Dorset Safeguarding Children Board

Bournemouth & Poole Local Safeguarding Children Board

Introduction to the pan-Dorset Inter-agency Safeguarding Procedures

Dorset's children should all be able to grow up in circumstances where they are safe and supported, so that they can have the best opportunities throughout childhood, teenage years and into adulthood.

To achieve this, organisations need to work together to safeguard children and prevent them from suffering harm.

Therefore the Dorset Safeguarding Children Board and the Bournemouth & Poole Local Safeguarding Children Board have developed procedures in order to provide all organisations working with children and young people with clear processes for responding to concerns about a child.

The pan-Dorset Inter-agency Safeguarding Procedures have been produced on behalf of the following agencies who are a part of the LSCBs:

- Dorset PCT
- Dorset Community Health Service
- Dorset County Council
- Bournemouth Borough Council
- Borough of Poole
- Dorset Police
- Dorset Healthcare University NHS Foundation Trust
- Dorset County Hospital NHS Foundation Trust
- CAFCASS
- Dorset Probation Services
- UK Border Agency
- Purbeck District Council
- North Dorset District Council
- Weymouth & Portland Borough Council
- Christchurch Borough Council
- East Dorset District Council
- West Dorset District Council

The Pan-Dorset Inter-agency safeguarding procedures are relevant for professionals (including unqualified and volunteer staff) and front-line staff/managers who have a responsibility for safeguarding and promoting the welfare of children.

To find out more about the work of both LSCBs and access the Pan-Dorset procedures, please go to:

www.dorsetlscb.co.uk/site/advice-for-people-working-with-children/local-inter-agency-procedures

or

www.bournemouth-poole-lscb.org.uk/inter-agency_safeguarding_procedures

The procedures are no longer available in a hard copy due to the regular update and review of content. The DSCB recommends that you do not print these procedures but refer to them electronically. In order to access directly, save this page to your internet favourites and put a note in staff areas informing them of how to access this and/or print the web-link and put this on staff notice boards explaining how to access the procedures via your computers

As procedures are updated they will be clearly marked on the website as 'updated' and each chapter will have a date of latest update marked on it.

You should receive updates by email via the safeguarding lead in your organisation. However, if you have a query about accessing the procedures, please contact:

Dorset LSCB:	01305 221196	s.j.ferguson@dorsetcc.gov.uk
Bournemouth & Poole LSCB:	01202 458873	lynn.hall@bournemouth.gov.uk

Content of the Procedures

The procedures are displayed in 4 chapters:

1. Introduction
2. Managing Individual Cases in Bournemouth, Dorset & Poole.
3. Bournemouth, Dorset & Poole: Locally agreed protocols for Managing Individual Cases.
4. Good Practice Guidance

Please access the chapter and sub-section relevant to your concern.

You will also find a copy of Working Together to Safeguard Children 2010 as a part of the procedures; this is attached as an additional document at the end of the procedures. This is the statutory guidance on which the procedures are based and was last revised by central government in March 2010.

Following the revision of this statutory guidance, the pan-Dorset Policy & Procedures group has updated the content of the pan-Dorset Inter-agency Safeguarding Procedures ensuring they reflect current expectation of practice.

If you have any comments or queries about the pan-Dorset procedures please contact your relevant LSCB Business Manager at:

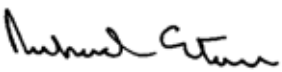
Dorset:	n.halsey@dorsetcc.gov.uk
Bournemouth & Poole:	g.nash@poole.gov.uk

Equality Impact Assessment

The Inter-Agency Safeguarding Children Procedures underwent an Equality Impact Assessment in August 2009. The assessment found that the:

"Implementation of the Safeguarding Children policies complied with anti-discrimination legislation and does **not** include discriminatory conditions or requirements in relation to age, colour, disability or illness, ethnic origin, gender, marital status, nationality, race, religion or belief, sexual orientation or social background."

Yours Sincerely,



Richard Stowe
Independent Chair
Dorset LSCB

Ron Lock
Independent Chair
Bournemouth & Poole LSCB

Dorset Safeguarding Children Board

Bournemouth & Poole Local Safeguarding Children Board

CONTENTS

PART 1

Chapter 1.1 Introduction
Chapter 1.2 Contents

Chapter 2 Managing Individual Cases in Bournemouth, Dorset and Poole

2.1 Introduction
2.2 Working with children about whom there are child welfare concerns
2.3 Principles underpinning work to safeguard and promote the welfare of children
2.5 The process for safeguarding and promoting the welfare of children
2.7 Being alert to children's welfare
2.14 The welfare of unborn children
2.15 Referrals to children's services where there are child welfare concerns
2.17 Responding to child welfare concerns where there is or may be an alleged crime
2.23 Allegations of harm arising from underage sexual activity
2.31 Fabricated or induced illness
2.42 Response of children's services to a referral
2.48 Initial assessment
2.58 Next steps – child in need but no suspected, actual or likely significant harm
2.60 Next steps – child in need and suspected actual or likely significant harm
2.61 Immediate protection
2.66 Strategy discussion
2.76 Co-ordination of strategy meetings where the children are from more than one family
2.78 Section 47 enquiries and core assessment
2.86 Child assessment orders
2.87 The impact of section 47 enquiries on the family and child
2.90 The outcome of section 47 enquiries
2.91 The concerns are not substantiated
2.93 Concerns are substantiated, but the child is not judged to be at continuing risk of significant harm
2.97 Concerns are substantiated and the child is judged to be at continuing risk of significant harm
2.98 The Initial Child Protection Conference
2.157 Action following the Initial Child Protection Conference
2.177 The Child Protection Review Conference
2.186 Children Looked After by the Local Authority
2.188 Adoption
2.189 Historical Allegation

2.190 Pre-birth Child Protection Conferences and Reviews
2.191 Recording that a child is the subject of a child protection plan
2.193 Managing and providing information about a child
2.203 Recording
2.206 Request for a change of worker

2.207 Effective support and supervision

Flow chart 1 – Referral
Flow chart 2 – What happens following initial assessment?
Flow chart 3 – Urgent action to safeguard children
Flow chart 4 – What happens after the strategy discussion?
Flow chart 5 – What happens after the Child Protection Conference, including the review process?

Chapter 3 Bournemouth, Dorset and Poole Locally agreed protocols for Managing Individual Cases

3.1 Guidance on Consent, Confidentiality and Information Sharing
3.2 Dorset Police/Bournemouth, Dorset and Poole Children & Families Joint Working Arrangements
3.3 LSCB Child Protection Conference Complaints Procedure
3.4 (A and B) Sexual Exploitation of Children & Young People
3.5 Serious Case Reviews
3.6 Sudden Unexpected Deaths in Childhood
3.7 Children who are subject to Protection Plans who are Looked After
3.8 Joint Mental Health, Substance Misuse & Childcare Protocol
3.9 Managing Allegations against People who Work with Children
3.10 Missing Children
3.11 Managing Individuals who may Pose a Risk of Harm to Children
3.12 Notifications and Transferring Information
3.13 Safeguarding Children who may be trafficked
3.14 Domestic Violence

Chapter 4 Good Practice Guidance

4.1 Safer Recruitment
4.2 Safe Practice
4.3 Child Performance Working Practice Guidance
4.4 Text Messaging

PART 2 Working Together To Safeguard Children 2010

Bournemouth & Poole Local Safeguarding Children Board

Dorset Safeguarding Children Board

PAN DORSET INTER-AGENCY SAFEGUARDING PROCEDURES

CHAPTER 2

MANAGING INDIVIDUAL CASES IN BOURNEMOUTH, DORSET AND POOLE

Procedures Effective from: **November 2010**

Review Date: **2012**

If you have any comments or queries about the pan-Dorset procedures please contact your agency representative on the Pan Dorset Policy and Procedures Group or notify the LSCB using the following email addresses:

info@dorsetlscb.co.uk
info@bournemouth-poole-lscb.org.uk

Introduction

Chapter 2 of the Dorset, Bournemouth and Poole Inter-agency procedures for safeguarding children and young people have been revised following the publication of "Working Together to Safeguard Children" (Department for Children, Schools and Families 2010). This document was approved by the multi-agency pan-Dorset Policy & Procedures Group on 19.10.2010.

It replaces the previous Chapter 2 of the Inter-agency Area Child Protection Procedures, 2006.

This document recreates the full text of "Working Together to Safeguard Children" DCSF 2010, supplementing it with Pan-Dorset agreed policy and protocol. The Working Together text has also had yellow highlights added to show where changes are made between the 2006 and 2010 versions. It is hoped this will assist those reading it to understand new expectations as well as local protocols.

"Safeguarding children" is everyone's responsibility and all are encouraged to read thoroughly the contents of this document.

CONTENTS

Introduction 5

Working with children about whom there are child welfare concerns 5

Principles underpinning work to safeguard and promote the welfare of children 6

The processes for safeguarding and promoting the welfare of children 9

Being alert to children's welfare 9

Use of the Common Assessment Framework 10

Discussion of concerns about a child's safety and welfare 11

The welfare of unborn children 11

Referrals to local authority children's social care where there are concerns about a child's safety or welfare 11

Responding to child welfare concerns where there is or may be an alleged crime 12

Response of local authority children's social care to a referral 17

Initial Assessment 19

Next steps – child in need but no suspected actual or likely significant harm 24

Next steps – child in need and suspected actual or likely significant harm 25

Immediate Protection 25

Strategy Discussion 26

Section 47 Enquiries and Core Assessment 30

Child Assessment Orders 32

The Impact of s47 Enquiries on the Family and Child 33

The Outcome of S47 Enquiries 33

Concerns are not substantiated 34

Concerns are substantiated, but the child is not judged to be at continuing risk of significant harm 34

Concerns are substantiated and the child is judged to be at continuing risk of significant harm 35

The Initial Child Protection Conference 36

Purpose 36

Timing 36

Attendance 36

Involving the Child and Family Members 37

Chairing the Conference 42

Information for the Conference 42

Action and Decisions for the Conference 44

Chair's right to overrule 1

Complaints about a Child Protection Conference 49
Administrative arrangements and record keeping 49
Action Following the Initial Child Protection Conference 50
The Role of the Lead Social Worker 50
The Core Group 50
Completion of the Core Assessment 51
The Child Protection Plan 52
Agreeing the plan with the child 53
Negotiating the plan with parents 53
Intervention 53
The Child Protection Review Conference 55
Timescale 55
Purpose 56
Discontinuing the Child Protection Plan 57
Children Looked After by the Local Authority 58
Pre-Birth Child Protection Conferences and Reviews 60
Recording that a child is the subject of a child protection plan 60
Managing and Providing Information about a Child 61
Recording in individual cases 62
Request for a change of worker 64
Effective Support and Supervision ..... **Error! Bookmark not defined.**
Flow Chart 1: Referral 65
Flow Chart 2: What happens following initial assessment 66
Flow chart 3: Urgent action to safeguard children 67
Flow chart 4: What happens after the strategy discussion? 68
Flow chart 5: What happens after the child protection conference, including the review process? 69

Introduction

2.1. This chapter provides guidance on what should happen if somebody has concerns about the safety and welfare of a child (including those living away from home) and in particular, concerns that a child may be suffering, or is likely to suffer, significant harm. It incorporates the guidance on information sharing and sets out the principles which underpin work to safeguard and promote the welfare of children. Fundamental to safeguarding and promoting the welfare of each child is having a child centred approach. This means seeing the child and keeping the child in focus throughout assessments, while working with the child and family, and when reviewing whether the child is safe and his or her needs are being met. Undertaking direct work with the child is key: seeing the child alone when appropriate, ascertaining the child's wishes and feelings and understanding the meaning of their daily life experiences to them. Throughout this process, the safety of the child should be ensured.

2.2. This chapter is not intended as a detailed practice guide but it sets out clear expectations about the ways in which agencies and professionals should work together to safeguard and promote the welfare of children. In addition, the related practice guidance *What to do if you're worried a child is being abused*[1] is intended to be an accessible resource for practitioners and first line managers to use in their every day work.

Working with children about whom there are child welfare concerns

2.3. Achieving good outcomes for children requires all those with responsibility for assessment and the provision of services to work together according to an agreed plan of action. Effective collaboration requires organisations and people to be clear about:

- their roles and responsibilities for safeguarding and promoting the welfare of children (see the *Statutory guidance on making arrangements to safeguard and promote the welfare of children under section 11 of the Children Act 2004* (2007) and Chapter 2);
- the purpose of their activity, the decisions that are required at each stage of the process and what are the planned outcomes for the child and family members;
- the legislative basis for the work;
- the protocols and procedures to be followed, including the way in which information will be shared across professional boundaries and within agencies, and be recorded for each child;
- which organisation, team or professional has lead responsibility, and the precise roles of everyone else who is involved, including the way in which children and family members will be involved; and
- any timescales set down in regulations or guidance which govern the completion of assessments, making of plans and timing of reviews.

[1] www.dcsf.gov.uk/safeguarding

Principles underpinning work to safeguard and promote the welfare of children

2.4. The following principles, which draw on findings from research, underpin work with children and their families to safeguard and promote the welfare of children (see also paragraph 2.18 in the Guidance issued under S11 of the Children Act 2004). These principles should be followed when implementing the guidance set out in this chapter. They will be relevant to varying degrees depending on the functions and level of involvement of the organisation and the individual practitioner concerned.

2.5. Work to safeguard and promote the welfare of children should be:

- **Child centred**

The child should be seen (alone when appropriate) by the lead social[2] in addition to all other professionals who have a responsibility for the child's welfare. His or her welfare should be kept sharply in focus in all work with the child and family. The significance of seeing and observing the child cannot be overstated. The child should be spoken and listened to, and their wishes and feelings ascertained, taken into account (having regard to their age and understanding) and recorded when making decisions about the provision of services. Some of the worst failures of the system have occurred when professionals have lost sight of the child and concentrated instead on their relationship with the adults.

- **Rooted in child development**

Those working with children should have a detailed understanding of child development and how the quality of the care they are receiving can have an impact on their health and development. They should recognise that as children grow, they continue to develop their skills and abilities. Each stage, from infancy through middle years to adolescence, lays the foundation for more complex development. Plans and interventions to safeguard and promote the child's welfare should be based on a clear assessment of the child's developmental progress and the difficulties the child may be experiencing. Planned action should also be timely and appropriate for the child's age and stage of development.

- **Focused on outcomes for children**

When working directly with a child, any plan developed for the child and their family or caregiver should be based on an assessment of the child's developmental needs and the parents/caregivers' capacity to respond to these needs within their family and environmental contexts. The plan should set out the planned outcomes for each child; progress against these should be regularly reviewed and the actual outcomes should be recorded.

The purpose of all interventions should be to achieve the best possible outcomes for each child, recognising that each child is unique. These outcomes should contribute to the key outcomes set out for all children in the Children Act 2004 (see paragraph 1.1). and at review the actual outcomes should be recorded.

- **Holistic in approach**

Having an holistic approach means having an understanding of a child within the context of their family (parents or caregivers and the wider family) and of the educational setting,

[2] Local authority children's social care is required by the Children Act 1989 (as amended by section 53 of the Children Act 2004) to ascertain the child's wishes and feelings and to give due consideration to the child's wishes and feelings having regard to their age and understanding, when determining what (if any) services to provide.

community and culture in which he or she is growing up. The interaction between the developmental needs of children, the capacities of parents or caregivers to respond appropriately to those needs and the impact of wider family and environmental factors on children and on parenting capacity requires careful exploration during an assessment.

The ultimate aim is to understand the child's developmental needs and the capacity of the parents or caregivers to meet them and to provide services to the child and to the family members that respond to these needs. The child's context will be even more complex when they are living away from home and looked after by adults who do not have parental responsibility for them.

- **Ensuring equality of opportunity**

Equality of opportunity means that all children have the opportunity to achieve the best possible developmental outcomes, regardless of their gender, ability, race, ethnicity, circumstances or age. Some vulnerable children may have been particularly disadvantaged in their access to important opportunities, and their health and educational needs will require particular attention in order to optimise their current welfare as well as their long-term outcomes in young adulthood.

- **Involving of children and families**

In the process of finding out what is happening to a child it is important to listen to the child develop a therapeutic relationship with the child and through this gain an understanding of his or her wishes and feelings.

The importance of developing a co-operative working relationship is emphasised, so that parents or caregivers feel respected and informed, they believe staff are being open and honest with them, and in turn they are confident about providing vital information about their child, themselves and their circumstances. The consent of children or their parents/caregivers, where appropriate, should be obtained for sharing information unless to do so would place the child at risk of significant harm. Similarly, decisions should also be made with their agreement, whenever possible, unless to do so would place the child at risk of significant harm.

- **Building on strengths as well as identifying difficulties**

Identifying both strengths (including resilience and protective factors) and difficulties (including vulnerabilities and risk factors) within the child, his or her family and the context in which they are living is important, as is considering how these factors have an impact on the child's health and development. Too often it has been found that a deficit model of working with families predominates in practice, and ignores crucial areas of success and effectiveness within the family on which to base interventions. Working with a child or family's strengths becomes an important part of a plan to resolve difficulties.

- **Integrated approach**

From birth, there will be a variety of different agencies and services in the community involved with children and their development, particularly in relation to their health and education. Multi and inter-agency work to safeguard and promote children's welfare starts as soon as it has been identified that the child or family members have additional needs requiring support / services beyond universal service, not just when there are questions about possible harm.

- **A continuing process not an event**

Understanding what is happening to a vulnerable child within the context of his or her family and the local community, and taking appropriate action are continuing and interactive processes and not single events. Assessment should continue throughout a period of intervention, and intervention may start at the beginning of an assessment.

- **Providing and reviewing services**

Action and services should be provided according to the identified needs of the child and family in parallel with assessment where necessary. It is not necessary to await completion of the assessment process. Immediate and practical needs should be addressed alongside more complex and longer term ones. The impact of service provision on a child's developmental progress should be reviewed at regular intervals.

- **Informed by evidence**

Effective practice with children and families requires sound professional judgements which are underpinned by a rigorous evidence base, and draw on the practitioner's knowledge and experience. Decisions based on these judgements should be kept under review, and take full account of any new information obtained during the course of work with the child and family.

The processes for safeguarding and promoting the welfare of children

2.6. Four key processes underpin work with children and families, each of which has to be carried out effectively in order to achieve improvements in the lives of children in need. They are assessment, planning, intervention and reviewing as set out in the Integrated Children's System (Department of Health, 2002).

2.7. The flow charts at the end of this chapter illustrate the processes for safeguarding and promoting the welfare of children:

- from the point that concerns are raised about a child and are referred to a statutory organisation that can take action to safeguard and promote the welfare of children (Flow chart 1);
- through an initial assessment of the child's situation and what happens after that (Flow chart 2);
- taking urgent action, if necessary (Flow chart 3);
- to the strategy discussion, where there are concerns about a child's safety, and beyond that to the child protection conference (Flow chart 4); and
- what happens after the child protection conference, and the review process (Flow chart 5).

Being alert to children's welfare

2.8. Everybody who works or has contact with children, parents, and other adults in contact with children should be able to recognise, and know how to act upon, evidence that a child's health or development is or may be being impaired - especially when they are suffering, or likely to suffer significant harm. Practitioners, foster carers, and managers should be mindful always of the safety and welfare of children – including unborn children, older children and children living away from home or looked after by the local authority – in their work:

<u>With children</u>

2.9. *For example*: early years staff, teachers, school nurses, health visitors, GPs, Accident and Emergency and all other hospital staff, and staff, in the youth justice system, including the secure estate, should be able to recognise situations where a child requires extra support to prevent impairment to his or her health or development or possible signs or symptoms of abuse or neglect in children. All professionals working with children and especially those in health and social care should be familiar with the core standards set out in the *National Service Framework for Children, Young People and Maternity Services Core Standards* and in particular, standard 5 *Safeguarding and Promoting the Welfare of Children and Young People.*

Those working with children living away from home should also be familiar with the relevant statutory Regulations and National Minimum Standards[3]. Children living in custodial settings should be assessed as potential children in need under section 17 of the Children Act 1989 and all children subject to a court ordered secure remand (COSR) automatically acquire the status of a looked after child.

With parents or caregivers who may need help in promoting and safeguarding their children's welfare

2.10. *For example:* adult mental health, substance misuse services and criminal justice agencies should always consider the implications for children of patients' or users' behaviours and the impact they may have on their parenting capacity. Day nurseries, children's and family centres should keep the interests of children uppermost in their minds when working with parents, work in ways intended to bring about better outcomes for children, and be alert to possible signs or symptoms of abuse or neglect. When dealing with cases of domestic violence, the police and other involved agencies should consider the impact that this behaviour has on children, in particular their emotional development, and the victim's capacity to protect a child from harm and meet their identified needs.

With family members, employees, or others who have contact with children

2.11. *For example:* the police probation and prison services, mental health services, and housing authorities should be alert to the possibility that an individual may pose a risk of causing harm to a particular child, or to children in a local community. Employers of staff or volunteers who have substantial unsupervised access to children should guard against the potential for abuse or neglect, through rigorous selection processes, appropriate supervision and by taking steps to maintain a safe environment for children. For further details on this matter see Chapter 12 Working Together to Safeguard Children 2010

Use of the Common Assessment Framework

2.12. The Common Assessment Framework (CAF) offers a basis for early identification of children's additional needs, sharing of this information between organisations and the co-ordination of service provision. Where it is considered a child may have additional needs, with the consent of the child, young person or parents/carers, practitioners may undertake a common assessment in accordance with the national practice guidance[4] to assess these needs and to decide how best to support them. The findings from the common assessment may however give rise to concerns about a child's safety and welfare. Practitioners should be particularly concerned regarding children whose parents or caregivers are experiencing difficulties in meeting their needs as a result of domestic violence, substance misuse, mental illness and/or learning disability (see paragraphs 9.13–9.66). All staff members who have or become aware of concerns about the safety or welfare of a child or children should know:

- who to contact in what circumstances, and how; and
- when and how to make a referral to local authority children's social care services or the police.

[3] www.dcsf.gov.uk/everychildmatters/safeguardingandsocialcare/childrenincare/childrenincare/
[4] See www.dcsf.gov.uk/everychildmatters/strategy/deliveringservices1/caf/caframework

Discussion of concerns about a child's safety and welfare

2.13. Irrespective of whether a common assessment has been undertaken, where there are concerns that a child may be a possible child in need, and in particular where there are concerns about a child being harmed, relevant information about the child and family should be discussed with a manager, or a named or designated health professional or a designated member of staff depending on the organisational setting. Concerns can also be discussed, without necessarily identifying the child in question, with senior colleagues in another agency, (for example, children's social care services) in order to develop an understanding of the child's needs and circumstances.

2.14. Where a child is not considered to be a possible child in need under section 17 of the Children Act 1989 the practitioner should consider what other types of services, including possibly a common assessment, should be offered. If it is agreed that the child may be a child in need under the Children Act 1989 (see paragraph 1.25), then a referral to children's social care should be discussed with the child and parents. If they consent, then the child should be referred to local authority children's social care and the processes set out in this chapter followed. If the child is believed or suspected to be suffering significant harm a referral should always be made to children's social care (see paragraph 2.17 below). If concerns arise about a child who is already known to local authority children's social care the allocated social worker should be informed immediately of these concerns.

2.15. There should always be the opportunity to discuss concerns about a child's safety and welfare with, and seek advice from, colleagues, managers, a designated or named professional, or other agencies but:

- never delay emergency action to protect a child from harm;
- always record in writing concerns about a child's welfare, including whether or
- not further action is taken; and
- always record in writing discussions about a child's welfare in the child's file. At the close of a discussion, always reach a clear and explicit recorded agreement about who will be taking what action or that no further action will be taken.

The welfare of unborn children

2.16. The procedures and time scales set out in this chapter should also be followed when there are concerns about the welfare of an unborn child.

Referrals to local authority children's social care where there are concerns about a child's safety or welfare

2.17. Local authorities with children' services functions have particular responsibilities towards all children whose health or development may be impaired without the provision of services, or who are disabled (defined in the Children Act 1989 as 'children in need'). Where a child is considered to be a possible child in need a referral to children's social care should be made in accordance with the agreed LSCB procedures and formats. Where a common assessment has already been

undertaken it should be used to support a referral to children's social care: however undertaking a CAF is not a prerequisite for making a referral.

2.18. If somebody believes that a child may be suffering, or is likely to suffer, significant harm, then s/he should always refer his or her concerns to the local authority children' social care services. In addition to social care, the police and the NSPCC have powers to intervene in these circumstances.

Pan-Dorset Note
In exceptional circumstances the situation may be so urgent as to require an emergency police response, in which case professionals should dial 999.

2.19 Sometimes concerns will arise within children's services itself, as new information comes to light about a child and family with whom staff are already in contact. While professionals should seek, in general, to discuss any concerns with the family and, where possible, seek their agreement to making referrals to children's services, **this should only be done where such discussion and agreement-seeking will not place a child at increased risk of significant harm**.

Pan-Dorset Note
It should be noted however, that professionals cannot make anonymous referrals.

Responding to child welfare concerns where there is or may be an alleged crime

2.20 Whenever local authority children's social care have a case referred to them which constitutes, or may constitute, a criminal offence against a child, they should always discuss the case with the police at the earliest opportunity.

2.21 Whenever other agencies, or the Local Authority (LA) in its other roles, encounter concerns about a child's welfare which constitute, or may constitute, a criminal offence against a child, they must always consider sharing that information with children's services or the police in order to protect the child or other children from suffering significant harm. If a decision is taken not to share information, the reasons must be recorded.

2.22 Sharing of information in cases of concern about children's welfare will enable professionals to consider jointly how to proceed in the best interests of the child and to safeguard children more generally (see paragraph 2.3).

2.23 In dealing with alleged offences involving a child victim, the police should normally work in partnership with children's services and/or other agencies. In circumstances where it is suspected that the child may have been conceived as a result of an incestuous relationship or interfamilial abuse, consideration should be given to the use of DNA testing and the role of genetics and geneticists. Whilst the responsibility to instigate a criminal investigation rests with the police, they should consider the views expressed by other agencies. There will be less serious cases where, after discussion, it is agreed that the best interests of the child are served by a children's services led intervention rather than a full police investigation.

2.24 In deciding whether there is a need to share information, professionals should consider their legal obligations, including whether they have a duty of confidentiality to the child. Where there is such a duty, the professional may

Where there is a clear likelihood of a child suffering significant harm or an adult suffering serious harm, the public interest test will almost certainly be satisfied. However, there will be other cases where practitioners will be justified in sharing some confidential information in order to make decisions on sharing further information or taking action - the information shared should be proportionate.

2.25 The child's best interests must be the overriding consideration in making any such decision including in the cases of underage sexual activity on which detailed guidance is given below. The cross-government guidance, Information sharing; Guidance for practitioners and managers (2008) provides advice on these issues[5]. Any decision whether or not to share information must be properly documented. Decisions in this area need to be made by, or with the advice of, people with suitable competence in child protection work such as named or designated professionals or senior managers.

Allegations of harm arising from underage sexual activity

2.26 Cases of underage sexual activity which present cause for concern are likely to raise difficult issues and should be handled particularly sensitively[6]. This includes situations where girls aged under 16 years present at a termination of pregnancy.

2.27 A child under 13 is not legally capable of consenting to sexual activity. Any offence under the Sexual Offences Act 2003 involving a child under 13 is very serious and should be taken to indicate that the child is suffering, or is likely to suffer, significant harm.

2.28 Cases involving children aged under 13 years should always be discussed with a nominated child protection lead in the organisation. Under the Sexual Offences Act, penetrative sex with a child under 13 is classed as rape. Where the allegation concerns penetrative sex, or other intimate sexual activity occurs, there would always be reasonable cause to suspect that a child, whether girl or boy, is suffering or is likely to suffer significant harm. There should be a presumption that the case will be reported to children's social care and that a strategy discussion will be held in accordance with the guidance set out in paragraph 2.56 below. This should involve children's social care, police, health and other relevant agencies in discussing appropriate next steps with the professional. All cases involving under 13s should be fully documented including detailed reasons where a decision is taken not to share information. These decisions should be exceptional and only made with the documented approval of a senior manager.

2.29 Sexual activity with a child under 16 is also an offence. Where it is consensual it may be less serious than if the child were aged under 13 years but may, nevertheless, have serious consequences for the welfare of the young person. Consideration should be given in every case of sexual activity involving a child aged 13-15 as to whether there should be a discussion with other agencies and whether a referral should be made to children's social care. The professional should make this assessment using the considerations below. Within this age range, the younger the child, the stronger the presumption must be that sexual activity will be a

[5] See www.dcsf.gov.uk/informationsharing
[6] Further guidance is provided by the Department of Health best practice guidance for doctors and other health professionals on the provision of advice and treatment to young people under 16 on contraception, reproductive and sexual health.

matter of concern. Cases of concern should be discussed with the nominated child protection lead and subsequently with other agencies if required. Where confidentiality needs to be preserved, a discussion can still take place as long as it does not identify the child (directly or indirectly). Where there is reasonable cause to suspect that significant harm to a child has occurred or is likely to occur, there would be a presumption that the case is reported to children's services and a strategy discussion should be held to discuss appropriate next steps. Again, all cases should be carefully documented including where a decision is taken not to share information.

2.30 The considerations in the following checklist should be taken into account when assessing the extent to which a child (or other children) is suffering or is likely to be suffer, significant harm, and therefore the need to hold a strategy discussion in order to share information:

- the age of the child. Sexual activity at a young age is a very strong indicator that there are risks to the welfare of the child (whether boy or girl) and, possibly, others;
- the level of maturity and understanding of the child;
- what is known about the child's living circumstances or background;
- age imbalance, in particular where there is a significant age difference;
- overt aggression or power imbalance;
- coercion or bribery;
- familial child sex offences;
- behaviour of the child i.e. withdrawn, anxious;
- the misuse of substances as a disinhibitor;
- whether the child's own behaviour, because of the misuse of substances, places him/her at risk of harm so that he/she is unable to make an informed choice about any activity;
- whether any attempts to secure secrecy have been made by the sexual partner, beyond what would be considered usual in a teenage relationship;
- whether the child denies, minimises or accepts concerns;
- whether the methods used are consistent with grooming; and
- whether the sexual partner/s is known by one of the agencies.

2.31 In cases of concern, when sufficient information is known about the sexual partner/s the agency concerned should check with other agencies, including the police, to establish whatever information is known about that person/s. In appropriate cases the police may share the required information without beginning a full investigation if the agency making the check requests this.

2.32 Sexual activity involving a 16 or 17 year old, even if it does not involve an offence, may still involve harm or the likelihood of harm being suffered. Professionals should still bear in mind the considerations and processes outlined in this guidance in assessing whether harm is being suffered, and should share information as appropriate. It is an offence for a person to have a sexual relationship with a 16 or 17 year old if they hold a position of trust or authority in relation to them.

Pan Dorset Note
Appendix 3.4 of the Local Inter-agency Safeguarding Procedures cover this area and are supported by inter-agency training, which will offer more detailed guidance in this area of work.

Pan Dorset Note - Fabricated or Induced Illness

A protocol is being developed for inclusion in Local Inter-agency Safeguarding Procedures.

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

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

There may be a number of explanations for these circumstances and each requires careful consideration and review.

There are three main ways of fabricating or inducing illness in a child. These are not mutually exclusive:

- fabrication of signs and symptoms. This may include fabrication of past medical history;
- fabrication of signs and symptoms and falsification of hospital charts and records, and specimens of bodily fluids. This may also include falsification of letters and documents
- induction of illness by a variety of means.

Professionals should be alert to the possibility of fabricated or induced illness, in which a child is presented for medical treatment as sick, but the signs and/or symptoms have been fabricated, exaggerated or even induced, with the intention of obtaining unnecessary medical attention and/or treatment for the child. This is not to be confused with anxious or even overly anxious parents who want to ensure that their child's health is given the best attention possible and may inadvertently exaggerate the symptoms or the need for further tests to explore a diagnosis for their child's ill health.

When a possible explanation for the signs and symptoms present in a child is that they may have been fabricated or induced by a parent/carer and as a consequence the child's health or development is, or is likely to be impaired, a referral should be made to children's services. The same action should be taken when a pregnant woman is identified as having a history of fabricating illness in herself and/or there is evidence of illness being fabricated or induced in an older sibling or another child. Additionally it should be noted that children can be subjected to abuse by those who work with them in any and all settings.

A referral to children's services about fabricated or induced illness should be followed by a strategy meeting to include at a minimum, a consultant paediatrician with police and children's services. The strategy meeting will follow the guidance and requirements as set out in paragraph 2.58 of these procedures.

It is important to note that whilst it is normally appropriate to discuss concerns with parents/carers and seek their permission to making referrals to children's services, in cases of suspected fabricated or induced illness, parents should not be alerted to the referral or to a strategy meeting until/unless the meeting or strategy discussion agrees that this is appropriate. In all cases where the police are involved, the decision about when to inform the parents must be first agreed with the police.

The strategy meeting will need to consider whether to collate relevant information about a child about whom there are concerns regarding fabricated or induced illness and which agency should do so. These records should provide a detailed chronology of the case, including the medical, psychiatric and social histories of the child, parents/carers, siblings and other significant family members.

This chronology will enable the multi-agency group to identify patterns of presenting for medical treatment not only in relation to the child but also across generations. It will also inform decisions about intervention strategies as necessary to safeguard the child.

