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# Guidance on the High Security Psychiatric Services (Arrangements for Visits by Children) Directions 2013

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# Guidance on the High Security Psychiatric Services (Arrangements for Visits by Children) Directions 2013

**Prepared by Andrew Herd**

## Summary

1. This guidance accompanies the High Security Psychiatric Services (Arrangements for Visits by Children) Directions 2013, which cover the arrangements for visits by children to high secure hospitals. The 2013 Directions and this guidance replace the previous directions (Visits by Children to Ashworth, Broadmoor and Rampton Hospitals Directions 1999) and associated guidance. Following the report of the Savile Investigation in 2014, this guidance will be updated if necessary.
2. High secure providers must ensure that visits by children only take place in accordance with these Directions and taking into account this guidance.

## Key principles

3. As with the previous Directions, the key principles of the Directions and guidance are:
  - (i) decisions should always be made in the child's best interests;
  - (ii) the child's wishes and feelings about the visit, taking account of his/her age and understanding, should be considered;
  - (iii) the child's welfare should be safeguarded and promoted; and
  - (iv) the child's contact with family members should be supported, whenever that contact is in the child's best interests.

## Other legislation and guidance

4. This guidance should be read in conjunction with the Mental Health Act 1983 Code of Practice and Working Together to Safeguard Children (DfE, March 2013) guidance on safeguarding.
5. The Mental Health Act 1983 Code of Practice states (paragraphs 19.17 to 19.19) that:

“All hospitals should have written policies and procedures regarding the arrangements for children and young people who visit patients in hospital and for visits to patients who are children or young people. Policies should be drawn up in consultation with local social services authorities and local safeguarding children boards.

“Local policies should ensure that the best interests and safety of the children and young people concerned are always considered and that visits by or to children and young people are not allowed if they are not in their best interests. However, within that overarching framework, hospitals should do all they can to facilitate the maintenance of children's and young people's contact with friends and family.

“Information about visiting should be explained to children and young people in a way that they are able to understand. Environments that are friendly to children and young people should be provided where necessary.”

6. Local Authority Circular LAC(99)23 refers to the specific tasks to be undertaken by local social service authorities in receipt of a request from the hospital for advice on whether it is in the best interests of a child to visit a named patient. Local Authority Circular LAC(2000)18 refers to who can accompany a child on a visit to a named patient. It is issued as statutory guidance under section 7 of the Local Authority Social Services Act 1970.

## Visits by children

7. A high secure provider may not allow a child to visit any patient in a high secure hospital unless it is satisfied that the visit is in the child's best interests and has approved the visit in accordance with these Directions. The only exception to this is where there is a contact order made under the Children Act 1989, which specifies that the child may visit the patient in the high secure hospital. In such cases, visits should be allowed unless there are concerns about a patient's mental state at the time of the visit such that the nominated officer decides a visit would not be in the child's best interests.
8. In the case of a patient judged to present a risk of harm or potential harm to a child, the child must be within the permitted categories of relationship to the patient as set out in paragraph (2)(2)(b) of the Directions. If the child does not satisfy the relationship criteria, the hospital must refuse the request for a visit.
9. Those with parental responsibility for the child are required to give their consent in writing for the child to visit the patient. They should be asked to provide the provider with correct, accurate information on the relationship between the child and patient. They should be asked to take account of the views of the child, their wishes and feelings about the visit and consider his/her age and understanding in deciding whether to give their consent.
10. If more than one person has parental responsibility for the child, it is the person with parental responsibility with whom the child lives who is required to give their consent, though consideration should be given to seeking the views of the person sharing parental responsibility. If, however, the child is subject to a care order, it is the designated local authority in whose care the child is placed, who is required to give consent. The local authority should consult with those persons who share parental responsibility before reaching a decision.

## Nominated officer

11. Paragraph (3)(1)(a) of the Directions requires the high secure provider to nominate a senior manager in the high secure hospital who is to be responsible for overseeing the process of dealing with any request for permission for a child to visit a patient and for deciding whether to approve the visit. This nominated officer should be directly accountable to the Chief Executive, and will usually be the Head of Social Care or an equivalent post.
12. Providers must also establish a multi-disciplinary panel to assist and advise the nominated officer in carrying out his/her responsibilities and reaching decisions on applications. The provider must ensure contingency arrangements are in place to cover the nominated officer and panel roles during periods of annual leave, sickness or other periods of absence.

