of the term 'grooming' suggests a course of conduct evolving over a period of time while the offender subtly gains the trust of his victim. It's easy for groomers to hide their identity online, they may pretend to be a child and then chat and become 'friends' with children they are targeting.

Children and young people can be groomed online or in the real world, by a stranger or by someone they know. Groomers can be of any age or gender.

Whilst slow grooming of a single victim still occurs, there is evidence that the dynamics of this threat have changed considerably over the last few years. A key departure from traditional ideas of online grooming is that offenders focus on quickly gaining leverage over a victim rather than first establishing a trusting relationship and there is investment of small amounts of time by perpetrators in large numbers of potential victims.

In general the initial offending outcome from OCSE takes place entirely online and increasingly groomers are sexually exploiting their victims by persuading them to take part in online sexual activity. However it is recognised that such engagement can in turn lead to offline meetings for sexual purposes.

Many children and young people don't understand that they have been groomed, or that what has happened is abuse.

The practice of self generating indecent imagery, a risk factor for OCSE is becoming increasingly widespread among children and young people in the UK.

Sexual Abuse On-Line

When sexual exploitation happens online, young people may be persuaded or forced to send or post sexually explicit images of themselves; take part in sexual activities via a webcam or smart phone; have sexual conversations by text or online. This abuse usually involves lone offenders but group sexual and offending associated with street gang culture can also occur.

Abusers may threaten to send images, video or copies of conversations to the young person's friends and family unless they take part in other sexual activity.

Images or videos may continue to be shared long after the sexual abuse has stopped.

Cyber Bullying

Cyber bullying is an increasingly common form of bullying behaviour which happens on social networks, games and mobile phones. Cyber bullying can include spreading rumours about someone, or posting nasty or embarrassing messages, images or videos. Children may know who's bullying them online, it may be an extension of offline peer bullying or they may be targeted by someone using a fake or anonymous account. It's easy to be anonymous online and this may increase the likelihood of engaging in bullying behaviour.

Cyber bullying includes:

- sending threatening or abusive text messages
- creating and sharing embarrassing images or videos
- 'trolling' - the sending of menacing or upsetting messages on social networks, chat rooms or online games
- excluding children from online games, activities or friendship groups
- setting up hate sites or groups about a particular child
- encouraging young people to self-harm
- voting for or against someone in an abusive poll
- creating fake accounts, hijacking or stealing online identities to embarrass a young person or cause trouble using their name
- sending explicit messages, also known as sexting
- pressuring children into sending sexual images or engaging in sexual conversations.

16 SUICIDE AND SELF HARM

Suicide and self harm are serious public health and social problem. Both the Welsh Governments strategy [Talk to Me 2](#) and [NICE guidance](#) agree that Primary care staff including doctors, nurses, reception staff, district nurses and health visitors have a key role in the care of people who self harm. Appropriate suicide prevention education for primary care staff can have an impact on preventing suicide at a population level.

Suicide

Suicide is one of the three leading causes of death in Wales in the age group 15-44 years and it is the second leading cause of death among young people age 15-19 years. Each year in Wales between 300 and 350 people die from suicide, about three times the number killed in road accidents.

Men are around three times more likely to die by suicide than women. Women are more likely to engage in non-fatal suicidal behaviours that require hospital admission. Men aged between 30 and 49 are now the group with the highest suicide rate and this appears to be an increasing issue for men in the most deprived areas of Wales.

The current economic climate may exacerbate the risk factors for this group making middle aged men priority people on whom to focus preventative efforts. In Wales and the rest of the UK there is a secondary but lower peak in suicide rates in those aged over 65. This is again particularly evident in men and may reflect unrecognised or unmanaged depression, physical illness, bereavement or social isolation.

Approximately a quarter of those who commit suicide are known to mental health services. Although much is being done in Wales to improve quality and access for mental health services, people with mental health problems remain a group at high risk. People with severe mental illness, are at particular risk; inpatients, people recently discharged from psychiatric hospital and those who refuse treatment in the community are at highest risk. At least a quarter of those known to mental health services have been in contact with services in the week prior to their death, this provides a window of opportunity for intervention. The provision of high quality mental health services across primary, secondary and tertiary care in collaboration with the Third sector that are equally accessible to all according to need is vital to the prevention of suicide across the life course.

Measures to strengthen social relationships for men, support the bereaved, improve the recognition and management of mental health issues in particular depression, reduce alcohol misuse and support employment and manage debt should be actively and explicitly supported. Measures should value physical and mental health equally.

A prior suicide attempt (i.e. where intent is known) is the single most important predictor of suicide in the general population. Approximately half of those who complete suicide have a history of self harm and approximately one in four have been treated in hospital for self harm in the preceding year. Those who repeat self harm or who have used violent and/or dangerous methods are at a particularly increased risk for suicide.

Providing those who self harm with appropriate follow up care and support is essential.

Self Harm

Self harm is one of the top five reasons for medical admission in the United Kingdom and results in significant social and economic burden due to the utilisation of health services, particularly with respect to unscheduled hospital care. There are approximately 5,500 admissions for self harm in Wales each year.

However many people who self harm do not seek help from primary or secondary care or attend emergency departments but leave before they are seen. There is also the psychological and social impact for the individual, friends, family and professionals.

The UK has one of the highest rates of self-harm in Europe. The true scale of self harm - including those who do not seek or require medical attention - is estimated to be 1 in every 130 people. Self harm is more common in females and the risk of repetition is extremely high at up to 40%.

