Wolverhampton Substance Misuse Service

Integrated Safeguarding Framework

Whilst policies and procedures are very important, ultimately it is the professionalism and commitment of our staff which protect children and adults.

Section	Contents	Page

Section 1: The purpose of the Integrated Safeguarding Framework

1. This document is the overarching safeguarding document for Wolverhampton Substance Misuse Service (WSMS), and individual partner agency policies feed into it.

2. This Integrated Safeguarding Framework (ISF) is designed to provide all staff with a simple integrated framework which helps them to quickly and confidently respond to complex situations involving child protection and vulnerable adult issues.

3. This ISF is intended to complement not duplicate the policies or procedures of the Wolverhampton Safeguarding Children's Board (WSCB) and Wolverhampton Safeguarding Vulnerable Adults Board (WSVAB).

4. The ISF is not intended to cause any delay in professionals making timely referrals to the local authorities where a vulnerable child or adult is experiencing, or may be at risk of, harm.

Section 2: The principles underpinning the ISF

The four complementary principles underpinning this ISF are as follows:

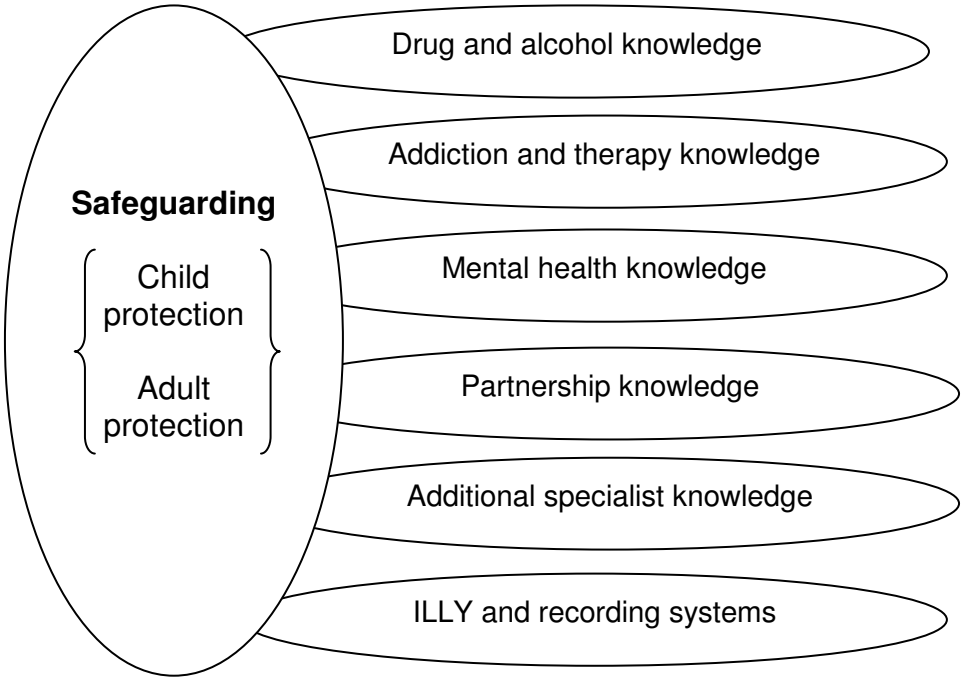
1. Safeguarding is everyone's responsibility: for services to be effective, each professional and each organisation should play their full part.

2. A child (and adult) centred approach: for services to be effective, they should be based on a clear understanding of the needs and views of children (and adults).[1]

3. All safeguarding arrangements should reflect the following values: empowerment, protection, prevention, proportionality, partnership and accountability.[2]

4. Professionals needs to be aware of, and sensitive to, the fact that sometimes they may need to reorientate their attention in order to view someone less as an alleged offender and more as an alleged victim, for example in certain types of child sexual exploitation/prostitution.

As illustrated in the following diagram, safeguarding is not an optional activity; it runs through all that we do.



[1] Department for Education (2013) *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children* London: Department for Education
[2] Department of Health (2011) *Statement of Government Policy on Adult Safeguarding* London: Department of Health

Section 3: Individual professional knowledge audit

How much do you really know about safeguarding? To effectively safeguard service users, whatever their age, you need to have a basic working knowledge of safeguarding, child protection and the protection of vulnerable adults.

See how well you do in answering the following questions. Answers can be found on page 28.

	Questions	Your answer
1	What is the difference between safeguarding and child/adult protection?	
2	Who is your designated safeguarding professional (DSP)?	
3	Where are your safeguarding, child/adult protection policies kept?	
4	When should you make a child/adult protection referral to social care?	
5	Where are child/adult protection referral forms kept?	
6	What are the timescales for making a telephone/written child/adult protection referral to social care?	
7	Do I have to have firm evidence before I make a child/adult protection referral to social care?	

Section 4: Definitions

Child
There is no single law which defines the age of a child across the UK. However the Children Act 1989 follows the UN Convention on the Rights of the Child (1989), which notes "a child means any person under the age of 18 years (16 years if married)."[3]

Safeguarding and protecting children
"Safeguarding and promoting the welfare of children is defined as:

- protecting children from maltreatment
- preventing impairment of children's health or development
- ensuring children are growing up in circumstances consistent with the provision of safe and effective care.

Child protection is a part of safeguarding and promoting welfare. It refers to the activity that is undertaken to protect specific children who are suffering, or are likely to suffer, significant harm.

Effective child protection is essential as part of wider work to safeguard and promote the welfare of children. However, all agencies and individuals should aim to proactively safeguard and promote the welfare of children so that the need for action to protect children from harm is reduced."[4]

Child in need
A child is in need if:

a. He/she is unlikely to achieve or maintain, or have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him/her of services by a local authority

b. His/her health or development is likely to be significantly impaired, or further impaired, without the provision for him/her of such services or

c. He/she is a disabled child.[5]

Child abuse
"Abuse is a form of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or failing to protect from harm. Children may be abused in a family or in an institution or community setting by those known to them or, more rarely by others (e.g. via the internet). They may be abused by an adult or adults or another child or children. There are four types of child abuse.

1. Physical abuse
2. Emotional abuse
3. Sexual abuse

[3] s.2.1, Children Act 1989
[4] Department for Education (2013) *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children* London: Department for Education
[5] s.17, Children Act 1989

4. Neglect"[6]

In addition to the four main types of abuse, one needs to be mindful of other types of abuse which may span several categories of abuse, such as female genital mutilation. Bullying is not defined as a form of abuse in *Working Together* but there is clear evidence that it is abusive and will include at least one, if not two, three or all four of the defined categories of abuse.

"Recognising child abuse is not easy. It is not your responsibility to decide whether or not child abuse has taken place or if a child is at significant risk of harm from someone. You do, however, have both a responsibility and duty, as set out in your organisation's child protection procedures, to act in order that the appropriate agencies can investigate and take any necessary action to protect a child."[7]

Vulnerable adult

A vulnerable adult is a person aged 18 years or over who is or may be in need of community care services by reason of mental health or other disability, age or illness and who is unable to protect themselves against harm or exploitation.

Safeguarding and protecting adults

"Safeguarding is the term that describes the function of protecting adults and children from abuse or neglect. It is an important shared priority of many public services, and a key responsibility of local authorities. Safeguarding relates to the need to protect certain people who may be in vulnerable circumstances. These are people who may be at risk of abuse or neglect, due to the actions (or lack of action) of another person. In these cases, it is critical that services work together to identify people at risk, and put in place interventions to help prevent abuse or neglect, and to protect people."[8]

Abuse (general)

"A violation of an individual's human and civil rights by another person or persons. Abuse can be: a single act or repeated acts; physical, verbal, psychological; an act of neglect or an omission to act; when a vulnerable person is persuaded to enter into a financial or sexual transaction to which he/she has not consented or cannot consent. Abuse can occur in any relationship and may result in significant harm to, or exploitation of, the person subjected to it."[9]

Significant harm (general)

"Ill treatment (including sexual abuse and forms of ill treatment that are not physical) or the impairment of, or an avoidable deterioration in, physical or mental health and the impairment of physical, intellectual, emotional, social or behavioural development."[10]

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[6] Department for Education (2013) *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children* London: Department for Education p.85

[7] This extract is from the NSPCC. See http://www.nspcc.org.uk for more information.

[8] Department of Health (2000) *No Secrets: Guidance on protecting vulnerable adults in care* London: Department of Health

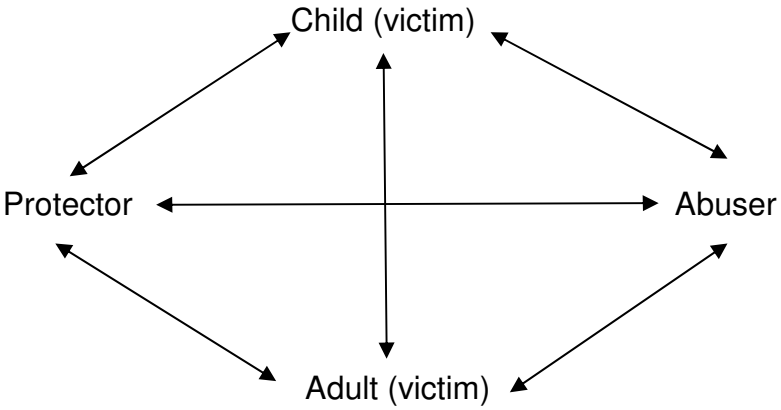
[9] Department of Health (2000) *No Secrets: Guidance on protecting vulnerable adults in care* London: Department of Health

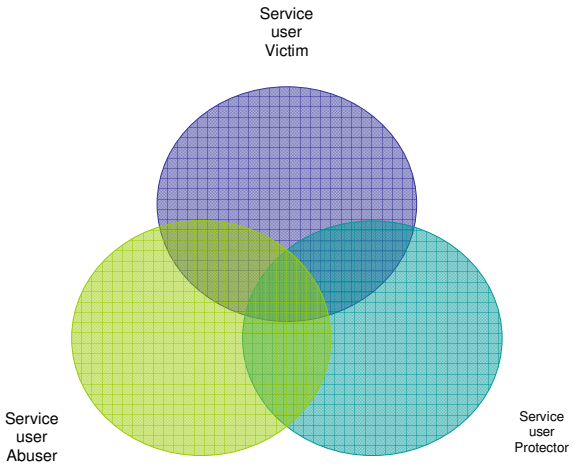
[10] Lord Chancellor's Department (1997) *Who Decides? Making decisions on behalf of mentally incapacitated adults* London: Stationery Office; Law Commission's 2010 consultation: *Review of Adults Social Care Law*

Section 5: How the ISF links together

Thinking about, let alone responding appropriately to, the different levels of need which our service users and those who make up their family and/or social network have can at times be a daunting and confusing prospect.

