Assessment Protocol

Contents

1. Introduction

This protocol has been developed and agreed by:

- Leicestershire County Council;
- Rutland County Council;
- Leicester City Council;
- Leicestershire & Rutland LSCB;
- Leicester City LSCB;
- Health partners;
- Police;
- Other partners.

The purpose of this protocol is to clarify arrangements for how cases will be managed when a child is referred into Children's Social Care.

Each local authority is publicly accountable for this protocol and all organisations and agencies have a responsibility to understand their role in helping to implement it.

This document should be read in conjunction with the **Principles of Assessment**.

2. Types of Assessment

Assessments led by Children's Social Care or the, Early Help Assessment, or Team Around the Family (TAF), will be conducted in line with the **Threshold document** and **Principles of Assessment Procedure**.

Assessments will be conducted for the following purposes:

- Early Help Assessment to determine the type and level of Early Help Assessment services to be provided. In Leicester City and Rutland this assessment will be conducted by the Early Help Assessment or TAF Team. In Leicestershire this assessment will be conducted by the Early Help Assessment Service. These assessments may be conducted by a **Lead Professional** or a social worker;
- Assessment to determine statutory services under:
    - **Section 17** of the Children Act 1989 (children in need) see **Child in Need Assessment and Plan**;

  - **Section 47** of the Children Act 1989 (reasonable cause to suspect children suffering or likely to suffer significant harm);
  - **Section 31** (care orders); and
  - **Section 20** (duty to accommodate a child) of the Children Act 1989.

All statutory assessments will be completed by a suitably qualified and experienced social worker who will lead the multi-agency process.

3. Timescales

Assessments will be conducted in a timely manner that is transparent and proportionate to the needs of individual children and their families. Primarily it is the needs of the child which should drive the assessment: delay is not in the child's interest. At any point in the process of the assessment there is a concern that a child is likely to or is suffering **Significant Harm,** the child's immediate safety must be considered and a **Strategy Meeting** convened.

The timeframes for statutory assessment are as follows:

- The assessment starts on the date it is received as a referral by Children's Social Care;
- The assessment should be completed within a maximum of 45 days from the referral but usually sooner and any locally agreed practice standard should be applied;
- An initial review date should be agreed between the social worker and their manager at the point of allocation (which is no more than 10 days from the initial start date or in line with locally agreed practice standards);
- The timescale for the assessment should be continually reviewed in supervision. If it appears the assessment will not be completed within the agreed timescale Service Manager authorisation will be required;
- The child or young person must be seen according to Working Together to Safeguard Children within "…timescale that is appropriate to the nature of the concerns expressed at referral, according to an agreed plan". For example, within 24 hours if injuries or high risk are indicated. If there is delay and/or the child is not seen alone, this should be recorded along with the reasons why. Any locally agreed practice standards will be applied in respect of visiting the child and timescales;
- In line with the relevant timescales key decision or review points will be agreed which involve the child, family, social worker and relevant professionals. The review points will be used to monitor the progress of the assessment and to ensure it is completed within the 40 working days timescale.

Review points may include, for example:

- At the point the social worker should have seen the child alone, and their views and wishes have been heard and recorded; the child's home address has been visited and the child's bedroom has been seen;
- At the point all the individual children in the household have been seen and their needs considered;
- At the point the parents have been seen and their views and wishes have been recorded and taken into account;
- At the point early findings may indicate whether no further action is required, a child is in need, or a Section 47 Enquiry should be considered;
- At the point the assessment analysis and evaluation has been completed.

Review points provide assurances that the intervention is timely and proportionate (if any is required), and that the impact of this will be analysed and evaluated in terms of the improved outcomes and welfare of the child.

4. Consent and Involvement of Child or Young Person and their Family

The child’s lived experiences (through their views and wishes, observations, links to child development theories) should be considered within all stages of involvement (assessment, planning, intervention and review processes).

The child or young person and their family have the most vital role to play in the process of assessment. Depending on age and ability, they must agree to the assessment, understand its purpose, who is involved and what is expected of them especially in terms of what change is required and how this is going to be measured. The involvement of wider family and friends should be assessed.