A child presenting health problems which may be the result of fabricated or induced illness may present as a medical emergency, for example blue attacks or fits in babies caused by intentional suffocation. However some children may present with chronic illnesses which are not immediately life threatening, and in those circumstances it may take professionals some time to recognise that the child is being abused by a parent/carer fabricating or inducing illness in the child.

It is vital that medical records are kept meticulously in situations where there are concerns about fabricated or induced illness, always recording exactly what is reported by the parent/carer and also recording exactly what was observed or evidenced by the medical staff. The majority of cases of fabricated or induced illness in children are confirmed in a hospital setting, because medical findings - or the absence of them - provide evidence of this type of abuse.

For further information including information about the main roles and responsibilities of statutory agencies, professionals, the voluntary sector and the wider community in relation to circumstances where illness has been fabricated and/or induced in a child by a carer, refer to the guidance. 'Safeguarding Children in Whom Illness is Fabricated or Induced' Department of Health, August 2002 at:

http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/fs/en

In some instances the use of covert video surveillance may be required. Good practice advice for police officers in relation to this is available from the National Crime Faculty.

Response of local authority children's social care to a referral

2.33 When a parent, professional, or another person contacts Bournemouth, Dorset or Poole children's services with concerns about a child's welfare, it is the responsibility of the Children's Services to clarify with the referrer (including self-referrals from children and families):

- the nature of concerns
- how and why they have arisen
- what appear to be the needs of the child and family; and
- what involvement they are having or have had with the child and/or family members.

2.34 The referrer should have the opportunity to discuss their concerns with a qualified social worker. The process of clarifying the nature of the referral should always identify clearly whether there are concerns about maltreatment and the associated risk factors, the evidence for these concerns and whether it may be necessary to consider taking urgent action to ensure the child(ren) are safe from harm. Local authority children's social care should specifically ask the referrer if they hold any information about difficulties being experienced in the family/household due to domestic violence, mental illness, substance misuse and/or learning disability in order to inform its decision making.

2.35 Professionals who telephone local authority children's social care should confirm referrals in writing within 48 hours. The CAF provides a structure for the written referral but prior completion of a CAF should not be a pre-requisite for a referral being accepted by the local authority. At the end of any discussion or dialogue about a child, the referrer (whether a professional or a member of the public or family) and children's services should be clear about

- the children's social care's proposed course of action in response to the referral,
- timescales and
- who will be taking this action, or
- if no further action will be taken.

The decision should be recorded by children's social care in the child's case file, and by the referrer (if a professional in another service). Local authority children's social care should acknowledge a written referral within one working day of receiving it. If the referrer has not received an acknowledgement within 3 working days, they should contact local authority children's social care again.

2.36 **Local authority children's social care should decide how they will respond to the referral and record next steps of action within one working day.** This information should be consistent with the information set out in the Referral and Information Record (DoH 2002). This decision should normally follow discussion with any referring professional/service[7], consideration of information held in any existing records, and involve discussion with other professionals and services as necessary (including the police, where a criminal offence may have been committed against a child). An initial consideration of the case should address – on the basis of the available evidence – whether there are concerns about either the child's health and development or the child suffering harm which justifies an initial assessment to establish whether this child is a child in need. Local authority children's social care should ensure that the social work practitioners who are responding to referrals are supported by experienced first line managers competent in making sound evidence based decisions about what to do next. Further action by children's social care may also include referral to other agencies, the provision of information or advice – such as suggesting the completion of a common assessment by the referring agency or organisation – or no further action.

2.37 The parents' permission, or the child's where appropriate, should be sought before discussing a referral about them with other agencies, unless permission-seeking may itself place a child at increased risk of significant harm. When responding to referrals from a member of the public rather than another professional, children's social care should bear in mind that personal information about referrers, including identifying details, should only be disclosed to third parties (including subject families and other agencies) with the consent of the referrer. In all cases where the police are involved, the decision about when to inform the parents (about referrals from third parties) will have a bearing on the conduct of police investigations.

2.38 Where local authority children's social care decide to take no further action at this stage, feedback should be provided to the referrer, who should be told of this decision and the reasons for making it. In the case of public referrals, this should be done in a manner consistent with respecting the confidentiality of the child. Sometimes it may be apparent at this stage that emergency action should be taken

[7] ContactPoint provides an efficient way for people working with children to find out who else is working with the same child. Information is available at: www.dcsf.gov.uk/ecm/contactpoint

to safeguard and promote the welfare of a child (see paragraph 2.53). Such action should normally be preceded by an immediate strategy discussion between the police, local authority children's social care and other agencies as appropriate.

2.39 New information may be received about a child or family where the child or family member is already known to local authority children's social care. If the child's case is open, and there are concerns that the child is or is likely to be suffering significant harm then a decision should be made about whether a strategy discussion should be held in order to consider whether to initiate section 47 enquiries (see paragraph 2.58). It may, also, be appropriate to consider undertaking a core assessment or to update a previous one in order to understand the child's current needs and circumstances and inform future decision making.

Initial Assessment

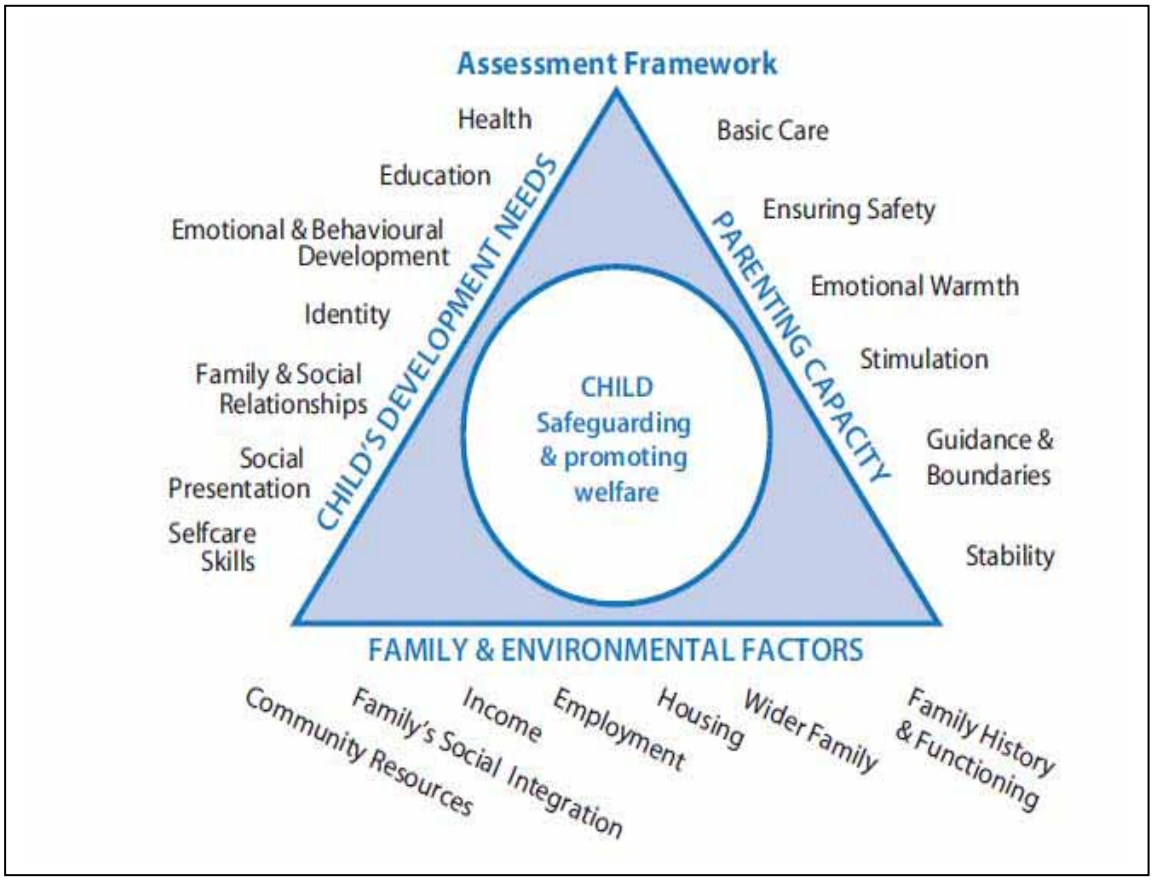
2.40 The initial assessment is a brief assessment of each child referred to local authority children's social care where it is necessary to determine whether

- the child is in need,
- there is reasonable cause to suspect the child is suffering or is likely to suffer, significant harm;
- any services required, and of what types; and
- a further, more detailed core assessment should be undertaken (paragraph 3.9 of the Framework for the Assessment of Children in Need and their Families (2000)).

2.41 The initial assessment should be completed by local authority children's social care, working with colleagues, within a maximum of ten working days of the date of referral. An initial assessment is deemed to be complete once the assessment has been discussed with the child and family (or caregivers) and the team manager has viewed and authorised the assessment. The initial assessment period may be very brief if the criteria for initiating s47 enquiries are met, ie. it is suspected that the child is suffering or is likely to suffer significant harm. The initial assessment should be undertaken in accordance with the *Framework for the Assessment of Children in Need and their Families* (Department of Health et al, 2000). Where a common assessment has been completed this information should be used to inform the initial assessment. Information should be gathered and analysed within the 3 domains of the Assessment Framework (see Figure1), namely:

- the child's developmental needs;
- the parents' or caregivers' capacity to respond appropriately to those needs; and
- the wider family and environmental factors.

Figure 1 – The Assessment Framework



2.42 The initial assessment should address the following questions:

- what are the developmental needs of the child? What needs of the child are not being met and how? What needs of the child are not being met and why not?
- are the parents able to respond appropriately to the child's identified needs? Is the child being adequately safeguarded from harm, and are the parents able to promote the child's health and development?
- what impact are family functioning (past and present) and history, the wider family and environmental factors having on the parent's capacity to respond to their child's needs and the child's developmental progress?
- is action required to safeguard and promote the welfare of the child? Within what timescales should this action be taken?

2.43 The initial assessment, should be led by a qualified and experienced social worker who is supervised by a highly experienced and qualified social work manager. It should be carefully planned, with clarity about who is doing what, as well as when and what information is to be shared with the parents. The planning process and decisions about the timing of the different assessment activities should be undertaken in collaboration with all those involved with the child and family. The process of initial assessment should involve:

- seeing and speaking to the child, including alone when appropriate
- seeing and meeting with parents, the family and wider family members, as appropriate
- involving and obtaining relevant information from professionals and other in contact with the child and family; and

- drawing together and analysing available information (focusing on the strengths and positive factors as well as vulnerabilities and risk factors) from a range of sources (including existing agency records)

Pan Dorset Note
In Bournemouth, Poole and Dorset a qualified and experienced social worker will undertake the initial assessment where concerns have been expressed about possible significant harm of a child. Other initial assessments may be completed by non-DIPSW trained scial care practitioners.

All relevant information (including information about the history and functioning of the family both currently and in the past, and Adult problems such as domestic violence, substance misuse, mental illness and criminal behaviour / convictions) should be taken into account. This includes seeking information from relevant services if the child and family have spent time abroad. Professionals from agencies such as health, local authority children's social care or the police should request this information from their equivalent agencies in the country(ies) in which the child has lived. Information about who to contact can be obtained via the Foreign and Commonwealth Office or the appropriate Embassy or Consulate based in London[8].

2.44 The child should be seen by the lead social worker, without his or her caregiver present, when appropriate, within a timescale which is appropriate to the nature of concerns expressed at the time of the referral, according to the agreed plan. Seeing the child includes observing and communicating with the child in a manner appropriate to his or her age and understanding. Local authority children's social care are required by the Children Act 1989 (as amended by s53 of the Children Act 2004) to ascertain the child's wishes and feelings and to give due consideration to the child's wishes and feelings, having regard to their age and understanding when making decisions about what (if any) services to provide. Interviews with the child should be undertaken in the preferred language of the child. For some disabled children interviews may require the use of non-verbal communication methods.

2.45 **It will not necessarily be clear whether a criminal offence has been committed**, which means that even initial discussions with the child should be undertaken in a way that minimises distress to them and maximises the likelihood that she or he will provide accurate and complete information, avoiding leading questions or suggesting answers.

2.46 Interviews with family members (which may include the child) should also be undertaken in their preferred language and where appropriate for some people by using non-verbal communication methods.

2.47 In the course of an initial assessment, local authority children's social care should ascertain:

- is this a child in need? (s17 of the Children Act 1989); and
- is there reasonable cause to suspect that this child is suffering, or is likely to suffer, significant harm? (s47 of the Children Act 1989).

2.48 The focus of the initial assessment should be both on the safety and the welfare of the child. It is important to remember that even if the reason for a referral was a concern about abuse or neglect that is not subsequently substantiated, a child and family may still benefit from support and practical help to promote a child's health

[8] See the London Diplomatic List (The Stationery Office), ISBN 0 11 591772 1, the FCO website www.fco.gov.uk or phone 020 7008 1500

and development. When services are to be provided a child in need plan should be developed based on the findings from the initial assessment and on any previous plans for example, those made following the completion of a common assessment. If the child's needs and circumstances are complex, a more in-depth core assessment under s17 of the Children Act 1989 will be required in order to decide what other types of services are necessary to assist the child and family (see the Framework for the Assessment of Children in Need and their Families). Working Together to Safeguard Children 2010 Appendix 1 sets out the statutory framework including relevant sections of the Children Act 1989. Appendix 3 Using standardised assessment tools to evidence assessment and decision making is intended for use by practitioners to support evidence-based assessment and decision making.

2.49 Once an Initial Assessment has been completed (see paragraph 2.41 for definition of completed) local authority children's social care should decide on the next course of action, following discussion with the child and family, unless such a discussion may place a child at increased risk of suffering harm. If there are concerns about a parent's ability to protect a child from harm, careful consideration should be given to what the parents should be told when and by whom, taking account of the child's welfare. Where it is clear that there should be a police investigation in parallel with an s47 enquiry, the considerations at paragraph 2.69 should apply. Whatever decisions are taken, they should be endorsed at a managerial level agreed within children's services and recorded in writing. This information should be consistent with that contained in the Initial Assessment Record (DoH 2002). The local authority children's social care record in relation to the child should include whether the child was seen alone at the time of each visit and also the reasons for deciding (or not) to see the child alone. The local authority children's social care record should also set out the decisions made and future action to be taken. The family, the original referrer, and other professionals and services involved in the assessment, should as far as possible be told what action has been and will be taken, consistent with respecting the confidentiality of the child and family concerned, and not jeopardising further action in respect of concerns about harm (which may include police investigations). This information should be confirmed in writing to the agencies, the family and where appropriate the child.

Pan Dorset - Practice Guidance

Initial assessment and enquiries: Ten pitfalls and how to avoid them

(Cleaver H, Wattam C, and Cawson P. 1998. *Assessing Risk in Child Protection*.London: NSPCC)

1. Not enough weight is given to information from family, friends and neighbours. *Ask yourself:*

Would I react differently if these reports had come from a different source? How can I check whether or not they have substance? Even if they are not accurate, could they be a sign that the family are in need of some help or support?

2. Not enough attention is paid to what children say, how they look and how they behave. *Ask yourself:*

Have I been given appropriate access to all the children in the family? If I have not been able to see any child, is there a very good reason, and have I made arrangements to see him/her as soon as possible? How should I follow up any uneasiness about the child(ren)'s health or development? If the child is old enough and has the communication skills, what is the child's account of events? If the child uses a language other than English, or alternative non verbal communication, have I made every effort to enlist help in understanding him/her? What is the evidence to support or refute the child or young person's conduct?

3. Attention is focused on the most visible or pressing problems and other warning signs are not appreciated. *Ask yourself:*

What is the most striking thing about this situation? If this feature were to be removed or changed, would I still have concerns?

4. Pressures from high status referrers or the press, with fears that a child may die, lead to over precipitate action. *Ask yourself:*

Would I see this referral as a safeguarding matter if it came from another source?

5. Professionals think that when they have explained something as clearly as they can, the other person will have understood it. *Ask yourself:*

Have I double-checked with the family and the child(ren) that they understand what will happen next?

6. Assumptions and pre-judgements about families lead to observations being ignored or misinterpreted. *Ask yourself:*

What were my assumptions about this family? What, if any, is the hard evidence which supports them? What, if any, is the hard evidence which refutes them?

7. Parents' behaviour, whether co-operative or unco-operative, is often misinterpreted. *Ask yourself:*

What were the reasons for the parents' behaviour? Are there other possibilities besides the most obvious? Could their behaviour have been a reaction to something I did or said rather than to do with the child?

Next steps – child in need but no suspected actual or likely significant harm

8. When the initial enquiry shows that the child is not at risk of significant harm, families are seldom referred to other services which they need to prevent longer term problems. *Ask yourself:*

Is this family's situation satisfactory for meeting the child(ren)'s needs? Whether or not there is a concern about harm, does the family need support or practical help? How can I make sure they know about services they are entitled to, and can access them if they wish?

9. When faced with an aggressive or frightening family, professionals are reluctant to discuss fears for their own safety and ask for help. *Ask yourself:*

Did I feel safe in this household? If not, why not? If I or another professional should go back there to ensure the child(ren)'s safety, what support should I ask for? If necessary, put your concerns and requests in writing to your manager.

10. Information taken at the point of referral is not adequately recorded, facts are not checked and reasons for decisions are not noted. *Ask yourself:*

Am I sure the information I have noted is 100% accurate? If I didn't check my notes with the family during the interview, what steps should I take to verify them? Do my notes show clearly the difference between the information the family gave me, my own direct observations, and my interpretation or assessment of the situation? Do my notes record what action I have taken/will take? What action all other relevant people have taken/will take?

2.50 An initial assessment may indicate that a child is a 'child in need' as defined by s17 of the Children Act 1989, but that there are no substantiated concerns that the child may be suffering, or is likely to suffer, significant harm. There may be sufficient information available on which to decide what services (if any) should be provided by whom according to an agreed plan. On the other hand a more in-depth assessment may be necessary in order to understand the child's needs and circumstances. In these circumstances, the Assessment Framework provides guidance on undertaking a core assessment which builds on the findings from the initial assessment and addresses the central or most important aspects of the needs of a child and the capacity of his or her parents or caregivers to respond appropriately to these needs within the wider family and community context. This core assessment can provide a sound evidence base for professional judgements on what types of services are most likely to bring about good outcomes for the child. Family Group Conferences may be an effective vehicle for taking forward work in such cases.

2.51 The definition of a 'child in need' is wide, and it will embrace children in a diverse range of circumstances. The types of services that may help such children and their families will vary greatly according to their needs and circumstances.

The rest of the guidance in this chapter is concerned with the processes which should be followed where a child is suspected to be suffering, or is likely to suffer, significant harm.

The Children Act 1989 introduced the concept of significant harm as the threshold that justifies compulsory intervention in family life, in the best interests of children. It gives local authorities a duty under section 47 to make enquiries when they have *reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or likely to suffer, significant harm* to enable them to decide whether they should take action to safeguard or promote the child's welfare.

This statutory guidance adopts specifically the legislative terminology of 'significant harm' in preference to the use of the word "risk", given the need both to reflect the legislative requirements and to avoid confusion with the wide variety of contexts and associated tools and methodologies associated with risk assessment/analysis. When assessing whether a child is suffering, or likely to suffer, significant harm local authority children's social care will of course draw on a wide variety of information including the outcomes of relevant risk assessments or judgments provided by other agencies and professionals to inform their own evidence based assessment.

Next steps – child in need and suspected actual or likely significant harm

2.52 Where it is suspected that a child is suffering, or is likely to suffer, significant harm, the local authority is required by s47 of the Children Act 1989 to make enquiries, to enable it to decide whether it should take any action to safeguard and promote the welfare of the child. A section 47 enquiry should be carried out through a core assessment (see paragraph 2.65). The *Framework for the Assessment of Children in Need and their Families* provides a structured framework for collecting, drawing together and analysing available information about a child and family within the following three domains:

- the child's developmental needs,
- parenting capacity and
- family and environmental factors.

Using the framework will help provide sound evidence on which to base often difficult professional judgements about whether to intervene to safeguard and promote the welfare of a child, and if so, how best to do so and with what intended outcomes.

Immediate Protection

2.53 Where there is a risk to the life of a child or a likelihood of serious immediate harm, an agency with statutory child protection powers[9] **should act quickly to secure the immediate safety of the child**. Emergency action might be necessary as soon as a referral is received, or at any point in involvement with a child/ren and families (see Working Together to Safeguard Children 2010 Appendix 1, paragraph 18 for the range of emergency protection powers available). The need for emergency action may become apparent only over time as more is learned about the circumstances of a child or children. Neglect, as well as abuse, can result in a child suffering significant harm to the extent that urgent protective action is necessary. When considering whether emergency action is required, an agency

[9] Agencies with statutory child protection powers comprise the local authority, the police and the NSPCC.

should always consider whether action is also required to safeguard and promote the welfare of other children in the same household, the household of an alleged perpetrator, or elsewhere.

2.54 Planned emergency action will normally take place following an immediate strategy discussion between police, children's services, and other agencies as appropriate (including NSPCC where involved). Where a single agency has to act immediately to protect a child, a strategy discussion should take place as soon as possible after such action to plan next steps. Legal advice should normally be obtained before initiating legal action, in particular when an Emergency Protection Order (EPO) is to be sought. For further guidance on EPOs see pages 55-65 of Volume 1 of the Children Act 1898 Guidance and Regulations, Court Orders[10].

2.55 In some cases, it may be sufficient to secure a child's safety by a parent taking action to remove an alleged perpetrator or by the alleged perpetrator agreeing to leave the home. In other cases, it may be necessary to ensure either that the child remains in a safe place or that the child is removed to a safe place, either on a voluntary basis or by obtaining an Emergency Protection Order. The police also have powers to remove a child to suitable accommodation in cases of emergency. If it is necessary to remove a child, children's services should wherever possible – and unless a child's safety is otherwise at immediate risk – apply for an Emergency Protection Order. **Police powers should only be used in exceptional circumstances where there is insufficient time to seek an Emergency Protection Order or for reasons relating to the immediate safety of the child.**

2.56 The local authority in whose area a child is found, in circumstances that require emergency action, is responsible for taking that action. If the child is looked after by, or the subject of a child protection plan in another authority, the first authority should consult the authority responsible for the child. Only when the second local authority explicitly accepts responsibility is the first authority relieved of its responsibility to take emergency action. Such acceptance should be subsequently confirmed in writing.

2.57 Emergency action addresses only the immediate circumstances of the child(ren). The Local Authority should follow this action quickly by initiating section 47 enquiries as necessary. The agencies primarily involved with the child and family should be involved in the core assessment to understand the needs and circumstances of the child and family, and agree action to safeguard and promote the welfare of the child in the longer-term. Where an Emergency Protection Order applies, local authority children's social care will have to consider quickly whether to initiate care or other proceedings, or to let the order lapse and the child return home.

Strategy Discussion

2.58 Whenever there is reasonable cause to suspect that a child is suffering, or is likely to suffer significant harm, there should be a strategy discussion involving local authority children's social care, the police, health and other bodies as appropriate (for example, children's centre/ school or family intervention projects), in particular any referring agency.

[10] www.dcsf.gov.uk/everychildmatters/publications/documents/childrenactguidanceregulations/

Pan-Dorset Note
Discussion with all relevant agencies should normally take place before the strategy discussion as part of the information sharing process in relation to the initial assessment. However, before decisions are reached at a strategy discussion, as a minimum, information the appropriate health practitioners must normally be sought and taken into account.

2.59 The strategy discussion should be convened by local authority children's social care and those participating should be sufficiently senior and able, therefore, to contribute to the discussion of available information and to make decisions on behalf of their agencies. If the child is a hospital patient (in- or out-patient) or receiving services from a child development team, the medical consultant responsible for the child's health care should be involved, as should the senior ward nurse if the child is an in-patient. Where a medical examination may be necessary or has taken place a senior doctor from those providing services should also be involved. Where the parents or adults in the household are experiencing problems such as domestic violence, substance misuse or metal illness it will also be important to consider involving the relevant adult services professional(s).

Pan-Dorset Note
Where the child is receiving therapeutic services, the therapist should be involved, and account taken of the likely impact of any enquiries on the individual child's ability to access ongoing therapy. However, the individual child's therapeutic needs must be balanced against the need to safeguard him / her and any other children who may be at risk.

2.60 A strategy discussion may take place following a referral, or at any other time (for example, if concerns about significant harm emerge in respect of child receiving support under s17).

Pan-Dorset Note
When information is obtained that a child has been subjected to physical abuse or serious neglect, a strategy discussion involving at least the police and children's services must take place on the same working day. Where a single agency has to act immediately to protect a child, a strategy discussion should take place as soon as possible after that action is taken.

Where a situation arises which is not in normal working hours, a strategy discussion will take place between the children's services out of hours service and the police to discuss immediate protective action. The outcome of this strategy discussion and any action taken will then be passed to the appropriate staff in children's services and the police the next working day.

The action from a strategy discussion must be within a timescale that ensures:

- that where there is a risk to the life of a child or a likelihood of serious immediate harm as a result of abuse and/or neglect, the intervention to protect the child must take place without delay;
- that where the information suggests that the child has been physically abused or subject to serious neglect, this may require an immediate or same day response. A judgement must be made about the urgency of the intervention, which in any event should include seeing the child within 24 hours of the strategy discussion;
- all other concerns about a child's safety should be within a timescale which ensures the safety and protection of the child and all other children in the household.

2.61 The strategy discussion should be used to:

- share available information;
- agree the conduct and timing of any criminal investigation;
- decide whether section 47 enquiries should be initiated and therefore a core assessment be undertaken under s47 of the Children Act 1989 or continued if it has already begun under s17 of the Children Act 1989;
- plan how the s47 enquiry should be undertaken (if one is to be initiated), including the need for medical treatment, and who will carry out what actions, by when and for what purpose;
- agree what action is required immediately to safeguard and promote the welfare of the child, and/or provide interim services and support. If the child is in hospital, decisions should also be made about how to secure the safe discharge of the child;
- determine what information from the strategy discussion will be shared with the family, unless such information sharing may place a child at increased risk of suffering significant harm or jeopardise police investigations into any alleged offence(s); and
- determine if legal action is required.

2.62 Relevant matters will include:

- agreeing a plan for how the core assessment under s47 of the Children Act 1989 will be carried out – what further information is required about the child(ren) and family and how it should be obtained and recorded;
- agreeing who should be interviewed, by whom, for what purpose, and when. The way in which interviews are conducted can play a significant part in minimising any distress caused to children, and increasing the likelihood of maintaining constructive working relationships with families. When a criminal offence may have been committed against a child, the timing and handling of interviews with victims, their families and witnesses, can have important implications for the collection and preservation of evidence;
- agreeing, in particular, when the child will be seen alone (unless to do so would be inappropriate for the child) by the lead social worker during the course of these enquiries and the methods by which the child's wishes and feelings will be ascertained so that they can be taken into account when making decisions under s47 of the Children Act 1989;
- in the light of the race and ethnicity of the child and family, considering how these should be taken into account, and establishing whether an interpreter will be required; and
- considering the needs of other children who may affected, for example, siblings and other children, such as those living in the same establishment – in contact with alleged abusers.

2.63 A strategy discussion may take place at a meeting or by other means (for example, by telephone). In complex types of maltreatment a meeting is likely to be the most effective way of discussing the child's welfare and planning future action. More than one strategy discussion may be necessary. This is likely to be where the child's circumstances are very complex and a number of discussions are required to consider whether and, if so, when to initiate s47 enquiries, as well as how best to undertake them. Such a meeting should be held at a convenient location for the key attendees, such as a hospital, school, police station or children's services office. Any information shared, all decisions reached, and the basis for those decisions, should be clearly recorded by the chair of the strategy discussion and circulated within one working day to all parties to the discussion. Children's Services should record information in the child's file which is consistent with the

information set out in the Record of Strategy Discussion (DoH 2002). Any decisions about taking immediate action should be kept under constant review.

Pan-Dorset Note
Where there are unresolved differences of opinion about the decisions and actions planned in a strategy discussion, these should be resolved by senior operational managers of the respective agencies in liaison with each other. This should be actioned within a timescale commensurate with the need to safeguard the child or other children but does not override an individual agency's responsibilities to act in accordance with these procedures and/or their own agency procedures.

However once the decision to initiate s47 enquiries has been made (via a strategy discussion) there may still be a need to discuss progress with the key agencies involved. This is **NOT** a strategy discussion, but more simply a review of progress before the outcome of s47 enquiries are decided.

2.64 Significant harm to children gives rise to both child welfare concerns and law enforcement concerns, and s47 enquiries may run concurrently with police investigations concerning possible associated crime(s). The police have a duty to carry out thorough and professional investigations into allegations of crime, and the obtaining of clear strong evidence is in the best interests of a child, since it makes it less likely that a child victim will have to give evidence in criminal court. Enquiries may, therefore, give rise to information that is relevant to decisions that will be taken by both children's services and the police. The findings from the assessment and/or police investigation should be used to inform plans about future support and help to the child and family. They may also contribute to legal proceedings, whether criminal, civil or both.

2.65 Each LSCB should have in place a protocol for Children's Services and the police, to guide both agencies in deciding how section 47 enquiries and associated police investigations should be conducted jointly and in particular, in what circumstances section 47 enquiries and linked criminal investigation are necessary and / or appropriate. When joint enquiries take place the police have the lead for the criminal investigation and Children's Services have the lead for section 47 enquiries.

Pan Dorset Note
Chapter 3.4 of the Pan-Dorset Interagency procedures - Sexual Exploitation of children and young people sets out the protocol for Bournemouth, Dorset and Poole Children's Services and Police.

Pan Dorset Note

Co-ordination of strategy meetings where the children are from more than one family

In some situations, there may be children from more than one family who are alleged to have been abused by the same perpetrator, or who are alleged to have been abused in the same setting. This situation is especially likely to occur where the alleged abuse has occurred in a residential or educational setting.

In these cases it is very useful for the strategy meetings, and any subsequent planning meetings, to be held together. This enables the effective sharing of information, a consistent approach and an overall plan of action to be devised if required.

In such situations it is helpful to have one children's services manager responsible for the co-ordination and chairing of such meetings, even where the children involved may be from more than one team or local authority area.

In order to decide which children's services manager should take this responsibility the following principles should be applied:

Residential Provision (including boarding schools) - The local authority where the children are physically present has responsibility to conduct the s47 enquiry unless this has been otherwise negotiated with another local authority.

Day care (eg non-boarding schools)- Where the educational setting is a day setting, the home address of the first child subject of the referral of harm (ie the first alleged 'victim') will be the relevant factor in deciding where lead responsibility lies. The team manager responsible for this child should normally coordinate any subsequent strategy/planning meetings of other children with that of the child for whom s/he holds casework responsibility.

Clearly, a degree of common sense and flexibility is required in the application of this procedure. It would not usually make sense for example, to have a local authority manager who has no children involved in the investigation chairing the strategy/planning meetings.

Section 47 Enquiries and Core Assessment

2.66 The core assessment is the means by which a section 47 enquiry is carried out. It should be led by a qualified and experienced social worker. Local authority children's social care have lead responsibility for the core assessment under section 47 of the Children Act 1989. In these circumstances the objective of the local authority's involvement is to determine whether action is required to safeguard and promote the welfare of the child or children who are the subjects of the section 47 enquiries. The *Framework for the Assessment of Children in Need and their Families (2000)* provides the structure for helping to collect and analyse information obtained in the course of s47 enquiries. The core assessment should begin by focusing primarily on the information identified during the initial assessment as being of most importance or seriousness when considering whether the child is suffering or is likely to suffer significant harm. It should, however, cover all relevant dimensions in the Assessment Framework before its completion. Those making enquiries about a child should always be alert to the potential needs and safety of any siblings, or other children in the household of the child in question. In addition, enquiries may also need to cover children in other

households, with whom the alleged offender may have had contact. At the same time, the police will have to (where relevant) establish the facts about any offence that may have been committed against a child, and to collect evidence.

2.67 The Children Act 1989 places a statutory duty on health, education and other services, to help the Local Authority in carrying out its social services functions under Part III of the Children Act 1989 and in undertaking section 47 enquiries. Assessing the needs of a child and the capacity of their parents or wider family network to ensure his or her safety, health and development, very often depends on building a picture of the child's situation on the basis of information from many sources. The Local Authority social worker, in leading the s47 enquiry should do his or her utmost to secure willing co-operation and participation from all professionals and services, by being prepared to explain and justify the local authority's actions, and to demonstrate that the process is being managed in a way that can help to bring about better outcomes for children. The LSCB has an important role to play in cultivating and promoting a climate of trust and understanding between different professionals and services.

2.68 The child's wishes and feelings should be ascertained and regard given to their age and understanding when making decisions about what (if any) services to provide. Section 47 enquiries should always involve interviews with the child who is the subject of concern. The child should be seen by the lead social worker and communicated with alone when appropriate. Some children may need to be seen, for example, with an interpreter or a person who can use their preferred method of communication (see paragraph 2.68). Others, such as babies, may need to be seen in the presence of their primary caregiver so as to minimise their distress. In addition, the enquiries should involve interviews with parents and/or caregivers (both with the child present and in the child's absence) and observations of the interactions between parents and child(ren) (where appropriate in a variety of settings).

Pan-Dorset Note

Consideration should also be given to the need to separately access and interview other children in the household.