The highest rates of self harm are in children and young people, particularly, girls and young women aged 11-19. Risk factors in Children and young people those a background of vulnerability including;

- adverse childhood experiences
- socio-economic deprivation
- low educational attainment
- drugs and alcohol misuse

- mental health issues
- Looked after children and care leavers
- children and young people in the contact with the youth offending system
- those with limited employment prospects
- those who might find themselves not in education, employment or training.

An important issue in children and young people is the potential effect of new media in both supporting prevention efforts and the possible detrimental effects of social media, chat rooms and websites that may encourage self harm or suicidal behaviours.

Suicide is uncommon in comparison to self harm. Many people may have thoughts of suicide; up to 19% people will have thoughts of suicide at some point in their life. These thoughts are distressing and can further isolate an individual, creating additional barriers to seeking help. Only a very small number of those who harm themselves or who think about suicide will actually die in this way

Services need to address how they respond to, assess and follow up people who present with self harm particularly where alcohol is involved. Similarly stigma in relation to self harm and suicide needs to be tackled to encourage help seeking behaviour.

TALK to ME2: Strategic Aims and Objectives

This strategy document and associated action plan builds on *Talk to Me*, the 2009 national action plan to reduce suicide and self harm in Wales. It sets out the strategic aims and objectives to prevent and reduce suicide and self harm in Wales over the period 2015-2020. It identifies priority care providers to deliver action in certain priority places to the benefit of key priority people, and confirms the national and local action required.

The overall strategic aims are to:

Reduce the suicide and self harm rates in the general population in Wales; and

Promote, co-ordinate and support plans and programmes for the prevention of suicidal behaviours and self harm at national, regional and local levels.

To do this it identifies six key strategic objectives

Objective 1: Further improve awareness, knowledge and understanding of suicide and self harm amongst the public, individuals who frequently come in to contact with people at risk of suicide and self harm and professionals in Wales

Objective 2: To deliver appropriate responses to personal crises, early intervention and management of suicide and self harm

Objective 3: Information and support for those bereaved or affected by suicide and self harm

Objective 4: Support the media in responsible reporting and portrayal of suicide and suicidal behaviour

Objective 5: Reduce access to the means of suicide

Objective 6: Continue to promote and support learning, information and monitoring systems and research to improve our understanding of suicide and self harm in Wales and guide action

NICE Guidance: Short and Long Term Management

The NICE guidelines make recommendations for the physical, psychological and social assessment and treatment of people in primary and secondary care in the first 48 hours after having self-harmed. The term self-harm is defined as 'self-poisoning or injury, irrespective of the apparent purpose of the act'. Self-harm is an expression of personal distress, not an illness, and there are many varied reasons for a person to harm him or herself.

Throughout the guideline, the need to treat people who self-harm with compassion and understanding is emphasised as the experience of care for people who self-harm is often unacceptable.

The guideline is relevant to all people aged 8 years of age and older who have self-harmed. Where it refers to children and young people, this applies to all people who are between 8 and 16 years of age inclusive.

The guideline makes recommendations that apply across the whole health community, wherever people who self-harm present for help, including good practice points to improve the integration of the different services involved. In the second part of the guideline, the recommendations directly address the care offered to people who self-harm presenting in primary care, in the community, or in secondary care.

The full guidance can be found at the links above. Here are parts with particular reference to Primary Care:

General Considerations

- People who have self-harmed should be treated with the same care, respect and privacy as any patient. In addition, healthcare professionals should take full account of the likely distress associated with self-harm.
- Wherever possible, people who have self-harmed should be offered the choice of male or female staff for both assessment and treatment. When this is not possible, the reasons should be explained to the service user and written in their notes.
- When assessing people who self-harm, healthcare professionals should ask service users to explain their feelings and understanding of their own self-harm in their own words.
- When caring for people who repeatedly self-harm, healthcare professionals should be aware that the individual's reasons for self-harming may be different on each occasion and therefore each episode needs to be treated in its own right.
- Healthcare professionals should involve people who self-harm in all discussions and decision-making about their treatment and subsequent care. To do this, staff should provide people who self-harm with full information about the different treatment options available.
- People who self-harm should be allowed, if they wish, to be accompanied by a family member, friend or advocate during assessment and treatment. However, for the initial psychosocial assessment, the interview should take place with the service user alone to maintain confidentiality and to allow discussion about issues that may relate to the relationship between the service user and carers.
- Healthcare professionals should provide emotional support and help if necessary to the relatives/carers of people who have self-harmed, as they may also be experiencing high levels of distress and anxiety.
- People who have self-harmed should be offered treatment for the physical consequences of self-harm, regardless of their willingness to accept psychosocial assessment or psychiatric treatment.
- Adequate anaesthesia and/or analgesia should be offered to people who have self-injured throughout the process of suturing or other painful treatments.
- When physical treatment of self-injury is likely to evoke distressing memories of any previous sexual abuse, for example when repairing harm to the genital area, sedation should be offered in advance.
- Clinical and non-clinical staff who have contact with people who self-harm in any setting should be provided with appropriate training to equip them to understand and care for people who have self-harmed.