Written Consent must be obtained from the child or young person and parents in cases assessed by Early Help Assessment. Consent is necessary for all assessments unless to do so would risk the child’s welfare, safety or further harm.

If consent cannot be obtained to proceed with the assessment or to see the child the reason for the assessment should be reviewed by the Team manager and Social Worker and consideration given to holding a strategy discussion if the threshold is met. This evaluation will need to be recorded with a clear rationale.

5. Case Recording

The purpose of case recording is to maintain a record of contact with children, their families and other professionals. Case recording provides the basis for an analysis of needs or risk and for decision making and planning. Recording should include information on the child's development and presentation, their views and wishes so that progress can be monitored to ensure their outcomes are improving. Case file records will be regularly monitored through supervision, management oversight and in addition single and multi-agency audits.

6. Social Worker / Lead Professional's Role in Assessment

It is the responsibility of the social worker/ lead professional to analyse all the information gathered from the enquiry stage of the assessment, ascertain the nature and level of the child's needs and the level of risk, if any, they may be facing.

In all assessments, information from previous assessments conducted by other agencies such as an Early Help Assessment, Education through Education Health Care Plans (EHCP), etc. should be used to inform the assessment.

The line manager of the social worker / lead professional should provide regular supervision, to ensure the assessments are well informed by evidence, reflect the current levels of risks and needs faced by the child leading to proportionate intervention (in any).

Supervision should be reflective and:

- Be focused on the precise assessment of developmental progress with consideration of when there is a need for expert advice;
- Emphasise the assessment of parenting capacity, with identification of difficulties to be targeted and plans established for how this will happen;
- Identify intervention designed to improve parenting and reduce risk;
- Provide opportunities to critically reflect on the issues emerging from the Assessment to support analysis (see **Working Together to Safeguard Children**).

7. Contribution of Agencies Involved with the Child and Family

All agencies and professionals involved with the child, young person and the family, have a responsibility to contribute to the assessment process. This contribution will vary depending on the circumstances of the child; it can include the provision of information and services. Agencies who contribute to the assessment should be involved in its planning, review and analysis. Contribution from the following agencies should always be considered:

- Police, especially if an offence may have been committed;
- Health, especially in relation to the child's development and the family history;
- Education, including where relevant, pre-school and further/higher education.

Other agencies and organisations may need to be asked to contribute to the assessment process, depending on the circumstances of the child and their family. This may include agencies which work with adults, for example where parents or another adult living in the household have drug, alcohol or mental ill health problems or learning difficulties. Professionals who are primarily providing a service to the child's parents or carers have a vital role to play in developing an understanding of the parent's capacity and they have a duty to participate in the process of assessment.

Partner agencies who have been involved in the assessment should be informed of the outcome. Where they are involved in providing services to the child, this information should clearly state action points, review dates and intended outcomes for the child, as agreed between them and the social worker or lead professional.

It is possible that professionals have different experiences of the child and family and understanding these differences will actively contribute to the understanding of the child / family.

Differences of opinion between professionals should be resolved speedily but where this is not possible, the arrangements for resolving practitioner disagreements should be implemented - see **Resolving Practitioner Disagreements and Escalation of Concerns Procedure**.

8. Children in Specific Circumstances

Where particular needs are identified at any stage of the assessment, the social worker/ lead professional should not wait until the assessment is concluded before commissioning services to support the child and their family

The needs of disabled children, young carers and children involved in the youth justice system should be addressed specifically in the assessment process

8.1 Disabled Children

A disabled child is defined under Section 17 of the Children Act 1989 as: "A child is disabled if he is blind, deaf or dumb or suffers from mental disorder of any kind or is substantially and permanently handicapped by illness, injury or congenital deformity or such other disability as may be prescribed".

Each LA has their definition of "Disabled Child". The CSC manual covers many of the issues of assessment, including Disabled Children - the Principles of Services for Disabled Children. See **Leicester City, Leicestershire and Rutland Children Social Care Procedures Manual**.

Care should be taken wherever possible to ensure that duplication of assessment is avoided. Children with specific communication needs (e.g. language, disability, asylum seeking, age or understanding) should be considered carefully to ensure their contribution to the assessment reflects their views and opinions where possible.

