



Royal College  
of Nursing

# Safeguarding children and young people – every nurse's responsibility

*RCN guidance for nursing staff*





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# Safeguarding children and young people – every nurse’s responsibility

## RCN guidance for nursing staff

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## Introduction

This guidance is for all nurses, not just those whose work focuses on safeguarding children. Whether you work directly with children and young people or with adults whose lives impact on children, what you see – and what you do about it – can make all the difference. This guidance recognises that children are best protected when professionals are clear about what is required of them and how they need to work effectively with staff in other partner agencies.

There is no single law that defines the age of a child across the UK. England, Wales, Northern Ireland and Scotland each have their own guidance setting out the duties and responsibilities of organisations to keep children safe, but all agree that child protection legislation and guidance applies to children until they reach their 18th birthday. In this publication the term 'children and young people' applies to anyone who has not yet reached their 18th birthday.

This is not comprehensive guidance. The purpose of the publication is to highlight the issues that will enable you to recognise the warning signs of abuse. It also indicates when and how you should seek further information, training, support and advice in your organisation. The Department for Education and Skills' guidance *What to do if you think a child is being abused* (DfES, 2006) is extremely helpful.

## Learning from experience

'Professionals and organisations protecting children need to reflect on the quality of their services and learn from their own practice and that of others... Conversely, when things go wrong there needs to be a rigorous, objective analysis of what happened and why, so that important lessons can be learnt and services improved to reduce risk future harm to children.'

*Working together to safeguard children* (HM Gov, 2013)

In England each Local Safeguarding Childrens Board (LSCB) is required to maintain a local learning and improvement framework to enable this to happen: in Northern Ireland, case management reviews are undertaken; in Scotland, significant case reviews take place; while in Wales, this is achieved through child practice reviews. While many children are abused, specific cases have resulted in widespread governmental action on safeguarding. One such case in England was that of Peter Connolly who, during the last month of his life, was presented to health professionals eight times, and in his last week was seen by a social worker and a paediatrician. The view of the SCR (serious case review) panel was that:

'Everybody working as 'safeguarders' in the safeguarding system, especially those working in the universal services provided by health...needs to become more aware of the authority in their role, and to use it to safeguard the children as well as to support parents. The mode of relationship with parents, especially on first meeting them, needs to be observing and assessing as well as helpful. Those agency roles which are the protectors – doctors, lawyers, police officers and social workers – need to become much more authoritative both in the initial management of every case with child protection concerns, and in the subsequent child protection plan. It is crucial to be sceptical of the accounts which are given for any maltreatment of the children, and they should be tested thoroughly against the facts.'

*Executive summary of the second serious case review on the death of Peter Connolly*, Haringey Local Safeguarding Children Board (2009)

This case prompted the *Munro review of child protection* (DfE, 2011), a key recommendation of which was that there should be ‘a radical reduction in the amount of central prescription to help professionals move from a compliance culture to a learning culture, where they have more freedom to use their expertise in assessing need and providing the right help.’

Similarly, the findings of a case management review of the deaths of Madeleine and Lauren O’Neill (WHSSB and EHSSB, 2008) in Northern Ireland included a range of national and local organisational recommendations.

All UK countries have a process of producing composite learnings from reviews.

## Maltreatment of children – the facts

UK statistics make grim reading. The National Society for the Prevention of Cruelty to Children (NSPCC) estimates that approximately 50,500 children in the UK are known to be at risk of abuse. Latest available figures show that there were 50,573 children on child protection registers or the subject of child protection plans in the UK as at 31 March 2012 (or 31 July 2012 in Scotland).

The UK country breakdowns are as follows:

England	42,850
Northern Ireland	2,127
Scotland	2,706
Wales	2,890

The findings of a recent UK-wide research report into child abuse and neglect (NSPCC, 2011) included:

### Severe maltreatment

- One-in-four young adults (25.3 per cent) had been severely maltreated during childhood.
- Around one-in-five (18.6 per cent) children aged 11-17 have been severely maltreated.
- One-in-seven young adults (14.5 per cent) had been severely maltreated by a parent or guardian during childhood.
- More than one-in-eight children aged 11-17 (13.4 per cent) have experienced severe maltreatment by a parent or guardian.