## Complaints procedure

13. Each provider is required to operate a formal system for considering representations about any decision not to allow a child to visit (paragraph (5) of the Directions). This system should be consistent with the provider's overall complaints procedure and should contain an independent element. At least some of those considering representations should have relevant child safeguarding experience. Assistance and guidance on the use of the complaints procedure should be made available to patients. Patients may need assistance to make a complaint, and there may be a role for an advocate from an independent agency to provide this help.
14. If the complaint relates to whether procedures were adhered to, the complaint will be dealt with through this procedure. If the complaint relates to the outcomes (i.e. a decision to refuse a visit) the complaint should also be dealt with through this procedure but the nominated officer must decide whether the local social services authority should be involved. If the local social services authority advice was to refuse the visit, the complaint should be copied to them to investigate via their local authority complaints procedure. The local social services authority will be expected to share the outcome of its investigation with the hospital.

## Records

15. Providers should have clear policies on record-keeping in relation to the arrangements for children visiting high secure hospitals. These policies should cover records on requests for visits, decisions on whether visits should take place, and actual visits. Policies should also state retention periods.

## Provision of Information

16. The nominated officer must ensure that information is provided to patients and parents and any other persons with parental responsibility for the child, or caring for the child, concerning the arrangements for visits by children to the hospital. An information leaflet should be available which sets out:
  - (i) the child visits policy, which should meet the requirements of the Directions. It is important that the leaflet stresses the context for the policy i.e. that visits should only take place where they are in the best interests of the child, and as part of the provider's safeguarding policy;
  - (ii) the procedures for dealing with requests (as set out below);
  - (iii) the role of local social services authorities in assessing whether a visit is in the best interests of a child and clarifying that information will need to be disclosed to and by the local social services authority;
  - (iv) arrangements at the hospital for visitors;
  - (v) the requirement that all children approved for visits must be accompanied by the person with parental responsibility for the child and with whom the child lives or another person caring for the child. However, a child aged 16 or 17 may visit unaccompanied if the nominated officer is satisfied that it is safe for them to do so;
  - (vi) complaints procedure if a patient is refused permission for a child to visit;
  - (vii) decisions to permit a child to visit are reviewed after one year using the same criteria as for the initial decision; and

- (viii) the provider reserves the right to refuse to allow a visit to take place, for example, if there are concerns about the patient's mental state at the time of the proposed visit.
17. The information leaflet has an important role to play in assisting providers and local social services authorities to work constructively with families and in ensuring that when making the decision, the nominated officer takes account of all relevant information.

## Procedure for deciding requests for visits

18. The procedure is intended to work as follows:
- (i) The patient makes a request in writing for a child to visit. This request must be forwarded promptly to the nominated officer (paragraph (3)(2) of Directions). Staff in the hospitals must be aware that some patients may require support in making a written application (either from their family or their clinical team). There may be a role for an advocate from an independent agency to provide this.
  - (ii) If the patient is judged to be a risk, or potential risk of harm, to children, the child must be within the permitted categories of relationship as set out in paragraph (2)(2)(b) of the Directions. If it is clear from the written application that the child does not satisfy the relationship criteria, the nominated officer must refuse the visit (paragraph (3)(11) of the Directions). The nominated officer must notify the patient in writing of the decision and reasons for it. However, the patient has no right to make representations against this decision.
  - (iii) If (ii) does not apply, the nominated officer should obtain written permission from the patient to contact those with parental responsibility for the child. The nominated officer should then write to the person(s) with parental responsibility for the child explaining that a request for a visit has been made. The leaflet produced by the provider should be enclosed. Those with parental responsibility should be asked to confirm the relationship between the patient and the child, and to state whether they agree to the child visiting the patient. It should be explained that the nominated officer is required to contact their local authority to ask them for advice on the child's best interests. This advice assists them to make a decision on whether the request for visits should be approved. If more than one person has parental responsibility for the child, it is the person with parental responsibility with whom the child lives who is required to give their consent.
  - (iv) In the case of a child who is looked after by the local authority and subject to a care order (with parental responsibility shared by the local authority and the parent(s)), the designated local authority has responsibility for providing consent but their decision should be taken following consultation with those with parental responsibility. Where a child is looked after by the local authority but is not subject to a care order, the person with parental responsibility is required to give their consent.
  - (v) In the case of a child living with someone who does not have parental responsibility (e.g. the child lives with a grandparent), the nominated officer should write also to the person with day-to-day care for the child explaining that a request for a visit has been made and that the person with parental responsibility will be contacted as in (iii) above.