8.2 Young Carers

The specific needs of young carers should be given sufficient recognition and priority in the assessment process. The **Supporting the Health and Wellbeing of Carers in Leicester, Leicestershire and Rutland - A Strategy and Delivery Action Plan 2012** defined a young carer as "… a child or young person under 18 who provides regular, ongoing care and emotional support to a family member who is physically or mentally ill, disabled or misuses substances. A young person becomes vulnerable when the level of care-giving and responsibility to the person in need of care becomes excessive or inappropriate for that child, risking impacting on his or her emotional or physical wellbeing or educational achievement and life chances".

The needs of children/young people undertaking caring activities within their family environment need to be identified and support put in place to reduce the impact of inappropriate levels of caring on their lives.

An assessment may be needed to decide what type and level of support is needed. Young carers may be entitled to services in their own right, under the Children Act, and therefore it may be appropriate for a young carer to be assessed under this Act.

For the cared-for person a Community Care Assessment should identify the support that is required and for this to be supplied, so that the young carer's role is not excessive in the light of their age and their own educational, health and social needs.

For more information see:

Leicester Young Carers (see Leicester City Council website)

Leicester and Leicestershire Young Carers Project - Barnado's CareFree Project Rutland

8.3 Children and Young People who Commit Offences

The Youth Offending Service and each Local Authority have a protocol for the assessment and support to children who offend, and their families. These can be accessed here: **Leicester City, Leicestershire and Rutland Children and Young People's Service Procedures Manual**.

8.4 Children Subject to a Section 47 Enquiry

In relation to assessments conducted as part of a Section 47 Enquiry:

- The assessment should always be initiated by a **Strategy Meeting/Discussion** between the Police, children's social care, health and education(if appropriate), and any other agencies who are involved with the child and who can provide relevant information. This meeting/discussion must consider any steps that need to be taken immediately to protect the child's welfare;
- The conduct of the assessment and the information and analysis may be kept from a parent or carer if, in passing on the information, the child's safety would be compromised. The principle of working in partnership with the parents and the child should, however, be upheld wherever possible;
- If one child in a household is being assessed as part of a Section 47 Enquiry, any other children living there may also be assessed if they may have had contact with the alleged perpetrator.

8.5 Children who are to be Returned from Care to live with their Families

Careful assessment and consideration should be given when children are to be returned from care to live with their families. Assessments to inform transition and contingency plans should specifically address risk and danger statements to ensure the safety of children and sustainability of the plan.

8.6 Young People aged 16 years or 17 years who are homeless

Assessment and services to young people aged 16 years or 17 years should be provided in line with the judgment in the House of Lords, (R(G) v Southwark LBC in May 2009. This judgment clarified the responsibility of children's services for accommodating homeless young people aged 16 and 17 under the Children Act 1989. There is national guidance: Provision of Accommodation for 16 and 17 year old young people who may be homeless and/or require accommodation.

The judgment made clear that children's services should presume that any lone, homeless child should be provided with accommodation under **Section 20** unless the child is not (based on an initial screening assessment) a **Child in Need** and that the Children Act has primacy over the Housing Act in providing for children in need. It also emphasised the continuing duty of housing and children's services to collaborate in the discharge of their duties to children and young people;

The initial point of contact for a young person presenting as homeless to Children's Social Care will be the First Response Children's Duty (FRCD) in Leicestershire, Children's Duty &

Advice Team in Leicester City and Referral Assessment and Intervention Service (RAIS) in Rutland. For more information see **Referrals to Children's Social Care Procedure**.

A **Section 17** assessment must be initiated in order to inform whether the need for accommodation is to be met under S20 of the Children Act 1989 or within the Housing Act.

The criteria for accommodation are specified in Section 20 (1) as follows:

- Every local authority shall provide accommodation for any child in need within their area as a result of:
    - There being no person who has **Parental Responsibility** for him;
    - The child being lost or abandoned; or
    - The person who has been caring for him being prevented from providing him with suitable accommodation or care (temporarily or permanently).

