



# Safeguarding Children (Level 2)

# Safeguarding Children

## (Level Two)

### INTRODUCTION

The UN Convention on the Rights of the Child includes the requirement that children live in a safe environment and be protected from harm. These duties are an explicit part of NHS employment contracts.

To protect children and young people from harm, **all** healthcare staff must have the competences to recognise child maltreatment and to take effective action as appropriate to their role.

Following every serious case of child maltreatment or neglect there is considerable consternation that greater progress has not been made to prevent such occurrences. Over the last three decades reviews and enquiries across the UK, have often identified the same issues – among them, poor communication and information sharing between professionals and agencies, inadequate training and support for staff, and a failure to listen to children.

All staff who come into contact with children and young people have a responsibility to safeguard and promote their welfare and should know what to do if they have concerns about safeguarding issues, including child protection. This responsibility also applies to staff working primarily with **adults** who have dependent children that may be at risk because of their parent/carers health or behaviour. To fulfil these responsibilities, it is the duty of healthcare organisations to ensure that all health staff have access to appropriate safeguarding training, learning opportunities, and support to facilitate their understanding of the clinical aspects of child welfare and information sharing.

The intercollegiate Document 2014 sets out the minimum training requirements for health care staff.

Staff who are required to complete level 2 training include, nurses working in adult community/acute services, adult allied health professionals, all other adult orientated secondary care health care professionals, administrators for looked after children and safeguarding teams, health care students, dental care professionals, (clinical laboratory staff, phlebotomists and pharmacists if they come into contact with children and /or families in their day to day work), physicians, surgeons, anaesthetists and radiologists who work within the adult setting.

If you are not sure which level of training that you are required to complete please ring the safeguarding team on **01253 957592/955444**

**Staff who are required to complete Level 2 safeguarding children training  
DO NOT need to complete level 1 first as the competencies for level 1 are included in level 2**

NHS Blackpool Teaching Hospitals Foundation Trust workforce has a duty of care to ensure they safeguard and protect children at risk of harm and neglect and promote their welfare. All those who come into contact with children and their families as part of their day to day work, and those who do not, have a duty to safeguard and promote the welfare of children.

All staff have a duty to familiarise themselves with the risk factors signs and symptoms of child abuse and be aware of the action to be taken should such an incident present itself.

The aim of this unit is to ensure that children and young people can 'stay safe' by minimising the risk and incidence of child abuse, thus enabling them to achieve. All children have the right to be safeguarded from harm and exploitation. One agency alone cannot protect children and neither can procedures alone, promoting children's wellbeing and safeguarding them from significant harm depends on effective information sharing collaboration and understanding between agencies and professionals.

#### **Staff need to:**

- Recognise their responsibilities in relation to safeguarding and protecting children
- Be able to recognise signs of child maltreatment

- Understand the impact of child maltreatment
- Know who to contact for advice and support available within the organisation
- Know where to access safeguarding policy's (Internal, and Lancashire Safeguarding Children Board Procedures)
- Know how to act upon their concerns and to know what to do if they feel that their concerns are not being taken seriously or they experience barriers to referring a child/family.
- Be aware of the support systems in place for staff
- Have an understanding and acceptance that child abuse occurs
- Have an awareness of the normal development of children and young people
- Be able to act as an advocate for a child or young person
- To be able to contribute to enquiries about the child and family and refer when appropriate (PLO – public law outline )
- To be able to participate in child protection conferences
- To be able to maintain records that are “fit for purpose”

Lancashire's Safeguarding Children procedures can be found at [www.lancashire.gov.uk](http://www.lancashire.gov.uk).

The organisations Internal Safeguarding Children procedures can be found on Sharepoint on the Trust Intranet.

### **Professional Responsibilities**

- To recognise where children are in need, or suffering, or at risk of suffering significant harm
- To be able to assess the needs of a child and the capacity of parent/carer(s) to meet those needs
- To be able to contribute to enquiries about the child and family and refer when appropriate
- To be able to participate in child protection conferences
- To be able to maintain records that are “fit for purpose”

### **The Children Act**

The Children Act 1989 and 2004 introduced the concepts of:

- Welfare of the child is paramount
- Local Authority has duty to provide a range and level of services to children's needs
- Concept of significant harm
- Parental responsibility

The Children's Act 2004 identified that safeguarding is everybody's business

## **LOOKED AFTER CHILDREN**

Children become looked after when their birth parents are unable to provide ongoing care in either a temporary or permanent capacity.

Children can either be looked after as a result of a voluntary agreement by their parents or as the result of a care order. Children may be placed with family members, friends or foster carers depending on individual circumstances.

Wherever possible, the local authority will work in partnership with parents. Many children and young people who become looked after keep strong links with their families and many eventually return home.

### **REASONS WHY A CHILD MAY BECOME LOOKED AFTER**

There are many reasons why a child may become looked after. Some will have had harmful experiences, including physical and sexual abuse, while others may be in care because of the illness or death of a parent.

The majority of young people in care come from families who experience difficulties. They are separated from their family because it is unable to provide the care needed. Vulnerable unaccompanied children seeking asylum in the

UK will also become looked after if they are assessed as being under 18 and have no family members here who can look after them. A small percentage of children and young people are in care because of offences they have committed.

Looked after children are usually cared for by foster carers. Some children live in children's homes and a few live in specialist homes. Sometimes extended family members will look after a child, which is often a preferable arrangement so they are not then placed with strangers. Although looked after children and young people have many of the same health risks and problems as peers, the extent is often exacerbated due to their experiences of poverty, abuse and neglect.

For example

- Mental health and emotional wellbeing, looked after children show significantly higher rates of mental health disorders than others (45%, rising to 72% for those in residential care, compared to 10% of the general population aged 5 to 15) – conduct disorders being the most prevalent, with others having emotional disorders (anxiety and depression) or hyperactivity.
- 11% are reported to be on the autism spectrum and many others have developmental problems.
- Two thirds of looked after children have been found to have at least one physical health complaint, such as speech and language problems, bedwetting, co-ordination difficulties and eye or sight problems.
- Generally the health and well-being of young people leaving care has consistently been found to be poorer than that of young people who have never been in care, with higher levels of teenage pregnancy, drug and alcohol abuse clearly evident.
- The high geographical mobility of the looked after children population, linked with not being registered with a GP and often being educated outside of mainstream schools exacerbates these problems.

Whilst looked after children have poorer outcomes, research also demonstrates that maltreated children who remain in care have better long term outcomes than those who are reunited with their families.

## **UNDERSTANDING THE HEALTH NEEDS OF YOUNG OFFENDERS**

A high percentage of the young people open to the Youth Justice Service have complex lives and life experiences, presenting with significant health inequalities and current or historical trauma in their lives, which then often manifest into offending behaviour.

