An open learning programme for pharmacists and pharmacy technicians

Safeguarding children: a guide for the pharmacy team
Second edition

CPPE
The University of Manchester

Educational solutions for the NHS pharmacy workforce

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http://www.cppe.ac.uk
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About CPPE

The Centre for Pharmacy Postgraduate Education (CPPE) is funded by the Department of Health to provide continuing education for practising pharmacists and pharmacy technicians providing NHS services in England. We are part of the Workforce Academy, within the School of Pharmacy and Pharmaceutical Sciences, which is part of the Faculty for Medical and Human Sciences.

CPPE offers a wide range of learning opportunities for the pharmacy workforce. Our full learning portfolio is available on the internet at: http://www.cppe.ac.uk

Themes

We have allocated themes to all our learning programmes. There are 28 themes in total and they allow you to navigate easily through our full learning portfolio. We have assigned a different colour to each of our themes, and this is used to identify the theme in the annual prospectus, in CPPE news & events, on our website, and on the covers of all the learning programmes.

This learning programme is part of the Child health theme. You will find additional learning programmes within this theme in our prospectus and on our website.

This programme can be downloaded in PDF format from our website: http://www.cppe.ac.uk

CPPE 1 2 3

We recognise that people have different learning needs and not every CPPE learning programme is suitable for every pharmacist or pharmacy technician. Some of our programmes contain core learning, while others deliver more complex learning that is only required to support certain roles. So we have created three categories of learning – CPPE 1 2 3 – and allocated each programme to an appropriate category.

The categories are:

- CPPE 1 Core learning (limited expectation of prior knowledge)
- CPPE 2 Application of knowledge (assumes prior learning)
- CPPE 3 Supporting specialisms (CPPE may not be the provider and will signpost you to other appropriate learning providers).

This is a CPPE 1 learning programme.
Continuing professional development

You can use this learning programme to support your continuing professional development (CPD). Consider what your learning needs are in this area. You may find it useful to work with the information and activities here in a way that is compatible with the Royal Pharmaceutical Society of Great Britain’s approach to continuing professional development (http://www.rpsgb.org.uk/registrationand support/continuingprofessionaldevelopment) because you will be able to relate it to your personal circumstances more closely. Use your CPD record sheets or go to: http://www.uptodate.org.uk/home/welcome.shtml to plan and record the actions you have taken.

Activities

Exercises

We include exercises throughout this programme as a form of self-assessment. Use them to test your knowledge and understanding of key learning points.

Practice points

Practice points are an opportunity for you to consider your practical approach to the effective care of patients or the provision of a service. They are discrete activities designed to help you to identify good practice, to think through the steps required to implement new practice, and to consider the specific needs of your local population. We have designed the practice points in this programme to help you and your team to make links between the learning and your daily practice and to co-ordinate with other healthcare professionals.

Assessing your learning on safeguarding children

The assessment linked to this programme is the Safeguarding children online e-assessment. You can only access this e-assessment through our website: http://www.cppe.ac.uk You must submit your answers online.

References and further reading

You can find references for all the books, articles, reports and websites mentioned in the text, together with a list of further reading to support your learning at the end of the programme. References are indicated in the text by a ‘superscript’ number (like this3).
Programme guardians

CPPE has adopted a quality assurance process called ‘programme guardians’. A programme guardian is a recognised expert in an area relevant to the content of a learning programme who will review the programme every six months. We will post any corrections, additions, deletions or further supporting materials that are needed as an update to the programme on the CPPE website. We recommend that you refer to these updates if you are using this (or any other) learning programme significantly after its initial publication date. A full list of programme guardians is available on our website. You can email your comments about this programme to them at: info@cppe.ac.uk

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Disclaimer

CPPE recognises that local interpretation of national guidance may differ from the examples used in this learning programme and you are advised to check with your own relevant local guidelines. You are also advised to use this programme with other established reference sources. If you are reading this programme significantly after the date of initial publication you should refer to current published evidence. CPPE does not accept responsibility for any errors or omissions.

Feedback

We hope you find this learning programme useful for your practice. Please help us to assess its value and effectiveness by completing the online feedback form available on our website: http://www.cppe.ac.uk via the My CPPE tab. Simply scroll down to find the learning programme title and click on the Tell us what you think icon. CPPE may email you a reminder to do this. You can also email us direct if you feel your comments are urgent, using the email address: feedback@cppe.ac.uk
The subject of children’s safety has rarely left the political agenda over the last 30 years, with cases of child abuse and neglect making the headlines with unacceptable regularity. In February 2000, the shocking and tragic death of Victoria Climbie prompted a public enquiry and subsequent recommendations which continue to inform policy and legislative changes. Many of these changes affect the pharmacy workforce who, together with all adults working with children, are responsible for safeguarding them. In August 2007, the equally tragic death of Baby P triggered national outrage and calls for reform of the safeguarding system in England. Three inquiries and a nationwide review of social care services are underway.

Pharmacists and pharmacy technicians regularly come into contact with children and their families and are ideally placed to identify children at risk of abuse and neglect. It is important therefore that they are familiar with current legislation and guidance relating to the issues surrounding the safeguarding of children. Local procedures should be in place in the event that a case of suspected abuse or neglect is identified. To take no action could potentially result in serious injury or even the death of a child.

**NSF for children, young people and maternity services¹**

**Standard 5**

All agencies work to prevent children suffering harm and to promote their welfare, provide them with the services they require to address their identified needs and safeguard children who are being or who are likely to be harmed.

**Point 6:**

**Recognising a Child or Young Person who requires protecting from harm**

‘Safeguarding children and young people from harm depends upon staff being alert to signs and symptoms of abuse or neglect, high quality assessments and effective communication and sharing of information. Recording and communicating information in a clear and timely manner and systematically gathering information from a range of sources improve identification of children and young people in need or at risk of harm.’

This booklet seeks to provide an overview of the background and policy surrounding the safeguarding of children and to identify resources and procedures available to support the pharmacy workforce and other health professionals working with children. Once you have read through the booklet you should be familiar with the relevant legal and government policy issues and know where to access appropriate local services so that you feel confident to act if confronted with a suspected case of child neglect or abuse.

This programme should take you approximately **1.5 hours** to work through.