- All healthcare professionals who have contact, in the emergency situation, with people who have self-harmed should be adequately trained to assess mental capacity and to make decisions about when treatment and care can be given without consent.
- Primary healthcare practitioners, ambulance staff, triage nurses and emergency department medical staff should assess and document mental capacity as part of the routine assessment of people who have self-harmed. Within the bounds of patient confidentiality, and subject to the patient's consent, staff should attempt to obtain relevant information from relatives, friends, carers and other key people, to inform the assessment.
- In the assessment and treatment of people who have self-harmed, mental capacity should be assumed unless there is evidence to the contrary.
- Staff should provide full information about the treatment options, and make all efforts necessary to ensure that someone who has self-harmed can give, and has the opportunity to give, meaningful and informed consent before any and each procedure (for example, taking the person to hospital by ambulance) or treatment is initiated.
- If a person is assessed as being mentally incapable, staff have a responsibility, under common law, to act in that person's best interests. If necessary, this can include taking the person to hospital, and detaining them to allow assessment and treatment against the person's stated wishes.
- Staff should take into account that a person's capacity to make informed decisions may change over time. Whether it has been possible to obtain consent or not, attempts should be made to explain each new treatment or procedure and obtain consent before it is initiated.
- Staff working with people who self-harm should understand when and how the Mental Health Act can be used to treat the physical consequences of self-harm.
- Staff working with people who self-harm should have easy access to legal advice about issues relating to capacity and consent at all times.

The Acute Management of Self-Harm in Primary Care

Primary care has an important role in the assessment and treatment of people who self-harm. Careful attention to prescribing drugs to people at risk of self-harm, and their relatives, could also help in prevention. In remote areas, access to TOXBASE (the national database of the National Poisons Information Service [NPIS]) may be necessary.

- When an individual presents in primary care following an episode of self-harm, healthcare professionals should urgently establish the likely physical risk, and the person's emotional and mental state, in an atmosphere of respect and understanding.

- All people who have self-harmed should be assessed for risk, which should include identification of the main clinical and demographic features and psychological characteristics known to be associated with risk, in particular depression, hopelessness and continuing suicidal intent. The outcome of the assessment should be communicated to other staff and organisations who become involved in the care of the service user.
- In the assessment and management of self-injury in primary care, healthcare professionals should refer service users for urgent treatment in an emergency department, if assessment suggests there is a significant risk to the individual who has self-injured.
- In most circumstances, people who have self-poisoned and present to primary care should be urgently referred to the nearest emergency department, because the nature and quantity of the ingested substances may not be clearly known to the person who has self-poisoned, making accurate risk assessment difficult.
- If there is any doubt about the seriousness of an episode of self-harm, the general practitioner should discuss the case with the nearest emergency department consultant, as management in secondary care may be necessary.
- Consideration should be given to the service user's welfare during transportation to any referral organisation and, if necessary, this should be supervised by an appropriate person where there is a risk of further self-harm or reluctance to attend other care centres, or the service user is very distressed.
- In remote areas at considerable distance from an emergency department or where access is likely to be delayed, consideration should be given to initiating assessment and treatment of self-harm in the primary care setting, following discussion with the nearest emergency department consultant. This should include taking samples to test for paracetamol and other drugs, as indicated in TOXBASE.

When Urgent Referral to an Emergency Department is Not Necessary

- If urgent referral to an emergency department is not considered necessary for people who have self-injured in primary care, a risk and needs assessment should be undertaken to assess the case for urgent referral to secondary mental health services.
- Assessment of the service user's needs should be comprehensive and should include evaluation of the social, psychological and motivational factors specific to the act of self-harm, current intent and hopelessness, as well as a full mental health and social needs assessment.
- Following assessment and treatment of self-harm in primary care, the outcome of the risk and needs assessment, and full details of the treatment provided, should be forwarded to the appropriate secondary mental health team at the earliest opportunity.

- Healthcare professionals who may have to assess and/or treat people who have self-harmed should ensure that they are properly trained and competent to undertake assessment and treatment as necessary.

Service Users at Risk of Self-Poisoning in Primary Care

- In service users who are considered at risk of self-poisoning, healthcare professionals should prescribe, whenever possible, those drugs which, whilst effective for their intended use, are least dangerous in overdose, and should consider prescribing fewer tablets at any one time.
- Consideration should be given to preventing or reducing the prescription of co-proxamol, especially for people who are at risk of self-poisoning.
- As medication intended for relatives is often used in self-poisoning, healthcare professionals should prescribe, whenever possible, those drugs which, whilst effective for their intended use, are least dangerous in overdose when prescribing medication to relatives who live with a person who is considered at risk of self-poisoning. They should also consider prescribing fewer tablets at any one time. Care must be taken, however, to preserve confidentiality appropriately.

Long Term Management in Primary Care

If a person presents in primary care with a history of self-harm and a risk of repetition, consider referring them to community mental health services for assessment. If they are under 18 years, consider referring them to CAMHS for assessment.

Make referral a priority when:

- levels of distress are rising, high or sustained
- the risk of self-harm is increasing or unresponsive to attempts to help
- the person requests further help from specialist services
- levels of distress in parents or carers of children and young people are rising, high or sustained despite attempts to help.

If a person who self-harms is receiving treatment or care in primary care as well as secondary care, primary and secondary health and social care professionals should ensure they work cooperatively, routinely sharing up-to-date care and risk management plans. In these circumstances, primary health and social care professionals should attend CPA meetings.

Primary care professionals should monitor the physical health of people who self-harm. Pay attention to the physical consequences of self-harm as well as other physical healthcare needs.

17 PREVENT

What does this mean in Primary Care?

Counter terrorism like safeguarding is everybody's responsibility. The PREVENT Strategy was published in 2011 and is part of CONTEST the Government's counter-terrorism strategy. As health professionals it is important that we know what role we can play and what the PREVENT Strategy means to us both as Health Professionals and as citizens.

