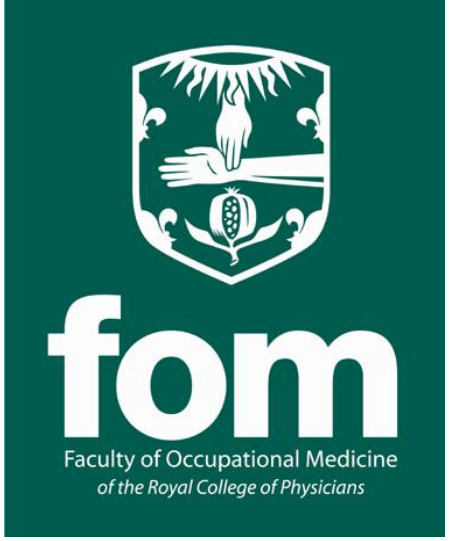

SAFEGUARDING CHILDREN:

GUIDELINES FOR

OCCUPATIONAL HEALTH PROFESSIONALS

May 2014

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Safeguarding children:
Guidelines for occupational health professionals

In the following text there are references to child protection legislation. The principles of child protection are similar within the four constituent countries of the UK, but there are differences in the specific legislation. To check what applies, please refer to the NSPCC website at: http://www.nspcc.org.uk/Inform/policyandpublicaffairs/ppa_wda48585.html which provides details of the child protection system, framework, guidance, legislation, case review process, research and statistics as well as the NSPCC's training, consultancy and policy work in each nation.

BACKGROUND AND INTRODUCTION

Over the past five years, there has been an increasing focus on safeguarding the safety and wellbeing of children. New legislation has underpinned the mechanisms for raising concerns about children who might be at risk, and the safeguarding duties of practitioners in health and social care have been emphasised. Occupational health practitioners occasionally advise about young people in the workplace (eg, aged 16-17 years) who would be covered by child protection legislation. Moreover, they need to be aware of safeguarding issues because parents or carers who present to an occupational health service could have health problems that might impact the health and wellbeing of children. Therefore these guidelines have been developed with the particular setting of occupational health in mind. They were drafted by a joint working group of the Faculty of Occupational Medicine (FOM) and the Royal College of Paediatrics and Child Health (RCPCH), and have been ratified by the FOM Board and the RCPCH Standing Committee on Child Protection respectively.

Safeguarding children is the process of protecting children from abuse and neglect, preventing impairment of their health and development, and ensuring that they are growing up in circumstances that are consistent with the provision of safe and effective care. Abuse includes physical, emotional and sexual abuse, which are the result of deliberate acts, and neglect, which is often the result of acts of omission. The person committing these acts is usually, but not necessarily, an adult. Safeguarding also includes promoting the welfare of children and young people and taking action to enable all children to have the best outcomes, optimum life chances and to enter adulthood successfully.[1] Childhood lasts until a child's 18th birthday.[2] Concerns about an unborn child should be referred to Children's Social Care who will plan to intervene if necessary as soon as the child is born. Two per cent of children who have Child Protection Plans (CPPs) are unborn children.[3]

Safeguarding children includes supporting children and families in need who require extra help and support, as well as child protection when children are suffering, or are likely to suffer, significant harm through acts or omissions by their parents or carers. The principles underpinning Safeguarding Children are enshrined in the United Nations Convention on the Rights of the Child,[4] The Children Acts 1989[2] and 2004[5] and governmental guidance such as Working Together To

Safeguard Children.[1] The General Medical Council has published ethical guidance on how medical practitioners should treat children along with separate more recent guidance on protecting children and young people.[6] This guidance applies to doctors who either have child clients or whose adult clients give rise to a concern about a child, whether this concern arises from something they say or from their physical, emotional or mental health status.