The Care Quality Commission report 'Re-actions' 2011 found that majority of children and young people who have offended, or who are likely to, have a higher percentage of health needs than the general youth population. These needs span a range of physical, emotional and mental health areas and substance misuse problems, learning and communication difficulties, and are potentially linked to crime. They have to be recognised and addressed as early as possible in order to increase the likelihood of making the lives of these children and young people better and free of crime.

Many of these young people are vulnerable to exploitation and abuse, come from deprived households, and demonstrate significant risk taking behaviours that impact on their health and wellbeing. They may engage in early sexual experiences, high level substance misuse and have difficulties in regulating their emotional health, many present with signs of mental ill health. Most young people open to the service are aged between 12-19, many having disengaged with universal services and are not accessing the health messages that other young people are. This is one of the reasons why it is imperative that such young people have access to support and guidance in helping them achieve their potential.

## PRIVATE FOSTERING

Private fostering is a private arrangement made between a child's parents and someone who is not a close relative to care for a child for 28 days or more; where the child lives with the carer. Close relatives are an aunt, uncle, brother, sister or grandparent but not a great aunt or uncle. Private fostering covers arrangements made for children aged less than 16 or less than 18 if the child is disabled. It does not mean arrangements made for children who have been placed by Children's Social Care.

As private fostering is a **private arrangement** it can be hidden from agencies who have a responsibility to safeguard the welfare of children. Privately fostered children can be vulnerable as they may not see their families very often. It is therefore important that their needs are assessed and their situation monitored to safeguard their well being.

Birth Parents must:

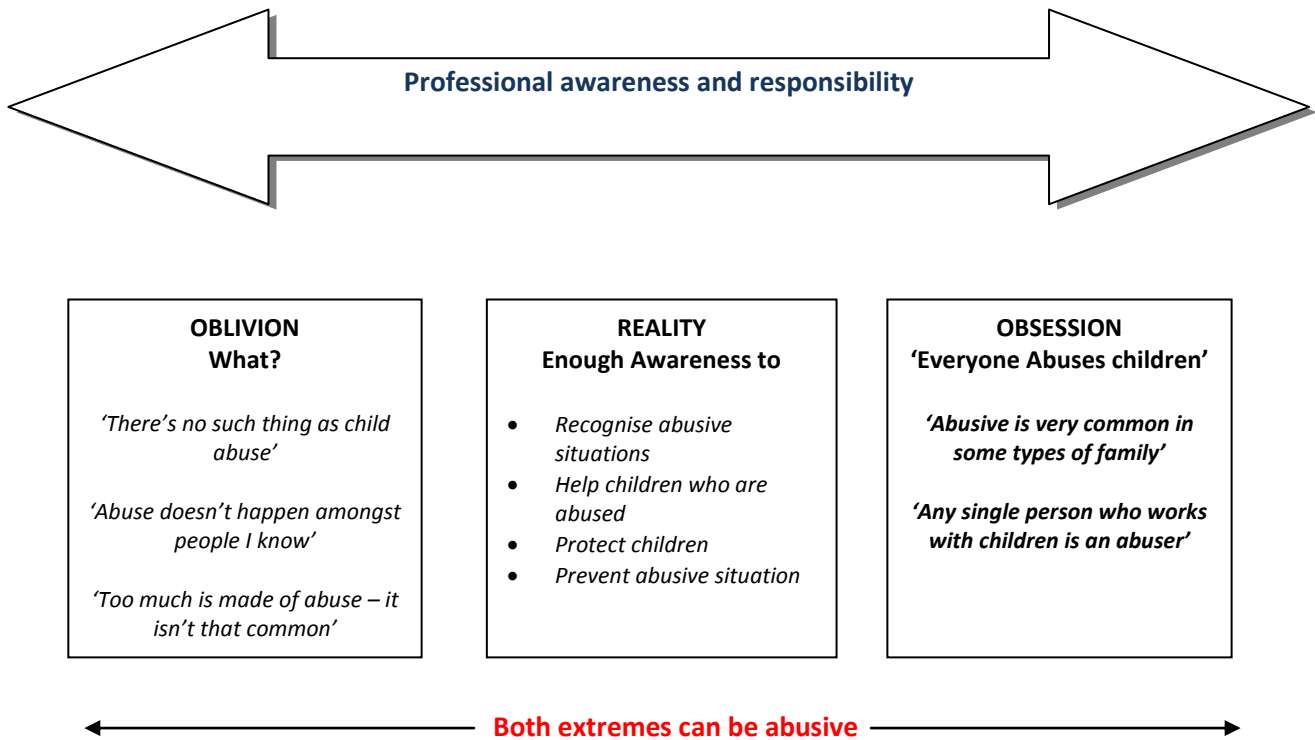
- retain parental responsibility for their child(ren) by initiating and participating in all decision making processes in the placement
- give the prospective carer as much information about the child as possible. This includes health records, dietary needs or preferences, school records, hobbies, religion and ethnicity
- advise us of the private fostering arrangement if the prospective carer has not already done this. The death of Victoria Climbié whilst in the care of her great aunt, has highlighted the requirement to improve notification rates and compliance with existing legislative framework as follows:
- The law says that children being privately fostered must have their welfare safeguarded and promoted ([The Children Act 1989](#) and [The Children and Private Arrangements for Fostering Regulations 2005](#))
- If there are plans for a child to be privately fostered, [Children's Social Care](#) must be informed by anyone who has been involved in making the arrangements
- Notification must be to the [Children's Social Care](#) area where it is planned that the child will live
- Notification must be no later than 6 weeks before a child is to go and live with a private foster carer
- Where a child is placed in an emergency, [Children's Social Care](#) should be informed within 48 hours
- [Children's Social Care](#) must also be informed if a child leaves a private foster carer and of the child's new address
- It is an offence not to notify [Children's Social Care](#) of a private fostering arrangement

Professionals should encourage parents/carers to notify Children's Social Care. If they feel Children's Social Care has not been made aware by parents/carers, then they should notify Children's Social Care themselves via the Customer Service Centre on 0300 123 6701

## CHILDREN'S RIGHTS IN THE HUMAN RIGHTS FRAMEWORK

The Convention on the Rights of the Child sets out the rights that must be realized for children to develop their full potential, free from hunger and want, neglect and abuse. It reflects a new vision of the child. Children are neither the property of their parents nor are they helpless objects of charity. They are human beings and are the subject of their own rights. The Convention offers a vision of the child as an individual and as a member of a family and community, with rights and responsibilities appropriate to his or her age and stage of development. By recognizing children's rights in this way, the Convention firmly sets the focus on the whole child.

