Somerset Partnership NHS
NHS Foundation Trust

CHILD PROTECTION LEGAL GUIDANCE POLICY

RESPONDING TO REQUESTS FOR INFORMATION SHARING, REPORTS AND STATEMENTS

TO BE READ IN CONJUNCTION WITH THE TRUST *CONFIDENTIALITY AND DATA PROTECTION POLICY* and *SAFEGUARDING AND PROTECTION OF CHILDREN POLICY*

Version:	3
Ratified by:	Senior Managers Operational Group
Date ratified:	February 2016
Title of originator/author:	Named Nurse Safeguarding Children
Title of responsible committee/group:	Clinical Governance Group
Date issued:	**February 2016**
Review date:	**January 2019**
Relevant Staff Group/s:	All Trust Staff

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DOCUMENT CONTROL

Reference Number SA/Feb16/CPLG	**Version** 3	**Status** Final	**Author** Named Nurse Safeguarding Children
Amendments	Review included the 2013 Caldicott review and addition of further Caldicott standard on information sharing.		
Document objectives: To inform Trust staff of their roles and responsibilities when requests have been made to them to provide legal and police statements, Court reports, and reports for Children and Family Court Advisory and Support Service, (CAFCASS).			
Intended recipients: All Trust staff			
Committee/Group Consulted: Clinical Policy Review Group, Safeguarding Children Team, Safeguarding Children Best Practice Group, Safeguarding Steering Group, Clinical Governance Group			
Monitoring arrangements and indicators: Quality Assurance measures in place facilitated by the Named and Locality Safeguarding Children Nurses.			
Training/resource implications: Training via Level 3 Child Protection Training – resource already in place.			
Approving body and date	Clinical Governance Group	Date: January 2016	
Formal Impact Assessment	Impact Part 1	Date: February 2016	
Clinical Audit Standards	YES	Date: January 2016	
Ratification Body and date	Senior Managers Business Group	Date: February 2016	
Date of issue	**February 2016**		
Review date	**January 2019**		
Contact for review	Named Nurse Safeguarding Children		
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1 INTRODUCTION

1.1 Somerset Partnership NHS Foundation Trust recognises the duty to cooperate with all multi-agency partners in order to safeguard and promote the welfare of children, (Section11 Children Act 2004).

1.2 Part of this duty requires Trust staff to share health information with Criminal, Civil and Family Courts, and with the Police, in the form of legal statements or reports. This will also include private custody proceedings involving the Children and Families Court Advisory and Support Service (CAFCASS).

1.3 Trust staff will also co-operate with requests for information made by Local Authority solicitors, in connection with proceedings under the Children Act 1989 and 2004, or involving Care Proceedings.

1.4 The following guidance clarifies the role of health staff who have been asked to provide information held by professionals within written and electronic health records, about children, young people and their families, and the procedures they should follow to provide it.

2. DUTIES AND RESPONSIBILITIES

Requests for Information

2.1 **The Trust Board** has a duty to ensure that it fulfils its statutory responsibilities to safeguard and promote the welfare of children in accordance with the 1989 and 2004 Children Acts.

2.2 **The Designated Non-Executive Director** supports the Executive Lead and the safeguarding team in all aspects of the Safeguarding Children agenda, monitors activity and outcomes and provides additional assurance to the Board in this area.

2.3 **The Director of Nursing and Patient Safety** is the Executive Lead for Safeguarding Children within the Trust.

2.4 **All Trust Staff** have a statutory responsibility to safeguard and promote the welfare of children whilst carrying out their roles. The culture and diversity of children must be taken into account by staff at all times as part of this duty.

2.5 **All Trust Staff** must inform the Named Nurse or Locality Safeguarding Children Nurse immediately following receipt of a request for information. These requests will be made by Local Authority or privately engaged solicitors, the Police or the Courts concerning civil proceedings, (such as Section 8 order applications, care proceedings or adoption proceedings), or criminal proceedings. A copy of the request for information must also be shared with the Named Nurse or a Locality Safeguarding Children Nurse.

2.6 **All Trust Staff** will co-operate with requests for information made by the Police in connection with criminal enquiries, (see also points 2.9 and 2.10 below).

2.7 **The Named or Locality Safeguarding Children Nurse** will work in partnership with the practitioner receiving the request to prepare a report that fulfils the criteria identified in the request / Court Order, using the Trust's *Report for Court* template, (Appendix 1), or other suitable format.