Enquiries may also include

- interviews with those who are personally (for example, wider family members) and professionally connected with the child;
- specific examinations or assessments of the child by other professionals (for example, medical or developmental checks, assessment of emotional or psychological state); and
- interviews with those who are personally and professionally connected with the child's parents and/or caregivers.

2.69 Individuals should always be enabled to participate fully in the enquiry process. Where a child or parent is disabled, it may be necessary to provide help with communication to enable the child or parent to express him/herself to the best of his or her ability. Where a child or parent speaks a language other than that spoken by the interviewer, an interpreter should be provided. If the child is unable to take part in an interview because of age or understanding, alternative means of understanding the child's wishes or feelings should be used, including observation where children are very young or where they have communication impairments.

2.70 Children are a key, and sometimes the only, source of information about what has happened to them, especially in child sexual abuse cases, but also in physical and other forms of abuse. Accurate and complete information is essential for taking action to safeguard and promote the welfare of the child, as well as for any criminal proceedings that may be instigated concerning an alleged perpetrator of abuse. When children are first approached, the nature and extent of any harm suffered by them may not be clear, nor whether a criminal offence has been committed. It is important that even initial discussions with children are conducted in a way that minimises any distress caused to them, and maximises the likelihood that they will provide accurate and complete information. It is important, wherever possible, to have separate communication with a child. Leading or suggestive communication should always be avoided. Children may need time, and more than one opportunity, in order to develop sufficient trust to communicate any concerns they may have, especially if they have a communication impairment, learning disabilities, are very young, or are experiencing mental health problems.

2.71 Exceptionally, a joint enquiry/investigation team may need to speak to a suspected child victim without the knowledge of the parent or caregiver. Relevant circumstances would include the possibility that a child would be threatened or otherwise coerced into silence; a strong likelihood that important evidence would be destroyed; or that the child in question did not wish the parent to be involved at that stage, and is competent to take that decision. As at paragraph 2.45 above, in all cases where the police are involved, the decision about when to inform the parent or caregiver will have a bearing on the conduct of police investigations, and the strategy discussion should decide on the most appropriate timing of parental participation.

2.72 In accordance with the *Achieving Best Evidence* guidance (2002), all such joint interviews with children should be conducted by those with specialist training and experience in interviewing children. Additional specialist help may be required if

- the child is very young
- the child does not speak English at a level which enables him or her to participate in the interview;
- the child appears to have a degree of psychiatric disturbance but is deemed competent;
- the child has an impairment; or
- the interviewers do not have adequate knowledge and understanding of the child's racial, religious or cultural background.

Consideration should also be given to the gender of interviewers, particularly in cases of alleged sexual abuse.

2.73 Criminal justice legislation, in particular the Youth Justice and Criminal Evidence Act 1999, creates particular obligations for Courts who are dealing with witnesses under 17 years of age. These include the presumption of evidence-giving through pre-recorded videos, as well as the use of live video links for further evidence-giving and cross examination.

Child Assessment Orders

2.74 Local authority children's social care should make all reasonable efforts to persuade parents to cooperate with s47 enquiries. If, despite these efforts, the parents continue to refuse access to a child for the purpose of establishing basic

facts about the child's condition – but concerns about the child's safety are not so urgent as to require an emergency protection order – the local authority may apply to the court for a child assessment order. In these circumstances, the court may direct the parents/caregivers to co-operate with an assessment of the child, the details of which should be specified. The order does not take away the child's own right to refuse to participate in an assessment, for example, a medical examination, so long as he or she is of sufficient age and understanding. For further guidance on child assessment orders see pages 52–55 of Volume 1 of the Children Act 1989 Guidance and Regulations, Court Orders11.

The Impact of s47 Enquiries on the Family and Child

2.75 Section 47 enquiries should always be carried out in such a way as to minimise distress to the child, and to ensure that families are treated sensitively and with respect. Local authority children's social care should explain the purpose and outcome of s47 enquiries to the parents and child (having regard to their age and understanding) and be prepared to answer questions openly, unless to do so would affect the safety and welfare of the child. It is particularly helpful for families if local authority children's social care provide written information about the purpose, process and potential outcomes of section 47 enquiries. The information should be both general and specific to the particular circumstances under enquiry. It should include information about how advice, advocacy and support may be obtained from independent sources.

2.76 In the great majority of cases, children remain with their families following section 47 enquiries, even where concerns about abuse or neglect are substantiated. As far as possible, s47 enquiries should be conducted in a way that allows for future constructive working relationships with families. The way in which a case is handled initially can affect the entire subsequent process. Where handled well and sensitively, there can be a positive effect on the eventual outcome for the child.

2.77 Where a child is living in a residential establishment, consideration should be given to the possible impact on other children living in the same establishment. Paragraphs 6.10–6.13 of Working Together set out a summary of the Government's practice guidance on dealing with complex abuse cases.

The Outcome of S47 Enquiries

2.78 Local authority children's social care should decide how to proceed following s47 enquiries, after discussion between all those who have conducted, or been significantly involved in those enquiries, including relevant professionals and agencies (as well as foster carers where involved) and the child and parents themselves. The information recorded on the outcome of the section 47 enquiries should be consistent with the information set out in the Outcome of the section 47 enquiries Record (DoH 2002). The children's social care record for the child should set out clearly the dates on which the child was seen by the lead social worker during the course of enquiries, if they were seen alone and if not, who was present and for what reasons. Parents and children of sufficient age and appropriate level of understanding (together with professionals and agencies who have been significantly involved) should receive a copy of this record, in particular in advance of any initial child protection conference that is convened. This information should be conveyed in an appropriate format for younger children and those people whose preferred language is not English. Consideration should be given to whether the

[11] www.dcsf.gov.uk/everychildmatters/publications/documents/childrenactguidanceregulations/

core assessment has been completed or what further work is required before it is completed. It may be valuable, following an evaluation of the outcome of enquiries, to make recommendations for action in an inter-disciplinary forum, if the case is not going forward to a child protection conference. Enquiries may result in a number of outcomes. Where the child concerned is living in a residential establishment which is subject to inspection, the relevant inspectorate should be informed.

Concerns are not substantiated

2.79 Section 47 enquiries may not substantiate the original concerns that the child was suffering, or was likely to suffer significant harm, but it is important that the core assessment is completed. In some circumstances it may be decided that the completion of the s47 enquiry means that the core assessment is completed and no further action is necessary. However, local authority children's social care and other relevant agencies, as necessary, should always consider with the family what support and/or services maybe helpful; how the child and family might be provided with these services (if they wish it) and by whom. The focus of section 47 enquiries is the welfare of the child, and the assessment may well reveal a range of needs. The provision of services to these children and their families should not be dependent on the presence of abuse and neglect. Help and support to children in need and their families may prevent problems escalating to a point where a child is abused or neglected.

2.80 In some cases, there may remain concerns about the child's safety and welfare, despite there being no real evidence. It may be appropriate to put in place arrangements to monitor the child's welfare. Monitoring should never be used as a means of deferring or avoiding difficult decisions. The purpose of monitoring should always be clear, that is, what is being monitored and why, in what way and by whom. It will also be important to inform parents about the nature of any on-going concern. There should be a time set for reviewing the monitoring arrangements through the holding of a further discussion or meeting.

Concerns are substantiated, but the child is not judged to be at continuing risk of significant harm

2.81 There may be substantiated concerns that a child has suffered significant harm, but it is agreed between the agencies most involved and the child and family, that a plan for ensuring the child's future safety and welfare can be developed and implemented without having a child protection conference or a child protection plan. Such an approach will be of particular relevance where it is clear to the agencies involved that the child is not continuing to suffer, or be likely to suffer, significant harm.

2.82 A child protection conference may not be required when there are sound reasons, based on an analysis of evidence obtained through section 47 enquiries, for judging that a child is not continuing to, or likely to suffer significant harm. This may be because, for example, the caregiver has taken responsibility for the harm they caused the child, the family's circumstances have changed or the person responsible for the harm is no longer in contact with the child. It may be because significant harm was incurred as the result of an isolated abusive incident (for example, abuse by a stranger).

2.83 The agencies most involved may judge that a parent, caregiver, or members of the child's wider family are willing and able to co-operate with actions to ensure the

child's future safety and welfare and that the child is therefore not continuing to, or be likely to suffer significant harm. This judgement can only be made in the light of all relevant information obtained during a s47 enquiry, and a soundly based assessment of the likelihood of successful intervention, based on clear evidence and mindful of the dangers of misplaced professional optimism. Local authority children's social care have a duty to ascertain children's wishes and feelings and take these into account (having regard to the child's age and understanding) when deciding on the provision of services. A meeting of involved professionals and family members may be useful to agree what actions should be undertaken by whom, and with what intended outcomes for the child's health and development, including the provision of therapeutic services. Whatever process is used to plan future action, the resulting plan should be informed by the core assessment findings. It should set out who will have responsibility for what actions, including what course of action should be followed if the plan is not being successfully implemented. It should also include a timescale for review of progress against planned outcomes. Family Group Meetings (pages 10.2-10.4 of Working Together 2010) may have a role to play in fulfilling these tasks.

2.84 Local authority children's social care should take carefully any decision not to proceed to a child protection conference where it is known that a child has suffered significant harm. A suitably experienced and qualified social work manager within children's services should endorse the decision. Those professionals and agencies who are most involved with the child and family, and those who have taken part in the s47 enquiry, have the right to request that children's services convene a child protection conference if they have serious concerns that a child's welfare may not otherwise be adequately safeguarded. Any such request that is supported by a senior manager, or a named or designated professional, should normally be agreed. Where there remain differences of view over the necessity for a conference in a specific case, every effort should be made to resolve them through discussion and explanation but as a last resort, LSCBs should have in place a quick and straightforward means of resolving differences of opinion.

Pan Dorset Note
Where there remain differences of view over the necessity for a conference in a specific case, these should be resolved by senior operational managers of the respective agencies in liaison with each other.

Concerns are substantiated and the child is judged to be at continuing risk of significant harm

2.85 Where the agencies most involved judge that a child may continue to, or be likely to, suffer significant harm, local authority children's social care should convene a child protection conference. The aim of the conference is to enable those professionals most involved with the child and family, and the family themselves, to assess all relevant information, and plan how best to safeguard and promote the welfare of the child.

The Initial Child Protection Conference

Purpose

2.86 The initial child protection conference brings together family members, the child who is the subject of the conference (where appropriate) and those professionals most involved with the child and family, following section 47 enquiries. Its purpose is:

- to bring together and analyse, in an inter-agency setting, the information which has been obtained about the child's developmental needs, and the parents' or carers' capacity to respond to these needs to ensure the child's safety and promote the child's health and development within the context of their wider family and environment;

- to consider the evidence presented to the conference and taking into account the child's present situation and information about his or her family history and present and past family functioning, make judgements about the likelihood of a child suffering significant harm in future and decide whether the child is continuing to, or is likely to suffer significant harm; and

- to decide what future action is required in order to safeguard and promote the welfare of the child, including the child becoming the subject of a child protection plan, what the planned developmental outcomes are for the child and how best to achieve these.

Timing

2.87 The timing of an initial child protection conference will depend on the urgency of the case and on the time required to obtain relevant information about the child and family. If the conference is to reach well-informed decisions based on evidence, it should take place following adequate preparation and assessment of the child's needs and circumstances. At the same time, cases where children are continuing to or are likely to, suffer significant harm should not be allowed to drift. Consequently, all initial child protection conferences should take place within 15 working days of the strategy discussion, or the strategy discussion at which section 47 enquiries ere initiated, if more than one has been held (see paragraph 2.60).

Attendance

2.88 Those attending conferences should be there because they have a significant contribution to make, arising from professional expertise, knowledge of the child or family or both. The local authority children's social care social work manager should consider whether to seek advice from, or have present, a medical professional who can present the medical information in a manner which can be understood by conference attendees and enable such information to be evaluated from a sound evidence base. There should be sufficient information and expertise available – through personal representation and written reports – to enable the conference to make an informed decision about what action is necessary to safeguard and promote the welfare of the child, and to make realistic and workable proposals for taking that action forward. At the same time, a conference that is larger than it needs to be can inhibit discussion and intimidate the child and family members. Those who have a relevant contribution to make may include:

- the child, or his or her representative;
- family members (including the wider family);

- local authority children's social care staff who have led and been involved in an assessment of the child and family;
- foster carers (current or former);
- residential care staff;
- professionals involved with the child (for example, health visitors, midwife, school nurse, children's guardian, paediatrician, school staff, early years staff, the GP, NHS Direct, staff in the youth justice system including the secure estate);
- professionals involved with the parents or other family members (for example, family support services, adult services (in particular those from health, substance misuse, domestic violence and learning disability), probation, the GP, NHS Direct);
- professionals with expertise in the particular type of harm suffered by the child or in the child's particular condition, for example, a disability or long term illness;
- those involved in investigations (for example, the police);
- local authority legal services (child care);
- NSPCC or other involved voluntary organisations;
- a representative of the armed services, in cases where there is a Service connection.

Pan Dorset note
Inter-Agency Representation at Child Protection Conference / Quoracy
The essential requirement for each child protection conference is that there are sufficient participants to provide appropriate information, and to contribute to a full and reasoned evaluation of risk, decision making and the formulation of a protection or action plan which will include the participation and co-operation of all relevant professionals and the family. As a minimum, at every conference, in addition to the chair, there should be at least the following:

- a professional representative from children's social care;
- representatives from at least two other professional groups or agencies who have had relevant/direct contact with each child who is subject of the conference

In addition, attendees may include those whose contribution relates to their professional expertise or responsibility for relevant services.
Professionals and agencies who are invited but are unable to attend should submit a written report.
An exception to this rule would be where a child has not had relevant/direct contact with 3 agencies (i.e. children's services and two others) in which circumstances this minimum quorum may be breached. Where there is a breach of quoracy the Chair of the Conference will write to missing agencies seeking their view/ decision.
These criteria for quoracy should be met for each child.

Involving the Child and Family Members

2.89 Before a conference is held, the purpose of a conference, who will attend and the way in which it will operate, should always be explained to a child of sufficient age and understanding, and to the parents, and involved family members. Where the child/family members do not speak English well enough to understand the discussions and express their views, an interpreter should be used. The parents (including absent parents) should normally be invited to attend the conference and helped to participate fully. Children's social care staff should give parents information about local advice and advocacy agencies and explain that they may bring an advocate, friend or supporter. The child, subject to consideration about age and understanding, should be invited to attend and to bring an advocate, friend

or supporter if s/he wishes. Where the child's attendance is neither desired by him/her nor appropriate, the local authority children's social care professional who is working most closely with the child should ascertain what his/her wishes and feelings are and make these known to the conference.

2.90 The involvement of family members should be planned carefully. It may not always be possible to involve all family members at all times in the conference, for example, if one parent is the alleged abuser or if there is a high level of conflict between family members. Adults and any children who wish to make representations to the conference may not wish to speak in front of one another. Exceptionally, it may be necessary to exclude one or more family members from a conference, in whole or in part. The conference is primarily about the child and while the presence of the family is normally welcome, those professionals attending must be able to share information in a safe and non-threatening environment. Professionals may themselves have concerns about violence or intimidation, which should be communicated in advance to the conference chair.

2.91 LSCB procedures should set out criteria for excluding a parent or caregiver, including the evidence required. A strong risk of violence or intimidation by a family member at or subsequent to the conference, towards a child or anybody else, might be one reason for exclusion. The possibility that a parent/caregiver may be prosecuted for an offence against a child is not in itself a reason for exclusion although in these circumstances the chair should take advice from the police about any implications arising from an alleged perpetrator's attendance. If criminal proceedings have been instigated the view of the Crown Prosecution Service (CPS) should be taken into account. The decision to exclude a parent or caregiver from the child protection conference rests with the chair of the conference, acting within LSCB procedures. If the parents are excluded, or are unable or unwilling to attend a child protection conference, they should be enabled to communicate their views to the conference by another means.

Issues to be considered are:

- the child's own view on whether s/he wishes to attend;
- the view of the person with parental responsibility on whether the child should attend. If there are conflicting views from the child and parent, the weight given to each view should depend on the age and understanding of the child and on other factors below;
- the ability of the child to understand the conference procedure and to express him/herself at the conference, either directly or through an appropriate agency representative of his/her choice, an advocacy worker (where available) or a supporter (previously agreed by the chair);
- when the child does not wish to attend the conference whether s/he would like to meet prior to the conference with the chair in order to give his/her views directly. S/he may wish to meet alone or with the supporter of his/her choice;
- the ability of the child to cope emotionally with the pressure and formality of the conference. In assessing this, the views of key people in direct contact with the child should be sought;
- the type of issues to be discussed at the conference and whether it is appropriate for the child to hear such information and subsequent discussion;
- whether it is likely that the child will need to withdraw from the conference whilst confidential information about parents/carers/other children is shared;
- the degree of conflict or intimidation which might be experienced by the child from her/his parents
- whether, on balance, a child's attendance at the conference is likely to have a serious adverse effect on the parent/child relationship, and whether this could initiate further abuse
- whether, taking all the above factors into account, it is in the child's best interests to attend, and whether the experience of the conference and consequences of attending are likely to be generally positive or negative for the child or young person.

Preparation of the child

If the child is to attend the child protection conference, s/he must be well prepared. The responsibility for ensuring that preparation takes place rests with the social worker. However, the preparation work may be delegated if the child has a relationship with a trusted adult who will attend the conference. In preparing the child the following should be discussed:

- purpose and structure of the conference; who is likely to be present what kind of information will be shared; issues of confidentiality, why it may be necessary to withdraw for some parts
- whether the child would like to be accompanied
- whether the child feels able to present his/her own views and feelings or would prefer these to be represented by another relevant adult
- whether the child wishes to attend the whole or part of the conference.

Occasionally such decisions may need to be made during the course of the conference if it is being disrupted. Exclusions should be kept to a minimum and should meet one or more of the following criteria.

- *threats of or risk of physical violence to staff*
- *verbal abuse which will inhibit the process of the conference*
- *risk of physical violence from one parent to another, or to another family member*

In this situation the parent/person with parental responsibility who is the main or sole carer of the child should be invited to attend. The other parent/carer can be invited to attend part of the conference at the discretion of the chair. S/he should also be invited to submit his/her views in writing or verbally to the social worker before the conference. The parent who is not the main carer but who has parental responsibility and/or contact with the child should be invited to meet with the chair immediately following the conference or as soon as possible after this, in order to go through a summary of the information given and decisions reached.

- Disruption *of the conference by a parent who may not be violent but may be preventing the proper consideration of a child's interests*

A parent/carer who is excluded as above should receive details of the decision of the conference and where appropriate, details of the category of abuse or neglect, the name of the keyworker, the lead professional, and the core group membership, unless in order to protect the child/ren or other parties, there are valid reasons for not doing so. At the discretion of the chair s/he could also be sent the fuller record of the conference.

On occasions, it may become necessary for professionals to have a discussion, or hear confidential information, without the parent/carer being present with the child protection conference. The following are instances when this might arise:

- *Disclosure of confidential information about a third party arising from any professional source*

Where the information concerns a current partner or a parent who no longer lives with the family but has contact with the child or any other significant adult, every effort should be made to encourage that person to disclose the information him/herself to the main carer(s). It is not reasonable to expect a parent/carer to protect a child if s/he is unaware of where risks may lie. Social workers should check with the agency holding information, whether it has sought permission from the relevant party to disclose information openly in the conference. It is hoped that situations where there is exclusion of parents/other family members for the disclosure of confidential information should be the exception rather than the norm;

- *Disclosures in accordance with the Home Office Guidance*

The police should request that a person who is attending as a supporter rather than a professional, is excluded to enable the police to share convictions or concerns about any individual where they do not have that person's consent to share such information. Where this is anticipated, the police should discuss this situation with the chair in advance of the conference;

Disclosure of confidential information regarding a joint investigation of child abuse or investigations of other serious crime where this is commensurate with the handling of a criminal investigation

The possibility that a parent/caregiver may be prosecuted for an offence against a child is not in itself a reason for exclusion although in these circumstances the chair should take advice from the police about any implications arising from an alleged perpetrator's attendance.

If criminal proceedings have been instigated, the view of the Crown Prosecution Service should be taken into account:

- *Where the source of information needs to be protected*

This criteria would not normally be used where the information arises from direct observation or knowledge within an agency. Professionals should be prepared to be accountable for the information they provide to a child protection conference. It could be used for example where a neighbour or family friend has given information to a professional but does not want the client to know the source of this information;

- *Where legal advice needs to be given to the conference in confidence*

During the exclusion period, professionals would also need to consider what action would need to be taken to address any risks identified from the confidential information shared and how this would be covered in the protection plan

Parents should only be excluded for the time needed to share the confidential information and any questions arising from this.

In cases of conflict between the interests of the parent(s) and the child, priority must be given to the child's interests.

Separate attendance by family members

Whilst not strictly an exclusion, situations can arise where there is no risk of violence but one family member refuses to be in the same room as another. In this case every effort should be made to encourage both family members to stay, if this is in the best interests of the child.

If the situation remains unresolved the parent/person with parental responsibility who is the main or sole carer of the child should be invited to attend. S/he should also be invited to submit his/her views in writing or verbally to the social worker before the conference. The parent who is not the main carer but who has parental responsibility and/or contact with the child should be invited to meet with the chair immediately following the conference or as soon as possible after this, in order to go through a summary of the information given and decisions reached.

Alternatively, at the discretion of the chair, consideration could be given to each separately attending part of the conference. However, it should be ensured that there are real and genuine reasons for the refusal and that family members are not acting without due consideration or with any malicious intent.

In some circumstances a young person may wish to attend a conference but there is conflict between this and the attendance of another family member. In such situations the social worker must bring this to the attention of the chair who will exercise discretion as to how the conference should proceed.

If any member of the conference is being disruptive and repeatedly interrupting and inhibiting the progress of the conference, the chair has the discretion to exclude this person for the remainder of the conference.

Chairing the Conference

2.92 A professional who is independent of operational or line management responsibilities for the case should chair the conference[12]. The conference chair is accountable to the Director of Children's Services. The status of the chair should be sufficient to ensure inter-agency commitment to the conference and the child protection plan. Wherever possible, the same person should also chair subsequent child protection reviews in respect of a specific child. The responsibilities of the chair include:

- meeting the child and family members in advance, to ensure that they understand the purpose of the conference and what will happen;
- setting out the purpose of the conference to all present, determining the agenda and emphasising the confidential nature of the occasion;
- enabling all those present, and absent contributors, to make their full contribution to discussion and decision-making;
- ensuring that the conference takes the decisions required of it, in an informed, systematic and explicit way; and
- being accountable to the Director of Children's Services for the conduct of conferences.

2.93 A conference chair should be trained in the role and should have:

- a good understanding and professional knowledge of children's welfare and development, and best practice in working with children and families;
- the ability to look objectively at, and assess the implications of the evidence on which judgements should be based;
- skills in chairing meetings in a way which encourages constructive participation, while maintaining a clear focus on the welfare of the child and the decisions which have to be taken;
- knowledge and understanding of anti-discriminatory practice; and
- knowledge of relevant legislation, including that relating to children's services and human rights.

Information for the Conference

2.94 Local authority children's social care should provide the conference with a written report that summarises and analyses the information obtained in the course of the initial assessment and the core assessment undertaken under s47 of the Children Act 1989 (in as far as it has been completed within the available time period) and information in existing records relating to the child and family.

[12] In addition to this guidance *Putting Care into Practice,* the statutory guidance which accompanies the Care Planning, Placement and Case Review (England) Regulations 2010, sets out the expectations of the Independent Reviewing Officer (IRO) in relation to chairing the child protection review conference as part of the overarching review of the looked after child's case.

2.95 Where decisions are being made about more than one child in a family there should be a report prepared on each child. The information in the report for a child protection conference, which is be likely to be in the current core assessment record, should be consistent with the information which is set out in the Initial Child Protection Conference Report (Department of Health, 2002). The conference report should include information on the dates the child was seen by the lead social worker during the course of the section 47 enquiries, if the child was seen alone and if not, who was present and for what reasons. The core assessment is the means by which a section 47 enquiry is carried out. Although a core assessment will have been commenced, it is unlikely it will have been completed in time for the conference given the 35 working day period that such assessments can take.

2.96 The child protection conference report should include:

- a chronology of significant events and agency and professional contact with the child and family;
- information on the child's current and past state of developmental needs;
- information on the capacity of the parents and other family members to ensure the child is safe from harm, and to respond to the child's developmental needs, within their wider family and environmental context;
- the expressed wishes and feelings of the child, parents, and other family members; and
- an analysis of the information gathered and recorded using the Assessment Framework dimensions to reach a judgement on whether the child is suffering, or likely to suffer, significant harm and consider how best to meet his or her developmental needs. This analysis should address:
  - how the child's strengths and difficulties are impacting on each other;
  - how the parenting strengths and difficulties are affecting each other;
  - how the family and environmental factors are affecting each other;
  - how the parenting that is provided for the child is affecting the child's health and development both in terms of resilience and protective factors, and vulnerability and risk factors; and
  - how the family and environmental factors are impacting on parenting and/or the child directly; and
- the local authority's recommendation to the conference.

2.97 Where appropriate, the parents and subject child should be provided with a copy of the report in advance of the conference. The contents of the report should be explained and discussed with the child and relevant family members in advance of the conference itself, in the preferred language(s) of the child and family members.

2.98 Other professionals attending the conference should bring with them details of their involvement with the child and family, and information concerning their knowledge of the child's developmental needs, capacity of the parents to meet the needs of their child within their family and environmental context. This information should include careful consideration of the impact that the current and past family functioning and family history are having on the parents' capacities to met the

child's needs. Contributors should, wherever possible, provide a written report in advance to the conference and these should be made available to those attending.

2.99 The child and family members should be helped in advance to think about what they want to convey to the conference and how best to get their points across on the day. Some may find it helpful to provide their own written report, which they may be assisted to prepare by their adviser/advocate.

2.100 Those providing information should take care to distinguish between fact, observation, allegation and opinion. When information is provided from another source, i.e. it is second or third hand, this should be made clear.

Pan Dorset Note

It is an expectation that the parents and each child (where appropriate) should be given a copy of the report (marked 'family copy') and this should be left with them to share with their supporter/solicitor as they wish. The contents of the report should be explained and discussed with the child and relevant family members at least 24 hours in advance of the conference itself, in the preferred language(s) of the child and family members.

It is expected that all contributors to a child protection conference will provide a written report to the conference which should be made available to those attending. In any event agency representatives should come to the conference well prepared and should avoid continually referring to case files throughout the conference. All those providing information should take care to distinguish between fact, what has been observed, allegation and opinion.

All agencies should;

- make every effort to share reports with the parent, and child (where relevant) **at least** 24 hours in advance of the initial conference, and 5 working days in advance of the review conference;
- give a copy of the report to parents, in the preferred language of the family;
- ensure a copy of the report is made available to the chair **at least** 24 hours in advance of the initial conference, and 5 working days (in advance) of the review conference.

Action and Decisions for the Conference

2.101 The conference should consider the following questions when determining whether the child should be the subject of a child protection plan:

- has the child suffered significant harm? And
- is the child likely to suffer significant harm in the future?

2.102 The test for likelihood of suffering harm in the future should be that either:

- the child can be shown to have suffered ill-treatment or impairment of health or development as a result of physical, emotional, or sexual abuse or neglect, and professional judgement is that further ill-treatment or impairment are likely; or
- professional judgement, substantiated by the findings of enquiries in this individual case or by research evidence, is that the child is likely to suffer ill-treatment or the impairment of health or development as a result of physical, emotional, or sexual abuse or neglect.

2.103 If the child protection conference decides that the child is likely to suffer significant harm in the future, the child will therefore require inter-agency help and intervention to be delivered through a formal child protection plan. The primary purposes of this plan are to prevent the child suffering harm or a recurrence of harm in the future and to promote the child's welfare.

2.104 Child protection conference participants should base their judgements on all the available evidence obtained through existing records, the initial assessment and the in-depth core assessment undertaken following the initiation of s47 enquiries, and any other relevant specialist assessments. The method of reaching a decision within the conference on whether the child should be the subject of a child protection plan should be set out in the relevant LSCB protocol. The decision making process should be based on the views of all agencies / professional groups represented at the conference and also take account of any written contributions that have been made.

Pan Dorset Note
Decision making will also need to take into account the need to obtain any missing information.

2.105 If the conference decided that the child is in need of a child protection plan, the chair should determine which category of abuse or neglect the child has suffered or is likely to suffer. The category used (that is physical, emotional, sexual abuse or neglect) will indicate to those consulting the child's social care record the primary presenting concerns at the time the child became the subject of a child protection plan.

The Pan-Dorset decision making process is that:

- each member of the conference should have his/her view heard and recorded;
- each agency / professional group can each convey only one view towards the registration decision (normally determined by the senior representative);
- the decision will reflect the unanimous or majority view, as taken from agency representatives;
- the record of the conference should always include the views and names of any representative who dissents to the decision.
- The decision of the conference and, where appropriate, details of the category of abuse or neglect, the name of the key worker, the lead professional and the core group membership should be circulated to all those invited to the conference within one working day.
- When a conference cannot reach a majority decision regarding registration, the conference chair's view will create the majority required.

Pan-Dorset Missing Information / Deferred Decision Making

In some circumstances the chair and/or conference members may consider that important information is not available or that an interpretation of important information is not available, to the conference.

The chair will normally proceed with the child protection conference, especially where this is an initial conference, so that the opportunity is taken to consider corporately all available information, in order to ensure the child is safeguarded.

The information at this child protection conference may indicate that a child is in need of a child protection plan and this should be drawn up on the basis of available information. The chair should ensure that conference members identify from whom and how the information will be obtained. Missing information should be obtained as soon as possible and shared with the chair and all conference members, in order to contribute to the child protection plan. Conference members need to agree as part of the outline child protection plan how to obtain, share, evaluate and respond to the missing information. The possibility of an early review child protection conference should be considered.

Alternatively it may become evident during the child protection conference that missing information is of crucial importance, and it may be necessary to agree the following steps:

- to adjourn the child protection conference;
- to defer the decision regarding whether a child is in need of a child protection plan, or whether a child protection plan should be discontinued for the period of the adjournment;
- to obtain and respond to the missing information as soon as possible;
- to reconvene the child protection conference within a maximum of 15 working days

An action plan which ensures the safety of the child should be agreed, to cover the period until the reconvened child protection conference takes place.

Chair's right to overrule

The conference chair may not always agree with the majority or unanimous view of the conference and may share her/his view when s/he deems it appropriate. In the rare circumstance where the chair judges that the proposed decision of the conference does not protect the child, s/he would overrule the conference members, insofar as a child's name will be placed on the register or retained on it, to allow senior managers to discuss the matter.

The senior managers in children's services with responsibility for child protection must be informed by the chair, in order to review the case in consultation with appropriate managers from other agencies. Where deemed appropriate following this consultation a further child protection conference will be arranged, within a four week period.

2.106 It is the role of the initial child protection conference to formulate the outline child protection plan in as much detail as possible. The decision of the conference and, where appropriate, details of the category of abuse or neglect, the name of the lead social worker (i.e. the social worker who is the lead professional for the case) and the core group membership should be recorded in a manner that is consistent with the Initial Child Protection Conference Report (Department of Health, 2002) and circulated to all those invited to the conference within one working day.

2.107 Where a child has suffered, or is likely to suffer, significant harm in the future it is the local authority children's social care duty to consider the evidence and decide what, if any, legal action to take. The information presented to the child protection conference should inform that decision making process but it is for the local authority to consider whether it should initiate, for example, care proceedings. In some situations the child may become accommodated and acquire looked after child status. Where a child who is the subject of a child protection plan becomes looked after by the children's services, the child protection plan should form part of the looked after child's overarching care plan (see paragraphs 2.149-2.153).

2.108 A decision may have been made that a child does not require a child protection plan but he or she may nonetheless require services to promote his or her health or development. In these circumstances, the conference together with the family should consider the child's needs and what further help would assist the family in responding to them. Subject to the family's views and consent, it may be appropriate to continue and to complete the core assessment to help determine what support might best help promote the child's welfare. Where the child's needs are complex, inter-agency working will continue to be important. Where appropriate, a child in need plan should be drawn up and reviewed at regular intervals – no less frequent than every six months (see paragraphs 4.33 and 4.36 of the *Framework for the Assessment of Children in Need and their Families*).

2.109 Where a child is to be the subject of a child protection plan, it is the responsibility of the conference to consider and make recommendations on how agencies, professionals and the family should work together to ensure that the child will be safeguarded from harm in the future. This should enable both professionals and the family to understand exactly what is expected of them and what they can expect of others. Specific tasks include the following:

- appointing the lead statutory body (children's social care) and a lead social worker (who is the lead professional), who should be a qualified, experienced social worker and an employee of children's social care;
- identifying the membership of a core group of professionals and family members who will develop and implement the child protection plan as a detailed working tool;
- establishing how the child, their parents (including all those with parental responsibility) and wider family members should be involved in the ongoing assessment, planning and implementation process, and the support, advice and advocacy available to them;
- establishing timescales for meetings of the core group, production of a child protection plan, and for child protection review meetings;
- identifying in outline what further action is required to complete the core assessment and what other specialist assessments of the child and family are required to make sound judgements on how best to safeguard and promote the welfare of the child;
- outlining the child protection plan, especially, identifying what needs to change in order to achieve the planned outcomes to safeguard and promote the welfare of the child;
- ensuring a contingency plan is in place if agreed actions are not completed and/or circumstances change, for example if a caregiver fails to achieve what has been agreed, a court application is not successful or a parent removes the child from a place of safety;
- clarifying the different purpose and remit of the initial conference, the core group, and the child protection review conference; and
- agreeing a date for the first child protection review conference, and under what circumstances it might be necessary to convene the conference before that date.