There is a further test in relation to 16 and 17 year olds, as follows:

- Every local authority shall provide accommodation for any child in need within their area who has reached the age of sixteen and whose welfare the authority consider is likely to be seriously prejudiced if they do not provide him with accommodation Section 20(3).

Section 20(6) states that before providing accommodation under this section, a local authority shall, so far as is reasonably practicable and consistent with the child's welfare ascertain the child's wishes regarding the provision of accommodation; and give due consideration (having regard to his age and understanding) to such wishes of the child as they have been able to ascertain.

8.7 Children affected by HIV

See **Appendix One Child Protection and HIV Procedure.**

9. Specialist Assessments

The social worker / lead professional should determine whether any specialist assessments should be undertaken to assist them in their assessment and decision making. This includes such assessments as for children with special educational needs, disabled children, and specialist health assessments such as CAMHS, consultant paediatrician or Occupational Therapy.

Reference should be made to previous assessments from any of these agencies to help the social worker understand the child's needs, and to improve assessment analysis and outcome decision making.

10. Complaints and Appeals Processes

See also **Leicester City, Leicestershire and Rutland Children and Young People's Service Procedures Manual**.

Complaints and representations can be made to each local authority.

Where the complaint is about a partner agency's role in the assessment process, the social work manager or other local authority personnel receiving the complaint should refer it to the relevant manager in the partner agency, or the agency's complaints department.

Appendix One - Child Protection and HIV

Contents

1. Introduction

HIV is never in itself a child protection issue. However, there will be a small number of families affected by HIV in which child protection issues arise, as they do in other families where there may be concerns about children. In some instances, concerns will be nothing to do with HIV and will be about parenting ability or Neglect or occasionally abuse. In other cases, concerns will be directly related to HIV and may be to do with treatment and care. This document builds on guidance produced by the Department of Health, incorporates medical advances and provides advice on those issues particular to families with HIV in the UK, which deserve special mention.

Children from families affected by HIV are entitled to the same support and protection by the local authority as children from other families. The Children Act, Department of Health Guidance and local child protection procedures should all be applied in the same way as they would be to any child, and the interests of the child must be the paramount consideration for all professionals involved with the family, regardless of their specific role.

The advent of combination therapy has brought hope to people with HIV, but it has also brought new moral and ethical dilemmas about treatment and testing, particularly in relation to children. Recent research into the role that ante-natal treatment and breastfeeding play in transmission raises new practice issues about promoting the health and welfare of infants. Parental wishes about treatment for their child may conflict with medical views about what is best for that child's health and development. Parents may fear that child protection procedures will be used to coerce them into making decisions about testing and treatment about which they are unhappy.

Children with HIV who were not expected to survive beyond their fifth birthday are now adolescents beginning relationships with their peers. They need to be able to make informed decisions about their own sexual health and the health of their prospective partners.

The majority of families are from the most affected African communities and, in addition to HIV, may be facing immigration difficulties, separation from their extended family and community, loss and dislocation, cultural and language differences, poverty and racism. The importance of addressing cultural issues and beliefs cannot be overstated.

2. Vertical Transmission

2.1 Background

Most children with HIV are infected as a result of transmission of HIV infection from their mothers. Mother to child (vertical) transmission can occur before or during the birth, or afterwards through breastfeeding. There is clear evidence that the risk of transmission can be greatly reduced by interventions such as anti-retroviral drug treatment, elective caesarean section and the avoidance of breastfeeding. Given that many of these women are from, and may return to, resource-poor countries, the decision to deliver vaginally may be agreed between the family and medical staff as their individual needs dictate. Many women currently deliver vaginally with anti-retroviral cover to reduce the risks of vertical transmission and results are currently promising. The estimated risk of mother-to-child HIV transmission in the UK and Europe, when breastfeeding was avoided, was between 15 and 25%. It has been estimated that breastfeeding more than doubles the risk of mother-to-child transmission of HIV. Together with other interventions as above, when breastfeeding is avoided the risk of mother-to-child HIV transmission can be reduced to less than 5%.