## DOES CHILD ABUSE EXIST?



**Where are you on the continuum? This may fluctuate depending on your experience and knowledge.**

So far example; If you were on the 'obsessive' side of the continuum and have the belief that everyone is an abuser this could lead to increased and unnecessary referrals, loss of objectivity and stress for the families and practitioner. Similarly, if you are of the belief that there is no such thing as child abuse this could lead to children being left in difficult and dangerous situations and not receiving the appropriate safeguarding services. The healthy position to be in is to recognise that children can be abused and at times require protection and that as practitioners we need to be able to recognise abusive situations and work to our roles and responsibility.

### **When we have to deal with abuse we may feel a mixture of some or all of the following:**

Dealing with child abuse can lead to a mixture of feelings that may include denial, guilt, fear, anger and pain. These are all normal emotions when dealing with such a sensitive subject. However, it is incumbent on professionals working in the NHS to act professionally to safeguard children and support when dealing with cases can be sought from managers, safeguarding team.

It is important to safeguard children as there are many children in society who are living in difficult situations as shown by the figures below:

### **National Statistics**

2009-2011 National Summary of SCR's

- 48% of deaths resulting from fatal physical injury
- 52% of non fatal cases involved a physical assault on a child
- 17% were deliberate murders( there was an increased number of filicide suicides from 07-09)

### **Filicide/Suicide**

- Occurs where a parent kills their child/ren and either the other parent or themselves

- Numbers rose from 7% of SCR 07-09 to 17% in 09-11
- Maternal perpetrators linked to mental illness
- Paternal perpetrators linked to domestic abuse
- Very difficult to predict

### Statistics-Lancashire

Number of children subject to child protection plan by category on 31<sup>st</sup> January 2014.

Emotional Abuse	451- 42.9%
Neglect	465- 44.3%
Physical	100- 9.5%
Sexual	35- 3.3%

### Childline

- Childline receives a call about physical abuse an average of more than twice an hour, every hour of the year.
- 30% have not told anyone else about it (25% girls; 34% of boys)
- Many said they were afraid that speaking up would make the problem worse
- Many feared they would not be believed or would be blamed
- Many loved the abuser and did not want to get them into trouble

## IMPACT OF CHILD ABUSE ON CHILDREN

Evidence states that the experience of maltreatment can have major long-term effects on all aspects of a child's health, growth and intellectual development and mental wellbeing and that it can impair their functioning as adults.

- The impact of child maltreatment includes a wide range of many complex social and economic problems, with an increased likelihood of mental disorders, health problems, education failure and unemployment, substance addiction, crime and delinquency, homelessness and an intergenerational cycle of abuse and neglect.
- The health effects of child abuse include physical injuries such as shaken baby syndrome, non-organic failure to thrive, broken bones, spinal injuries, stomach aches, migraines, speech and language and communication problems. Health problems later in life can include heart disease, obesity, liver disease, cancer and chronic lung disease.
- Depression, severe anxiety, panic attacks and post-traumatic stress disorder (PTSD) are the most common mental health consequences of abuse: the literature suggests that between 30 and 50 per cent of sexually abused children meet the full criteria for a PTSD diagnosis, and
- up to 80 per cent experience at least some 'post-traumatic' symptoms (These symptoms include hyper-vigilance, intrusive thoughts, and sudden intrusive flashbacks of the abuse experience.)  
**(NSPCC 2010)**

## SAFEGUARDING AND PROMOTING THE WELFARE OF CHILDREN IS:

- Protecting children from maltreatment
- Preventing impairment of a child's health and development

- Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care and undertaking that role so as to enable those children to have optimum life chances and enter adulthood successfully. (Working Together 2013)

Children are more vulnerable to abuse where there is parental substance misuse (drugs or alcohol), mental illness and or domestic abuse.

## HOW I LEARN

**When considering whether an injury is abusive or not consideration must always be given to the child's developmental age and even more so if the child has a developmental delay**

<p><b>Milestones of average Child Development</b></p> 	<p style="text-align: center;"><b>3 months</b></p> <p>Visually very alert., particularly preoccupied by nearby human face. <b>Holds</b> rattle for few moments when placed in hand <b>Turns</b> to nearby voice. <b>Responds</b> with pleasure to friendly handling. <b>Begins</b> to react to familiar situations, shown by smiling, coos and excited movements.</p>	<p style="text-align: center;"><b>6-12 months</b></p> <p>Lying on back, lifts and grasps foot. <b>Back</b> is straight and head is firmly erect when held in sitting position. <b>Kicks</b> strongly with legs alternating. <b>When</b> held standing, bears weight on feet and bounces up and down actively. <b>Immediately</b> stares at interesting small objects or toys within 15-30 cm and stretches out both hands to grasp. <b>Turns</b> immediately to familiar voice across the room. <b>Vocalises</b> tunefully to self and others. <b>Takes</b> everything to mouth. <b>Shows</b> delighted response to active play. <b>Pokes</b> at small objects using index finger. <b>Babbles</b> loudly "mama Dada". <b>Sits</b> upright and crawls on hands and feet. <b>May</b> stand alone or walk unaided. <b>Plays</b> peek a boo and imitates hand clapping. <b>Immediately</b> responds to own name. <b>Uses</b> both hands freely but may show preference for one. <b>Shows</b> interest in pictures. <b>Understands</b> simple instructions associated with a gesture – "give it to mummy".</p>
<p style="text-align: center;"><b>The Newborn Baby</b></p> <p><b>Smiles</b> and tracks people and objects with eyes. <b>Sensitive</b> to light and sound, turning towards source of light. <b>Startles</b> at sudden loud sounds. <b>Establishes</b> interaction with carer through eye contact, spontaneous and imitative facial gestures.</p>	<p style="text-align: center;"><b>2 to 3 ½ Years</b></p> <p><b>Walks</b> up and down stairs. <b>Runs</b> safely on whole foot, stopping and starting with ease and avoiding obstacles. <b>Sits</b> on small bike but cannot pedal at 2, pedals at 3 yrs. <b>Builds</b> tower of 6/7 cubes. <b>Can</b> point to body parts on request. <b>Uses</b> 50 or more recognizable words appropriately. <b>Puts</b> 2 or more words together to form sentences. <b>Engages</b> in make believe play. <b>Constantly</b> demands carers attention. <b>Eats</b> skilfully with spoon and may use fork. <b>Jumps</b> from bottom step (both feet together). <b>Matches</b> 2-3 primary colours (at 3 years). <b>Starts</b> to ask questions "what, where and who". <b>Washes</b> hands but needs adult supervision with</p>	
<p style="text-align: center;"><b>1 – 2 years</b></p> <p>Imitates what adults are doing and likes to help with tasks. <b>Manipulates</b> cubes and builds tower of 2. <b>Grasps</b> crayon with whole hand and scribbles to and fro. <b>Can</b> talk now and understand words and ideas. <b>Uses</b> between 6 and 20 recognisable words and understands many more. <b>Enjoys</b> nursery rhymes. <b>Likes</b> stories <b>Explores</b> environment. <b>Can</b> walk alone, feet apart arms assisting balance. <b>Can</b> climb stairs. <b>Starting</b> to show independence, but is more comfortable with known people.</p>		

**5 years**

**Curious** about people and how the world works. **Has** more confidence in physical skills. **Uses** words to express their feelings. **Likes** grown up activities. **Shows** definite sense of humour. **Tender** and protective towards younger children and pets. **General** behaviour more sensible, controlled and independent. **Needs** constant reminder for tidiness. **Engages** in elaborate make believe play.