2.110 The outline child protection plan should:

- identify factors associated with the likelihood of the child suffering significant harm and ways in which the child can be protected through an inter-agency plan based on the current findings from the assessment and information held from any previous involvement with the child and family;
- establish short-term and longer-term aims and objectives that are clearly linked to preventing the child suffering harm or a recurrence of the harm suffered, meeting the child's developmental needs and promoting the child's welfare, including contact with family members;
- be clear about who will have responsibility for what actions – including actions by family members – within what specified timescales;
- outline ways of monitoring and evaluating progress against the planned outcomes set out in the plan; and
- be clear about which professional is responsible for checking that the required changes have taken place, and what action will be taken, by whom, and when they have not.

Complaints about a Child Protection Conference

Pan-Dorset Note
Guidance concerning complaints about child protection conferences is detailed in Chapter 3.3 of the Pan-Dorset Inter-Agency Safeguarding procedures.

2.111 In addition, representations and complaints may be received by individual agencies in respect of services provided (or not provided) as a consequence of assessments and conferences, including those set out in child protection plans. Such concerns should be responded to by the relevant agency in accordance with its own processes for responding to such matters.

Administrative arrangements and record keeping

2.112 Those attending should be notified of conferences as far in advance as possible, and the conference should be held at a time and place likely to be convenient to as many people as possible. All child protection conferences both initial and review, should have a dedicated administrative person to take notes and produce a record of the meeting as a discrete role. The record of the conference is a crucial working document for all relevant professionals and the family. It should include:

- the essential facts of the case;
- a summary of discussion at the conference, which accurately reflects contributions made;
- all decisions and recommendations reached, with information outlining the reasons;
- a translation of decisions into an outline or revised child protection plan, enabling everyone to be clear about their tasks.

Pan Dorset Note
It will also include:
- an analysis of risk;
- an accurate record of any dissents to decisions.
- A reflection of the discussion and the decisions made.
- A contingency plan

2.113 A copy should be sent as soon as possible after the conference to all those who attended or were invited to attend, including family members, except for any part of the conference from which they were excluded. This is in addition to sharing the main decisions within one working day of the conference (see paragraph 2.106).

Pan-Dorset note about sending Conference Record
The full conference record will be completed within **10 working days** and circulated to all those professionals invited to attend the child protection conference and to family members who attended. Other family members who were invited but did not attend or were excluded will received a copy of the full record at the discretion of the chair.

2.114 The record is confidential and should not be passed by professionals to third parties without the consent of either the conference chair or the lead professional. However, in cases of criminal proceedings, the police may reveal the existence of the notes to the CPS in accordance with the Criminal Procedure and Investigation Act 1996. The record of the decisions of the child protection conference should be retained by the recipient agencies and professionals in accordance with their record retention policies.

Action Following the Initial Child Protection Conference

The Role of the Lead Social Worker

2.115 When a conference decides that a child should be the subject of a child protection plan, local authority children's social care should carry statutory responsibility for the child's welfare and designate a qualified and experienced member of its social work staff to be the lead social worker, ie. the lead professional. Each child who is the subject of a child protection plan will have a named lead social worker.

2.116 The lead social worker is responsible for making sure that the outline child protection plan is developed into a more detailed inter-agency plan. S/he should complete the core assessment of the child and family, securing contributions from core group members and others as necessary. The lead social worker is also responsible for acting as the lead professional for the inter-agency work with the child and family. S/he should co-ordinate the contribution of family members and other agencies to planning the actions which need to be taken, putting the child protection plan into effect, and reviewing progress against the planned outcomes set out in the plan. It is important that the role of the lead social worker is fully explained at the initial child protection conference and at the core group.

2.117 The lead social worker should see the child, alone when appropriate, in accordance with the plan. She or he should develop a therapeutic relationship with the child, regularly ascertain the child's wishes and feelings and keep the child up to date with the child protection plan and any developments or changes. The lead social worker should record in the child's local authority social care record when the child was seen and who else, if anyone, was present at the time of each visit and also the reasons for deciding (or not) to see the child alone.

The Core Group

2.118 The core group is responsible for developing the child protection plan as a detailed working tool and implementing it within the outline plan agreed at the initial child protection conference. Membership should include the lead social worker, who chairs the core group, the child if appropriate, family members, and professionals or foster carers who will have direct contact with the family. Although the lead social worker has lead responsibility for the formulation and implementation of the child protection plan, all members of the core group are jointly responsible for carrying out these tasks, refining the plan as needed, and monitoring progress against the planned outcomes set out in the plan. Agencies should ensure that members of the core group undertake their roles and responsibilities effectively in accordance with the agreed child protection plan.

2.119 Core groups are an important forum for working with parents, wider family members, and children of sufficient age and understanding. It can often be difficult for parents to agree to a child protection plan within the confines of a formal

conference. Their co-operation may be gained later when details of the plan are worked out in the core group. Sometimes there may be conflicts of interest between family members who have a relevant interest in the work of the core group. The child's best interests should always take precedence over the interests of other family members.

2.120 The first meeting of the core group and take place within 10 working days of the initial child protection conference. The purpose of this first meeting is to flesh out the child protection plan. The meeting should also decide what steps need to be taken, by whom, to complete the core assessment on time so that future decisions and the provision of services can be fully informed when making decisions about the child's safety and welfare. Thereafter, core groups should meet sufficiently regularly to facilitate working together, monitor actions and outcomes against the child protection plan, and make any necessary alterations as circumstances change.

Pan Dorset Note
The date of the first core group should be determined by the child protection conference. Timescales for core group meetings should be determined by the child protection conference.

2.121 The lead social worker should ensure that there is a record of the decisions taken and actions agreed at core group meetings, as well as of the written views of those who were not able to attend. The child protection plan should be updated as necessary.

Pan Dorset Note
If any professional is unable to fulfil their actions in relation to the child protection plan, including circumstances where access to a child is frustrated and / or denied, that professional should notify their line manager and the lead social worker, who will consult with their manager about future actions to be taken to ensure the child is safe.

Completion of the Core Assessment

2.122 Completion of the core assessment, within 35 working days, should include an analysis of the child's developmental needs and the parents' capacity to respond to those needs within the context of their family and environment. This analysis will include an understanding of the parents' capacity to ensure that the child is safe from harm. It should include consideration of the information gathered about the family's history and their present and past family functioning. It may be necessary to commission specialist assessments (for example, from child and adolescent mental health services, adult mental health or substance misuse services, or a specialist in domestic violence) which it may not be possible to complete within this time period. This should not delay the drawing together of the core assessment findings at this point. A core assessment is deemed complete once the assessment has been discussed with the child and family (or caregivers) and the team manager has viewed and authorised the assessment.

2.123 The analysis of the child's needs and the capacity of the child's parents or caregivers to meet these needs within their family and environment should provide evidence on which to base judgements and decisions on how best to safeguard and promote the welfare of a child and support parents in achieving this aim. Decisions

based on this analysis should consider what the child's future will be like if his or her met needs continue to be met, and if his or her unmet needs continue to be unmet. The key questions are, what is likely to happen if nothing changes in the child's current situation? What are the likely consequences for the child? The answers to these questions should be used to decide what interventions are required when developing the child protection plan and, in particular, in considering what actions are necessary to prevent the child from suffering harm or to prevent a recurrence of the abuse or neglect suffered.

The Child Protection Plan

2.124 The initial child protection conference is responsible for agreeing an outline child protection plan. Professionals and parents/caregivers should develop the details of the plan in the core group. The overall aim of the plan is to:

- ensure the child is safe and prevent him or her from suffering further harm by supporting the strengths, addressing the vulnerabilities and risk factors and helping to meet the child's unmet needs;
- promote the child's health and development i.e. his or her welfare; and
- provided it is in the best interests of the child, to support the family and wider family members to safeguard and promote the welfare of their child.

2.125 The child protection plan should be based on the findings from the assessment following the dimensions relating to the child's developmental needs, parenting capacity and family and environmental factors, and drawing on knowledge about effective interventions. Where the child is also the subject of a care plan, the child protection plan should be part of the looked after child's care plan (see paragraph 2.149). The content of the child protection plans should be consistent with the information set out in the Child Protection Plan record (Department of Health, 2002). It should set out what work needs to be done, why, when and by whom. The plan should:

- describe the identified developmental needs of the child, and what therapeutic services are required to meet these needs;
- include specific, achievable, child-focused outcomes intended to safeguard and promote the welfare of the child;
- include realistic strategies and specific actions to bring about the changes necessary to achieve the planned outcomes;
- set out when and in what situations the child will be seen by the lead social worker, both alone and with other family members or caregivers present;
- clearly identify and set out roles and responsibilities of family members and professionals, including those with routine contact with the child (for example, health visitors, GPs and teachers) and the nature and frequency of contact by professionals with children and family members;
- include a contingency plan to be followed if circumstances change significantly and require prompt action (including initiating family court proceedings to safeguard and promote the child's welfare); and
- lay down points at which progress will be reviewed, and the means by which progress will be judged; and

2.126 The child protection plan should take into account the wishes and feelings of the child, and the views of the parents, insofar as they are consistent with the child's welfare. The lead social worker should make every effort to ensure that the children and parents have a clear understanding of the planned outcomes, that they accept the plan and are willing to work to it. If the parents are not willing to co-operate in the implementation of the plan the local authority should consider what action, including the initiation of family proceedings, it should take to safeguard the child's welfare.

2.127 The plan should be constructed with the family in their preferred language and they should receive a written copy in this language. If family members' preferences are not accepted about how best to safeguard and promote the welfare of the child, the reasons for this should be explained. Families should be told about their right to complain and make representations, and how to do so.

Agreeing the plan with the child

2.128 The child protection plan should be explained to and agreed with the child in a manner which is in accordance with their age and understanding. An interpreter should be used if the child's level of English means that s/he is not able to participate fully in these discussions unless they are conducted in her/his own language. The child should be given a copy of the plan written at a level appropriate to his or her age and understanding, and in his or her preferred language.

Negotiating the plan with parents

2.129 Parents should be clear about the evidence of significant harm which resulted in the child becoming the subject of a child protection plan, what needs to change, and about what is expected of them as part of implementing the plan for safeguarding and promoting their child's welfare. All parties should be clear about the respective roles and responsibilities of family members and different agencies in implementing the plan. The parents should receive a written copy of the plan so that they are clear about who is doing what, when and the planned outcomes for the child.

Intervention

2.130 Decisions about how to intervene, including what services to offer, should be based on evidence about what is likely to work best to bring about good outcomes for the child[13]. A number of aspects of intervention should be considered in the context of the child protection plan, in the light of evidence from assessment of the child's developmental needs, the parents' capacity to respond appropriately to the child's needs, and the wider family and environmental circumstances. Particular attention should be given to family history (for example, of domestic and other forms of violence, childhood abuse, mental illness, substance misuse and/or learning disability) and present and past family functioning.

[13] For further information from research findings on effective interventions see www.dcsf.gov.uk/nsdu/research.shtml

2.131 The following questions need to be considered:

- What are the options for interventions which might help support strengths and / or help meet the child's identified unmet needs as well as addressing the known vulnerabilities and risk factors?
- What resources are available?
- With which agency or professional and with which approach is the family most likely to co-operate?
- Which intervention is most likely to produce the most immediate benefit and which might take time?
- What should be the sequence of interventions and why?
- Given the severity of any ill-treatment suffered or impairment to the child's health or development, the child's current needs and the capacity of the family to co-operate, what is the likelihood of achieving sufficient change within the child's time frame?

2.132 It is important that services are provided to give the child and family the best chance of achieving the required changes. If a child cannot be cared for safely by his or her caregiver(s) she or he will have to be placed elsewhere whilst work is being undertaken with the child and family. Irrespective of where the child is living, interventions should specifically address:

- the developmental needs of the child;
- the child's understanding of what has happened to him or her;
- the abusing caregiver / child relationship and parental capacity to respond to the child's needs;
- the relationship between the adult caregivers both as adults and parents;
- family relationships; and
- possible changes to the family's social and environmental circumstances.

2.133 Intervention may have a number of inter-related components:

- action to make a child safe from harm and prevent recurrence from harm;
- action to help promote a child's health and development i.e. welfare;
- action to help a parent(s)/caregiver(s) in safeguarding a child and promoting his or her welfare;
- therapy for an abused child; and
- support or therapy for a perpetrator of abuse or neglect to prevent future harm to the child and where necessary to other children.

2.134 The development of secure parent–child attachments is critical to a child's healthy development. The quality and nature of the attachment will be a key issue to be considered in decision making, especially if decisions are being made about moving a child from one setting to another; re-uniting a child with his or her birth family; or considering a permanent placement away from the child's family. If the plan is to assess whether the child can be reunited with the caregiver(s) responsible for the maltreatment, very detailed work will be required to help the caregiver(s) develop the necessary parenting skills.

2.135 A key issue in deciding on suitable interventions will be whether the child's developmental needs can be responded to within his or her family context, and **within timescales that are appropriate for the child**. These timescales may not be compatible with those for the caregiver(s) who is/are in receipt of therapeutic help. The process of decision making and planning should be as open as possible, from an ethical as well as practical point of view. Where the family situation is not improving or changing fast enough to respond to the child's needs, decisions will be necessary about the long-term future of the child. In the longer term it may mean it will be in the best interests of the child to be placed in an alternative family context. Key to these considerations is what is in the child's best interests, informed by the child's wishes and feelings and by the parents' capacity to make the required changes.

2.136 Children who have suffered significant harm may continue to experience the consequences of this abuse irrespective of where they are living, whether remaining with or being reunited with their families or alternatively being placed in new families; this relates particularly to their behavioural and emotional development. Therapeutic work with the child should continue, therefore, irrespective of where the child is placed, in order to ensure the needs of the child are responded to appropriately.

2.137 More information to assist with making decisions about interventions is available in the Chapter 4 of the Assessment Framework and the accompanying practice guidance (Department of Health, 2000). Recent research evidence on effective interventions in safeguarding children has been published by DCSF and DH95[14].

The Child Protection Review Conference

Timescale

2.138 The first child protection review conference should be held within three months of the initial child protection conference, and further reviews should be held at intervals of not more than six months for as long as the child remains the subject of a child protection plan. Where the child is also looked after, the child protection review should be part of the looked after child review (see paragraphs 2.149-2.153).It is important to ensure that momentum is maintained in the process of safeguarding and promoting the welfare of the child. Where necessary, reviews should be brought forward to address changes in the child's circumstances. Attendees should include those most involved with the child and family in the same way as at an initial child protection conference, and the LSCB protocols for establishing a quorum should apply.

Pan-Dorset Note
Situations when a review may be brought forward should include where there is a need to significantly revise the child protection plan.

[14] www.dcsf.gov.uk/cgi-bin/rsgateway/search.pl?cat=3&subcat=3_1&q1=Search

Purpose

2.139 The purposes of the child protection review are to

- review whether the child is continuing to suffer, or is likely to suffer significant harm and their health and development against planned outcomes set out in the child protection plan;
- to ensure that the child continues to be safeguarded from harm; and
- to consider whether the child protection plan should continue or should be changed.

2.140 The reviewing of the child's progress and the effectiveness of interventions are critical to achieving the best possible outcomes for the child. The child's wishes and feelings should be sought and taken into account during the reviewing process. Every review should consider explicitly whether the child is suffering, or is likely to suffer, significant harm and hence continues to require safeguarding from harm through adherence to a formal child protection plan. If not, then the child should no longer be the subject of a child protection plan. If the child is considered to be suffering significant harm, the local authority should consider whether to initiate family court proceedings. For further guidance see Volume 1 of the Children Act 1989 Guidance and Regulations, Court Orders[15] .

2.141 The same LSCB decision-making procedure should be used to reach a judgement on continuing to have a child protection plan as is used at the initial child protection conference (see 2.101). As with initial child protection conferences, the relevant LSCB protocol should specify a required quorum for attendance at review conferences (see 2.88). As a minimum, at every review conference there should be attendance by local authority children's social care and at least two other professional groups or agencies, which have had direct contact with the child who is the subject of the conference. In addition, attendees may also include those whose contribution relates to their professional expertise or responsibility for relevant services. In exceptional cases, where a child has not had relevant contact with three agencies (that is, local authority children's social care and two others), this minimum quorum may be breached.

2.142 The review requires as much preparation, commitment and management as the initial child protection conference. Each member of the core group has a responsibility to produce an individual agency report on the child and family for the child protection review. Together these reports provide an overview of the wor undertaken by family members and professionals and evaluate the impact of the interventions on the child's welfare against the planned outcomes set out in the child protection plan. Those unable to attend should send their report to the lead social worker prior to the core group meeting[16] and where possible, delegate attendance to a well-briefed colleague. The content of the report to the review child protection conference should be consistent with the information set out in the Child Protection Review (DoH, 2002).

[15] www.dcsf.gov.uk/everychildmatters/publications/documents/childrenactguidanceregulations/.

[16] Jill Aiken believes this is an error in WT 2010 and should refer to RCPC not core group.

Discontinuing the Child Protection Plan

2.143 A child should no longer be the subject of a child protection plan if:

- it is judged that the child is no longer continuing to, or likely to suffer significant harm and therefore require safeguarding by means of a child protection plan (for example, the likelihood of harm has been reduced by action taken through the child protection plan; the child and family's circumstances have changed; or re-assessment of the child and family indicates that a child protection plan is not necessary). Under these circumstances, only a child protection review conference can decide that a child protection plan is no longer necessary;
- the child and family have moved permanently to another local authority area. In such cases, the receiving local authority should convene a child protection conference within 15 working days of being notified of the move, only after which event may discontinuing the child protection plan take place in respect of the original local authority's child protection plan; the child has reached 18 years of age (to end the child protection plan, the local authority should have a review around the child's birthday and this should be planned in advance), has died or has permanently left the UK.

Pan-Dorset Note

The status of children subject to a child protection plan must not be changed until the children's views about this have been ascertained (independently of parents) and discussed in the appropriate multi-agency forum. Specifically, the child's view must be ascertained prior to any CP review conference, with the use of advocacy service as necessary and taken into account in the decision making process.

Child Protection Plans must not be discontinued until a Core Assessment has been completed and fully recorded, including an analysis of the child's needs, parenting capacity and family dynamics, including risks and outcomes of interventions. The outcome of the Core Assessment must be included in the social worker's report and considered at the CP Conference during the decision making process.

Discontinuation at a first review conference should only occur in exceptional circumstances, for example where;

- The child is no longer cared for by or living with the person attributed with being responsible for placing them at risk of significant harm e.g. they may be looked after by a member of the extended family or in foster care and permanency planning is in place.
- The child was subject to a pre-birth conference and is the youngest of a sibling group where progress on the child protection plan has been made over a period of time.
- The initial conference was as a result of the family moving from another area i.e. a transfer conference, and the assessment concludes the family's circumstances have changed sufficiently to permanently reduce the risk of harm. This should include an assessment of stability where there is a history of moving home.
- Where an older young person has expressed a clear wish not to be subject to a child protection plan, their vulnerability/resilience has been assessed and they have sufficient support outside of their immediate family to go to for advice or help if their home circumstances change

2.144 When a child is no longer the subject of a child protection plan, notification should be sent, as minimum, to all those agency representatives who were invited to attend the initial child protection conference that led to the plan.

2.145 A child who is no longer the subject of a child protection plan may still require additional support and services. Discontinuing the child protection plan should never lead to the automatic withdrawal of help. The key worker should discuss with the parents and the child what services might be wanted and required, based upon the re-assessment of the needs of the child and family.

Pan Dorset Note
Discontinuing a child protection plan where a key professional is not present or a minimum quorum for decision making has not been reached.

Although the chair has decided that the representation is sufficient for a conference to proceed, there may be a professional who has a key role with child / family who is not present or whose views are not clear; or it may be that the minimum quorum for decision-making has not been reached. Where the chair deems this is so, discontinuation of the child protection plan as recommended by the conference cannot take place until the agreement of the identified professional/s has been confirmed. The chair may decide this is applicable even where a professional who was not present, has provided a written report prior to the conference. The chair of the conference should write to the identified professional/s seeking their agreement to discontinuation of the child protection plan, at the point the full conference minutes are circulated.

If there are no dissenting views the parents and all key professionals will be informed of the confirmation to discontinue the child protection plan.

If dissenting views are received, the chair will communicate with the relevant professional, and if the situation remains unresolved, will bring the reasons for the dissenting views to the attention of their manager. This manager will consider the dissenting views in consultation with the chair and managers in key agencies as appropriate in reaching a decision as to whether the conference should be reconvened or whether the decision to discontinue the child protection plan can be confirmed.

Where is it necessary for a conference to be reconvened this should occur within 4 weeks of the original conference.

Children Looked After by the Local Authority

2.146 In most cases where a child who is the subject of a child protection plan becomes looked after it will no longer be necessary to maintain the child protection plan. There are however a relatively few cases where safeguarding issues will remain and a looked after child should also have a child protection plan. These cases are likely to be where a local authority obtains an interim care order in family proceedings but the child or young person who is the subject of a child protection plan remains at home, pending the outcome of the final hearing or where a young person's behaviour is likely to result in significant harm to themselves or others.

2.147 Where a looked after child remains the subject of a child protection plan it is expected that there will be a single planning and reviewing process, led by the Independent Reviewing Officer (IRO), which meets the requirements of both this guidance and the Care Planning, Placement and Case Review (England) Regulations 2010 and accompanying statutory guidance *Putting Care into Practice*.

2.148 The systems and processes for reviewing child protection plans and plans for looked after children should be carefully evaluated by the local authority and consideration given to how best to ensure the child protection aspects of the care plan are reviewed as part of the overall reviewing process leading to the development of a single plan. Given that a review is a process and not a single meeting, both reviewing systems should be aligned in an unbureaucratic way to enable the full range of the child's or young person's needs to be considered in the looked after child's care planning and reviewing processes.

2.149 It is recognised that there are different requirements for independence of the IRO function compared to the chair of the child protection conference. In addition, it is important to note that the child protection conference is required to be a multiagency forum while children for the most part want as few external people as possible at a review meeting where they are present. However, it will not be possible for the IRO to carry out his or her statutory function without considering the child's safety in the context of the care planning process. In this context consideration should be given to the IRO chairing the child protection conference where a looked after child remains the subject of a child protection plan. Where this is not possible it will be expected that the IRO will attend the child protection review conference.

2.150 This means that the timing of the review of the child protection aspects of the care plan should be the same as the review under the Care Planning, Placement and Case Review (England) Regulations 2010, to ensure that up to date information in relation to the child's welfare and safety is considered within the review meeting and informs the overall care planning process. The looked after child's review when reviewing the child protection aspects of the plan should also consider whether the criteria continue to be met for the child to remain the subject of a child protection plan. Significant changes to the care plan should only be made following the looked after child's review.

Pan Dorset Note – Adoption

Children who are Accommodated and/or subject to an Order and Looked After, and for whom it is not possible to rehabilitate with their parents, extended family or other carers may be placed for adoption.

It can all too easily be assumed that these children are safe from significant harm and are not at risk from abuse. This is not always the case (see Brighton and Hove, Part 8 Report concerning JAS, 2001).

It is crucial to ensure that all children placed for adoption continue to be reviewed in accordance with Regulation 36, Adoption Agencies Regulations 2005, as part of the continuing review process until the Adoption Order is made. Vigilance should be applied to such children as would be the case for any child who is Looked After.

All adopted children including those who are in receipt of adoption support services should be provided with the same level of protection under safeguarding procedures as any other child.

Adoption support workers and others working with a child who is receiving adoption support services should ensure that allegations of abuse or neglect of a child placed in Bournemouth, Dorset or Poole are followed up in compliance with these inter agency procedures. If the child is placed in another Local Authority area but still receiving adoption support services from Bournemouth, Dorset or Poole, concerns should be referred to the Local Authority in which the child resides for follow up under local safeguarding procedures. Bournemouth, Dorset and Poole and other Local Authorities should work co-operatively to ensure allegations are fully investigated. The responsible Authority should retain a written record of any investigation and its outcome.

Historical allegations

Historical allegations of abuse or neglect made by children or adults should be followed up using these inter-agency safeguarding procedures as for any other child.

Liaison will be required between the Authority or service receiving the allegation and the Authority (and relevant agencies) where the abuse is alleged to have occurred. The advice of legal services should also be sought at the earliest opportunity since there may be issues of disclosure to consider and potential litigation, particularly where the child or adult was in the care of the Local Authority.

Historical allegations of abuse or neglect made by children and adults who have been adopted, pertaining to their care before they were placed for adoption, should be followed up using these inter-agency safeguarding procedures as for any other child or adult. Adults and children who have received an adoption support service should be made aware that they should contact the adoption support service in the event of a historical allegation of abuse or neglect, so that the adoption support service can refer to the safeguarding service in the area where it is alleged that the abuse took place.

Pre-Birth Child Protection Conferences and Reviews

2.151 Where a core assessment under s47 of the Children Act 1989 gives rise to concerns that an unborn child may be likely to suffer significant harm, local authority children's social care may decide to convene an initial child protection conference prior to the child's birth. Such a conference should have the same status, and proceed in the same way, as other initial child protection conferences, including decisions about a child protection plan. Similarly in respect of child protection review conferences. The involvement of midwifery services is vital in such cases.

Recording that a child is the subject of a child protection plan

2.152 Local authority children's social care IT systems should be capable of recording in the child's case record when the child is the subject of a child protection plan, including where the child is also looked after by the local authority. A key purpose of having the IT capacity to record that a child is the subject of a child protection plan is to enable agencies and professionals, when appropriate, to be aware that these children are the subject of a child protection plan. It is equally important that agencies and professionals can obtain relevant information about any child in need who is known or has been known to the local authority. Consequently, agencies and professionals who have concerns about a child's safety and welfare should be able to obtain information about a child that is recorded on the local

[17]. It is essential that legitimate enquirers such as police and health professionals are able to obtain this information both in and outside office hours.

2.153 Children should be recorded as having been, or being likely to be abused or neglected under one or more of the categories of physical, emotional, or sexual abuse or neglect, according to a decision by the chair of the child protection conference. These categories help indicate the nature of the current concerns. Recording information in this way also allows for the collation and analysis of information locally and nationally and for its use in planning the provision of services. The categories selected should reflect all the information obtained in the course of the initial assessment and core assessment under section 47 or the Children Act 1989 and subsequent analysis, and should not just relate to one or more abusive incidents. The initial category may change as new information becomes available during the time that the child is the subject of a child protection plan.

Pan Dorset Note
Bournemouth, Dorset and Poole children's services each have their own separate computerised system, which has the names of children in each respective authority area for whom there is a child protection plan. The principle purpose of being able to record that a child is the subject of a child protection plan is to enable agencies and professionals to be aware of those children who are judged to be at continuing risk of significant harm and who are the subject of a child protection plan. Additionally, agencies and professionals can obtain relevant information about other children who are known or have been known to the local authority.

Managing and Providing Information about a Child

2.154 Each Local Authority should designate a manager, normally an experienced social worker, who has responsibility for:

- ensuring that each local authority record on a child who has a child protection plan is kept up to date;
- ensuring enquiries about children about whom there are concerns or who have child protection plans are recorded and considered in accordance with paragraph 2.155;
- managing other notifications of movements of children into or out of the local authority area such as children who have a child protection plan and looked after children;
- managing notifications of people who may pose a risk of significant harm to children who are either identified with the local authority area or have moved into the local authority area; and
- managing requests for checks to be made to ensure unsuitable people are prevented from working with children.

This manager should be accountable to the Director of Children's Services.

2.155 The child's individual file should provide a record of information known to local authorities children's social care about that child and therefore it should be kept

[17] www.everychildmatters.gov.uk/socialcare/ics

up-to date on the LA's ICS IT system. The content of the child's record should be confidential, available only to legitimate enquirers. This information should be accessible at all times to such enquirers. The details of enquirers should always be checked and recorded on the system before information is provided.

2.156 If an enquiry is made about a child and the child's case is open to LA children's social care, the enquirer should be given the name of the child's lead social worker, and the lead social worker should be informed of this enquiry so that they can follow it up. If an enquiry is made about a child at the same address as a child who is the subject of a child protection plan, this information should be sent to the lead social worker of the child who is the subject of the child protection plan. If an enquiry is made but the child is not known to LA children's social care, this enquiry should be recorded on a contact sheet, together with the advice given to the enquirer. In the event of a second enquiry about a child who is not known to children's social care, not only should the fact of the earlier enquiry be notified to the later enquirer, but the designated manager should ensure that LA children's social care considers whether this is, or may be, a child in need.

2.157 The Department for Children, Schools and Families holds a list of the names of designated managers and should be notified of any changes in designated managers.

Pan Dorset Note

When a professional is concerned that a child living in Bournemouth, Dorset or Poole is suspected of suffering or likely to suffer significant harm, an enquiry should be made of the designated manager of the local authority in which the child is living. When it is known or suspected that a child has previously lived in another local authority, enquiries should also be made of the designated managers for each of those authorities.

All agencies and professionals may make enquiries when the above criteria is met. The Out of Hours Service acts as the designated manager for Bournemouth, Dorset and Poole outside of normal working office hours, and thus has the ability to make enquiries and checks of the information held in all three local authority areas.

The enquirer should normally discuss their concerns with the family (see paragraph 2.14) and inform that enquiries are being made of the designated manager in children's services.

The enquirer must provide as much information as is available in respect of the child and family details in order for a comprehensive check to be completed. Details required include:

- child's full name and aliases
- child's date of birth
- present address and previous addresses where known
- details of parents/carers/significant others with date of birth where available
- the Enquirer's name, role and agency/organisation.
- Details of the enquirer, e.g.: name, agency and telephone number will be taken.

All enquirers will be telephoned back with the information requested to a recognised telephone number only.

The necessary details in respect of the enquiring and enquirer will be recorded.

The following information will be provided to the enquirer:

- whether the child is currently the subject of a child protection plan
- whether the child has previously been the subject of a child protection plan
- whether there has been a child protection conference but the child was not deemed to require a child protection plan
- whether the child's case is/has been open to children's services and the name of the child's key worker
- whether there has been any other relevant information in respect of family members / members of the household.

In the event of an enquiry being made about a child who is an open case to children's services, the appropriate designated manager will ensure that the key worker for the child is notified of the enquiry.

If an enquiry is made about a child at the same address as a child who is an open case to children's services, the designated manager will ensure the key worker for the child is notified of the enquiry.

In the event of a second enquiry being received about a child who is not an open case to children's services the fact of the earlier enquiry will be notified to the latter enquirer. The designated manager will also be notified of both enquiries. The designated manager will then pass the details of both enquiries to the relevant children's services team who must then consider whether this is or may be a child in need.

Any further action to safeguard the child including referral to children's services is the responsibility of the enquirer.

Recording in individual cases

2.158 Keeping a good quality record about work with a child in need and his or her family is an important part of the accountability of professionals to those who use their services. It helps to focus work, and it is essential to working effectively across agency and professional boundaries. Clear and accurate records ensure that there is a documented account of an agency's or professional's involvement with a child and/or family or caregiver. They help with continuity when individual workers are unavailable or change, and they provide an essential tool for managers to monitor work or for peer review. The child or adult's record is an essential source of evidence for investigations and inquiries, and may also be required to be disclosed in court proceedings. Where a child has been the subject of a s47 enquiry which did not result in the substantiation of referral concerns, his or her record should be

2.159 To serve these purposes records relating to work with the child and his or her family should use clear, straightforward language, be concise, and be accurate not only in fact, but also in differentiating between opinion, judgement and hypothesis.

2.160 Well kept records about work with a child and his or her family provide an essential underpinning to good professional practice. Safeguarding and promoting the welfare of children requires information to be brought together from a number of sources and careful professional judgements to be made on the basis of this information. These records should be clear, accessible and comprehensive, with judgements made and decisions and interventions carefully recorded. Where decisions have been taken jointly across agencies, or endorsed by a manager, this should be made clear.

2.161 The records (Department of Health, 2002) produced to support the implementation of the Integrated Children's System contain the information requirements for local authority children's social care together with others when recording information about work with an individual child in need and his or her family. The appropriate type of record to use at different stages of the process of working with a child and his or her family has been referenced throughout this chapter.

2.162 The GP should retain child protection initial conference and review reports as part of the child's health record, where practicable. Ultimately, it is down to the individual GP, depending on their type of health recording system, to make the best judgement on how to incorporate this information into the child's health record.