### Sexual abuse

- One-in-20 children (4.8 per cent) have experienced contact sexual abuse.
- Over 90 per cent of children who experienced sexual abuse were abused by someone they knew.
- More than one-in-three children (34 per cent) who experienced contact sexual abuse by an adult did not tell anyone else about it.
- Four-out-of-five children (82.7 per cent) who experienced contact sexual abuse from a peer did not tell anyone else.

## Physical violence

- One-in-nine young adults (11.5 per cent) had experienced severe physical violence during childhood at the hands of an adult.
- One-in-14 children aged 11-17 (6.9 per cent) have experienced severe physical violence at the hands of an adult.

## Neglect

- Neglect was the most prevalent type of maltreatment in the family for all age groups.
- One-in-six young adults (16 per cent) had been neglected at some point in their childhood and nearly one-in-ten (nine per cent) had experienced severe neglect.
- One-in-seven children aged 11-17 (13.3 per cent) have been neglected. Almost one-in-ten (9.8 per cent) have experienced severe neglect.

## Emotional abuse

- One-in-14 young adults (6.9 per cent) experienced emotional abuse during childhood.
- One-in-14 children aged 11-17 (6.8 per cent) have experienced emotional abuse.

## Experiencing domestic abuse

- Nearly one-in-four young adults (23.7 per cent) were exposed to domestic violence between adults in their homes during childhood.
- Just under one-in-five children aged 11-17 (17.5 per cent) have experienced domestic violence between adults in their home.
- More than one-in-five children aged 11-17 (22.9 per cent) who were physically hurt by a parent or guardian did not tell anyone else about it.

Child maltreatment does not just happen in certain socio-economic groups within deprived inner cities; it can happen in any family and to any child or young person. Professionals and services often focus on babies and younger children but adolescents can be neglected too (Rees et al., 2011); 23 per cent of the serious case reviews undertaken in 2009/10 related to young people over 11 years of age. Reviews and inquiries into such cases often identify the same concerns (DfE, 2012):

- poor communication and information sharing between professionals and agencies
- inadequate training and support for staff
- failure to listen to children.

**Nurses are well placed to identify children and young people who may be at risk and act to safeguard their welfare.**

## Key principles

Effective safeguarding arrangements in every local area should be underpinned by two key principles:

- safeguarding is everyone's responsibility - for services to be effective each professional and organisation should play their full part
- a child-centred approach – for services to be effective they should be based on a clear understanding of the needs and views of children.

'Providing early help is more effective in promoting the welfare of children than reacting later. Early help means providing support as soon as a problem emerges, at any point in a child's life, from the foundation years through to the teenage years.'

(DfE, 2013)

In England, each LSCB is required to publish a threshold document which sets out the process for early help assessment, the type and level of early help services to be provided, and the criteria – including the level of need – for a case to be referred to the local authority for statutory services under the Children Act 1989. Detail of legislation relating to the safeguarding and promoting the welfare of children (including children in need and Section 47 enquiries) can be found in Appendix B of *Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children* (DfE, 2013) which is available at [www.education.gov.uk](http://www.education.gov.uk)

The 1001 critical days cross party manifesto (2013) demonstrates the widespread acceptance of the important link between early brain development in babies and future emotional and mental health, and draws attention to the need for early intervention if this development is being affected.

No single professional can have a full picture of a child's needs and circumstances. If children and families are to receive the right help at the right time, everyone who comes into contact with them has a role to play in identifying concerns, sharing information and taking prompt action.

To be effective, safeguarding systems should be child-centred. All too often, failings occur as a result of losing sight of the needs and views of the children within them, or placing the interests of adults ahead of the needs of children.

## Identifying a vulnerable child

'Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting; by those known to them or, more rarely, by a stranger.'