## 6-8 years

Can dress themselves. Catches a ball more easily with only their hands. Can easily tie their shoes. Developing independence from family becomes more important now. Events such as starting school bring children this age into regular contact with the larger world. Friendships become more and more important. Physical, social, and mental skills develop rapidly at this time. This is a critical time for children to develop confidence in all areas of life, such as through friends, schoolwork, and sports.

## 9-11 years

Growing independence from the family and interest in friends might be obvious by now. Healthy friendships are very important to your child's development, but peer pressure can become strong during this time. Children who feel good about themselves are more able to resist negative peer pressure and make better choices for themselves. This is an important time for children to gain a sense of responsibility along with their growing independence. Also, physical changes of puberty might be showing by now, especially for girls. Another big change children need to prepare for during this time is starting senior school

## 12-14 years

More concern about body image, looks, and clothes. Focus on self, going back and forth between high expectations and lack of confidence. Moodiness. More interest in and influence by peer group. Less affection shown toward parents. May sometimes seem rude or short-tempered. Anxiety from more challenging school work. Eating problems sometimes start at this age. Has more ability for complex thought. Better able to express feelings through talking. Has a stronger sense of right and wrong. Many teens sometimes feel sad or depressed. Depression can lead to poor grades at school, alcohol or drug use, unsafe sex, and other problems.

## 15-17 years

Middle adolescence is a time of physical, mental, cognitive, and sexual changes for teenagers. Most girls will be physically mature by now, and most will have completed puberty. Boys might still be maturing physically during this time. They may have concerns about her body size, shape, or weight. Eating disorders can also be common, especially among females. During this phase of development, the teenager is developing their unique personality and opinions. Peer relationships are still important, yet will have other interests as he develops a more clear sense of identity. Middle adolescence is also an important time to prepare for more independence and responsibility; such as part time work, and many will be leaving home soon after high school. Increased interest in the opposite sex. Decreased conflict with parents. Increased independence from parents. Deeper capacity for caring and sharing and the development of more intimate relationships. Decreased time spent with parents and more time spent with peers

## Groups that are more vulnerable to abuse

Families living in poverty  
Domestic Violence  
Teenage/young parents  
Where a parent has a mental illness  
Substance misuse (drugs or alcohol)  
Learning Disability  
Disability  
Social Isolation  
Areas of high crime, poor housing, high unemployment  
Children Looked After

**Definition of abuse :**

The abuse of power by a person that is developmentally older / stronger than another, resulting in some distress, harm or neglect of necessary attention for the victim.

Abuse and neglect are forms of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm or failing to act to prevent harm. A child may be abused in a family or in an institutional or community setting by those known to them or more rarely by a stranger ie: the internet. They may be abused by an adult or another child or children. Abuse of children falls into 4 categories

**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 the symptoms of or deliberately induces illness in a child. In experience, immobile babies do not bruise themselves; bruising of any kind in an immobile baby should be questioned. Parental explanations – fell on a plastic toy or slept on his dummy (a recent explanation for an injury) are often accepted. Often the same story is given to explain a series of injuries.

**Physical abuse may involve the following:**

- Hitting
- Shaking
- Slapping
- Punching
- Suffocating
- Stabbing
- Burning or scalding
- Female genital mutilation
- Prolonged deprivation of food or water
- Inappropriate restraint
- Giving a child alcohol or inappropriate drugs
- Fabricated & induced illness

**The following may indicate physical abuse;**

- Injuries that the child cannot explain, explains unconvincingly or have not been treated
- Bite marks or cigarette burns, bruising resembling hand or finger prints
- Blunt instrument marks or iron burns
- Immersion burns or scald marks
- Bruising in immobile babies

**Bruising in babies**

- In experience, immobile babies do not bruise themselves, bruising of any kind in an immobile baby should be questioned
- Parental explanations – fell on a plastic toy or slept on his dummy (a recent explanation for an injury) are often accepted. Often the same story is given to explain a series of injuries

## **Fabricated and Induced illness (FI)**

FI occurs when a caregiver misrepresents the child as ill either by fabricating, or much more rarely, producing symptoms and then presenting the child for medical care, disclaiming knowledge of the cause of the problem. Usually this is with the purpose of obtaining an emotional or psychological benefit.

- Usually this type of abuse is perpetrated by women, it is thought that it is a way of the carer getting their own needs met by the contact with medical staff
- Can be a very difficult category of abuse to work with and can cause children to have painful investigations
- Medical staff usually believe parents and will sometimes medicate on information from parents alone
- Behaviours can be life threatening i.e. suffocation (hard to judge when to stop), giving laxatives, putting their own blood in child's urine, underfeeding
- Children and young people can believe that they are ill

## **Neglect**

Neglect is the persistent failure to meet a child's basic physical and /or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance misuse. Once a child is born neglect may involve a parent or carer failing to provide adequate clothing, food/shelter (including exclusion from home or abandonment) or, failing to protect a child from physical harm or danger or ensuring adequate supervision including the use of inadequate care givers or failing to ensure access to appropriate medical care or treatment. It may also include neglect of unresponsiveness to a child's basic emotional needs.

### **Neglect may involve failing to provide:**

- Food and clothing, shelter including exclusion from home or abandonment
- Emotional warmth
- Access to health care
- Parental substance misuse
- Adequate supervision
- Protection from physical and emotional harm or danger

### **The following may indicate neglect of a child:**

- Unkempt
- Under /overweight
- Inappropriately dressed for conditions / age
- Untreated medical conditions
- Playing out late
- Hungry / stealing food
- Dirty / smelly? (consider circumstances)
- Untreated head lice
- Dental decay
- Speech disorders

## **Emotional Abuse**

Emotional abuse is the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to children that they are worthless or unloved, inadequate or valued only in so far as they meet the needs of the other person. It may include not giving the child opportunities to express their views, deliberately silencing them or making fun of what they say or how they communicate. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond the child's developmental capability, as well as overprotection and limitation of exploration and learning or preventing the child participating in normal social interaction. It may

involve hearing or seeing the ill treatment of another it may involve serious bullying including cyber bullying causing children frequently to feel frightened or in danger or the exploitation or the corruption of children. Some level of emotional abuse is involved in all types of mal treatment of a child, though it may occur alone.

