National Safeguarding Team (NHS Wales)

Guidance for Dental Teams on Safeguarding Children & Adults at Risk

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Purpose and Summary of Document

This guidance replaces the version published in 2011 and all other guidance previously issued by Public Health Wales

It has been revised to take into account the Social Services and Well-being (Wales) Act of 2014 and to clarify the roles and responsibilities of dentists and dental teams in promoting the safety and well being of children, young people and adults at risk. In the Act the term “adult at risk” is used in place of Protection of Vulnerable Adults (POVA). Other documents refer to POVA and in general the 2 terms are interchangeable

This guidance also supports dental practitioners in meeting the Welsh Government Health and Care Standards (Standard 2.7) and the General Dental Council Standards for the Dental Team (Standard 8.5). This document should be read alongside the All Wales Child Protection Procedures (2008) and the Wales Interim Policy and Procedures for the Protection of Vulnerable Adults from Abuse (2010).

Further Information

Standards for the Dental Team (available on www.gdc.uk.org)

Health and Care Standards (available on gov.wales web site)

Safeguarding in Dental Practice (welsh version) (available on Public Health Wales web site)

http://nww.publichealthwales.wales.nhs.uk/safeguarding-in-dental-practice **(Intranet)**

Foreword

There have been significant changes in safeguarding knowledge, priorities, practice and legislation since 'A guide for Safeguarding Children and Vulnerable Adults in Dental Practice' was first published by the Safeguarding Children Service in 2012. As a consequence safeguarding has evolved. The original guidance was devised mainly for safeguarding children with only some parts looking at adult safeguarding, whereas currently there is a move to safeguarding across all ages.

The biggest changes are due to the Social Services and Well-being (Wales) Act 2014 which came into effect in April 2016 (see below for details of the Act with particular respect to safeguarding). This major legislative change will have a significant impact on the safeguarding of children, young people and adults.

Other recent legislative and strategy changes impacting on safeguarding are:

- Well-being of Future Generations (Wales) act 2015
- Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015
- Safeguarding Children and Young People from Sexual Exploitation: Supplementary guidance to Safeguarding Children: Working Together Under The Children Act 2004
- Prevent Duty Guidance, 2015
- Mandatory Reporting of FGM
- Health and Care Standards (Wales) April 2015
- Talk to Me 2: Suicide and self harm prevention strategy for Wales 2015-2020
- Response to the Supreme Court Judgment/ Deprivation of Liberty Safeguards 2015
- The Revised Caldicott Principles

In safeguarding children and young people the themes of suicide and self harm, child sexual exploitation, female genital mutilation (FGM), domestic abuse and internet and technology based abuse have become much more prominent. The local Safeguarding Children Boards have merged to become six Regional Safeguarding Children Boards (RSCBs) across Wales. The profile of child abuse has increased not just in the media but within public bodies such as Health, Education and the Police. There is now a National Safeguarding Board set up in April 2016 that looks at safeguarding across Wales, across all ages and across all public service agencies. Health Boards and Trusts have also moved to a safeguarding structure where they have merged many aspects of children's and adult safeguarding.

The safeguarding of Adults at Risk (formerly vulnerable adults) has become a much larger priority, particularly within Health. There are now Adult Safeguarding Boards similar to RSCBs, with the likelihood of children's and adult boards merging in the future. The Social Services and Well-being (Wales) Act 2014 has made it a duty to report all adults at risk, as well as children, to the relevant local authority department.

The Mental Capacity Act and deprivation of Liberty Standards are having a huge impact on adults in nursing homes and residential care and hence on Primary Care.

As a consequence of this we have undertaken to rewrite the guidance in full.

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1 INTRODUCTION

The dental team includes dentists, dental care professionals and all those who are registered with the GDC. It also includes others who work in the practice / clinic including practice managers and receptionists. This guidance will help people working in general dental practice and the Community Dental Service (CDS) to understand their duties in protecting the welfare of children and adults at risk. It is supplementary to the processes as laid out in the 'All Wales Child Protection Procedures' and the Wales Interim Policy & Procedures for the Protection of Vulnerable Adults from Abuse which remain the definitive reference sources. Professionals working in the CDS must also be aware of and follow their employing Health Board Policies and procedures.

All health professionals, including all members of the dental team, have a statutory duty of care to their patients and service users. This duty includes making sure that safeguarding arrangements are in place to promote the health of, and protect, the most vulnerable members of society. The Social Care and Wellbeing (Wales) Act 2014 makes it clear that all staff in the public sector have a duty to safeguard the welfare of children, young people and adults at risk and to report to the local authority when they have a reasonable cause to suspect that a person is at risk.

The dental team are well placed to recognise when an individual is being harmed or at risk of harm. They are also well placed to recognise when a parent or other adult has problems which mean that they pose a risk of harm to a child or vulnerable person in their care.

Dental teams are able to identify the risks to oral and general health that are associated with dental neglect and inadequate oral hygiene, both in the short and long term. Where teams are concerned that oral health problems contribute to safeguarding issues they will need to act appropriately, possibly working together with Senior Clinician in the CDS or with the health board Dental Practice Advisor. See section 2.4.3 for more information.

The GDC notes that:

- "As a dental professional, you are likely to notice injuries to the head, eyes, ears, neck, face, mouth and teeth, as well as other welfare concerns. Bruising, burns, bite marks and eye injuries could suggest that a concern should be raised".
- "If you make a professional judgement and decide not to share your concern with the appropriate authority, you must be able to justify how you came to this decision. You should contact your defence organisation for advice".
- You should keep accurate contemporaneous records for all patients, but you must also record any safeguarding concerns.

Dental teams are in a position to become aware of safeguarding concerns at an early stage given their relationship with individual patients/service users, their families and communities. Therefore dental teams should:

- Be alert to the potential indicators of abuse and neglect,
- Be familiar with local procedures for promoting and safeguarding the welfare of children, young people and adults at risk, and
- Understand the principles of patient confidentiality and information sharing.

The Welsh Government Health Standard on Safeguarding Children and Safeguarding Adults at Risk requires that that, Health services promote and protect the welfare and safety of children and adults who become vulnerable or at risk at any time. *(See Appendix 1 for further details).*

The GDC Standards for Dental Teams 8.5 states "You must take appropriate action if you have concerns about the possible abuse of children or vulnerable adults" and:

8.5.1 You must raise any concerns you may have about the possible abuse or neglect of children or vulnerable adults. You must know who to contact for further advice and how to refer concerns to an appropriate authority such as your local social services department.

8.5.2 You must find out about local procedures for the protection of children and vulnerable adults. You must follow these procedures if you suspect that a child or vulnerable adult might be at risk because of abuse or neglect.

This guidance aims to support dental teams in establishing and maintaining safeguarding arrangements for children, young people and adults at risk that they come into contact with during the course of their work.

2 DEFINITIONS

What is a Safeguarding Issue?

Safeguarding means preventing harm and acting to protect children and adults at risk from actual or potential abuse, neglect or exploitation and ensuring they receive proper care that promotes health and welfare.

Safeguarding concerns can arise within almost all areas of practice. It is important that all members of staff have an appropriate level of understanding of the signs and presentations of abuse and neglect and are able to implement the Child Protection or Protection of Vulnerable Adults (POVA) procedures.

Definition of a Child and Young Person

The Social Care and Wellbeing (Wales) Act 2014 defines a child as being any person under 18 years old. The term child includes children and young people. The fact that a child has reached 16 years of age, is living independently, is in further education, is a member of the Armed Forces or is in hospital, prison or a young offender's institution does not change their status or their entitlement to services or protection under the Act.

Definition of an Adult at Risk

The Social Care and Wellbeing (Wales) Act 2014 states "Adult" means a person who is aged 18 or over and an "adult at risk" is an adult who:

a) Is experiencing or is at risk of abuse or neglect,
b) Has needs for care and support (whether or not the authority is meeting any of those needs), and
c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

In general terms, an adult is classed as at risk when they are receiving one of the following services:

- Continuing health care;
- Relevant personal care;
- Social care work;
- Assistance in relation to general household matters by reason of age, illness or disability;
- Relevant assistance in the conduct of their own affairs; or
- Assistance with communication that may be due to age, illness, disability in some circumstances or where English is not their first language.

People with learning disabilities or mental health problems, older people and disabled people may fall within this definition, particularly when their situation is complicated by additional factors such as physical frailty or chronic illness, sensory impairment, challenging behaviour, social or emotional problems, poverty or homelessness.

Definitions of Abuse and Neglect

Abuse is a violation of an individual's human rights and is a criminal act. It may be a single or repeated incident of neglect or abuse. It may be physical, sexual, psychological, emotional or financial abuse and includes abuse taking place in any setting, whether in a private dwelling, an institution or any other place. It can be an act of neglect or omission to act, or be the unintended result of a person's actions. Self-neglect or self-abuse is a failure to provide for oneself, through inattention or inappropriate diversion of resources[1].

Harm in relation to a child, means abuse or the impairment of—

(a) physical or mental health, or

(b) physical, intellectual, emotional, social or behavioural development,

and where the question of whether harm is significant turns on the child's health or development, the child's health or development is to be compared with that which could reasonably be expected of a similar child[1];

Abuse and Neglect of Children and Young People

In safeguarding children and young people there are four recognised forms of abuse.

- Neglect
- Physical Abuse
- Emotional Abuse
- Sexual Abuse.

The definitions and some examples of abuse are in Appendix 2.

A child is abused or neglected when somebody inflicts harm or fails to act to prevent harm. Abuse may take place within the family or in an institutional or community setting by those known to them or more rarely by a stranger. Signs and symptoms will vary but may be indicated through injury, the child's presentation or the behaviour of parents or carers. Significant factors in parents and carers that lead to safeguarding concerns are Domestic Abuse, Substance and Alcohol Misuse, and Mental Health Problems.

Female genital mutilation, trafficking, child sexual exploitation, enforced marriages and honour based violence are amongst other safeguarding concerns of which health practitioners should be aware.

Any observations or comments that lead to concerns or uncertainty about abuse or neglect should be acted upon by implementing the All Wales Child Protection Procedures (2008) or by seeking advice and guidance.

Adults at Risk

Seven discrete but related forms of abuse have been identified for adults at risk:

- Physical abuse
- Emotional abuse
- Sexual abuse
- Neglect and acts of omission
- Financial abuse
- Discriminatory abuse
- Institutional abuse.

There is often considerable overlap e.g. domestic abuse is often a combination of physical, emotional, financial and sexual abuse.

The definitions and some examples of abuse are in Appendix 2.

Suspicions of abuse, neglect or exploitation of adults at risk may also be triggered by observations of the patient's presentation or by concerns or comments about the lack of appropriate care at their home or in a community or residential placement.

"A duty of care exists when duties or responsibilities are placed on paid carers" (Ashton & Ward, 2008). It is also important that caregivers realise that the Department of Health publication *No Secrets* (2000) states that a consensus has emerged identifying 'neglect and acts of omission' as a form of abuse. This includes ignoring medical and physical care needs, failure to provide access to appropriate health services and withholding the necessities of life, such as medication, adequate nutrition and heating. Such statements apply to oral hygiene and access to oral health care.