(DfES, 2006)

There are factors that indicate a child could be vulnerable. Here are some of the warning signs to look out for:

- younger children, particularly infants, and especially those who are admitted to a neonatal intensive care unit (Feldman and Rotenberg, 2004; Findler et al., 2004) as the separation this involves can lead to delayed attachment and make the psychological adjustment to parenthood more difficult and the babies can be more difficult to care for; multiple births (Fisher, 2006; Groothuis et al., 1982; Pector, 2004; Taubman-Ben-Ari and Findler, 2010; Tanimura et al., 1990) because of the practical and financial demands placed on parents; children who have a language or learning disability or physical disabilities (DfE, 2009a) are more vulnerable than those who can communicate their distress clearly
- family and social factors including poverty, homelessness, domestic violence, drug or alcohol abuse, parents with gambling, animal abuse and mental health problems
- looked after children and those who are held in criminal justice settings; for example, a survey (Carnie and Broderick, 2011) in a youth offenders institution revealed that 13 per cent of young offenders reported fearing for their safety and one-in-ten reported being bullied in the month before the survey; a recent report has identified children and young people who go missing from care as at risk of sexual exploitation (Berolowitz et al., 2012).

**Vulnerable children** often live in circumstances where they are exposed to specific forms of abuse which may include:

- peer abuse and bullying (including cyber bullying)
- domestic abuse and violence (including forced marriage and honour-based violence)

- abuse linked to spiritual or religious beliefs
- internet pornography
- child trafficking and abduction
- domestic servitude.

**Vulnerable groups are children and young people:**

- with links to gangs
- who run away
- who are excluded from school, go missing from school, or who are school refusers
- who are privately fostered (an arrangement made without the involvement of the local authority for the care of a child under 16 or 18 if disabled, by someone other than a parent or close relative for 28 days or more in the carer's home)
- with mental health problems such as self harming and suicidal ideation
- who are young carers
- who are looked after by the local authority, and especially those who go missing from care
- who have been sexually abused through the misuse of technology, coerced into sexual activity by criminal gangs or victims of trafficking. They are all vulnerable to child sexual exploitation (CSE), a form of sexual abuse that involves the manipulation and/or coercion of young people under the age of 18 into sexual activity in exchange for things such as money, gifts, accommodation, affection or status. The manipulation or 'grooming' process involves befriending children, gaining their trust, and often feeding them drugs and alcohol, sometimes over a long period of time, before the abuse begins. The abusive relationship between victim and perpetrator involves an imbalance of power which limits the victim's options. Sexual exploitation is often linked to other issues, therefore young people should receive a holistic assessment of their needs
- who are unaccompanied asylum seekers; in other words they are under 18 years of age, are seeking asylum but not living with their parents, relatives or guardians in the UK.

## The signs of harm

There are signs of harm that nurses must learn to recognise in the care of children and in their work with adults who may pose a potential risk to their own children or other children's welfare and safety. The following sections highlight what those signals are, and what you should look out for.

# What is abuse and neglect?

The forms of abuse and neglect as defined in the Department for Education statutory guidance *Working together to safeguard children* (2013), and in similar documents produced by other countries of the UK, are:

## Physical abuse

This 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.

## Emotional abuse

The persistent emotional maltreatment of a child so as to cause severe and persistent adverse effects on the child's emotional development. This may involve:

- conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person
- 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
- seeing or hearing the ill-treatment of another
- serious bullying (including cyber bullying) causing children frequently to feel frightened or in danger, or the exploitation or corruption of children.

Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.

## Sexual abuse

Involves forcing or enticing a child or young person to take part in sexual activities, including prostitution, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (rape, buggery or oral sex) or non-penetrative acts. They may include non-contact activities such as involving children in looking at, or in the production of,

sexual online 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 also commit acts of sexual abuse, as can other children.

## Neglect

The persistent failure to meet a child's basic physical and/or psychological needs that is 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 abuse.