**A child may believe they are:**

- Worthless
- Unloved
- Inadequate
- Experience attachment difficulties
- Inappropriate expectations may be imposed on a child

**The following may indicate emotional abuse of a child:**

- Physical, mental and emotional developmental delay
- Fear or over- reaction to mistakes, low self esteem
- Sudden speech disorders, speech delay or mutism
- Fear of new situations
- Inappropriate emotional responses to stressful situations
- Neurotic behaviour
- Self harming
- Running away, drug/solvent abuse
- Continually putting themselves down
- Frozen awareness
- Parents excessively negative towards child, highly critical/low warmth

**Sexual Abuse**

Sexual Abuse involves forcing or enticing a child or young person to take part in sexual activities not necessarily involving a high level of violence whether or not the child is aware of what is happening.

The activities may involve physical contact – including assault by penetration for example; rape or oral sex or non – penetrative such as masturbation, kissing, rubbing or touching outside of clothing. This may also include non contact activities such as involving children in looking at, or in the production of, sexual images, watching sexual activities or encouraging children to behave in sexually inappropriate ways or grooming a child in preparation for abuse (including via the Internet).

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

**Sexual abuse may involve the following:**

- Physical contact (Inappropriate touching)
- Penetrative sex
- Prostitution
- Use of pornographic material
- Use of internet
- Visual ie: television/videos

**Physical signs which may indicate sexual abuse:**

- Bites, slaps/grasp/punch marks
- Sexually transmitted infections
- Recurrent urinary tract infections
- Soreness or injury to genitals, anus, thighs, lower abdomen, buttocks
- Soreness in throat or mouth
- Vaginal bleeding / discharge

- Torn, stained or bloody underwear
- Pregnancy

**Emotional signs which may indicate sexual abuse**

- Sexual knowledge inappropriate for age
- Sexualised behaviour in young children
- Sudden changes in behaviour, running away, self harming
- Suicide attempts, night mares, bedwetting

**(Working Together 2013)**

**Sexual offences Act (2003)**

- The Sexual Offences Act makes “new provision about sexual offences, their prevention and the protection of children from harm from other sexual acts.

It states that:

- Rape includes penetration of the mouth as well as penetration of the vagina or anus or any other body orifice by the penis
- Any sexual intercourse with a child under 13 will be treated as rape and advice should be sought from the safeguarding team regarding **all** incidents of sexual activity where either of the children are under 13 years of age.

**Allegations Against Members of Staff**

Professionals can also abuse children that they come into contact with

Where allegations of child abuse are made against members of staff either in their home or work life, the situation requires sensitive but appropriate management. It is important to remember that the allegation will be investigated by other agencies outside of health and the Local Authority Designated Officer (LADO) will be consulted.

The procedure **must** be followed for all cases in which it is alleged that a person who works with children and vulnerable adults has: -

- Behaved in a way that has harmed or may have harmed a child;
- Possibly committed a criminal offence against or related to a child;
- Behaved towards the child or children in a way that indicates that he/she is unsuitable to work with children.

There may be up to three strands in consideration of an allegation:

- A police investigation of a possible criminal offence;
- Enquiries and assessment by Children’s Integrated Services about whether a child is in need of protection or in need of services;
- Consideration by an employer of disciplinary action in respect of the individual or notification to professional regulatory bodies.

Where there are concerns that a member of staff has behaved in such a way as to harm a child advice must be sought from the safeguarding team.

**For further information**

## Parental substance misuse

Almost one million children in the UK live with drug users. While not all drug-using parents mistreat their children, parental problematic substance misuse features in 20-70% of social workers' caseloads (Manning et al, 2009). Exposure to parental substance misuse does not always lead to poor outcomes for dependent children. However, parental substance misuse can harm children's development both *directly* through exposure to toxins in utero and through the effects of withdrawal at birth; and also *indirectly* through its impact on parenting capacity and the home environment in which children are brought up (Cuthbert, 2011)

## Domestic Abuse

Domestic abuse 'includes any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults or young people, who are or have been intimate partners, family members or extended family members, regardless of gender or sexuality'. This includes forced marriage, female genital mutilation, honour based abuse as well as elder abuse. (Working Together 2013)

An adult is a person aged 18 years and over. Abuse by a family member or others under the age of 18 is considered to be child abuse.

Domestic abuse is likely to have a damaging effect on the health and development of children, who are likely to suffer emotional and psychological maltreatment. The definition of 'harm' in the Children Act 1989 was amended in Section 120 of the Adoption and Children Act 2002 to include:

"Impairment suffered from seeing or hearing the ill-treatment of another"

Women are more likely to experience the more serious forms of domestic abuse but it is important to acknowledge that there are female perpetrators and male victims and domestic abuse occurs within same sex relationships. (Working Together 2013)

- Domestic abuse can pose a threat to an unborn child as assaults on pregnant women may involve kicks or punches to the stomach.
- Children may be greatly distressed by witnessing the physical and emotional suffering of another family member e.g. parent.
- Children may suffer injuries during domestic abuse episodes.
- Children can be used as shields during violent episodes.
- It can lead to behavioural, emotional and long-term developmental problems.
- It can result in antisocial behaviour such as bullying and criminal activity.
- Some adults suffering domestic abuse may struggle to look after their children.

Domestic abuse is a widespread and often hidden health problem and it can be difficult to assess its impact on victims. Health staff must be pro-active in tackling this issue.

- 22% of women and 14% of men report being the victim of domestic abuse
- 47% of female homicides were killed by present or previous partners compared to 8% of men
- 33.3% of all children on the child protection register/plan are affected by domestic abuse
- A woman is physically abused approx 35 times before she reports it to anyone
- It is estimated that 95% of all incidents are witnessed by children
- Children are more likely to be at risk of physical, sexual or emotional abuse from perpetrators of domestic violence. Perpetrators may abuse the child as part of their violence against women
- It is important to remember that such patterns of behaviour usually escalate over time, and become increasingly more threatening and more serious.

## **Risk factors in Domestic Abuse**

- Women separating from their partners are at much higher risk of domestic abuse
- Incidents occurring during pregnancy
- Escalation of violence, use of weapons, threats to kill
- Cultural factors
- Previous domestic abuse
- Stalking
- Sexual assault
- Minimizing by both / toxic trio/ multiple attendance at A&E for non specific illnesses (help seeking behaviour)

For more information please see CORP/PROC/073

## **Impact of Domestic Abuse on Children**

Children can experience both short and long term cognitive, behavioural and emotional effects as a result of witnessing domestic abuse. Each child will respond differently to trauma and some may be resilient and not exhibit any negative effects.

Children's responses to the trauma of witnessing DV may vary according to a multitude of factors including, but not limited to, age, race, sex and stage of development. It is equally important to remember that these responses may also be caused by something other than witnessing domestic violence, and therefore a thorough assessment of a child's situation is vital.