3 SPECIFIC INDICATORS OF ABUSE IN DENTAL PRACTICE

Dental Neglect

Dental Neglect can be defined as the persistent failure to meet basic oral health needs, likely to result in the serious impairment of oral or general health or development. It may occur in isolation or may be an indicator of a wider picture of neglect or abuse

Dental health staff are able to identify the risks to oral and general health associated with inadequate oral hygiene. The assessment process must identify the factors that may cause problems or impact on the quality of life of the individual patient concerned. To reach such a decision, it is essential that the assessment is approached in a multi-professional way, in collaboration with all those involved in the care of the patient. This will enable appropriate management strategies to be identified and written into care plans. Where General Dental Practitioners have concerns about non-attendance by young children or adults at risk, or about dental neglect, they can discuss with colleagues in the local Community Dental Service how best to provide appropriate preventive care and treatment.

When dental neglect has been recognised, a tiered response has been recommended with three stages of intervention (Harris, Sidebotham and Welbury, 2006):

1. Preventive dental team management;
2. Preventive with the support of multi-agency management; and
3. Child protection referral.

NICE Clinical Guideline 89 (When to suspect Child Maltreatment, July 2009) includes dental disease as a possible sign of child maltreatment. Where dental professionals consider child maltreatment i.e. there may be a possibility of child maltreatment, they should liaise with other Health professionals involved. However when they suspect child maltreatment i.e. it is likely child maltreatment is happening they should refer the child to social services. In the latter case they should follow the process as laid out in the All Wales Child Protection Procedures (2008). The Nice guidance also states “Consider neglect if parents or carers have access to but persistently fail to obtain NHS treatment for their child's dental caries”.

An Example of Good Practice

Cwm Taf Paediatric Dental team raised concerns about processes for alerting other staff when children with gross dental caries present for dental extraction under GA.

A system was introduced to automatically alert all GMPs, the Health Visitor attached to the medical practice or the school nurse after an anaesthetic is administered for exodontia.

The thresholds for alert are:

- Child is having a repeat General Anaesthetic for the removal of teeth
- Siblings in the same family have also had a General Anaesthetic for the removal of teeth
- 9 or more teeth will be/have been removed under General Anaesthetic
- Child is 3 years old or younger

(*Ceri Hoddell, Senior Dental Officer, Community Dental Service, Cwm Taf*)

Domestic Abuse

Domestic Abuse has an adverse impact on family health and well being; it is a major factor in Child Protection cases (Welsh Assembly Government, 2007). Domestic abuse can include all kinds of physical, sexual and emotional abuse and can occur within any intimate relationship including same sex relationships. Women and children suffer in particular but men can also be victims.

The head and neck are common targets in assaults including domestic abuse. Dental teams have a pivotal role to play in the identification of domestic abuse as dental and/or facial injury may provide the only contact point with a professional who can recognise the significance of the injuries and act.

It is not the job of the Dental Team to offer advice to a victim of domestic abuse. They do need to know what local services are available and how victims can access them.

Injuries to an adult indicating domestic abuse could also have implications for children in their care. It is usual to make a child protection referral to social services where domestic abuse is proven or suspected.

(See also chapter 9).

Substance and Alcohol Misuse

Any dental patient may be abusing alcohol or drugs – legal and/or illegal, or may have a history of substance misuse, or treatment for substance misuse. There is a high burden of dental disease in substance misusers which can be further complicated by emotional/ behavioural/personality issues, poor general health, inadequate nutrition and oral hygiene as well as the pathological effects of the drugs on the dentition, gums and soft tissues. Substance misusers may lead chaotic lifestyles and may fail to attend dental appointments.

Dental teams

- need to be aware that any patient can be a substance misuser and that these patients can present for dental care at any stage of their misuse;;
- may want to be familiar with local community treatment services for patients with substance misuse disorders and have information about services for patients who want to stop;
- should use their professional judgement in advising patients who are heavy drinkers to cut back, or users of illegal drugs to stop;
- are obliged to protect patient confidentiality of substance misuse in accordance with applicable statutory law, except where the substance misuse may impact on the safety of a child or adult at risk;
- may need to consult the patient's GP when the patient has a history of alcoholism or other substance misuse disorder, usually with the consent of the patient.

Dentists are encouraged to be knowledgeable about substance misuse disorders – both active and in remission – in order to safely prescribe medications (including any controlled drugs).

A review of substance abuse case management and dental treatment can be found at this link. (http://www.scielo.org.za/pdf/sadj/v69n7/07.pdf)

There is further information on adult safeguarding for dental teams at this link. (http://www.nature.com/bdj/journal/v219/n6/full/sj.bdj.2015.721.html)

(See also Chapter 10).

4 REPORTING CONCERNS: WHAT TO DO IF YOU IDENTIFY OR SUSPECT ABUSE OR NEGLECT

As a member of the dental team you have a legal duty to report concerns and take action to safeguard the welfare and safety of a child, young person and/or adult at risk.

Any member of the dental team who detects possible signs of neglect or abuse in a child or adult should take immediate action as below.

Listen and Observe

Note factual signs and symptoms of potential or suspected abuse or neglect without alarming the patient or alerting a possible abuser. If appropriate, listen sympathetically to what a child or adult at risk tells you (as they are often ignored) but do not agree not to tell anyone.

Imminent Danger

Where you are concerned that the child, young person or adult at risk is in immediate danger you **must** contact the appropriate Local Authority Social Services Emergency Duty Team (EDT) straight away. If there are severe injuries requiring further medical treatment a 999 call for police and ambulance should be made **and** then the EDT contacted.

Share Concerns

Alert and discuss your concerns with your manager, senior professional or designated staff member depending on your practice procedure.
If necessary seek advice from the local Health Board and/or Local Authority Safeguarding Team.

Consider and agree whether it is appropriate to seek agreement to the referral from the child, young person, adult at risk and/or parent/carer, or for them to be informed of the referral. You need to consider whether doing so would place the child, young person or adult at risk at increased risk of suffering significant harm.

Report

If after consideration and discussion you feel that a safeguarding referral is appropriate you should contact the EDT by phone to report your concerns. EDT teams are available 24 hours a day, but may have different phone numbers to contact in hours or out of hours.

This should be followed up within 48 hours with a written report. Social services will usually send a copy of their local referral form by fax/e-mail for completion. These forms can be long and ask for information that is not available to you or your team. You should endeavour to complete those parts for which you are able to provide information.

When reporting information, reports should be restricted to the nature of the injury, suspicious behaviour or concern facts to support the possibility that the injuries or concerns are suspicious.

Agree with recipient of referral what the patient and relatives/carers will be told, by whom and when (and note this).

You should receive confirmation of referral within one working day
If you have not had confirmation within three working days you should contact the EDT again.

Referral not Appropriate

You should consider whether the child, young person or adult at risk would still benefit from support or help from social services or another appropriate agency.
If you feel that this is appropriate you should seek consent from the child, young person, adult at risk or their parent/carer to make this referral.

If consent is refused you should contemplate whether this would alter your decision about a safeguarding referral and consider taking further advice.

Record

You must ensure that all observations, advice sought/received, including from whom and all actions taken are recorded. You should justify any actions you have taken and also give reasons where you have decided not to take any action. These records must be stored confidentially in the patient record.

Review

You should look to review the case and or patient whether you took any action or not. This affords the opportunity to re-evaluate the situation and to confirm that any actions needed have been followed up. There may also be new information available.

If on review or re-evaluation you still have concerns or there are new concerns, you should reconsider your decision about referral to the EDT or inform social services of this additional information.

When providing further information it is important to do this by using the same process as for a referral to ensure that this information is incorporated into social services system. Again record and justify any decisions made.

You may then decide to continue to monitor and review the case or to close it.

Appendix 4 provides a Flowchart for actions to be taken when there are safeguarding concerns.

N.B. You should also refer to the 'All Wales Child Protection Procedures' and the Wales Interim Policy & Procedures for the Protection of Vulnerable Adults from Abuse

5 ROLES AND RESPONSIBILITIES OF DENTAL PRACTICE

Safeguarding Practice Lead

All health professionals and employees have a duty to safeguard. It is expected that each dental practice should have a named Safeguarding Practice Lead (SPL) who must be a registered dental professional. The SPL is not expected to be an expert in safeguarding or deal with all safeguarding issues but a central person who will have oversight of safeguarding matters. The SPL will enable the other members of the practice to be aware of and access relevant guidance, recognise training needs and appropriate training events and be able to access appropriate support and advice on safeguarding matters.

It is best practice for the SPL to be competent to ICD level 3 (See section on safeguarding training in this chapter).

Key Tasks of the Safeguarding Practice Lead

The functions of the SPL are to maintain an overview of safeguarding practice and will include:

- Ensuring that the practice has local procedures for safeguarding children, young people and adults at risk available to all staff.
- Ensuring all staff in the practice are aware of their duty to safeguard and are familiar with safeguarding children and protection of adults at risk (Protection of Vulnerable Adults) procedures.
- Ensuring that the dental team has safeguarding children and safeguarding adults at risk policies as required by Health Inspectorate Wales.
- Ensuring all staff are trained to an appropriate level in safeguarding children, young people and adults at risk.
- Providing, within their normal capabilities, practical up to date everyday support and guidance to staff who have concerns about the welfare and safety of a child or adult at risk.
- Ensuring that they and all members of the practice are aware of who to contact locally in the health service, social services and the police in the event of child protection and PoVA concerns.
- Being aware of how to access sources of current dental and safeguarding support and advice.
- Maintaining an overview of complaints against the practice in order to identify any which might have a safeguarding element and consult with the Primary Care Dental Practice Adviser and Named or Designated Professionals about complaints where there are safeguarding issues particularly if there is an inferred allegation of professional abuse.

Provision of a Safe and Appropriate Environment

Within dental practice there is a need to ensure that facilities are appropriate and that staff are appropriately trained and qualified for the examination and treatment of children, young people and adults at risk. Registered dental team members must comply with GDC Standards for the Dental Team and Healthcare Inspectorate Wales inspection process for dental practices includes equipment and facilities.

Dental practices and community clinics should provide a safe environment. This is particularly important where children are concerned. Parents or carers should be encouraged to remain with their child or the patient that they are accompanying at all times. Where this is not possible, or a young person or adult at risk wishes to attend alone, then a second registrant member of the team must be present. Such safe practice should apply to any environment where dental care is provided. Practices may helpfully display information on local authority and confidential help lines such as ChildLine, NSPCC and Domestic Abuse.

Safe Recruitment Practice

Employers must ensure that all staff engaged to work with children, young people and adults at risk are suitable to do so. All reasonable steps must be taken in the employment process including:

- Availability of a full employment history with satisfactory explanations for any gaps in employment history.
- Qualifications and professional registration are checked.
- Proof of identity is checked (birth certificate and passport).
- References are properly validated.
- Have a process in place for undertaking DBS checks at the appropriate level for staff that require a check. Dentists must have an enhanced disclosure and barring (DBS) check, this is a requirement for registration with HIW to provide private dental services and for a dentist to be included on the NHS performers list. Dental therapists and hygienists who provide private direct access services will also require an enhanced DBS check.

For all other team members, Practices need to assess the different responsibilities and activities of staff to determine if they require a DBS check and to what level. Remember that the eligibility for checks and the level of that check depends on the roles and responsibilities of the job not the individual being recruited and is based on the level of contact staff have with patients, particularly children and adults at risk.

In addition *you need to decide whether to accept previously-issued CRB/DBS check. You should consider the following before making a decision:*

- *The applicant's criminal record or other relevant information may have changed since its issue.*
- *The certificate was issued for a role elsewhere.*
- *Another organisation will have validated the* identity of the applicant - *you should ensure that the identity details on the certificate match those of the applicant.*

- The candidate should be clear that failure to disclose previous and any new convictions is a disciplinary issue.