2.2 Reducing the risk

Intervention to reduce the risk of vertical transmission can only take place if a pregnant woman is aware of her own HIV infection. The Government has set targets for the increased uptake of ante-natal HIV testing and testing is now offered to all pregnant women, although it is not compulsory. A number of women will decline an HIV test in pregnancy and this is their prerogative. The most rapid spread of HIV infection is now as a result of unprotected heterosexual sex. As a result of these factors, there will be an increase in the number of pregnant women who test positive for HIV.

Once women are aware of their HIV infection, most choose to accept interventions that will reduce the risk of vertical transmission and protect their babies. Most women will agree a plan with medical and midwifery staff for the management of the pregnancy and birth and will agree not to breastfeed. It is essential that women be offered every support to carry out the plans made. For example, assistance may be needed to arrive at a strategy for explaining decisions to partners/relatives in a way that does not breach confidentiality. Women may also need practical or financial assistance in order to carry out the plan e.g. access to bottle-feeding equipment and money for formula milk. This will be particularly important for women who do not have access to public funds. Local health trusts/social care departments may need to develop working arrangements to ensure that culturally appropriate support is offered, including the use of advocates. Within Leicestershire and Rutland confidential advice, support and advocacy can be accessed through Leicestershire Aids Support Services (LASS).

Pregnancy can be an anxious time and women will naturally be concerned about the health and safety of their baby. Receiving a positive test result during pregnancy leaves little time for a woman to come to terms with the result while having to also consider making a plan for her baby. It is expected that healthcare professionals will do everything possible to agree plans with women that reduce the risk of vertical transmission.

2.3 Rejection of medical advice

Children's Social Care Services should be consulted where parents appear to be refusing intervention to reduce the risk of vertical transmission. Such refusal may be due to a number of reasons, for example cultural beliefs, concerns about bonding, or in order to maintain confidentiality about HIV status. The referral should be actioned as soon as concerns become evident due to the fact that appropriate interventions are time-limited.

In rare situations, before the birth, a pregnant woman may decline some or all of the interventions offered, or may indicate that she intends to breastfeed. Under UK law, unborn children do not have any legal status, and pregnant women cannot be compelled to have an HIV test, to accept medication or to undergo a caesarean delivery. However, Children's Social Care Services should become involved where there is concern that an unborn child may be likely to suffer Significant Harm. Such involvement can include convening a Pre-Birth Child Protection Conference, placing the unborn child on the list of children subject to a Child Protection Plan and agreeing a plan to protect the baby as soon as she/he is born. For more information see Initial Child Protection Conferences Procedure.

Following the birth, the baby has rights of her/his own, including a right to 'the highest attainable standard of health and to facilities for the treatment of illness' (UN Convention on the Rights of the Child: Article 24). Consideration may need to be given to whether the baby is suffering, or is likely to suffer, Significant Harm (Children Act 1989: Section 47) and whether action is needed to safeguard the baby. In practice, concerns will arise at this stage where parents are declining anti-retroviral medication for the baby following the birth, or breastfeeding where safe alternatives are available.

Whether concerns arise before or after the birth, the first aim regarding the risk of vertical transmission must be to work in partnership with the parents to reduce the risk to the baby. In almost every case it is in the child's best interests to be cared for by parents and this principle should underpin the assistance offered to the family.

There can be no universal guidelines as to the best course of action and each family will require an assessment and decisions made on the basis of:

- The opinion of an Obstetrician/Paediatrician with expertise in HIV infection;
- The nature and degree of harm to the child;
- The general context of parenting.

The conclusion of the assessment may be that the baby is at increased risk of being infected with HIV as a result of actions or inactions by the parents. A decision will need to be made whether this constitutes a likelihood of suffering significant harm, and therefore whether child protection procedures and legal intervention are indicated.

3. Testing of Children

The PCR (polymerase chain reaction) test can provide accurate information about the HIV status of babies from the first few weeks of life. Given the advances in treatment, there are real advantages in determining the HIV status of children who may have been exposed to the risk of infection. This is particularly the case for children under the age of 1 year, where prophylactic (protective) treatment reduces the risk of life threatening opportunistic infections. If a baby is found not to be infected it prevents him or her being exposed to unnecessary monitoring and treatment with antibiotics.

The most common route of HIV infection in a child is through vertical transmission, but there may also be concern that children may have been exposed to infection where:

- Children have received medical treatment in countries without access to sterile equipment or safe blood products;
- Children have been sexually abused; or

- Young people are practising unsafe sex or sharing needles.