Children are individuals and may respond to witnessing abuse in different ways. These are some of the effects described in a briefing by the Royal College of Psychiatrists (2004):

- They may become anxious or depressed
- They may have difficulty sleeping
- They have nightmares or flashbacks
- They can be easily startled
- They may complain of physical symptoms such as tummy aches
- They may start to wet their bed
- They may have temper tantrums
- They may behave as though they are much younger than they are
- They may have problems with school
- They may become aggressive or they may internalise their distress and withdraw from other people
- They may have a lowered sense of self-worth
- Older children may begin to play truant or start to use alcohol or drugs
- They may begin to self-harm by taking overdoses or cutting themselves
- They may have an eating disorder

Children may also feel angry, guilty, insecure, alone, frightened, powerless or confused. They may have ambivalent feelings towards both the abuser and the non-abusing parent.

## Human Trafficking

What is human trafficking?

Human trafficking is the recruitment, movement, harbouring or receiving of children, women or men through the use of force, coercion, abuse of vulnerability, deception or other means for the purpose of exploitation.

Most children are trafficked for financial gain. This can include payment from or to the child's parents. In most cases, the trafficker also receives payment from those wanting to exploit the child once in the UK. Trafficking is carried out by organised gangs and individual adults or agents

Trafficked children may be used for:

- Sexual exploitation;
- Domestic servitude;
- Sweatshop, restaurant and other catering work;
- Credit card fraud, begging or pick pocketing or other forms of petty criminal activity;
- Agricultural labour, including tending plants in illegal cannabis farms;
- Benefit fraud;
- Drug mules, drug dealing or decoys for adult drug traffickers;
- Illegal inter-country adoptions.

### **Signs of trafficking for adults, children and young people include:**

- A person being accompanied by someone who appears controlling, who insists on giving information and coming to see the healthworker

### **The person:**

- Is withdrawn and submissive, seems afraid to speak to a person in authority and the accompanying person speaks for them
- Gives a vague and inconsistent explanation of where they live, their employment or schooling
- Has old or serious injuries left untreated. Has delayed presentation and is vague and reluctant to explain how the injury occurred or to give a medical history
- Is not registered with a GP, nursery or school
- Has experienced being moved locally, regionally, nationally or internationally
- Appears to be moving location frequently
- Their appearance suggests general physical neglect



- They may struggle to speak English
- In all cases, trust and act on your professional instinct that something is not quite right. It is usually a combination of triggers, an inconsistent story and a pattern of symptoms that may cause you to suspect trafficking

**If you have *any* concerns about a child, young person or adult take immediate action to ask further questions and seek out additional information and support.**

Do not raise your trafficking concerns with **anyone** accompanying the person

#### **Remember:**

- Trafficked people may not self-identify as victims of trafficking
- Trafficking victims can be prevented from revealing their experience to health care staff from fear, shame, language barriers and a lack of opportunity to do so. It can take time for a person to feel safe enough to open up
- Err on the side of caution regarding age - if a person tells you they are under 18 or if a person says they are an adult, but you suspect they are not, then take action as though they were under 18 years old
- Support for victims of human trafficking is available

#### **Female Genital Mutilation (FGM)**

Female genital mutilation (FGM) is also known as female circumcision or female genital cutting, and in practising communities by local terms such as “tahor” or “sunna”. It is the collective term used for procedures which include the partial or total removal of the external female genital organs for cultural or other non therapeutic reasons. It is a form of child abuse which can have devastating physical and psychological consequences for girls and women. The World Health Organisation describes it as:

“Procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons” (WHO,2013).

Since 1985 it has been a serious criminal offence under the Prohibition of Female Circumcision Act to perform FGM or to assist a girl to perform FGM on herself. In 2003, the Female genital Mutilation Act tightened this law to criminalise being carried out on UK citizens overseas. Anyone found guilty of the offences a maximum penalty of 14 years in prison.

#### **Prevalence**

Whilst accurate data on the numbers affected by FGM in England is lacking, there are some communities in this country where FGM is comparatively common. FGM is prevalent in 28 African countries as well as in parts of the Middle East and Asia. It is estimated that over 20,000 girls under the age of 15 are at high risk of FGM in the UK and that around 66,000 women in the UK are living with the consequences, although its true extent is unknown. The age at which girls undergo FGM varies enormously according to the community. The procedure may be carried out when the girl is newborn, during childhood or adolescence, just before marriage or during the first pregnancy. However, the majority of cases of FGM are thought to take place between the ages of 5 and 8 and therefore girls within that age bracket are at a higher risk

Health staff must have an awareness and understanding of FGM and know what to do if they come across it. In cases involving children they must follow the Pan–Lancashire Safeguarding Children Procedures

<http://www.lancashire.gov.uk/corporate/web/view.asp?siteid=3829&pageid=20741&e=e>

## **Prevent**

### **Reducing risk of radicalisation and terrorism**

Prevent strategy aims to stop people becoming terrorists or supporting terrorism.

- To prevent people from being drawn into terrorism and ensure that they are given appropriate advice and support.
- To work with sectors and institutions where there are risks of radicalisation that we need to address.
- Prevent is part of existing safeguarding responsibilities for the health sector, not an additional job.
- Healthcare workers have the opportunity to refer vulnerable individuals for support in a pre-criminal space by:
  - Recognising vulnerable adults, children and young people who may be at risk of radicalisation;
  - Working in partnership to reduce risk and protect the individual and
  - Providing adequate and necessary support as part of a proportionate multi-agency response to any concerns.

### **Vulnerability factors**

- Radicalisation is a process, not one off event.
- There is no single profile of a terrorist – there is no checklist to measure someone against.
- This is not about race, religion or ethnicity - the programme is to prevent the exploitation of susceptible people

There are many factors that could make somebody susceptible to radicalisation.

It is about early intervention to protect and divert people away from the risk they face before illegality occurs. It should not be assumed that the characteristics set out on a slide necessarily indicate that a person is either committed to terrorism or may become a terrorist. The assessment framework involves three

dimensions: engagement, intent and capability, which are considered separately. (from Channel Vulnerability Assessment Framework )

### **Engagement**

- Feelings of grievance and injustice
- Feeling under threat
- A need for identity, meaning and belonging
- A desire for status
- A desire for excitement and adventure
- A need to dominate and control others
- Susceptibility to indoctrination
- A desire for political or moral change
- Opportunistic involvement
- Family or friends involvement in extremism
- Being at a transitional time of life
- Being influenced or controlled by a group
- Relevant mental health issues

### **Intent**

- Over-identification with a group or ideology
- Them and Us' thinking
- Dehumanisation of the enemy
- Attitudes that justify offending
- Harmful means to an end
- Harmful objectives

### Capability

- Individual knowledge, skills and competencies
- Access to networks, funding or equipment

### Recognise, Understand and Share Concerns

You could reduce the risk of someone being exploited by radicalisers and subsequently drawn into terrorist-related activity.