- It is now a criminal offence to appoint a person who is unsuitable to work with children by virtue of a previous relevant conviction. (This offence carries a prison sentence). Not knowing is not considered a defence if you did not undertake suitable pre-employment checks and suitable checks thereafter.

- If any practice requires clarification whether their recruitment policy is robust, this can be sought from the Named Professionals within the Health Board or the Designated Professionals, National Safeguarding Team (NHS Wales), Public Health Wales.

The appointment should be subject to all the above being in place. If the checks are not fully completed the appointing officer will need to make a decision on the appointment date and whether it is suitable for the appointee to begin work but with no unsupervised contact with children or adults at risk. No employee should be given unsupervised access to children or adults at risk without all satisfactory recruitment checks having been made.

Under The Rehabilitation of Offenders Act 1974 (Exceptions) Order 1975 (Amendment) (England and Wales) Order 2013, dental registrants and those applying for registration or restoration are required to declare all convictions and cautions that are not considered "protected" under this act e.g. public protection sentences including sexual or violent crimes and custodial sentences over four years. Except exempt persons applying to provide services on a temporary and occasional basis under section 36Z3 and Schedule 4 of the Dentists Act 1984 (as amended) If temporary staff are recruited from an agency then the practice should be assured that appropriate checks have been made.

A Disclosure and Barring (DBS) check is be needed for certain jobs relating to healthcare, and where required, they must be carried out in line with current legislation. It is a criminal offence for an employer to knowingly allow a barred person to work in regulated activity.

Dental professionals are required to disclose to the GDC if they have been barred from regulated activity. The Home Office provides further details about regulated activity, disclosure and barring, and the duty to refer to the DBS.

Clarification on recruitment policy in relation to safeguarding can be sought from the Named Professionals for Safeguarding within health boards in Wales. Advice may

also be sought from your dental protection organisation or equivalent body and from the safeguarding advisors e.g. if unsure about how to proceed following notice of a criminal conviction for a member of the practice staff.

Allegations of Professional Abuse/Whistle Blowing

It is important that all staff in contact with any patient always act in a professional manner and in ways in which their behaviour cannot be misinterpreted or lead any reasonable person to question their suitability to work with children, young people or adults at risk. The GDC standard 8.5 explicitly require dental professionals to take appropriate action if they have concerns about the possible abuse of children or adult at risk. Staff should also be aware that behaviour in their personal lives and actions of their partner (or other family members) drawn to the attention of other agencies, may raise questions about their suitability to work with children, young people and adults at risk. Dental Teams should refer to the GDC Standards for additional guidance, in particular the standards within Principle 9 “make sure your personal behaviour maintains patients’ confidence in you and the dental profession”.

Safeguarding concerns may arise in all areas of work. All allegations of abuse of children or adults at risk by a staff member should be taken seriously and managed in accordance with the All Wales Child Protection Procedures (2008) and the Wales Interim Policy and Procedures for the Protection of Vulnerable Adults from Abuse (2010). Allegations or concerns about the behaviour of a member of staff should not be investigated internally and advice should be sought if uncertain about what action to take. The Named Professionals for Child Protection / PoVA should be contacted for advice and support when concerned about professional abuse.

The GDC has issued very helpful guidance to its registrants on raising concerns.
http://www.gdc-uk.org/Dentalprofessionals/Fitnesstopractise/Pages/Advice-on-raising-concerns.aspx

The GDC Standards Include:

Standard 8.3

You must make sure if you employ, manage or lead a team that you encourage and support a culture where staff can raise concerns openly and without fear of reprisal.

- 8.3.1 You must promote a culture of openness in the workplace so that staff feel able to raise concerns.
- 8.3.2 You should embed this culture into your policies and procedures, beginning with staff training and induction.

If someone is dismissed or removed from regulated activity, or they would have been had they not already left, because they harmed or posed a risk of harm to vulnerable groups including children, the employer is legally required to forward information about that person to the DBS. It is a criminal offence not to do so. If the person is believed to have committed a criminal offence, the DBS strongly advise that the information is shared with the police. The employer should also make a referral to the GDC.

Safeguarding Training

Dental professionals and their support staff must clearly understand their responsibilities and should be supported by their employing organisation and health board to fulfil their duties. To fulfil these responsibilities, the dental team should have access to appropriate safeguarding training, learning opportunities, and support to facilitate their understanding of the clinical aspects of child welfare and adult protection, including information sharing.

The intercollegiate document *Safeguarding Children and Young people: roles and competences for health care staff* (ICD) states that in order to protect children and young people from harm all healthcare staff must have the competences to recognise child maltreatment and to take effective action as appropriate to their role. It details competences, knowledge and skills at various levels that specific healthcare staff are required to meet.

The relevant levels for Dentistry are:

ICD Level 1: All dental staff must complete, safeguarding training at level one or equivalent.
ICD Level 2: All dentists and dental care professionals are required to attain the competences at ICD level 2 as well.
ICD Level 3: Dentists registered as paediatric specialists are required to attain competences at this level. It is also best practice for CDS Clinical Directors to be competent to ICD level 3. Safeguarding Practice Leads would be encouraged to attain competences at this level.

Any member of the dental team is required to complete all appropriate levels of training. However you are only required to update at the higher level for your position. Training should be updated every three years.

Dental teams in the CDS & HDS must comply with their Health Board guidance.
There is currently no ICD equivalent for training regarding safeguarding adults at risk. However it is a requirement of Statutory and Mandatory training that healthcare staff have adult safeguarding training. The training for Safeguarding Adults at Risk has 2 levels; Level 1 is part of the induction programme and Level 2 is required for all staff every three years.

Safeguarding training for dental teams is available through the Wales Deanery via several routes:

- Level 2 child protection training is provided as in-practice training to the team and also at postgraduate centres across Wales.
- Wales Deanery has developed bespoke POVA training for dental teams which is delivered at various postgraduate centres throughout Wales.

The Wales Deanery website provides more information at https://dental.walesdeanery.org/

Training may also be available via health boards and other organisations such as Learning@NHSWALES. There is information on the National Safeguarding Team (NHS Wales) about how to access level 1 and 2 training free for all NHS staff.

In addition to this level of training, dental professionals should ensure that they keep up to date with safeguarding developments. An up-to-date record should be maintained in each dental practice of the safeguarding training undertaken by every member of staff.

6 CONFIDENTIALITY, CONSENT, INFORMATION SHARING AND CAPACITY

Confidentiality and Information Sharing

Healthcare professionals and their support staff have a legal duty to share concerns and take action to safeguard the welfare and safety of children, young people and adults at risk. Fears about sharing information cannot be allowed to stand in the way of the need to safeguard.

The revised Caldicott Principle 7 states that "the duty to share information can be as important as the duty to protect patient confidentiality".

Sharing of information between practitioners and organisations is essential for effective identification, assessment, risk management and service provision. Many Serious Case Reviews into serious harm or death in children cite information sharing concerns as a contributory factor. Legislation and professional guidance concerned with confidentiality protects individual patients, but they are not intended to prevent exchange of information between the professionals and agencies that have a responsibility for ensuring the protection of children, young people and adults at risk.

In cases where there are safeguarding concerns, there is a duty to share all relevant information with the professionals and agencies that need to know. This may include disclosing information to other professionals who need access to that information for the purposes of safeguarding with or without the permission of the child, young person, adult at risk, parents or carers. You do not need to be certain that a person is at risk of significant harm to take this step. If a child, young person or adult is at risk of, or is suffering, abuse or neglect, the possible consequences of not sharing relevant information will, in the overwhelming majority of cases, outweigh any harm that sharing your concerns with an appropriate agency might cause.

In sharing concerns about possible abuse or neglect, you are not making the final decision about how best to protect a person. That is the role of the local authority and, ultimately, the courts. Even if it turns out that the person is not at risk of, or suffering, abuse or neglect, sharing information will be justified as long as your concerns are honestly held and reasonable, you share the information with the appropriate agency, and you only share relevant information.

Whilst the Data Protection Act 1998 places duties on organisations and individuals to process personal information fairly and lawfully, it is not a barrier to sharing information where the failure to do so would result in a child or vulnerable adult being placed at risk of harm. It does not prohibit the collection and sharing of personal information but provides a framework to ensure that personal information about an individual is shared appropriately. Similarly the common law duty of confidence and human rights concerns, such as respecting the right to a private and family life, would not prevent sharing where there are real safeguarding concerns.

Confidentiality is an important duty, but it is not absolute. There are circumstances when it may be appropriate to disclose confidential patient information. These are:

- when you have the patient's consent, or
- when the law says you must, or
- when it is in the public interest to do so.

Adults at risk and children are entitled to the same duty of confidence as any other person provided that they have the ability to understand their choices and the consequences of any actions.

A complete record of what has been shared should always be kept.

The most important consideration is whether sharing information is likely to safeguard

Note *See Appendix 5a – The Seven Golden Rules to Information Sharing.*

Consent

Seeking a patient's consent to disclosure of information shows respect, and is part of good communication. Wherever possible, you should seek consent and be open and honest with the individual (and/or where appropriate, their family or carers) from the outset as to why, what, how and with whom, their information will be shared.

In safeguarding the child, young person or adult at risk may not have the capacity to give consent (see below for details about capacity). If you believe that a patient may be a victim of neglect or physical, sexual or emotional abuse, that they lack capacity to consent to disclosure and where you believe that the disclosure is in the patient's best interests or necessary to protect others from a risk of serious harm, you must give information promptly to an appropriate responsible person and the local authority. The responsible person may be the patient's parent, family, carer or an advocate. If, for any reason, you believe that disclosure of information is not in the best interests of a neglected or abused patient, you should discuss the issues with an experienced colleague. If you decide not to disclose information, you should document in the patient's record your discussions and the reasons for deciding not to disclose. You should be prepared to justify your decision.

You do not necessarily need the consent of the patient or their parent/carer to share their personal information. It is still possible to share personal information if it is necessary in order to carry out your role, or to protect the vital interests of the individual.

Working in partnership with families is essential to promoting the welfare of children and vulnerable adults. When making a safeguarding referral, it is good practice to inform the parents or carers. There may be occasions when it is believed that informing the parents or carers may place the individual at further or additional risk. In such circumstances consent should not be sought and the parent or carer should not be informed of the referral. The professional is charged with the protection of the child, young person or adult at risk not with the protection of the parent or carers.

If consent is withheld by a parent or carer to share information, a risk assessment of the child, young person or adult at risk's concerns should be undertaken and further advice sought, as the refusal to consent may increase concerns.

You would also not need to seek consent if it was unsafe to do so because of a risk of harm to you or your staff. In the process of any subsequent investigations by the police and social services it should be expected that the referral and its source will be made known to parents or carers. Therefore any concerns about the impact of this on healthcare professionals and/or their support staff should be shared with the police or social services departments at the time of referral.

The Carlile review: *Too serious a thing*: *review of safeguards for children and young people treated and cared for by the NHS in Wales*, stated.

"There is nothing within the Caldicott Report, the Data Protection Act 1998, or the Human Rights Act 1998, which should prevent the justifiable and lawful exchange of information for the protection of children or prevention of serious crime".

Therefore while consent is desirable it is not necessary for safeguarding referrals.

Safeguarding is dependent on raising concerns and on sharing information appropriately. However, healthcare professionals are frequently uncertain as to whether their concerns reach a threshold for action. In these circumstances advice should be sought from a professional with expertise in safeguarding. Contact details of local Safeguarding Children and Adult teams within health and social care should be readily available locally.

