Kent Safeguarding Children Board

Kent Procedures and Practice Guidance for Working with Children and Young People who are Sexually Active

June 2018

Review Date: June 2020

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Summary of Purpose	The procedures have been designed to guide the response of all professionals who have a responsibility for children and young people within the statutory, private or voluntary sector within Kent and Medway, who come into contact with children and young people under the age of 18 who are sexually active.	
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	Version 2	Consultation with the Policy and Procedures Group. Document was revised, and necessary changes were made.
Equalities Impact Assessment	During the preparation of this policy and when considering the roles and responsibilities of all agencies, organisations and staff involved, care has been taken to promote fairness, equality and diversity, in the services delivered regardless of disability, ethnic origin, race, gender, age, religious beliefs or sexual orientation.	
Version	**Detail of Change**	**Date**
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Contents

Introduction	**4**
The Principles, Guidance and Legislation Underpinning the Procedures	**5**
Assessment and Referral to the Local Authority Children's Services	**6**
Early Help	**8**
Thresholds for Referral to the Local Authority Children's Services	**9**
Responding to Individual Cases of Children and Young People Who Engage in Mutual Experimental or Sexual Activity	**9**
Responding to Individual Cases of Harmful Behaviour	**10**
Responding to Individual Cases of Seriously Harmful Behaviour	**10**
Abuse through Sexual Exploitation	**11**
Criminal Investigations	**11**

Appendices

Appendix 1: The Kent and Medway Tool for Sexually Active Children and Young People	**12**
Appendix 2: Brook Sexual Behaviours Traffic Light Tool	**17**
Appendix 3: Gillick Competency and Fraser Guidelines	**19**
Appendix 4: The Role of the Police	**22**
Appendix 5: Definition of Sexual Activity	**25**
Appendix 6: Factors Regarding Age and Assessing Risk	**26**
Appendix 7: The Role of the Local Authority Children's Services	**27**
Appendix 8: Children and Young People Living Away from Home	**29**
Appendix 9: Role of Education Settings and Professionals Visiting Education Setting	**31**
Appendix 10: The Role of Health Professionals	**33**
Appendix 11: Flowchart	**36**

1. Introduction

1.1. These procedures and guidance provide a framework for assessing the risk of harm to sexually active children and young people and are designed to guide the response of all professionals who have responsibility for children and young people within the statutory, private or voluntary sector within Kent who come into contact with children and young people under the age of 18 who are sexually active in a relationship that appears consensual.

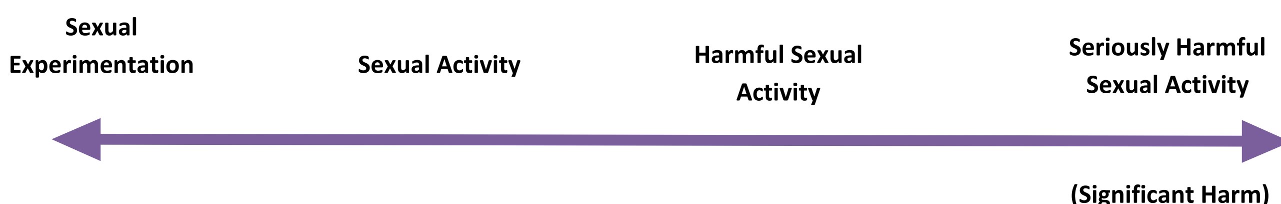
1.2. When it is identified that a child or young person under the age of 18 is sexually active there need to be an appropriate response and assessment of risk. This is to ensure they are accessing the right sexual health services but also that they are not being abused. The guidance recognises that whilst sexual activity involving children and young people may not be lawful i.e. under the age of consent (16 years) it is not always abusive or seriously harmful. It also recognises implications of sexual activity under the age of 13.

1.3. These procedures and guidance are gender neutral and apply to all children and young people under the of age of 18, regardless of their sexual orientation. Professionals also need to bear in mind the particular needs of children and young people that present with learning or physical disability and how the children and young people communicates due to their disability.

1.4. Safeguarding is everyone's responsibility therefore if the professional concerned finds that these procedures conflict with their religious, cultural or moral beliefs, and this conflict might affect the care or advice provided, then this should be discussed with their line manager.

1.5. It is important to note that Section 28 of the Local Government Act 1986 was repealed in November 2003, and it is no longer unlawful to discuss issues of homosexuality with children and young people.

1.6. The sexual behaviour of a child or young person is conceptualised as lying on a continuum (see below) from mutual exploration to behaviours that are seriously harmful to them or to others. This forms the basis of the Kent and Medway Assessment Tool for Sexually Active Children and Young People (Appendix 1).



1.7. To support professionals to identify if a sexual behaviour is harmful the Kent Safeguarding Children Board support the use of the Brook Sexual Behaviours Traffic Light Tool (Appendix 2), alongside the Risk Assessment Tool.

2. The Principles, Guidance and Legislation Underpinning the Procedures

2.1. The welfare a child or young person is paramount, and professionals should work together when assessing the risk of harm when underage sexual activity is taking place. Furthermore, professionals should continue to offer confidential advice and support regarding a child or young person's sexual health.

2.2. Appropriate information may lawfully be shared with appropriate agencies. This facility for an initial sharing or limited information is an important element of these procedures as it is unlikely that information or concerns about a child or young person and their parents/carers will be held by a single agency.

Confidentiality

2.3. The test of competence in respect of underage sexual activity falls within the ambit of the 'Fraser Guidelines' (Appendix 3). Decisions to share information with parents/carers require professionals to use their judgement and should be informed by guidance on Information Sharing and Confidentiality in the Kent and Medway Safeguarding Children Procedures.

2.4. For those children and young people who are referred to the Local Authority Children's Services and the Police, it will normally be necessary for professionals to inform the parent/carer of the reasons for the enquiries being made. This may be highly sensitive for the child or young person and their partner is also a child or young person.

2.5. Confidentiality is never absolute and competent professionals will be able to determine the need to seek information from the Kent Police Vulnerability Investigation Team (under 18's) in a manner that does not undermine the integrity of the agency concerned (Appendix 4).

Consent

2.6. The age of consent for children and young people who are in a relationship of trust is 18 years. Broadly speaking the definition of persons who may have a duty of trust includes family members, babysitters, foster carers, teachers, youth workers or social workers etc.

2.7. All professionals are reminded that they must respect the duty of confidentiality to a young person who is assed as being 'Gillick Competent' (Appendix 3), unless there are concerns of a child protection nature which requires this duty to be breached. Professionals should seek advice from their Designated Safeguarding Lead if they do not feel confident in assessing whether a young person is 'Gillick Competent' (Appendix 3).

Guidance and Legislation

2.8. The primary legislation and guidance falls within the Children Act 1989, Working Together 2015, and the Sexual Offences Act 2033, with its related guidance and the revised guidance for Health Professionals on the Provision of Contraceptive Sexual and Reproductive Health Services for Under 16's (Appendix 5).

2.9. The Children Act 1989 provides a helpful outline of how social care professionals should respond when working with sexually active children and young people, especially with regards to children and young people who have experienced abuse and neglect and are living away from home.

3. Assessment and Referral to the Local Authority Children's Services

3.1. The starting point for assessment begins with making professional judgments involving the age and age differential in in children and young people's sexual relationship, which can be a complex undertaking and may require consultation with a Designated Safeguarding Lead. The Risk Assessment Tool (Appendix 1) is designed to assist in making these judgements and should be considered with the factors found in Appendix 6.