**Target audience**

We have written this learning programme for all pharmacists and pharmacy technicians offering NHS services. As health professionals you must ensure that you understand your roles and responsibilities in relation to safeguarding children.
Learning style adopted in this programme
This learning programme is split into six sections. We suggest that you work through these in order. This will allow you to develop an understanding of the policy and legislation in this area and how these apply to your role as a pharmacy professional.

Learning objectives
CPPE has linked all its learning programmes to the Royal Pharmaceutical Society of Great Britain’s competences for pharmacists and pharmacy technicians. This will make it easier for you to connect your professional practice to your learning needs and learning activities. We have selected only the competences for general pharmacists and pharmacy technicians, but we are aware that others exist.

We have also linked the learning to the dimensions of the NHS Knowledge and Skills framework (KSF).

The competences and dimensions relevant to this programme are:

<table>
<thead>
<tr>
<th>Learning objectives</th>
<th>RPSGB competences</th>
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<tbody>
<tr>
<td>Summarise the background and policy surrounding the safeguarding of children and the issues this raises for pharmacists and pharmacy technicians.</td>
<td>G1, TG2, TG16</td>
<td>Core</td>
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<td></td>
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<td>Personal and people development</td>
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<td>Level 3</td>
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<tr>
<td>Convey the importance for pharmacists and pharmacy technicians to increase their awareness of child abuse and neglect and develop ways of working with other health professionals to promote best practice to deal with situations involving suspected abuse or neglect.</td>
<td>G1, G2, TG1, TG16</td>
<td>Core</td>
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<td>Communication Level 3</td>
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<td>Health, safety and security Level 3</td>
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<td>Equality and diversity Level 3</td>
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<td>Highlight situations in which you are best placed to observe signs of abuse or neglect and the legal issues to consider when making a referral.</td>
<td>G1, G2, TG1, TG2</td>
<td>Health and well-being</td>
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<td>Identify sources of useful information and contacts for the development of local procedures for dealing with suspected child abuse or neglect observed in a pharmacy setting.</td>
<td>G1, G2, G8, TG1, TG7</td>
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Section 1

Background and policy

1.1 The Victoria Climbie Inquiry report


The report detailed a catalogue of administrative, managerial and professional failures. It outlined a number of occasions upon which the most minor and basic intervention on the part of the staff concerned could have made a material difference to the eventual outcome. Victoria came into contact with:

- four social care departments
- three housing departments
- two specialist child protection teams of the Metropolitan Police
- two hospitals
- a families centre managed by the National Society for the Prevention of Cruelty to Children.

Many of the concerns identified in Victoria’s case have been replicated in a number of cases elsewhere in the country.

The chairman of the inquiry, Lord Laming, reported that in general the required legislation was in place, but that there were failures to implement it. Senior staff were criticised for poor organisation and delivery of services, lack of accountability and the low priority given to keeping children safe.

Recommendations

The report outlined three areas for improvement:

- a fundamental change in the focus of managers in key public services towards the quality of front-line services and away from bureaucracy
- a clear and unambiguous line of managerial accountability both within and across public services
- the replacement of area child protection committees or any proposal for a national child protection agency, with a new national agency for children and families. This agency should have powers to ensure the efficiency of all of the key services affecting children. The Chief Executive of this agency could undertake the functions of a Children’s Commissioner for England.

Lord Laming called for immediate action for many of the 108 recommendations made in his report. Seventy-five percent of these represent improvements to basic professional practice in police, health and local government services. He recommended that chief executives undertake an audit of services for children as a matter of urgency.

For further information see: http://www.victoria-climbie-inquiry.org.uk
1.2 Key policies and legislation

The first national guidelines for dealing with child abuse issues were produced in 1974, following an enquiry into the death of Maria Colwell in 1973. Further deaths in the 1980s prompted enquiries, leading to the publication by the Department of Health in 1988 of *Protecting children*. This document expanded on types of abuse beyond physical abuse, to address issues surrounding neglect, sexual and emotional abuse – the Children Act then followed in 1989.

The following section provides a chronological overview of legislation which impacts on procedures relating to the safeguarding of children and highlights important issues arising from this legislation.

**Children Act 1989 and Children Act 2004**

The Children Act 1989 provides a comprehensive framework for the care and protection of children. It centres on the welfare of children up to their 18th birthday, defines parental responsibility and encourages partnership working with parents. It continues to be important that concerns about children are discussed with parents, unless there is a risk of harm to the child or the professional.

The reason for deciding not to share information or concerns with a parent should be documented.

Issues of race, religion, culture and language were also considered in an holistic approach and inter-agency co-operation encouraged. This provided the legislative framework for procedures relating to the safeguarding of children.

The Children Act 2004 supplemented the 1989 Act, reinforcing the message that all organisations that work with children and families share a commitment to safeguard and promote their welfare; for many agencies that is underpinned by a statutory duty or duties. Note: All NHS agencies and those commissioned by the NHS have a statutory duty towards safeguarding children.

Section 13 of the Children Act 2004 sets out a requirement for the establishment of a local safeguarding children board (LSCB) in each local authority area. The membership of each LSCB is made up of relevant statutory partners who are responsible for the overseeing of all issues relating to the safeguarding of children across the local authority area.

**Hidden harm – responding to the needs of children of problem drug users (2003)**

*Hidden harm*, published by the Advisory Council on the Misuse of Drugs (ACMD) is the report of an Inquiry focused on parental problem drug misuse and its actual and potential effects on children. The report estimates that there are between 250,000 and 350,000 children of problem drug users in England and Wales, that is two to three percent of all children under the age of 16. The report also concludes that parental drug misuse can and does cause harm to children (and young people) at every age, from conception to adulthood, including physical and emotional abuse and neglect. A thorough assessment of the child or young person is required to determine the extent of need and level of risk of harm in each case.
Every child matters (2003)
In response to the report by Lord Laming, the Green Paper, *Every child matters*, was produced in September 2003, proposing changes designed to improve the care of children. This consultation document made recommendations about how to ensure that all children and young people receive protection and are given the opportunities to maximise their potential, while ensuring that no child ‘falls through the net’. One of the main focus areas of the Green Paper is ‘early intervention and effective protection’.

A requirement of the report was for local authorities to combine children’s services, and for one person with increased accountability to oversee them.

The document focuses on five outcomes as targets for all those working with children – explaining that every child ‘whatever their background or circumstance’ should have the support they need to:

- be healthy
- stay safe
- enjoy and achieve
- make a positive contribution
- achieve economic well-being.