2.8 **The Safeguarding Children Team** will train and advise staff about safeguarding and child protection issues and ensure that legal requirements and professional standards are met.

2.9 **The Safeguarding Children Team** is responsible for liaising with the Trust's Information Governance Manager and / or dedicated Solicitors where appropriate, on behalf of staff involved in complex safeguarding or child protection legal matters.

3. EXPLANATION OF TERMS USED

3.1 **Redaction –**

- the process of editing text for publication
- the censoring or obscuring of part of a text for legal or security purposes
- a version of a text, such as a new edition or an abridged version

4. CONSENT AND INFORMATION SHARING

Sharing information with the police

4.1 The Police may request voluntary disclosure of a patient's health records if they do not have a warrant or a Court order. Although it is an offence to obstruct the Police in the execution of their duty, the Police have no automatic right to confidential patient information and disclosure should not take place unless:

1. the patient consents to disclosure, or in the case of children, consent from a person with Parental Responsibility is obtained),
2. it can be justified in the public interest
3. it is required by law.

4.2 All Trust staff who are required to disclose confidential health information to the Police must always consider the following:

- The extent of the information to be disclosed
- The nature and impact of the crime or harm justifying the disclosure
- Whether the disclosure is for the detection or prosecution of crime or harm to others, or whether or not it is preventative
- Whether there is a statutory requirement or barrier to the disclosure of the information

Overall Trust staff must balance the public interest in disclosure e.g. prevention/detection of a serious crime, against the private and public interest in maintaining patient confidentiality.

Ultimately health professionals must objectively assess public interest on a case-by-case basis

Sharing Information with CAFCASS

4.3 **The Named Nurse or Locality Safeguarding Children Nurse** will always be present when a practitioner gives verbal information to a Court Reporter or Children's Legal Guardian. In their absence, a Line Manager may provide this support. When a written report is required the appropriate Trust templates should be used.

4.4 **All Trust Staff** when requested to share information with clients' solicitors in private law matters, (i.e. divorce and custody hearings), should instead share their information with CAFCASS, (0844 353 4590). CAFCASS will ensure all parties in the proceedings have equal access to this information. Trust staff must discuss these situations with the Named Nurse or Locality Safeguarding Children Nurse before information is divulged to any party.

4.5 **Trust Staff** must consider the Trust *Confidentiality and Data Protection Policy* whenever they receive a request to share information

4.6 **Trust staff** should always attempt to gain consent from the child, young person or their carer, to share information with any other professional or agency, even when there is no legal requirement to do so. A young person aged 16 or 17, or a child under 16 who has the capacity to understand and make their own decisions, may give, or refuse, consent to share information. Children under 16 should be assessed to establish whether they have competence to make a particular decision at the time it needs to be made, using specific criteria (see Appendix B). For further information please refer to the Trust's Consent and Capacity to Consent to Examination and/or Treatment Policy

4.7 **Trust Staff** must be aware that there are some situations in which a professional should *not* seek consent to share information, (including with the Police, Courts and CAFCASS), for example where to seek consent would:

- place a child at increased risk of significant harm
- place an adult at risk of serious harm
- prejudice the prevention or detection of a serious crime
- lead to unjustified delay in making enquiries about allegations of significant harm.

4.8 **Trust staff** must be aware of the Seventh Caldicott, (revised Caldicott 2 principles, DoH, 2013), principle which confirms information sharing is legitimate and provides clinicians and others with the clear requirement that:

- The duty to share information can be as important as the duty to protect patient confidentiality.

Health and social care professionals should have the confidence to share information in the best interests of their patients within the framework set out by the revised Caldicott principles. They should be supported by the policies of their employers, regulators and professional bodies.

4.9 **Trust Staff** must always be mindful of their duty to manage confidential information within local and national policy including the Trust *Confidentiality and*

Data Protection Policy. Information can be shared without breaching common law duty if:

- the information is not confidential in nature; or
- the person to whom the duty is owed has given explicit consent; or
- there is an overriding public interest in disclosure; or
- sharing is required by a court order or other legal obligation.

4.10 **Trust Staff** should not refuse a request for sharing information without considering the relative risks of *not* sharing that information, if necessary without consent, against the potential risk to a child if information is not shared.

4.11 **All Trust Staff** must record when they have shared information, with or without consent, and must record details of the risk of harm. In addition, if any member of Trust staff shares information without seeking consent, this should be clearly recorded, including the reasons for not seeking consent.