Request for a change of worker

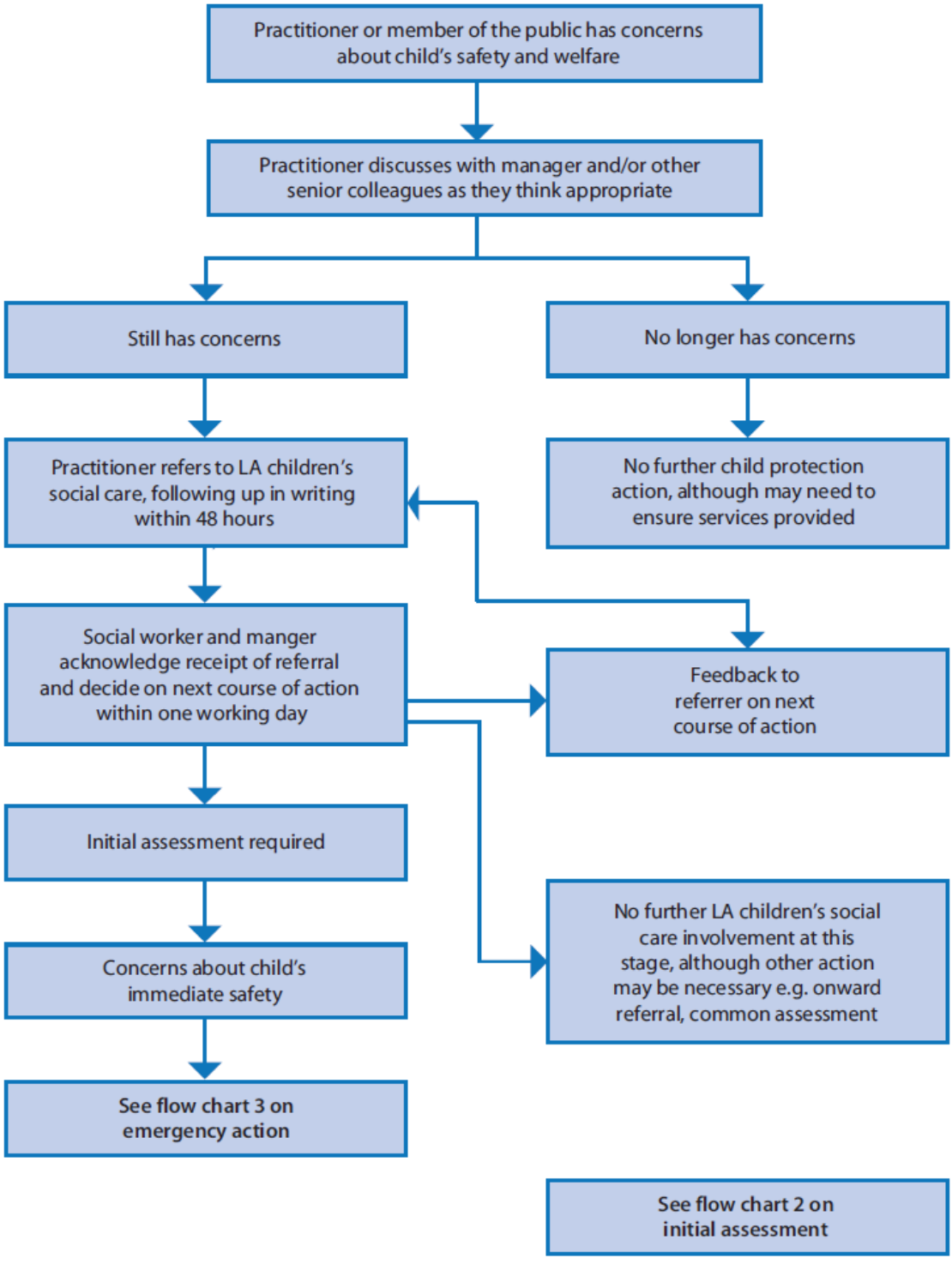
2.163 Occasions may arise where relationships between parents, or other family members, are not productive in terms of working to safeguard and promote the welfare of their children. In such instances, agencies should respond sympathetically to a request for a change of worker, provided that such a change can be identified as being in the interests of the child who is the focus of concern.

Pan Dorset Note
Effective Support and Supervision
Working to ensure children are protected from harm requires sound professional judgements to be made. It is demanding work that can be distressing and stressful. All of those involved should have access to advice and support from, for example, peers, managers, named and designated professionals.

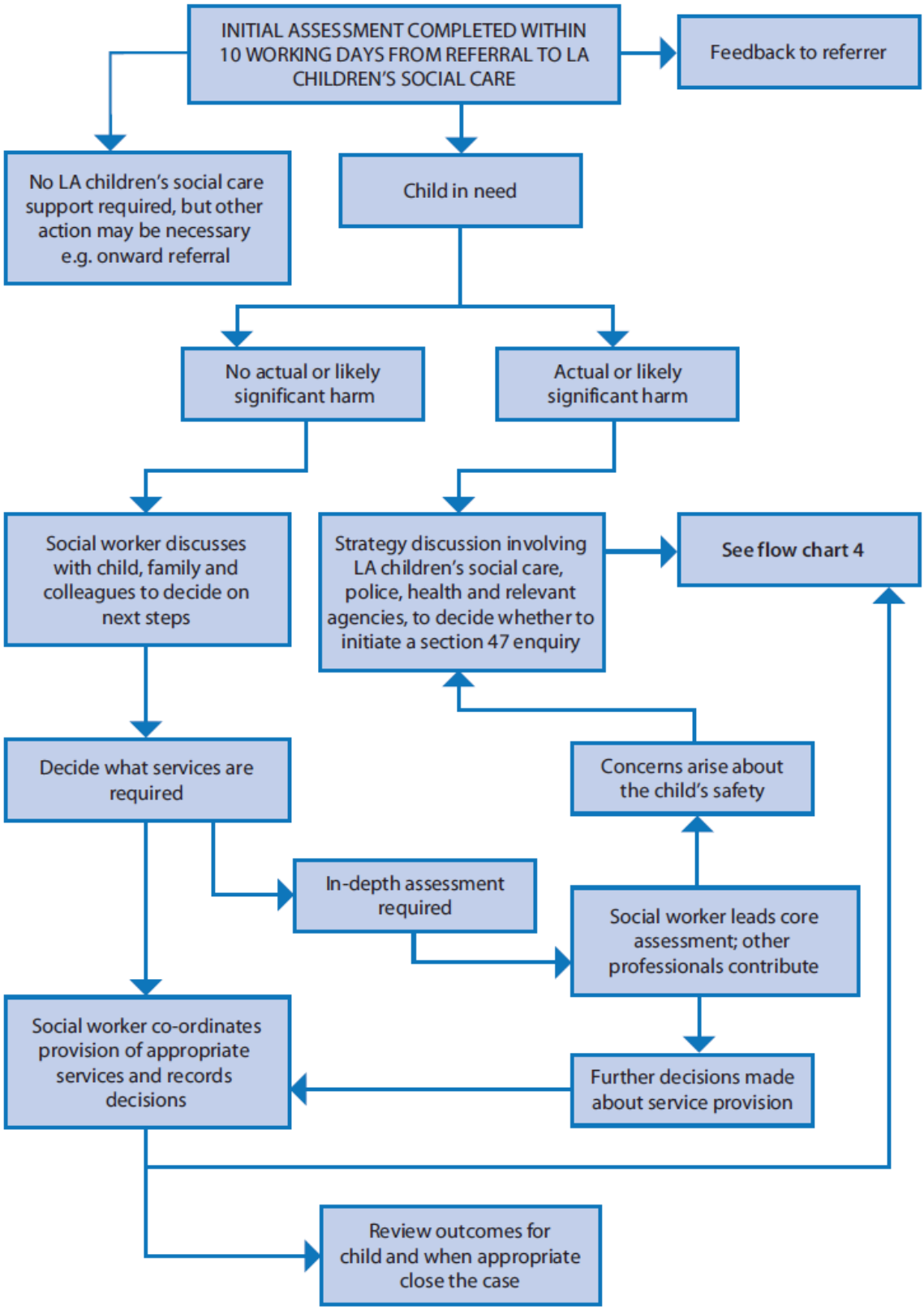
For many practitioners involved in day-to-day work with children and families, effective supervision is important to promoting good standards of practice and to supporting individual staff members. Supervision should help to ensure that practice is soundly based and consistent with good practice and organisational procedures. It should ensure that practitioners fully understand their roles, responsibilities and the scope of their professional discretion and authority. It should also help identify the training and development needs of practitioners, so that each has the skills to provide an effective service.

Supervision should include reflecting on and scrutinising and evaluating the work carried out, assessing the strengths and weaknesses of the practitioner and providing coaching development and pastoral support. Supervisors should be available to practitioners as an important source of advice and expertise and may be required to endorse judgements at certain key points in time. Supervisors should also record key decisions within the child's case records.

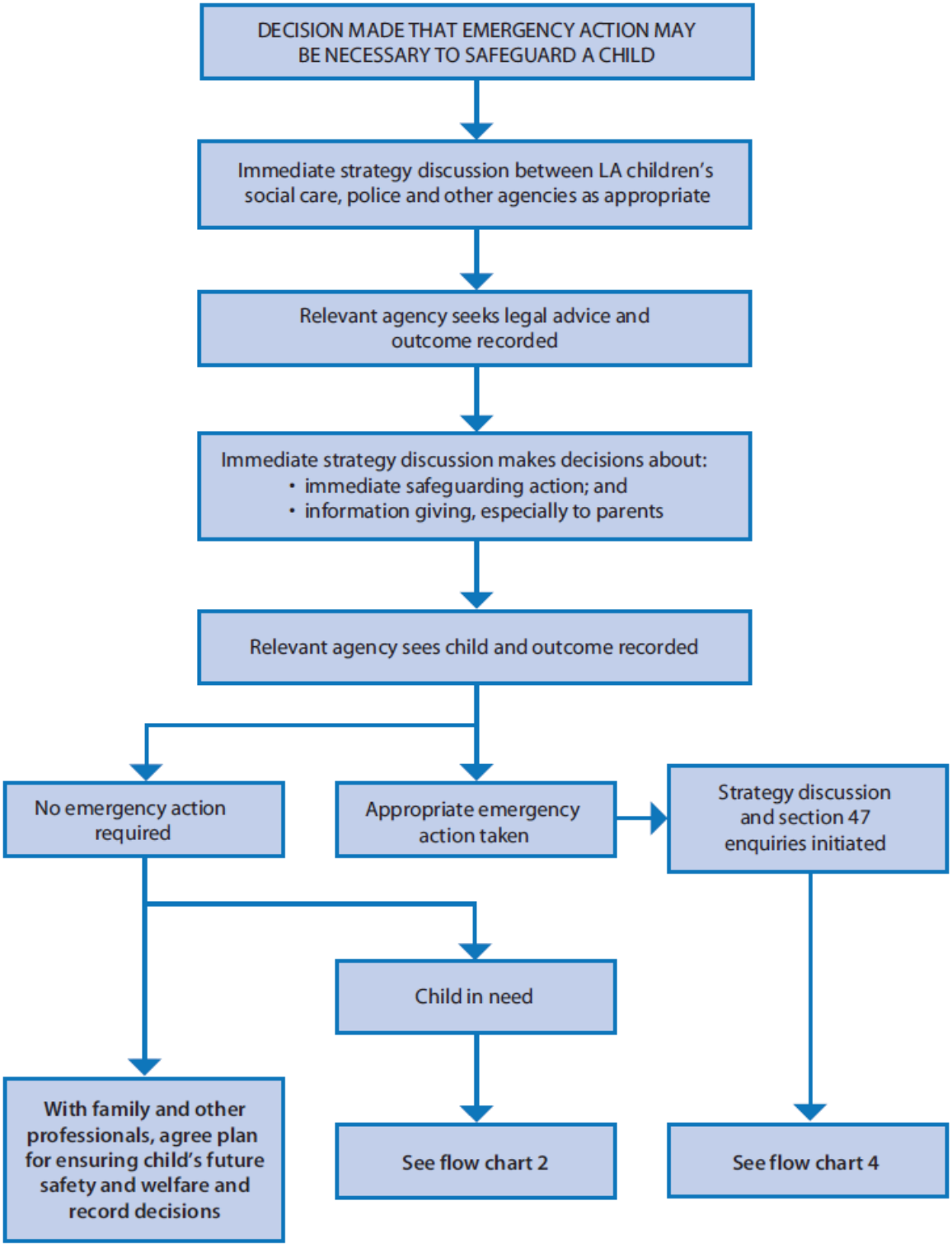
Flow Chart 1: Referral



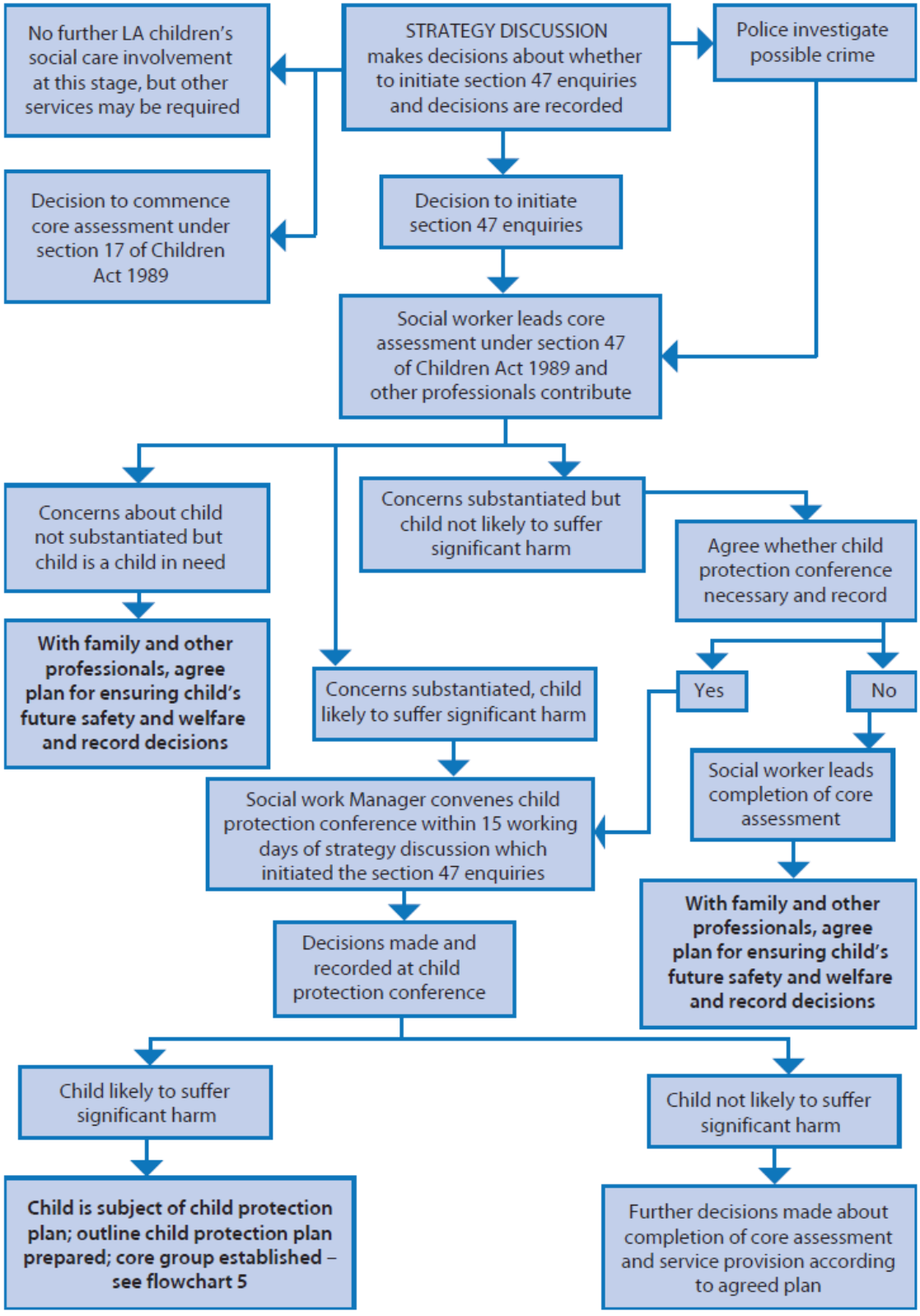
Flow Chart 2: What happens following initial assessment



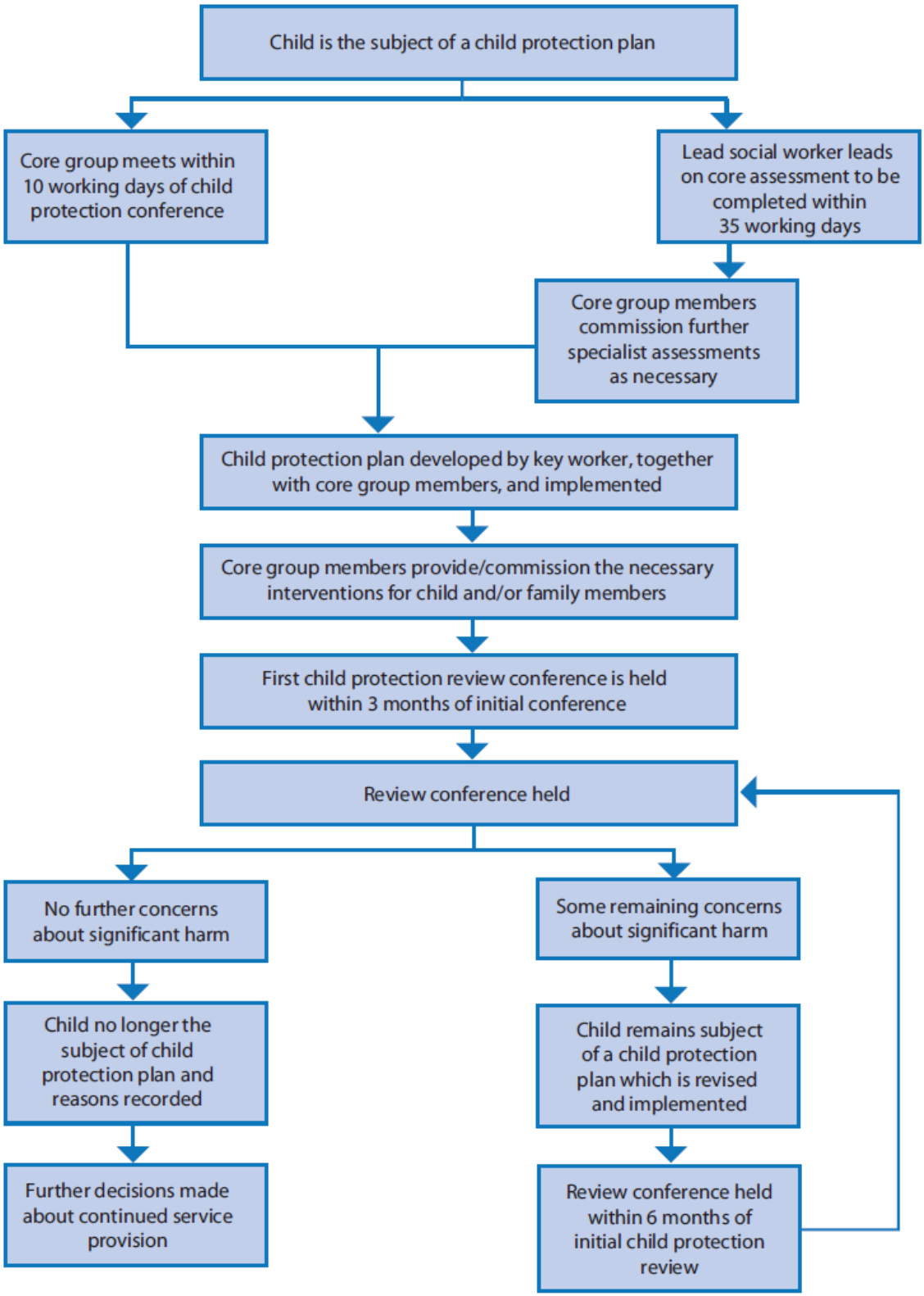
Flow chart 3: Urgent action to safeguard children



Flow chart 4: What happens after the strategy discussion?



Flow chart 5: What happens after the child protection conference, including the review process?



Bournemouth & Poole Local Safeguarding Children Board

Dorset Safeguarding Children Board

PAN DORSET INTER-AGENCY SAFEGUARDING PROCEDURES

CHAPTER 3

3.1 GUIDANCE ON CONSENT, CONFIDENTIALITY AND INFORMATION SHARING
'WHAT TO DO IF YOU'RE WORRIED A CHILD IS BEING ABUSED'

Procedures Effective from: **2006**

Review Date: **2012**

If you have any comments or queries about the pan-Dorset procedures please contact your agency representative on the Pan Dorset Policy and Procedures Group or notify the LSCB using the following email addresses:

info@dorsetlscb.co.uk
info@bournemouth-poole-lscb.org.uk

HM Government

What to do if you're worried a child is being abused – Summary









Every Child Matters
Change For Children

NON-STATUTORY GUIDANCE

Contents

Introduction – Safeguarding children 3

Everyone working with children and families should… 4

If you have concerns about a child's welfare… 6

Everyone should… 6

Social workers and their managers, in responding to a referral, should… 8

Police officers should… 9

What should happen later in the child protection process 10

Social workers and their managers should… 10

Police officers should… 10

Everyone else should… 10

If you need further information 11

Flow chart 1 – Referral 12

Flow chart 2 – What happens following initial assessment? 13

Flow chart 3 – Urgent action to safeguard children 14

Flow chart 4 – What happens after the strategy discussion? 15

Flow chart 5 – What happens after the child protection conference, including the review process? 16

Appendix 1 – Information sharing 17

Flowchart of key principles for information sharing 19

Introduction – Safeguarding children

All those who come into contact with children and families in their everyday work, including practitioners who do not have a specific role in relation to safeguarding children, have a duty to safeguard and promote the welfare of children. You are likely to be involved in three main ways:

- you may have concerns about a child, and refer those concerns to children's social care or the police. School staff (both teaching and non-teaching) should be aware of the local procedures to be followed for reporting concerns about a particular child. This will normally be via the school's designated senior member of staff or their nominated deputy or if neither are available, another senior member of the school's staff. In emergencies however, contact the police direct;
- you may be approached by children's social care and asked to provide information about a child or family or to be involved in an assessment. This may happen regardless of who made the referral to children's social care;
- you may be asked to provide help or a specific service to the child or a member of their family as part of an agreed plan and contribute to the reviewing of the child's progress.

The flow charts starting on page 12 illustrate the processes for safeguarding children:

- from the point that concerns are raised about a child and are referred to a statutory agency that can take action to safeguard and promote the welfare of the child (flow chart 1);
- through an initial assessment of the child's situation and what happens after that (flow chart 2);
- taking urgent action, if necessary (flow chart 3);
- to the strategy discussion, where there are concerns about the child's safety, and beyond that to the child protection conference (flow chart 4); and
- what happens after the child protection conference, and the review process (flow chart 5).

Everyone working with children and families should…

- Be familiar with and follow your organisation's procedures and protocols for promoting and safeguarding the welfare of children in your area, and know who to contact in your organisation to express concerns about a child's welfare.
- Remember that an allegation of child abuse or neglect may lead to a criminal investigation, so don't do anything that may jeopardise a police investigation, such as asking a child leading questions or attempting to investigate the allegations of abuse.
- If you are responsible for making referrals, know who to contact in police, health, education, school and children's social care to express concerns about a child's welfare.

- When referring a child to children's social care you should consider and include any information you have on the child's developmental needs and their parents'/carers' capacity to respond to these needs within the context of their wider family and environment. This information may have been obtained during the completion of a Common Assessment (2006). Similarly, when contributing to an assessment or providing services you should consider what contribution you are able to make in respect of each of these three domains. Specialist assessments, in particular, are likely to provide information relevant to a specific dimension, such as health, education or family functioning.

- See the child and ascertain his or her wishes and feelings as part of considering what action to take in relation to concerns about the child's welfare.

- Communicate with the child in a way that is appropriate to their age, understanding and preference. This is especially important for disabled children and for children whose preferred language is not English. The nature of this communication will also depend on the substance and seriousness of the concerns and you may require advice from children's social care or the police to ensure that neither the safety of the child nor any subsequent investigation is jeopardised. Where concerns arise as a result of information given by a child it is important to reassure the child but not to promise confidentiality.

- Record full information about the child at first point of contact, including name(s), address(es), gender, date of birth, name(s) of person(s) with parental responsibility (for consent purposes) and primary carer(s), if different, and keep this information up to date. In schools, this information will be part of the pupil's record.

- Record in writing all concerns, discussions about the child, decisions made, and the reasons for those decisions. The child's records should include an up-to-date chronology, and details of the lead worker in the relevant agency – for example, a social worker, GP, health visitor or teacher.

If you have concerns about a child's welfare…

Everyone should…

- Discuss your concerns with your manager, named or designated health professional or designated member of staff, depending on your organisational setting. If you still have concerns, you or your manager could also, without necessarily identifying the child in question, discuss your concerns with senior colleagues in another agency in order to develop an understanding of the child's needs and circumstances.

- If, after this discussion, you still have concerns, and consider the child and their parents would benefit from further services, consider which agency, including another part of your own, you should make a referral to. If you consider the child is or may be

a child in need, you should refer the child and family to children's social care. This may include a child whom you believe is, or may be at risk of, suffering significant harm. If your concerns are about a child who is already known to children's social care, the allocated social worker should be informed of your concerns. In addition to children's social care, the police and the NSPCC have powers to intervene in these circumstances.

- In general, seek to discuss your concerns with the child, as appropriate to their age and understanding, and with their parents and seek their agreement to making a referral to children's social care unless you consider such a discussion would place the child at an increased risk of significant harm. (Appendix 1 sets out six key points on information sharing reproduced from *Information sharing: Practitioners' guide* (HM Government 2006) – Section 4 of this information sharing guidance provides more in-depth guidance on consent, confidentiality and information sharing. See www.ecm.gov.uk/deliveringservices/informationsharing)
- When you make your referral, agree with the recipient of the referral what the child and parents will be told, by whom and when.
- If you make your referral by telephone, confirm it in writing within 48 hours. Children's social care should acknowledge your written referral within one working day of receiving it, so if you have not heard back within 3 working days, contact children's social care again.

Social workers and their managers, in responding to a referral, should…

- Following a referral, you and your manager should decide on the next course of action within one working day and record this decision on the Referral and Information Record (Department of Health, 2002). Further action may include undertaking an initial assessment, referral to other agencies, provision of advice or information, or no further action.

- If you and your manager decide that you should take no further action at this stage, tell the referrer of this decision and the reasons for making it. Where a referral has been received from a member of the public, do this in a way that is consistent with respecting the confidentiality of each party.

- New information may be received about a child or family where the child or family member is already known to children's social care. If the child's case is open, and there are concerns that the child is or may be suffering harm, then a decision should be made about whether a strategy discussion should be initiated. It may not be necessary to undertake an initial assessment before deciding what to do next. It may, however, be appropriate to undertake a core assessment or to update a previous one, in order to understand the child's current needs and circumstances and inform future decision-making. If this information causes you to be concerned about a child's safety then discuss it with your manager. If you consider the child is or may be suffering harm, decide whether, as the child and family will be well known to children's social care it is appropriate to hold a strategy discussion without undertaking an initial assessment.

- You and your manager should consider whether a crime may have been committed. If so, discuss the child with the police at the earliest opportunity, as it is their responsibility to carry out any criminal investigation in accordance with the agreed plan for the child.

- When you have received a referral from a member of the public, rather than another professional, remember that personal information about referrers, including anything that could identify them, should only be disclosed to third parties (including subject families and other agencies) with the consent of the referrer. If the police are involved, you will need to discuss with them when to inform the parents about referrals from third parties, as this will have a bearing on the conduct of police investigations.

Police officers should…

- Where you become involved with a child about whom you have child welfare concerns, refer to children's social care and agree a plan of action.

- Where you are contacted by children's social care about a child, consider whether to begin a criminal investigation and lead on any investigation.

- Undertake the evidence gathering process whilst working in partnership and sharing relevant information with children's social care and other agencies.

- Take immediate action where necessary to safeguard a child, consulting with children's social care and agreeing a plan of action as soon as practicable.

What should happen later in the child protection process

Social workers and their managers should…

- Lead on the assessment and planning processes, ensuring planned interventions are carried out and the child's developmental progress reviewed, and provide support or specific services to the child or member of the family as part of an agreed plan.

Police officers should…

- Investigate any allegations of crime or suspected crime and use the information gained to assist other agencies in understanding the child's circumstances, in the interests of the child's welfare.
- Investigate the criminal history of any known or suspected offender and where appropriate refer to the multi-agency public protection arrangements (MAPPA) so that any future risk of serious harm can be properly assessed and managed.

Everyone else should…

- provide relevant information to children's social care or the police about the child or family members;
- contribute to initial or core assessments and undertake specialist assessments, if requested, of the child or family members;

- provide support or specific services to the child or member of the family as part of an agreed plan, and contribute to the reviewing of the child's developmental progress.