The Children Act 2004 provides the legal framework for new legislation to enable the changes required to achieve the five outcomes listed above. For example, provisions in the Act enable better sharing of information between professionals, and include plans for the production of a national database (contact point) which would hold information on all children and young people.

For further information visit: [http://www.everychildmatters.gov.uk](http://www.everychildmatters.gov.uk)

Every child matters: next steps (2004)
In March 2004, more detailed guidance was provided in response to the consultation document. *Every child matters: next steps* also included an overview of the Children Bill, introduced in April 2004, which became the Children Act in November 2004.

For further information visit: [http://www.everychildmatters.gov.uk](http://www.everychildmatters.gov.uk)

A national framework to be used to implement the changes to children’s services outlined in earlier documents and supported by the Children Act 2004 was presented in *Every child matters: change for children*. The emphasis of this document is to prevent problems, rather than deal with them as they arise. The framework encompasses far-reaching changes to children’s services, with all agencies required to develop ‘a shared sense of responsibility... for safeguarding children and protecting them from harm’ and to ensure they are ‘working together more effectively’.

The framework builds on the five outcomes listed above and includes targets and indicators, together with inspection criteria on which organisations will be assessed. A useful summary of the outcomes framework is available from the *Every child matters* website given overleaf.
Pharmacists and pharmacy technicians working as part of a multidisciplinary team can make an important contribution to these outcomes, as outlined in the examples provided below.

1. Pharmacists and pharmacy technicians can help to improve all five outcomes by providing good quality information, advice, support and signposting to appropriate services when a need is identified.

2. The outcome for which pharmacists and pharmacy technicians can make a significant impact is ‘be healthy’, which targets smoking, alcohol intake and the promotion of a healthy diet, to include five portions of fruit and vegetables each day.

3. The pharmacy team can contribute towards the outcome, ‘stay safe’, by recognising and referring suspected neglect or abuse to relevant people as discussed below and by promoting good physical and mental health (see Section 6 of this booklet). Safeguarding children issues are included in this outcome which focuses on keeping children safe from maltreatment, neglect, violence and sexual exploitation.

4. The outcome ‘make a positive contribution’ recommends that children are included in decision-making. Pharmacists and pharmacy technicians should consider this when developing new services, for example, by inviting children and young people to contribute to focus groups.

For further information visit: http://www.everychildmatters.gov.uk

*Working together to safeguard children (2006)*

*Working together to safeguard children (2006)* sets out how organisations and individuals should work in partnership to safeguard and promote the welfare of children. The guidance has been updated since the previous version of *Working to safeguard children* (1999). The new version reflects developments in legislation, policy and practice.

This guidance outlines the key responsibilities for those who have specific duties to safeguard children. Part 1 of the document is issued as statutory guidance; Part 2, incorporates good practice information. Clear guidance is provided as to the functions of an LSCB.

Part 1 (statutory guidance), Chapter 2 of the document clearly states the role of health professionals and organisations in safeguarding and promoting the welfare of children. The general principles to be applied are:

- aim to ensure that all affected children receive appropriate and timely therapeutic and preventative interventions
- those professionals who work directly with children should ensure that safeguarding and promoting their welfare forms an integral part of all stages of the care they offer
- those professionals who come into contact with children, parents and carers in the course of their work also need to be aware of their safeguarding responsibilities
ensure that all health professionals can recognise risk factors and contribute to reviews, enquiries and child protection plans, as well as planning support for children and providing ongoing promotional and preventative support through proactive work.

The document outlines the new statutory requirement (since April 2008) to review all child deaths and the need for professional involvement.

Part 2 (non-statutory guidance), Chapter 9 summarises the impact of maltreatment on children’s health and development. It highlights that where children or young people are living in particularly stressful circumstances there is a requirement on professionals to take special care to help safeguard them.

These circumstances would include:
- living in poverty
- where there is domestic violence
- where a parent has a mental illness
- where a parent is misusing drugs or alcohol
- where a parent has a learning disability
- facing racism and other forms of social isolation
- living in areas with a high level of crime, poor housing and high unemployment.

*Working together to safeguard children (2006)* also provides guidance on how to intervene with:
- children living away from home
- children involved in sexual exploitation
- disabled children
- children pornography and the internet.

Section 2.40 of the document states ‘All healthcare organisations must ensure they have in place safe recruitment policies and practices, including enhanced criminal record bureau (CRB) checks, for all staff including agency staff, students and volunteers.’

Section 2.73 of the document lists pharmacists as one of the professional groups who should have knowledge of the LSCB procedures and how to contact named professionals for advice and support relating to safeguarding children issues.

*Working together to safeguard children* (1999) and (2006) have resulted in many improvements to the area of safeguarding children.

For further information visit: [http://www.everychildmatters.gov.uk](http://www.everychildmatters.gov.uk)

**The common assessment framework**

The common assessment framework (CAF) is a shared assessment tool for use across all children’s services. It aims to help early identification of need and promote co-ordinated service provision. The assessment tool can be used by any professional providing a service for the child or family with the family’s consent. It is unlikely that pharmacy staff will be required to complete a CAF but could be approached by another professional to contribute information.

For further information visit: [http://www.everychildmatters.gov.uk](http://www.everychildmatters.gov.uk)
1.3 Legislation and guidance relating to sexual health services

Recommended standards for sexual health services\textsuperscript{14} aims to reduce the conception rate in young people aged under 18. Pharmacists are already helping to address this issue by targeting 12 to 17-year-olds and providing emergency hormonal contraception under patient group directions. In providing this service pharmacists may encounter situations of sexual abuse. It is important therefore to be aware of legislation and guidance in this area. Further guidance on the provision of emergency hormonal contraception can be found in the CPPE open learning programme, \textit{Emergency contraception}.