4.12 **All Trust Staff** should seek clarification of the request to share information if they are concerned about consent and information sharing issues. Members of staff should obtain advice from a Safeguarding Children Team member, Trust Information Governance Manager or the Trust Caldicott Guardian. Further information can be found in the Trust *Confidentiality and Data Protection Policy*.

4.13 **Trust Staff** may be required to redact written information they share. Redaction is defined as preparing information for publication or editing or re-editing information. The majority of situations involving redaction of a child's records occur when a copy of that child's health records has been requested. Information not relating directly to that child, and not generated by the service from which records are requested, is redacted. This also applies to information in Trust records shared under normal working practices with other agencies.

Paper records:

For paper records, it is usual to make two photocopies of the relevant records, and to use a black marker pen to obliterate completely any information not directly related to the subject child. A further photocopy of this redaction is then taken to avoid reading from the imprinting on the paper.

Rio records:

For electronic records, the process of redaction follows either one of two approaches:

1) A full print off of all the relevant records is made. Entries not relevant to the request for records can then be redacted, using the process as above for paper records.

2) Information of relevance from Rio, such as case notes, is temporarily saved as a Word document. The Word document record can be manipulated to redact the information not required in the request. This temporary document can then be printed and provided for disclosure.

Specific redaction requests:

On occasion specific redaction requests are made. For instance, this may be when any detail about the child, which may lead to a third party gaining information about the child's whereabouts or education provider, is redacted.

Ideally, the member of staff receiving the request, and the Named Nurse or Locality Safeguarding Children Nurse, will agree the information to be redacted together. Otherwise, the member of staff will make specific arrangements with the Named Nurse or Locality Safeguarding Children Nurse for them to manage the redaction process.

In every case the Named Nurse or Locality Safeguarding Children Nurse will require a copy of the request for information sharing with or without redaction.

The information should be posted securely, and the recipient informed of this action.

Further advice and guidance can always be sought from the Trust Information Governance Team.

Attending Court to give evidence

4.14 **All Trust Staff,** in accordance with the philosophy of the Children Act 2004, will attend Court to give evidence in Child Care Proceedings, if asked to do so by the Local Authority, without a witness summons being served.

4.15 **Trust Staff** should not attend Court to give evidence on behalf of a child's parents unless a witness summons has been served on them. When a witness summons is served on them, staff must notify their Manager and the Named Nurse or Locality Safeguarding Children Nurse. The Named Nurse or Locality Safeguarding Children Nurse may seek further legal advice.

4.16 **The Named Nurse or Locality Safeguarding Children Nurse** will accompany any practitioner called to give evidence to Court in Child Care Proceedings. In the event of the Named Nurse or Locality Safeguarding Children Nurse being unavailable, this duty may be undertaken by an appropriately briefed Manager or competent colleague.

4.17 **The Named Nurse or Locality Safeguarding Children Nurse** will ensure the practitioner attending Court receives the appropriate level of preparatory support prior to attendance, including a pre-attendance visit to the Court if necessary, , and the appropriate level of debrief following their visit and/or appearance.

Police and Coroners Inquest Statements

4.18 **All Trust staff** must notify the Named Nurse or Safeguarding Children Nurse whenever the Police or Coroner's Office request a meeting in order to take a proof of evidence (witness) statement. The Named Nurse or Locality Safeguarding Children Nurse and the Manager should ensure that the staff member is able to prioritise attendance at the interview. The witness will be accompanied to the interview by the Named Nurse or Locality Safeguarding Children Nurse.

4.19 **The Named Nurse, Locality Safeguarding Children Nurse or the practitioner's Line Manager** will arrange for further legal advice or representation when this has been identified as a need.

5. PROCESS FOR WRITING LEGAL STATEMENTS

5.1 Trust staff may be asked to provide written reports and legal statements for legal purposes or in connection with investigations into accidents or complaints.

General Principles

5.2 Written reports and legal statements should be:

- Word-processed, (using Arial typeface and 12 font)
- Concise (avoiding unnecessary words)
- Factual (avoiding subjective statements and opinions)
- Relevant to the matter being reported on
- Accurate as to dates, times and personnel involved
- Signed on every page and dated on the final page.