Sometimes our primary service user may be an adult, a child (under the age of 18), a protector (parent or child), an abuser, a child victim or an adult victim or, sometimes, as illustrated in the two diagrams below, a combination of these.





Knowing which policy and procedures to follow, and when, is crucial to ensuring that you are able to appropriately safeguard the children and vulnerable adults you work with.

The first thing to say is: “Don't worry … you genuinely aren't alone.” You are in fact surrounded by experienced colleagues whose job it is to help you.

The second thing to say is that WSMS has in place robust and rigorous safeguarding, child protection and vulnerable adult policies and procedures so that you and your colleagues can respond appropriately to any given situation.

The third and final thing to say is that whilst we all need to have robust and rigorous policies and procedures in place to help us navigate the numerous scenarios which might unfold when dealing with child protection and vulnerable adult issues, ultimately it is the professional commitment of people like you, not policies and procedures alone, that protect people.

With the above in mind, this ISF helps you to consider three basic safeguarding questions which you should consider with each and every case you become involved with:

1. Do you think that through the course of your work a child is in need of support?

2. Are you concerned that through the course of your work a child is need of protection?

3. Are you concerned that through the course of your work a vulnerable adult is in need of protection?

If you have answered yes to any of the above questions, then the following sections will help you to identify how you need to proceed, who now needs to become involved and which policies and procedures you need to follow. Remember the best decisions are nearly always ones made after consulting with colleagues, so if in any doubt, always ask.

If, however, in your view the situation is an emergency, then do not delay in calling 999 for immediate appropriate assistance.

Children in need of support and protection

As a matter of best practice in all non-child protection cases you should always complete a pre-CAF[11] checklist[12] for all children under the age of 18. This exercise ensures that children's needs are not overshadowed by the adult's needs.

If this checklist highlights that a child may have an 'additional' need such as a need for speech therapy, physiotherapy etc, then in the first instance you should initiate a CAF by following the local protocol. This process will not normally involve children's social care.

However, if the child in question is registered as disabled, has more complex needs or is in your view in need of protection from actual/likely harm, then you need to make a 'child

[11] CAF stands for Common Assessment Framework. See page 27 for more information on CAF.
[12] The pre-CAF checklist is available at http://www.education.gov.uk/childrenandyoungpeople/strategy/integratedworking/caf/a0068970/the-pre-caf-and-full-caf-forms

in need' or 'child protection' referral to children's social care who have a statutory duty to carry out a 'child in need' assessment.

Section 17 of Children Act 1989 requires the local authority (children's social care) to: "determine whether the child is in need, the nature of any services required and whether any specialist assessments should be undertaken to assist the local authority in its decision making."[13]

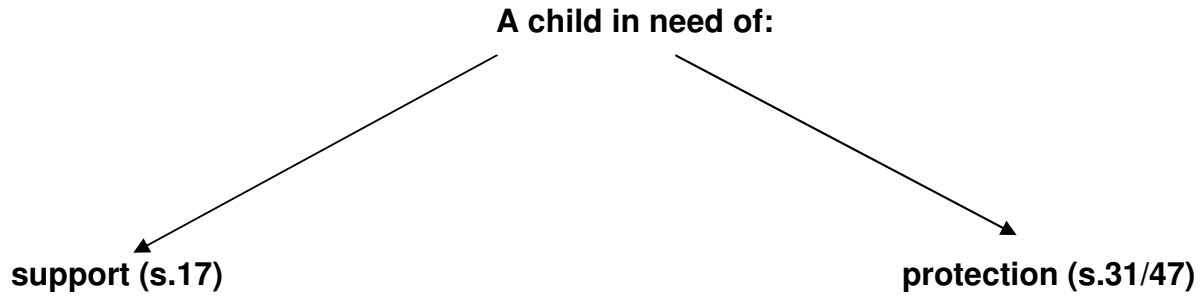
Within one working day of receiving your referral to children's social care, the local authority social worker will make a decision about what type of response is required. This will be one of the following scenarios:[14]

1. Immediate protection/urgent action.
2. Child protection enquiries are required (s.47, Children Act 1989).
3. A comprehensive 'child in need' assessment is required within 45 days (s.17, Children Act 1989).
4. Further specialist services are required to help decide how to move forward.
5. That there is at present no role for social care, but that a CAF or family support or universal services may be more appropriate.

It should be acknowledged that even for those experienced in working with children, the terminology surrounding the term 'child in need' can be confusing because it is used for both:

- A child in need of support (s.17, Children Act 1989)
- A child in need of protection (s.47/31, Children Act 1989)

Use the diagram below to remember the two ways in which a child can be in need.



[13] Department for Education (2013) *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children* London: Department for Education p.30

[14] For all relevant flowcharts, see Department for Education (2013) *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children* London: Department for Education pp.26-35.

Furthermore, the timeframes by which a referral is made to children's social care for the two different types of referral are also slightly different.

- For a child in need of support, although the referral to children's social care may not be urgent, it should ideally be made as soon as possible.

- For a child in need of protection, by definition the referral to children's social care is of a more urgent nature and should therefore be made by telephone the same working day and followed up in writing – if not the same day then at least within 48 hours.

Adult in need of protection: action and timeframe flowchart
If you think that a vulnerable adult is in need of protection, then you need to adhere to the actions and timeframes outlined in the following flowchart:[15]

Stage	Action	Timeframe
1	Alert by you to your agency alert manager	Within the same working day
2	Alert manager makes a referral to social care	A decision will be taken the same working day by a social care manager whether the referral is a safeguarding case
3	Strategy meeting/discussion	Within five working days
4	Investigation/assessment	Completed within 20 working days from referral
5	Case conference	Completed within 20 days from the completion of the investigation/assessment
6	Review	Completed within a maximum of six months after the case conference
7	Closure	Anytime

Concerns: why, when and how to escalate them
By the very nature of the subject we are dealing with and however experienced those involved in these matters are, whether we are discussing children or adults, there are

[15] See http://www.wolverhampton.gov.uk/article/2958/Policy-and-procedures-for-professionals for more information.

going to be times when professional differences of opinion exist as to the extent of any actual or perceived risk, and therefore by definition whether or not a referral should be regarded as requiring one type of response (protection procedures) or another (support procedures).

As a referrer, if having submitted a child or adult protection referral into social care and the response from them is that the referral would be more appropriately dealt with by way of non-child or adult protection/safeguarding procedures and we are reassured by this, then we need take no further action other than to support the referral along another route.

If, however, you are not reassured by the response from social care and remain concerned that your referral should be regarded as a child/adult protection issue and therefore ought to be responded to as such, then you have a duty (along with the support of your line manager) to escalate the matter upwards through social care.

The intention of this process is not necessarily to force a consensus of professional opinion (although frequently this process does result in a better shared understanding); rather it is designed to ensure that any initial assessment/decision making carried out by social care about the nature of a referral is robust, rigorous and transparent.

It should be remembered that of the children who have been the subject of a serious case review (namely, where they were either killed or seriously injured), approximately fewer than 20% were the subject of a child protection plan at the time of the incident.[16]

For further information about the above procedure, please refer to sections 16 and 17 of this document.

For more information on escalation policy (which is sometimes referred to as a professional disagreement policy) please see page 36.

[16] Department for Education (2009) *Understanding Serious Case Reviews and Their Impact: A biennial analysis of serious case reviews between 2005 and 2007* London: Department for Education

Section 6: Knowing who to respond to first

One of the greatest challenges that social care professionals face when dealing with a child and an adult who are potentially exposed to risk of significant harm at the same time is knowing who to try and help/protect first.

Some professionals will refer to the fact that as the Children Act 1989 highlights the importance of the 'paramountcy principle' when it comes to children's well-being, then the needs of children should come first.

Some professionals will refer to the fact that as adults are older and often also parents/carers who may have some rights and responsibilities over a child, then their needs should come first.

Other professionals may take a more pragmatic approach and simply champion the needs of their service user, regardless of the age and needs of others.

Imagine a paramedic who is attending the scene of a road traffic accident saying that he or she will only treat people in order of age, then on the basis of gender, then on the basis of disability, etc. If such an approach was taken, then in all likelihood the consequences would be mayhem, with a high chance that those most in need would receive too little help too late.

Of course, as we know, in such situations paramedics respond to and treat people on the basis of a simultaneous initial assessment of the situation and the immediate needs of the people involved, regardless of age, gender, disability etc.

It sounds simple, yet so often professionals when dealing with a child and adult who may be both at risk of harm struggle with trying to decide who morally and legally they have a duty to help and protect first.

As professionals concerned with trying to help families in a holistic manner, like the paramedic, our first duty is to remain focused on the level of need of that person and our concerns about the individual, regardless of their age, gender, disability, etc.