\section*{Sexual Offences Act 2003}

The Sexual Offences Act 2003\textsuperscript{15} was introduced with the aim of protecting children under 16 years of age from sexual abuse. The Department of Health has also produced related guidance for health professionals relating to the provision of sexual health services as exempted in the Act. This includes advice on how to deal with a request for contraception from a young person under 16 years of age. The guidance clarifies issues such as confidentiality and refers health professionals to \textit{Working together to safeguard children} (1999)\textsuperscript{13} and (2006)\textsuperscript{12} (see Section 1 of this booklet) which provides recommendations for locally agreed safeguarding children protocols. \textit{(Further information regarding confidentiality issues is provided in Section 4 of this booklet.)}

The Family Planning Association (FPA) published a useful factsheet entitled: \textit{The law on sex}\textsuperscript{16} which summarises UK law relating to sexual activity; it is available online at: \url{http://www.fpa.org.uk/Information/Factsheets/} Alternatively, pharmacists and pharmacy technicians may obtain advice from their local safeguarding children team, the pharmacy law section at the Royal Pharmaceutical Society, or helplines provided by their professional indemnity insurer.

In summary, the key issues include:

- the age of consent for homosexual or heterosexual activity in England and Wales is 16 years
- consensual sex between two teenagers aged under 16 years is not likely to lead to prosecution under the Sexual Offences Act 2003 unless abuse or exploitation has occurred
- children aged under 13 years are not legally able to give their consent to sexual activity under any circumstances and ignorance about age cannot be used as a defence, unlike for 13 to 15-year-olds
- rape is defined as the intentional penile penetration of the vagina, mouth or anus of another person without consent or if the other person is less than 13 years old. Women cannot therefore be charged with rape, but can be charged with sexual assault.
- penetration for sexual purposes, of the vagina or anus of another person by a body part or anything else without consent is also an offence under the Sexual Offences Act 2003.
Sex with a 12-year-old is therefore always a criminal offence and there is a strong moral obligation for anyone aware that such an offence has taken place to report this to the police. Sex with a person between the ages of 13 and 16 years of age is also an offence in law. However, in the case of mutually consenting teenagers of a similar age most health professionals would not feel obliged to inform the police or social care, and police would be unlikely to bring charges.

Consent, confidentiality and sexual health services

If appropriate, it is recommended that parental consent is obtained when treating patients under 16 years of age, although this is not legally necessary for young people who understand the nature of their treatment. Further guidance has been provided by Lord Fraser, following the Gillick case which began in 1982.

In this case Mrs Victoria Gillick failed to obtain reassurance from her local area health authority that her daughters would not receive contraceptive advice or treatment without her consent. The case was subsequently heard in the High Court, Appeal Court and the House of Lords and ultimately resulted in a policy review, and the provision of revised guidance by Lord Fraser in 1986.

Lord Fraser’s response to the Gillick case (1986)

These guidelines\[17\] apply in England and are included in a useful factsheet\[18\] available from the Family Planning Association (FPA), together with a summary of the history of the debate surrounding the issue of consent.

In summary, the Fraser guidelines set out good practice for health professionals for the treatment of the under-16 age group without parental consent. This is considered appropriate if the following criteria are met:

- the young person must understand the advice
- the young person could not be persuaded to inform their parents or agree for the doctor to do this on their behalf
- the young person is likely to start or continue sexual behaviour whether contraceptive treatment is given or not
- the young person’s mental or physical health is likely to suffer if contraceptive advice or treatment is not offered
- it is in the young person’s best interest that parental consent is not obtained prior to offering contraceptive services.
2.1 Types of abuse and neglect

Abuse and neglect are forms of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting, by those known to them or, more rarely, by a stranger. They may be abused by an adult or adults, or another child or children. Types of abuse are described under four main headings: physical, emotional, sexual abuse and neglect.

Physical abuse
Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces, illness in a child (see fabricated or induced illness below).

Emotional abuse
Emotional abuse is the persistent emotional maltreatment of a child that causes 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 feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond the child’s developmental capability, as well as overprotection and limitation of exploration and learning or preventing the child from participating in normal social interaction. It may involve seeing or hearing the ill treatment of another or serious bullying, causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Emotional abuse may occur alone, but it is involved at some level in all types of maltreatment of a child.

Sexual abuse
Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, including prostitution, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative (eg, rape, buggery or oral sex) or non-penetrative acts. They may include non-contact activities, such as involving children in looking at, or in the production of, sexual online images, watching sexual activities or encouraging children to behave in sexually inappropriate ways.
Neglect

Neglect is the persistent failure to meet a child’s basic physical and/or psychological needs, likely to result in the serious impairment of the child’s health or development. Neglect may occur during pregnancy as a result of maternal substance 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 caregivers)
- ensure access to appropriate medical care or treatment.

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

Fabricated or induced illness

Concerns may be raised when it is considered that the health or development of a child is likely to be significantly or further impaired by a parent or caregiver who has fabricated or induced illness. These concerns may arise when:

- reported symptoms and signs found on examination are not explained by any medical condition from which the child may be suffering, or
- physical examination and results of medical investigations do not explain reported symptoms and signs, or
- there is an inexplicably poor response to prescribed medication and other treatment, or
- new symptoms are reported on resolution of previous ones, or
- reported symptoms and signs found on examination are not seen to begin in the absence of the caregiver, or
- over time, the child is repeatedly presented by the parent or caregiver with a range of symptoms, or
- the child’s normal activities are being curtailed beyond what might be expected for any medical disorder from which the child is known to suffer.

There may be a number of explanations for these circumstances and each requires careful consideration and review. Concerns about a child’s health or suspicion of fabricated or induced illness should be discussed with the GP or paediatrician responsible for the child’s health.

As with other types of suspected abuse or neglect, pharmacists and pharmacy technicians have a duty to report their concerns. Further information can be found in the document, *Safeguarding children in whom illness is fabricated or induced*, available from the Department of Health website: [http://www.dh.gov.uk](http://www.dh.gov.uk).
2.2 Safeguarding children and pharmacy

There are many ways that the issue of safeguarding children may arise in hospital or in the community, and the pharmacy workforce should be vigilant when coming into contact with children. For example, pharmacy staff should consider the possible effects on the children of problem drug users or patients with mental health problems. When information is shared a number of minor concerns, when considered together, may signify serious neglect or abuse.

The RPSGB Guidance on child protection (June 2006)\(^{20}\) is intended to inform pharmacists and pharmacy staff about their responsibilities under safeguarding children legislation.

**Exercise 1**

Consider possible signs of child abuse and neglect that you may observe during your work as a pharmacist or pharmacy technician.