The key components include:

- Recognising the vulnerability of someone being drawn into terrorism
- An awareness of how to respond to concerns
- Potentially referring onwards for further advice and support
- Balancing information sharing and managing issues of confidentiality

The intercollegiate guidance document, Safeguarding Children and Young People: roles and competencies for health care staff, is now inclusive of PREVENT information and identifies competences for healthcare staff.

The aim of PREVENT is to stop people from becoming terrorists (often referred to as being radicalised) or supporting terrorism. Health and Primary Care are expected to be mindful of this as they work with vulnerable people in the community who are often targeted by extremists to radicalise in order to coerce them into committing acts of terrorism.

A member of the practice team may have concerns relating to an individual's behaviour, which could indicate that they may be being drawn into terrorist activity. This may include:

- Graffiti symbols, writing or artwork promoting extremist messages or images
- Patients/staff accessing terrorist related material online, including through social network sites
- Parental/family reports of changes in behaviour, friendships or actions, coupled with requests for assistance
- Partner healthcare organisations', local authority services' and police reports of issues affecting patients in other healthcare organisations
- Patients voicing opinions drawn from terrorist related ideologies and narratives
- Use of extremist or hate terms to exclude others or incite violence.

The document Building Partnerships, Staying Safe gives details about the **Prevent** strategy and provides advice to healthcare organisations on their role in preventing radicalisation of vulnerable people as part of their safeguarding responsibilities.

PREVENT Duty Guidance

Section 26 of the Counter Terrorism and Security Act (2015) places a duty on specified authorities, including health, in exercising their function and having due regard to the need to prevent people from being drawn into terrorism. Prevent Duty Guidance is now in place in England and Wales. The three main aims are:

1. To respond to the ideological challenge of terrorism and the threat we face from those who promote it;
2. Prevent people from being drawn into terrorism and ensure that they are given appropriate advice and support;
3. Work with sectors and institutions where there are risks of radicalisation that we need to address.

A risk-based approach is required in the PREVENT duty, demonstrating an understanding and awareness of the risk of radicalisation for each area, institution or body.

Prevent deals with all kinds of terrorist threats to the United Kingdom. The most significant of these threats is currently from organisations in Syria and Iraq and so called IS (Islamic State) associated groups. Terrorist activity associated with the extreme right wing also poses a continued threat to safety and security.

Workshop to Raise Awareness of PREVENT (WRAP)

This training (raising awareness of the UK counter-terrorism strategy) should be delivered to all employees who require Level 2 Safeguarding training and above. Additionally all managers and those in IT roles should attend this short, one-off session.

The workshops aim to give staff:

- An understanding of the Prevent strategy and their role within it;
- The ability to use their existing expertise and professional judgment to recognise vulnerable individuals who may need support.

18 RECOMMENDED READ CODES FOR USE IN SAFEGUARDING CHILDREN AND ADULTS AT RISK

Good communication is vital to safeguarding those who are vulnerable. Modern GP software systems now mean that this often happens electronically particularly with the regular transfer of information with out of hours providers and emergency departments. The electronic transfer of GP records between GP practices is also possible and should be happening in the near future. The upcoming NWIS Community Care Information Solution project will soon make possible the sharing of information across community services in health and social care. It is therefore important that there is a consensus on what Read Codes to use.

Mandatory reporting of female genital mutilation, Ask and Act, clinical governance, contractor reviews, practice inspections, audit and GP appraisal all require evidence of participation in safeguarding. This can be easily evidenced through the consistent use of Read coding.

Evidence also shows that GPs are likely to suspect abuse from the problems of and consultations with the wider family as well as with the abused person or child. We know that the strongest risk factors for abuse are the presence of the so-called "Toxic Trio" of substance misuse, mental health problems and domestic abuse in parents/carers. Coding that allows us to know about these risk factors and the relationship between carers with these problems and adults and children at risk is therefore vital. Included below are Read Codes that allow us to indicate the wider family members of those who are vulnerable or have been abused.

We recommend that all safeguarding concerns are recorded using Read codes in the records of those at risk, victims, perpetrators and vulnerable family/household members e.g. children.

These lists do not cover all situations and Practitioners are encouraged to use other codes that they feel are helpful to their practice.

It is our hope that this updated list of recommended Read Codes will improve the consistency of coding within Primary Care to identify at risk and abused children and adults and improve the transfer of this information between practices and with other health care providers.

Safeguarding Children Codes

Read Codes for use in Child/Young Persons Records

Child on Protection Register	13IM
Child removed from Protection Register	13IO
Child at Risk	131F
Suspected child abuse	13Ip
History of abuse	13G4
Vulnerable child	13IF
Child no longer vulnerable	13IW
Child is cause for safeguarding concern	13WX
Child no longer safeguarding concern	9NgB
Child in care	13IB
Looked after child	13IB1
Child leaving care	13I83
Non accidental injury to child	SN552
Child Referral-social services	64RA
Referral to safeguarding children team	8hKH
No safeguarding issues identified	9Ngf

Codes Regarding Risk Factors in Parents /Carers

Family history of substance misuse	12X
Drug misuser in household	13W
Family history of alcohol misuse	12XO
Alcohol misuser in household	13Wf
Family history of psychiatric condition	ZV170
Domestic abuse victim in household	13Wd
Family history of learning disability	12W2