There is no doubt that in due course once the immediate issue of protecting someone from risk of harm has been achieved, one can then, as part of the unfolding assessment, consider all the other issues of the person’s age, parental responsibility, whose service user they are, their mental capacity, their degree of dependency, their impact on others, etc. But, crucially, at the point of becoming aware through the course of our work that anyone regardless of their age is suffering, or likely to suffer, significant harm, then we have a professional duty to act and follow the appropriate procedures referred to above.

Section 7: Referral pathways in and out of the service

Central to the service is the ability of members of the public and other agencies to know who we are as a service, what we do and how they can access our services.

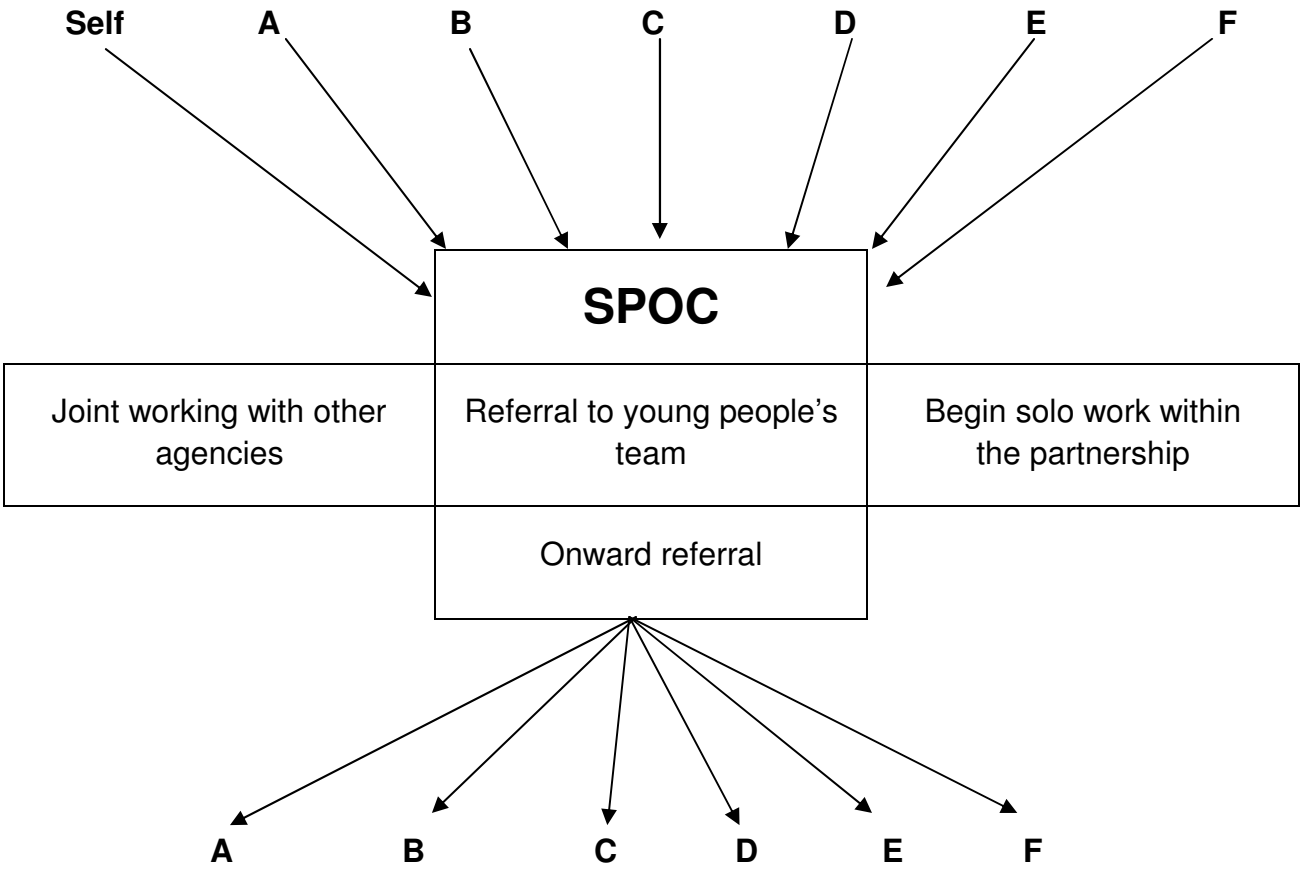
Equally, it is essential that all staff know the appropriate referral pathways necessary to refer service users on to other services when required.

All inward referral pathways to the service will be through the 'Single Point of Contact' (SPOC) based at Thornhurst House, 1 Connaught Road, Wolverhampton WV1 4SJ.

The relevant telephone numbers are:

- Children, young people and families: 0300 123 3360
- Adults: 0300 200 2400

Inward referral pathways
(self-referral and agencies i.e. A-F)



Outward referral pathways
(Agencies i.e. A-F)

The following is a list of the most common referral pathways currently operating across the city. Please note this is not an exhaustive list and if you need to make a referral which is not listed below please discuss this with your senior or manager who will help you.

1. Social care: child protection, child in need etc
2. Targeted youth support
3. Education (re-entry)
4. General practice (re-entry)
5. Housing
6. Youth offending teams (inward referral pathway only)
7. Police
8. Guns and gangs
9. Child and Adolescence Mental Health Services (CAMHS)
10. Maternity pathway

In the event that you need to refer your service user on to another service which does not have a referral pathway, simply contact the service and ask how to make an inward referral. The absence of an agreed referral pathway should not in and of itself be a barrier to making an appropriate and timely onwards referral.

N.B. In addition to referral pathways, please remember that there are also a number of joint working protocols which specify how professionals from different local agencies should work together. One example is the joint working protocol between WSMS and children's centres which sets out how WSMS staff can do a joint home visit with children centre staff where there is a child aged five or under living with one of our service users.

Section 8: Your roles and responsibilities

When it comes to working with children in need or vulnerable adults, you will invariably be working with other professionals from other agencies. Knowing what your role is and what you are responsible for is central to effective multi-agency work. Nowhere is this more important than when you might have to attend and represent your own agency in multi-agency meetings.

These multi-agency meetings might be:

1. Common Assessment Framework (CAF) meetings: to consider if a child should have a CAF put in place.

2. Child in need (CIN) meetings: to consider if a child should be the subject of a child in need plan.

3. An initial child protection conference (ICPC): to consider any possible abuse, if a child is suffering or is likely to suffer significant harm and if that child should be made the subject of a protection plan.

4. Review child protection conference (RCPC): to consider if a child should continue to be the subject of a protection plan.

5. Core group meeting: to review a child's protection plan and contribute/play an active part in any ongoing risk assessments being co-ordinated by social care.

6. Safeguarding vulnerable adults meeting: to consider if an adult is vulnerable to abuse or harm and what can be done to support that person in removing or reducing any actual or potential harm or risk.

How to prepare:

1. Always prepare beforehand.

2. Find out as much as you can from your agency's perspective about the service user's current situation.

3. Be prepared to positively engage with those at the meeting. Unless you are specifically invited as an observer, you will have been invited because of what you can bring to the meeting. As such, you will be expected to appropriately share relevant information, knowledge and your professional opinion.

4. If this is your first time attending one of these meetings, ask your senior or manager to attend the meeting with you for support and, where appropriate, to show through example how best to take part in the meeting.

5. Don’t be afraid to ask the Chair for guidance, clarification or help in sharing your views. Chairs will welcome the fact that you have taken the initiative by asking for help and will appreciate your professionalism.

6. Always ensure that you take your own notes during a meeting or very soon afterwards which highlight the agreed plan, recommendations, timescales and what you have agreed or been directed to do.

7. Always get a copy of the meeting minutes and chase a copy up if you have to. Make sure all recorded minutes are placed on the service user’s file clearly.

Section 9: What happens when you refer to social care?

When you make a referral to children's social care they have a range of options as to how they might respond. These are set out below.

Section 17 of the Children Act 1989 requires the local authority (children's social care) to "determine whether the child is in need, the nature of any services required and whether any specialist assessments should be undertaken to assist the local authority in its decision making".[17]

Within one working day of receiving your referral to children's social care the local authority social worker will make a decision about what type of response is required. This will be one of the following scenarios:[18]

1. Immediate protection/urgent action.
2. Child protection enquiries are required (s.47, Children Act 1989).
3. A comprehensive 'child in need' assessment is required within 45 days (s.17, Children Act 1989).
4. Further specialist services are required to help decide how to move forward.
5. That there is at present no role for social care, but that a CAF, family support or universal services may be more appropriate.

[17] Department for Education (2013) *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children* London: Department for Education p.30

[18] For all relevant flowcharts, see Department for Education (2013) *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children* London: Department for Education pp.26-35.

Section 10: Drug[19] screening: why, when and how does it help?

The following is a very brief overview outlining the role of drug screening and how it helps you and the service user. There is also a useful flowchart on page 21.

For further information please refer to:

1. Drugs of Abuse Testing Guidance (Birmingham and Solihull Mental Health NHS Foundation Trust Addiction Services, August 2013)
2. SCODA's Assessment Framework (1997) which is a useful tool when working with service users who misuse drugs.

Before considering the specific why, when and how questions below, one needs to be mindful of the following:

- Drug screening should not take centre stage in your assessment or work with a service user. Although an important tool in your professional toolkit, it is still only one of many.

- One should never assume that a negative screening proves that a service user is not taking drugs. Some service users can and do manipulate the screening process which is why random rather than planned screening is much more reliable.

- Beware of you and your colleagues thinking that a positive screening or a false negative means one thing when in fact it may mean a number of other things.

- The vast majority of service users are not screened because as a service we do not prescribe for them as it serves no useful purpose.