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**Hidden harm: children of problem drug users or parents/carers with mental health problems**

Misuse of drugs and/or alcohol, and mental health problems are strongly associated with significant harm to children, especially when combined with other circumstances, such as domestic violence. The pharmacy team may be the first to observe problems, for example, when a patient visits the pharmacy regularly to collect supplies of methadone. It is particularly important that information be shared between the health professionals involved and that appropriate support be provided to lessen the potential adverse effects for children.
The risk of harm may arise from:

- use of family resources to fund the parent’s/carer’s dependency, resulting in inadequate food, heat and clothing for the children
- exposing children to unsuitable carers or visitors
- disinhibited behaviours, such as inappropriate sexual and/or aggressive behaviour
- irritability, emotional unavailability, irrational behaviour, and reduced parental vigilance
- drug withdrawal and mood disturbances
- unsafe storage of drugs and medicines and injecting equipment
- adverse impact on the growth and development of an unborn child
- social isolation.

It is the responsibility of LSCBs to take full account of the particular challenges and complexities of work in this area by ensuring that there are appropriate:

- LSCB policies and procedures in place
- inter-agency protocols in place for the co-ordination of assessment and support, particularly across adult drug services and children’s services
- close collaborative relationships in place with local drug action teams (DATs) and crime disorder reduction partnerships (CDRPs) and local drug services, as well as a number of other agencies including health, maternity services, adult and children’s social care, courts, prisons and probation services.

**Lessons from research and inspection**

Our knowledge and understanding of children’s welfare and how to respond in the best interests of a child to concerns about maltreatment (abuse and neglect), develops over time, informed by research, experience and the critical scrutiny of practice. Sound professional practice involves making judgments supported by evidence: evidence derived from research and experience about the nature and impact of maltreatment and when and how to intervene to improve outcomes for children, and evidence derived from a thorough assessment of a specific child’s health, development and welfare and his or her family circumstances.

Chapter 9 *Working together to safeguard children* (2006) summarises what is known about the impact of maltreatment on children’s health and development and the sources of stress in families that may also have an impact on children’s developmental progress. Read *Working together to safeguard children* (2006) Chapter 9, pages 183-188 to find out more.

**Children at risk – what you can do to help**

Pharmacists and pharmacy technicians have the same responsibilities as everyone working with children and families – to be vigilant and report suspected cases of child abuse or neglect.

The Department for Education and Skills document, *What to do if you’re worried a child is being abused*, provides a useful summary of these responsibilities, together with guidance – as outlined overleaf.
The document is relevant for anyone who comes into contact with children and families as part of their work. Guidance is provided for three main scenarios which may arise as part of ‘the duty to safeguard and promote the welfare of children’.

Most relevant to the pharmacy workforce are:

- concerns about a child requiring referral to another organisation, eg, social care
- a request for information about a child or family made by social care.

It recommends that all health professionals should:

- be familiar with local protocols for safeguarding children
- be aware that a criminal investigation may follow an allegation of child abuse and therefore take care not to ask leading questions or investigate allegations, as this may hinder a subsequent police investigation
- ensure concerns of abuse or neglect are referred to social care or the police
- ensure that any concerns are discussed with a ‘named or designated healthcare professional’.

Guidance is also provided on the sharing of information because of the concerns surrounding the issue of confidentiality, as discussed in Section 4 of this booklet. Also of note is the issue of ‘proportionality’ and disclosure of information on a ‘need to know’ basis:

‘the amount of confidential information disclosed, and the number of people to whom it is disclosed, should be no more than is strictly necessary to meet the public interest in protecting the health and wellbeing of a child...’

The document includes useful flowcharts for referral which are also available as laminated copies. Copies of the booklet are available from the Department of Health publications office or website. Local hospital and primary care trusts may provide their own version incorporating local procedures and useful telephone numbers.

Safeguarding children teams or units (see information on local safeguarding children boards in Section 3 of this booklet) and key ‘named’ professionals working for local trusts are an important source of information and advice. Other health professionals, such as health visitors, receive intensive training on dealing with safeguarding children issues and are also a good source of advice.
Suggested answers

Exercise 1 (page 10)

Consider possible signs of child abuse or neglect that you may observe during your work as a pharmacist or pharmacy technician.

Signs of child abuse and neglect involving drug treatment may involve parents or carers (or sometimes doctors and nurses) administering drugs or substances to children inappropriately.

For example:

- drugs given in overdose or for no good reason. A community pharmacist or technician may detect administration of excessive doses by working with surgeries to monitor the rate of requests for repeat prescriptions.
- tampering with lines for intravenous fluid or total parenteral nutrition or possibly fluid balance and drug charts
- giving the wrong information about which drugs a child is taking or is supposed to be taking
- non-administration by parents of prescribed drugs
- adults giving their own medication to children.

Other possible signs include:

- requests for dressings for wounds in unusual places
- inappropriate smacking of children while waiting in the pharmacy
- observation of suspicious bruises, scratches or marks
- a parent or carer delaying their request to treat a child
- inappropriate use of the pharmacy and avoidance of GPs or emergency departments
- inappropriate treatments against pharmacy advice
- observations when making home deliveries.
Section 3

Working across boundaries

3.1 Working with primary care trusts and local authorities

The Children Act 2004\textsuperscript{7} strengthened the requirement of the Children Act 1989\textsuperscript{3} for co-operation between all agencies providing children’s services, to safeguard children.

Working in partnership across agencies and services is vital for an effective assessment of risk and to ensure child safety; information needs to be exchanged between childcare social workers, health visitors, school nurses, and midwives (ie, across both geographical and professional boundaries). All agencies have a duty to co-operate when enquiries are being made into whether a child is suffering harm (under Section 27 of the Children Act 1989).

Each primary care trust is required to have a designated doctor and designated nurse who provide a strategic lead in relation to all aspects of safeguarding children across the health services.

NHS trusts (including ambulance trusts) have identified named professionals who lead on issues relating to safeguarding children for their respective trusts and services.

Accountability and responsibilities for safeguarding children

Lord Laming’s report\textsuperscript{2} called for greater accountability for safeguarding children services.

The chief executive of each trust is accountable for their organisation’s safeguarding children structures and processes. This includes ensuring that their staff contribute to inter-agency working.

Similarly, local authorities are required by the Children Act 2004 to appoint a director of children’s services and a lead member for children’s services who will be accountable for these services, and subject to inspection. This is to ensure that reports of concerns about children are followed up efficiently.