- (vi) If the person(s) with parental responsibility responds to the nominated officer stating they do not agree to the child visiting the patient, the nominated officer must refuse the visit. The decision and the reasons for the decision must be put in writing to the patient.
- (vii) If those with parental responsibility state they are prepared to agree that their child may visit the patient, the nominated officer should arrange for the patient's clinical team to undertake an assessment. This assessment is to judge the level of risk, if any, presented by him or her to children and to the particular child for whom the visit request has been made. The voice of the child, their feelings and wishes about the visit should be taken into account. Procedures for undertaking this type of assessment should be agreed with both the local authority children's services departments and local safeguarding children's boards.
- (viii) If the provider's assessment indicates that the patient's mental health state and/or risk to children is such (in the immediate or longer-term) that it would not be appropriate for the child to visit the patient, the nominated officer should refuse the request for the visit (paragraph (3)(5)(a) of the Directions). The decision to refuse the visit must be put in writing to the patient and the person with parental responsibility and include details of the complaints procedure.
- (ix) If the provider's assessment does not rule out a visit on the grounds of (viii) above, the nominated officer must in all cases contact the local authority where the child resides, to seek their advice on whether it is in the best interests of the child involved to visit the patient (paragraph (3)(5)(b) of the Directions). The written request for this advice should be addressed to the local authority and include a copy of the provider's assessment. The nominated officer should share any relevant information about the patient with the local authority in the area in which the child resides, in order to assist the local authority to undertake its assessment of the child's best interests with regard to the proposed visit. If the nominated officer has knowledge of any other local authorities which have relevant information about the child or the child's family, this information should be shared also with the relevant local authority.
- (x) On receipt of the request from the provider, if the request falls within the local authority's statutory responsibilities, the local authority should contact those with parental responsibility (and those caring for the child if they are different) to arrange to undertake an assessment. In relation to the proposed visit to the named patient, this assessment should establish:
- the child's legal relationship with the named patient;
  - the quality of the child's current relationship with the named patient and prior to their hospitalisation;
  - whether there has been past, alleged or confirmed abuse of the child by the patient;
  - future risks of significant harm to the child if the visit took place;
  - the child's wishes and feelings about the visit, taking account of his/her age and understanding;
  - the views of those with parental responsibility and, if different, person(s) with day to day care for the child;
  - if it is known the child has lived in other local authority areas, what other relevant information is known about the child and family; and