If you need further information

Framework for the Assessment of Children in Need and their Families. Website: http://www.dh.gov.uk/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4003256&chlc=fss1lca

Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children. Website: http://www.everychildmatters.gov.uk/resources-and-practice/IG00060/

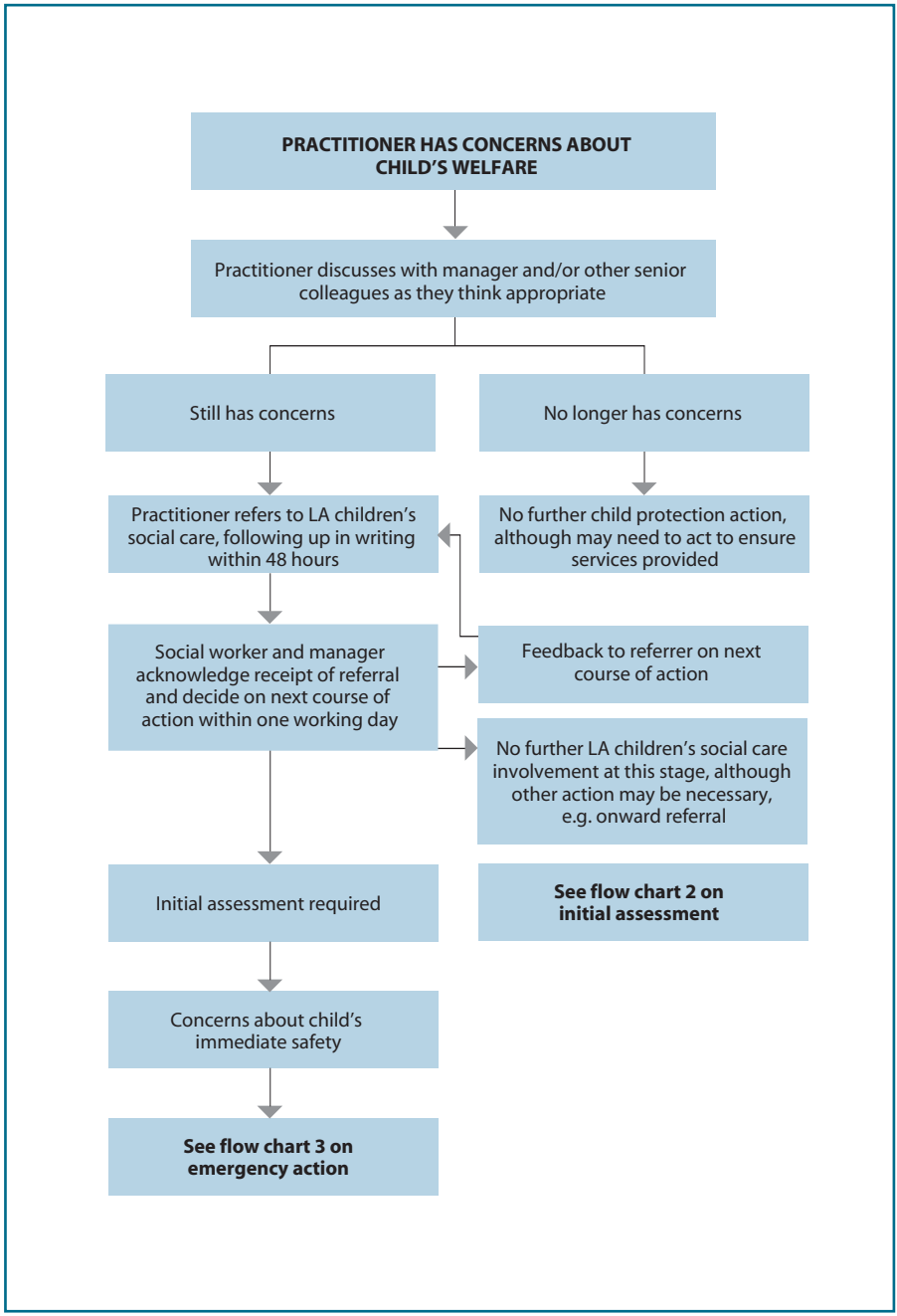
What To Do If You're Worried A Child Is Being Abused. Website: http://www.everychildmatters.gov.uk/search/?asset=dowmeat&id=17378

Information sharing: Practitioners' guide. Website: http://www.ecm.gov.uk/deliveringservices/informationsharing

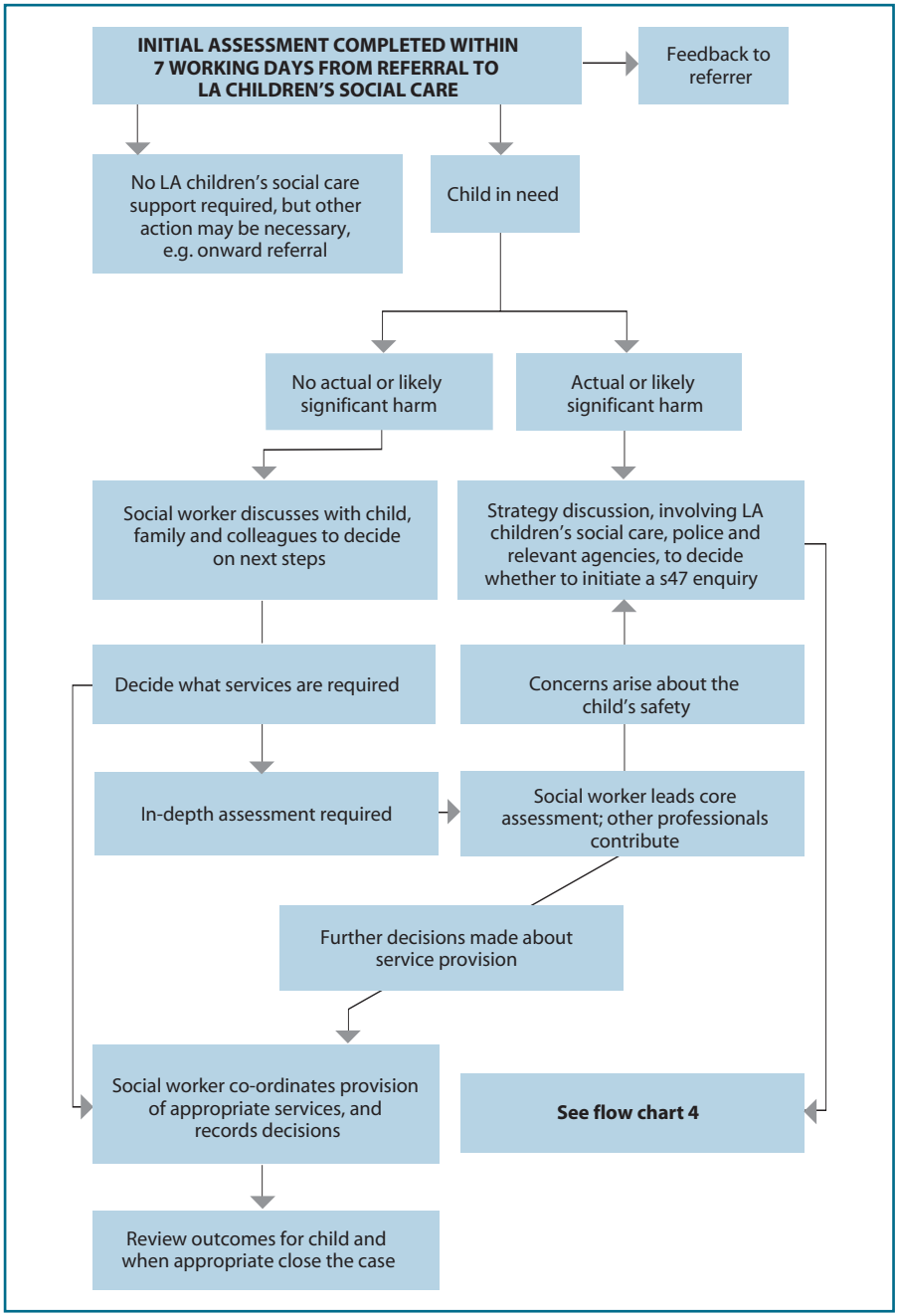
The Common Assessment Framework for Children and Young People: practitioners guide. Website: http://www.ecm.gov.uk/caf

The Exemplar Records for the Integrated Childrens' System Website: http://www.everychildmatters.gov.uk/ics

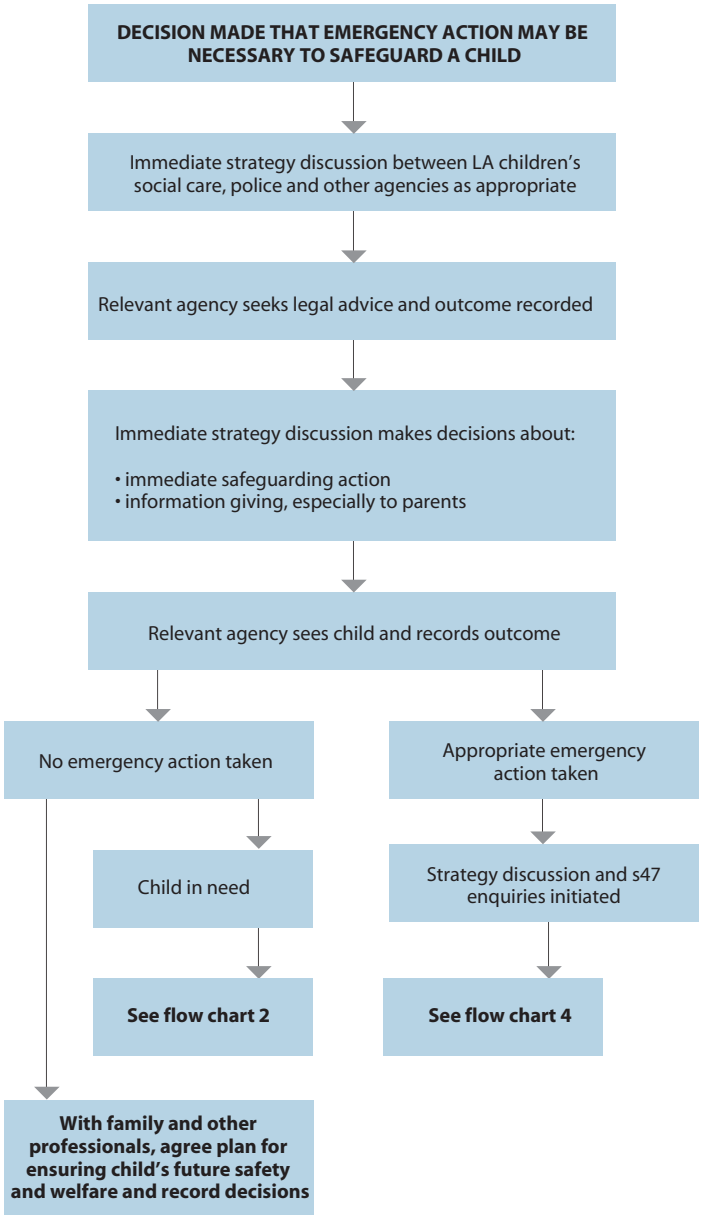
Flow chart 1 – Referral



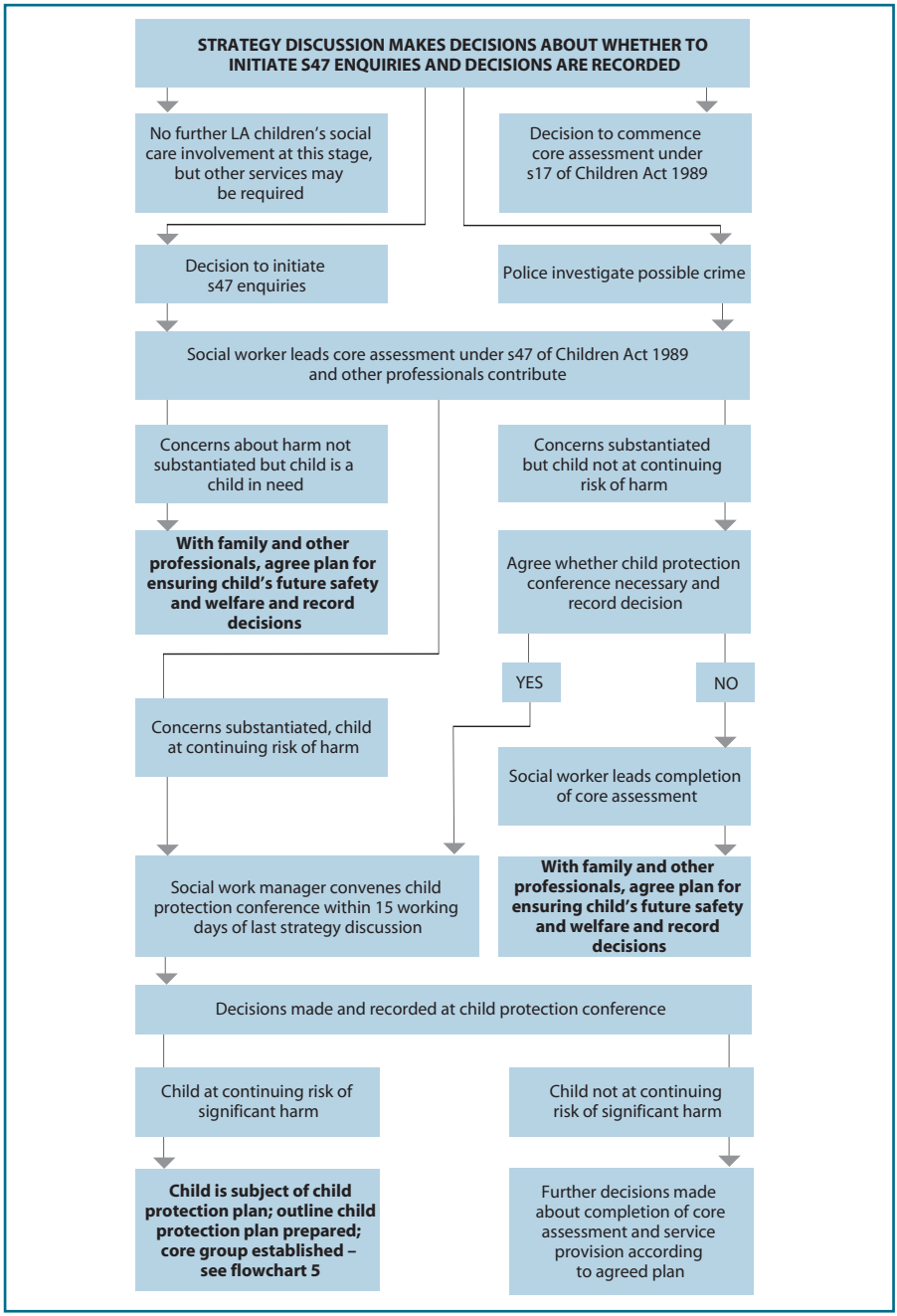
Flow chart 2 – What happens following initial assessment?



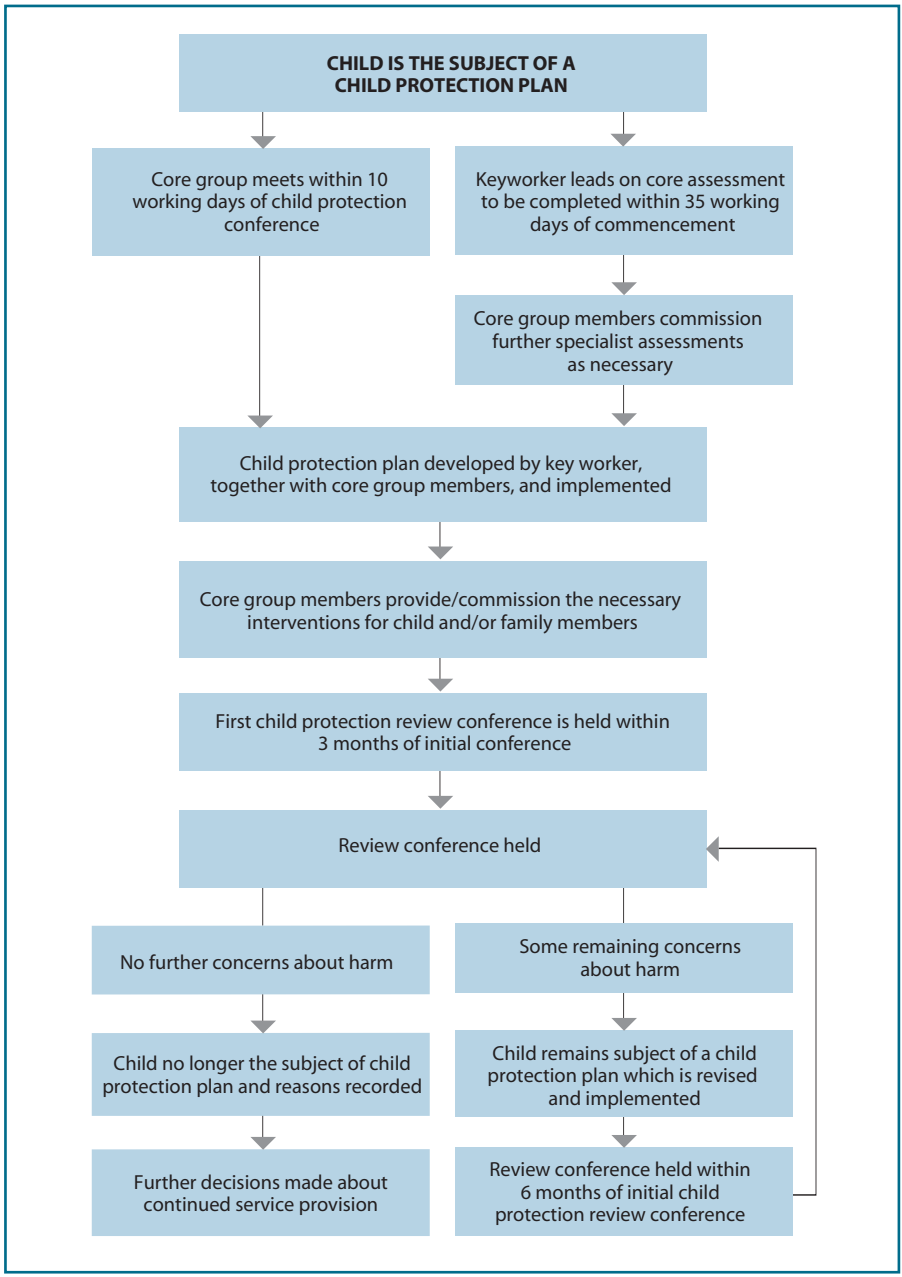
Flow chart 3 – Urgent action to safeguard children



Flow chart 4 – What happens after the strategy discussion?



Flow chart 5 – What happens after the child protection conference, including the review process?



Appendix 1 – Information sharing: Practitioners guide

(Reproduced from *Information sharing: Practitioners' guide* (HM Government, 2006, Page 5)

Six key points on information sharing

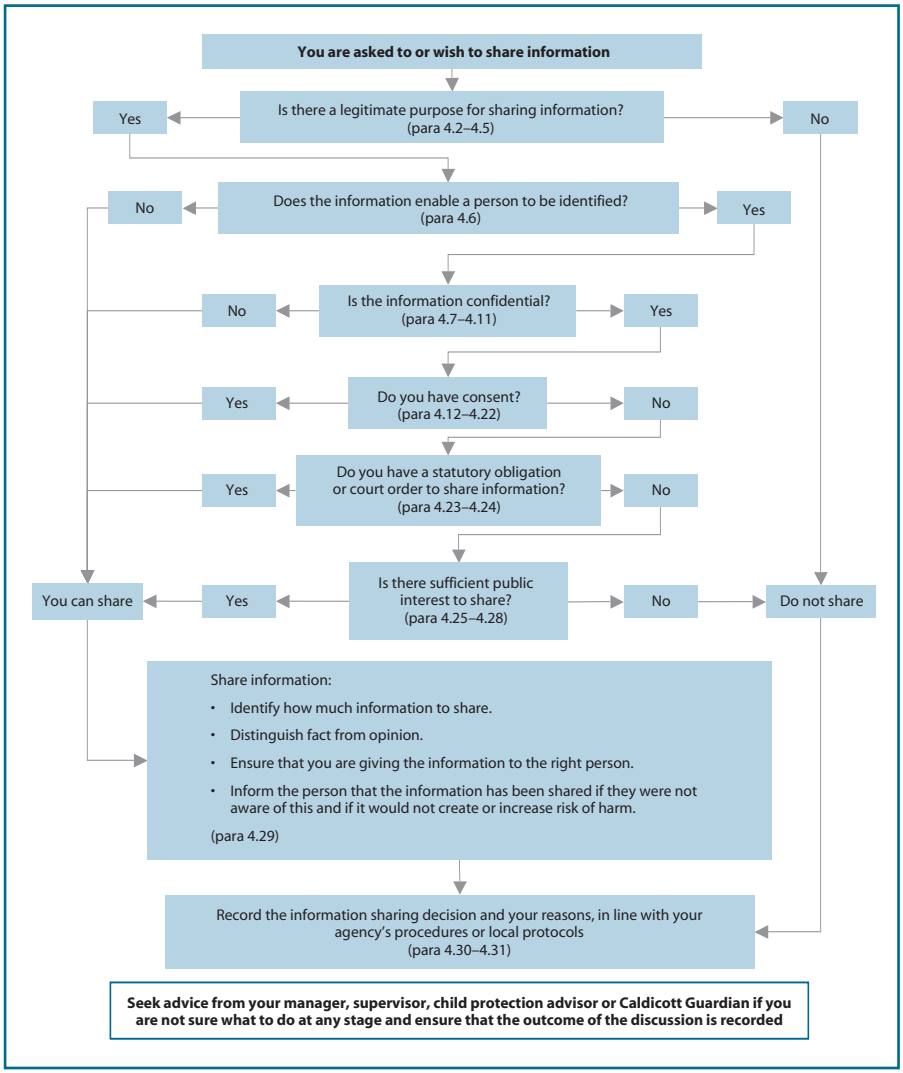
- You should explain to children, young people and families at the outset, openly and honestly, what and how information will, or could be shared and why, and seek their agreement. The exception to this is where to do so would put that child, young person or others at increased risk of significant harm or an adult at risk of serious harm, or if it would undermine the prevention, detection or prosecution of a serious crime including where seeking consent might lead to interference with any potential investigation.

- You must always consider the safety and welfare of a child or young person when making decisions on whether to share information about them. Where there is concern that the child may be suffering or is at risk of suffering significant harm, the child's safety and welfare must be the overriding consideration.

- You should, where possible, respect the wishes of children, young people or families who do not consent to share confidential information. You may still share information, if in your judgment on the facts of the case, there is sufficient need in the public interest to override that lack of consent.

- You should seek advice where you are in doubt, especially where your doubt relates to a concern about possible significant harm to a child or serious harm to others.
- You should ensure that the information you share is accurate and up-to-date, necessary for the purpose for which you are sharing it, shared only with those people who need to see it, and shared securely.
- You should always record the reasons for your decision – whether it is to share information or not.

Flowchart of key principles for information sharing (Reproduced from *Information sharing: Practitioners' guide* (HM Government, 2006, Page 19). The paragraph numbers refer to those in the Information Sharing guidance.)



You can download this publication at www.everychildmatters.gov.uk

You can also download this publication at www.teachernet.gov.uk/publications
Search using the ref: 04319-2006BKT-EN

Copies of this publication can be also obtained from:
DfES Publications
PO Box 5050
Sherwood Park
Annesley
Nottingham NG15 0DJ
Tel: 0845 60 222 60
Fax: 0845 60 333 60
Textphone: 0845 60 555 60
Please quote ref: 04319-2006BKT-EN

ISBN: 978-1-84478-868-2

PPCOL/D16-6841/1206/155

Produced by the Department for Education and Skills

department for
education and skills

Creating Opportunity
Releasing Potential
Achieving Excellence

Bournemouth & Poole Local Safeguarding Children Board

Dorset Safeguarding Children Board

PAN DORSET INTER-AGENCY SAFEGUARDING PROCEDURES

CHAPTER 3

3.2 DORSET POLICE/BOURNEMOUTH, DORSET AND POOLE CHILDREN AND FAMILIES JOINT WORKING ARRANGEMENTS

Procedures Effective from: **May 2009**

Review Date: **January 2012**

If you have any comments or queries about the pan-Dorset procedures please contact your agency representative on the Pan Dorset Policy and Procedures Group or notify the LSCB using the following email addresses:

info@dorsetlscb.co.uk
info@bournemouth-poole-lscb.org.uk

DORSET POLICE/BOURNEMOUTH DORSET AND POOLE CHILDREN'S SERVICES JOINT WORKING ARRANGEMENTS

1 INTRODUCTION

1.1 This guidance supplements the guidance contained in Part 1, and should be read in conjunction with Chapter 2 of the Inter-Agency Safeguarding Procedures.

1.2 It is intended to provide guidance for Bournemouth, Dorset and Poole Children's Services and Dorset Police in deciding how section 47 enquiries and associated Police investigations should be conducted and in particular in what circumstances section 47 enquiries under the Children Act 1989 and linked criminal investigations are necessary and/or appropriate (see appendix A, flowchart of joint investigation process). For clarity the remit of the Child Abuse Investigation Team (CAIT) is attached at Appendix C.

1.3 Whilst Children's Services and Police have distinct and separate roles in the investigation of concerns about significant harm to children, they have a joint responsibility to safeguard children. Thus the planning and assessment should be a continual joint process until the s47 enquiry is concluded.

1.4 It is appreciated that it is not possible for guidance to cover all eventualities. The over-riding principle must be the safeguarding of children and compliance with the law and good practice guidance. It is essential that the key personnel in each agency maintain a frequent dialogue and agree any departure from this guidance, which is necessary in relation to individual children. Any such departure must be endorsed and documented by a manager or someone with delegated responsibility in each agency.

2 REFERRAL

2.1 Whenever Children's Services encounter concerns about a child's welfare that constitutes, or may constitute, a criminal offence against a child, they must discuss the case with their local Child Abuse Investigation Team (CAIT). Where Children's Services are unable to make contact with their local CAIT they should contact the Communication Centre (COMCEN) at Police headquarters within a timeframe commensurate with the child's needs. Staff at the COMCEN will be able to facilitate communication with an appropriately trained officer. This will particularly apply to situations which arise out of office hours.

2.2 When Police make a telephone referral to Children's Services about actual or likely significant harm, the details of the referral should be confirmed in writing and faxed to Children's Services within 24 hours. Children's Services should acknowledge in writing receipt of the referral within one working day. (NB. This may be by distribution of the record of strategy discussion).

2.3 Referrals from members of the public should also be acknowledged and information given in a manner which is consistent with respecting the confidentiality of those referred.

3 STRATEGY DISCUSSION MEETING

3.1 Whenever there is reasonable cause to suspect that a child is suffering, or is likely to suffer significant harm, there should be a strategy discussion involving Children's Services and the Police, and other bodies as appropriate (for example, Children's Centre/School and Health), and in particular any referring agency.

3.2 The strategy discussion should be convened by Children's Services and those participating should be sufficiently senior and able, therefore, to contribute to the discussion of available information and to make decisions on behalf of their agencies.
In Children's Services this will normally be a manager, assistant manager or senior practitioner. In the Police, this may be any CAIT officer, but the plan and decisions made will be seen and agreed by a Detective Sergeant within 24 hours.

3.3 If the child is a hospital patient (in or outpatient) or receiving services from a child development team, the medical consultant responsible for the child's health care should be involved, as should the senior ward nurse if the child is an in-patient. Where the child is receiving therapeutic services, the therapist should be involved, and account taken of the likely impact of any enquiries on the individual child's ability to access ongoing therapy. However, the individual child's therapeutic needs must be balanced against the need to safeguard him / her and any other children who may be at risk. Where a medical examination may be necessary or has taken place a senior doctor from those providing services should also be involved.

3.4 A strategy discussion may take place following a referral, or at any other time (for example, if concerns about significant harm emerge in respect of child receiving support under s17).

3.5 When Children's Services receive a referral that indicates that there is risk to the life of a child or a likelihood of serious immediate harm, they must initiate a strategy discussion with Police immediately to discuss planned emergency action or as soon as possible if an agency has had to take immediate protective action.

3.6 Where a situation arises which is not in normal working hours, a strategy discussion will take place between the Children's Services out of hours service and the Police to discuss immediate protective action. The outcome of this strategy discussion and any action taken will then be passed to the appropriate staff in Children's Services and the Police the next working day.

3.7 The action from a strategy discussion must be within a timescale that ensures:

- that where there is a risk to the life of a child or a likelihood of serious immediate harm as a result of abuse and/or neglect, the intervention to protect the child must take place without delay;
- that where the information suggests that the child has been physically abused or subject to serious neglect, this may require an immediate or same day response. A judgement must be made about the urgency of the intervention, which in any event should include seeing the child within 24 hours of the strategy discussion;
- all other concerns about a child's safety should be within a timescale that ensures the safety and protection of the child and all other children in the household.

3.8 The strategy discussion should be used to:

- share available information;
- agree the conduct and timing of any criminal investigation;
- decide whether a core assessment under s47 of the Children Act 1989 (s47 enquiries) should be initiated, or continued if it has already begun;
- plan how the s47 enquiry should be undertaken (if one is to be initiated), including the need for medical treatment, and who will carry out what actions, by when and for what purpose;
- agree what action is required immediately to safeguard and promote the welfare of the child, and/or provide interim services and support. If the child is in hospital, decisions should also be made about how to secure the safe discharge of the child;
- determine what information from the strategy discussion will be shared with the family, unless such information sharing may place a child at increased risk of significant harm or jeopardise Police investigations into any alleged offence(s); and
- determine if legal action is required.

3.9 Relevant matters will include:

- agreeing a plan for how the core assessment under s47 of the Children Act 1989 will be carried out – what further information is required about the child(ren) and family and how it should be obtained and recorded;
- agreeing who should be interviewed, by whom, for what purpose, and when. The way in which interviews are conducted can play a significant part in minimising any distress caused to children, and increasing the likelihood of maintaining constructive working relationships with families. When a criminal offence may have been committed against a child, the timing and handling of interviews with victims, their families and witnesses, can have important implications for the collection and preservation of evidence;
- agreeing, in particular, how the child's wishes and feelings will be ascertained so that they can be taken into account when making decisions under s47 of the Children Act 1989;
- in the light of the race and ethnicity of the child and family, considering how this should be taken into account, and establishing whether an interpreter will be required; and

- considering the needs of other children who may be affected, for example, siblings and other children, such as those living in the same establishment, or those who may come into contact with alleged abusers, through the alleged abusers employment, voluntary activities or family/friendships.

3.10 A strategy discussion may take place at a meeting or by other means (for example, by telephone). In complex types of maltreatment a meeting is likely to be the most effective way of discussing the child's welfare and planning future action. Such a meeting should be held at a convenient location for the key attendees, such as a hospital, school, police station or children's services office.

3.11 Any information shared, all decisions reached, and the basis for those decisions, should be clearly recorded by the chair of the strategy discussion and circulated within one working day to all parties to the discussion. This should be on the "Record of Strategy Discussion Form". When Police and other professionals receive the copy of this record, they should check the content and any inaccuracies should be reported immediately so that amendments can be made or matters resolved between the relevant managers.

3.12 Where there are unresolved differences of opinion about the decisions and actions planned in a strategy discussion, these should be resolved by senior operational managers of the respective agencies in liaison with each other. This should be actioned within a timescale commensurate with the need to safeguard the child or other children but does not override an individual agency's responsibilities to act in accordance with these procedures and/or their own agency procedures.

3.13 Any decisions about taking immediate action should be kept under constant review. Exceptionally more than one strategy discussion may be necessary. This is likely to be where the child's circumstances are very complex and a number of discussions are required to consider whether and, if so, when to initiate s47 enquiries, as well as how best to undertake them.

3.14 However once the decision to initiate S47 enquiries has been made (via a strategy discussion) there may still be a need to discuss progress with the key agencies involved. This is **NOT** a strategy discussion, but more simply a review of progress before the outcome of S47 enquiries is decided.

3.15 Significant harm to children gives rise to both child welfare concerns and law enforcement concerns, and s47 enquiries may run concurrently with police investigations concerning possible associated crime(s). The Police have a duty to carry out thorough and professional investigations into allegations of crime, and the obtaining of clear strong evidence is in the best interests of a child, since it makes it less likely that a child victim will have to give evidence in criminal court. Enquiries may, therefore, give rise to information that is relevant to decisions that will be taken by both children's services and the Police. The findings from the assessment and/or police investigation should be used to inform plans about future support and help to the child and family. They may also contribute to legal proceedings, whether criminal, civil or both.

4. MEDICAL ASSESSMENTS

4.1 The conduct and timing of any criminal investigation will include a decision regarding the requirement and timing, where appropriate, of a medical examination / assessment of the child (ren). Where this is required to obtain evidence of a criminal offence the Police Officer/Social Worker investigating the case will make contact with the appropriate health professional to instigate the examination / assessment. Where it is anticipated that there may be recovery of forensic evidence from the child (ren) then the medical examination will usually be conducted jointly by a Forensic Medical Examiner and Paediatrician.

4.2 Police should also consider whether it is necessary to have photographs or a video taken as part of their enquiries. Where this involved recording injuries this should be arranged as sensitively, yet as soon, as possible. Gathering the best possible evidence may help to safeguard a child through other means even if a prosecution is ultimately not pursued.

4.3 In instances where a criminal investigation is not being conducted, a medical examination/assessment of the child (ren) may be necessary as part of the s47 enquiries to ensure the child's physical and/or emotional well-being. In order to facilitate such an examination/assessment the Social Worker should instigate contact with the relevant health professional and provide details using the multi-agency referral form whenever possible.

4.4 The flowchart for Paediatric Assessments in relation to possible child sexual abuse is contained in Appendix B.

5. JOINT INVESTIGATION

5.1 All children about whom there are concerns regarding significant harm should be seen and spoken to providing their age or cognitive ability does not prohibit this. A child should never be interviewed in the presence of an alleged or suspected perpetrator of abuse or somebody who may be colluding with the perpetrator.

5.2 Circumstances when a joint investigation is likely to be necessary are:

- allegations/reasonable suspicions that sexual abuse of a child has been committed by a person known to a child;
- allegations/reasonable suspicions of physical injury of a child by a person known to the child.
- allegations/reasonable suspicions of cruelty or neglect which may be actionable under Section 1 of the Children and Young Persons Act 1933. (This section of the Children and Young Persons Act 1933 includes offences of assaulting, ill treating or abandoning the child, or causes or procures or exposes the child to any of these so that the child suffers unnecessarily or his/her health is damaged).

- allegations/reasonable suspicions which involve unusual circumstances e.g. organised or institutional abuse or concerns about Fabricated or Induced Illness (FII).

- Person against whom the allegations/concerns exist works with children (see also Inter-agency safeguarding procedures Part 1, Ch. 3.9)

5.3 **Additionally**, there may be other circumstances where a joint investigation is necessary, outside of the criteria above e.g. where it is evident that input from the Police will enable Children's Services to protect and secure the best outcome for the child.

6. FACTORS TO CONSIDER AT THE PLANNING STAGE

6.1 Prior to any joint interview, whether to be video-recorded or not, the investigating police officer and social worker must plan how the interview will be conducted. This is a critical stage in safeguarding children effectively. Account should be taken of the child's needs and a plan drawn up which details how these needs will be met. (for further guidance see "Achieving Best Evidence in Criminal Proceedings: Guidance for Vulnerable or Intimidated Witnesses Including Children". Chapter 2, paragraphs 2.47 – 2.54.) Factors to be considered include:

- Child's age
- Child's gender and sexuality
- Child's race, culture, ethnicity, religion
- Child's first language and preferred name/mode of address
- The child's use of language/ability to communicate and understanding of relevant concepts such as time and age. *Does the child appear clear and in touch yet actually have confused and limited thinking?*
- Any apparent clinical or psychiatric problems (e.g. panic attacks, depression) which may impact upon the interview, and for which the child may require referral for a formal assessment.
- The child's cognitive, social and emotional development. *Does the child appear 'street-wise' yet in reality have limited understanding?*
- Any special requirements the child may have. *Does s/he suffer from separation anxiety or have an impairment? Is s/he known to have suffered past abuse, or to have previously undergone an investigative interview?*
- Family members, carers and relationships
- Overall sexual education, knowledge and experience.
- Routines
- An assessment of the child's competency to give consent to interview and medical examination.
- How and by whom the interview should be conducted and who should have lead if undertaken jointly.

6.2 Planning for the interview must be recorded on police form SUJ2. Where needs are identified that are likely to have an impact on any interview, form SUJ2A must also be completed. This should detail how these needs will be addressed. Both the police officer and the social worker MUST sign the SUJ2 and a copy retained by both.

7. ASSESSMENT PRIOR TO INTERVIEW

7.1 Interviewers may often decide that the needs of the child and the needs of criminal justice are best served by an assessment of the child prior to the interview taking place, particularly if the child has not had previous or current involvement with Children Services or other public services. Such an assessment should be considered for any child, and offers the opportunity to explore further the factors detailed in 6.1.

7.2 In any contact with the child before the videotaped interview, interviewers must be careful to balance the need to ensure the child is ready and informed about the interview process against the possibility of allegations at trial of coaching or collusion.

7.3 Interviewers should have clear objectives for assessment(s) prior to interview, and should apply this guidance on talking with children during such assessment. For example, they should avoid discussing substantive issues (in any detail) and must not lead the child on substantive matters. Interviewers should never stop a child who is freely recalling significant events. Instead, the interviewers must make a full written record of the discussion, making a note of the timing and personnel present, as well as what was said and in what order using police form SUJ1. The interviewers should begin by explaining the objectives of the interview to the child; one possibility may be as follows:

"Tomorrow, we will talk about the things you are concerned about. Today, I want to get to know you a bit better and explain what will happen if we do a video interview"

7.4 The interviewer can also use the opportunity to answer any questions the child may have about the conduct of the interview and explain any transport arrangements. Some interviewers use this opportunity to introduce some of the ground rules to the child, while others do so exclusively on the videotape. If any of the ground rules are introduced at this stage, then they should be repeated in the formal interview to demonstrate that the necessary procedures have been completed.