5.3 Each report should contain full demographic information about the child and any relevant family members. The following "protected characteristics" should also be included where they are applicable to the subjects of the report:

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race
- religion or belief
- gender
- sexual orientation

5.4 Reports and statements must be prepared as soon as possible after receiving the request. This will ensure that there is adequate time for typing, correction and quality assurance.

5.5 Staff must make clear in their report how regular the planned contact with the child and family was meant to be. They should indicate which contacts were part of that planned programme and which were in response to unplanned events.

5.6 Where there is considerable historical detail a paragraph must be included to "set the scene" summarising these details and to indicate what the pattern of contacts were with the family or child, particularly indicating how the pattern compares to 'routine' contacts.

5.7 Using the practitioner's professional records a *chronological* history of contacts / events should form the main part of the statement, giving the following information:

- The aims of the contacts and the outcomes planned and / or achieved

- Details of failed contacts, or non-attendance for health appointments if these are relevant to the concerns being reported on

- Only factual evidence of events within the professional's personal knowledge. Opinion evidence should only be used in the statement to explain factual evidence e.g. explaining that the child's growth is within normal limits. Opinions should be confined to expressions of professional opinion

- Third party medical information must not be divulged, nor should information which has been obtained from medical notes or other professionals / members of the family / members of the public. This information should be obtained from the relevant practitioner or member of public by the Court if appropriate. Information detailing information-sharing processes with other professionals / agencies, should be documented and reference made to the relevant Trust policy and protocol, where this guidance has been followed by the practitioner

- Whenever appropriate the age of the child *at the* cited contact should be recorded in the report / statement, particularly if required to illustrate professional opinion about health or developmental status. If the statement covers a long period of time it is helpful to the Court to periodically to indicate the children's ages at a particular contact

- Explain any technical information, for example "centile"

5.8 Statements should be written in the past tense and be specific about the source of information, particularly where it may require substantiation.

5.9 The Court needs to know the professional opinion of the practitioner in relation to the implications for the child or children of the information provided in the statement. This conclusion should be written in the present tense and should reflect the practitioner's view of the needs of the child or children.

5.10 A copy of the statement must be retained in the professional record for reference and review. N.B. The practitioner may be required to attend Court at a later date.

5.11 The statement must be reviewed and approved in line with the Clinical Audit standards at Appendix 3 by a member of the Trust Safeguarding Children Team. The final page of the report will be signed and dated, before sending via Royal Mail Recorded Delivery to the County Solicitor. In urgent cases reports may be emailed to the County Solicitor using their somerset.gov.uk address but this will not replace a signed hard copy being sent as above. Staff who hand deliver statements to the Court must obtain a signed receipt to evidence that the statement was received.

5.12 The practitioner may be questioned on their statement in Court by a legal representative for the Local Authority, to clarify or further highlight points of evidence, and/or by a Legal representative for the other parties represented, (cross examination). It is therefore important for practitioners to be aware of this

when writing their statement. An accurately written statement may result in the practitioner having little input to the actual Court proceedings.

6. TRAINING REQUIREMENTS

6.1 The Trust will work towards all staff being appropriately trained in line with the organisation's Staff Mandatory Training Matrix (training needs analysis). All training documents referred to in this policy are accessible to staff within the Learning and Development Section of the Trust Intranet.

6.2 The Named Nurse will ensure that mandatory Level 3 Child Protection training always includes information in relation to managing report writing for Child Protection Case Conferences and Court. The Named Nurse will also ensure training is available to teach staff how to present reports at conferences and in Court.

7. EQUALITY IMPACT ASSESSMENT

7.1 All relevant persons are required to comply with this document and must demonstrate sensitivity and competence in relation to the nine protected characteristics as defined by the Equality Act 2010. In addition, the Trust has identified Learning Disabilities as an additional tenth protected characteristic. If you, or any other groups, believe you are disadvantaged by anything contained in this document please contact the Equality and Diversity Lead who will then actively respond to the enquiry

8. MONITORING COMPLIANCE AND EFFECTIVENESS

8.1 The quality of legal statements and reports will be monitored by the Named and Locality Safeguarding Children Nurses.

8.2 Poor quality report writing will be managed in conjunction with the practitioner's line manager.

8.3 Numbers of legal statements and reports produced will be measured as part of the quarterly Care Quality Commission data collected by the Named Nurse to illustrate compliance with CQC Outcome 7. This data is reviewed by the Trust Safeguarding Children Best Practice Group and Trust Safeguarding Steering Group. Any trends will be noted and appropriate actions taken.