Once a child is born, neglect may involve a parent or carer failing to:

- provide adequate food, clothing and shelter (including exclusion from home or abandonment)
- protect a child from physical and emotional harm or danger
- ensure adequate supervision (including the use of inadequate care-givers)
- ensure access to appropriate medical care or treatment.

It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

# The signs of child abuse

All nurses need to be aware of the potential signs of child abuse. Common indicators of abuse and neglect include:

- physical signs such as hand-slap marks, bruising in unusual areas, bruised eyes, bite marks
- poor physical care and inadequate hygiene, inappropriate dress or failure to seek appropriate health care/repeated missed appointments/cancellations and failed access visits
- unrealistic parental expectations and over protection of a child
- poor school attendance not justified on health (including mental health) grounds
- a child's behaviour may also indicate that they have been abused; for example, the child may show fear of adults or a fear of certain adults when they approach them, display aggressive behaviour or deliberate self harm and substance abuse
- the story provided by the adult might be inconsistent with any injuries
- the child may have repeatedly attended a health care organisation with different types of injuries in a short period of time or presented in a variety of health care settings
- a parent or caregiver may be thought to be fabricating or inducing illness (DfE, 2008).

It is important to listen to the child and see them on their own if this is appropriate.

**There is no one definitive sign, symptom or injury. A series of seemingly minor events can be just as damaging as any one event.**

The NICE clinical guideline *When to suspect child maltreatment* (NICE, CG89) sets out the alerting features of maltreatment and is a key tool to help identify it (available online at [www.guidance.nice.org.uk](http://www.guidance.nice.org.uk)).

## Think family

Families have a range of needs and from time to time will require support or services to help meet them.

Difficulties that impact on one family member will inevitably have a knock on effect on other family members. For this reason all practitioners should 'think family'.

In a system that 'thinks family', both adults and children's services should:

- have no wrong door – help should be accessible no matter how the family tries to access it
- look at the whole family
- build on family strengths
- provide support tailored to need.

Individual practitioners working with either children or adults or both should:

- ensure they know who has parental responsibility
- ensure they know who is living with the child/children
- consider the involvement, potential contribution and (when appropriate) the risks associated with all the adults who have a significant influence on a family, even if they are not living in the same house, or are not formally a family member
- have ready access to information to enable themselves and other practitioners to consider the impact of parents/carers' condition, behaviour, family functioning and parenting capacity
- identify and provide responsive services for families that are family focused.

**Always prioritise the safety and welfare of children within a family** (NHS Midlands and East Midlands Safeguarding Children Network, 2012).

# Prevent

The government's *Prevent strategy* (2011) for counter terrorism includes a focus on working with vulnerable individuals who may be at risk of being exploited by radicalisers and subsequently drawn into terrorism related activity. It is important that, should you be concerned that any individual you are in contact with may be being exploited in this way, you report your concerns according to your organisation's policy and discuss them with your named nurse.

# Your role and responsibilities

## **As a nurse you must be able to demonstrate the following core competences:**

- use professional and clinical knowledge and understanding of what constitutes child maltreatment, to identify any signs of child abuse or neglect
- act as an effective advocate for the child or young person and listen to them
- recognise the potential impact of a parent's/carer's physical and mental health on the wellbeing of a child or young person
- be clear about your own and colleagues' roles, responsibilities, and professional boundaries
- be able to refer as appropriate to social care if a safeguarding/child protection concern is identified, using tools such as the SAFER communication guidelines (DH, 2013) to make an effective referral
- document safeguarding/child protection concerns in order to be able to inform relevant staff and agencies as necessary; maintain appropriate record keeping, and differentiate between fact and opinion
- share appropriate and relevant information with other teams
- act in accordance with key statutory and non-statutory guidance and legislation including the UN Convention on the Rights of the Child and the *Human Rights Act 1998*.

A child's welfare is paramount in every respect, regardless of whether you feel sympathy for the parent or carer. You must always act on a child's behalf if you have concerns.