Professionals must also be aware of their governing bodies guidance on consent.

Note: See appendix 4 for a flowchart on actions to be taken when sharing information.

Capacity

Every adult and young person aged 16-17 is presumed to have the capacity to make their own decisions and to give consent unless there is enough evidence to suggest otherwise.

For consent to be valid the patient must:

- have the capacity to give consent
- be acting voluntarily – they must not be under any undue pressure from you or anyone else to make a decision
- have sufficient, balanced information to allow them to make an informed decision
- be capable of using and weighing up the information provided.

You must **not** assume that a patient lacks capacity based just upon their age, disability, beliefs, condition and behaviour or because they make a decision you disagree with. You must base an assessment of capacity on an individual basis taking into account the patient's ability to make a specific decision at the time it

needs to be made, as well as the complexity and importance of that decision. At any time a person may be capable of making some decisions but not others.

In the case of adults at risk reference should be made to the Mental Capacity Act 2005 and its Code of Practice. (See also Appendix 6).

Children under 16 are not presumed to have the capacity to consent, they must demonstrate their competence. A child can give consent if you are satisfied that the treatment or action is in their best interests and that they have the maturity and ability to fully understand the information given and what they are consenting to. The Mental Capacity Act 2005 does not apply to children under 16. However the principles of assessing capacity are the same. The Fraser Guidelines are often used to assess capacity in children under 16 years of age though they were originally intended for the prescribing of contraception to this group. Consideration should always be given to getting consent from a child under 16 years of age where they are felt to be competent. In this case you do not also need consent from a person with parental responsibility.

When making decisions about whether to disclose information about a patient who lacks capacity, you must:

(a) make the care of the patient your first concern;
(b) respect the patient's dignity and privacy, and;
(c) support and encourage the patient to be involved, as far as they want and are able, in decisions about disclosure of their personal information.

7 RECORD KEEPING

Accurate record keeping is an essential part of the accountability for safeguarding children, young people and adults at risk. It is an extremely important element to ensure effective inter-agency working. Principle 4 of the GDC Standards provides clear guidance with regards to record keeping for dental professionals and the standards expected. Documentation within dental practices should accurately reflect not only the care provided but also any concerns in respect of a child, young person or adult at risk. This may include any injury observed. In this case accurate documentation is essential, using diagrams when appropriate.

Documentation may include:

- Description of location of injury.
- Nature of injury e.g. bruise, laceration.
- Size (measured in centimetres) and shape of injury.
- Other relevant comments and observations that have been made by the parent or carer.
- A note of the behaviour, presentation or comments concerning an accompanying adult or others accompanying the child. This could include for example; information on dental neglect, repeat GA or dental pain that has been ignored by parents/carers.

Concerns may also be raised in respect of how a parent or carer has related to, or behaves towards, a child or adult at risk. These should be recorded along with any actions taken including seeking advice and noting the advice given.

It may also be relevant to record concerns about observations, presentation or comments of anyone accompanying the patient.

Appendix 3a includes examples of Facial, Oral and Body Maps that can be used by dental practitioners to record any injury a child or adult may present with.

8 DOMESTIC ABUSE AND FAMILY VIOLENCE

The definition of domestic abuse has recently been changed so that it now includes 'coercive control' and encompasses young people under 18.

The new definition of domestic violence and abuse is:
"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse: psychological, physical, sexual, financial and emotional".

Where:
Controlling behaviour: is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

***Coercive behaviour**: is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim*.

This definition is not a legal definition but is used by government departments for the purposes of, for example, targeting support services (Home Office, 2015).

Domestic Abuse and Children

Domestic abuse and family violence has a profound effect on children and young people who experience it within their family. Research shows that children experiencing domestic abuse can be affected in every aspect of their functioning; safety, health, school attendance, educational achievement, economic well-being and emotional and social development. In the most extreme cases children are at risk of serious injury or death**.**

It is a major factor in Child Protection cases and one of the commonly recurring features in Serious Case/Child Practice Reviews. Children are put at risk of experiencing physical harm from the perpetrator or by being caught up or trying to intervene in arguments and fighting between family members. Children are hugely affected by the fear of abuse as well as seeing and hearing abuse within their family.

The link between domestic abuse and child abuse is so strong that it is usual practice to always make a referral to Social Services in cases where there are children dependent on the perpetrator or victim.

This is true even where the adult victim has capacity and declines referral for themselves. The children do not have to be present at the time of the incident triggering concern; the nature of domestic abuse is such that there has often been a long period of abuse before there is a disclosure or revelation. In these circumstances the professional making the referral is acting as an advocate for the

child who normally cannot make an informed choice about reporting the abuse they are suffering.

Young People, Family Violence and Domestic Abuse

The British Crime Survey 2009/10 found that 16-19-year-olds were the group most likely to suffer abuse from a partner and this has prompted the change in the definition of domestic abuse.

Young people can also be perpetrators of abuse towards their parents or carers. This can include physical violence, damage to property, emotional and financial abuse (Home Office 2015). For young people 16 and over this meets the official definition for domestic abuse. Given the complicated nature of these situations interventions should focus on treating and supporting the family including the perpetrator.

Adults – Violence and Abuse

The prevalence of physical assaults from a partner or adult family member is higher among heterosexual women than among men. Heterosexual women experience more repeated physical violence, more severe violence, more sexual violence, more coercive control, more injuries and more fear of their partner (NICE, 2014).

It is important to remember that violence and abuse which meets the definition of domestic abuse are also experienced by other adults, within family settings and relationships. This includes in same sex relationships, in the elderly between partners and from their children, between other family members and by men who are abused by women. Recognising, responding and supporting victims should be about an inclusive approach for all potential victims, providing effective responses to all.

Ask and Act

Following the Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015 it is now the role of the entire Public Service to provide an effective response to those experiencing violence against women, domestic abuse and sexual violence.

Ask and Act is a process of targeted enquiry that recognises that there are indicators of potential violence against women. These should be used as a prompt for professionals to ask patients whether they have been affected by any of these issues. The implementation of 'Ask and Act' should acknowledged that women disproportionately experience domestic abuse, sexual violence and other abuse, such as forced marriage and female genital mutilation.

Violence against women, domestic abuse and sexual violence require a Public Service response. Professional confidence to identify these issues, to ask about them and to respond effectively is fundamental for good clinical practice.

Multi-Agency Risk Assessment Conference (MARAC)

Working in a multi-agency partnership is the most effective way to approach domestic abuse at both an operational and strategic level. The MARAC is a process to address the safety and protection of those most at risk from serious assault or murder as a result of domestic abuse.

In many high risk situations, victims may adopt an increasingly passive stance and an acceptance of their situation without the possibility of change, leading to them being unlikely to seek help. The MARAC is a vital tool in addressing their safety and is a way of moving the responsibility for addressing domestic abuse from the victim to a broad group of agencies.

Effective protection of victims and their children is a multi agency responsibility. This meeting combines up to date risk information with a comprehensive assessment of a victim's needs linking those directly involved to the provision of appropriate services for the victim, children and perpetrator.

Health professionals may be asked to attend, or provide information for, the MARAC. The duty of responsibility to co-operate with this process is the same as for Child Protection Case Conferences.

The aims of the MARAC are to:

- Share information to enhance the safety, health and well being of victims, adults and their children;
- Raise awareness of the impact of domestic abuse on children;
- Agree and implement a risk management plan;
- Reduce repeat victimisation;
- Determine whether the perpetrator poses a significant risk to any particular individual or to the general community;
- Reduce domestic homicide and abuse;
- Prevent child abuse;
- Ensure agency accountability;
- Provide support for staff members and professionals involved in high risk domestic abuse cases.

The MARAC may recommend a referral to social services. Similarly at any point in a social service assessment process a MARAC may be recommended and arrangements must be in place to share information between the 2 processes.

MARAC partner agencies recognise the overlap between domestic abuse and the abuse of children. The legal definition of harm to children has been extended to include those living in households where domestic abuse is taking place. Amendment, *Section 120, Adoption & Children Act 2002*.

Advice can also be accessed through Local Authority and Health Board Domestic Abuse leads.

There is also advice for victims on the Welsh Government Live Fear Free website.

9 CHILD SEXUAL EXPLOITATION (CSE)

The Welsh Government and the All Wales Child Protection procedures definition of Child sexual exploitation is the coercion or manipulation of children and young people into taking part in sexual activities. It is a form of sexual abuse involving an exchange of some form of payment which can include money, mobile phones and other items, drugs, alcohol, a place to stay, 'protection' or affection. The vulnerability of the young person and grooming process employed by perpetrators renders them powerless to recognise the exploitative nature of relationships and unable to give informed consent.

Those exploiting the child hold power over the child or young person (by virtue of age, gender, intellect, physical strength, money and / or other resources). CSE involves exploitative relationships as well as violence, intimidation and coercion and prays on the child's emotional or social or economic vulnerability.

In contrast to other forms of sexual abuse, children and young people who are sexually exploited may not recognise that they are being abused as they perceive the perpetrator as giving them something they need or want. This may change over time as the perpetrator's behaviour becomes more coercive, but fear of consequences may stop them from disclosing.

Sexual exploitation results in children and young people suffering harm, and causes significant damage to their physical and mental health. Some young people may be supported to recover whilst others may suffer serious life-long impairments which may, on occasion, lead to their death, for example through suicide or murder.

There are different ways in which sexual exploitation may take place such as:

- An inappropriate relationship often characterised by a significant age difference - the perpetrator exercises power over the young person through giving them something they need in exchange for sexual activity.
- The 'boyfriend' model - the young person is groomed to view the person as a boyfriend but is then forced into performing sexual behaviours for others.
- Peer-on-peer exploitation - the young person is drawn into sexual activities by their peers e.g. as part of the ritual of belonging to a gang.

It should not be assumed that children aged 16 and 17 years are safe from CSE. A young person who has been subject to a complex pattern of life experiences including sophisticated grooming and priming processes that have brought them to a point where they are at risk of, or are abused, through CSE, are often not able to recognise the exploitative relationships and situations they are in. They may even present as being in control.

Health services have a role and responsibility in relation to prevention and recognition of CSE. Staff working across agencies need to be familiar with risk indicators, assessment procedures and the contents of the *All Wales Protocol.* Information sharing and multi-agency working is central to safeguarding and promoting the welfare of children and young people vulnerable to, at risk of and abused through child sexual exploitation.

Please see Appendix 8 for details on vulnerability and risk factors.

10 SUBSTANCE AND ALCOHOL MISUSE

The Welsh Government's ten year substance misuse strategy, (Working Together to Reduce Harm, 2008 - 2018) has prioritised supporting substance misusers to reduce harm to themselves and their families by the provision of advice, brief intervention and recovery based services. Adult and child services need to continue working together, aiming for effective treatment and support for the adult, leading to major benefits, and improved outcomes for the child.

Adults at Risk: Using Substances and/or Alcohol

Substance and alcohol misuse in adults could mean that they prioritise obtaining and using drugs and/or alcohol above all other things in their lives. Such life styles and priorities can often lead people to be particularly vulnerable to abuse.

Where adults and young people with co-existing mental health needs use substances or alcohol there is a potential for self neglect. This may mean there is a decline in the way they manage their health, mismanage or omit prescribed medications and fail to attend appointments. Communities, friends and families may notice changes in friendship groups as well as concerns about living conditions and who the adult is spending time with.