8.4 Please refer to the detailed Clinical Audit Standards at Appendix 4.

8.5 Legal statements and reports produced using this policy will be audited by the Trust Safeguarding Children Team as part of the process of quality assurance, (see point 3.11 above).

8.6 Audit of safeguarding (adult and/or children) is incorporated into the Trust's Three Year Clinical Audit Plan, and will be appropriately prioritised according to an agreed system for determining the frequency of audit. The responsibility for undertaking the audit and signing off key recommendations is held by the appropriate Best Practice Group. Progress with any recommendations is included within the Best Practice Group six-monthly report to Clinical Governance Group.

9. RELEVANT CARE QUALITY COMMISSION (CQC) REGISTRATION STANDARDS

9.1 Under the **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3), the fundamental standards** which inform this procedural document, are set out in the following regulations:

Regulation 10: Dignity and respect
Regulation 11: Need for consent
Regulation 12: Safe care and treatment
Regulation 13: Safeguarding service users from abuse and improper treatment
Regulation 15: Premises and equipment
Regulation 16: Receiving and acting on complaints
Regulation 17: Good governance
Regulation 18: Staffing
Regulation 19: Fit and proper persons employed
Regulation 20: Duty of candour
Regulation 20A: Requirement as to display of performance assessments.

9.2 Under the **CQC (Registration) Regulations 2009 (Part 4)** the requirements which inform this procedural document are set out in the following regulations:

Regulation 16: Notification of death of service user
Regulation 17: Notification of death or unauthorised absence of a service user who is detained or liable to be detained under the Mental Health Act 1983
Regulation 18: Notification of other incidents

9.3 Detailed guidance on meeting the requirements can be found at http://www.cqc.org.uk/sites/default/files/20150311%20Guidance%20for%20providers%20on%20meeting%20the%20regulations%20FINAL%20FOR%20PUBLISHING.pdf

Relevant National Requirements
Department of Health initiatives

NICE and other clinical guidance

10. REFERENCES, ACKNOWLEDGEMENTS AND ASSOCIATED DOCUMENTS
Cross reference to other procedural documents

Confidentiality and Data Protection Policy

Consent and Capacity to Consent to Treatment Policy

Freedom of Information Policy

Information Security Policy

Learning Development and Mandatory Training Policy

Record Keeping and Records Management Policy

Risk Management Policy and Procedure

Safeguarding –and Protection of Children Policy

Serious Incidents Requiring Investigation (SIRI) Policy

Staff Mandatory Training Matrix (Training Needs Analysis)

Untoward Event Reporting Policy and procedure

All current policies and procedures are accessible in the policy section of the public website (on the home page, click on 'Policies and Procedures'). Trust Guidance is accessible to staff on the Trust Intranet.

11. APPENDICES

11.1 For the avoidance of any doubt the appendices in this policy are to constitute part of the body of this protocol and shall be treated as such. This should include any relevant Clinical Audit Standards.

Appendix A	Report for Court Template/Family Support Meeting/Core Assessment/CAFCASS Template
Appendix B	Criteria for assessing a child's capacity to consent
Appendix C	Clinical Audit Standards
Appendix D	Guidance for completion of the *framework for the assessment of children in need and their families*, (Department of Health, 2000)

APPENDIX A

Somerset Partnership NHS
NHS Foundation Trust

Court Order Number: (or specify Public Law Outline process)

Our Reference:

Your reference:

Work Address: (of practitioner completing the report)

Dear Sir/Madam

REPORT FOR COURT

I am **insert name** and I work for Somerset Partnership NHS Foundation Trust as a **job title**.

I have been asked to prepare a statement for Court and confirm that I am not an expert witness, as I am not a Consultant, have not been instructed by the Court as an expert nor accepted by the Court as an expert.

PATIENT DETAILS

Name: **D.O.B: (always use full dates e.g. 20 May 2012)**

Rio number: **NHS Number:**

Address:

Date of report: (for Court always use full dates e.g. 20 May 2012)

Capacity to Consent (remove this section if not required)

Patient's name does not have the capacity to make consent because either the patient is a child and not of an age to be able to understand consent (Gillick Competent) or, as confirmed by the Mental Capacity Act assessment of **insert date** or, the patient has learning disabilities to an extent that they cannot make informed consent.