- It is rare to screen any service user under the age of 16.

- The minimum drug screening frequency for service users in treatment is twice a year.[20]

- The maximum drug screening frequency for service users is weekly. Twice weekly screening will not provide any more information than weekly screening.

- A screening will only tell you so much about a service user and their situation. Professional dialogue and curiosity will often tell you a lot more.

[19] For alcohol testing, a service user would need to use a breathalyser.

[20] See Department of Health (2007) *Drug Misuse and Dependence: UK guidance and clinical management* London: Department of Health

Why do we need to screen service users?

To check that service users are giving a true account of their drug usage so that:

- We can establish if it is safe for them to have a certain type of prescription.
- We don't unknowingly end up making service users become dependent drug users.

When is the best time to screen service users?

The key times to carry out a drug test in order to assess any risk, clarify usage and reduce the risk of harm are:

- If someone is new to the service.
- If there is a clinical change in, or in the presentation of, the service user which is unexplained/hard to account for.
- If a service user is restarting treatment.

How should screening be carried out?

1. Within WSMS there are generally two types of drug tests used: a urine test (often regarded as the gold standard) and a saliva test.[21]

2. Urine screen: with guidance, you might request a service user provides a urine test by giving out a sample bottle with the name of the service user previously written on it and asking them to provide a sample in the toilet.

3. When the service user returns from the toilet always check that the sample bottle is warm. If it is not, it may be that the service user has used a pre-prepared sample of urine which may not even be theirs.

4. This sample can then be checked through the usual channels.

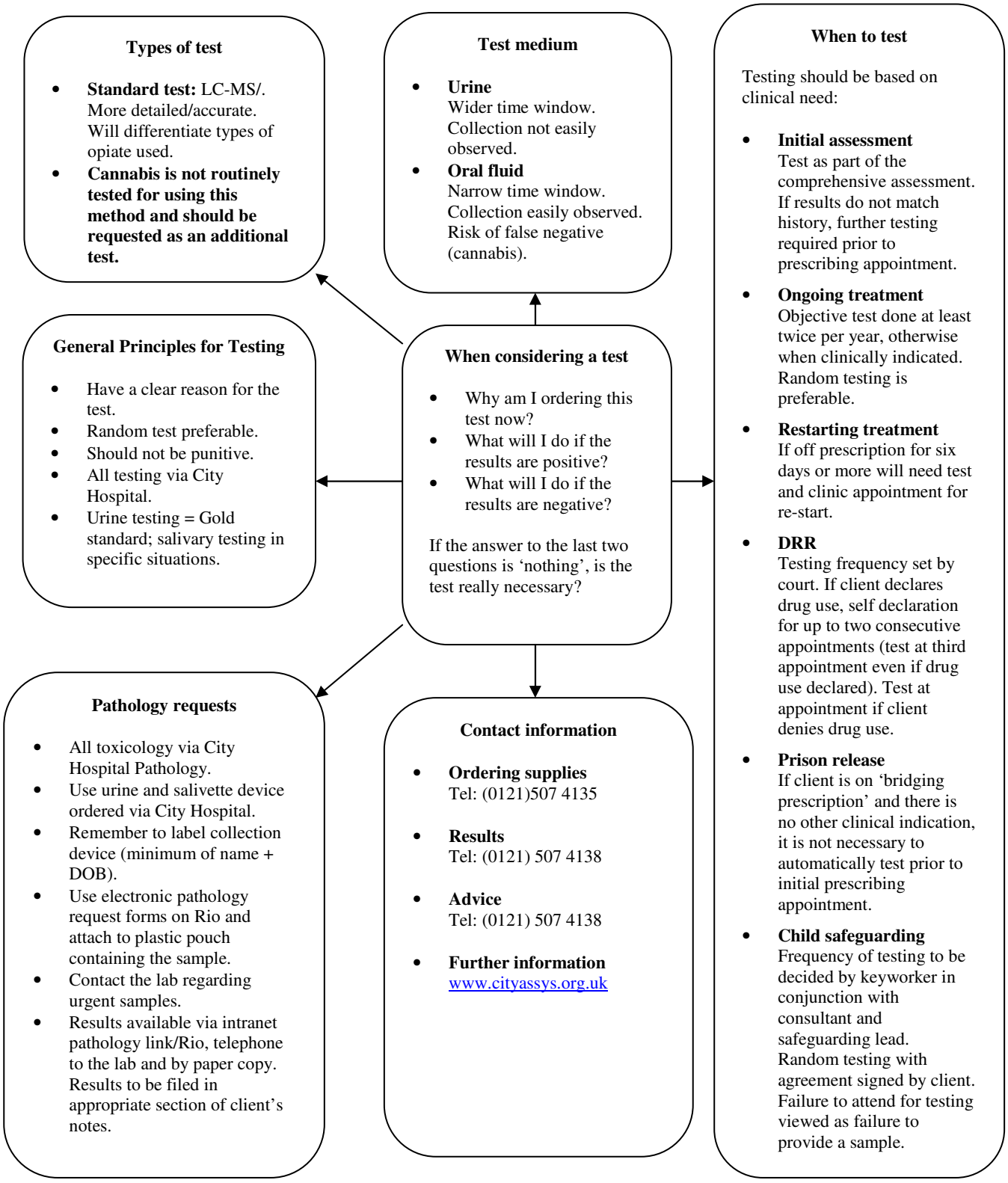
5. Saliva screen: with guidance, you might request that a service user provides a saliva test by asking them to chew on a piece of cotton wool (in front of you). This usually takes the form of them chewing a long cotton bud and placing it in a tube which is then sent off for testing.

Safeguarding

Where a service user is known to live with children or is a child themselves and refuses to comply with screening or does not attend for a screen appointment, then in all cases this should be reported to children's social care the same day. For all other cases, this should be the subject of ongoing discussion with your senior or line manager.

[21] Hair strand screening is only carried out in order to establish drug usage over a period of time. Therefore it is of little use in establishing current usage.

'Drugs of abuse' testing summary[22]



N.B. If you are unsure when to test, please consult a senior colleague for advice.

[22] Drugs of Abuse Testing Guidance (2013) courtesy of Birmingham and Solihull Mental Health NHS Foundation Trust

Section 11: When and how should I report an incident?

Within WSMS there are a number of different reporting procedures which you need to follow. These may be subject to change at short notice, so if in any doubt, always ask your senior or manager.

Essentially, all reporting procedures are there to alert senior staff to significant events which they need to be aware of as a matter of urgency.

For the purposes of this ISF, there are two particular reporting procedures which all WSMS staff need to be aware of:

1. Child protection and vulnerable adult referrals to social care: in all cases, staff should also inform their local designated safeguarding professional (DSP) the same working day. The DSP will normally be your local workplace manager.

   At agreed regular intervals, the local DSP will provide the strategic DSP (WSMS service manager) with an account of all such referrals and progress made.

2. Critical incidents (prescribing failures, complaints, aggression, etc): BSMHFT employees have to report all such incidents back to the trust via their Eclipse IT system. If a critical incident involves a non-BSMHFT employee, then that staff member will need to seek the assistance of a BSMHFT member of staff to access the Eclipse system to file the report.

Section 12: Information sharing[23]

This section is split into two parts. The first part deals with information sharing as it relates to situations that involve child protection/vulnerable adult issues. The second part relates to how and when we share information which does not involve child protection and vulnerable adult issues.

Part 1: The 'seven golden principles' which apply to child protection and vulnerable adult situations[24]

1. Remember that the Data Protection Act 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 well-being: Base your information sharing decisions on considerations of the safety and well-being 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, that 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 not to share, make sure you record the reasons for it.

[23] Within the context of safeguarding.
[24] Department for Education (2006) *Information Sharing: Guidance for practitioners and managers* London: Department for Education

Part 2

The practice of sharing personal information about service users with other professional and agencies in non-child protection, non-vulnerable adults or non-emergency situations requires different factors to be taken into account.

Wherever possible, all service users at their initial point of contact with WSMS should be encouraged to sign the consent agreement on file that we can share relevant personal information about them with other professional agencies.

If a service user refuses to give this consent then it must be made very clear to them, both verbally and in writing, that as we work in close partnership with other agencies, their refusal to give this consent significantly limits our ability to provide them with the level of service they may need. In extreme situations, we may even have to refuse them service.

For further guidance in relation to information sharing please refer to the purpose specific information sharing agreement (PSISA): tier three agreement for sharing information between partners of the WSMS programme, which sits within the Wolverhampton overarching information sharing protocol (version 1.6).

For additional guidance in respect of sharing information to reduce crime and disorder, please refer to the information sharing protocol drawn up by the Safer Wolverhampton Partnership (February 2012).

Section 13: How to ensure good record keeping

Why keeping good records helps with the safeguarding and protection of children and adults

1. It provides evidence of a clear history/patterns of work undertaken.
2. It helps to capture important moments in the service user's life.
3. It provides evidence of planning, any progress, why decisions were taken, and by whom.
4. It helps you and others to monitor, review and improve your practice.
5. It compensates for poor memory recall and helps with information sharing.
6. It records and assists inter-agency working, not least in child/adult protection investigations/case reviews.
7. It prevents duplication by others of work already undertaken.
8. Some professionals take the view that if something isn't recorded it hasn't happened.

Recording principles

1. Records should be legible, completed in black ink and preferably typed onto Illy Care Path.
2. Any written errors should be crossed out with a single line and initialled.
3. Records should be accurate, clear, concise and to the point, but able to expand on areas when required. Avoid judgemental language.
4. All statements should seek to be objective, unless otherwise noted as feelings, thoughts and opinions.
5. Encourage service users to access their file to help promote discussion/bring a context to their needs (be mindful that there may be third party information in the file and that permission from the third party may be required before that information is shared).
6. Records should be written up within 24 hours (not several days or weeks later).
7. Records should note where the information came from (if necessary): "the child's mother said…"
8. Records should give a date and time and be signed by the person completing them.