Using the Kent and Medway Risk Assessment Tool for Sexually Active Children and Young People

3.2. The Risk Assessment Tool identifies a range of indicators that should be considered when assessing the potential risk of harm to a child or young person that has been identified as sexually active; these include disabilities and learning difficulties. The tool should be completed with the information known by the professional at the time and can be reviewed as more information becomes available. It is a dynamic

assessment tool which can and should, as a model of best practice, be repeated. Wherever possible this should be carried out in conjunction with the child or young person and their views documented.

3.3. The assessment, in conjunction with the Brook Sexual Behaviours Traffic Light Tool, will support professionals to make a judgement as to the level of risk to associate with the child or young person's behaviour (Appendix 2).

3.4. Cases of underage sexual activity, which present cause of concern are likely to raise difficult issues and should be handled particularly sensitively. Child and young people may need time to establish trust before sufficient information is available to make an informed assessment of their needs and any risk of harm.

Children Under the Age of 13

3.5. A child under 13 is not legally capable of consenting to sexual activity. Any offence under the Sexual Offence Act 2003 involving a child under the age of 13 is very serious and should be taken to indicate a risk of significant harm to the child. Cases involving under 13's should always be referred to the Local Authority Children's Services. Under the Sexual Offences Act 2003, penetrative sex with a child under 13 is classed as rape.

3.6. The Strategy Discussion should include the professional making the referral, and representatives from the Local Authority Children's Services, Kent Police Vulnerability Investigation Team (under 18's) and other relevant agencies. Particular sensitivity will be required if the other party is also under 13, as both children may be at risk of significant harm. All cases involving under 13's should be fully documented including giving detailed reasons where a discussion is taken not to share information.

Children and Young People Aged 13-15

3.7. Sexual activity with a child or young person under 16 is also an offence. It may be less serious than if they were under 13, but nevertheless has serious consequences for the welfare of the child or young person. Practitioners may find the following definition useful since it goes some way to overcoming the limitations of the age differential.

'Consent is based on choice. Consent is active not passive. Consent is possible only when there is equal power. Forcing someone to give in is not consent. Going along with something because of wanting to fit in with the group is not consent. If you can't say 'no' comfortably then 'yes' has no meaning. If you are unwilling to accept 'no' then 'yes' has no meaning.

3.8. Consideration should be given in every case of sexual activity involving a child aged 13-15. The professionals should make this assessment using the Risk Assessment Tool (Appendix 1) and the guidance contained within these procedures.

Young People Aged 16-17

3.9. Consensual activity is not an offence with young people who have reached the age of 16 expect that it is an offence for a person to have a sexual relationship with a 16-17-year-old if they hold a position of trust or authority in relation to them.

3.10. Young people aged 16-17 are not deemed able to give consent if the sexual activity is with an adult in a position of trust or a family member as defined by Section 27 of the Sexual Offences Act 2003.

3.11. Young people aged 16 -17 are still vulnerable to harm through an abusive sexual relationship and sexual activity involving a 16-17-year-old may still involve harm or the risk of harm. Practitioners providing service for this age group need to assess their safety and wellbeing using the Risk Assessment Tool (Appendix 1) and should make a referral to the Local Authority Children's Services if they are suffering significant harm.

3.12. The fact that the young person is older than the age of consent should not exclude them from being safeguarded and professionals are reminded that child protection procedures apply to child up until their eighteenth birthday.

4. Early Help

4.1. As an outcome of using the Risk Assessment Tool (Appendix 1), where the needs of the child or young person and their family are identified to meet the threshold for intensive support (using the Kent Inter-Agency Threshold Criteria for Children and Young People), consideration may be given to request Early Help support

4.2. Early Help support may be considered at any time where the needs are more complex which may include children and young people engaging in underage sexual activity. The decision about whether to request support should normally be made jointly with the child or young person and/or their parents/carers. However, if the child is old enough and competent (Fraser Competent) to understand they may make their own decisions.

5. Thresholds for Referring to the Local Authority Children's Services

5.1. The Risk Assessment Tool (Appendix 1) is compatible with the Kent Inter-Agency Threshold Criteria for Children and Young People (Appendix 7).

5.2. All cases of children under the age of 13 believed to be engaged in penetrative sexual relationships or imitate sexual activity should be referred to the Local Authority Children's Services and the Police. The Local Authority Children's Services will discuss the case with the Kent Police Vulnerability Investigation Team (under 18's) and convene a Strategy Discussion as appropriate.

5.3. In exceptional circumstances a decision may be made not to inform the child or young person's parents/carers. The circumstances that might lead to such a decision being made to withhold information are:

- There would be risk of significant harm to the child or young person, or their partner, if their parents/carers were to become aware that their child was sexually active. Gay, lesbian, bisexual or transgender relationships may present additional difficulties for the child or young person. Similar issues may arise in respect of faith or culture.
- The child or young person's ability to access confidential sexual advice would be compromised if their parents/carers was advised and the Strategy Discussion has decided on the information available at the Section 47 enquiries were not required or that the child or young person was not found to be suffering significant harm.
- There is a risk of contamination evidence in a criminal investigation.

6. Responding to Individual Cases of Children and Young People Who Engage in Mutual Experimental or Sexual Activity

6.1. Where an agency involved knows that a child or young person is sexually active, and the risk assessment does not raise concerns then the professional should continue to make arrangements for the child or young person to receive confidential advice and support from appropriate sexual health or other relevant services. The circumstances of the case should be regularly reviewed with the child or young person using the Risk Assessment Tool (Appendix 1) as trust develops and more information becomes available.

7. Responding to Individual Cases of Harmful Behavior

7.1. Where it is assessed that the sexual activity is harmful the professional should continue to make arrangements for the child or young person to receive confidential advice and support e.g. emergency contraception, and refer to other agencies as required, following the Kent and Medway Safeguarding Children Procedures.

7.2. In all such cases there should be an agreement with the child or young person to establish means by which the harm can be reduced. The circumstances of the case must then be regularly reviewed using the Risk Assessment Tool (Appendix 1) in conjunction with the child or young person.

7.3. If concerns persist consideration for consultation with the Designated Safeguarding Lead and/or the Local Authority Children's Services should be made. Proportional information can also be shared including the child or young person's mane in order to check if they are known to the Local Authority Children's Services without this being treated as a referral.

7.4. Professionals can make a request for intelligence checks from the Kent Police Vulnerability Investigation Team (under 18s). The request can be made using the designed request form which should be securely emailed to the Kent Police Vulnerability Investigation Team (under 18s), although urgent enquires can be conducted via phone.

8. Responding to Individual Cases of Seriously Harmful Behaviour

8.1. Where a practitioner has concerns that a relationship presents a risk of significant harm (seriously harmful behaviour within the Risk Assessment Tool) to a child or young person, they should have a consultation with the Local Authority Children's Services, unless there is a risk of immediate harm when a referral will be made. During the consultation the professional can also request a consultation with the Kent Police Vulnerability investigation team (under 18s), if details of the other party are known or other concerns such as breach of trust are thought to have occurred.

8.2. If a referral is needed, practitioners should complete the Inter-Agency Referral Form and seek consent of the child or young person as there is a duty of confidentiality in respect of sexual activity, unless there are concerns of a child protection nature. In an emergency the referral should made verbally and followed by a written referral within 48 hours, as described in the Kent and Medway Safeguarding Children Procedures. The Risk Assessment Tool should be securely sent at the time of the referral.

8.3. If there is doubt about how to manage the issues of consent and the competing imperatives preserving evidence, then a consultation should made with the Local Authority Children's Services before informing the child or young person.