Recommendations for consideration under the Court Order (this section should include any specific requests for inclusion in the report detailed in the Judge's Order). For example "The *Health Visitor will provide information in relation to the parents' engagement with local Health services on behalf of the child*")

Additional points raised by the Solicitor (remove this section if not required)

BACKGROUND INFORMATION

This section may include how long the family have been known to the professional or service writing the report, the level of service required, for example was a higher level of service required given the needs of the parents/children.

MAIN REPORT

(based on the *Framework for the Assessment of Children in Need and their Families*, (DoH, 2000)

This section must answer any questions raised within the order from the Judge or the request from the Solicitor/CAFCASS. If there is a specific reason these questions cannot be answered Trust advice must be sought from the Safeguarding Children Tea, Information Governance Manager and/or Caldicott Guardian. Staff unsure how their information fits into the dimensions of the Framework for the Assessment of Children in Need and their Families, (DoH, 2000), listed by bullet point below should also refer to Appendix 4 below.

CHILD'S DEVELOPMENT NEEDS

Include all relevant information under the following headings:

- **Health**
- **Education**
- **Emotional and Behavioural Development**
- **Identity**
- **Family and Social Relationships**
- **Social Presentation**
- **Self-Care Skills**

PARENTING CAPACITY

Include all relevant information under the following headings:

- **Basic Care**
- **Ensuring Safety**
- **Emotional Warmth**
- **Stimulation**
- **Guidance and Boundaries**
- **Stability**

FAMILY AND ENVIRONMENTAL FACTORS

Include all relevant information under the following headings:

- **Family History and Functioning**
- **Wider Family**
- **Housing**
- **Employment, Income**
- **Family's Social Integration**
- **Community Resources**

SUMMARY: (RISKS AND PROTECTIVE FACTORS)

This section should not contain any new information but should concisely summarise the contents of the full report above, clearly identifying both risks and protective factors for the child/ren.

RECOMMENDATIONS

This section should include both recommendations in terms of the proceedings, (unless this is a criminal case), and recommendations in terms of the Health professional's action plan with the child / family going forward.

Statement of Truth

I believe the information given by me in this report is correct and accurate. Where information is provided from the patient's health record or other source and I did not make that entry, I believe that I have not misrepresented that information within this report, or taken it out-of-context to that in which it was written.

Signed

Dated

APPENDIX B

CRITERIA FOR ASSESSING A CHILD'S CAPACITY TO CONSENT

(see also Trust *Consent and Capacity to Consent to Examination and/or Treatment Policy*)

The following criteria should be considered in assessing whether a particular child on a particular occasion has sufficient understanding to consent, or refuse consent, to sharing of information about them.
:

- Can the child understand the question being asked of them?

- Does the child have a reasonable understanding of:
  - What information might be shared?
  - The main reason or reasons for sharing the information?
  - The implications of sharing that information, and of not sharing it?

- Can the child:
  - Appreciate and consider the alternative courses of action open to them?
  - Weigh up one aspect of the situation against another?
    Express a clear personal view on the matter, as distinct from repeating what someone else thinks they should do?
  - Be reasonably consistent in their view on the matter, or are they constantly changing their mind?

APPENDIX C

CHILD PROTECTION LEGAL GUIDANCE POLICY

CLINICAL AUDIT STANDARDS

04/01/2016

Service area(s) to which standards apply:

✓	**MH Inpatient (CAMHS)**	✓	**Community CAMHS**	✓	**CH Specialist Services**
✓	**MH Inpatient (Adult)**	✓	**C & YP Integrated Therapy**	✓	**MH Specialist Services**
✓	**MH Inpatient (Older)**	✓	**School Nursing**	✓	**MH Community Adult**
✓	**MH Rehab & Recovery**	✓	**Health Visitors**	✓	**MH Community Older**
✓	**Community Hospital**	✓	**CH Rehab**	✓	**Learning Disabilities**
✓	**MIU**	✓	**Musculo-Skeletal**	✓	**District Nurses**