Codes for Records of Family/Household Members

Family member on Child Protection Register	13Ig
Family member removed from Protection Register	13IP
Vulnerable child in family	13IQ
Child Abuse in Family	13W3
Family is cause for concern	13Ip

Safeguarding Adults at Risk Codes

Codes for Use in Adult at Risk's Records

Adult safeguarding concern	9Ngj
Adult no longer safeguarding concern	9Ngk
Referral to safeguarding adults team	8Hkc
Referral to social services for Adult Protection	8HHg
Vulnerable adult	133P
Adult no longer vulnerable	13IU
Learning disability	X00TL
Substance misuse	13cM
Alcohol misuse	136W
H/O: Psychiatric Disorder	146
History of domestic violence	14X3
No safeguarding issues identified	9Ngf

Codes for the Records of Family/Household Members

Family member on Protection Register	13IN
Family member removed from Protection Register	13IP

Codes Related to Risk Factors in Carers

Family history of substance misuse	12X
Drug misuser in household	13W
Family history of alcohol misuse	12XO
Alcohol misuser in household	13Wf
Family history of psychiatric condition	ZV170
Domestic abuse victim in household	13Wd
Family history of learning disability	12W2

Mental Capacity Act & Deprivation of Liberty Codes

Assess of mental capacity in accord Mental Capacity Act 2005	28N
Lack mental capacity make decision Mental Capacity Act 2005	2JR
Lacks capacity to give consent (Mental Capacity Act 2005)	9NdL
Independent mental capacity advocate instructed	9Ng6
Appl standard authorisation DOL MCA 2005	9NgzE
Standard authorisation deprivation liberty MCA 2005 declined	9NgzF
Standard authorisation deprivation liberty MCA 2005 given	9NgzG
Best interest decision made on behalf of patient (MCA 2005)	9Ng

Domestic Abuse Read Codes

Codes for Victim's records

History of domestic abuse	14XD
At risk violence in the home	13VF
Victim of domestic abuse	14XG
History of being victim of domestic violence	14XE
Routine enquiry about domestic abuse	9r0
Routine enquiry about domestic abuse declined	8IC0
Routine enquiry about domestic abuse not made	8IC1
Police domestic incident report received	9NDJ
Subject of multi-agency risk assessment conference	13Hm

Codes for household/family members

Domestic abuse victim in household	13Wd
Police domestic incident report received	9NDJ
Subject of multi-agency risk assessment conference	13Hm
At risk violence in the home	13VF

Codes for perpetrator's records

History of domestic abuse	14XD
Police domestic incident report received	9NDJ
Subject of multi-agency risk assessment conference	13Hm
Subject of multi-agency public protection arrangements	13HI

Female Genital Mutilation Read Codes

Family History of Female Genital Mutilation	12b
History of Female Genital Mutilation	15K
Female Genital Mutilation K578	
FGM Type 1	K5780
FGM Type 2	2K5781
FGM Type 3	K5782
FGM Type 4	K5783
Deinfibulation of vulva	7D045
Deinfibulation of vulva to facilitate delivery	7F1BS

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Appendix 1

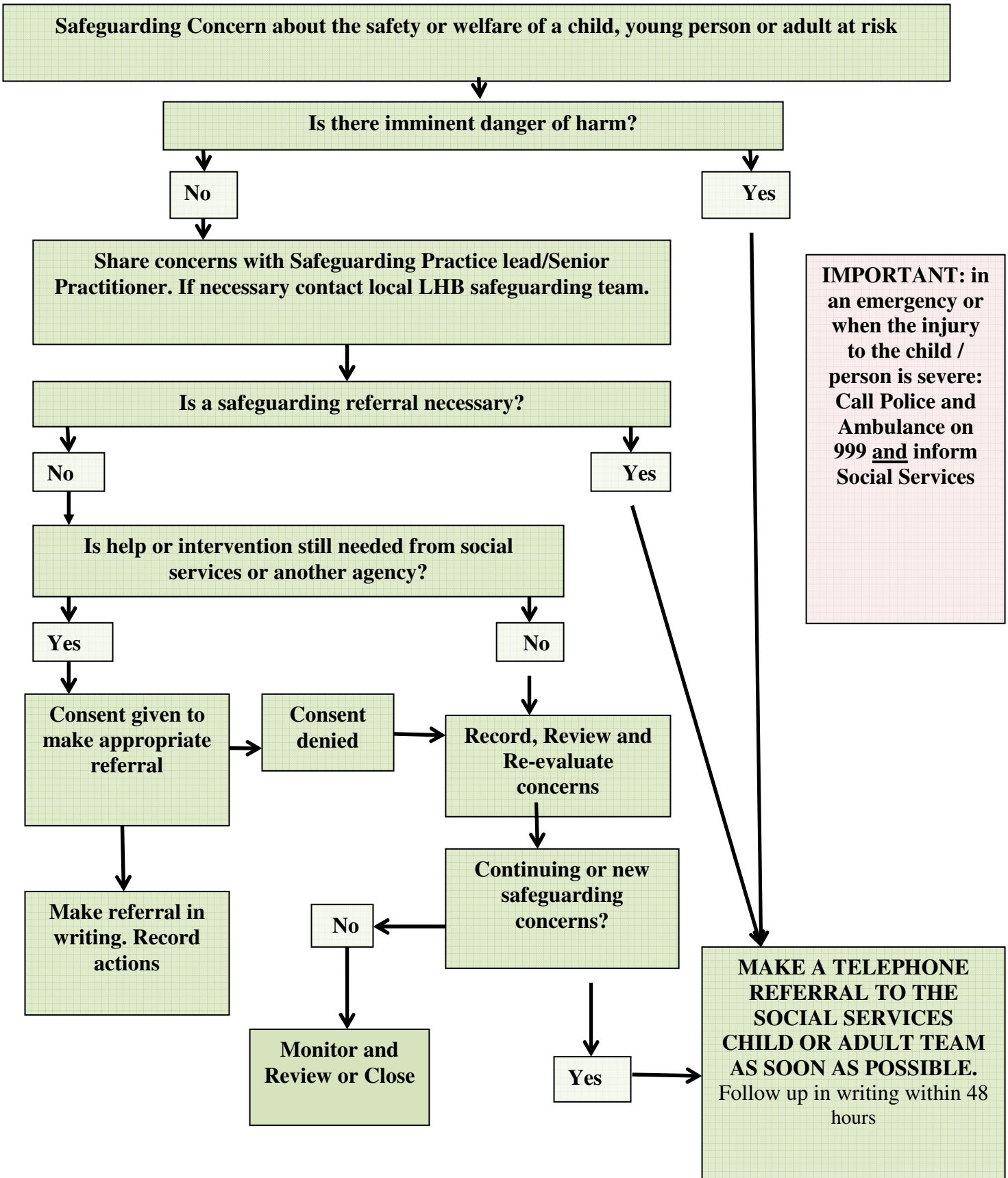
The Welsh Government Health Standard on Safeguarding Children and Safeguarding Adults at Risk