9. Abuse through Sexual Exploitation

9.1. If there are concerns that the child or young person may be at risk of abuse through sexual exploitation (exploitative situations which include the child or young person exchanging sex for accommodation, food, gifts, drugs/alcohol; pornography, including creating/exchanging images, grooming etc. through the internet), a referral to the Local Authority Children's Services and Police must be made in accordance with the Kent and Medway Safeguarding Children Procedures.

9.2. Practitioners should refer to the Kent and Medway Safeguarding Children Abused through Sexual Exploitation Procedures and complete the Child Sexual Exploitation Risk Assessment Tool and the Kent and Medway Risk Assessment Tool for Sexually Active Children and Young People (Appendix 1).

10. Criminal Investigation

10.1. It is an offence for any child or young person to engage in a sexual relationship under the age of 16. Nevertheless, in the majority of cases, it will not be in the best interest of the young person for criminal proceedings to be instigated against them or their partner unless there are specific concerns about the nature of the relationship. Appendix 4 outlines the roles of Kent Police and includes guidance about responding to requests for information about individuals believed to be in an underage sexual relationship. In all cases where a criminal offence is disclosed it will be recorded as such, however, it may not result in Police action.

10.2. It is important to note that the impact of gender neutrality with the Sexual Offence Act 2003 means that the parties in an underage sexual relationship have the potential to be classified by the Police as both offender and victim. This could have lifelong repercussions for the children and young people concerned.

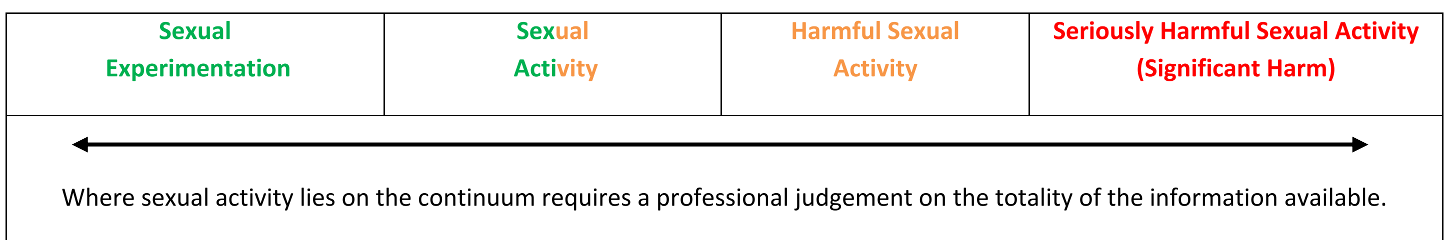
Appendix 1: Kent and Medway Risk Assessment Tool for Sexually Active Children and Young People

Kent and Medway Risk Assessment Tool for Sexually Active Children and Young People
Consideration for Assessment

Indicator of Risk or Harm	Consideration for Assessment
1. Age of child or young person	Sexual activity at a young age is a very strong indicator that there are risks to the welfare of children and young people, whether boy or girl, and possibly others. This is particularly relevant if one of the parties is pre-pubertal. Children under 13yrs cannot lawfully give consent to sexual activity and there must be referred to the Local Authority Children's Services.
2. What is the attitude, level of maturity and behaviour of the child or young person?	Is the child or young person withdrawn or anxious? Is there a pattern of casual sexual relationships with different partners? Are there more than two people involved in the sexual activity? Does the child or young person deny, minimise or accept the concerns? Is the child willing to work with the professional to reduce the concerns? Is this realistic?
3. What are the living circumstances or background of the child or young person? Is a Social Worker involved?	Has a Child in Need (Section 17) or referral (Section 47) been made in respect of the child or young person, or their siblings. Do cultural or religious beliefs have an impact on their circumstances and/or on sharing information?
4. Is the child or young person in education, employment or training?	If not, do you need to take any action.
5. Are there any disabilities or learning difficulties impending choice?	Disabled children and young people are more likely to be abused than non-disabled children. However, disabled children and young people have a right to a private life, which should be respected.
6. Is the relationship being kept a secret from parents/carers or friends? If yes, is there a reason for this?	Has the sexual partner attempted to secure secrecy beyond what might be considered usual in a teenage relationship?
7. Is the evidence of coercion, bribery or a power imbalance in their relationship? Does this include child sexual exploitation or domestic abuse?	Has the child or young person been encouraged to exchange sex for favours or other inducements such as supply of alcohol or substances? Is there evidence of persuasion, emotional blackmail, threats or use of pornography? Is the relationship reasonably equal and consensual? Power imbalances can occur in many different forms including threats and aggression. Is there an age differential greater than 3 years?
8. Is the child or young person's use of internet and social media placing them at risks of abuse?	Consideration needs to be given as to whether the young person is being bullied or groomed online. Is the child or young person planning to, or has, met someone as a result of online contact? Is there sharing of inappropriate texts and images using social media, including mobile devices?
9. Sexual grooming – are there behaviours consistent with grooming?	If you are unclear as to whether grooming may be occurring, consider consultation with the Designated Safeguarding Lead for your organisation or the Local Authority Children's Services.

10. Does the child or young person’s use of drugs or alcohol cause concern?	The child or young person’s own behaviour in misusing substance or alcohol may place them at increased risk of harm as they may be unable to give them informed consent. Is alcohol or drugs being used as a dis-inhibitor? Consider if a referral to another service should be discussed.
11. Are there indicators of self-harm?	If yes, have they had Kent Children and Young People’s Mental Health Service (CYPMHS) intervention? Does the child or young person need to be referred to another service?
12. Is the partner known to agencies i.e. Local Authority Children’s Services, Police or Probation etc.?	Does one or more of the agencies already know the sexual partner? Does this information raise concern? Are there sufficient concerns about the sexual partner that information is needed from other agencies to support the risk assessment? Follow service procedures of seeking advice from the Designated Safeguarding Lead and consider consultation.
13. Are any family or friends know sex offenders or considered to pose a sexual risk to children?	Is any family member considered to be a risk to children, or have convictions for sex offences? Does the sexual partner fall within any of the following categories beyond the normal family relationships? Step-parent, foster carer, step-sibling who live in the same household or have been regularly involved in caring for the child, or care workers such as nannie or au pairs if they live with or regularly care for the child. Consider the Kent and Medway Sexual Exploitation Guidance.
14. What is the age of the child or young person’s partner? Length of time of the current relationship? If 16-17yrs, is there a breach of trust?	Is the child or young person competent to consent to the sexual activity? The law and procedures are gender neutral. Is there an age differential greater than 3 years? If so, consider additional risk factors. Although same age relationships may still be exploitative. Is there a relationship of trust? A legal definition is provided at Section.27, Sexual Offences Act 2003.
15. Have you referred to the Fraser Guidelines? If over 16yrs MCA 2005 applies.	Remember that the Mental Capacity Act 2005 applies to Young People over 16 years.

The Sexual Activity Continuum



Sexual Experimentation	Sexual Activity	Harmful Sexual Activity	Seriously Harmful Sexual Activity (Significant Harm)
Where sexual activity lies on the continuum requires a professional judgement on the totality of the information available.			

The Risk Assessment Tool should be based on and read in conjunction with these procedures.