Testing should never be routine and is only indicated on the basis of the child's health needs, rather than to alleviate the anxieties of carers or professionals.

3.1 Consent

Consent is always required before a child can have an HIV test. This consent must be both informed and freely given. Where a child has reached the age of 16, she/he is deemed to be capable of giving or refusing consent to their own medical examinations and treatment, but younger children may also be regarded as being capable if they are of sufficient age and understanding. This is known as being Gillick Competent and must be explored on a case-by-case basis with the child concerned. Where children are considered to be too young or otherwise unable to understand the issues, consent must be obtained from a person with parental responsibility. In situations where a child or young person is the subject of Public Law Children Act proceedings, decisions about HIV testing must be referred to the courts. Both parents and children should have access to culturally appropriate information and support to enable them to reach a decision.

3.2 Refusal of testing

Where a child is of sufficient age and understanding to be aware of all the issues and refuses to have an HIV test, this decision should be respected, but in the context of an ongoing dialogue with the child in the event of their wanting the test at a later date.

Where a parent refuses permission for their child to be tested, this may be considered to be a child protection issue, if it denies the child access to suitable health care. The age and health of the child are important considerations. It may be that there are more pressing reasons for knowing the HIV status of vulnerable children under the age of one year and/or children who are unwell, than older children who are in good health. Each case should be considered on its own individual basis and legal advice sought. Again, every effort should be made to work in partnership with parents before considering legal action to override their wishes.

3.3 Sexual abuse

Adults who have been raped are offered HIV testing and prophylactic (protective) treatment, but this is not routine practice with children who have been sexually abused. Consideration should be given as to whether such intervention may promote the health and well being of individual children where they have been exposed to the risk of HIV infection. It should also be recognised that children may have fears about HIV infection even where this is unlikely to be a realistic risk, and they should be provided with relevant information and support.

3.4 Young people who are sexually active/sharing needles

It is the responsibility of all those working with young people to ensure that they are aware of safe sexual practices and the dangers of needle sharing. Where a young person requests an HIV test, they will need advice or support. Unless there are exceptional circumstances, such requests must be on their own initiative rather than at the suggestion of adults. It is never appropriate to suggest that a young person have an HIV test because they are thought to pose an infection risk to others.

4. Treatment Issues

4.1 HIV disease in babies and children

Without any treatment, HIV infection in children may result in chronic disease and about 20% of HIV infected children develop AIDS or die in the first year of life. By the age of 6 years, about 25% of the children will have had some illness because of their infection. The long-term picture is unknown, but it is likely that most children with HIV will benefit from early life prolonging treatment. HIV may manifest as AIDS defining illnesses such as PCP (Pneumocystis Carinii Pneumonia), Candidiasis, Cytomegalovirus or Tuberculosis, or it may take a more non-specific form. Failure to thrive, unexplained persistent fever and diarrhoea are frequent features of this syndrome.

4.2 Monitoring and treatment of positive children

The progression of HIV disease is not the same in children as in adults, and the range of drugs used to treat children is not as extensive. Children and young people who are positive will require careful monitoring to ensure that the appropriate treatment options are considered at the right time. This is available via the Family Clinic in the Children's Hospital based at Leicester Royal Infirmary. Developmental checks, blood tests and hospital appointments are an important part of this process, and ongoing support is available through the Children's HIV Specialist Nurse.

Medication suitable for children is often made up as a liquid. This means that it has a short shelf-life and prescriptions have to be made up more frequently than is the case for tablets. If medication is missed, resistance to the drug can develop. Parents and carers may need help to understand the importance of regular medication and practical assistance in getting supplies. Some parents and carers may not want to give powerful drugs, whose long-term effects are not yet known, to a child who appears to be healthy.

Parents need access to good quality information in order to make informed decisions. Every situation involving a child where the giving, or not giving, of medication has become a cause for concern for professionals needs to be considered individually. These cases are unlikely to have simple solutions. Where a child's health is going to be adversely affected by the withholding of treatment, it is appropriate to institute child protection procedures and obtain legal advice. In many of these situations where child protection issues arise it will be possible to consider an application to the courts for a Specific Issue Order. It is good practice to consider the need to involve a culturally sensitive advocate who can represent the parents' views and also explain the concerns to the parents.