This concept is enshrined in the Nursing and Midwifery Council's *Code of conduct* (NMC, 2008). The code states that you should 'work with others to protect and promote the health and wellbeing of those in your care, their families and carers, and the wider community.'

This means that you must first know how to identify the children who are at risk, and then know where to seek expert

advice and support. Your local child protection committee/ LSCB and trust/organisation procedures will have detailed steps to follow. It is up to you to find out where these are kept and read them.

It is important YOU take action because in some instances, such as children or young people experiencing or at risk of experiencing honour-based abuse, forced marriage or female genital mutilation, there may only be one opportunity to speak to a victim/potential victim. For children who need help, every day matters.

If you report your concerns to the nurse in charge or to children's social care and you are unhappy with their lack of response you should discuss this with your named nurse or doctor. You should not accept their lack of response if you disagree with it without discussing this further.

### Designated professionals

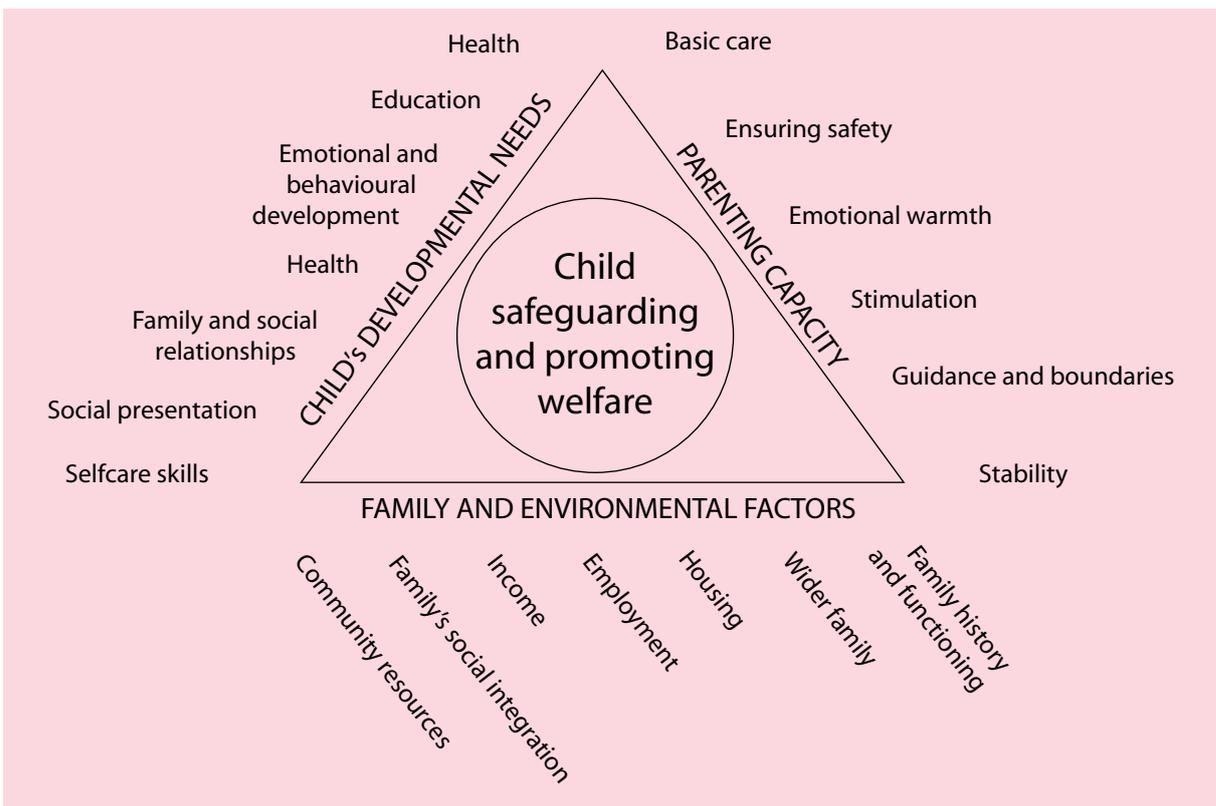
In England, all clinical commissioning groups (CCGs) are required to employ or secure the expertise of a designated nurse and doctor. Designated professionals work across the whole safeguarding system, both in health and with multi-agency partners. They provide professional advice and support to named professionals and are an additional source of support for staff if required.