Template

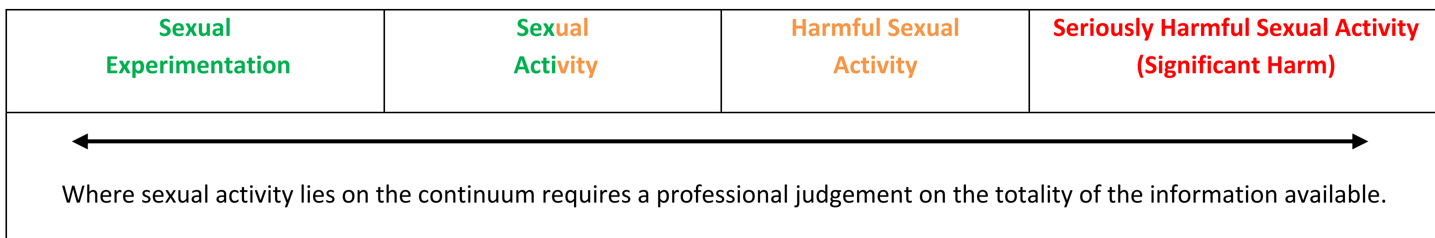
Kent and Medway Risk Assessment Tool for Sexually Active Children and Young People
(To be completed by practitioner)

Date of Assessment:
Name of Child or Young Person:
DOB:
Female/Male:
NHS Numbers (health only):
Address (if known):
School/College or Employed/Unemployed:

Indicator of Risk or Harm	Comments
1. Age of child or young person	
2. What is the attitude, level of maturity and behaviour of the child or young person?	
3. What are the living circumstances or background of the child or young person? Is a Social Worker involved?	
4. Is the child or young person in education, employment or training?	
5. Are there any disabilities or learning difficulties impending choice?	
6. Is the relationship being kept a secret from parents/carers or friends? If yes, is there a reason for this?	
7. Is there evidence of coercion, bribery or power imbalance in their relationships? Does this include child sexual exploitation or domestic abuse?	
8. Is the young person's use of the internet and social media placing them at risk of abuse?	
9. Sexual grooming – are there behaviours consistent with grooming?	
10. Does the use of alcohol or drugs cause concern? 11. Are there indications of self-harm?	
12. Is the partner known to agencies i.e. Local Authority Children's Services, Probation or Police?	
13. Are any family members or friends know sex offenders or considered to pose a risk to children?	
14. What is the age of the child or young person's partner?	

Length of time of the current relationship? If 16-17yrs, is there a breach of trust?	
15. Have you referred to the Fraser Guidelines? If over 16yrs MCA 2005 applies.	

The Sexual Activity Continuum



Sexual Experimentation	Sexual Activity	Harmful Sexual Activity	Seriously Harmful Sexual Activity (Significant Harm)
Where sexual activity lies on the continuum requires a professional judgement on the totality of the information available.			

Summary/Assessment of Risk. Include details of consultations:

Outcome (tick)	**Decision(s) (tick as many as required)**
☐ Sexual experimentation/sexually active-no immediate concerns. ☐ Harmful sexual activity. ☐ Seriously harmful sexual activity (significant harm).	☐ Continue to provide advice and/or services as necessary. ☐ Referral to specialist services i.e. sexual health clinics. ☐ Discuss with designated safeguarding lead and review risk assessment. ☐ Consult with the Local Authority Children’s Services. ☐ Referral to the Local Authority Children’s Services. ☐ Immediate referral or a potential crime to Kent Police.

View of Young Person:

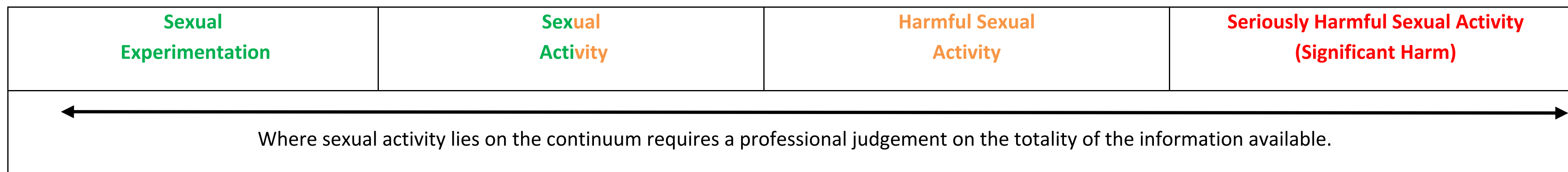
Future Action/Plan (please state by whom and indicate timescales):

Name of Practitioner: **Signature:** **Designation:** **Date:** **Signature of Child or Young Person:**

The Risk Assessment Tool should be based on and read in conjunction with the 'Kent Procedures and Practice Guidance for Working with Children and Young People who are Sexually Active'.

Appendix 2: Behaviours: Age 9-13

All green, amber and red behaviours require some form of attention and response. It is the level of intervention that will vary.



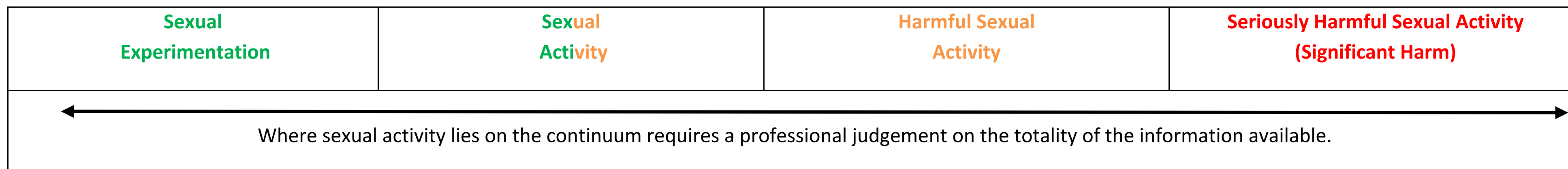
Sexual Experimentation	Sexual Activity	Harmful Sexual Activity	Seriously Harmful Sexual Activity (Significant Harm)
Where sexual activity lies on the continuum requires a professional judgement on the totality of the information available.			

What is a green behaviour?	What is an amber behaviour?	What is a red behaviour?
Green behaviours reflect safe and healthy sexual development. They may be: • Displayed between children or young people of similar age or development ability. • Reflective of natural curiosity, experimentation, consensual activities and positive choices.	Amber behaviours have the potential to be outside of safe and healthy behaviour. They may be: • Of potential concern due to age or development differences. • Of potential concern due to activity type, frequency, duration or context in which they occur.	Red behaviours are outside of safe and healthy behaviour: They may be: • Excessive, secretive, compulsive, coercive, degrading or threating. • Involving significant age, development or power differences. • Of concern due to the activity type, frequency, duration or the context in which they occur.
What can you do?	**What can you do?**	**What can you do?**
Green behaviours provide opportunities to give positive feedback and additional information.	Amber behaviours signal the need to take notice and gather information to assess the appropriate action.	Red behaviours indicate a need for immediate intervention and action.
Green Behaviours	**Amber Behaviours**	**Red Behaviours**
• Solitary masturbation • Use of sexual language including swear and slang words • Having girl/boyfriends who are of the same or opposite gender. • Interest in popular culture e.g. fashion, online games etc. • Need for privacy • Consensual kissing., hugging and holding hand with peers.	• Uncharacteristic and risk-related behaviour, e.g. sudden and/provocative changes in dress, withdrawal from friends, mixing with new or older people, having more or less money as usual, or going missing. • Verbal, physical or cyber/virtual sexual bullying involving sexual aggression. • LGBT (lesbian, gay, bisexual, transgender) targeted bullying. • Exhibitionism, e.g. flashing or mooning • Giving out contact details online • Viewing pornographic material • Worrying about being pregnant or having STIs.	• Exposing genitals or masturbating in public. • Distributing naked or sexual provocative images of self or others. • Sexually explicit talk with younger children. • Sexual harassment. • Arranging to meet with an online acquaintance in secret. • Genital injury to self or other. • Forcing other children of same age, younger or less able to take part in sexual activities. • Sexual activity e.g. oral sex or intercourse • Presence of sexually transmitted infections (STI). • Evidence of pregnancy.