Recording concerns

When a member of staff becomes aware of a cause of concern, a full clear record should be kept that includes details of:

- What occurred
- What was seen or heard (by whom; who said and did what)
- The date
- The time
- The place
- The names of people involved
- The behaviour and attitude of the people involved
- Any weapons involved
- The state of clothing
- Any injuries

Recording decisions

Records should be made of any decisions taken, including the reasons for those decisions and it should be made clear who contributed to the decision-making. Discussions with the vulnerable adult regarding their consent to any aspect of referral, and discussions and decisions relating to all assessments of a person's capacity should also be fully recorded. All records must clearly show the time and date that they were recorded, as well as the time of the matters they describe.

Section 14: Index of useful acronyms

CAF/eCAF	Common Assessment Framework A voluntary early intervention framework which is used to help identify and then meet the needs of children who have additional needs which universal services (i.e. school/GP) cannot meet. Other local authorities may use similar early intervention frameworks which are referred to as 'early help' assessment frameworks.
CIN	Child in need (s.17, Children Act 1989)
CP	Child protection
DNA	When a service user does not attend a planned appointment.
DPA	Data Protection Act 1998
DSP	Designated safeguarding professional
IA	Initial assessment
ISF	Integrated Safeguarding Framework
Tier 2	Within the context of substance misuse services this is a service offered by practitioners with some drug and alcohol experience. The aim and purpose of this tier is to be concerned with the reduction of risks and vulnerabilities by providing advice, information and harm reduction and referral on to other services as appropriate.
Level 2	The second level of the model used by the CAF and children's social care in assessing a child's level of needs.
Tier 3	Within the context of substance misuse services this is specialist services which work with complex cases requiring multi-disciplinary team based work, dealing not just with particular substance problems but sometimes also pharmacological interventions.
VA	Vulnerable adult
WSMS	Wolverhampton Substance Misuse Service
WSCB	Wolverhampton Safeguarding Children's Board
WSVAB	Wolverhampton Safeguarding Vulnerable Adults Board

Section 15: Answers to the professional knowledge audit

	Questions	The answers
1	What is the difference between safeguarding and child/adult protection?	See page 6.
2	Who is your designated safeguarding professional (DSP)?	In the first instance this will usually be your local operational senior or manager. If you don't know who that is, you need to find out who it is.
3	Where are your local safeguarding child/adult protection policies kept?	Agency policies: on your agency intranet. WSCB: on the internet. WSVAB: on the internet.
4	When should you make a child/adult protection referral to social care?	When you have a reasonable professional concern that either a child or adult may be at risk of significant harm or at serious risk.
5	Where are child/adults protection referral forms kept?	On your agency intranet.
6	What are the timescales for making a telephone/written child/adult protection referral to the local authority (social care)?	By telephone, within the same working day. In writing, within 48 hours, preferably the same day or asap.
7	Do I have to have firm evidence before I make a child/adult protection referral to social care?	No It is the duty of social care and the police to investigate any reasonable professional concern which you may have.

Section 16: Child protection policy and procedures

1. Policy statement

1.1 Wolverhampton Substance Misuse Service (WSMS) has a general responsibility to safeguard and promote the welfare of children and is committed to practice that ensures the welfare of the child is the paramount consideration and that children are protected from harm or abuse. This approach is based on and reflects the principles expressed in the following legislation and guidance: UN Convention on Rights of the Child; the Children Act 1989; *Working Together to Safeguard Children* 2013; Human Rights Act 1998; and Protection of Children Act 1999.

1.2 Through the use of this child protection policy and procedures, WSMS aims to ensure that staff are aware of their responsibilities to safeguard and promote the welfare of children and know what to do when they are concerned about the protection of a child.

1.3 WSMS is committed to working within locally agreed multi-agency child protection procedures as required by government guidance and local bodies such as the local safeguarding children's board. As a result WSMS will work co-operatively with statutory sector agencies such as the police and local authority children's services in their local area who are responsible for the investigation and assessment of child protection concerns.

1.4 WSMS staff should always record whether service users are parents and/or carers of children. Parents, carers and other adults will be made aware by their signing of a working agreement of the duties of WSMS in relation to child protection as required by this policy and that confidentiality will be broken to safeguard the welfare of a child or children.

1.5 WSMS will use this child protection policy and procedures in discussion and negotiation with organisations and groups with whom it enters into partnerships, working agreements and contracts. This will set the standard that will be met by WSMS projects in the provision of their services and the minimum standard expected by WSMS of other organisations and groups.

1.6 This child protection policy and procedures should be read and followed in conjunction with the WSMS code of professional conduct, the whistle blowing policy, protecting vulnerable adults and upholding client rights policy, serious untoward incidents policy, and disciplinary, capability and grievance procedures.

1.7 WSMS is committed to promoting the 'Think Family' approach to all work involving families. Therefore when different key workers are working with both parents and/or children who are in treatment, it is expected that the key workers liaise closely with each other and that this is evidenced in case recording.

2. Definitions

2.1 A child is anyone who has not yet reached their 18th birthday. 'Children' therefore means children and young people.[25]

2.2 Abuse is the violation of an individual's human and civil rights by any other person or persons.

2.3 A person may abuse or neglect a child by inflicting harm or by failing to prevent harm. It may consist of a single act or repeated acts. 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. A child may be abused by an adult or adults or another child or children.

2.4 The following main types of abuse are defined in the government's *Working Together* guidance.[26]

2.4.1 Physical abuse – A form of abuse which 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.

2.4.2 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 acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, 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.

2.4.3 Neglect – 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 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) or
- ensure access to appropriate medical care or treatment.

[25] s.2.1, Children Act 1989

[26] Department for Education (2013) *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children* London: Department for Education

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

2.4.4 Emotional abuse – 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 a child that they are worthless or unloved, inadequate or valued only insofar as they meet the needs of another 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 a 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 seeing or hearing 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 corruption of children. Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.

3. Child protection procedures

3.1. The following procedures set out the actions that must be taken when and by whom where there are any concerns relating to the protection of a child from abuse or harm. They are designed to ensure that any child protection concerns are dealt with swiftly and appropriately and in accordance with national and local legislation and guidance.

3.2 It is not the responsibility of WSMS staff to decide whether a child is being, or has been, abused or that someone poses a threat to a child's safety. The protection of children is a complex area. Under no circumstances should any individual worker or the organisation itself attempt to deal with the issue alone. It is the responsibility of every member of staff both legally and morally to take action to protect children by following these procedures.

3.3 It is the policy of WSMS to respect confidential information shared by service users. However it should be made clear to all service users that in matters of child protection, it may be necessary to break confidentiality, as the welfare of the child is paramount. Information must be shared as required by these procedures but must only be shared on a need-to-know basis. All related written information must be stored securely.

3.4 These procedures should be considered as mandatory actions and any failure to comply with them will be addressed through appropriate procedures.

3.5 WSMS management reserves the right to assess and act upon any concerns expressed under these procedures about the behaviour of a member of staff towards children irrespective of the outcome of any investigation undertaken by the police or local authority or a decision not to investigate by the police or local authority. This applies whether the behaviour has occurred in or outside the work situation.

3.6 It is the responsibility of all managers to ensure that every staff member for whom they are responsible is aware of, and understands, the importance of this policy and the related procedures.

3.7 It is the personal responsibility of each member of staff to ensure they are familiar with WSMS child protection policy and procedures and to act accordingly. Each WSMS workplace has either a full hard copy or access to an electronic copy of this child protection policy and procedures.

4. Procedure where there are concerns that a child is being abused or harmed

4.1 Concerns about actual or potential child abuse may be identified in a number of ways, including the following:

- Emergency situations may arise when a child(ren) is clearly at risk of abuse or harm.
- A service user may disclose information about the abuse of a child or make an allegation about the abuse of a child
- A child, if in contact with a member of staff, may disclose, allege or show signs through visible injury or behaviour that they have been or are being abused.
- A member of staff may become concerned about the abuse of a child through information that is shared by a service user or another member of staff.
- Something in the behaviour of a member of staff may alert a colleague or manager to concerns about the abuse of a child.
- Abuse is witnessed.

4.2 If an allegation or disclosure of abuse is made, staff should do the following:

- Listen carefully to what is being said.
- Explain that this information will need to be shared with a manager and possibly with others.
- Ask questions only to clarify matters already raised and not to investigate.
- Make a record as explained in 4.10 below.

4.3 All concerns must be treated seriously. Often child protection concerns emerge over a period of time during which suspicions and concerns accumulate slowly.

4.4 In an emergency situation where a child needs or may need immediate protection, staff should contact the police and then make a referral to local authority children's social care. Managers and senior managers must be informed as soon as possible, preferably immediately.

4.5 In circumstances other than in 4.4 above, if any member of staff has concerns about the welfare or safety of a child, they must discuss these with a manager or senior manager. Any concerns should be reported as quickly as possible and within a maximum of 24 hours of the concerns being raised or identified.

4.6 The manager will assess the information provided promptly and carefully, clarifying or obtaining more information about the matter as appropriate. Any child protection concerns must be passed to local authority children's social care without delay, initially verbally, and followed up in writing within 48 hours.

4.7 If the manager does not feel that there is any cause for concern but staff disagree, the concerns must still be passed on to local authority children's social care.

4.8 Managers need to be aware of their local child protection procedures provided by the local safeguarding children's board in their local authority area and of the relevant contact numbers and addresses of the statutory agencies in their locality.

4.9 The relevant statutory agencies will direct any investigation of the child protection concerns and direct WSMS staff's role within this investigation and assessment.