Approximately one third of UK mental health service users, half of the people seen by substance misuse services, and seven out of ten prisoners will experience co-existing substance misuse and mental health problems at some point in their lives. In order to deliver effective services to this client group, services have to be co-ordinated and have clear treatment protocols and care pathways in place. The National Treatment Agency for Substance Misuse has identified key principles in terms of ensuring appropriate care of drug misusers:

- Drug misusers have the same entitlement as other patients to the services provided by the National Health Service.
- The focus for the clinician treating a drug misuser is on patients themselves. However, **the impact of their drug misuse on other individuals – especially dependent children – and on communities should be taken into consideration.** (National Treatment Agency, 2007).

Substance/Alcohol Use Impacting on Parenting or Caring

Parental drug and alcohol misuse can cause serious and significant harm to children of all ages, from conception to adulthood. The adverse consequences for children are typically multiple and cumulative and will vary according to the child's stage of development. They include failure to thrive; blood-borne virus infections; incomplete immunisation and otherwise inadequate health care; a wide range of emotional, cognitive, behavioural and other psychological problems; early substance misuse and offending behaviour; and poor educational attainment. It is estimated that between 2–3% of children under 16 in England and Wales have one or both parents dealing with a serious drug problem.

The complexity of substance and alcohol misuse significantly affects children and families. Safeguarding and protecting vulnerable children and is a key theme of the Social Services and Well being Act (2014) recognising that children and young people are likely to be at greater risk of harm through their own substance misuse or parental substance misuse.

In order to make a comprehensive assessment of drug using parents, National Treatment Agency guidelines outline the following:

- Effect of drug misuse on functioning, for example, intoxication, agitation.
- Effect of drug seeking behaviour, for example, leaving children unsupervised, contact with unsuitable characters.
- Impact of parent's physical and mental health on parenting.
- How drug use is funded, for example, sex working, diversion of family income.
- Emotional availability to children.
- Effects on family routines, for example, getting children to school on time.
- Other support networks, for example, family support.
- Ability to access professional support.
- Storage of illicit drugs, prescribed medication and drug-using paraphernalia.

It is also helpful to consider what it is that a parent is **not doing** for their child (age appropriate expectations) that you would be reasonably expecting a parent to do. In addition to the above information the following examples of concerns or behaviours would hopefully lead to discussion about whether support is in place or if a specific intervention is needed for a family or an individual.

- Failing to attend appointments, not bringing a child to an appointment;
- A child or young person not attending school or college;
- Noticing apparent neglect issues, examples such as lack of self care in an adult or young person or neglectful care of a child;
- Parents associating with unsuitable or inappropriate adults impacts on children having chaotic and potentially unsafe lives;
- Where income may be being spent on drugs or alcohol, there is a lack of money for food, clothes and essential amenities for the children.

Support and Services

For children, young people, families and adults it is important to consider what (if any) services are currently involved giving support. It may be that asking appropriate questions is enough to open a discussion about supporting needs and current agency support.

Integrated Family Support Services are able to complete a specific and intensive planned intervention working with the most vulnerable children and families in Wales, specifically where substance misuse is impacting on parenting and child welfare.

Information about specific substances and the potential health risks to an individual is available from the NHS Choices website: NHS Choices - live well/drugs . As well as the confidential drugs advice site: 'Talk to Frank'.

11 FEMALE GENITAL MUTILATION (FGM)

Female genital mutilation (sometimes referred to as female circumcision or 'cutting') refers to procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons. FGM comprises all procedures involving partial or total removal of the external female genitalia for non-medical reasons. The practice is illegal in the UK under the FGM Act 2003.

FGM is a form of child abuse and violence against women. The health implications of FGM can be severe to fatal depending on the type of FGM carried out. Professionals need to be aware of the possibility of FGM.

For children the All Wales Child Protection Procedures have specific guidance on FGM. For Adults there is an All Wales FGM Pathway.

There are no health benefits to FGM. Removing and damaging healthy and normal female genital tissue interferes with the natural functions of girls' and women's bodies, causing both short and long term physical, emotional and psychological health problems. Simple descriptors and information about of FGM can be found on NHS Choices-FGM .

FGM is carried out on girls aged anywhere from infancy to late teenage years, and seems to be more common before puberty. Girls may be taken to the family country of origin over the school holiday periods, where FGM takes place on the child. Increasingly, girls may have FGM performed in the UK.

Appendix 9 has details of some indicators of FGM.

FGM: Mandatory Reporting

There is a 'Duty to Report' FGM as part of the FGM Act 2003; section 5B of the Act (inserted under section 74 of the Serious Crime Act 2015).

The legislation applies to all registered health professionals in England and Wales. It requires them to make a report to the police where, in the course of their professional duties, they either:

- are informed by a girl under 18 that an act of FGM has been carried out on her; or
- observe physical signs which appear to show that an act of FGM has been carried out on a girl under 18 and they have no reason to believe that the act was necessary for the girl's physical or mental health or for purposes connected with labour or birth.

For the purposes of the duty, the relevant age is the girl's age at the time of the disclosure/identification of FGM (i.e. it does not apply where a woman aged 18 or over discloses she had FGM when she was under 18).

Complying with the duty does not breach any confidentiality requirement or other restriction on disclosure which might otherwise apply. The duty is a personal duty which requires the individual professional who becomes aware of the case to make a report; the responsibility cannot be transferred. The only exception to this is if you know that another individual from your profession has already made a report then there is no requirement to make a second referral.

The duty does not apply in relation to at risk or suspected cases or in cases where the woman is over 18. In these cases, you should follow local safeguarding procedures as stated above.

Where there is a risk to life or likelihood of serious immediate harm, professionals should report the case immediately to police, including dialling 999 if appropriate.

Further information regarding procedural information can be sourced by following this link to the Home Office guidance: Mandatory Reporting of FGM - Procedural Information.

12 PREVENT – What does this mean in Primary Care?

Counter terrorism like safeguarding is everybody's responsibility. The PREVENT Strategy was published in 2011 and is part of CONTEST the Government's counter-terrorism strategy. As health professionals it is important that we know what role we can play and what the PREVENT Strategy means to us both as Health Professionals and as citizens.

The key components include:

- Recognising the vulnerability of someone being drawn into terrorism
- An awareness of how to respond to concerns
- Potentially referring onwards for further advice and support
- Balancing information sharing and managing issues of confidentiality.

The intercollegiate guidance document, Safeguarding Children and Young People: roles and competencies for health care staff, is now inclusive of PREVENT information and identifies competences for healthcare staff.

The aim of PREVENT is to stop people from becoming terrorists (often referred to as being radicalised) or supporting terrorism. Health and Primary Care are expected to be mindful of this as they work with vulnerable people in the community who are often targeted by extremists to radicalise in order to coerce them into committing acts of terrorism.

A member of the practice team may have concerns relating to an individual's behaviour, which could indicate that they may be being drawn into terrorist activity. This may include:

- Graffiti symbols, writing or artwork promoting extremist messages or images.
- Patients/staff accessing terrorist related material online, including through social network sites.
- Parental/family reports of changes in behaviour, friendships or actions, coupled with requests for assistance.
- Partner healthcare organisations', local authority services' and police reports of issues affecting patients in other healthcare organisations.
- Patients voicing opinions drawn from terrorist related ideologies and narratives.
- Use of extremist or hate terms to exclude others or incite violence.

The document Building Partnerships, Staying Safe gives details about the *Prevent* strategy and provides advice to healthcare organisations on their role in preventing radicalisation of vulnerable people as part of their safeguarding responsibilities.

PREVENT Duty Guidance

Section 26 of the Counter Terrorism and Security Act (2015) places a duty on specified authorities, including health, in exercising their function and having due regard to the need to prevent people from being drawn into terrorism. Prevent Duty Guidance is now in place in England and Wales.

The three main aims are:

1. To respond to the ideological challenge of terrorism and the threat we face from those who promote it;
2. Prevent people from being drawn into terrorism and ensure that they are given appropriate advice and support;
3. Work with sectors and institutions where there are risks of radicalisation that we need to address.

A risk-based approach is required in the PREVENT duty, demonstrating an understanding and awareness of the risk of radicalisation for each area, institution or body.

Prevent deals with all kinds of terrorist threats to the United Kingdom. The most significant of these threats is currently from organisations in Syria and Iraq and so called IS (Islamic State) associated groups. Terrorist activity associated with the extreme right wing also poses a continued threat to safety and security.

Workshop to Raise Awareness of PREVENT (WRAP)

This training (raising awareness of the UK counter-terrorism strategy) should be delivered to all employees who require Level 2 Safeguarding training an above. Additionally all managers and those in IT roles should attend this short, one-off session.

The workshops aim to give staff:

- An understanding of the Prevent strategy and their role within it;
- The ability to use their existing expertise and professional judgment to recognise vulnerable individuals who may need support.

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Appendix 1: The Welsh Government Health and Care Standard on Safeguarding Children and Safeguarding Adults at Risk

The Heath Standard on Safeguarding Children and Safeguarding Adults at Risk states that the health service will need to consider the following criteria for meeting the standard:

There is compliance with legislation and guidance to include:

- All Wales Child Protection and Adults at risk procedures.
- Mental Health Act 1983 in relation to persons liable to be detained, and the Mental Capacity Act 2005 regarding Deprivation of Liberty Safeguards.
- Assurance of safeguarding services and processes is evident across all levels of the organisation.
- Effective multi-professional and multi-agency working and co-operation are in place complying with the Social Services and Well-being (Wales) Act.
- Staff are trained to recognise and act on issues and concerns, including sharing of information and sharing good practice and learning.
- People are informed how to make their concerns known.
- Priority is given to providing services that enable children and adults at risk to express themselves and to be cared for through the medium of the Welsh language because their care and treatment can suffer when they are not treated in their own language. (They are recognised as a priority group in More than just Words).
- Suitable arrangements are in place for people who put their safety or that of others at risk to prevent abuse and neglect.
- Risk is managed in ways which empower people to feel in control of their life.
- Arrangements are in place to respond effectively to changing circumstances and regularly review achievement of personal outcomes.

Appendix 2a: Definitions of Child Abuse

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 or induces illness in a child whom they are looking after.

Physical abuse can lead directly to neurological damage, physical injuries, disability or at the extreme death. Harm may be caused to children both by the abuse itself and by the abuse taking place in a wider family or institutional context of conflict and aggression. Physical abuse has been linked to aggressive behaviour in children, emotional and behavioural problems, and educational difficulties. Violence is pervasive and the physical abuse of children frequently coexists with domestic abuse.

Emotional Abuse

Emotional abuse is the persistent emotional ill-treatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may feature age or developmentally inappropriate expectations being imposed on children. It may involve 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 ill-treatment of a child, though it may occur alone.

There is increasing evidence of the adverse long-term consequences for children's development where they have been subject to sustained emotional abuse. Emotional abuse has an important impact on a developing child's mental health, behaviour and self-esteem. It can be especially damaging in infancy. Underlying emotional abuse may be as important, if not more so, than other more visible forms of abuse in terms of its impact on the child. Domestic abuse, adult mental health problems and parental substance misuse may be features in families where children are exposed to such abuse.

Sexual Abuse

Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative or non-penetrative acts. They may include non-contact activities, such as involving children in looking at, or in the production of, pornographic material or watching sexual activities, or encouraging children to behave in sexually inappropriate ways.