Adapted from Brook sexual behaviours traffic light tool, adapted from Family Planning Queensland. (2012). Traffic Lights guide to sexual behaviours. Brisbane: Family Planning Queensland, Australia.

Behaviours: Age 13-17

All green, amber and red behaviours require some form of attention and response. It is the level of intervention that will vary.



Sexual Experimentation	Sexual Activity	Harmful Sexual Activity	Seriously Harmful Sexual Activity (Significant Harm)

Where sexual activity lies on the continuum requires a professional judgement on the totality of the information available.

What is a green behaviour?	What is an amber behaviour?	What is a red behaviour?
Green behaviours reflect safe and healthy sexual development. They may be: • Displayed between children or young people of similar age or development ability. • Reflective of natural curiosity, experimentation, consensual activities and positive choices.	Amber behaviours have the potential to be outside of safe and healthy behaviour. They may be: • Of potential concern due to age or development differences. • Of potential concern due to activity type, frequency, duration or context in which they occur.	Red behaviours are outside of safe and healthy behaviour: They may be: • Excessive, secretive, compulsive, coercive, degrading or threating. • Involving significant age, development or power differences. • Of concern due to the activity type, frequency, duration or the context in which they occur.
What can you do?	**What can you do?**	**What can you do?**
Green behaviours provide opportunities to give positive feedback and additional information.	Amber behaviours signal the need to take notice and gather information to assess the appropriate action.	Red behaviours indicate a need for immediate intervention and action.
Green Behaviours	**Amber Behaviours**	**Red Behaviours**
• Solitary masturbation • Sexually explicit conversations with peers. • Obscenities and jokes within the current cultural norm. • Interest in erotica/pornography • Use of internet to chat online • Having sexual or non-sexual relationships • Consensual kissing., hugging and holding hands with peers. • Consenting oral and/or penetrative sex with others of the same or opposite gender who are of a similar age and development ability. • Choosing not to be sexually active.	• Accessing exploitative or violent pornography. • Uncharacteristic and risk-related behaviour e.g. sudden and/provocative changes in dress, withdrawal from friends, mixing with new or older people, having more or less money as usual, or going missing. • Concern about body image. • Taking and sending naked or sexually provocative images of self or others. • Single occurrence of peeping, exposing, mooning or obscene gestures. • Giving out contact details online. • Joining adult only social networking sites. • Worrying about being pregnant or having STIs.	• Exposing genitals or masturbating in public preoccupation with sex which interferes with daily function. • Sexual degradation/humiliation of self or others. • Attempting/forcing other to expose genitals. • Sexually aggressive/exploitative behaviour. • Sexually explicit talk with younger children. • Sexual harassment. • Non-consensual sexual activity • Use of/acceptance of power and control in sexual relationships. • Genital injury to self or others. • Sexual contact with others where there is a big difference in age or ability. • Sexual activity with family members. • Involvement in sexual exploitation and/or trafficking, receipt of gifts or money in exchange for sex.

Appendix 3: Gillick Competency and Fraser Guidelines

When deciding whether a child or young person is mature enough to make decision, people often talk about whether a child or young person is Gillick Competent or whether they meet the Fraser Guidelines.

What do Gillick Competency and Fraser Guidelines refer to?

Gillick Competency and Fraser Guidelines refer to a legal case which looked specifically at whether doctors should be able to give contraceptive advice or treatment to under 16's without parental consent. But since then, they have been more widely used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

'Whether or not a child or young person is capable of giving the necessary consent will depend on the child or young person's maturity and understanding and the nature of the consent required. The child or young person must be capable of making a reasonable assessment of the advantages and disadvantages of the treatment proposed, so the consent, if given, can be properly and fairly described as true consent.' (Mr Justice Woolfe, 1985).

How are the Fraser Guideline applied?

The Fraser Guidelines refer to the guidelines set out by Lord Fraser in his judgement of the Gillick case in the House of Lords (1985), which apply specifically to contraceptive advice.

'A Doctor could proceed to give advice and treatment provided they are satisfied in the following criteria:

1) *The child or young person (although under the age of 16) will understand their advice;*
2) *That they cannot persuade the child or young person to inform their parents/carers and they cannot inform the parents/carers that their child is seeking contraceptive advice;*
3) *That the child or young person is very likely to continue have sexual intercourse with or without contraceptive treatment;*
4) *That unless the child or young person receives contraceptive advice or treatment their physical and/or mental health are likely to suffer;*
5) *That the child or young person's best interests require the Doctor to give them contraceptive advice and/or treatment without parental consent. '*

There are no age constraints in assessing Fraser Competence and health professionals may lawfully provide contraception to child under the age of 13. However, the Risk Assessment

Tool (Appendix 1) should always be used to establish whether the child or young person is suffering significant harm and decisions made accordingly.

How is Gillick Competency Assessed?

Lord Scarman's comments in his judgement of the Gillick case in the House of Lords (1985) are often referred to as the test of Gillick Competency.

'It is not enough that they should understand the nature of the advice which is being given: they must also have a sufficient maturity to understand what is involved.'

He also commented more generally on parents/carers versus children and young people's rights.

Parental right yields to the child or young person's right to make their own decisions when they reach a sufficient understanding and intelligence to be capable of making up their own mind on the matter requiring decision'.

The test of Gillick Competence in contrast provides clinicians with an objective test of competence in a wider area than contraption. This identifies children and young people under the age of 16 who have the legal capacity to consent to medical examination and treatment., providing they can demonstrate sufficient maturity and intelligence to understand and appraise the nature and implications of the proposed treatment, including the risks of and alternative causes of actions. Since the Gillick case, legal health and social work professionals continue to debate the issues of a child or young persons' right to consent or refuse treatment, and how to balance children and young people's rights with the duty of child protection professionals to act in the best interests of the child or young person.

Limitations of the Role of Social Workers and Foster Carers

Social Care professionals are not health professionals, so they should not give specific advice on forms of contraception, but they can engage in informal discussions prior to supporting a visit to the local contraception o sexual health service. This may include talking to children and young people about contraception and abortion and providing information on contraception and abortion. Workers should also make young people aware of emergency contraception, where it can be accessed and how to make use of such services effectively.

The following should be used as guidance for practitioners in determining and recording their decision as to whether a child or young person is able to give consent without the involvement and support from their parents/carers.

Consider:

1) Has the child or young person explicitly requested that you do not tell their parents/carers about the engagement and any services that they are receiving?
2) Have you done everything you can to persuade the child or young person to involve their parents/carers? And have encouraged them to do so.
3) Have you documented clearly why the child or young person does not want you to inform their parents/cares.
4) Can the child or young person understand the advice/information they have been given and have sufficient maturity to understand what is involved and what the implications are?

   Can they communicate their decision and reasons for it? Is this a rational decision based on their own religious belief or value system? Is the child or young person making the decision based on a perception of reality? E.G. this would not be the case for a chaotic substance misuse.
5) Are you confident that the child or young person is making the decision for themselves and not being coerced or influenced by another person?
6) Are you confident that you are safeguarding and prompting the welfare of the child or young person?
7) Without the service(s) would the child or young person's physical or emotional health be likely to suffer?
8) Would the child or young person's best interest require that the common assessment is done, and the identified services and support provided without parental consent?