SITUATIONS IN WHICH AN OCCUPATIONAL HEALTH PROFESSIONAL MAY NEED TO CONSIDER SAFEGUARDING CHILDREN ISSUES

The role of occupational health professionals (OHPs) includes the assessment of fitness for work, including when there have been allegations made against an employee, the facilitation of rehabilitation back to work after illness, and the support of employees who are experiencing difficulties in the work place. The OHP's responsibility is not only to their client but also to any child whom they believe to be at risk. The Children Act 1989 makes it clear that the child's welfare is paramount.[2] This belief may arise from information the OHP receives during consultation or through assessment of their client. An OHP may become involved in safeguarding children issues in the following circumstances:

1 When there is a significant risk that a client of the occupational health service might harm a child.

1.1. When there is a clear statement by their client that the client's own child or another (outside the workplace) may be at risk of abuse or neglect. In some circumstances when the potential abuse poses a risk to the life of a child or there is a likelihood of serious immediate harm, or evidence of a crime may be lost, immediate action may be required. However in most circumstances there is more time for thought and reflection about the situation.

1.2. When the client's medical condition or circumstances may put a child or children at risk (outside the workplace). Clients with certain physical health conditions may have difficulty looking after their own children. Clients with mental health or substance misuse issues or Fabricated or Induced Illness may neglect, emotionally, physically or sexually abuse their own children. In some circumstances clients may disclose domestic abuse, and the effect that this is having on any children needs to be considered in addition to the client's own personal safety. It is possible that clients may pose a risk to children who are not within their own immediate family. This is particularly the case with sexual abuse.

1.3. Information comes to light that suggests the client is a risk to children in the workplace. In these circumstances Human Resources and the Local Authority Designated Officer (LADO) should be involved in the discussion about concerns. The LADO has a particular role in ensuring thorough and impartial investigation of such concerns (see below).

1.4. In the situation where a client discloses their own past abuse, they should be encouraged to tell the Police. If they do not wish to do this and it seems likely that the perpetrator of the abuse against the individual could be continuing to harm children, then the OHP should seek advice with regard to whether the matter needs to be reported to either the Police or Children's Social Care, despite the client's lack of consent.

2 When the client of the occupational health service is a health or social care professional or police officer who works in the complex arena of safeguarding children or vulnerable adults.

This area can be sensitive and contentious and can be particularly stressful for those who hold positions of special authority in the local or regional child protection network including paediatricians, named or designated doctors or nurses for safeguarding children, children's social workers and their managers and child abuse unit police officers. It is important that OHPs recognise the stressful nature of this work, particularly when a child with whom the professional was involved dies, and ensure that appropriate support or counselling is available to those who are directly engaged in this field. Complaints, media campaigns and referrals to professional bodies such as the General Medical Council (GMC) can cause significant stress to practitioners who may seek help through the Occupational Health Service. The duty to report poor care or neglect of vulnerable patients has been highlighted in the Francis Report,[7] and similar stresses might be encountered by health and social care professionals who are considering whistle-blowing in this context.

CONSENT AND CONFIDENTIALITY

The rules of confidentiality and consent in occupational health practice should be applied particularly carefully in cases where there are recognised child protection issues. It is helpful to always summarise the usual rules of confidentiality to clients at the beginning of a new consultation. Where possible, sensitive medical or personal information should not form part of a report on fitness for work. However, an exception is where there is an over-riding concern about the safety of others including vulnerable children, and if in doubt the OHP must seek advice.

Further detailed generic guidance about confidentiality and information sharing in these circumstances is available from the GMC,[8,9] and the Faculty of Occupational Medicine.[10]

WHAT TO DO AND WHERE TO GO FOR ADVICE

1 Check local guidelines

Every organisation should have Safeguarding Children Guidelines, procedures or policies that can be consulted. In addition, the Local Authority's Local Safeguarding Children Board (LSCB) will have Safeguarding Children Guidelines. These can usually be accessed on the internet.