3.2 Local safeguarding children boards

Safeguarding and promoting the welfare of children requires effective co-ordination in every local area. For this reason the Children Act 2004\textsuperscript{7} requires each local authority to establish a local safeguarding children board (LSCBs).

The LSCB is the key statutory mechanism for agreeing how the relevant organisations in each local area will co-operate to safeguard and promote the welfare of children in that locality, and for ensuring the effectiveness of what they do.

The scope of LSCB’s role includes safeguarding and promoting the welfare of children in three broad areas of activity:

- activity that affects all children and aims to identify and prevent maltreatment, or impairment of health or development, to ensure children grow up in circumstances with safe and effective care
- proactive work that aims to target particular groups, eg, vulnerable groups, children living away from home
- responsive work to protect children who are suffering, or at risk of suffering harm.
While the LSCB has a role in co-ordinating and ensuring the effectiveness of the work of local individuals and organisations to safeguard and promote the welfare of children, it is not accountable for their operational work.

The core functions of LSCBs are the:

- policies and procedures function, eg, agreeing multi-agency procedures, agreeing referral thresholds
- communicating and raising awareness function, eg, public campaigns
- monitoring and evaluation, eg, audit
- function of participating in planning and commissioning
- function relating to child deaths
- serious case review function.

An LSCB may also engage in any other activity that facilitates, or is conducive to, the achievement of its objectives.

**Practice points**

- *Check whether your pharmacy has access to relevant information, such as PCT/LSCB procedures and contact details for the designated safeguarding children officer.*
- *Find out how referrals to social care are dealt with and documented.*

Local LSCB procedures are an important resource and may be available via PCT and individual local authority websites. The designated professional for your local trust should be able to advise on how you can obtain a copy.

Further information, including local contacts, is available at: [http://www.everychildmatters.gov.uk/socialcare/safeguarding/lscb/](http://www.everychildmatters.gov.uk/socialcare/safeguarding/lscb/)
4.1 Confidentiality and the law

An important issue raised by Lord Laming following the inquiry into the death of Victoria Climbié was the way that legislation may act as a barrier to the sharing of information about families and children.

Making a referral to a third party relating to concerns about possible child abuse or neglect raises a number of issues concerning the law on confidentiality and matters of professional ethics. A good introduction to this area can be found in the Professional standards and guidance for patient confidentiality published by the Royal Pharmaceutical Society of Great Britain and additional guidance can be found in Appendix 3 of What to do if you’re worried a child is being abused.

Practice points

Look at Professional standards and guidance for patient confidentiality (available online at http://www.rpsgb.org.uk/pdfs/coepspspatconf.pdf). Study the information and test your understanding by writing down a response to these questions:

a. What information is classed as confidential in your work as a pharmacist or pharmacy technician?

b. What is normally required before disclosing confidential information?

c. Describe as many types of circumstances you can think of where you either must or could disclose confidential information without consent.

Confidential information is personal. In other words it must relate to an individual. When you, or your staff, are carrying out your professional activities, you will acquire a considerable amount of personal information which should be regarded as confidential. This could include details of age, name and address and personal appearance, as well as information about medication, medical conditions or allergies. Normally such information should not be disclosed to anyone else without that individual’s consent.

However, confidentiality is all about balancing the interests of an individual against wider interests, perhaps those of other individuals or of society as a whole. Professional standards and guidance for patient confidentiality lists exceptional circumstances (including those permitted by law) where information can be disclosed without patient consent. These include any situation where abuse or neglect of a person is suspected. The standards state that ‘the person’s well-being is of the utmost importance and ensuring this must be your prime concern’. The standard also includes situations where the patient is incapable of consent, ie, very young children and people who have mental disorders or other forms of mental incapacity, such as dementia. However, the age at which children may become ‘competent’ to consent is never clear and if an adolescent makes it clear that information he or she is providing is to be regarded as confidential, that wish should be respected wherever possible.
A judgment is also required when deciding whether consent should be waived to prevent serious injury or damage to the health of the patient, a third party or to public health. As far as public health is concerned, there are a number of statutes (laws) which require disclosure even without consent; for example, to manage the occurrence of certain ‘notifiable’ infectious diseases. The law also requires disclosure to ensure that the process of justice in court is not hindered or to ensure that serious crime or fraud can be properly investigated and enforcement pursued.

### 4.2 Common law

The *Professional standards* set out the expectations of the profession and the public regarding confidentiality and any breach of the standards (in this or any other area) could be a matter of professional misconduct, leading to disciplinary measures. Because there is a professional obligation to respect confidentiality, this becomes part of the ‘duty of care’ expected of pharmacists under common law (see tint panel below).

In theory, a patient who had suffered some harm or injury because of unauthorised disclosure of confidential information by pharmacy staff could sue them for compensation – although to date no such case has arisen. In the case of suspected child abuse or neglect, the pharmacist who discloses confidential information because he or she believes the child is at risk of significant harm, is very unlikely to be challenged in court. Careful recording of the information disclosed and the rationale for doing so is essential, as this will provide evidence that the pharmacist believed they were acting in the child’s best interest and fulfilling their professional duty.

**What is common law?**

Common law derives from a system of justice developed after the Norman conquest of Britain in 1066. It describes the nationally applied ‘common’ laws and customs that gradually replaced locally applied laws and customs. Court judgments under ‘common law’ were recorded and published, so becoming a form of authority commonly applied to similar cases and being common to all citizens. Common law is associated with the protection of personal freedom, reputation and bodily security (such as rights against assault and trespass), as well as protecting rights of property and contract. It is therefore the basis and forerunner of civil law rights and human rights. Common law may also be understood as the application of common sense when adjudicating between competing rights of ‘common men’ or ordinary citizens.

### 4.3 Data Protection Acts 1984 and 1998

Until relatively recently there was little statutory law covering confidentiality. In 1984, the Data Protection Act\(^{23}\) introduced controls over the electronic processing of personal data and a second Data Protection Act in 1998\(^{24}\) extended these controls to all forms of processing of personal data (including paper records). The 1998 Act also created additional controls over sensitive personal data which includes information relating to the subject’s physical or mental health or
condition. In particular, sensitive personal data should not be disclosed without the subject’s consent, unless the disclosure is to a person who in the circumstances owes a duty of confidentiality which is equivalent to that which would arise if that person were a health professional.

**Exercise 2**

Do you think that a social worker, or an administrator in a children and young people social care office or children and families team, has the same duty of confidentiality as you, a nurse or a doctor?