You should be able to answer **yes** to these questions to enable you to determine that you believe the child or young person is competent to make their own decisions about consenting to sharing information and receiving services without their parents/carers consent. You should record the details of your decision making.

Appendix 4: The Role of the Police

Request for Police Information and Referrals to the Police

In cases of concern, where sufficient information is known about the sexual partner the agency concerned should check other agencies, including the Police to establish whether there are any child protection concerns about that individual. The Police will normally share this information without beginning a full investigation I the agency making the check request this.

Automatic formal referrals to the Police may stop children and young people confiding in social care and/or health practitioners, including those children and young people most at risks of abuse. Nevertheless, the Police may hold information about individuals who pose a danger to children and young people, which is not necessarily know to other agencies.

Kent Police have agreed therefore that, for the purpose of these procedures, the Central Referral Unit will provide information about children and young people and their sexual partners for the purpose of an agency's risk assessment (to which no decision has been made regarding making a referral or reporting of a crime) without treating the information as a formally referred allegation or crime. The Police will record the request for intelligence purposes in order that potential abusers can be identified.

This information may be obtained from the Central Referral Unit.

Protocol for Professionals who require information from Kent Police under this Guidance

- The Designated Safeguarding Lead will make the request to the Police.
- Contact will be made with the Central Referral Unit administrator.
- The request should contain the following details:

  a) Name of the professional submitting the request
  b) A reference number and return secure email address
  c) Name and date of birth of the client
  d) Name and date of child of client's sexual partner
  e) A signed Kent and Medway Risk Assessment Tool for Sexually Active Children and Young People
  f) Contact details for practitioners involved

- On receipt of the request the Central Referral Unit administrator will make the following Police checks:

  a) Police National Computer (PNC)
  b) All local intelligence data bases (i.e. Genesis, Lotus Notes, ViSOR)

c) The Supervisor will make a considered decision as to the relevance of the information in the knowledge that this is for a risk assessment, under this guidance.
d) The decision and information returned for each name supplied will be either 'no relevant information' or 'relevant information held by Police' (no other information will be provided at this stage).
e) The decision will then be securely sent back to the professional who submitted the request.

- If the Central Referral Unit Supervisor feels that the information held by the Police is current and of importance there will be an expectation that the Supervisor should contact that agency.
- Unless urgent, the Police will reply within 3 working days.
- If the requesting agency believes that the client and/or partner may have or had residence elsewhere in the country and this may have an impact on the risk assessment, then direct consultation with the Central Referral Unit should be made after receiving the result of the local checks. The consultation will be around further checks being made, by making use of the Police National Database.
- Details of the request will be recorded according to the Home Office Crime Recording Rules but both children or young people will be shown as involved parties and not suspects. No investigation will commence until instigated by a Strategy Discussion decision. Correspondence will be attached to the record.
- It should be noted that due to the difficulty of retrieving information with only name and date of birth, consideration should be given by the requesting agency to include place of birth and/or address. The decision to include this will remain with the requesting agency with the knowledge of the limitations (for example, the surnames Smith, Jones, Brown etc. will be difficult to process without a place of birth and an address).
- If, as a result of a decision being made by the requesting agency to make a referral under the Kent and Medway Safeguarding Children Procedures (Children Act 1989/Children Act 2004) the Police will then reveal the relevant information the appropriate agencies.
- The Police are fully aware of the difficulties confronted by agencies dealing with children and young people requesting advice on sexual health. Kent Police will remain open for a consultation, especially under certain aspect of the law such as Section 27 of the Sexual Offences Act 2003 (regarding advice on breach of trust).
- It is emphasised that failure to respect an agency's position, within the context of these procedures, could deter children or young people from accessing sexual health services and leave them at risk of significant harm.
- It is understood that building confidence with clients is essential and that consent should be obtained from the relevant client as a matter of good practice. This guidance has been considered in light of the Crime and Disorder Act 1998, Section

115, Data Protection Act 1998, Children Act 1989, Human Rights Act 1998 (Article 8) and the Common Law of Confidence.

Referral of a Report of Crime made to Kent Police

In cases where an agency or individual contacts the Police with a report of crime or potential crime the Police will receive the information and create a crime report and pass to the local Vulnerability Investigation Team (under 18's) or Central Referral Unit and asses the need for emergency action to protect a child or young person.

They will ten make a referral to the Local Authority Children's Service's according to the Kent and Medway Safeguarding Children Procedures and undertake the following actions:

- Share relevant information and have Initial Strategy Discussion with the Local Authority Children's Services, and the referring professional and confirm the need for a criminal investigation and/or Section 47 enquiry and agree any fast-track actions.
- Attend the Strategy Discussion meeting (or hold a more detailed Strategy Discussion) and plan the Section 47 enquiries, ensuring that the interests of the child or young person remains paramount.
- Conduct investigative activities as agreed and, if relevant, ensure the coordination of Section 47 enquiries.
- Conclude the investigation and decide, in consultation with the Crown Prosecution Service, an appropriate criminal justice disposal, taking into account the wishes of the victim, the public interest and the views of relevant professionals who are working with the child or young person.

Appendix 5: Definition of Sexual Activity

The Home Office guidance entitled 'Working with the Sexual Offences Act 2003' states that:

'Although the age of consent remains at 16, the law is not intended to prosecute mutually agreed teenage sexual activity between two young people of a similar age, unless, it involves abuse or exploitation. Young people, including those under 13, will continue to have the right to confidential advice on contraception, pregnancy and abortion.'

Under the Sexual Offences Act 2003, penetrative sex with a child under 13 is classed as rape.

Sexual activity with a child or young person under 16 is also an offence. Where it is consensual it may be less serious than if the child or young person were under 13 but may nevertheless, have serious consequences for the welfare of the child or young person.

For the purpose of these procedures, Section 9 of the Sexual Offences Act 2003 is shown in detail below in order to provide a definition of sexual activity. It should be noted that this definition also applies to child sex offences committed by children and young people.

'A person aged 18 or over (A) commits an offence if he intentionally touches another person (B) and the touching is sexual, and either-

(B) is under 16 and (A) does not reasonably believe that (B) is 16 or over, or (B) is under 13.

A person is guilty of an offence under this section, if the touching involved; penetration of B's anus or vagina with a part of A's body or anything else, the penetration of B's mouth with A's penis, penetration of A's anus or vagina with a part of B's body, or penetration of A's mouth with B's penis.

The definition does not provide a definition of non-penetrative intimate sexual touching and the extent to which sexual activity or touching is considered to be intimate will require a judgement by the professionals concerned.

Professionals are advised that understanding and implementing the Sexual Offences Act 2003 required expert knowledge and it is the responsibility of the Police and the Crown Prosecution Service to make the decision about whether a criminal offence has been committed and whether a criminal prosecution should ensue.

Appendix 6: Factors Regarding Age and Assessing Risk

The Committee of enquiry into children and young people who sexually abuse other children and young people found that there is cause of concern if there is an age difference or more than two years, or if one is under the age of consent and the other is past the age of consent (*NCH,1994, P4).* The issue of whether an action is abusive becomes less clear as the age gap narrows, and the sexual acts become less physically intrusive. In addition, the Committee of enquiry notes that a child or young person can abuse an older child or young person if the older one is disempowered because of disability. There are also examples of children and young people who have sexually abused adults.

Young people, particularly those is later adolescence, may struggle with the transition to adulthood fluctuating between different types of behaviours, sometimes wanting to be an independent adult and at other times presenting as a dependent young person. This can be a particularly concerning time for their family and professionals especially when the young person rejects advice and support (*Pearce 2006).*

At the same time this transition can be interrupted by a manipulative adult intent to create and widen the rift between the child or young person and their supportive networks and becomes harder to manage as this is the point that they are most rejecting of help.