States that the health service will need to consider the following criteria for meeting the standard:

There is compliance with legislation and guidance to include:

- All Wales Child Protection and Adult at risk procedures.
- Mental Health Act 1983 in relation to persons liable to be detained, and the Mental Capacity Act 2005 regarding Deprivation of Liberty Safeguards.
- Assurance of safeguarding services and processes is evident across all levels of the organisation.
- Effective multi-professional and multi-agency working and co-operation are in place complying with the Social Services and Well-being (Wales) Act.
- Staff are trained to recognise and act on issues and concerns, including sharing of information and sharing good practice and learning.
- People are informed how to make their concerns known.
- Priority is given to providing services that enable children and adult at risks to express themselves and to be cared for through the medium of the Welsh language because their care and treatment can suffer when they are not treated in their own language. (They are recognised as a priority group in More than just Words).
- Suitable arrangements are in place for people who put their safety or that of others at risk to prevent abuse and neglect.
- Risk is managed in ways which empower people to feel in control of their life.
- Arrangements are in place to respond effectively to changing circumstances and regularly review achievement of personal outcomes.

Appendix 2: Safeguarding Referral Flowchart



Local Contact Details:
 Children's Social Services
 Adult Social Services
 LHB Safeguarding Team.....
 Practice Safeguarding Lead