2 Consider referral to Social Services

Any professional can make a direct referral to Social Services but in most safeguarding children situations there is time to reflect and advice can be sought in a timely manner. Advice should normally be sought from a senior occupational health colleague and a safeguarding children health professional (initial risk assessment) before making a formal referral. Every health provider organisation will have a Named Nurse or Named Doctor for Safeguarding Children. These professionals have clinical expertise in the Safeguarding Children field. They can be contacted for advice in addition to the Designated Professionals for safeguarding children, who exist in each Clinical Commissioning Group in England. In non-healthcare organisations there will be no Named Nurse or Named Doctor. In these circumstances the OHP can seek advice from the Designated Nurse or Doctor for Safeguarding for the local area. Their contact details will be available on the Local Authorities Local Safeguarding Children Board website or through the Clinical Commissioning Group website (in England only). In addition it might be helpful for an OHP to discuss a case in principle with their professional indemnity provider, although care should be taken not to disclose the identity of the client.

3 Seek consent

Initial risk assessment

3.1 The initial risk assessment to decide whether a formal named referral is made can often be done on an anonymised basis (ie, without the OHP disclosing the identity of the client). In this instance, consent is not required. However, sometimes the local child protection experts are already aware of the identity of the client (eg, from an employer or a police report). If the discussion is not anonymised the OHP should consider carefully how much detailed information should be disclosed, and should seek consent. The aim is to provide as much detail as is necessary to inform an adequate risk assessment, but be proportionate, and be prepared to justify what is disclosed (either with or without consent).

Formal (named) referral

3.2 If it is decided that a referral to Social Services is desirable because the child and family need support this can only be done with parental consent.

3.3 On the other hand, if it is decided that a referral to Social Services is necessary because there appear to be child protection issues, the OHP should be prepared to refer without consent. They should consider whether seeking consent would in itself place the child(ren) at risk. In this situation, the OHP should be clear about the justification for disclosure or referral. All reasonable steps should be taken to gain consent in line with GMC guidelines. However, lack of consent (or the obtaining of consent) must not be allowed to delay referral or otherwise put the child(ren) at additional risk in cases where the risk to the child is significant. Disclosure without consent should be a rare occurrence. If the OHP is considering disclosing information without consent they should have sought advice from child protection experts and others (anonymised, as described above). The OHP should inform the individual what named information is being passed on, to whom, for what purpose and what the consequences might be,

but only if this would not further jeopardise the safety of the child(ren). This process should be documented carefully.

3.4 Rarely, immediate action may be required when the situation indicates there may be a risk to the life of a child or there is a likelihood of serious immediate harm, or evidence of a crime may be lost. This might involve direct threats or admissions of physical or sexual assault including situations when an adult discloses suicidal thoughts involving children such as a suicide pact, or a child is part of a delusional belief system that threatens to harm them. Even in these circumstances there is usually time to seek advice. If the situation is dire the Police should be contacted immediately. Police officers are the only professionals who can protect children immediately as they have police protection powers. Social workers are obliged to go to Court for an Order to protect children and this can take several hours. In these circumstances (if a child is at immediate risk) it may be justifiable not to disclose to the client that information will be shared with other agencies if this is likely to increase the risk to the child.

DOCUMENTATION

All documentation must be exceedingly thorough and defensible, and should include in-depth details of the safeguarding children concerns. This will include any statements made by the client, sometimes verbatim. Details of any communication between the OHP and other professionals and agencies must be recorded along with the plan agreed and the actions to be taken. There also must be details of the discussion with the client, their views and whether consent has been obtained for any referral to Social Services. If consent for referral has been refused then the reasons for overriding the client's wishes must be justified.

TRAINING AND SUPPORT

Most large organisations have Safeguarding Children training courses, which can be accessed through their training departments. Safeguarding children training can also be accessed through the Local Authority's Local Safeguarding Children Boards training programme, and through e-Learning for Healthcare.[11] As professionals with contact with parents or carers, OHPs should access safeguarding training to Level 2 as outlined in Safeguarding Children and Young people: roles and competences for health care staff.[12] Support for health professionals who are involved in child protection cases can be obtained from service managers, the Named or Designated health professionals or from psychological support services engaged by the employing organisation.

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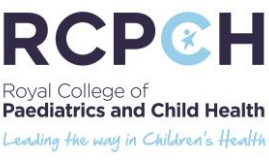

Compiled and published by the Faculty of Occupational Medicine & Royal College of Paediatrics & Child Health

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