4.10 In all situations it is extremely important to record the details of an allegation, disclosure or reported concerns about a child protection matter. The following information should be recorded:

- Date and time of the observation/incident/disclosure/allegation.
- Who was involved.
- Names of person reporting and to whom the observation/incident/disclosure/ allegation was reported.
- What was said or done by whom.
- Does the child have a disability? If so, what impact does it have on their ability to report, self-protect, etc?
- Does the child communicate in spoken English? If not, then how do they communicate, and is an interpreter required?
- What action (if any) was taken and by whom?
- When and to whom in the statutory agencies the information was passed and if a referral was not made, why this decision was made.
- All records should be dated and signed by staff involved and the manager.

4.11 The record should be clear and factually accurate and identify any difference between fact and professional judgement/opinion as this distinction may be useful for any subsequent investigation or if it is used as evidence in court proceedings or disciplinary proceedings.

4.12 The record must be kept in a secure place and only shared with those who need to know the information as required by this policy and other policies and procedures of WSMS. This is for the protection of confidentiality of information for any named persons and for the protection of WSMS.

4.13 Under the Data Protection Act 1998, any records containing personal information may only be disclosed without the consent of the subject under particular conditions, including the prevention or detection of a crime. Information concerning a child at risk of abuse or harm would fall into this category and should therefore not be withheld from appropriate authorities. The recording of information and the extent of any disclosure of information should be appropriate for the purpose, and confidentiality maintained as far as possible for all concerned.

4.14 Managers will be responsible for informing the service manager of any child protection concerns that involve this child protection procedure.

5. Referrals to children's services

5.1 Concerns relating to the safeguarding of children and child protection can be raised from information from the service user, family members/concerned others and other professionals.

5.2 All raised concerns are taken seriously and WSMS recognises that information obtained from sources other than the service user require sensitive handling in deciding whether to inform the service user of the concerns or not.

5.3 The well-being and safety of the child/children is the most important consideration and determines all courses of action.

5.4 This means information in its widest application, for example, a service user failing to attend appointments raises concerns regarding the well-being of children under the care of the service user.

5.5 Do not attend (DNA):[27] Any service user who disengages from treatment in an unplanned way or who has missed appointments who is a parent, carer or child requires further attention from the keyworker. This is to ascertain whether further action by WSMS, including a referral to children's services, is required.

5.6 To make this decision, contact with other involved professionals or family members will be needed. Wherever possible, service users of all ages will be encouraged to agree to a communication plan at their first point of contact with WSMS. This way if they do not attend, then alternative routes of communication with them may in the first instance be explored.

5.7 As detailed in the WSMS child protection policy, a referral to children's services must show that our assessment – from information that we are in receipt of – warrants potential further investigation.

5.8 The decision to investigate further is not WSMS's decision. This responsibility lies with children's services. It is therefore vital that WSMS provides children's services

[27] See page 27 for more information on this.

with all the relevant information in as much detail as possible to assist children's services in their assessment.

6. The referral

6.1 Referrals to children's services are made following discussion with a senior practitioner or service manager. This discussion must take place promptly.

6.2 If you are concerned that a child may be suffering, or may be at risk of suffering significant harm, report your concerns to children's social care. Do this on the same working day. Outside office hours you should contact the emergency duty team.

6.3 This telephone referral should then be followed up in writing to children's social care via an inter-agency referral form within 48 hours (preferably the same day).

6.4 The need to discuss the referral with a senior practitioner must not lengthen the referral process. If the senior practitioner whom the staff member reports to is unavailable, the staff member must discuss the concern with another available senior practitioner or the service manager. In the event of these members of staff being unavailable, then a senior manager must be contacted. Managers can always be contacted during working hours and through an on-call duty system.

6.5 All referrals will be in writing and a receipt obtained that the referral has been received.

6.6 The referral and receipt must be kept in the service user's file.

7. Follow-up

7.1 The service user's keyworker is responsible for following up the referral to ascertain what actions, if any, are being undertaken by children's services.

7.2 The first check is made no later than one week after the date of the referral. This follow-up may be made by telephone contact or by email, and it must be noted in the service user's file, including what actions children's services are planning or have undertaken, or are not taking.

7.3 An agreement between children's services and the WSMS keyworker will be reached on the frequency of liaison between the two agencies, depending on the nature of the concern and any resulting actions. This will be discussed with a senior practitioner and must be noted in the service user's care plan.

7.4 In the event of children's services failing to respond to our initial follow-up, the keyworker will inform the senior practitioner, and a timescale will be agreed that includes the frequency that the keyworker is to try to obtain a response, and a date agreed by which the senior practitioner will be informed of the outcome of this proactive follow-up.

7.5 The timescale will be dependent on the severity of the concerns raised, and will end no later than two weeks from the initial attempt at follow-up.

7.6 If the follow-up information is not received within the agreed timescale, the service manager will be informed, who will then formally contact the children's services manager to ascertain the reasons for the lack of communication and to obtain information related to any action plans in the relevant case.

7.7 The service manager will complete an incident form which is forwarded to senior management and the safeguarding lead.

7.8 If the manager is unsuccessful in obtaining this information, then a senior manager will be informed who will formally contact the senior management for children's services. The local safeguarding lead within the local drug and alcohol action team will also be notified of the concerns, with communication pathways between the two agencies.

7.9 The service manager will start an incident form and the senior manager will complete it, outlining the outcomes.

7.10 The safeguarding lead will be informed at all key points during this process.

7.11 The WSMS service manager will be informed of the outcomes of the actions.

7.12 All relevant details will be recorded in the service user's file.

8. Different opinions regarding an action plan (escalation policy)[28]

8.1 There are times when a referral to children's services results in their assessment of there being no need for further action from them.

8.2 WSMS will seek to obtain clarifying information as to why this decision has been made. This information will then assist WSMS in determining if, from the information it already holds, there is agreement in this course of no further action.

8.3 This discussion is usually held between the WSMS keyworker and the social worker.

8.4 In the event of disagreement with the decision, with the keyworker believing the needs are greater than those assessed by children's services, WSMS will discuss this with children's services in order to attempt to obtain a satisfactory agreement together. If this is not possible and the keyworker believes that further action is needed, a senior practitioner or manager must be informed immediately.

8.5 The keyworker will provide a detailed account of all the background information to enable the manager to judge whether there is agreement with children's services or not. If the manager disagrees with the decision from children's services, then the manager will contact children's services and pursue further discussion in an attempt to reach a satisfactory conclusion. This must happen within two working days.

[28] This is also sometimes referred to as a professional disagreement policy.

8.6 This will also involve a letter to the children's services manager outlining the concerns. The manager will complete an incident form and send it to senior management.

8.7 If the issue remains unresolved then the service manager will escalate this to the next management level in children's services. This must happen within two working days.

8.8 If a satisfactory conclusion is not reached, then a senior manager will be informed, who immediately on becoming aware of the situation, will formally raise the concern with children's services senior management. This enables the decision to be discussed at a senior management level as appropriate and action agreed. This must be within two working days wherever possible. The safeguarding lead within the local drug and alcohol action team will also be notified.

8.9 If the senior managers are unable to resolve the issue then consideration must be given to referring the case to the Director or Assistant Director of Social Care who will make the final decision. This must be within two working days wherever possible.

8.10 The senior manager will complete an incident form and the WSMS service manager will be informed of the situation.

8.11 All relevant details will be recorded in the service user's file.

8.12 The senior manager will feed back to the practitioner and service manager with the original concerns.

8.13 All agreements and discussions throughout the whole referral process will be followed up with a letter to children's services outlining the agreements and action plans.

8.14 Where it is believed that there are wider lessons or practice issues to be learnt, then the case is to be referred to the local safeguarding leads within the drug and alcohol action teams and the local safeguarding and child protection boards.

9 Ongoing involvement in child protection proceedings

9.1 WSMS staff may be asked to get involved at other stages of the statutory child protection proceedings, such as providing information for the section 47 enquiries, attending a strategy discussion, attending a child protection conference or becoming a member of a core group to implement a child protection plan.

9.2 The Children Act 1989 places a statutory duty on services to assist the local authority in carrying out its social care functions under Part III and section 47 enquiries. Assessing the needs of a child and the capacity of their parents or wider family network adequately to ensure their safety, health and development very often depends on building a picture of the child's situation on the basis of information from many sources. WSMS staff may be asked to contribute information to these assessments.

9.3 WSMS has a duty to balance legal requirements on sharing information as set out in the Children Act 1989, the Children Act 2004, Human Rights Act 1998, the Data Protection

Act 1998 and the common law duty of confidence. In general, the law allows and expects sharing of information where safeguarding a child's welfare overrides the need to keep information confidential.

9.4 WSMS staff who are involved in ongoing child protection proceedings should always involve their manager in discussions about this work and be clear about their roles and responsibilities at all stages of the child protection proceedings.

10 Allegations, concerns or suspicions about the behaviour of WSMS staff

10.1 Any allegations, concerns or suspicions about a WSMS staff member must be reported. These may relate either to current or past behaviour. Concerns may come to light in a number of ways:

- A direct allegation from a child, young person, parent, carer or any other person.
- A complaint which suggests a staff member has acted in a way that could be seen as abusive.
- Information leading to a suspicion that a staff member may have abused a child.
- Information giving rise to child protection concerns about a staff member outside their WSMS work activities.

10.2 Any concerns about a WSMS staff member must be reported to a line manager or senior manager. If the concern is about the line manager or senior manager, the matter should be reported to that person's manager. Concerns should not be shared with the staff member themselves or any other colleague at this stage.

10.3 Fear that the suspicion or allegation may turn out to be unfounded should not prevent anyone from expressing any concerns. Line managers and senior managers will treat such concerns confidentially as set out in this policy and support any worker who reports concerns.

