Hampshire, Isle of Wight, Portsmouth and Southampton (HIPS) Local Safeguarding Children Partnerships (LSCPs)

Guidelines for Practitioners who have a direct working relationship with a child who discloses abuse

1. Introduction

Children (referring to all those under the age of 18 years) who have a direct working relationship with any practitioner may disclose recent, or historic abuse. For many practitioners additional guidance is not required, but for some practitioners who are working closely with the child, for example CAMHS practitioners; a disclosure can cause anxiety as the child may be at risk of significant harm due to their own mental ill-health. Therefore, the decision to share information requires the practitioner to assess the level of risk faced by the child (including harm to themselves) and any other children who may be at risk from a potential perpetrator of abuse.

Practitioners need to be clear and confident in their management of such disclosures both in circumstances where consent to share information related to the abuse is given by the child and also when consent to share is refused. In addition, there may be cases where a disclosure is made to a practitioner but the child does not have competence (Gillick competence) or the mental capacity (under the Mental Capacity Act, 2005) to consent.

The following guideline sets out key points and principles for practitioners to underpin this complex area of work and offers a flow chart (see Appendix B) to aid clear decision making. It is noted that circumstances where consent from the child is **not** given to share information, or consent cannot be obtained or given, should be few in number.

Confidence in the ability of other agencies to act and respond to risk appropriately should underpin all decision making. A lack of confidence **must not** be used as a reason for not sharing information and for not making referrals.

2. Key Points

I. Risk can only be effectively managed through agencies sharing information. No one agency or practitioner can know, or understand all

risks related to a child's circumstances nor recognise the risks to others which a specific child's experiences may imply.

II. Any therapeutic relationship should be clear about the boundaries of confidentiality from the outset: Information which indicates risk to the child or others, cannot be treated as confidential and must be shared.

III. The default position is any abuse, current or historic, should be referred to Children's Services and the police through the normal referral channels (CRT /MASH). The child's consent should have been sought to do so. This includes historical abuse where the family may have been aware but have chosen not to report.
Note: If the child or family/carer report the abuse has previously been referred an information check should be conducted with the local children services department to confirm the abuse has been reported. This is to ensure that the appropriate action has taken place and there is not additional information now available that was previously not known.

IV. If consent to share is not given, a referral should still be made, to protect other potential victims (see point I). Practitioners should consider whether 'sharing the information could prevent further serious crime'?

V. In circumstances where it is judged that sharing information might place the subject child at risk of significant harm through their own actions, a case discussion should take place. The discussion should inform decision making about how the information should be shared, balancing the risks to the individual child, to others and/or to the wider community.

VI. This case discussion will involve as a minimum the practitioner working with the child, their manager, safeguarding lead, the service clinical lead. Head of service advice should be sought from the agency designated safeguarding lead.

VII. When a referral is made where consent is not given the 'Fabricated and Induced Illness' ('FII') model of covert referral and investigation may need to be followed. This should be guided by multi-agency discussion (see Appendix A). Such discussion about investigation should as a minimum involve the therapeutic provider, Children's Services and police in line with normal section 47 (Children Act, 1989) processes.

VIII. All decisions regarding referrals should be fully recorded within the child's records and include the underpinning rationale and the record of discussion which led to the decision.

IX. If a child is unable to consent to information being shared (rather than chooses not to give that consent) due to age, understanding or mental well-being a referral should still be made. Reference to mental capacity

and Gillick competence should be made to guide best interest decision making in such circumstances.

X. Where a referral is made without the child's consent the referrer must clearly state the reasons why. The referral should include the assessed risks to the child should they become aware that a referral has been made without their consent.

XI. For any referrals made without the child's consent or knowledge practitioners should inform the child a referral was made as soon as it is judged safe and appropriate to do so.

Appendix A – Extract from Government Guidance regarding Fabricated and Induced Illness

a) Extract from Government Guidance '**Safeguarding Children in whom illness is fabricated or induced'** (DCSF, 2008)

4.16. ….While professionals should seek, in general, to discuss any concerns about a child's welfare with the family and, where possible, seek their agreement to making a referral to children's social care, **this should only be done where such discussion and agreement-seeking will not place a child at increased risk of significant harm** (see paragraph 5.16, Working Together). Decisions should be agreed between the referrer and the recipient of the referral, in line with HIPS LSCP safeguarding children procedures, about what the parents *(in this case 'child')* will be told, by whom and when.

Glossary

CRT- Childrens reception team

LSCP local safeguarding children partnership

MASH- Multi agency safeguarding hub

References

Children Act (1989) London: The Stationary Office

Department of Health (2005). Mental Capacity Act. London: The Stationary Office

Department of Children Schools and Families (2008) *'Safeguarding Children in whom illness is fabricated or induced'* London: The Stationary Office

Appendix B – Flow chart for the management of disclosures of abuse