- the frequency of contact that would be appropriate.
- (xi) Once the assessment has been completed the local authority should send a report to the nominated officer at the hospital stating whether, in its opinion, the visit would be in the best interests of the child. The decision should take account of:
- the nature (for example, quality and duration) of the child's attachment to the patient;
  - past abuse and/or risk of significant harm to the child from the named patient;
  - the views of the child, taking account of his age and understanding, and of those with parental responsibility and, if different, person(s) with day to day care for the child;
  - the opinions of professionals who have knowledge of the child; and
  - the provider's assessment.
- (xii) If the person(s) with parental responsibility refuses to co-operate with the local authority assessment, the local authority should consider its legal position. If the child is known to the local authority, it could make its report on the basis of the information it has already, but make it clear that the information is not up to date and does not take account of the wishes and feelings of the child. If the local authority holds no information about the child, it will be unable to make any report to the hospital. This information should be conveyed to the hospital.
- (xiii) If the relevant local authority concludes that a visit is not or may not be in the child's best interests, the nominated officer must not allow the visit to take place (paragraph (3)(7) of the Directions). The decision to refuse the visit must be put in writing to the patient, the child (if appropriate), those with parental responsibility, person(s) with day to day care for the child, if different, and the local authority. Details of the complaints procedure should be given. If the local authority advises that, in their view, a visit would be in the child's best interests, the nominated officer should make a decision following discussion with the local authority. This should take account of shared information relating to any potential risk posed by the patient, and the potential risk of significant harm being suffered by the child (paragraph (3)(6) of the Directions).
- (xiv) Any visits by children must take place in an appropriate setting designated for visits by children and not in ward areas. Visits must be properly supervised. A child visiting a hospital may only have contact with the named patient for whom a visit has been approved. Areas designated for child-visiting should be child-centred and child-friendly, taking account of the age of the children, whilst maintaining the required level of security. The nominated officer must ensure there are sufficient staff, of an appropriate grade and with requisite knowledge and understanding, present to supervise children's visits at all times and to prevent unauthorised contacts (paragraph (7)(1)(e) of the Directions). Paragraph (7)(1)(d) of the Directions allows for a visit to take place in exceptional circumstances in an area or place not designated for child visits. This is to cover exceptional circumstances, such as a patient's serious illness. In such circumstances, the place for the visit must be appropriate, not detrimental to the child, and be approved by the nominated officer.

- (xv) The nominated officer must ensure that a child's contact with a patient within the hospital takes place at a frequency which is in the child's best interests, taking account of advice from the local authority. All visits by children should specifically authorised by the nominated officer.
  - (xvi) The nominated officer has the right to refuse a visit, for example, if there are concerns about the patient's mental state at the time of the visit (paragraph (4)(3) of the Directions). The reasons for the refusal should be explained to the patient, those with parental responsibility, people with day to day care for the child, if different, and, if appropriate, the child.
19. The flow chart attached at **Annex A** details these processes for identifying whether the visit is in the child's best interests.

## Visits in exceptional circumstances

20. Paragraph (6)(1) of the Directions permits the Chief Executive or Executive Director of a Trust to allow a visit from a child pending the full assessment, in exceptional circumstances, such as serious illness, death or visitors from overseas (paragraph (3) of the Directions). Paragraph (6)(2) makes clear that this discretion does not apply to a patient described in paragraph (2)(2)(b) of the Directions and the child does not fit the relationship criteria.

## Child safeguarding

21. Providers are responsible for ensuring the safety and promoting the best interests of children in contact with patients in high security hospitals. To address this matter, providers should have child safeguarding policies. There should be an annual review of children in contact with patients in high security hospitals to ensure that contact remains in the child's best interests. This review should take account of the child's views.
22. The nominated officer for each hospital should work closely with the local authority in developing its child safeguarding policies and procedures. Providers should have agreed consistent procedures across all sites. They should include the management of any information giving rise to concern about a child's welfare or protection which is disclosed to any member of the hospital staff during the course of their work. The procedures should make clear the lines of accountability for action by staff in relation to these concerns.
23. Providers should delegate responsibility to named senior managers for:
- (i) development and updating of policies, procedures and training programmes;
  - (ii) the operation and dissemination of child safeguarding procedures; and
  - (iii) a rolling programme of training to support the dissemination of the procedures which is monitored and reviewed over time.
24. Staff induction programmes should include training in child safeguarding procedures. Regular monitoring and review mechanisms should be developed to ensure that policies, procedures and practices adhere to the best contemporary standards in the field of child safeguarding. In addition, staff who will come into contact with children in the course of their work should be in receipt of appropriate professional supervision.

## Other contact with children

25. Patients in high secure hospitals may occasionally have contact with children outside of these arrangements for child visiting, for example, when patients are on medical leave of absence or when patients make a phone call. Providers should have clear and robust procedures in place for making decisions about such contacts in a way that is fair and transparent and in the best interests of the child.

## Annual report

26. An annual report on the implementation of the directions and the guidance must be submitted on an annual basis (direction 8). This can be included in other reports.

## Monitoring of the Directions

27. NHS England has mechanisms in place to assure itself of the safety and security of high secure services and will monitor the implementation of the directions through these mechanisms.

Annex A

Visits process flowchart