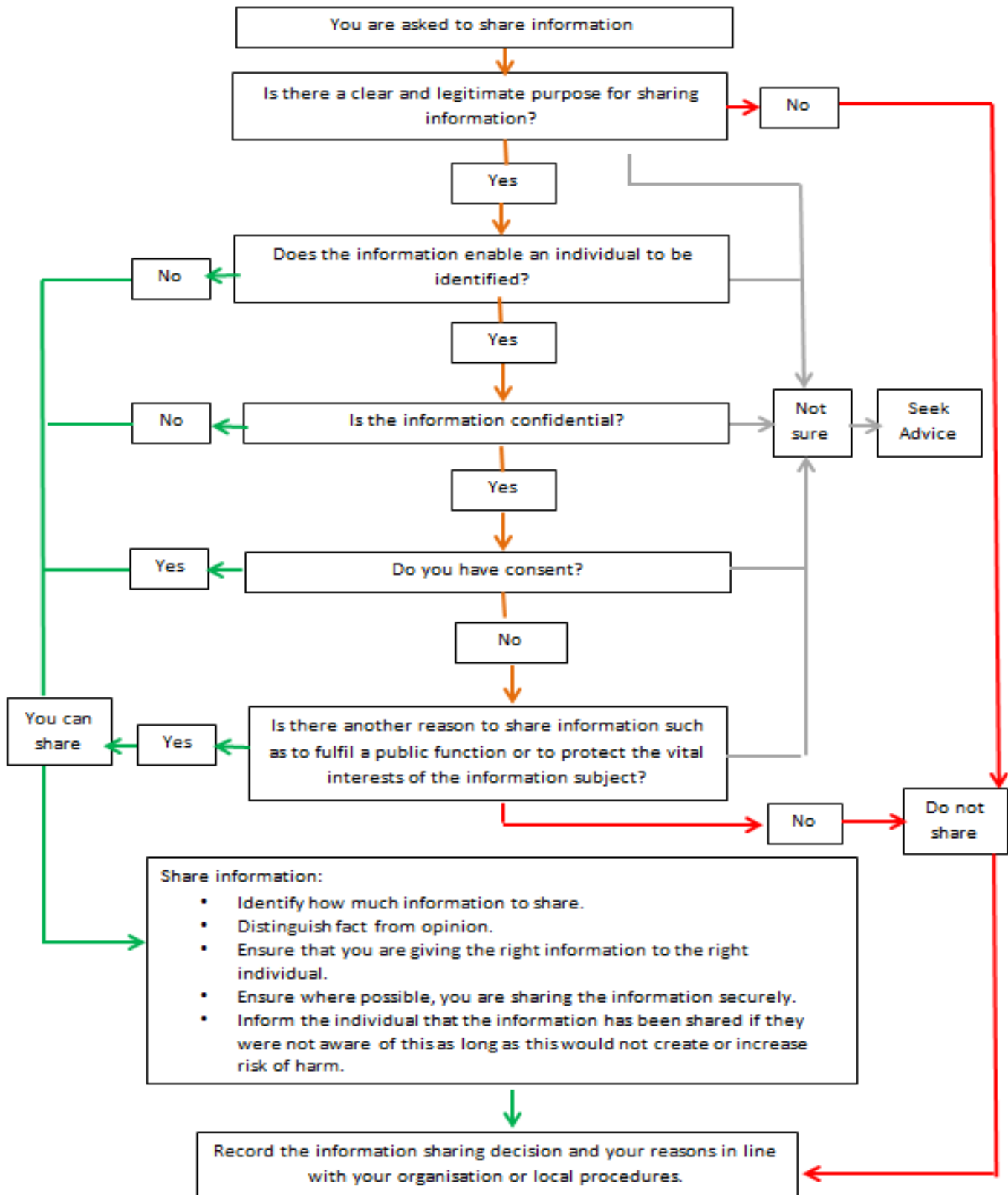
Appendix 3

The Seven Golden Rules to Sharing Information

1. Remember that the Data Protection Act 1998 and human rights law are not barriers to justified information sharing, but provide a framework to ensure that personal information about living individuals is shared appropriately.
2. Be open and honest with the individual (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 from other practitioners if you are in any doubt about sharing the information concerned, without disclosing the identity of the individual where possible.
4. Share with informed 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, there is good reason to do so, such as where safety may be at risk. You will need to base your judgement on the facts of the case. When you are sharing or requesting personal information from someone, be certain of the basis upon which you are doing so. Where you have consent, be mindful that an individual might not expect information to be shared.
5. Consider safety and well-being: Base your information sharing decisions on considerations of the safety and well-being of the individual and others who may be affected by their actions.
6. Necessary, proportionate, relevant, adequate, 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 individuals 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.

Appendix 4

Flowchart of When and How to Share Information



Appendix 5

The Mental Capacity Act 2005

The Five Statutory Principles of the Mental Capacity Act

1. A person must be assumed to have capacity unless it is established that they lack capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
4. An act done or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

Assessing Capacity

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

1. 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.)
2. 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?

Assessing 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?

Assessing Capacity to Make More Complex or Serious Decisions

- Is there a need for a more thorough assessment (perhaps by involving another professional expert)?

Appendix 6 – All Wales FGM Pathway

FGM is child abuse and illegal

Regulated health or social care professionals must report any cases of FGM if:

- A girl under 18 tells them they have had FGM
- They see physical signs that a girl has had FGM

This applies to all registered professionals in NHS and private healthcare settings, during the course of their work.

When should this clinical pathway be completed?

This Clinical Pathway should be completed every time a new case of FGM is identified or suspected in women/girls of **any age**, however not all of these instances will meet the statutory mandatory reporting threshold.

Please see end of the Clinical Pathway for support phone numbers if more assistance is required.

How to report FGM

If you are concerned that a child (under 18 years) may have had FGM, or they tell you that they have FGM or you observe physical signs that appear to show FGM, the mandatory reporting duty applies and you must report it.

You must:

- Complete the All Wales Clinical Pathway – Female Genital Mutilation (FGM) attached
- Inform the relevant health care professionals
- Make a Child Protection referral
- Inform the Police (101)
- Record all decisions and actions
- Be prepared for a Police officer to contact you to discuss
- Inform your local Safeguarding lead of the case

You will have to provide:

- The girl's name, date of birth and her address
- Your contact details
- The contact details of your Safeguarding lead

Do not carry out a genital examination unless this is already part of your role. A formal diagnosis will be sought as part of the subsequent multi-agency response.

Wherever possible, explain to the girl and / or her family that you are reporting FGM and what that means. Do not discuss it if you think that reporting could lead to a risk of serious harm to anybody. Contact your local Safeguarding lead for advice in these cases.

Always ask your local Safeguarding / FGM leads if in doubt.

If you believe that the person may be at a future risk of FGM you should inform your local Safeguarding lead.

If you are not sure whether FGM has been carried out

If you are not certain that FGM has been carried out, you should still report. A formal diagnosis will be sought as part of the subsequent multi-agency response.

If you are concerned about someone over 18

You must:

- Complete the All Wales Clinical Pathway – Female Genital Mutilation (FGM) attached
- Inform the relevant health care professionals
- Carry out a safeguarding risk assessment for any other children in the family who may be at risk or have had FGM
- Make a Child Protection referral if there is a possible risk to a child
- Consider if an Adult Protection referral may be required
- Inform your local Safeguarding lead if referrals are made
- Inform the patient of your actions
- Record all decisions and actions
- Signpost the woman to services that offer support and advice

Next Steps

In response to a referral, social care professionals, health and Police will consider:

- the use of FGM protection orders
- a care plan or other safeguarding response
- whether a safeguarding response is needed for anybody else related to the case, including other family members
- referral to community or third sector organisations
- the need for a criminal investigation

INITIAL ASSESSMENT

Please print

CHILD / ADULT DETAILS	
Name	
Hospital / ID no	
NHS number	
Address	
Date of Birth	
Nationality	
Country of Birth	