Report any Prevent related concerns to:

- Hazel Gregory Tel 01253 951262 or Robert Ward Tel 01253 953665
- Safeguarding Team Tel 01253 951262

### Further guidance available

'Building Partnerships, Staying Safe' Department of Health guidance for staff and organisations

<https://www.gov.uk/government/publications/building-partnerships-staying-safe-guidance-for-healthcare-organisations>

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/215253/dh\\_131912.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215253/dh_131912.pdf)

### Internet Safety- CEOP (Child Exploitation and Online Protection)

#### CEOP works across the UK to

- Maximise international links to tackle child sex abuse wherever and whenever it happens.
- Provides internet safety advice for parents and carers
- Provides information on internet safety and safe surfing for young people aged 11 to 16 years
- Reporting facility enabling anyone to report any inappropriate or potentially illegal activity with or towards a child online

## DO YOU KNOW WHO YOUR CHILD IS TALKING TO ?

Hi, you sound really cute, how old are you, what do you do after school?



**“I’m 14, a bit of a fitness fanatic and I often go power lifting after school.”**



**99% of children aged 8 – 17 access the internet**

**90% of children 5 – 16 now have a computer at home (Ofcom, 2008)**

**74% have internet access at home**

**98% have access somewhere**

**24% have broadband at home**

**22% of boys and 19% of girls had internet access in their bedroom**

**24% rely on school as main source of internet access**

**At home less than half of the computers were located in a public place. (Safekids.co.uk)**

427 children were subject to safeguarding or protection as a result of CEOP in 2011/2012

Children and young people are not always aware of the risks associated with the internet and social network sites. Parents can also be totally perplexed by the digital world and what their children are accessing.

- Most mobile phones now have internet access which can make children and young people even more vulnerable to the risks of grooming by perpetrators and sites that are not suitable.
- Children under the age of 13 years should not have access to Facebook, and there are systems in place to prevent people under the age of 13 having accounts.
- Young people can develop on line friendships with people that are not known to them placing them at risk of grooming. Sex offenders often take advantage of a young person’s trusting nature and use a range of sophisticated techniques to make contact and establish relationships on line.
- Children and young people are put at further risk if they meet up with people they have met on line.
- Children and young people are not always aware that the internet is a public place and they must be careful about revealing too much personal information about themselves online. This can include the school they attend, their address, 43% of teenagers believe that is completely safe to post personal information on line (Microsoft 2010)
- Children and young people can be exposed to sites that are not age appropriate if they lie about their age e.g.; gaming sites.
- Children and young people need to be aware of the consequences of sharing intimate or nude images online or via their mobile known as sexting.

## **Sexual Exploitation**

Sexual Exploitation of children & young people under 18 involves exploitative situations, contexts and relationships where young people (or a third person or persons) receive “something” (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of them performing, and / or another performing on them, sexual activities.

CSE can occur through the use of technology without the child’s immediate recognition ; for example being persuaded to post sexual images on the internet/mobile phones without immediate payment or gain. In all cases, those exploiting the child have power over them by virtue of age, gender, intellect, physical strength and/or economic or other resources. Violence, intimidation and coercion are common, involvement in exploitative

relationships being characterised in the main by the child or young person's limited availability of choice resulting from their social/economic and or emotional vulnerability

### **Sexual Exploitation Risk Indicators**

- Homelessness
- Financial necessity
- Drug/Alcohol abuse
- Previous abuse
- Estrangement from family
- Low self esteem
- Children in Public Care
- Out of School
- Social isolation
- Attachment issues, unmet needs?

### **Patterns of behaviour**

- Links with older men, older boyfriends
- Secretiveness & hostility
- Running away, staying out at night
- Not attending school
- Increase in health problems and self harm
- Possession of unexplained money, clothing, goods
- Excessive number of condoms
- Reports of child being seen in areas known to be used for sexual exploitation
- Association with adults/children known to be used for sexual exploitation
- Physical symptoms

### **Risks from sexual exploitation**

- Risks to physical, psychological & emotional health
- Criminal behaviour, drug and alcohol misuse and violence
- Higher incidence of murder associated with prostitution
- Vulnerable to other violent acts such as rape, physical and sexual assaults and coercion into pornography
- Increased likelihood of sexually transmitted diseases, including HIV.
- Physical injuries, non-attendance at school and/or under achievement, depression, self-harm, attempted and actual suicide

### **Serious Case Reviews**

When a child dies and abuse or neglect is known or suspected a SCR will be undertaken  
SCR's will also be considered if:

- A child suffers serious injury through suspected abuse or neglect
- A child has been subject to serious sexual abuse
- A child has been killed by a parent with a mental illness
- The purpose of the review is to identify lessons to be learned. It is not an inquiry into how the child died or who is responsible. That remains a matter for the Coroners and criminal courts
- Where a case does not reach the threshold for a Serious Case Review the LSCB or the organisation then selves could conduct a Internal management review regarding the case

## **Child Death Overview Panel**

The death of all children under the age of 18 must be reviewed by a Child Death Overview Panel on behalf of the Local Safeguarding Children Board. The Child Death Overview Panel in this area covers Lancashire and Blackburn with Darwen Safeguarding Children Board. The Child Death Overview Panels are groups of professionals who meet several times a year to review all the child deaths in their area. The Panel is not given the names of any children who died; all the details are dealt with anonymously. The main purpose is to learn how to prevent future deaths. The Panels make recommendations and report on the lessons learned to the Local Safeguarding Children Board. The Board produces an annual report which is a public document. Anyone can read the report, but it contains no details that could identify an individual child or their family.

## **Record Keeping in Child Protection**

Record keeping is an integral part of a health professional's professional practice and as such, it should inform all aspects of the care process (General Medical Council 2006, General Dental Council 2005, Health Professionals Council 2004 and Nursing and Midwifery Council 2004 and 2007). Accurate record keeping is fundamental to providing high quality patient care through effective communication with patients and health professionals within the multidisciplinary team and must differentiate between fact and opinion

Lord Lamings report into the death of Victoria Climbié (2003) in recommendation 12 stated: -

“Front-line staff who regularly come into contact with families with children must ensure that on each new contact, basic information about the child is recorded. This must include the child's name, address, age, the name of the child's primary carer, the child's GP and the name of the child's school if the child is of school age”.

Laming (2003) also recommended that there is only one set of health records kept for each child. This is something we need to be working towards. All children's records should clearly indicate which other health professionals are involved with the child and a chronology of significant events form must be maintained and updated in all records.

The results of inadequate record keeping can be catastrophic for both clients and professionals, particularly in relation to safeguarding issues.

## **What to do if you suspect child abuse or neglect?**

It is the responsibility of any person who has knowledge of or suspicion that a child is suffering, or is at risk of suffering significant harm due to abuse, to refer their concerns to the social services department or the police (the police in cases of emergency). Dependant on your role within the organisation concerns may be discussed with your line manager or the child protection team prior to the referral being made, providing this does not cause delay. Familiarise yourself with the Safeguarding Children Procedures and know who to contact if you need support or advice.