As a consequence, interventions may need to be differentiated with younger adolescents requiring the full measures of the child protection process. In contrast the older adolescent may benefit from an approach that recognises them both as suffering significant harm and as active agents who can be helped to gain constructive control of their circumstances.

It is likely that in all such cases a Strategy Discussion will be required in order to make decisions about the best way forward including how to respond to the other party. There may be situations of seriously harmful behaviour where the child or young person's right to confidentiality may need to be preserved and their parents/carers are not informed, provided that progress is made in reducing the harm.

Appendix 7: The Role of the Local Authority Children's Services

The Local Authority Children's Services have three main roles in working with sexually active children and young people:

1) Undertaking enquiries and an assessment of children and young people who have been made subject of a referral.
2) Within their role as a key worker with Children in Need including those subject to a Child Protection Plan.
3) Working with children and young people looked after by the Local Authority.

Referrals of a Child Protection Concern and/or Child in Need

If request the Central Duty Team will provide a consultation with professionals concerned about the welfare of a sexually active child or young person who is under the age of 18. Referrals should be made using the below contact details.

Central Duty Team (Kent)

Telephone: 03000 41 11 11
Out of Hours: 03000 41 91 91
Email: central.duty@kent.gov.uk

Consideration should also be given as to whether the other party, if under 18, may be at risk of harm from sexual activity or as a result of the referral.

If a parent/carer makes a referral to the Local Authority Children's Services, that their child is sexually active then the matter may be dealt with by completing the Risk Assessment Tool (Appendix 1) with the child or young person and their parent/carer, on a Child in Need basis and in consultation with Kent Police or via a Strategy Discussion and Section 47 enquiries.

In all cases of underage sexual activity that comes to the attention of the Local Authority Children's Services and where the other party can be identified, then the Social Worker will always obtain a check of the Police indices in the first instance. This should also apply to those aged 16 or 17, where there are concerns that behaviour may be harmful or involve a breach of trust or where the young person has additional needs.

The Role of Social Workers working with Children and Young People who are Sexually Active

These cases can prove very difficult to manage as the Social Worker may become aware of the child or young person who is sexually active, and the parents/cares are unaware. The Social Worker should take advice and refer to this guidance in order to inform decision-making.

It is lawful for a Social Worker to engage in informal discussions prior to supporting a visit to the local sexual health clinic. This advice can also be provided to children below the age of 13. The Social Worker should always advise the agency concerned that they have signposted the child or young person.

The Role of Social Workers working with Looked After Children and Young People who are Sexually Active

Looked After Children have the same rights to a private life as do all children and young people but their circumstances are naturally more complex. For example, they are entitled to seek contraceptive advice from a sexual health professional without the Social Worker or Carer being informed, provided that they are 'Fraser Competent'. At the same time the child or young person may inform their Social Worker that they are sexually active and do not want their Foster Carer told or vice versa.

In these circumstances, a child or young person should be advised that it is necessary for both the Foster Carer and Social Worker to both be aware, as there is a partnership of care. This is unlikely to come as a surprise to 'Looked After Children' as they know that their Social Worker and Foster Carer are kept informed about all aspects of their care.

Looked After Children may not want their parents informed and this should normally be respected unless agreed by a Strategy Discussion. This should apply to all Looked After Children whether or not the Local Authority shares parental responsibility.

Information about a child or young person's sexual behaviour should not normally be discussed at a Looked After Child Review unless there is a concern that the relationship and behaviour is seriously harmful. If it does need to be discussed as a result of concerns about the child or young person's welfare or safety, then this should only occur with restricted person present. For example, if the child or young person does not want their parents/carers to know then this should be respected unless there are compelling reasons for this information to be shared.

Wherever possible the Social Worker and Foster Carer should complete the Risk Assessment Tool (Appendix 1) with the child or young person, and the Social Worker should consult with their Designated Safeguarding Lead, if there are concerns that the relationship or behaviour is harmful. The Social Worker may benefit from seeking advice from a sexual health professional. Where there are concerns that the relationships or behaviour is seriously harmful then a referral must be made.

Where sexual activity between children or young people within a Foster or Children's Home takes place then reference should be made to the guidance under Appendix 5 (Children Living Away from Home).

Appendix 8: Children and Young People Living Away from Home

Where sexual activity takes place in a children's home or foster placement a very clear distinction will need to be made between seriously harmful behaviour which requires external child protection intervention and normal childhood behaviour and sexual exploration which should be dealt with by care staff.

Abuse will need to be reported and investigated as with any other abuse and these procedures should inform the process of assessment bearing in mind the particular vulnerability of Look After Children to non-consensual sexual activity. A child or young person in a children's home or foster home has the same rights to protection by the Police and care agencies as any child or young person. It is important that training and written guidance addresses the boundaries between behaviour which can be regarded as 'normal' and behaviour which cannot. Bullying or intimidation also needs to be taken into account.

Assessing this distinction is complex and must be done in consultation with a named professional and the child or young person's Social Worker.

Such behaviour will have implications for other children and young people within the placement who might have been abused by the same child or young person but not told their carers or have known about the abuse but felt too afraid or guilty to tell anybody.

It is important that staff in children's homes cooperate fully with external investigators in order that the full extent of abuse is discovered and that the children and young people involved receive proper counselling and the implications of the incident(s) for the future plans of each child or young person are considered methodically. Staff or carers will require managerial support to deal effectively with this process and avoid defensiveness. In this way the precipitate removal of children and young people, which may not be in their long-term interests, is most likely to be avoided.

The experience of children and young people being cared for should include the sexual education of the child or young person if their school does not provide this. This is considered to be absolutely vital since sexuality will be one of the most potent forces affecting any child or young person in the transition from childhood to adulthood.

More detailed guidance is available with the 'Relationships and Sex Education Policy and Guidance for Looked After Children (Kent County Council)'. However, these procedures should be followed in assessing the risk of harm to sexually active children and young people.

Disabled Children and Young People

Disabled children and young people have a right to a private life and at the same time they are more vulnerable to abuse. Their circumstances are complex and their emerging sexual identify can be a time of particular difficulty for them and those who care for them. There are a number of reasons for this including:

- Their need for intimate care from others where it may be difficult for them to set and maintain physical boundaries.
- They may have an impaired capacity to resist or avoid abuse or unwanted sexual attention from peers, or other children and young people or adults.
- Some disabled children and young people do not have lawful capacity to consent to sexual activity (Section 30, Sexual Offences Act 2003). The risk assessment tool takes this factor into account.
- They may have communication difficulties, which may make it difficult to tell others if they feel uncomfortable in a relationship or they may feel inhibited to complain for fear of losing services or being transferred.
- Disabled children and young people are especially vulnerable to bullying, intimidation or abuse by their peers.

Those with a disability can be labelled in one dimension only and not seen as anything but a disabled child or young person and where their emerging sexuality is seen as a problem or an added vulnerability. Disabled children frequently live their life according to other people's rules and may become internally complaint. Shared-care arrangements might undermine protective attachments. Ethnic minority status and a disability can compound the problems.

Many myths about disabled children and young people exist, for example, that they are not sexually attractive and desirable so will be protected. But their vulnerability may be appealing, as is their lack of assertiveness. Perpetrators may rationalise their actions as 'their only chance of a sexual experience' – 'it's not harmful, it's educational', and the perceived lower status of disabled children and young people may lower taboo levels. A further hazard for disabled children and young people is that if they do disclose and are not believed they are more vulnerable to psychotic breakdown (Hobbs et al 1999).