There is no clear answer to this question; continue studying the rest of this section and see if your views on this question have changed.

**4.4 Human Rights Act 1998**

The Human Rights Act, also passed in 1998, strengthens the right of individuals to expect confidentiality and privacy in matters which they regard as confidential and private. These rights go further than the common law and extend privacy rights to private and family life and to freedom of thought, conscience and religion. However, both common law and these parts of the Human Rights Act 1998 acknowledge that such rights are not absolute; they can be overridden in either the public interest or for the prevention of disorder or crime, for the protection of health or morals, or for the protection of rights and freedoms of others. Therefore in situations of abuse, the rights of the child override those of the adult in respect of private family life.

So, the decision of whether to act on suspicions of child abuse and disclose confidential information to a third party is essentially a matter of the pharmacist’s professional judgment. Pharmacists and pharmacy technicians need to balance their duty of care under professional confidentiality, common law and statute, against the risk of the adverse consequences of not making the report.

As explained above, in some instances the law negates the issue of discretion by making the report mandatory. All health professionals have a duty to safeguard and promote the welfare of children under the Children Act 2004:

You must judge whether your civic and professional duty to tackle child abuse, by whatever means, outweighs your legal and professional duties to respect confidentiality and the risk of unpleasant consequences if the report proves to be unfounded.
To make this judgment, you will want to consider answers to at least the following questions:

- What are my precise reasons for overriding consent to make this disclosure?
- What information am I going to disclose?
- To whom am I going to make the disclosure?
- In what form and by what method shall I make the disclosure?

**Procedures for reporting suspected child abuse**

*What to do if you’re worried a child is being abused* outlines why it is essential for pharmacists and pharmacy technicians to be aware of the local procedures in place for dealing with safeguarding children. A good place to start would be the named nurse or doctor attached to the local trust, or a health visitor or LSCB member, as described above. Pharmacy staff should also be trained in issues surrounding confidentiality and how to recognise potential problems and refer as appropriate.

Clear documentation is essential, as this may be required in the event that a case is taken to court and the pharmacist is required to attend. Pharmacists should devise a system for highlighting concerns on a patient’s medication record, for example, if regular requests for over-the-counter medicines are made, there is significant delay in collecting a child’s prescription, or frequent loss of medicines. Some surgeries add a red card to the patient’s notes to highlight concerns to other health professionals. Similarly, electronic systems may have ‘tags’ or ‘flags’ to highlight various concerns. Isolated concerns may not lead to a decision to refer. However, a sequence of observations by different health professionals may provide a more accurate picture.
5.1 Pharmacy and children’s services

In addition to the provision of general health promotion services by pharmacies, as discussed in the CPPE open learning programme, *Child health*, there are a number of specific schemes operating throughout the UK, many of which are driven by government policy. The pharmacy team has opportunities to work with other health professionals to promote and improve services for parents, carers and children. The internet is a useful resource for locating local initiatives; refer to the websites given below, as well as the others detailed within this booklet. Health visitors and practice nurses are also likely to be actively involved in these initiatives and the pharmacy team can work with them to provide information and signposting to help parents and children access these services.

5.2 Sure Start children’s centres

Children’s centres are service hubs where children under five years old and their families can receive seamless integrated services and information. By 2010, every community will be served by a Sure Start children’s centre, offering permanent universal provision across the country, ensuring that every child gets the best start in life.

These services vary according to the centre but may include:

- integrated early education and childcare – all centres offering early years provision have as a minimum one qualified teacher working half-time (increasing to full-time within 18 months of the centre opening)
- support for parents – including advice on parenting, local childcare options and access to specialist services for families
- child and family health services – ranging from health screening, health visitor services to breast-feeding support
- helping parents into work – with links to the local Jobcentre Plus and training.

The aim of the Sure Start children’s centres is to improve outcomes for all children. They are a vital part of the Government’s ten-year childcare strategy to enable all families with children to have access to an affordable, flexible, high-quality childcare place for their child. Further information and details of local initiatives are available at: http://www.surestart.gov.uk/surestartservices/settings/surestartchildrenscentres/

5.3 Education, training and professional development

The LSCB has a responsibility to ensure that single-agency and inter-agency training on safeguarding and promoting welfare is provided in order to meet local needs. It is not the responsibility of the LSCB to deliver inter-agency training, although a number of boards support and provide training. You can find contact details for your LSCB at: http://www.everychildmatters.gov.uk/lscb/
In addition, relevant open learning materials and workshops provided by CPPE will provide useful information, and relevant training may be offered by local primary care trusts. Training alongside other health professionals offers you a good opportunity to promote the benefits of working together. Pharmacy staff also have an important role to play in education relating to the safe use of medicines; other health professionals, such as health visitors, may value your input.
Section 6

Dealing with suspected child abuse and neglect

6.1 Assessing possible abuse

When presented with a case of possible abuse, questions to consider include:

- Is this abuse?
- Is the young person safe?
- Are there risks to other young people?
- Am I breaching confidentiality?
- Is this act of abuse unlawful?
- Have I heard the full story?
- Who is involved, eg, friends, family, neighbours?
- Are other professionals already involved?

A professional decision is then required as to whether to contact local authority social care and/or named health professionals within the safeguarding children team. As a minimum, the safeguarding children team should be contacted for advice and support in following up concerns. Child protection referrals are made directly to local authority social care under Section 47 of the Children Act 1989. Information that may be required includes:

- the name and address of the child
- a summary of your concerns
- whether or not the family has been informed
- the GP’s name and contact details.

Working together to safeguard children (2006) requires that a referral to social care should be followed up in writing within 48 hours. Referral forms may be available from the LSCB. In some areas referrals are made via call centres. Following your referral through a call centre a social worker from the duty initial assessment team will return your call and gather further details.

Receipt of the referral should be acknowledged by the social worker and manager and the course of action decided upon within one working day. It is good practice to document the reasoning which led to a referral being made, together with how the decision to share or not share information with a parent or carer, was reached. Remember that information should be shared with other professionals on a ‘need to know’ basis only. For example, the full medical history of a patient may not be relevant.