In Wales and Northern Ireland, professionals exist with similar responsibilities; Public Health Wales has a structure of designated and named professionals while in Northern Ireland each health and social services trust has named professionals for child protection.

In Scotland, there are lead paediatricians and consultant/ lead nurses who provide clinical leadership, advice and strategic planning and are members of the Child Protection Committee. In larger health boards there are child protection nurse advisers who support lead nurses.

### Assessment

The Children Act 1989 sets out a number of statutory assessments that should be undertaken by a local authority, including a Section 17 *Child in need assessment* and Section 47 enquiries to assess whether the local authority needs to take action because the child is suffering or likely to suffer significant harm. Each local authority will have its own approach to assessment, but a good assessment will investigate the three domains as set out in the model below (DHSSPS, 2011).



Assessment is not only concerned with the gathering and summarising of information, although this is an important part of the process. It also involves the analysis of that information (making sense of it) to identify needs (including safeguarding needs or risks), strengths and resilience and protective factors; making decisions and planning actions; the support and services required to meet needs; and taking action (implementing the decisions and plans made).

## Record keeping and report writing

You may see a child just once, yet your record of that visit could help save a life. Often it is only when many apparently unrelated factors are pieced together that practitioners can identify a case of child abuse.

Good record keeping is always factual, clear, accurate, accessible and comprehensive. You should:

- write down all observations and discussions as they happen, avoid asking leading questions – allow the young person to tell their story
- carefully record your judgements and any actions or decisions taken
- include details and outcomes of health care contacts as well as follow-up arrangements
- use good practice guidance on record keeping from the NMC (NMC, 2009)
- use a body map to identify specific anatomical marks or injuries
- add the date and time for every entry in to your records.

All information about an individual child should be held in one file, where it is accessible to all members of the team. The file should be made secure in accordance with local policy and with reference to national guidelines. All records should contain a chronology that clearly notes dates and reasons for attendance, non-attendance and significant incidents.

While oral communications do take place in all safeguarding children situations, you must always make referrals to other agencies in writing and record the outcome of each referral.

# Promoting interagency working and communicating concerns

The general principles relating to consent to share information are no different to caring for adults. The differences are related to the overall process. In all cases where consent to share is the appropriate route, you should:

- check the capacity of the child or young person to make the decision
- if the child/young person has capacity, seek their consent, including consent to share with those with parental responsibilities and act on the decision
- if the child/young person does not have capacity, it may still be appropriate to seek their views and if there are no concerns seek consent of those with parental responsibility
- if there are concerns, professional judgement needs to be carefully exercised in accordance with appropriate ethical and process guidance (Caldicott, 2013).

Adults who deliberately harm, neglect or exploit children often go to great lengths to conceal their behaviour. They do this by taking children for treatment in different health care settings, and using many different social care organisations. This is why it is vital to have effective systems for information sharing, collaboration and understanding between agencies and professionals. In England the *Child protection – information sharing* (CP-IS) project (DfCSF, 2008) is an NHS England sponsored work programme (NHS England, 2013). It proposes to connect local authorities' child protection social care IT systems with those used by staff in NHS unscheduled care settings, such as accident and emergency wards and walk-in clinics, over the next five years.

The information sharing focuses on three specific categories of child:

- only those with a child protection plan
- only those classed as 'looked after' by the local authority
- any unborn child that has a child protection plan.