Disturbed behaviour including self-harm, inappropriate sexualised behaviour, depression and a loss of self-esteem, have all been linked to sexual abuse. Its adverse effects may endure into adulthood. The severity of impact on a child is believed to increase the longer abuse continues, the more extensive the abuse, and the older the child. A number of features of sexual abuse have also been linked with

severity of impact, including the relationship of the abuser to the child, the extent of premeditation, the degree of threat and coercion, sadism, and unusual elements. A child's ability to cope with the experience of sexual abuse, once recognised or disclosed, is strengthened by the support of a non-abusive adult carer who believes the child, helps the child understand the abuse, and is able to offer help and protection. The reactions of practitioners also have an impact on the child's ability to cope with what has happened, and his or her feelings of self worth.

A proportion of adults who sexually abuse children have themselves been sexually abused as children. They may also have been exposed as children to domestic abuse and discontinuity of care. Sexual abuse on children can have an impact on future relationships and a proportion of children who have been sexually abused may go on to sexually abuse children themselves. However, it would be quite wrong to suggest that most children who are sexually abused will inevitably go on to become abusers themselves.

Neglect

Neglect means a failure to meet a person's basic physical, emotional, social or psychological needs, which is likely to result in an impairment of the person's well-being (for example, an impairment of the person's health or, in the case of a child, an impairment of the child's development).

It may involve a parent or carer failing to provide adequate food, shelter and clothing, failing to protect a child from physical harm or danger, or the failure to ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

The severe neglect of young children has adverse effects on children's ability to form attachments and is associated with major impairment of growth and intellectual development. Persistent neglect can lead to serious impairment of health and development, and long-term difficulties with social functioning, relationships and educational progress. Neglected children may also experience low self esteem, feelings of being unloved and isolated. Neglect can also result, in extreme cases, in death. The impact of neglect varies depending on how long children have been neglected, the children's age, and the multiplicity of neglectful behaviours children have been experiencing.

Appendix 2b: Different Types of Adult Abuse

Physical Abuse

Physical abuse can be defined as the non-accidental infliction of physical force that results in bodily injury, pain or impairment. For example, hitting, pushing, pinching, shaking, misusing medication, scalding and the misuse or illegal use of restraint.

Emotional Abuse

Emotional abuse is behaviour or actions that have a harmful effect on the emotional, health and/or development of an adult at risk.

This can include threats, deprivation of contact, shouting, ignoring, cruelty, bullying, humiliation, coercion, negating the right of the adult at risk to make choices and undermining self-esteem.

Sexual Abuse

Sexual abuse is the direct or indirect involvement of the adult at risk in sexual activity or relationships, which they:

- Do not want or have not consented to.
- Cannot understand and lack the mental capacity to be able to give consent to.
- Have been coerced into because the other person is in a position of trust, power or authority (for example a care worker).

This includes indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual photography, subjection to pornography or the witnessing sexual acts as well as rape.

Neglect and Acts of Omission

Neglect and acts of omission are the failure of any person, who has responsibility for the charge, care or custody of an adult at risk, to provide the amount and type of care that a reasonable person would be expected to provide. Neglect can be intentional or unintentional. For example, failure to provide for medical, social or educational needs. Withholding necessities such as food, drink and warmth and a lack of protection from hazards. Dental examples will include failure to; provide toothbrush and toothpaste, take the person for dental care or ignoring dental pain.

Financial Abuse

Financial abuse is the use of a person's property, assets, income, funds or any resources without their informed consent or authorisation. Financial abuse is a crime.

It includes:

- Theft or fraud
- Exploitation

- Undue pressure in connection with wills, property, inheritance or financial transactions
- The misuse or misappropriation of property, possessions or benefits
- The misuse of an enduring power of attorney or a lasting power of attorney, or appointeeship.

Discriminatory Abuse

Discriminatory abuse occurs where there is abuse or unfair treatment motivated because by age, gender, sexuality, disability, religion, class, culture, language, and race or ethnic origin.

It can be a feature of any form of abuse of an adult at risk and often occurs when values, beliefs or culture result in a misuse of power that denies opportunity to some groups or individuals e.g. exploiting a person's vulnerability by treating them in a way that excludes them from opportunities they should have as equal citizens, for example, education, health, justice and access to services and protection.

Institutional Abuse

Institutional abuse is the mistreatment, abuse or neglect of an adult at risk by a regime or group of individuals. It takes place in settings and services that adults at risk live in or use. It violates the person's dignity and is a lack of respect for their human rights.

Institutional abuse can occur when the routines, systems and regimes of an institution result in poor or inadequate standards of care and poor practice. It can take the form of an organisation failing to respond to, or address, examples of poor practice brought to their attention.

It can take place in day care, care homes, hostels, hospitals, sheltered and supported housing.

It can be difficult to identify the difference between a poor service and institutional abuse.

Where Can Abuse Happen?

Anywhere including:

- in a person's own home
- in a residential or nursing home
- in a hospital
- in the workplace
- at a day centre or educational establishment
- in sheltered or supported housing
- in the street.

Who can abuse?

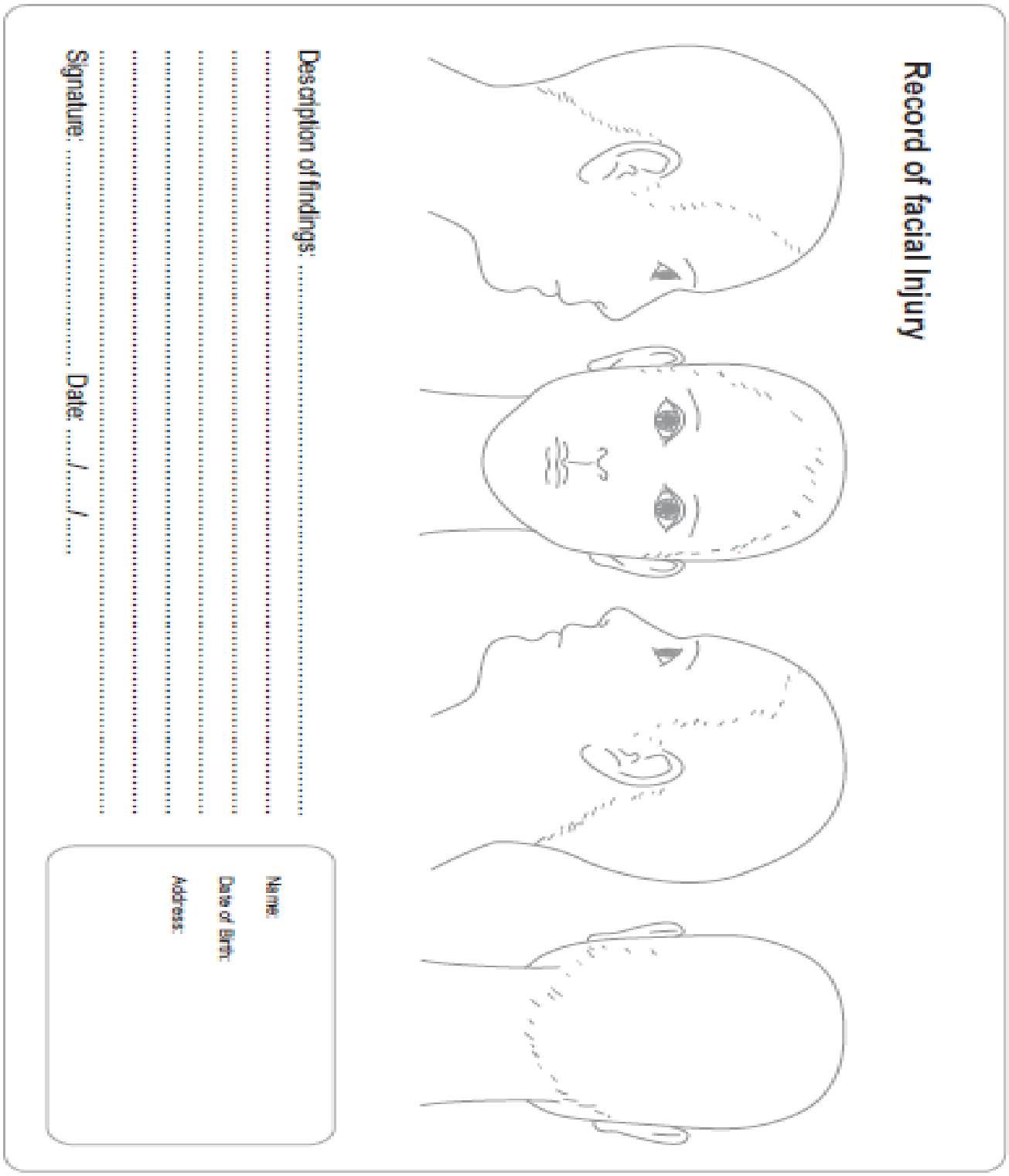
The person responsible for the abuse is often well known to the person being abused, and could be:

- a paid carer in a residential establishment or from a home care service
- a person employed directly by someone in their own home as a carer or a personal assistant
- a social care worker
- a health worker
- a relative, friend, or neighbor
- another resident or person using a service in a shared care setting
- someone providing a support service.

It can also be people who:

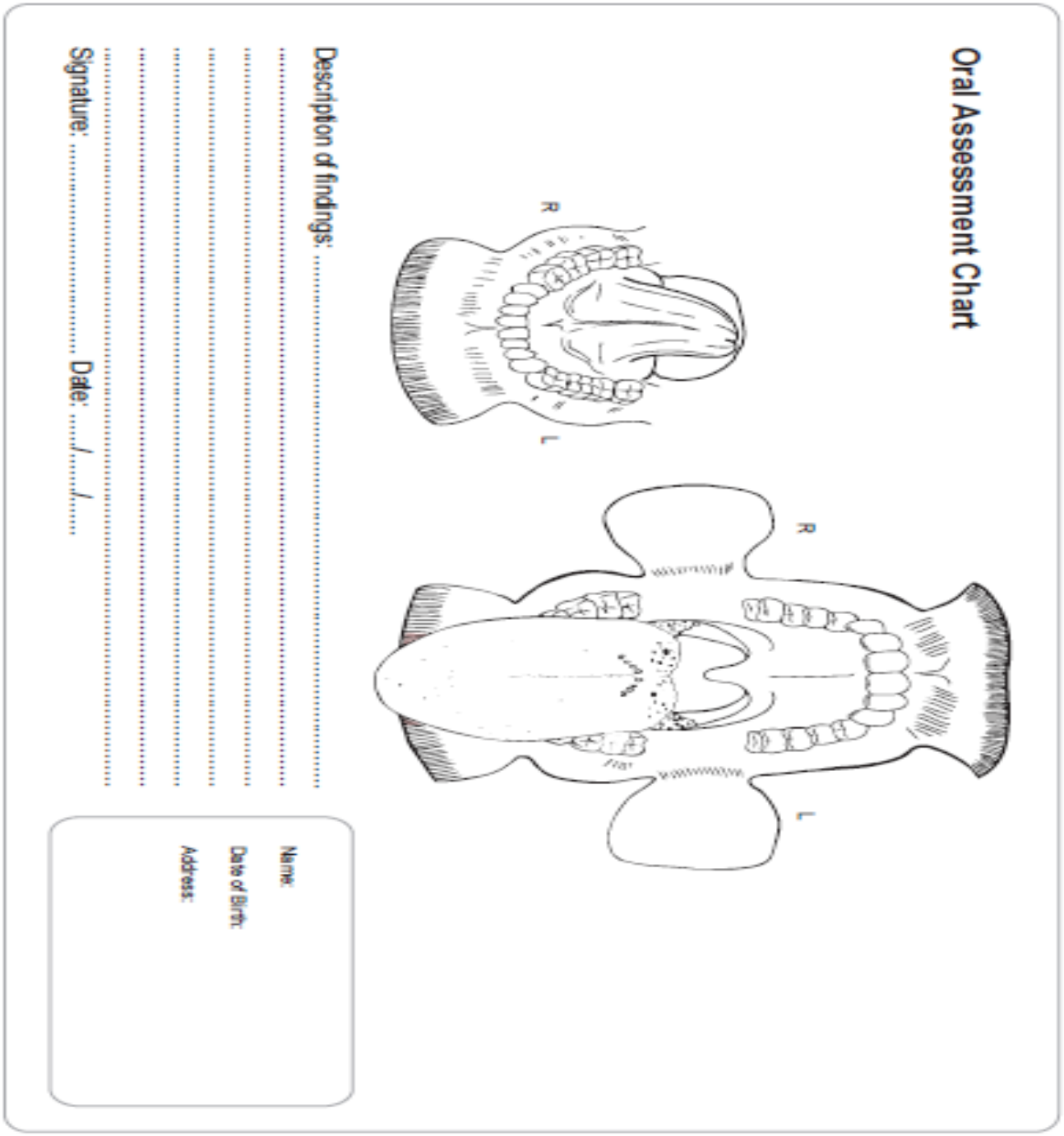
- befriend vulnerable people with the intention of exploiting them
- deceive people into believing they are from legitimate businesses, services or utility providers
- intimidate vulnerable people into financial transactions they do not want or cannot understand.