6.2 Over-the-counter medicines for children

The Professional standards and guidance for the sale and supply of medicines produced by the Royal Pharmaceutical Society of Great Britain (2007) for pharmacists and pharmacy technicians (available online at: http://www.rpsgb.org.uk/pdfs/coepsgssmeds.pdf) states that:

‘Particular care is exercised when supplying products for children, the elderly and other special groups of individuals...’
This means that children are listed as a special group, warranting more urgent referral to the pharmacist.

**Dealing with inappropriate medicines requests**

*Professional standards and guidance for the sale and supply of medicines*[^28] for pharmacists and pharmacy technicians states that:

> ‘All persons involved in the sale of OTC products are aware of the abuse potential of certain OTC medicines and other products. You must be alert to requests for large quantities and abnormally frequent requests and refuse to make a supply where there are reasonable grounds for suspecting misuse.’

Suspicion may be aroused by requests for excessive quantities of products or purchases made on a regular basis. For example, sedating antihistamines, such as promethazine in the products Phenergan and Medised, or chlorphenamine in Piriton are associated with a risk of overuse for sedation. Parents should be advised against using these products on a regular basis and advised to speak to their health visitor or GP if they are having difficulties due to children not sleeping. A non-judgmental approach should encourage parents to voice concerns openly in a private area of the pharmacy and referral should be made for further support if necessary.

It may be difficult to act on these observations, for example, it may not be easy to find out the name of the child or the family GP. However, these concerns should be shared with the appropriate health professionals if possible, as they may help to build a complete picture when combined with the observations of other health professionals. You should contact local named safeguarding children professionals for advice. There is no requirement at this stage to disclose confidential information, it may be that you just want assistance to process the information you currently hold.

> Seek advice from local named safeguarding children professionals if you are not sure what to do when presented with a suspected case of child abuse or neglect.

### 6.3 Complying with national clinical standards for safeguarding children

As discussed throughout this booklet, the development of national clinical standards in relation to safeguarding children is ongoing, so it is important for the pharmacy team and other health professionals to keep up to date with the latest information available from the websites detailed within this booklet, or their LSCB.

**In summary:**

When abuse or neglect of a child is suspected, doing nothing is not an option.
Exercise 3

How you would respond to a child who disclosed to you that they were being sexually abused? Choose from the following answers:

a. Tell them to keep quiet and not tell anyone.

b. Listen carefully to what the child is saying.

c. Go and tell the child's parent immediately what has been disclosed to you.

d. Clarify the concerns.

e. Cross-examine the child and press for information.

f. Offer reassurance about how he or she will be kept safe.

g. Tell the parents that you are concerned about their child and want to make a referral to the social care department.

h. Explain your actions clearly and simply.

i. Ask a named child protection or safeguarding children lead for advice if unsure of the appropriate course of action.

Turn to the end of the section for suggested answers.

Exercise 4

A drug misuser visits your pharmacy to collect a regular supply of methadone. He appears to be intoxicated and has no control over the toddler who appears to be in his care. The child wanders off and out of your pharmacy. What action should you take?

Turn to the end of the section for suggested answers.
Practice points

- Who is the child protection/safeguarding children lead person for your area?
- Does your hospital or primary care trust have local procedures in place for referral should you identify a child you consider to be at risk?
- Do you have contact numbers for the safeguarding children advisory team and emergency duty children and families team?
- Who are the trust’s named doctor and nurse for safeguarding children?
- Local LSCB procedures may be available on your local trust intranet or website.
- Contact your local LSCB or trust for information regarding training.
- Develop an easily located procedure and information file for referring and documenting cases of suspected child abuse.
- Does your pharmacy have a good supply of information leaflets available, for example, on the subject of sexual health? Sexual health leaflets are available from the FPA.
- Try to make contact with local health visitors and practice nurses and ask about local children’s services and any training which may be available for pharmacists and pharmacy technicians.
- Are there any services relating to the safe use of medicines which could be developed?
Suggested answers

**Answer to Exercise 3 (page 24)**

Responses b, d, f, h and i are considered suitable.

**Answer to Exercise 4 (page 24)**

Some suggestions are given in the text below, but you may have thought of other options.

When presented with a dilemma such as this, it is good practice initially to run through what legal and professional ethics issues apply to the situation. For example, the drug misuser has a right to expect that his personal information is kept confidential and there is no evidence at this stage that his competence to make such a decision is permanently compromised. The Code of Ethics and your duty of care under common law may expect you to pass on what you have seen to others, to avoid injury or harm to the child or other crimes against an unprotected toddler at large in the community.

You will want to consider whose interests will be most important and why – the child; the drug misuser; other people concerned with the child’s health and welfare; yourself; and your staff.

By now a number of options may occur to you:

- Contact the police?
- Contact the GP practice or clinic that manages the drug misuser?
- Go out and look for the child?
- Send a member of staff to look for the child?
- Detain the drug misuser in your pharmacy or not?
- Supply the methadone anyway or not?
- Contact the safeguarding children team?

You will also be considering how you will justify your decision, how clear your information is and who else, perhaps, can add some detail.

Finally you will have to take a decision and you may well have to justify at a later stage the course of action you chose to take. You may well want to record the reasons for your choice – where would you make such records?

Make sure that the information you report will only be received or seen by persons who themselves have a clear understanding of their duty to treat the details in confidence, with full regard to the interests of the originator of the report.
1. Prevention and early intervention is vital to protect children from the harmful, long-term and potentially fatal outcomes associated with child abuse.
2. Everybody coming into contact with children through their work has a duty to ensure their safety and protection and to report evidence of abuse appropriately.
3. National guidelines require improved and more effective working between different services and professions to ensure the safeguarding of children.

**Intended outcomes**

By the end of this booklet you should be able to:

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<td>Summarise the background and policy surrounding the safeguarding of children and the issues this raises for pharmacists and pharmacy technicians.</td>
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<td>Convey the importance for pharmacists and pharmacy technicians to increase their awareness of child abuse and neglect and develop ways of working with other health professionals to promote best practice to deal with situations involving suspected abuse or neglect.</td>
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<td>Highlight situations in which you are best placed to observe signs of abuse or neglect and the legal issues to consider when making a referral.</td>
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<td>Identify sources of useful information and contacts for the development of local procedures for dealing with suspected child abuse or neglect observed in a pharmacy setting.</td>
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**Further reading**

The FPA in England provides information and services for health professionals providing sexual health services and also information and leaflets for patients. [http://www.fpa.org.uk](http://www.fpa.org.uk)
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