## The seven golden rules of information sharing:

1. Remember that the Data Protection Act (1998) is not a barrier to sharing information but provides a framework to ensure that personal information about living persons is shared appropriately.
2. Be open and honest with the person (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could be shared, and seek their agreement unless it is unsafe or inappropriate to do so.
3. Seek advice if you are in any doubt, without disclosing the identity of the person, where possible.
4. Share with consent where appropriate and, where possible, respect the wishes of those who do not consent to share confidential information. You may still share information without consent if, in your judgement, that lack of consent can be overridden in the public interest. You will need to base your judgement on the facts of the case.
5. Consider safety and wellbeing: base your information sharing decisions on considerations of the safety and wellbeing of the person and others who may be affected by their actions.
6. Necessary, proportionate, relevant, accurate, timely and secure: ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those people who need to have it, is accurate and up to date, is shared in a timely fashion, and is shared securely.
7. Keep a record of your decision and the reasons for it – whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose.

## Gillick competencies/Fraser guidelines

When working with young people, practitioners should use the Gillick competencies/Fraser guidelines (NSPCC, 2012). These are in place to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions. The child must be capable of

making a reasonable assessment of the advantages and disadvantages of the treatment proposed, so the consent, if given, can be properly and fairly described as true consent.

Safeguarding children and promoting the welfare of children – and in particular protecting them from significant harm – depends on effective joint working between agencies and professionals that have different roles and expertise.

### Local safeguarding children boards

In England, local safeguarding children boards (LSCBs) are the interagency statutory boards that bring together the local authority, police, health organisations and other local agencies to co-ordinate and ensure effective local arrangements to safeguard children. These multi-agency boards have slightly different titles in some other countries of the UK.

You should be familiar with local LSCB procedures and protocols, including those related to information sharing. This includes the contact details of key members responsible for safeguarding children across the various agencies.

If you are unclear about your role as a nurse, or whether it is appropriate to share information, contact the named nurse for safeguarding children in your organisation for advice.

## Your employer's roles and responsibilities

Employer responsibilities are clearly defined both within the law and outlined fully in the Department for Education's *Working together* guidance document. Each provider organisation should have:

- a senior board level lead for safeguarding
- a culture of listening to children
- a named nurse and doctor for safeguarding children (and midwife where there are maternity services) whose contact details are known throughout the organisation
- safeguarding children procedures in place and available organisation-wide
- a single, integrated child health record system, including mechanisms for obtaining records of previous attendances/admissions from other organisations
- arrangements set out for the processes of sharing information
- a secure facility for storing records in line with Caldicott requirements
- clearly defined policies on how to raise concerns about colleagues, manage sickness and absence, and review individual performance, including when referral should be made to the NMC
- training, supervision and support for staff.

# Training and education

The Munro review (DfE, 2011) highlighted the importance of practitioners having “freedom to use their expertise in assessing need and providing the right help”. This requires all nurses, health visitors and midwives to be competent to make the right decision. The review of the deaths of Madeliene and Lauren O’Neill found; “It was clear that many staff lacked even basic understanding of issues such as recognition of risk, the proactive nature of the children in need concept, or the signs and symptoms of child abuse.”

The RCN, as a co-producer of the *Safeguarding children and young people: roles and competencies for health care staff* intercollegiate document (RCPCH, 2010), endorses the need for staff competence and emphasises the importance of maximising flexible learning opportunities to acquire and maintain knowledge and skills, drawing upon lessons from research, case studies and serious case reviews.

The RCN believes that there should be:

- mandatory safeguarding children training for all nurses and health workers who may come into contact with children and young people, including ancillary and office staff
- training provided on induction, with updating at least once a year throughout employment
- access to specialist post-registration safeguarding children education programmes for all professionals working in safeguarding children and selected professionals who take a lead role in safeguarding children at work
- safeguarding children training in all pre-registration nursing education, and as an integral part of student midwives’ programmes.

## University nursing and midwifery education programmes

A named senior lecturer should be appointed to oversee safeguarding children teaching. The training should ensure the level 2 competences as set out in the intercollegiate competence document (RCPCH, 2010) are reached for all undergraduate nursing courses.