**For advice please contact the Safeguarding Team: 01253 651265  
01253 955444  
01253 951457  
01253 957592**

## Information Sharing

“No enquiry into a child’s death or injury has ever questioned why information was shared. It has always asked the opposite”

(Georgina Nunney – Solicitor Lewisham **Making it Happen ECM** 2008).

Golden rules for information sharing remember that Data Protection Act is not a barrier to sharing information

- The Data Protection Act is not a barrier to sharing information
- Be open and honest
- Seek advice where in doubt
- Share with consent where appropriate
- Consider safety and well being
- Necessary, proportionate, relevant, accurate, timely and secure
- Keep a record

(Pocket Guide to Information Sharing HM Gov 2008)

The consequence of not sharing relevant information can be that a child is left in a unsafe/risky/dangerous situation. If you are unsure of what information you can share please contact the Safeguarding Team

## How to make a referral to Children’s Social Care where a child is in need of protection (Section 47 referral) (See flow chart)

- Have the facts ready and to hand
- May need to gather information from other professionals or agencies
- Determine if a child in need of protection or need of services
- Seek advice from Safeguarding team if unsure
- Use the correct form
- Follow the BtHFT procedures
- Be clear and succinct

**If staff feel that their concerns are not being taken seriously or they experience any other barriers to referring a child/family please contact the safeguarding team**

## MAKING A SECTION 47 REFERRAL

Practitioner has reasonable cause to suspect that a child is suffering or likely to suffer, significant harm  
**SECTION 47 referral required**

Good practice to gain consent from parent / carer, unless to do so would further endanger the child or practitioner. Do not involve the parents / carer in cases of Fabricated and Induced Illness (FII) and in some cases of sexual abuse, please seek advice from the safeguarding.

### For children residing within North Lancashire boundaries telephone:-

Contact the Contact Centre and Referral Team by telephone on:-

**08450 530 009 between 8.45am and 5.00pm**

**0845 6021043 Out of office hours and at weekends**

A Central Customer Care Officer will take the initial call and record preliminary details. A Social Worker from the Contact and Referral Team will be available to discuss the case if required.

Offer a clear, concise account of concerns about the child's welfare specifying whether these require urgent action to safeguard the child.

**Completed referral forms should be forwarded to Social Care WITHIN 48 HRS by either**

**FAX: 01772 538223**

**Or by**

**SECURE E-MAIL** which can be set up through the following link

<http://securemail.lancashire.gov.uk> (support for technical problems with this process 01772 532626)

### For children residing within Blackpool boundaries:-

Contact Children's Social Care on telephone - **01253 477299**

For Out of Office Hours and at weekends ring **01253 477600**

A Duty Social Worker will record the details of the referral. Provide a clear, concise account of concerns about the welfare specifying whether these require urgent action to safeguard the child.

**Completed Referral forms to be sent within 2 working days to:-**

Duty and Assessment Team, Blackpool Social Services Department, South King Street, FY1 4TR

**If a medical assessment of the child is necessary Children's Social Care either Blackpool or Lancashire will arrange for this to be completed.**

If the referrer has not been informed of the outcome of the referral within 48 hours, the referrer must contact Children's social care/ integrated services to determine the outcome of the referral.

A copy of the referral form should be held within the child's records

Liaise with other health professionals (including the GP) known to have involvement with the child or family and inform them of the referral.

**Any concerns relating to a response from children's social care / integrated services should be discussed with the safeguarding team.**



# Assessment

## Safeguarding Children (Level 2)

### 1. Which categories of abuse can a child be placed on a Child protection Plan under?

- (a) Physical Abuse, Neglect, Sexual Abuse, Emotional Abuse
- (b) Physical Abuse, Neglect, Financial Abuse, Emotional Abuse
- (c) Physical Abuse, Bullying, Financial Abuse, Neglect
- (d) Financial Abuse, Neglect, Emotional Abuse, Sexual Abuse

### 2. Where will you find the organisations Internal Safeguarding Children Procedures?

- (a) On the internet
- (b) On the Intranet

### 3. What is private fostering?

- (a) A private arrangement between a child's parents and anyone who looks after their child for 28 days or more where the child lives with the carer
- (b) A private arrangement between parents and grandparents who look after their child for 28 days or more where the child lives with the grandparents
- (c) A arrangement where a child attends a private nursery
- (d) A private arrangement between a child's parents and someone who is not a close relative to care for the child for 28 days or more where the child lives with the carer

### 4. What is Filicide/Suicide?

- (a) Where a parent kills their child/ren and either the other parent or themselves
- (b) Where a mother kills their child
- (c) Where a father kills their child
- (d) Where on parent kills the other parent

### 5. Which of the following groups are more vulnerable to child abuse

- (a) Domestic Violence
- (b) Teenage/young parents
- (c) Where a parent has a mental illness
- (d) Substance misuse (drugs or alcohol)
- (e) Learning Disability
- (f) Children Looked After
- (g) All of the above

### 6. What % of children on a Child Protection Plan are affected by Domestic Abuse

- (a) 10.2%
- (b) 15.6%
- (c) 33.3%
- (d) 48.7%

### 7. What is the main reason children are Trafficked

- (a) Financial Gain
- (b) To return then to their family
- (c) To remove them to a place of safety
- (d) To remove them from danger

**8. The prevent strategy aims to**

- (a) Stop children being abused
- (b) Stop people becoming terrorists or supporting terrorism
- (c) Stop domestic abuse
- (d) Stop sexual exploitation

# Safeguarding Children (Level 2) Completion Statement

PLEASE only sign and return when you are satisfied that your staff member has completed all of the relevant mandatory units and correctly answered questions.

A PHOTOCOPY of this completion statement ONLY, MUST be sent to Learning and Development. This is for input on to the Trusts Central Training Data Base (OLM) as evidence that your staff member has completed the Mandatory Training Assessment Pack.

A further copy should be placed in your staff members personal development file.

This is to confirm the Mandatory Training Assessment has been completed by:

Surname: (Block Capitals)

.....

Forename: (Block Capitals)

.....

Job Title: .....

Department/Ward:.....

Division/Directorate:.....

Date Completed: (This must be within 12 weeks of receipt) .....

Staff Signature: .....

Manager: (Printname) .....

Manager:( Signature) .....

**Return a copy to Learning and Development, Blackpool Teaching Hospitals,  
Learning and Development Department, Blackpool Stadium, Seaside Way, Blackpool, FY1 6JX**

**An electronic copy can be emailed to: [olm@bfwhospitals.nhs.uk](mailto:olm@bfwhospitals.nhs.uk)**

Date Sent: .....

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