10.4 The manager will assess the information provided promptly and carefully, clarifying or obtaining more information from the person reporting the concern as appropriate. The manager will be responsible for deciding whether child abuse is suspected and will record the process they went through to arrive at a decision, and give clear reasons.

10.5 In any case of suspected child abuse, the manager will report the matter to local authority children's social care. If a criminal offence may have been committed against a child, the local authority will involve the police. If the protection concerns are raised in an emergency situation where the child's safety or protection is at immediate risk, then contact will be made with the police directly.

10.6 Once the matter has been reported, WSMS will ensure that there is either no further contact between the worker and any child, parent or carer concerned until the investigation is complete, or that any contact is supervised.

10.7 As soon as the local authority or the police give permission, details of the allegation/suspicion will be given to the staff member by the line manager or senior manager. Where possible this will be given immediately but in some circumstances there may be a need for delay. It may be at this point that the staff member has to be suspended from duty pending further investigation and enquiries.

10.8 The manager will also inform the staff member promptly of the outcome of the child protection investigation as soon as they are able and in accordance with the advice of the local authority or the police.

10.9 Any investigation and action by WSMS under disciplinary procedures will occur after the completion of any criminal investigation and proceedings by the police and after the completion or suspension of any child protection proceedings by the local authority and police. Investigation and action under WSMS' disciplinary procedures is not dependent on the outcome of a criminal investigation or child protection proceedings but may be informed by it. The standard of proof for a prosecution is 'beyond reasonable doubt'. The standard of proof for child protection action and internal disciplinary action is usually the civil standard of 'on the balance of probabilities'.

10.10 In any case of a proved complaint or allegation, particularly where this involves professional malpractice by a worker, whether from criminal proceedings or disciplinary proceedings, WSMS will ensure relevant agencies/professional bodies are informed. WSMS will refer the individual's name to the Secretary of State for consideration of inclusion on the Protection of Children Act (POCA) list.

11. Recruitment and selection of staff

11.1 WSMS recognises the importance of including child protection issues in its recruitment and selection procedures in order to recruit safely and to aim to ensure that staff working for the organisation are fit to be in contact with children or to hold a position of authority and responsibility.

11.2 WSMS recognises that in relation to employment in a post which involves contact with children, those convicted of certain offences do not have the protection of the Rehabilitation of Offenders Act 1974. WSMS will ensure that all job descriptions, job specifications and requirements make it clear where this applies and this information will be included in all advertising for these positions. The following procedures will apply to the recruitment and selection of staff who have contact with children and young people or who are in a position of authority and responsibility.

11.3 At the point of submitting a written application form, an applicant will be asked to sign a confidential written declaration either stating that they have no past convictions or convictions which otherwise might be considered 'spent', or to sign a confidential written declaration in which they provide information about anything they may have to disclose in relation to the above.

11.4 In order to confirm identity, photographic documentation such as a passport or driving licence will be required. All qualifications will be confirmed through

provision of written documentation. The applicant will be asked to provide these documents at interview.

11.5 Written references will specifically seek information about the applicant's experience of working with or contact with children and the referee's opinion on the applicant's suitability to have contact with children as appropriate to the post.

11.6 All reasonable efforts will be made to check that referees are bona fide, and if there is any doubt, applicants will be asked to provide an alternative.

11.7 New employees will be required to obtain the appropriate criminal record certificate by providing a disclosure at the appropriate level from the Criminal Records Bureau (CRB). This disclosure will provide the opportunity to check the information already declared by the applicant. The standard level and enhanced level of disclosures are available in respect of posts which are exceptions to the Rehabilitation of Offenders Act 1974, for those whose duties include contact with children or who hold a position of authority or responsibility. Until the appropriate criminal record certificate is provided, new employees must not work unsupervised with service users.

11.8 A standard disclosure will contain details of any spent and unspent convictions, as well as cautions, reprimands and warnings held on the Police National Computer. It will also indicate if there are no such matters on record. The disclosure will also reveal whether an individual is barred from working with children and/or vulnerable adults by virtue of inclusion on lists maintained by the Department for Education or the Department of Health. The disclosure is sent to the applicant and also to the registered body requesting the disclosure.

11.9 The enhanced disclosure will contain the same information as the standard disclosure, but may also contain non-conviction information from local police records. This information is supplied to the registered body but not to the applicant.

11.10 In the event of a returned positive disclosure, it should be clarified with the applicant that they accept the information provided. If they do not accept it, then they need to take the matter up with the CRB. A risk assessment should be undertaken on the relevance of any positive disclosure to the post to which the applicant is being appointed. Senior management, in consultation with the manager, will be responsible for making the risk assessment.

11.11 Disclosure information is only accurate on the day it is issued. The CRB recommends that employers should seek disclosures every three years. WSMS will ensure that every existing employee, if they take up a new position within the organisation that involves contact with children and young people or a position of authority and responsibility, provides a confidential declaration form and has a valid disclosure certificate from the CRB. Also WSMS will ensure that all existing employees who have contact with children and young people or are in a position of authority and responsibility are required to provide a confidential declaration and valid disclosure certificate from the CRB every three years. All staff have a duty to report any convictions as they occur whilst in employment at WSMS.

11.12 Any disclosure information received by WSMS will be subject to the Code of Practice required by the CRB. This means disclosure information will either be destroyed immediately or kept as a confidential record only for the length of time required for appropriate decisions to be made. WSMS will treat all disclosure applicants fairly and will not discriminate because of a non-relevant conviction or other information revealed in a disclosure.

12. Training, supervision and support

12.1 It is the responsibility of WSMS to ensure that all staff receive appropriate training in order to raise their awareness and understanding of child abuse and protection and to develop their confidence in using this child protection policy and procedures in their practice.

12.2 It is the responsibility of WSMS to provide appropriate supervision to staff in order to ensure that they understand their roles and responsibilities under this child protection policy and procedures and that they are following it in their practice.

12.3 WSMS recognises that staff may find it stressful and challenging when dealing with child abuse and protection situations. WSMS will ensure that staff are fully supported and have access to specialist counselling as best as possible during this time.

13. Review and evaluation

13.1 The operation of this child protection policy and procedures will be subject to review and evaluation by the following means:

- Regular review at senior management level of incidents requiring the implementation of child protection procedures at project level.
- Regular audit of the frequency of discussion of and implementation of the child protection policy and procedures at project level.
- In response to any changes in legislation and national and local guidance.
- In response to feedback from members of WSMS and other partner organisations.

13.2 The content of this child protection policy and procedures and its application in practice will be formally reviewed on an annual basis.

14. Failure to comply

14.1 This policy and associated procedures should be considered as mandatory and any failure to comply with it will be addressed through appropriate procedures and could lead to disciplinary action.

Section 17: Vulnerable adult policy and procedures

Part 1: Policy

1. Purpose

1.1 The aim of this document is to promote the safety and protection of vulnerable adults in line with statutory guidance set out by the Department of Health in *No Secrets*.[29] It sets out the definitions of abuse and vulnerability and outlines WSMS' policy and procedures in the prevention and investigation of abuse.

2. Definitions

2.1 **Vulnerable adult**
A vulnerable adult is defined as a person aged 18 years and over "who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself or unable to protect him or herself against significant harm or exploitation".[30]

2.2 **Abuse**
Abuse is defined as "a violation of an individual's human and civil rights by any other person or persons"[31] Abuse can be:

- a single act or repeated acts
- physical, verbal or psychological
- an act of neglect or an omission to act
- when a vulnerable person is persuaded to enter into a financial or sexual transaction to which he/she had not consented, or cannot consent.

Abuse can occur in any relationship and may result in significant harm to, or exploitation of, the person subjected to it.

2.3 **Significant harm**
Significant harm is defined as:

- "Ill treatment (including sexual abuse and forms of ill treatment that are not physical) or
- the impairment of, or an avoidable deterioration in, physical or mental health and the impairment of physical, intellectual, emotional, social or behavioural development".[32]

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[29] Department of Health (2000) *No Secrets: Guidance on protecting vulnerable adults in care* London: Department of Health
[30] Department of Health (2000) *No Secrets: Guidance on protecting vulnerable adults in care* London: Department of Health
[31] Department of Health (2000) *No Secrets: Guidance on protecting vulnerable adults in care* London: Department of Health
[32] Lord Chancellor's Department (1997) *Who Decides? Making decisions on behalf of mentally incapacitated adults;* Law Commission's 2010 consultation: *Review of Adults Social Care Law*

3 Responsibility for the safeguarding of vulnerable adults

3.1 All WSMS staff and volunteers have a responsibility to work in the interests of individual service users and to act in a way which promotes and safeguards their well-being. Accordingly, they must take all reasonable steps to protect vulnerable adults from abuse, understand the risk factors, types of abuse and indicators (physical, sexual, emotional/psychological, financial, neglect and discriminatory and know how to respond when they witness it or when it is disclosed to them. All staff and volunteers working within agencies have a responsibility to address vulnerable adult abuse. Ignoring abuse is not an option.

3.2 All managers have a responsibility to ensure:

- they have an operational knowledge of WSMS' vulnerable adults policy and procedure
- that the staff they supervise have the appropriate support, training and supervision to recognise and alert the appropriate person when they have any concerns or suspicions of abuse
- that the staff they supervise are aware of both the policy and procedures in this document
- they are able and prepared to refer any concerns to social care or the police as required by the procedures in part 2
- that where other simultaneous procedures apply (e.g. grievance, complaints, disciplinary) the welfare and safety of the vulnerable adult remains paramount.