5. Disclosure

5.1 Confidentiality

HIV status should normally only be disclosed with the informed consent of the person concerned. Where the child is infected, their consent to the sharing of information about their status must be sought if they are of sufficient age and understanding. Otherwise, consent should be from the parent or other person with parental responsibility. Consideration should only be given to disclosing an individual's HIV status where there is a clear 'need to know' in order to safeguard the child. Fears about infection risk do not constitute a legitimate reason for disclosing information about HIV status. If a child and/or her/his family are opposed to the disclosure of HIV status, they should only be overruled if a failure to do so would place the child at increased likelihood of suffering significant harm and/or there is legal requirement to disclose.

5.2 Inadvertent disclosure of HIV status

All workers should take care that they do not inadvertently disclose a service user's HIV status during the course of a child protection investigation, e.g. a number of families will not have disclosed their HIV status to their GP. A worker unfamiliar with HIV work might not know this and might inadvertently disclose the client's HIV status to the GP as part of a routine check. Only where the HIV status is integral to the concerns raised should it be discussed

5.3 Child protection conferences

There will be situations in which HIV status is not relevant to the matters to be decided at the child protection conference. In other cases, it may be impossible to decide about concerns regarding a child without mentioning their medical needs associated with the HIV infection, although this may be discussed using alternative terminology for example, 'a medical degenerative condition'. It is good practice for all conference chairs to reiterate confidentiality issues at the outset. Remember that the informed consent of the infected person or their carer can alleviate difficulties around issues of confidentiality

5.4 Disclosure to the child or young person

Disclosure to the child or young person is a very sensitive issue. Parents and carers may have strong views about when disclosure should take place. These views may not always fit with professionals' ideas about best practice. Each family needs to find the time and the way that is right for them. Culturally sensitive professional support should be offered to families to help them tackle this difficult task

5.5 Disclosure to an affected child or young person

A child who is affected does not have a clear right to know information about the HIV status of another person, even though that person may be their parent or sibling. The right to confidentiality remains with the person who is HIV positive.

5.6 Disclosure to an infected child or young person

A child who is infected has a clear right to know information about their own medical situation but parents and carers may want to protect their child from some of the consequences of knowing (fear, concerns about their parents, whether to tell friends at school). Disclosure needs to be age appropriate, and the child needs to be able to understand what they are being told. They also need some understanding of wider issues, like prejudice and confidentiality, that affects the lives of people with HIV. A child or young person who does not know their status and is on combination therapy may have questions about their medication and hospital appointments. Disclosure can make sense of a situation that has become worrying. Decisions to disclose diagnosis should always be taken with other professionals and the family

5.7 Refusal to allow disclosure

There may be situations in which a parent or carer is adamant that disclosure should not be made. In such circumstances an ongoing dialogue with the parent or carer should be maintained. Additionally it is possible to provide the child/young person with detailed information about their health and illness without naming their disease.

While affected children and young people have no absolute right to information about another family member the strain of living with this sort of secret can affect the whole family. Again it is possible to provide appropriate information and support without disclosing the diagnosis of the individual family members.

If the child is a young adult over 16 or is under 16 but Gillick Competent, and it is their own health that is affected, there may be compelling reasons for disclosure to take place. A young person of 16 has a right to make decisions about their medical care and to give consent to treatment. In addition, they may be in a sexual relationship or be considering a sexual relationship.

In the case of a child or young person under 16 who is not Gillick competent, it is the parent or guardian who has the right to make decisions about whether disclosure is made.

A delicate balance needs to be struck between considering the wishes of the parent or carer and the rights and emotional well being of the young person and if disclosure is considered to be necessary, legal advice should be sought before such disclosure takes place.

6. Conclusion

HIV is rarely a sole cause for child protection concerns. Professionals should maintain collaborative working and refer to existing procedures in order to ensure that the diagnosis of HIV within a family does not prejudice the assessment or outcomes of any child protection/welfare concern.