Appendix 3a – Record of Facial Injury



Note: Copy of record of facial injury chart available via National Safeguarding Team (NHS Wales), Public Health Wales online links

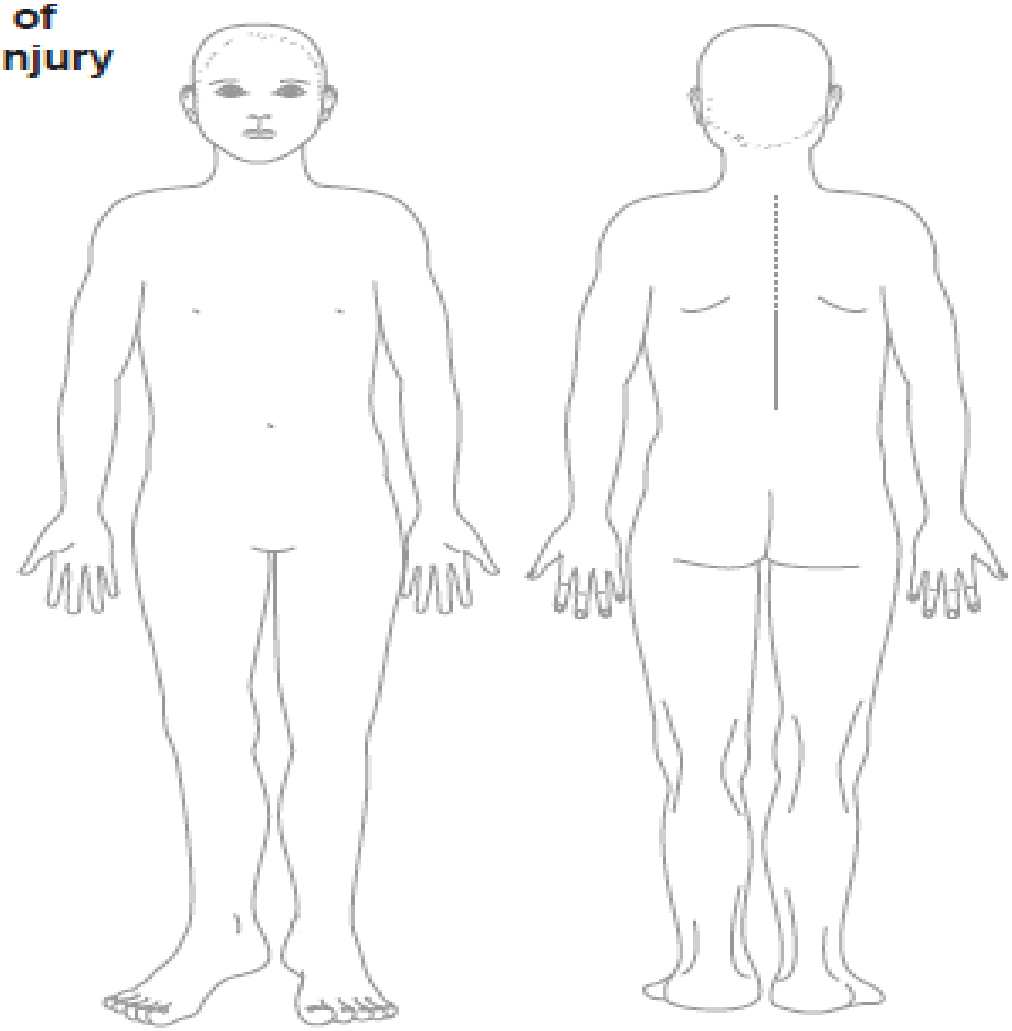
Appendix 3b – Oral Assessment Chart



Note: Copy of oral assessment chart available via National Safeguarding Team (NHS Wales), Public Health Wales online links

Appendix 3c – Record of Bodily Injury

Record of bodily injury



Description of findings: .....
.....
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.....
.....
.....
Signature: ..... Date: ...../...../.....

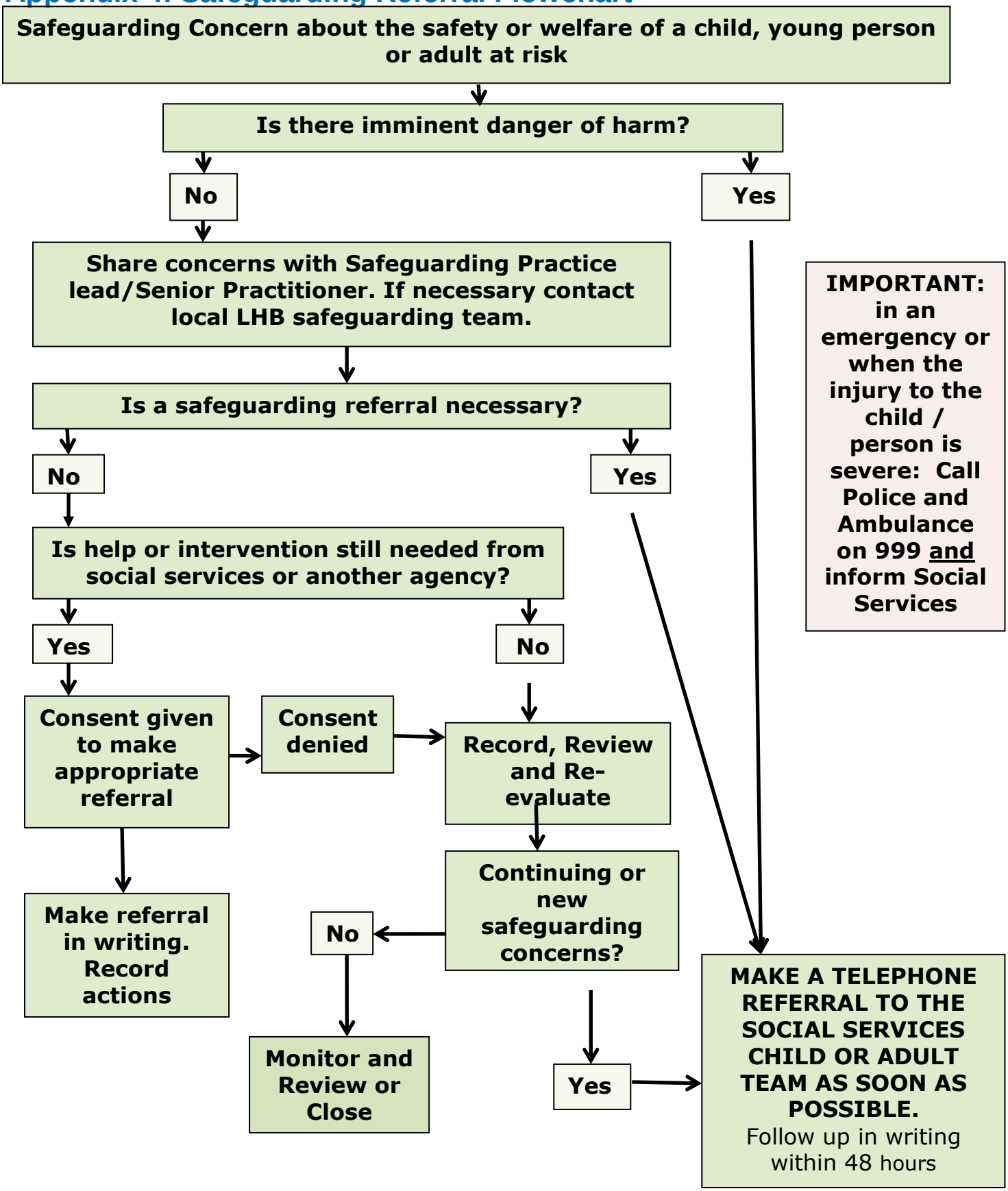
Name:

Date of Birth:

Address:

Note: Copy of record of bodily injury chart available via National Safeguarding Team (NHS Wales), Public Health Wales online links