7.5 The needs of the child may require that this assessment should take place in the child's home or another setting and/or over a number of sessions. No inducements should be offered for complying with the investigative process.

7.6 It is likely that for some children, assessment (s) will indicate that their needs are not best met by proceeding with a full formal interview.

7.7 The assessment should be made jointly and should inform the planning process.

7.8 Additional factors to be explored in the assessment prior to a video interview may include:

- The child's ability and willingness to talk within a formal interview setting to a police officer, social worker or other trained interviewer;
- An explanation to the child of the reason for a video interview for criminal proceedings;
- The ground rules for the interview;
- The opportunity to practise answering open questions
- Will the needs of the child and the needs of Criminal Justice best be met by use of a video record?

8. VIDEO TAPED INTERVIEW

8.1 All joint video interviews will be conducted using the PEACE model of investigative interviewing, as detailed in The Practical Guide to Investigative Interviewing.

8.2 As part of the planning for interview, the joint interviewing pair will need to consider how and by whom the video interview is conducted. Where the interview is to be undertaken jointly, consideration should be given to who will take the lead based on the needs of the child.

8.3 Whilst Police and Children Services have distinct and separate roles in the investigation of concerns, both have a joint responsibility to assess risk and ensure appropriate safeguards are in place to protect the child. Thus at the conclusion of a joint interview, the conclusions arising from the interview, and any subsequent actions required will be discussed and agreed between the police officer and the social worker.

9. CONSENT

9.1 The decision about when to inform the parent or carer will have a bearing on the conduct of police investigations. The strategy discussion should therefore decide how and when parents/carers will be informed and their subsequent level of participation.

9.2 Interviewers are responsible for ensuring that, as far as possible, the child is freely participating in the interview, and not merely complying with a request from adult authority figures.

9.3 Permission to interview a child, whether video-recorded or not, will normally be sought from a person with parental responsibility for the child.

9.4 There may be occasions when the investigating team needs to interview a child without the knowledge of the parent or carer. Relevant circumstances would include:

- the possibility that a child might be threatened or otherwise

coerced into silence
- a strong likelihood that evidence might be destroyed
- the child does not wish the parent to be involved at that stage, and is competent to make such a decision.

Proceeding with the interview without parental knowledge will need to be carefully managed and legal advice should normally be sought.

10. RECORDING

10.1 Police and Children's Services will each produce their own records in accordance with their own agency procedures.

10.2 However, Police forms SUJ1 (Contact with a vulnerable witness) and SUJ2/A (Planning for vulnerable witness) should be completed jointly in joint investigations, and a copy retained by the Police Officer and Social Worker.

10.3 When a joint interview is video-recorded, this will provide the main record – however, the conclusions arising from the interview and any subsequent action required will be discussed and the outcome agreed between the Police Officer and Social Worker. This will be recorded on SUJ1. Additionally, the social worker will need to record the details of the interview for the case record.

10.4 At the conclusion of the S47 enquiry, Children's Services will complete a "Record of the outcome of S47 enquiries" form, in consultation with the Police (and other agencies where appropriate), and a copy will be retained on both Police and Children's Services files.

10.5 Sample copies of SUJ 1 and 2/A are included at appendix 4.

11. SINGLE AGENCY INVESTIGATIONS

11.1 Children's Services

This section relates to circumstances when a strategy discussion has concluded that s47 enquiries should be initiated, or continued but that a criminal investigation is not indicated.

11.2 The following are circumstances where the strategy discussion/meeting is likely to indicate an initial response by Children's Services alone:

- Allegations/reasonable suspicions of physical abuse where no injuries are apparent or the injuries are very minor.
- Allegations/reasonable suspicions of child sexual abuse which are indirect or anonymous and there is no other evidence available to substantiate concern; or the child is exhibiting over-sexualised behaviour.
- Allegations or reasonable suspicions of inadequate supervision, lack of parental care.
- Allegations/reasonable suspicions of emotional abuse unless there

are additional circumstances.

11.3 If, following initial enquiries by Children's Services, further information gained suggests that a criminal offence may have been committed against a child, the Police should be informed as soon as possible and a further strategy discussion held.

NB There may be occasions when Children's Services staff request Police involvement other than to conduct a joint investigation, for example in potentially violent situations. In these circumstances the reason for the request should be made specific, with the call for assistance normally being to the Police Control Room.

11.4 **Police**

There may be occasions when the Police will liaise with Children's Services concerning vulnerable witnesses. This will occur where the Police identify historical or current child welfare concerns and may lead to a strategy discussion.

12. CONCLUSION

12.1 The above criteria for the joint or single agency response cannot be prescriptive or exhaustive and judgement will need to be exercised in individual circumstances.

12.2 A flexible approach is required. Concerns about significant harm may cause a Children's Services single agency enquiry to commence, but this may then need to change to a joint agency response because the initial enquiries find that the parent or child/young person wants this, or there are additional factors which identify the need for this, and/or it is apparent further enquiries need to be made about a potential criminal offence.

12.3 Similarly, the Police may initially respond on their own to a situation and it may then become clear that there are unresolved child protection or welfare issues, in which case the Police Officer involved should ensure that the issues are communicated to the relevant Children's Services staff.

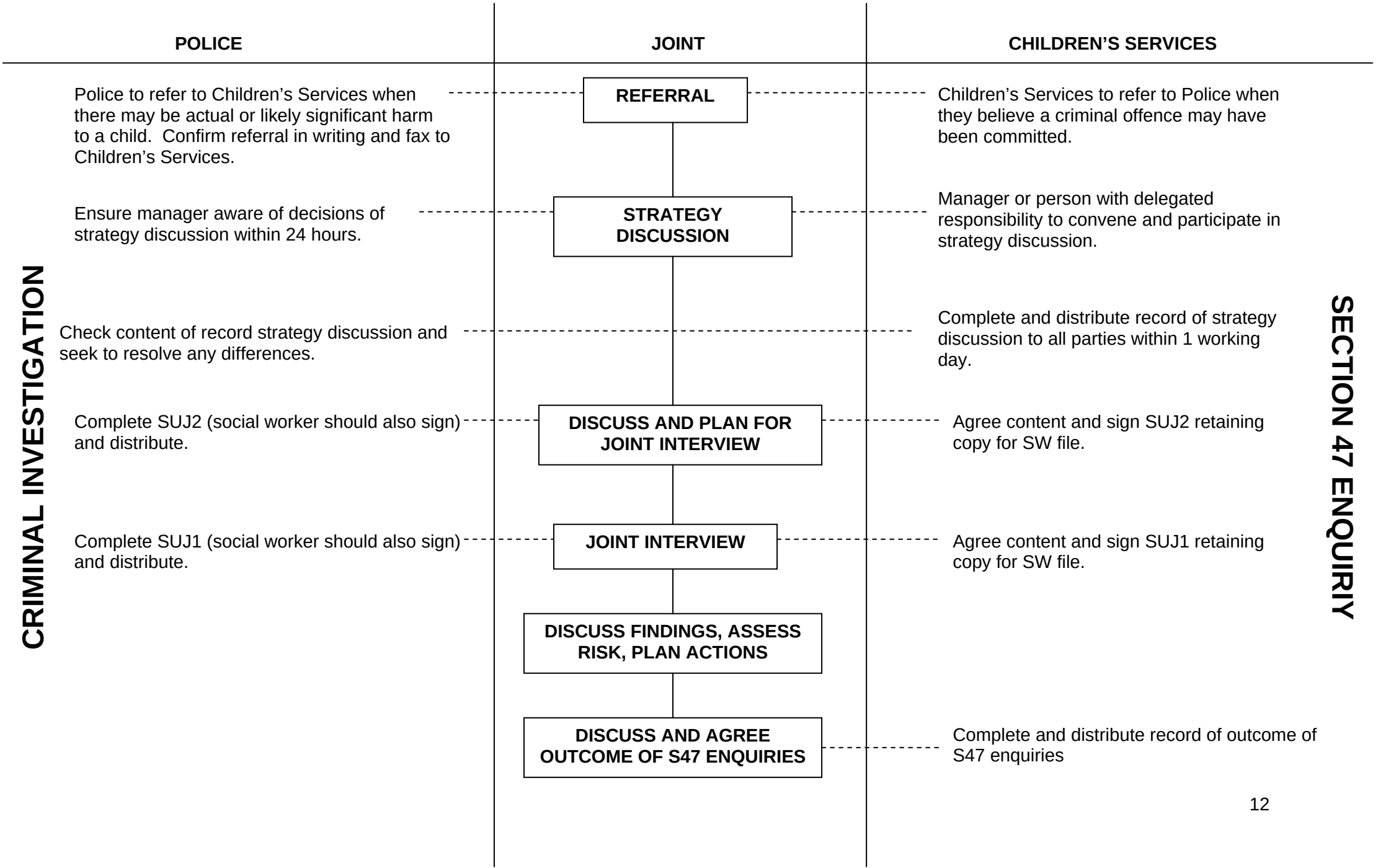
12.4 If, following discussion between the Police and Children's Services managers, disagreement remains over any matter such as the necessity for a joint investigation or a contentious decision by either party, the matter should be referred to the Detective Inspector, Police Child Abuse Investigation Unit and relevant operational Senior Manager, Children's Services.

12.5 Whenever there is a single agency response in child protection cases, by either Children's Services or Police, the outcome should be shared in writing with the other agency.
E.G. via outcome of s47 enquiries form (Children's Services)

FLOWCHART – JOINT INVESTIGATION PROCESS APPENDIX A

CRIMINAL INVESTIGATION

SECTION 47 ENQUIRIY



APPENDIX B

Guidance for Social Workers & Police re: Referral of Children for Medical Assessment in relation to Safeguarding.

In order to aid joint working and to meet the best interests of the child it is important that the referrer communicates clearly to the doctor a) their specific concerns b) the child's details c) a description of the injury/ suspected injury and d) what it is hoped the assessment will achieve. This will then ensure that the child is seen by the most appropriate clinician.

Verbal referrals should be followed up by a written referral, using where possible an interagency referral form.

Please see the separate flowchart and referral processes into Paediatrics for East Dorset, Poole & Bournemouth and for West Dorset at the end of this document.

1. *Physical Injury*

This is most likely to represent bruising / suspected bruising but may include other suspected injury such as a swelling.
Referrals should be directed to **Paediatrics** in the following instances:

- Very young children (and particularly infants < 1 year of age)
- Child not previously known to Children's Social Care & NAI suspected
- Significant but not life-threatening physical injury which may require *medical* intervention. (Children with life-threatening injuries should be referred to A&E via a 999 ambulance call. Children with obvious fractures should be accompanied to A&E – the A&E team will involve the paediatrician if NAI is suspected.).
- GP declines to perform the assessment
- If in doubt, please discuss with community paediatrician on call (East) / paediatrician for the week or paediatrician on call if outside of normal working hours (West)

Referrals may be directed to the child's **GP** in the following circumstances:

- Child known to Children's Social Care presents with minor physical injury and for which documentation of the injury is requested.

Whenever a GP accepts such a referral an examination should be made of the whole child, not just the area injured (unless the child refuses a full medical assessment and is of sufficient age to do so). Any injuries must be documented on appropriate body maps.

The GP may decline to perform the assessment if they feel that they have insufficient training / expertise in this area of work. In such cases the referral should be redirected to Paediatrics.

2. Concerns re: Emotional Abuse or Neglect
Referrals should be made to Paediatrics.

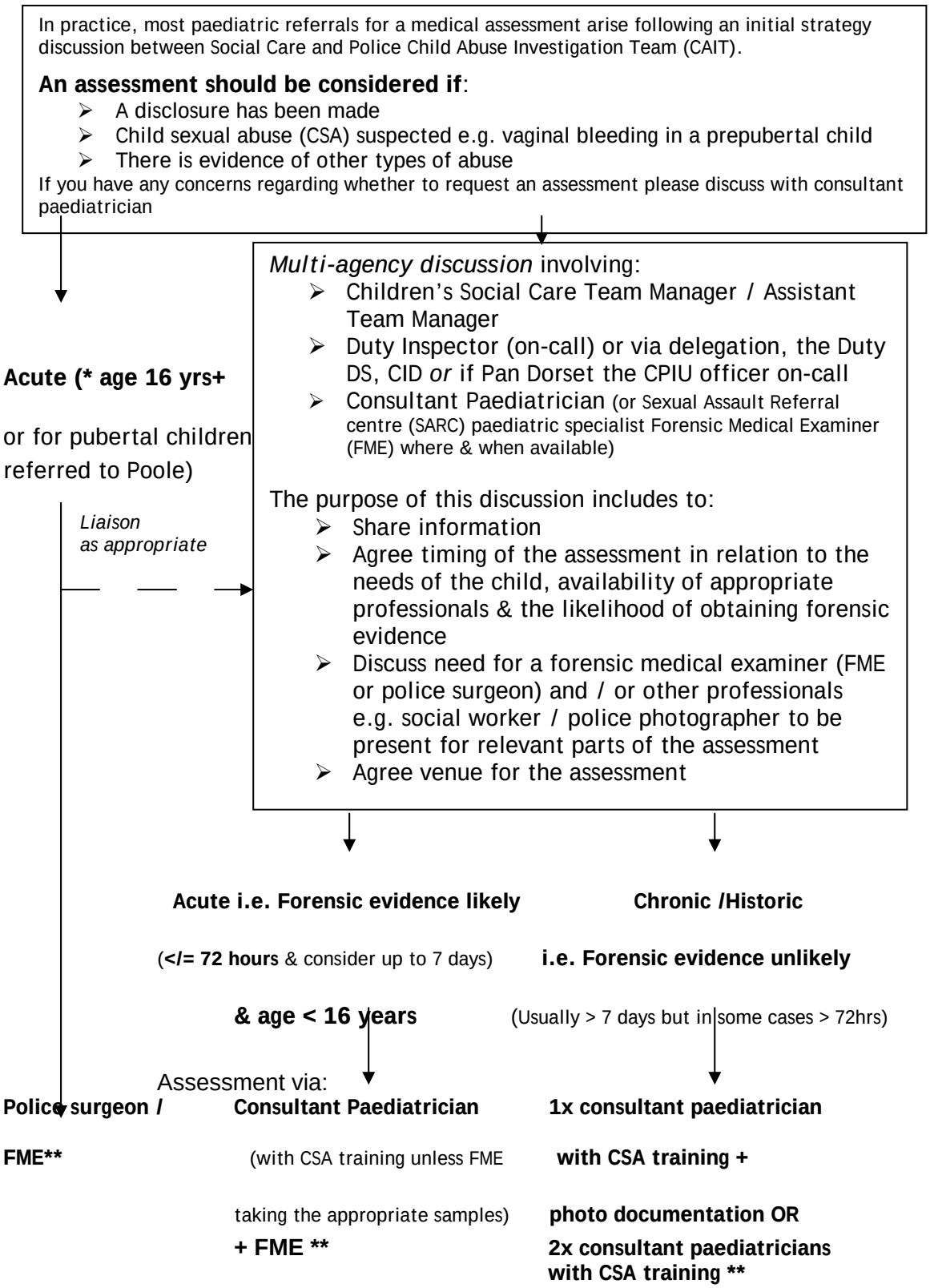
3. Concerns re: Sexual abuse
Referrals should be made to Paediatrics. It is important that an initial multi-agency discussion takes place for the reasons outlined within the flowchart below.

For cases where it is considered likely that acute injuries could still visible or forensic evidence could be obtained the assessment should be conducted within 24 - 72 hours.

For cases where chronic or historic abuse is suspected then children/young people will normally be seen within the next available CSA clinic

(usually conducted jointly by Dr Doherty & Dr Mancais for West Dorset children). This may in practice mean waiting time of up to 5 weeks.

Flowchart for Paediatric Assessments in relation to possible Child Sexual Abuse



* Referral to a Paediatrician may be more appropriate if the child:

- Is already under the care of a Paediatrician (West Dorset) or Community Paediatrician (East Dorset, Poole & Bournemouth)
- Has learning difficulties
- Is aged 16 or 17 years and a request for a paediatric assessment is made

** OR SARC with paediatric specialist training where this facility is available

Consultant Paediatrician Contact details (for all categories of suspected child abuse / Non-Accidental Injury):

West Dorset (includes children residing in the areas of Dorchester; Bridport; North Dorset; Weymouth & Portland; Wareham; Wool**)-**

Via child protection administrator for health on 01305 254748 during normal working hours Out of Hours please contact Dorset County Hospital switchboard on 01305 251150 and ask for the consultant paediatrician on-call.

There is also a rota for the availability of on-call paediatricians specialising in the assessment of children who may have been sexually abused across the South West network. This rota is for *urgent CSA* cases only & may be accessed in the event of either Dr. Doherty or Dr Mancais from West Dorset being unavailable. Access to this rota is via the child protection office or the consultant paediatricians at Dorset County Hospital.

East Dorset (including children from Poole, Bournemouth, Purbeck, Ferndown and Christchurch)
Via child protection coordinator on 01202 448312 during normal working hours.

Out of Hours please contact Poole Hospital switchboard on 01202 665511 and ask for the consultant paediatrician on-call for child protection.

APPENDIX C

REMIT OF THE CHILD ABUSE INVESTIGATION TEAM (CAIT)

CAIT have responsibility for investigating allegations involving the following: -

1. **Adult on Juvenile Abuse**

Sexual abuse, physical abuse, emotional abuse, neglect and cruelty where the victim is a child or young person under the age of 18 years, in the following circumstances: -

i) The victim and the alleged perpetrator are related (blood tie or step family)

or

ii) The alleged perpetrator was acting as carer or in a professional or voluntary capacity when entrusted with the care of the victim at the time of the alleged offence.

or

When the offence(s) have taken place historically and either i) or ii) above applied at the time of the offence.

2. **Juvenile on Juvenile Abuse**

Sexual abuse, physical abuse, emotional abuse, neglect and cruelty involving a child victim where the alleged perpetrator is a juvenile in the following circumstances;

i) The victim and the alleged perpetrator are related (blood tie or step family)

or

ii) The alleged perpetrator was acting as carer or had responsibility for the victim at the time of the alleged offence.

or

iii) Where the allegation is of a sexual nature, the victim is 12 years old or younger at the time of the allegation AND the victim previously knew the alleged perpetrator.

N.B. All other child related investigations are dealt with by Divisional staff.

SUJ1
(Rev 04/05)
APPENDIX D

DORSET POLICE
AND DORSET, POOLE & BOURNEMOUTH CHILDREN'S SERVICES

CONTACT WITH VULNERABLE WITNESS

This form is required to be completed on each occasion where there is contact by Police/or Children's Services with a vulnerable witness subject of an investigation.

Witness's Name: DOB:

Meeting Place:
(Do not show home
address, 'home' will suffice)

Time and Date:

Purpose of Visit:

Persons present, job title, relationship with witness:

Nature of concerns:

Focus of discussion with witness and record in verbatim of anything said by the witness in relation to the allegation by the witness or in the presence of the witness.

Further actions to be undertaken/when and by whom as a result of this contact:

	SIGNATURE	DATE
POLICE		
SOCIAL WORKER		

SUJ2
APPENDIX E

DORSET POLICE AND BOURNEMOUTH, DORSET AND POOLE CHILDREN'S SERVICES
PLANNING FOR VULNERABLE WITNESS

Name of Witness: …….. Place: ……..

Date: …….. Persons Present: ……

FACTOR CHECKLIST	CONSIDERED ✓	COMMENT/NEED IDENTIFIED	HOW NEED WILL BE MET IN INTERVIEW
Witness's age			
Witness's race, culture, ethnicity and first language			
Witness's religion			
Witness's gender and sexuality			
Any physical and/or mental health needs			
Witness's cognitive abilities (e.g. memory, attention span)			
Witness's linguistic abilities (e.g. how well do they understand spoken language and how well do they use it?)			
Witness's current emotional state and range of behaviours			

Witness's family members/carers and nature of relationships			
Witness's overall sexual education, knowledge and experiences			
Any significant stresses recently experienced buy the child and/or family (e.g. bereavement, sickness, domestic violence, divorce, job loss etc.)			
Bathing, toileting and bedtime routines			
Sleeping arrangements			
Requirement for social support in interview room			
Any other issue identified? E.G> Dietary needs			

Where will the interview take place?……. Date: ……. Time: …….

Proposed Lead Interviewer: Name:…….. Signature: …….

Proposed Co-interviewer: Name: …… Signature: …….

Bournemouth & Poole Local Safeguarding Children Board

Dorset Safeguarding Children Board

PAN DORSET INTER-AGENCY SAFEGUARDING PROCEDURES

CHAPTER 3

3.3 CHILD PROTECTION CONFERENCE COMPLAINTS PROCEDURE

Procedures Effective from: **2006**

Review Date: **2012**

If you have any comments or queries about the pan-Dorset procedures please contact your agency representative on the Pan Dorset Policy and Procedures Group or notify the LSCB using the following email addresses:

info@dorsetlscb.co.uk
info@bournemouth-poole-lscb.org.uk

LOCAL SAFEGUARDING CHILDREN BOARD CHILD PROTECTION CONFERENCE COMPLAINTS PROCEDURE

1.0 General Introduction

1.1 The Local Safeguarding Children Boards for Dorset and Bournemouth and Poole have agreed the procedure for dealing with representations and complaints about child protection conferences. This procedure is known as the LSCB Complaints Procedure.

1.2 When a parent/carer or young person wishes to complain about aspects of a child protection conference including the outcome, this LSCB conference complaints procedure should be followed. However, minor issues about a conference, including accuracy of the minutes, should be taken up directly with the chairperson of the conference.

1.3 Representations and complaints about the work of individual agencies, their performance and/or the provision or non-provision of services, (including those as a consequence of assessments and conferences and those set out in child protection plans) should be responded to in accordance with the particular agency's own complaints process.

1.4 It should be noted that whilst the LSCB Complaints Panel can recommend that a further child protection conference is held where the complaint is upheld, decisions about whether or not the child is made the subject of a child protection plan remain the responsibility of the multi-agency child protection conference.

2.0 Who can complain?

Within 28 days of the child protection conference a complaint can be raised by:

- parents/carers with parental responsibility;
- other adult(s) who have no parental responsibility for the child(ren) subject to a child protection conference but who are directly affected by a child protection conference decision, such as extended family members and foster carers;
- young people who are the subject of a child protection conference. Such young person should be enabled to engage the assistance of an Advocacy Service where available, or a supporter of their choice.

2.1 What can be complained about?

- the process of the conference;
- the outcome, in terms of the fact of and/or the category of primary concern at the time the child became the subject of a child protection plan;

- a decision for the child to become, or not to become, the subject of a child protection plan or not to cease the child being the subject of a child protection plan.

3.0 The Complaints Process

3.1 It is important to note that for the duration of the LSCB complaints process, the decisions and recommendations reached in the child protection conference stand, and must be adhered to by staff from all agencies.

Initial Response to a Complaint

3.2 Complaints should initially be responded to by the line manager of the person who chaired the child protection conference, or another nominated person.

3.3 Upon receipt, the line manager should

- forward a copy of the complaint to members of the LSCB Complaints Panel for information only. A date should be identified for a panel meeting, in the event that the complainant remains dissatisfied following the line manager's response. This date should be set taking into account that it is expected that the LSCB Complaints Panel should have met and completed the response to the complaint within 28 days of being notified that the complainant remains dissatisfied and wishes their complaint to be heard by the LSCB Complaints Panel;

- inform the Local Authority Complaints Manager of the fact of the complaint to ensure that in the event of concurrent investigations and/or representations and complaints, these are responded to in a co-ordinated and appropriate manner.

3.4 The manager of the person who chaired the conference , or nominated person, should undertake the process of clarifying the complaint. This might involve a meeting to which the complainant, his/her supporter, the chairperson of the child protection conference and a representative from another agency, as appropriate, could be invited.

3.5 During the process of clarification it may be possible to resolve the complaint where the issues are not complex and can be easily righted.

3.6 In clarifying the complaint, the key points of the complaint, as agreed between the manager and complainant, should be established.

It should also be established:

- whether procedures or practice have been in accordance with procedural guidance or expected standards (as far as can be determined at this stage);

- whether there was any additional key information available at the time of the child protection conference that should have been shared at the conference.

3.7 Should either a breach of the procedures or a lack of key information being shared strongly indicate that the outcome of the child protection conference might have been different, a recommendation to reconvene a child protection conference at the earliest opportunity should be made to the LSCB Complaints Panel.

Where this is not the case the matter should be referred to the LSCB Complaints Panel, unless the complainant feels that the issues have been resolved to his/her satisfaction with the manager.

3.8 During this initial stage, consultation with other managers and/or other staff from key agencies may take place as necessary.

3.9 The outcome of the initial response to the complaint should be recorded in writing by the manager who responded to the complaint, setting out the response to the complaint and any agreed actions. A copy should be sent to:

- the complainant;
- the conference chairperson;
- any other agency representative who attended a meeting with the complainant, if held;
- LSCB Complaints Panel members.

3.10 If the manager and complainant consider that a resolution has been reached at this point, LSCB Complaints Panel members can still ask for a panel meeting to be convened when they do not agree with the proposed resolution.

3.11 Unless the complainant considers that a resolution has been reached during the initial response, s/he will be advised of the panel procedure which will then be instigated unless the complainant no longer wishes this. It is not the intention of the initial response to deny the opportunity for a complainant to have his/her complaint heard by the panel.

3.12 When a panel meeting is required, the line manager or nominated person should provide a report to the LSCB Complaints Panel, detailing the initial response to the complaint.

Single Agency complaint

3.13 If during the initial response it becomes apparent that the complaint, or some components of the complaint, do not fall within the remit of the LSCB child protection conference complaints procedure, the manager should refer the complaint or components of the complaint to:

- the local authority complaints manager,

  or

- the appropriate agency for consideration under its complaints procedure.

3.14 The manager responding to the complaint should write to the complainant to advise him/her that this has happened identifying the names of agency representatives who will be contacting him/her to pursue the complaint.

4.0 LSCB Complaints Panel Process

4.1 The LSCB Complaints Panel meeting and the response to the complainant following the panel should be within 28 days from the date the complainant confirmed their wish to have their complaint heard by the LSCB Complaints Panel. Where this cannot be met the reasons must be given to the complainant and recorded, with revised timescales. However, panel members must take into account the date of the next child protection conference. The whole process should in any event not exceed three months and should, wherever possible, be concluded before the next Child Protection Conference.

4.2 The LSCB Complaints Panel should comprise of a minimum of three senior representatives from LSCB member agencies, all of whom must be independent of line management responsibility for those professionals involved in the child protection conference.

4.3 The manager of the child protection conference chairperson or a nominated officer will convene an LSCB Complaints Panel and will:

- consider in liaison with designated agency panel representatives the most appropriate composition of the LSCB Complaints Panel dependant upon the nature of the complaint;

- agree with the other agency representatives arrangements for chairing and minuting the panel meetings.

4.4 Panel members should have considered beforehand the following documents:

- a copy of the outstanding complaint(s);

- copies of all the relevant child protection conference minutes and the written reports submitted to the child protection conferences;

- a copy of all documents relating to the complaint.

The person responsible for convening the panel will ensure that each panel member and the complainant have a copy of each of these documents.

4.5 The LSCB Complaints Panel chairperson in liaison with each designated agency representative should consider whether any further information should be sought and shared prior to the meeting with the complainant and who will undertake this.

4.6 The LSCB Complaints Panel will meet with the complainant to discuss the issues contained in the complaint. The complainant may be accompanied by a supporter of his/her choice, and will be asked to notify the chairperson of the panel of the supporter's name prior to the meeting. In exceptional circumstances where the complainant does not feel able to attend, consideration can be given to a complaint in writing or by being presented by a suitable person.

4.7 The LSCB Complaints Panel will also meet and interview the Chair of the child protection conference in relation to the complaint.

4.8 The LSCB Complaints Panel may need to pursue matters or take account of other information, in which case a further discussion or meeting will be needed.

4.9 As part of the process of the LSCB Complaints Panel, the panel members will normally make their decision without the complainant present. Once the information has been presented to the panel, members will take the opportunity without the complainant present to discuss the matters arising and reach a decision.

5.0 Actions following LSCB Complaints Panel

5.1 The LSCB Complaints Panel will recommend to the Chair of the LSCB that the complaint, or components of it, should be upheld or not upheld.

5.2 **If the recommendation is that the complaint should be upheld**

In respect to one of the following:

- the category of concern (where the child has been made the subject of a child protection plan);
- a decision to make the child the subject of a child protection plan or not, or to continue with the child protection plan where one already exists;
- the process of the conference where it is thought to have affected the above.

The chair of the LSCB Complaints Panel should recommend that the child protection conference should be re-convened, and consider the points and decision(s) of the LSCB Complaints Panel.

5.3 As far as possible the reconvened conference should consist of the same representatives who were present at the original conference. However the child protection conference must be chaired by a different conference chairperson.

5.4 Where the complaint is recommended to be upheld but is about process only, and it is not believed to have affected the outcome of the conference thereby not requiring a reconvened conference, the panel should recommend an alternative plan of action in order to resolve the complaint. This may be in the form of recommendations to appropriate agency managers or may consist of acknowledging that procedures were not correctly followed or that practice was not in accordance with expected standards.

5.5 Following the LSCB Complaints Panel meeting, the chairperson of the panel will write to the Chair of the LSCB, with a copy to the other members of the panel, within fifteen working days of the panel meeting, setting out the issues raised in discussion, the recommendation(s) reached and the rationale behind the recommendation(s), stating any agreements reached with proposed actions.

5.6 The LSCB Chair will write to the complainant within five working days of receiving the report from the LSCB Complaints Panel, enclosing a copy of the panel's report and indicating his/her response to the recommendation(s).

5.7 **If the complaint is not upheld**

The chairperson of the LSCB Complaints Panel will write to the Chair of the LSCB within fifteen working days setting out the issues raised in discussion, the recommendation(s)) reached and the rationale behind the recommendation(s), and stating that the complaints process has come to a conclusion.

The LSCB Chair will write to the complainant within five working days of receiving the LSCB Complaints Panel report, enclosing a copy of the panel's report and indicating his/her response to the recommendation(s)

5.8. Whether the recommendation is that the complaint should be upheld or not, a copy of the report sent by the chairperson of the LSCB Complaints Panel should also be sent to the line manager of conference chairperson, who will ensure that the findings and recommendations of the LSCB Complaints Panel are passed to the chairperson of the next child protection conference if agreed with the Chair of the LSCB. A copy of the panel report and the LSCB Chair's response will also be sent to the chairperson and all those who attended the original child protection conference.

5.9 A copy of the findings and recommendations of the LSCB Complaints Panel should also be placed on the relevant child's case record held by children's services and a copy sent to the local authority Complaints Manager.

5.10 A summary with conclusions and recommendations from a complaint should be forwarded to the chairperson of the LSCB so that any learning points, issues raised and actions taken as a result of complaints can be considered by the LSCB as appropriate. The LSCB should review the outcome of all complaints at least annually.

6.0 Actions in relation to a child protection conference following a complaint

At the reconvened or next review child protection conference following the LSCB Complaints Panel, the following should occur:

- the chairperson of the child protection conference should make it clear at the conference that a complaint has been received and considered by the LSCB Complaints Panel and should detail the conclusions and recommendations;

- the members of the LSCB Complaints Panel should be notified by the conference chairperson of the decisions and recommendations of the reconvened child protection conference.

7.0 Actions where complainant remains dissatisfied

If the complainant continues to be dissatisfied, the chairperson of LSCB should be advised and s/he, in liaison with the LSCB Complaints Panel chairperson will consider whether any further action is appropriate.

Bournemouth & Poole Local Safeguarding Children Board

Dorset Safeguarding Children Board

PAN DORSET INTER-AGENCY SAFEGUARDING PROCEDURES

CHAPTER 3

3.4 SEXUAL EXPLOITATION OF CHILDREN & YOUNG PEOPLE

Procedures Effective from: **2006**

Review Date: **June 2011**

If you have any comments or queries about the pan-Dorset procedures please contact your agency representative on the Pan Dorset Policy and Procedures Group or notify the LSCB using the following email addresses:

info@dorsetlscb.co.uk
info@bournemouth-poole-lscb.org.uk

SEXUAL EXPLOITATION OF CHILDREN AND YOUNG PEOPLE

Introduction and Definition.

1.1 Children and young people involved in prostitution and other forms of commercial exploitation should be treated primarily as the victims of abuse and their needs require careful assessment. They are likely to be in need of welfare services, and in many cases, protection under the Children Act 1989. Similarly, Safeguarding Children Involved in Prostitution (DoH 2000) gives additional guidance as to the inter – agency approach to be taken and aims to both safeguard and promote the welfare of children and young people, and to encourage the investigation and prosecution of criminal activities by those who coerce children and into and abuse them through prostitution.

1.2 This protocol has been re-written in line the with the revised Working Together To Safeguard Children 2006 and is linked to Guidance for Professionals Working With Sexually Active Young People under the Age of 18 in Bournemouth, Dorset and Poole 2007) and Guidance for Professionals Working with Sexually Active Young People Under the Age of 18 In Bournemouth, Poole and Dorset. (is there enough reference to this in the Appendix)

1.3 For the purpose of this protocol the sexual exploitation of children and young people can be defined as:

- Prostitution

A female or male under the age of 18 is being abused through prostitution when sexual activity, whether agreed or coerced, is provided in exchange for some form of payment or reward. 'Payment or reward' may be in the form of money, drink, drugs, food, shelter or protection *(this list is not exhaustive)*.