COMPLETING CLINICIANS DETAILS	
Name	
Role / Designation	
Base	
Work e-mail	
Work phone number	
Bleep number	
Line Manager	

INFIBULATION HISTORY

These are some examples of what can be asked (*in a sensitive none judgmental manner*)

Have you had the cut?	Yes	No
Are you open or closed?	Yes	No
Have you experienced FGM? (This may also be known as female circumcision)	Yes	No

If the person discloses or you still suspect FGM please continue with the Risk Assessment

RISK ASSESSMENT

Identify features below to assess the impact of the procedure on health and emotional wellbeing
Has the patient a history of any of the following? (please tick)

SYMPTOMS	CLINICAL PROBLEMS	PSYCHOLOGICAL ISSUES
Painful or delayed micturition <input type="checkbox"/>	Pelvic inflammatory disease <input type="checkbox"/>	Emotional withdrawal <input type="checkbox"/>
Painful intercourse <input type="checkbox"/>	Keloid scar formation <input type="checkbox"/>	Symptoms of Post traumatic stress disorder <input type="checkbox"/>
Painful periods <input type="checkbox"/>	History of infertility <input type="checkbox"/>	Flashbacks <input type="checkbox"/>
Irregular periods <input type="checkbox"/>	Recurrent urinary infections <input type="checkbox"/>	
	Vaginal infections <input type="checkbox"/>	
	Difficulty in performing vaginal examinations <input type="checkbox"/>	

Age at which FGM procedure was performed	
Year FGM was performed	
Country where it was performed	
Age now	

Memories of procedure (A short description to enable further clinical plan)

.....

.....

.....

Family situation / any others females at risk (consider referral)?

.....

.....

.....

If under 18, you have a legal duty to report - follow local reporting arrangements and make a Child Protection referral under the All Wales Child Protection Procedures*

* If the person is a vulnerable adult / adult at risk consider making an Adult Protection referral

IDENTIFICATION OF FGM


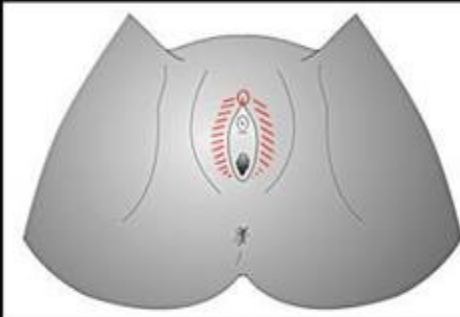
Please identify type of FGM (If no trained health professional available to identify type of FGM please refer to Health Board FGM lead).



Date of Examination:

Time:

Name & Designation of Examiner:

Venue of Examination:

<p>TYPE 1: Prepuce removal only or partial or total removal of the clitoris</p>	<p>TYPE 2: Removal of the clitoris plus part or all of the labia minora</p>
	
<p>Comments</p>	<p>Comments</p>
<p>Clinical Management Plan</p>	<p>Clinical Management plan</p>

<p>TYPE 3: Removal of part or all of the labia minora with the labia majora either being sewn together covering the urethra and vagina leaving only a small opening for urine and menstrual fluid</p>	<p>TYPE 4: All other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterization</p>
	 <p>Diagram above shows normal genitalia</p>
<p>Comments</p>	<p>Comments</p>
<p>Clinical Management Plan</p>	<p>Clinical Management plan</p>

PREGNANCY PATHWAY	PAEDIATRIC PATHWAY	ADULT PATHWAY
<ol style="list-style-type: none"> 1. Routine enquiry re FGM at booking and document 2. Refer for Consultant led care 3. Prior to 20 weeks, FGM type should be identified and reversal offered if required 4. Referral for psychological or other support if required 5. Discussion and education of FGM and illegality in the UK 6. Assessment of risk to any female children and education to family members 7. Child Protection referral to Social Services under the AWCPP 8. Inform GP and Health Visitor ante-natally 9. Agree follow-up care plan and provide education support 	<ol style="list-style-type: none"> 1. Initial identification of FGM (actual or potential risk) 2. Refer to Social Services under the AWCPP 3. A Child Protection medical must be considered at the Strategy discussion / meeting 4. Care plan to consider FGM reversal, psychological or other support 5. Inform GP, Health Visitor and School Nursing 6. Agree follow-up care plan and provide education support 	<ol style="list-style-type: none"> 1. Initial identification of FGM (actual or potential risk) 2. Plan for examination and assessment of type (with consent) 3. Assessment of risk and refer any female child via AWCPP 4. Inform GP 5. Data collection 6. Care plan re FGM reversal timing and procedure (with consent), psychological or other support 7. Discussion of other options if the woman does not want reversal 8. Consider capacity assessment 9. Consider best interests meeting 10. Follow-up care 11. Data collection

DATA IN PREGNANCY	DATA PAEDIATRIC	DATA ADULT
Date of Birth	Date of Birth	Date of Birth
Country of Birth	Country of Birth	Country of Birth
Nationality	Nationality	Nationality
Date of diagnosis / disclosure	Date of diagnosis / disclosure	Date of diagnosis / disclosure
Type of FGM	Type of FGM	Type of FGM
Date of deinfibulation	Date of deinfibulation	Date of deinfibulation
Date referral to Social Services	Date referral to Social Services	Date referral to Social Services (if appropriate)

NSPCC FGM Helpline:
0800 028 3550
Email: fgmhelp@nspcc.org.uk

BAWSO FGM 24 hr Helpline:
0800 731 8147