## Employer safeguarding children training programmes

Employer safeguarding children training programmes should be based on the competences found in the intercollegiate competence document (RCPCH, 2010), which is available online at [www.rcn.org.uk/publications](http://www.rcn.org.uk/publications)

## Recruitment and selection processes

Trusts, health care providers and universities should have stringent screening programmes in place as part of their recruitment and selection processes that relate to staff working with children and young people, including volunteers and nursing students.

Trust and university recruitment and selection checks should be in line with national guidance, such as NHS Employers' safe recruitment policies, and should include:

- enhanced disclosure and barring checks (see the Disclosure and Barring Service and Home Office updated guidelines (2012))
- relevant professional registers – NMC PIN
- identity check via official documents
- authenticity of qualifications
- two references from previous employers (including one from the current or last employer)
- references from the general practitioner and university senior lecturer for newly qualified nurses
- application forms that highlight evidence of employment/education gaps
- pre-employment occupational health checks, and medical report from the GP when necessary.

If you are worried about the behaviour of a colleague or student, you must use the local policy to raise your concerns. In the absence of a policy, contact your RCN steward.

## Supervision and support

Regular high-quality safeguarding supervision is an essential element of effective arrangements to safeguard children.

However, there is evidence to indicate that safeguarding supervision in the NHS has at times been found lacking in terms of quality and frequency for cases which subsequently become the subject of serious case reviews (DfE, 2009b).

Local arrangements for supervision must be robust, meet the specific needs of staff in their area, and as such demonstrate the effective discharge of NHS trust statutory duties to safeguard children and promote their welfare.

All practitioners delivering safeguarding supervision should be offered training in the supervision process and should have undertaken the NSPCC child protection supervision course or its equivalent.

Where the requirement to provide supervision is part of a practitioner's job role, sufficient time must be allocated in order for supervision to be carried out effectively. This is particularly important where arrangements for supporting school nurses and health visitors fall outside of the named nurse role and is provided by other NHS professionals.

In addition supervisors should receive regular supervisor supervision, either one-to-one or as a group.

The RCN believes that:

- all staff working in safeguarding children should receive regular supervision and support from a safeguarding children expert
- individual or group supervision and support should be available for anyone to access on a monthly or more frequent basis if necessary
- trusts/health care providers should ensure that the above is available for staff
- trusts/health care providers must communicate effectively across the organisation that supervision and support is available.

The RCN fully supports members in raising concerns regarding the care of children and young people, and the protection of their rights as individuals. If you feel compromised – for example, if training provided by your employing organisation is inadequate and you are not getting the help you need – contact RCN Direct on 0345 772 6100.

## Managing allegations

This publication should be read in conjunction with the RCN guidance *Protection of nurses working with children and young people* (2013). You have a duty to act if you have concerns about the behaviour of a colleague or student. You should report them according to local child protection committee/local safeguarding children board, trust or university policies whilst bearing in mind your responsibilities to inform the authorities of any breach in criminal law. In England there will be a local authority designated officer (LADO) who your organisation should inform and work with.

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# Other useful documents

## Scotland

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Office of the First Minister and Deputy First Minister (2006) *Ten year strategy for children and young people in Northern Ireland*. Available at [www.ofmdfmi.gov.uk](http://www.ofmdfmi.gov.uk)

## Wales

All Wales Child Protection Procedures Review Group (2008) *All Wales child protection procedures*.

Welsh Assembly Government (2007) *Safeguarding children: working together under the Children Act 2004*.

## Disclosure and barring

See [www.gov.uk/government/organisations/disclosure-and-barring-service](http://www.gov.uk/government/organisations/disclosure-and-barring-service) for information on the Disclosure and Barring Service which helps employers in England, Wales and Northern Ireland.

For Information on disclosure for individuals working with vulnerable groups in Scotland, see [www.disclosurescotland.co.uk](http://www.disclosurescotland.co.uk)

## Safeguarding

Department for Education (2009) *Safeguarding children and young people from sexual exploitation: supplementary guidance to working together to safeguard children*. Available online at [www.gov.uk/publications](http://www.gov.uk/publications)



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