Appendix 4: Safeguarding Referral Flowchart

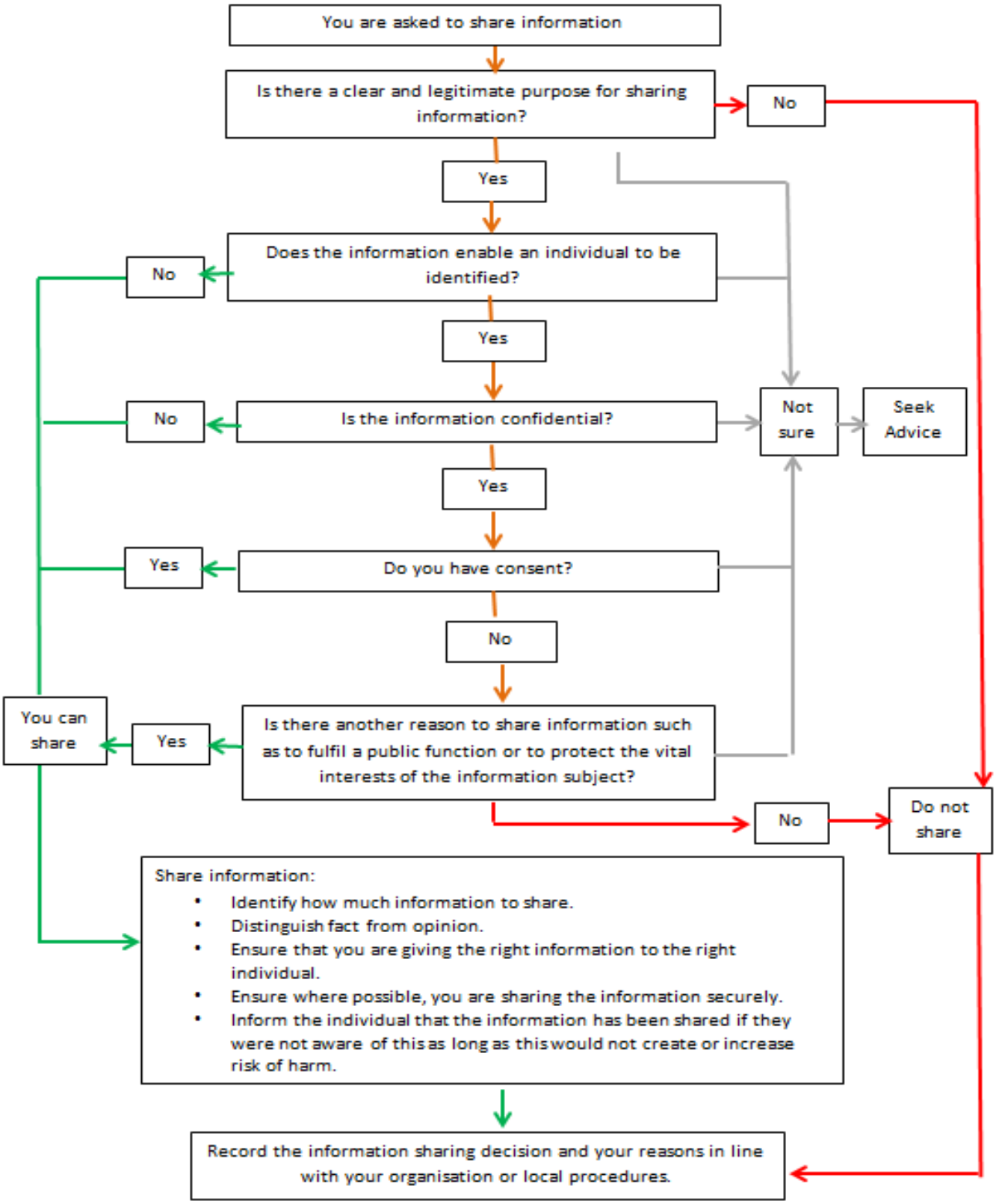


Local Contact Details:
Children's Social Services .....
Adult Social Services .....
LHB Safeguarding Team .....
Practice Safeguarding Lead .....

Appendix 5a: The Seven Golden Rules to Sharing Information

1. Remember that the Data Protection Act 1998 and human rights law are not barriers to justified information sharing, but provide a framework to ensure that personal information about living individuals is shared appropriately.
2. Be open and honest with the individual (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 from other practitioners if you are in any doubt about sharing the information concerned, without disclosing the identity of the individual where possible.
4. Share with informed 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, there is good reason to do so, such as where safety may be at risk. You will need to base your judgement on the facts of the case. When you are sharing or requesting personal information from someone, be certain of the basis upon which you are doing so. Where you have consent, be mindful that an individual might not expect information to be shared.
5. Consider safety and well-being: Base your information sharing decisions on considerations of the safety and well-being of the individual and others who may be affected by their actions.
6. Necessary, proportionate, relevant, adequate, accurate, timely and secure: Ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those individuals who need to have it, is accurate and up-to-date, is shared in a timely fashion, and is shared securely.
7. Keep a record of your decision and the reasons for it – whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose.

Appendix 5b: Flowchart of When and How to Share Information



Appendix 6: The Mental Capacity Act 2005

The Five Statutory Principles of the Mental Capacity Act

1. A person must be assumed to have capacity unless it is established that they lack capacity.

2. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.

3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.

4. An act done or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.

5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

Assessing Capacity

Anyone assessing someone's capacity to make a decision for themselves should use the two-stage test of capacity.

1. Does the person have an impairment of the mind or brain, or is there some sort of disturbance affecting the way their mind or brain works? (It doesn't matter whether the impairment or disturbance is temporary or permanent).
2. If so, does that impairment or disturbance mean that the person is unable to make the decision in question at the time it needs to be made?

Assessing ability to make a decision

- Does the person have a general understanding of what decision they need to make and why they need to make it?
- Does the person have a general understanding of the likely consequences of making, or not making, this decision?
- Is the person able to understand, retain, use and weigh up the information relevant to this decision.
- Can the person communicate their decision (by talking, using sign language or any other means?). Would the services of a professional (such as a speech and language therapist) be helpful?

Assessing capacity to make more complex or serious decisions

- Is there a need for a more thorough assessment (perhaps by involving a doctor or other professional expert?).

Appendix 7: Indicators of Potential Domestic Abuse

Signs

The potential outward and physical signs someone is experiencing violence against women, domestic abuse and sexual violence will be both physical and linked to the demeanour and behaviour of the client. They may include attitudinal change.

- Changes in attitude or behaviour: becoming very quiet, anxious, frightened, tearful, aggressive, distracted, depressed etc
- Constant accompaniment by partner, even where this seems supportive and attentive
- Partner exerting unusual amount of control or demands over interactions with service, including constant accompaniment
- Reliance on partner for decision making-lack of free will and independence.
- Obsession with timekeeping
- Secretive regarding home life
- Worried about leaving children at home with partner or family
- Partner or ex-partner exerting unusual amount of control or demands over clients schedule
- Social isolation from family/friends
- Unexplained injuries
- Change in the pattern or amount of make-up used
- Change in the manner of dress: for example, clothes which do not suit the climate which may be used to hide injuries
- Substance use/misuse
- Fatigue/sleep disorders.

Symptoms

As the term would indicate it is expected the identification and subsequent enquiry based on symptoms will be rooted within clinical and medical practice. Symptoms which should trigger an enquiry include (this list is not exhaustive):

- Depression
- Anxiety
- Medically unexplained chronic pain
- Tiredness
- Alcohol or other substance use
- Self harm
- Suicide attempts
- Eating disorders
- Medically unexplained chronic gastrointestinal symptoms
- Medically unexplained reproductive symptoms, including pelvic pain, sexual dysfunction
- Adverse reproductive outcomes, including multiple unintended pregnancies and/or terminations, delayed pregnancy care, adverse birth outcomes
- Gynaecological problems
- Medically unexplained genitourinary symptoms, including frequent bladder or kidney infections or other

- Repeated vaginal bleeding and sexually transmitted infections
- Problems with the central nervous system – headaches, cognitive problems, hearing loss
- Repeated health consultations with no clear diagnosis or medically unexplained symptoms
- Intrusive or controlling partner in Consultations.

Cues

A cue describes either a piece of information or pattern of behaviour which merits enquiry. This could include taking an overview of a client's engagement with services over time and querying the reasons behind sporadic or crisis based engagement. It might also include information provided by a partner agency, based on referral or shared via use of local Information Sharing Protocols which indicates concern, suspicion or unsubstantiated intelligence the client might be experiencing violence against women, domestic abuse and sexual violence.

To "Ask and Act" is not to interrogate, but where a cue is observed or received a professional should make appropriate enquiry.

Settings

There is evidence which suggests in some settings routine enquiry is appropriate as the reason for the patient's engagement within the setting is also a trigger for enquiry in relation to violence against women, domestic abuse and sexual violence.
Professionals working in the following settings should routinely ask all clients whether they are experiencing violence against women, domestic abuse and sexual violence due to the known co-occurrence of domestic abuse with the core purpose of the service they provide (mental health issues, pregnancy, child maltreatment).

Mental Health

The risk of developing depression, post-traumatic stress disorder (PTSD), substance use issues or becoming suicidal is 3 to 5 times higher for women who have experienced violence in their relationships compared to those who have not.
Acknowledging mental health settings as an indicator for "Ask and Act" offers practitioners an opportunity to address these links pro-actively and offer care which addresses the co-occurring issues.

Maternal and Post Partum Settings

30% of domestic violence starts in pregnancy and is associated with low birth weight and pregnancy complications including miscarriage and still-birth. A process of "Ask and Act", with additional training will further strengthen the existing maternity care pathway which uses an evidence based approach to asking all women about domestic abuse in the antenatal period.

Concerns about Child Maltreatment

Nearly three quarters of children on the child protection register live in households where domestic violence occurs and 52% of child protection cases involve domestic violence. 62% of children exposed to domestic abuse are also directly harmed.

There are missed opportunities to identify violence against women, domestic abuse and sexual violence and to identify risks to children.

Appendix 8: Child Sexual Exploitation

Disclosure of this form of abuse is rare and there is a perception that CSE is a hidden form of abuse that takes place out of sight. However as quoted by a young victim of CSE to researchers from the University of Bedfordshire “It’s not hidden, you just aren’t looking”.

Almost all children and young people come into contact with Primary Care and it is possible to reduce the risks associated with CSE at all levels of risk. Vulnerability and risk indicators of CSE are well established. So there is an opportunity to recognise those at risk and to involve other agencies in preventing abuse. Early identification and a timely response are central to effective safeguarding practice.

Vulnerability Factors for CSE

Whilst generally more females than males suffer from CSE and the average age when concerns are first identified is 13-15 years old, no one is immune.
Particular life experiences associated with increased risk of CSE are:

- Family dysfunction
- Prior (sexual) abuse or neglect
- Going missing / running away
- Substance misuse
- Disengagement from education
- Social isolation
- Low self esteem
- Socio-economic disadvantage
- Learning difficulties / disabilities
- Peers who are sexually exploited
- Gang-association
- Attachment issues
- Homelessness
- Being in care

Possible Warning Signs of CSE (drawn from CCSEGG interim report, 2012)

- Missing from home or care
- Physical injuries
- Drug or alcohol misuse
- Involvement in offending
- Repeated STIs, pregnancies and termination
- Absent from school
- Change in physical appearance
- Evidence of sexual bullying/vulnerability through the internet and/or social networking sites
- Estranged from their family
- Receipt of gifts from unknown sources
- Recruiting others into exploitative situations

- Poor mental health
- Self-harm or thoughts of or attempts at suicide

In Wales the Barnardo's Sexual Exploitation and Risk Assessment Form (SERAF) is the recommended tool to identify those at risk from CSE. Some research done in South Wales on the questions used in the SERAF has identified four questions that are the most important to ask. The wording used in these questions has been established in consultation with young people.

They are:

- Have you ever stayed out overnight or longer without permission from your parent(s) or guardian?
- How old is your partner or the person(s) you have sex with? (Is the age difference 4 or more years?)
- Does your partner stop you from doing things you want to do?
- Thinking about where you go to hang out, or to have sex. Do you feel unsafe there or are your parent(s) or guardian worried about your safety?

Appendix 9: Indicators of FGM

The following are some indicators of FGM. However this is not an exhaustive list and professionals should be vigilant at all times.

Indications that FGM may be about to take place include:

- The family comes from a community that is known to practice FGM e.g., Somalia, Sudan and other African countries. It may be possible that they will practice FGM if a female family elder is around.
- Parents state that they or a relative will take a girl out of the country for a prolonged period.
- A girl may talk about a long holiday to her country of origin or another country where the practice is prevalent, including African countries and the Middle East.
- A girl may confide to a professional that she is to have a 'special procedure' or to attend a special occasion.
- A professional hears reference to FGM in conversation, for example a girl may tell other children about it.
- A girl may request help from a teacher or another adult.
- Any girl born to a woman who has been subjected to FGM must be considered to be at risk, as must other female children in the extended family.
- Any girl who has a sister who has already have undergone FGM must be considered to be at risk, as must other female children in the extended family.

Indications that FGM may have already taken place include:

- A girl may spend long periods of time away from the classroom during the day with bladder or menstrual problems if she has undergone Type 3 FGM.
- There may be prolonged absences from school if she has undergone Type 3 FGM.
- A prolonged absence from school with noticeable behaviour changes on the girl's return could be an indication that a girl has recently undergone FGM.
- Professionals also need to be vigilant to the emotional and psychological needs of children who may/are suffering the adverse consequences of the practice e.g withdrawal, depression etc.
- A girl requiring to be excused from physical exercise lessons without the support of her GP.
- A girl may ask for help.