	CHILD PROTECTION LEGAL GUIDANCE POLICY CLINICAL AUDIT STANDARDS				
Ref No	**Standard**	**Paragraph number from Policy**	**Compliance**	**Exceptions**	**Definitions** *(e.g. any interpretations, directions, or instructions on where/how to find information,* ***plus*** *relevant service where applicable)*
1	Trust Staff must inform the Named Nurse or Locality Safeguarding Children Nurses immediately they receive a request for information by Local Authority or privately engaged solicitors, the Police or the Courts concerning civil (such as Section 8 order applications, care proceedings or adoption proceedings) or criminal proceedings.	2.5	100%	None	
2	A copy of the request for information must always be shared with the Named Nurse or Locality Safeguarding Children Nurse.	2.5	100%	None	
3	The Trust *Court Report Template* or other suitable Trust agreed template will always be used to provide information requested by Statutory agencies	2.12	100%	None	If Trust staff do not use the standardised template the format used must include all the elements required as described in this report including clear demographic and consent information
4	A member of the Trust Safeguarding Children Team must always be present when a practitioner gives verbal information to a Court Reporter or Children's Legal Guardian. In their absence, a Line Manager may provide this support.	2.12	100%	None	

	CHILD PROTECTION LEGAL GUIDANCE POLICY CLINICAL AUDIT STANDARDS				
Ref No	**Standard**	**Paragraph number from Policy**	**Compliance**	**Exceptions**	**Definitions** *(e.g. any interpretations, directions, or instructions on where/how to find information,* ***plus*** *relevant service where applicable)*
5	All Trust Staff must record when they have shared information, with or without consent.	2.20	100%	None	
6	All Trust Staff, in accordance with the philosophy of the Children Act 2004, will attend Court to give evidence in Child Care Proceedings, if asked to do so by the Local Authority, without a witness summons being served.	2.23	100%	None	Attendance at Court will be required even if the member of staff is no longer a member of the Trust or has retired.
7	A Member of the Trust Safeguarding Children Team, a Manager or appropriately competent colleague will accompany any practitioner called to give evidence to Court in Child Care Proceedings.	2.25	100%	None	
8	Every draft legal statement involving children must be reviewed by a member of the Trust Safeguarding Children Team before it is sent to Court.	3.11	100%	None	
9	The Named Nurse will ensure that mandatory Level 3 Child Protection training always includes information regarding managing report writing for Child Protection Case Conferences and Court.	4.2	100%	None	Staff may also access external training in this subject provided by the Somerset Local Safeguarding Children Board

GUIDANCE FOR COMPLETION OF THE *FRAMEWORK FOR THE ASSESSMENT OF CHILDREN IN NEED AND THEIR FAMILIES*, (DEPARTMENT OF HEALTH, 2000)

The guidance below is intended to assist practitioners who are required to complete a report for Court as at Appendix 1 above.

CHILD'S DEVELOPMENTAL NEEDS

Health
Includes growth and development as well as physical and mental wellbeing. The impact of genetic factors and of any impairment should be considered. Involves receiving appropriate health care when ill, an adequate and nutritious diet, exercise, immunisations where appropriate and developmental checks, dental and optical care and, for older children, appropriate advice and information on issues that have an impact on health, including sex education and substance misuse.

Education
Covers all areas of a child's cognitive development which begins from birth. ***Includes*** opportunities: for play and interaction with other children; to have access to books; to acquire a range of skills and interests; to experience success and achievement. Involves an adult interested in educational activities, progress and achievements, who takes account of the child's starting point and any special educational needs.

Emotional and Behavioural Development
Concerns the appropriateness of response demonstrated in feelings and actions by a child, initially to parents and caregivers and, as the child grows older, to others beyond the family.
Includes nature and quality of early attachments, characteristics of temperament, adaptation to change, response to stress and degree of appropriate self control.

Identity
Concerns the child's growing sense of self as a separate and valued person.
Includes the child's view of self and abilities, self image and self esteem, and having a positive sense of individuality. Race, religion, age, gender, sexuality and disability may all contribute to this. Feelings of belonging and acceptance by family, peer group and wider society, including other cultural groups.

Family and Social Relationships
Development of empathy and the capacity to place self in someone else's shoes.
Includes a stable and affectionate relationship with parents or caregivers, good relationships with siblings, increasing importance of age appropriate friendships with peers and other significant persons in the child's life and response of family to these relationships.

Social Presentation
Concerns child's growing understanding of the way in which appearance, behaviour, and any impairment are perceived by the outside world and the impression being created.
Includes appropriateness of dress for age, gender, culture and religion; cleanliness and personal hygiene; and availability of advice from parents or caregivers about presentation in different settings.