4. Guiding principles

4.1 All WSMS staff and volunteers will adhere to the following principles in working with vulnerable adults:

- The human and civil rights of vulnerable adults will be promoted and protected.
- The independence, well-being and choices of vulnerable adults will be actively promoted.
- Vulnerable adults will be assumed to have capacity except where it is established that this is not the case. Where a vulnerable adult lacks the mental capacity to make decisions, assistance will be offered on a multi-disciplinary basis to safeguard his/her best interests.
- A vulnerable adult who has mental capacity has the right to take risks. WSMS recognises and accepts that an individual has the right to self-determination that may involve a degree of risk. WSMS will undertake and record risk assessments to monitor this.
- Vulnerable adults have a right to receive the protection of the law, have access to justice and to be appropriately supported through the criminal justice process. WSMS will provide suitable advice and support to enable this to occur.

- Vulnerable adults' views will be considered and where possible they will be fully involved in actions taken under the procedures. A vulnerable adult has the right to an advocate to assist them in this process.

- When intervention is necessary to reduce risk to a service user who is a vulnerable adult, account will be taken of the disruption to the service user and every effort will be made to minimise this disruption and to keep it in proportion to the identified risks.

- Confidentiality relating to vulnerable adults will be ensured when it is practicable, and personal information will only be shared with other agencies with the permission of the individual concerned or in line with what is permitted by the law and local policy or protocols.

- WSMS will work to promote awareness and understanding of the law, guidance and new initiatives relating to safeguarding vulnerable adults.

Part 2: Procedure

5. Overview of the process

5.1 The prevention and investigation of abuse will be carried out in accordance with the following process:

- The 'alerting role': this describes the stage at which adult protection concerns are first recognised.

- The 'referral role': this describes the notification of concerns to one or more of the statutory investigating or regulatory agencies (e.g. social care, the Commission for Social Care Inspection, the police).

5.2 Any investigations will be undertaken by the investigating or regulatory agencies. The term 'investigation' in this context describes the process of exploring concerns to ensure a full understanding of the situation so that appropriate action can follow. Investigations can have many strands, including one or more of the following issues: criminal justice, protection of others, regulation, contracts, employee discipline, care management, health and safety or professional practice.

WSMS staff should not take part in any investigation. Their duty is to report only.

6. The 'alerting' role

6.1 All WSMS staff and volunteers who work with, or have contact with, vulnerable adults must:

- be alert to the possibility of abuse

- know who they should report any concerns or suspicions to

- be able to share their concerns with appropriate people.

In addition, staff are required to recognise and report oppressive, abusive, discriminatory or otherwise poor care practices.

No suspicion of abuse should ever be ignored.

6.2 Staff may become aware of possible abuse when they:

- witness an abusive act
- are told about abuse by someone else
- are told about abuse by the service user
- find evidence of abuse
- recognise several of the abuse indicators and become concerned.

6.3 Staff who become aware of possible abuse should do the following:

- Try and ensure the immediate safety of the alleged victim. If there is a major injury, appropriate healthcare should be arranged (e.g. an ambulance or a visit to an accident and emergency department).
- Contact their line manager so that the matter can be reported in accordance with the policy and procedures in this document.
- Record clearly, factually and accurately any information about allegations, concerns and disclosures of abuse as soon as possible (see section 13 for details of how to record information). When recording any disclosure, record the actual words used by the person.
- Take the necessary steps to preserve any evidence of abuse, which may be used to assist an investigation, by keeping it safe and free from contamination.
- Co-operate with any investigation undertaken in accordance with these procedures.

7. Do's and don'ts when abuse is disclosed

Do's

- Listen carefully, stay calm and be sympathetic.
- Be aware that medical evidence may be needed.
- Reassure the person that the information will be treated seriously.
- Tell the person it was not their fault.
- Explain the referral process and that a line manager has to be informed.
- Advise that the matter will be referred on if they consent.
- Explain that in some circumstances the matter may be referred without their consent on a need-to-know basis but their wishes will be made clear if this occurs.

Don'ts

- Question or put pressure on the person for more details.
- Act in a way that may prevent the person talking about the abuse in future.
- Promise to keep secrets.
- Make promises you can't keep (e.g. "it won't happen again").
- Question the alleged abuser.

8. Concerns about employees, volunteers or adult placement carers

8.1 All staff have a responsibility to report any suspicions of poor or abusive practice. This will usually be to their line manager unless it is believed that that person may be involved or colluding with the abusive practice, in which case the whistleblowing procedure will be used.

8.2 Where a concern has been raised in good faith about an organisation or a worker, the person raising the concern should be supported, whatever the outcome.

8.3 When suspected abuse is reported to managers, any necessary action should be taken immediately to ensure the safety of the alleged victim and other service users. It is initially for the manager to consider whether it is appropriate for the worker to continue to work while a referral is being made. Suspension should certainly be considered by the WSMS service manager in situations where:

- there is any possibility of further incidents or abuse
- continuing to work might compromise evidence
- continuing to work would adversely affect the worker, colleagues or service users.

No disciplinary investigation should be undertaken prior to a referral to social care or the police or the WSMS service manager.

9. Risk assessment

9.1 In all situations where abuse has been alleged or suspected (even if a referral is not made) staff should undertake an assessment of risks in line with WSMS user risk assessment policy. This is to ensure that anyone who may need to be aware of specific or general risks is informed of them as soon as they are identified. It is equally important that any information that might affect the risk assessment is shared immediately.

9.2 Risk assessments should consider all factors that might reasonably be considered to have a potentially harmful effect on service users, carers, staff or the public. The risk assessment must identify the actual or potential impact of the identified concerns and the probability of them occurring. Once these issues have been identified, the assessment will show what steps have been taken to address or mitigate these risks.

10. Making a referral

10.1 Where a concern about abuse has been raised, a referral should be made immediately, and in all instances within one working day of the abuse being suspected or disclosed.

10.2 Staff who make a referral should follow up the verbal referral with written information by completing the necessary referral form and sending it to their line manager. It is the line manager's responsibility to make the referral to social care.

10.3 Referrals should always be made by telephone, and managers should ensure that the referral is received by someone who is able to act upon the information given. It is not safe or acceptable for referrals to be made only by letter, fax and email or by leaving messages on answering machines or mobile telephones.

10.4 Where concerns or allegations relate to the behaviour of a paid worker or volunteer then these should be reported through the line management arrangements to the appropriate manager who deals with that person, as well as through the routes detailed in these procedures as necessary.

11. Referral information

11.1 Where a referral is made, the following information (if available) should be provided.

- Personal details of the vulnerable person (name, date of birth, address, gender, race, faith, culture and current whereabouts).
- Referrer's name, address, contact number, role and the nature of their involvement.
- The details of what has occurred (what, where, when and how it came to light).
- Details of the alleged abuser (name, address, current whereabouts) and their relationship to the alleged victim.
- Nature of the abuse and its impact on the alleged victim.
- Details of any witnesses.
- Whether immediate action is required to protect the vulnerable adult.
- Whether other people may be at risk.
- Details of any action already taken (e.g. a call to the emergency services, crime number and interim protection measures).
- Details of other agencies involved and the nature of their involvement.
- Whether the vulnerable adult is aware of the referral being made.
- Whether the vulnerable adult has given consent to the referral being made.
- The views of the alleged victim.
- Any view about the mental capacity of the alleged victim.
- Whether the matter has already been referred to another agency.
- Any known language or communication issues (e.g. the need for an interpreter).

12. If the alleged abuser is a vulnerable adult

12.1 In cases where the alleged abuser is a vulnerable adult they should be referred to the social work team of the local social care authority. This person may need an assessment in their own right to ascertain whether they require any specialist services. If the incident is subject to a criminal investigation the person may need assistance to ensure they are appropriately represented and that they receive appropriate assistance.

13. Outcomes of referrals

13.1 There are several possible outcomes for referrals. The decision on any outcome will be taken by the local safeguarding board.

Section 18: References

- Drugs of Abuse Testing Guidance (Birmingham and Solihull Mental Health NHS Foundation Trust Addiction Services, 8 August 2013)

- Department for Education (2009) *Understanding Serious Case Reviews and Their Impact: A biennial analysis of serious case reviews between 2005 and 2007* London: Department for Education

- Department for Education (2013) *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children* London: Department for Education

- Department of Health (2011) *Statement of Government Policy on Adult Safeguarding* London: Department of Health

- Department of Health (2000) *No Secrets: Guidance on protecting vulnerable adults in care* London: Department of Health

- Department of Health (2007) *Drug Misuse and Dependence: UK guidance and clinical management* London: Department of Health

- Purpose specific information sharing agreement (PSISA) – tier three agreement for sharing information between partners of the WSMS programme (Nacro, 2013)

- Department for Children, Schools and Families, Department of Health and National Treatment Agency for Substance Misuse (2009) *Joint Guidance on Development of Local Protocols Between Drug and Alcohol Treatment Services and Local Safeguarding and Family Services* London: Department for Children, Schools and Families

- Ofsted (2013) *What About the Children? Joint working between adult and children's services when parents or carers have mental ill health and/or drug and alcohol problems*, available at http://www.ofsted.gov.uk

- Information sharing protocol (Safer Wolverhampton Partnership, February 2012)

- Standing Conference on Drug Abuse (SCODA) (1997) *Assessment Framework: Guidelines on assessment* London: SCODA

- Wolverhampton overarching information sharing protocol (Wolverhampton City Council, version 1.6)

- Wolverhampton Safeguarding Children Board (2013) *Hidden Harm – Parental Substance Misuse and the Effects on Children: Multi-agency guidance* Wolverhampton: Wolverhampton Safeguarding Children Board

- Wolverhampton Safeguarding Vulnerable Adults Board (2012) *Local Guidance for Partner Agencies and Service Providers* Wolverhampton: Wolverhampton Safeguarding Vulnerable Adults Board