With long standing abuse the child or young person may have accommodated the abuse, as with other children or young people, and not be able to speak of the abuse even if it has become evident to others (Hobbs et al 1999).

Appendix 9: Role of Education Settings and Professionals Visiting Education Settings.

The Sexual Offences Act 2003 clarifies the role of teachers, health care professionals, sexual health counsellors and youth workers in providing sexual health advice. This states that:

'*Professionals are not liable to prosecution when they are acting to protect a child or young person, including those with a mental disorder from becoming pregnant or promoting their wellbeing by giving advice.'*

Education settings have a vital role to play in supporting the health and welfare needs of children and young people. It is imperative that all staff involved have a clear understanding about their responsibilities relating to confidentiality and information sharing (*'schools must be absolutely clear about the boundaries of their legal and professional roles and responsibilities. A clear and explicit confidentiality policy should ensure good practice through the school which both pupils and parents understand'- Paragraph 7.1, Department of Education Guidance: Sex and Relationship Education 2000).*

Section 175 of the Education Act 2002 also places a statutory duty on education settings to safeguard children and promote their welfare. Any professional within such a setting who becomes aware of sexually active children and young people must consider this procedure when assessing risk and considering whether or not the information needs to be shared with key professionals in other agencies, particularly when the child is insistent that they do not want their parents informed. An initial consultation should be held with the Designated Safeguarding Lead within the education setting who will apply the Risk Assessment Tool (Appendix 1) as appropriate with the member of staff sharing the concern. It is vital that the completed Risk Assessment Tool (Appendix 1) is retained on the child or young person's record to provide evidence of the rationale behind the decision-making process of whether or not to refer. If at this stage an education setting is still unclear about whether or not to refer the matter to the Police or Local Authority Children's Services, then a consultation can be sought with a member of the Education Safeguarding Team who provides immediate support and guidance to education settings in all matters relating to child welfare.

This procedure also applies to visiting professionals who have been commissioned to provide a service to the education setting (e.g. school counsellor, education psychologist etc.). Any concern regarding underage sex that becomes apparent or a disclosure of significant harm by a child to the visiting professional must be discussed with the education setting's Designated Safeguarding Lead. This will ensure that appropriate information is shared, and a more informed decision taken on whether or not to refer. If a referral is considered to be appropriate, then agreement needs to be established on who takes responsibility for referring the matter to the local authority children's services in line within the Kent and Medway Safeguarding Children Procedures and how the child or young person is to be informed.

Specific Guidance for Specialist Community Public Health Nurse/School Nurse

Specialist Community Public Health Nurse / School Nurses are employed by NHS Trusts and must follow the Kent and Medway Safeguarding Procedures and adhere to their employer's policies, procedures and Nursing and Midwifery Code of Conduct. Good practice would be to consult with either their own line manager or the named doctor or nurse for safeguarding children for their trust.

'Fraser Competent' children and young people who are not deemed to be at risk of serious or significant harm are entitled to confidential advice and support.

Some education settings may employ their own nurse and they should follow the education setting's agreed child protection procedures, which should include an agreement regarding those young people which the health professional assesses to be 'Fraser Competent' and not at risk of serious or significant harm.

Appendix 10: The Role of Health Practitioners

Health professionals have a critical role to play in safeguarding and promoting the welfare of children (Working Together 2015). Their key role in providing advice on staying healthy and safe places them at the heart of assessing risks to sexually active young people. These professionals may include:

- Professionals working in General Practices (GPS, Practice Nurses and Nurse Practitioners).
- Those employed by other independent contractors (Pharmacists).
- Professionals working in the community (School Nurses, Health Visitors, Family Nurse Partnership, Named Nurses for Looked After Children and Midwives).
- Professionals employed by Specialist Services (Contraception and Sexual Health Services and Genito Urinary Medicine).
- Professionals working in acute specialties (Accident and Emergency and Minor Injuries).

A child or young person may approach any health professional for advice and support. Health professionals may have the opportunity to work with a child or young person over a prolonged period of time but may also be required to assess risk based on one single 'cold contact'.

On each occasion that a child or young person is seen, an assessment of risk/need must be done, and consideration given as to whether their circumstances have changed, or further information is given which will inform the appropriate action required.

Due to the nature of the role of the health professional, dilemmas associated with working with sexually active young people can occur particularly with the balance between safeguarding, legislation and professional codes of conduct relating to confidentiality. These dilemmas must be resolved by consulting with the Designated Nurses or/and Doctors or seeking a consultation with the Local Authority Children's Services.

Guidance for Good Practice

All health professionals must be trained in accordance with the Health Intercollegiate Document 2014, to recognise signs of abuse and how to act on their concerns as outlined in the Kent and Medway Safeguarding Children Procedures.

Assess Risk using this Guidance

In working with children and young people, it must always be made clear to them at the earliest appropriate point, that absolute confidentiality cannot be guaranteed, and that there will be some circumstances where the needs of the young person can only be safeguarded by sharing information with others. This discussion with the child or young person should include asking them their thoughts, feelings and wishes. The discussion can be useful as a means of emphasising the gravity of some situations.

It is important that workers are aware that children and young people under the age of 18 may be seeking help and advice from services where they may be subject to sexual exploitation, and/or may have been trafficked. In such cases children and young people are always likely to suffer significant harm and appropriate action in line with the Kent and Medway Sexual Exploitation Procedures must be taken.

Health professionals have a duty to give information when seeking consent to disclose information in the same way as they do in respect of seeking consent to treatment, depending on the capacity of the particular child or young person. The advice needs to be careful and full, setting out what the professional sees as the potential consequences, risks/benefits of disclosure versus non-disclosure.

Decisions to share information with parents will be taken using worker judgement, consideration of Fraser guidelines, and in consultation with safeguarding procedures and guidance. Decisions will be based on the child's age, maturity and ability to appreciate what is involved in terms of the implications and risks themselves. This should be coupled with the parents/carers ability and commitment to protect the young person. Given the responsibility that parents/cares have for the conduct and welfare of their child, workers should encourage the young person, at all points, to share information with their parents wherever safe to do so.

Decisions by health professionals not to share information should be informed by the Fraser Guidelines and that the child or young person:

- Understands the professional advice
- Cannot be persuaded to inform his/her parents/carers
- Is likely to have intercourse without contraception
- Physical and/or mental health is likely to suffer without advice and support
- Best interest requires advice and support without parental consent

Health professionals have a duty to maintain accurate and contemporaneous records which detail how the assessment of risk has been made, whether information has been shared or not and why such a decision has been made, including any further advice sought or signposting to other agencies.

Professionals should consider requesting identification from the young person, but this must be considered alongside an assessment of the risks of not treating or giving advice if such a request is declined.

When administering emergency contraception, the health professional is advised to ensure that where possible they should witness the young person taking the medication.

Where there is reasonable cause to suspect that significant harm to a child has occurred or might occur, the case must be reported to the Local Authority Children's Services in accordance with the Kent and Medway Safeguarding Children Procedures. A record of all discussions must be made, regardless of what action is taken, and should include an

explanation as to the reasons for the decision, who is responsible for carrying out any actions agreed during the discussion and who was spoken to.

Concerns identified with referring can be discussed with the Designated Safeguarding Lead within the professionals employing agency. Full professionals' consultation must take place once concerns have been identified and professionals should not make decisions alone. All such decisions must be recorded contemporaneously in the child or young person's record and details must include the concerns, reasons for making a referral and the parties to the decision.

Appendix 11: Flowchart