Self-Care Skills
Concerns the acquisition by a child of practical, emotional and communication competencies required for increasing independence. Includes early practical skills of dressing and feeding, opportunities to gain confidence and practical skills to undertake activities away from the family and independent living skills as older children.
Includes encouragement to acquire social problem solving approaches. Special attention should be given to the impact of a child's impairment and other vulnerabilities, and on social circumstances affecting these in the development of self-care skills.

DIMENSIONS OF PARENTING CAPACITY

Basic Care
Providing for the child's physical needs, and appropriate medical and dental care.
Includes provision of food, drink, warmth, shelter, clean and appropriate clothing and adequate personal hygiene.

Ensuring Safety
Ensuring the child is adequately protected from harm or danger.
Includes protection from significant harm or danger, and from contact with unsafe adults/other children and from self-harm. Recognition of hazards and danger both in the home and elsewhere.

Emotional Warmth
Ensuring the child's emotional needs are met and giving the child a sense of being specially valued and a positive sense of own racial and cultural identity.
Includes ensuring the child's requirements for secure, stable and affectionate relationships with significant adults, with appropriate sensitivity and responsiveness to the child's needs. Appropriate physical contact, comfort and cuddling sufficient to demonstrate warm regard, praise and encouragement.

Stimulation
Promoting child's learning and intellectual development through encouragement and cognitive stimulation and promoting social opportunities.
Includes facilitating the child's cognitive development and potential through interaction, communication, talking and responding to the child's language and questions, encouraging and joining the child's play, and promoting educational opportunities. Enabling the child to experience success and ensuring school attendance or equivalent opportunity. Facilitating child to meet challenges of life.

Guidance and Boundaries
Enabling the child to regulate their own emotions and behaviour.
The key parental tasks are *demonstrating and modelling* appropriate behaviour and control of emotions and interactions with others, and *guidance* which involves setting boundaries, so that the child is able to develop an internal model of moral values and conscience, and social behaviour appropriate for the society within which they will grow up. The aim is to enable the child to grow into an autonomous adult, holding their own values, and able to demonstrate appropriate behaviour with others rather than having to be dependent on rules outside themselves. This includes not over protecting children from exploratory and learning experiences.
Include*s* social problem solving, anger management, consideration for others, and effective discipline and shaping of behaviour.

Stability

Providing a sufficiently stable family environment to enable a child to develop and maintain a secure attachment to the primary caregiver(s) in order to ensure optimal development.
Includes: ensuring secure attachments are not disrupted, providing consistency of emotional warmth over time and responding in a similar manner to the same behaviour. Parental responses change and develop according to child's developmental progress. In addition, ensuring children keep in contact with important family members and significant others.

FAMILY AND ENVIRONMENTAL FACTORS

Family History and Functioning
Family history includes both genetic and psycho-social factors.
Family functioning is influenced by who is living in the household and how they are related to the child; significant changes in family/household composition; history of childhood experiences of parents; chronology of significant life events and their meaning to family members; nature of family functioning, including sibling relationships and its impact on the child; parental strengths and difficulties, including those of an absent parent; the relationship between separated parents.

Wider Family
Who are considered to be members of the wider family by the child and the parents?
Includes related and non-related persons and absent wider family. What is their role and importance to the child and parents and in precisely what way?

Housing
Does the accommodation have basic amenities and facilities appropriate to the age and development of the child and other resident members? Is the housing accessible and suitable to the needs of disabled family members?
Includes the interior and exterior of the accommodation and immediate surroundings. Basic amenities include water, heating, sanitation, cooking facilities, sleeping arrangements and cleanliness, hygiene and safety and their impact on the child's upbringing.

Employment
Who is working in the household, their pattern of work and any changes? What impact does this have on the child? How is work or absence of work viewed by family members? How does it affect their relationship with the child?
Includes children's experience of work and its impact on them.

Income
Income available over a sustained period of time. Is the family in receipt of all its benefit entitlements? Sufficiency of income to meet the family's needs. The way resources available to the family are used. Are there financial difficulties which affect the child?

Family's Social Integration
Exploration of the wider context of the local neighbourhood and community and its impact on the child and parents.
Includes the degree of the family's integration or isolation, their peer groups, friendship and social networks and the importance attached to them.

Community Resources

Describes all facilities and services in a neighbourhood, including universal services of primary health care, day care and schools, places of worship, transport, shops and leisure activities.
Includes availability, accessibility and standard of resources and impact on the family, including disabled members.