- The making of indecent images; also known as pornography. This may include visual and audio images or photographs, videotapes, the Internet and audiotapes**.**

1.4 It is important to recognise that those who use or abuse children through prostitution often physically, sexually and emotionally abuse them and may effectively imprison them. It should also be recognised that not all sexual activity by children and young people under the age of 16 years is considered as coercive or exploitative. Most young people will have an interest in sex and sexual relationships.

1.5 Although in recent years there has been an increase in awareness and information on the extent and nature of the problem, child sexual exploitation remains largely a hidden problem. It is increasingly recognised for the vast majority of children and young people who enter prostitution and other forms of sexual exploitation that:

- they do not enter into it willingly; their involvement is indicative of coercion or desperation rather than choice,

- they are being exploited by other persons even though they may think they are exercising free choice, and

- they are victims of abuse.

1.6 Scant regard is paid towards male prostitution, and does not, in general raise the same issues regarding drug use or coercion and so rarely comes to the attention of agencies. It is important that all agencies should not focus solely on female prostitution and be mindful that young males can also be coerced or willingly, for a variety of reasons become involved in prostitution.

1.7 Additionally, attention should also be drawn to unaccompanied and asylum seeking children and young people, who are particularly vulnerable to becoming involved or coerced into prostitution.

1.8 All children and young people have a right to be protected from harm. Children and young people who might be involved in, or at risk of becoming involved in, prostitution and pornography, should be identified by professionals as "children in need", who may be suffering, or may be likely to suffer significant harm. Professionals and services that come into contact with these children and young people have a responsibility to safeguard and promote their well-being, and to co-operate effectively to prevent children becoming involved in, and to divert children out of, sexual exploitation.

1.9 It is recognised that a multi-agency approach is essential in dealing with the complex and diverse issues that constitute child sexual exploitation. The Police and Children's Services are the lead agencies dealing with sexually exploited children and young people and the adults who abuse them. Within the Police Service the Sex Offender Investigation Unit are charged with the lead responsibility for child sexual exploitation.

Purpose and Aims

2.1 *'Working Together to Safeguard Children' (HM Government 2006)* sets out the framework for all agencies and professionals in responding to the safeguarding and promotion of the welfare of children.

2.2 *'Safeguarding Children involved in Prostitution – Supplementary Guidance to Working Together to Safeguard Children' (DoH 2000)* reinforces and expands the former, by setting out guidance which aims to enable agencies and professionals to work collaboratively to:

- recognise the problem of child prostitution;
- treat the child/young person primarily as a victim of abuse;
- safeguard children and young people and promote their well-being;
- work together to prevent abuse and provide children and young people with opportunities and strategies to exit from prostitution;
- investigate and prosecute criminal activities by those who coerce children and young people into and abuse them through prostitution.

2.3 *'The National Plan for Safeguarding Children from Commercial Sexual Exploitation' (DoH 2001),* forms part of the Governments' drive to improve safeguards for

children, in particular those who are induced or coerced into unlawful sexual activities for the commercial advantage of others.

2.4 *A Coordinated Prostitution Strategy; and a Summary of Response to Paying The Price (2006*) sets out the many responses of a public consultation and is informing the development of a coordinated prostitution strategy, including children and young people.

2.5 This protocol should be read in conjunction with the guidance documents listed above. It is intended to formalise local arrangements between Children's Services, the Police, other statutory agencies and voluntary organisations in Bournemouth, Dorset and Poole regarding children and young people involved in/at risk of becoming involved in sexual exploitation, and is in accordance with the aims stated above.

2.6 This protocol sets out

<u>In Section 1</u>

- the principles governing work with children and young people involved in or at risk of involvement in prostitution and other forms of sexual exploitation;
- guidance relating to recognition of the problem;
- the role and responsibilities of key agencies and the services provided by them;

<u>In Section 2</u>

- procedure and practice guidance for individuals and agencies

2.7 *Guidance For Professionals Working with Sexually Active Young People Under the Age of 18 in Bournemouth, Poole and Dorset (this document is supplementary to and should be read in conjunction with appendix 6)* has been devised with the understanding that that most young people under the age of 18 will have an interest in sex and sexual relationships; it will assist those working with children and young people to identify where such relationships may be abusive, and may need protection and additional services.

SECTION 1

Key Principles

3.1 The well being of individual children/young people is paramount.

3.2 Children's Services need to be aware of

- children and young people up to the age of 18 and
- young people up to the age of 21 who were looked after for whom the local authority has statutory responsibility
- who are at risk of/are being sexually exploited and for whom there may be child in need and/or child protection issues

3.3 Cultural tradition and religious beliefs alone neither explain nor condone acts of commission or omission which places a young person at risk of significant harm through prostitution. Issues relating to ethnicity will become apparent when children and young people are identified as being at risk of being involved in prostitution, and consideration should be given to the use of interpreter services.

3.4 Where possible, work will occur in partnership with the parent(s) as well as the child/young person.

3.5 Agencies and services will work together to safeguard the child/ young person involved and promote their welfare.

3.6 The priority for the police will be to investigate and prosecute those who involve or coerce a child/young person in sexual exploitation.

3.7 In the case of prostitution children/young people will be treated as victims of abuse. However, in exceptional cases the police may use the criminal justice system, where there is a refusal to respond and prostitution continues. This route would normally be taken only when a multi-agency meeting concludes that this is necessary, and should include those who are able to represent the child/young person's views where possible e.g. advocacy worker/project worker.

3.8 The response to any child/young person who is being sexually exploited will be on a non-discriminatory basis.

3.9 Confidentiality will be respected, but information will be shared between agencies on a need to know basis in order to ensure the child/young person is protected. *(refer appendix 1)*

3.10 Agencies and services should seek to work together to prevent abuse and provide children and young people with opportunities and strategies to exit from prostitution.

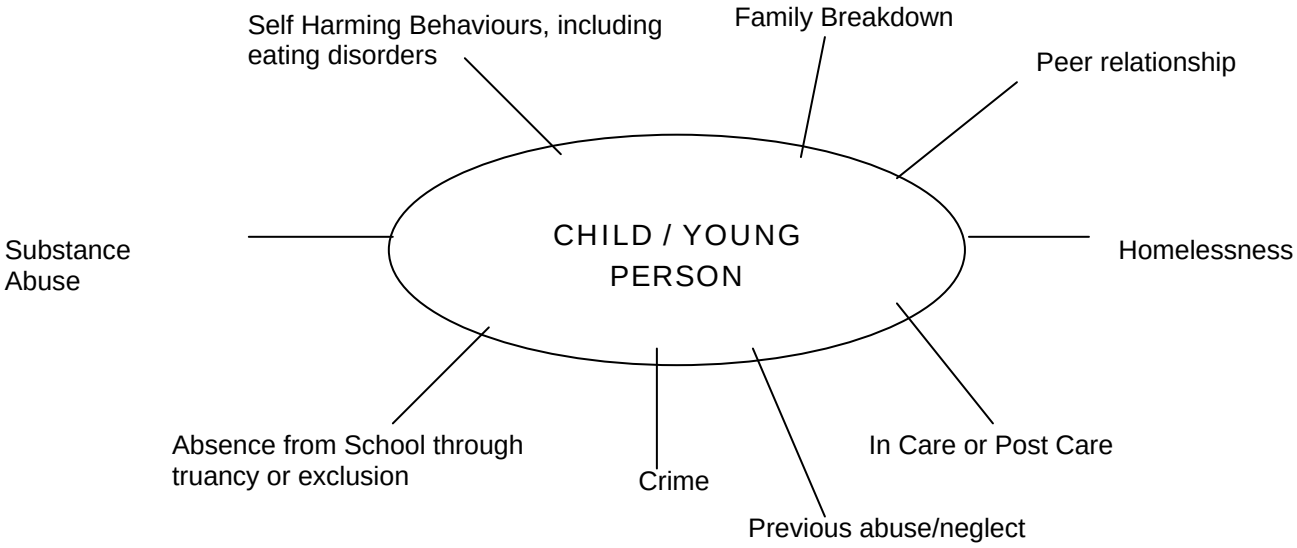
Recognition and early warning signs

4.1 All agencies are responsible for ensuring that their staff are able to recognise situations where a child/young person might be involved in, or at risk of becoming involved in sexual exploitation

Children and Young People

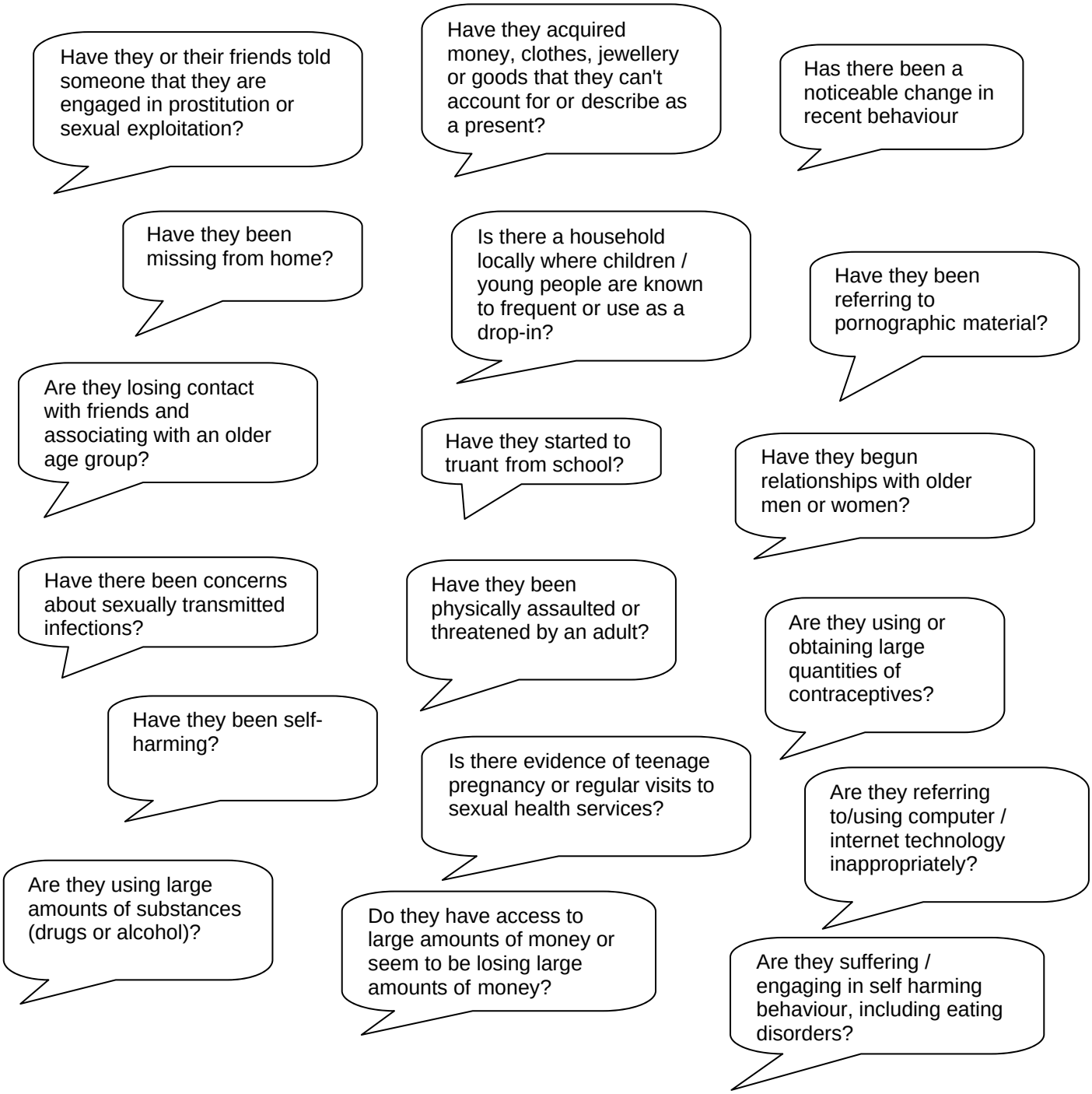
4.2 Agencies should regard prostitution and involvement in the production of indecent images of children or similar activities, as one aspect of the child/young person's behaviour, which brings them to the attention of agencies and indicates the need for intervention.

4.3 Victims are often, but not always, part of a wider group of disaffected children/ young people for whom sexual exploitation is one route open to them. Vulnerability and low self esteem are factors which sometimes feature in the background of children and young people drawn into prostitution and several factors may contribute and lead to their increased vulnerability.



4.4

4.4 Workers need to be aware of the following possible indicators as part of their general assessment of the needs of a child/young person:



The above list is not exhaustive. However, it might help consideration of possible sexual exploitation.

4.5 Indicators that adults might be sexual exploiting or seeking to sexually exploit children may include:

Those expressing a sexual or violent interest or attitude towards children/young people

Those who have numbers of children visiting their house regularly and appear to be using it as an open house to drop in to

Those who have or are suspected of having a relationship or series of relationships with children/ young people

Those who harbour children/young people who are truanting from school or missing from home or may have taken a child/young person into their home as a lodger/boyfriend or girlfriend

Those who give children/young people treats, money or favours

5.0 Role of Agencies

Children's Services

Bournemouth, Dorset and Poole Children's Services have a duty to children and young people under the age of 18 years, to promote their health and development. Dorset Police also have responsibilities under the Children Act 1989 to ensure the safety and protection of children and young people in collaboration with other agencies and professionals.

Children's Services Duty and Assessment teams will undertake an assessment of a child or young person's circumstances in liaison with other statutory agencies, and where appropriate voluntary sector agencies. The child or young person will remain paramount in the assessment of risk.

Sex Offenders Investigation Unit (Dorset Police)

The Sex Offenders Investigation Unit manages investigations and prosecutes those who abuse a child and those who coerce or are involved in the prostitution / sexual exploitation of a child.

Health Services

Primary Care Foundation Trusts across Dorset, and Dorset Healthcare Foundation Trust (Are these titles sufficient?) provide primary care services, contraception services and sexual health advice.

Bournemouth and Poole Primary Care Trust, Contraceptive Health Services provide young person centred Youth Advisory Drop Ins in Bournemouth and Poole.

The Dorset Working Women's Project (DWWP) is funded by Bournemouth and Poole PCT and is a HIV prevention and sexual health project targeting women who sell sex, particularly those who also misuse drugs and/or alcohol.

The Project aims to assist working women to increase control over their health by enabling access to local health and social care resources and providing information upon which they can base healthy choices. The DWWP provides twice weekly Street Outreach providing condoms, lubricants, newsletters, information on safer sex, safer drug use, HIV, reproductive and sexual health, safety at work and attack alarms.

The DWWP provides home visits to indoor sex workers who are offered crisis and on-going one-to-one support, along with the delivery of condoms, lubricants, clean injecting equipment, newsletters, information on safer sex, safer drug use, HIV, reproductive and sexual health and safety at work.

As the project is street based the workers will often be the first to identify possible young people at risk of prostitution. The project works to a policy of contacting the Police and Children's Services when concerns are raised.

Bournemouth and Poole Primary Care Trust Sexual Health Team provide regular training to Children's Services staff and Education Welfare staff on Sex and Relationships and Young People. Included in the training package is a presentation from Dorset Working Women's Project on their work and risk factors for young people who might engage in prostitution.

Bournemouth Teenage Pregnancy Strategy operates a condom distribution service, free and confidential to young people under 18, called the C-Card Scheme. This operates from various young people friendly services across Bournemouth and Poole, such as Connexions and Youth Services.

Education

Teachers and those working with children and young people in school have a duty to safeguard and promote the welfare of children and young people. Whenever staff in schools have concerns about a child or young person, they have a duty to report these concerns to Children's Services and/or the Police, via the designated teacher with child protection responsibilities within each school.

The Education Welfare Service (EWS) or Education Social Work Service (ESWS) is a social work service to children/young people of school age and their families. It carried out the Local Authority's duty to investigate absence. Any child/young person who is missing school and at risk of possible or actual sexual exploitation should be discussed with the EWS/ESWS. Each school has a link Education Welfare Officer/Education Social Worker linked to it.

Bournemouth Community Care provide Sex and Relationship education, and operate a C-Card Scheme

Criminal Justice Action

6.1 Sections 47 to 51 of the Sexual Offences Act 2003 deal with the exploitation of children, whether through prostitution or pornography. The Act creates a number of offences that apply to both types of exploitation.

6.2 Dorset Police will treat children involved in prostitution and in the production of indecent images primarily as victims of abuse and their needs will be carefully assessed.

6.3 Information and/or comments should be passed in the first instance to the relevant Dorset Police Child Protection Investigation Unit. An officer will be allocated to manage the investigation who will in turn consult with the Dorset Police Sex Offender Investigation Unit who will deal with any issues involving the 'suspect offender'.

6.4 Irrespective of the nature or source of the concern, once the Police receive a referral / information, a careful assessment of need and risk will be undertaken in consultation with other agencies as appropriate and then steps will be taken to identify adult coercers. The priority for criminal justice action must be to investigate and prosecute those who abuse a child and those who coerce or are involved in the prostitution / sexual exploitation of a child.

6.5 The concerns identified will vary in their significance and seriousness. The concerns may not warrant or enable significant intervention, but may indicate other forms of abuse. However, it is acknowledged that children being sexually exploited are involved in high risk activities and will therefore be in need of support services and in some cases protection under the Children Act 1989.

6.6 All agencies involved with the child/young person where the child/young person has been involved in prostitution should be meticulous in their record keeping and document carefully any information which could be used to assist the bringing of charges against those exploiting a child/young person.

Voluntary and persistent return to prostitution

6.7 The vast majority of children do not freely and willingly become involved in prostitution. However, there may be rare cases where a boy/girl under 18 freely chooses to continue to solicit, loiter or importune in a public place for the purpose of prostitution and knowingly and willingly breaks the law. In such cases, the Police should only start to consider whether criminal justice action is required following a strategy meeting when all diversion work has failed over a period of time and a judgement is made that it will not prove effective in the foreseeable future.

6.8 The decision on whether to initiate criminal justice action is for the Police and at a later stage the Crown Prosecution Service. However, in the context of this inter-agency approach unilateral action by the Police would not be appropriate. If the Police Officers think that it would be appropriate to consider criminal justice options then an inter-agency meeting should take place. Particular attention should be paid to the following factors: -

- the age and vulnerability of the child;
- the needs of the child;
- any drug misuse by the child;
- that the return is genuinely voluntary and that there is no evidence of physical, mental or emotional coercion;

- that resources to meet the young persons assessed need have been offered i.e. housing, medical care, rehabilitation, relocation;
- that the child understands that criminal proceedings may follow and the effect these could have in later life.

6.9 Support Services will continue to be offered to children and young people throughout the time they are involved with the criminal justice process. The Youth Offending Team will be involved at the reprimand stage and throughout to the final warning stage and any subsequent court process.

SECTION 2

Responding to concerns

7.1 Any concern about the sexual exploitation of a child /young person (including those aged 16 and 17) should be discussed with Children's Services. This is so that Children's Services can initiate the required response to help the child, in partnership with the agency raising the concern and other key agencies with an interest. This should always involve contacting the police where there is an alleged or suspected offence, in order to share information and facilitate any criminal investigation.

7.2 Any initial referral should be made to Children's Services in the geographical area where the young person is staying and/or where there is thought to be a risk. When a young person lives in one Children's Services area but regularly or occasionally visits another Children's Services area where there is thought to be risk to that young person, Children's Services in both areas will need to collaborate.

7.3 The police force for the areas where an offence may have been committed would normally be responsible for investigating such offences.

7.4 The initial response to the referral will include a determination of need and risk.

7.5 The age of consent is 16 years for males and females. Those under 16 years are not legally able to give consent to sexual activity and any concerns about involvement in prostitution and/or pornography within this age group will require an initial assessment and a decision about whether to initiate section 47 enquiries. For 16/17 year olds involved, or suspected of being involved in prostitution assessment is necessary to determine the nature of the 'consent' and to ascertain if coercion and/or exploitation is a factor. (It is illegal for anyone to pay for the sexual services of 16/17 year olds)

7.6 A child under the age of 13 is not legally capable of consenting to sexual activity. Any offence under the Sexual offences Act 2003 involving a child under 13 is very serious and should be taken to indicate a risk of significant harm to the child and, should always be discussed with a nominated child protection lead in Children's Services and a strategy discussion will be held.

Working Together To Safeguard Children (2006), Chapter 5 para 5:27 sets out the considerations that should be taken into account when assessing whether a child may be at risk of significant harm, and therefore the need to hold a strategy discussion in order to share information:

- The age of the child – sexual activity at a young age is a very strong indicator that there are risks to the welfare of the child (whether boy or girl) and, possibly, others
- The level of maturity and understanding of the child
- What is known about the child's living circumstances or background
- Age imbalance – in particular where there is a significant age difference
- Overt aggression or power imbalance
- Coercion or bribery
- Familial child sex offences
- Behaviour of the child – i.e. withdrawn, anxious

- The misuse of substances as a disinhibitor
- Whether the child's own behaviour, because of the misuse of substances, places him or her at risk of harm so that he or she is unable to make an informed choice about activity
- Whether any attempts to secure secrecy have been made by the sexual partner, beyond what would be considered usual in a teenage relationship

7.7 Unsubstantiated concerns that a child/young person may be being sexually exploited should be treated seriously but with sensitivity, recognising that mishandled intervention may have a negative impact on the outcome for the child/young person and may alienate them further into exploitative circumstances.

7.8 In the event that there are concerns, and information is limited about the child/young person, there will remain a requirement for Children's Services and Police to be informed of the concerns and a decision taken about how further information might be sought and by whom.

The agreed plan could be for the principal worker in contact with the child/young person to establish more about their concerns and needs.

Progress of the initial response would be monitored by Children's Services with multi-agency meetings to plan the continuing intervention.

7.9 Where it becomes evident, that there is sexual exploitation which constitutes or may constitute an offence, Children's Services and the Police must be notified at the earliest opportunity.

7.10 Whenever there is thought to be immediate danger to the child/ young person, an urgent referral to the Police *(emergency service)* should be made. This will include those who are aged 16/17 years as well as younger children.

The enquiry process and immediate protection issues

7.11 Whenever concerns about a child's/young person/s involvement in prostitution/sexual exploitation are referred, Children's Services should decide on its course of action within 24 hours. This would normally follow discussion with any referring professional service and other professionals and services as necessary, and the police, would be notified at the earliest opportunity where a criminal offence may have been committed against a child/young person.

7.12 Referrals may lead to:

- no further action;
- directly to the provision of services or other help - including from other agencies following an initial assessment;
- the initiation of section 47 enquiries. (Children Act 1989) and/or
- a core assessment

7.13 A multi-agency initial assessment, led by Children's Services, using the framework set out in the *"Framework for the Assessment of Children in Need and their Families (DoH 2000)* should address the following:

- what are the needs of the child?

- are the parents able to respond appropriately to the child's needs? Is the child adequately safeguarded from significant harm and are the parents able to promote the child's health and development?
- is action required to safeguard and promote the child's well being?
- Is the harm attributable to the care being given or not given?

In the course of the assessment Social Services should ask:

- is this a child in need?
- is there reasonable cause to suspect that this child is suffering, or is likely to suffer, significant harm?

7.14 When there are no substantiated concerns that the child/young person may be suffering, or at risk of suffering significant harm, a further assessment *(core assessment)* may be required to establish whether services would be helpful and, if so, what kind of help is most likely to bring about the best outcomes for the child/young person.

7.15 Following this assessment and/or at any time in the course of assessment, when there are wider issues to consider, an inter-disciplinary planning meeting should be held to:

- decide what help is required to meet the child's needs;
- develop a plan based on the findings of the core assessment;
- put in place arrangements for the implementation and review of the plan.

7.16 Any intervention should result in a multi-agency plan to support the child/young person's withdrawal from prostitution and any exploitative activities where these exist. The involvement of the child/young person in drawing up the plan will be essential.

7.17 In planning any response / intervention it is important to take account of the following:

- parents / carers may be aware of or even involved in the activities giving rise to concern;
- the child / young person may be fearful about / unable to exit from the activity giving rise to concern.

7.18 If however at any stage, there is reasonable belief that the child/young person is suffering, or is likely to suffer significant harm, section 47 enquiries will be necessary.

7.19 A strategy discussion/meeting should take place to consider whether the criteria for initiating section 47 enquiries are met and if so plan the enquiries.

7.20 The outcome of section 47 enquiries may include:

- concerns not being substantiated;
- ongoing concerns but no real evidence;
- concerns being substantiated but the child not being judged to be at continuing risk of significant harm;
- the concerns being substantiated and the child being judged to be at risk of significant harm.

7.21 When there is agreement between those agencies/professionals involved that the child/young person can be assisted as being vulnerable and in need of help and

services, but any continuing/future risk of exploitation/prostitution is no longer evident, an inter-disciplinary planning meeting should be considered to identify the child's/young person's needs, and develop and implement a plan to meet those needs. This meeting should include the child/young person, their parents/carers, supporter or advocate and all relevant agencies/services.

7.22 Where a young person is under 16, and there are concerns about continuing/future risk of significant harm, a child protection conference will normally be convened. A child protection conference should be convened, within 15 working days of the last strategy meeting. Any decision not to convene a child protection conference where the threshold criteria are met should be made in accordance with current procedures.

7.23 Where a young person is 16/17, the need for a child protection conference to be convened will be determined in relation to the child/young person's individual circumstances, including an analysis of the level continuing risk of significant harm.

7.24 It is important to recognise that just as entry into sexually exploitative activities may involve a complex set of factors, so will leaving it, particularly if there is a strong relationship of dependency with a coercer or abuser, or where there is drug misuse. The exit strategy should be developed with the child and family and should address the needs of the individual child. It could include mentoring to assist a return to education or employment, and help to secure appropriate health services, pursue leisure activities and develop a positive network of friends and relatives to offer continuing support.

Immediate action

7.25 It may be apparent at any stage during the assessment/enquiry process that emergency and/or urgent action should be taken to safeguard a child/young person and secure his/her safety because of the risk to the child's life or likelihood of serious harm.

7.26 Such action should normally be preceded by an immediate strategy discussion/ meeting between the Police Child Protection Investigation Unit, Children's Services and other agencies as appropriate.

Factors to be considered in relation to a child/young person who may be exploited/abused through prostitution

- How and why the child/young person became involved in prostitution.
- The nature of that involvement (frequency, style, activities engaged in, who else is involved).
- The level of coercion that may be influencing their actions, and the likely response of those adults exploiting the child / young person.
- The risks involved and consequences for their well being (including actual and likely physical and emotional effects).
- The feasibility of controlling the child's/young person's movements and the likely effects of attempting to do so.
- The likely impact on a child's/young person's education either by non-attendance concerns and/or educational achievement concerns.
- The identity and role of significant children / adults in their life and their likely response.

- The knowledge/awareness of parents/carers that their child/young person is involved in prostitution and the ability of parents/carers to work with agencies to protect the child/young person.
- The feasibility of promoting the child's young person's participation/involvement with other agencies and identification of those agencies.
- The child's/young person's age, level of maturity and understanding; their ability to assimilate information; their level of cognitive development including their ability to fend and care for themselves and understand the issues of their own protection.
- The young person's perception and interpretation of their involvement of such activities.
- Immediate circumstances of physical safety: where they are staying that night; use of condoms; negotiation of safe sex; drug use and actual physical state.
- Sexual health needs of the child/young person with respect to HIV, other sexually transmitted infections (and contraception other than condoms for females).

Appendix 1

Consent and Confidentiality

Sharing Information with other agencies

1.1 Good practice requires that children/young people and/or their parent(s) should be consulted prior to information being shared between agencies.

1.2 Guidance in respect of information sharing and consent can be found in Appendix 3 What to do if You're Worried A Child is being Abused (DfES 2006) and Appendix 1 of the summary booklet by the same title.

1.3 In situations where the available information suggests the child/young person may be at risk of significant harm, it will always be necessary to share information between relevant agencies, despite consultation having occurred and the child/young person and/or their parent(s) not agreeing to this. If there is a belief that the child/young person may be a victim of sexual exploitation or prostitution, this would constitute a risk of significant harm.

1.4 There will be exceptions to any consultation with the child or young person, about sharing information about them with other agencies; this is when doing so would place the child/young person at increased risk of significant harm.

1.5 Occasions will arise when the child/young person is not at risk of significant harm, but is in need and appears to require services from Social Services so as to safeguard and promote that child/young person's welfare. In this circumstance agencies may be able to share information with Social Services, the test being to address the following:

- Why is consent to information sharing being withheld - what are the implications arising from this?
- From the available information what is the likely impact on the child/young person if information is not exchanged/
- Does it appear that providing a service to the child/young person is necessary, in order to safeguard and promote the welfare of that child/young person?

1.6 Any decision to proceed without the agreement of the child/young person and/or parent(s) should be accounted for in writing.

Appendix 2

CONTACT DETAILS FOR AGENCIES

1. Dorset
Children's Services

North Dorset Office
Bath Road
Sturmaster Newton
DT10 1DR

Tel: 01258 472652

Bridport Office
The Grove
Rax Lane
Bridport DT6 3JL

Tel: 01308 422234

Purbeck Office
19 Bonnets Lane
Wareham
BH20 4HB

Tel: 01929 553456

Christchurch Office
Loring Road
Off Jumpers Road
Christchurch
Dorset BH23 2JT

Tel: 01202 474106

Ferndown Office
Victoria Road
Penny's Walk
Ferndown
BH22 9JY

Tel: 01202 877445

Weymouth & Portland Office
Jubilee Retail Park
17 Jubilee Close
Weymouth
DT4 7BG

Tel: 01305 760139

Sherborne Office

The Sheilings
The Avenue
Sherborne
DT9 3AJ

Tel: 01935 814104

Bournemouth ChildCare and Family Support

Bournemouth Central
9 Madeira Road
Bournemouth
BH1 1QN

Tel: 01202 458101

Poole Children & Young People's Social Care
14a Commercial Road
Parkstone
Poole
Dorset BH14 0JW

Tel: 01202 735046

2 Dorset Police Child Protection Investigation Unit

Bournemouth
5 Madeira Road
Bournemouth Tel: 01202 222446

Poole
Ashley Road Police Station
Parkstone
Poole Tel: 01202 223149

Weymouth
Western Divisional Headquarters
Radipole Lane
Chickerell
Weymouth Tel: 01305 226460

3. Dorset Police Sex Offender Investigation Unit
Sex Offender Investigation Unit
Police Station
Madeira Road
Bournemouth Tel: 01202 222160

4. Dorset Working Women's Project Tel: 07973 235438
Dorset House
First Floor
20-22 Christchurch Road
Bournemouth
BH1 3NL

5. Primary Care Trusts (Health)

Bournemouth & Poole	Tel:	01202 443700
North Dorset	Tel:	01305 361300
South East Dorset	Tel:	01202 850600
South West Dorset	Tel:	01305 368900

6. Education Welfare Service

Bournemouth Education Welfare Service
Dorset House
20/22 Christchurch Road
Bournemouth
Dorset Tel: 01202 456179

Dorset Education Social Work and Attendance Service
Building C51F Winfrith Technology Park Tel: 01305 224422
Winfrith Newbury
Dorset DT2 8BH (South and West Dorset)

Cedar House, Cobham Road
Ferndown, Dorset BH21 7SB (North and East)

Poole Education Welfare Service
Borough of Poole
The Dolphin Centre
Poole
BH15 1FA Tel: 01202 261900

West Dorset General Hospital NHS Trust
Poole Hospital NHS Trust

Bournemouth & Poole Local Safeguarding Children Board

Dorset Safeguarding Children Board

PAN DORSET INTER-AGENCY SAFEGUARDING PROCEDURES

GUIDANCE FOR PROFESSIONALS WORKING WITH SEXUALLY ACTIVE YOUNG PEOPLE UNDER THE AGE OF 18 IN BOURNEMOUTH, POOLE AND DORSET

Procedures Effective from: **2006**

Review Date: **June 2011**

If you have any comments or queries about the pan-Dorset procedures please contact your agency representative on the Pan Dorset Policy and Procedures Group or notify the LSCB using the following email addresses:

info@dorsetlscb.co.uk
info@bournemouth-poole-lscb.org.uk

CONTENTS

Introduction

1. Assessment
2. Process
3. Young People under the Age of 13
4. Young People between 13 and 16
5. Young People between 17 and 18
6. Sharing Information with Parents and Carers

Appendices

Appendix 1 - Additional information

Appendix 2 - DOH Best Practice Guidance for Doctors and Other Health Professionals

Points of Reference

Pan Dorset Inter-agency Safeguarding Procedures

- Chapter 3, Appendix 11, Protocol for Working With Children & Young People with Sexually Harmful Behaviour
- Part 2, Chapter 4, Working Together To Safeguard Children 2006, Appendix 5, Procedures for Managing allegations against people who work with Children
- Fraser Guidelines – Sex and the Law www.under-cover.org.uk www.brook.org.uk
- Bournemouth Prostitution Strategy (Draft) 2007

Note

Reference to Children's Services in this document relates to Local Authority Children's Services.

Acknowledgement

This Protocol was based on the Protocol developed by Cumbria & Lancashire.

Introduction.

This protocol has been devised with the understanding that most young people under the age of 18 will have an interest in sex and sexual relationships.

It is designed to assist those working with children and young people to identify where these relationships may be abusive, and the children and young people may need the provision of protection or additional services.

It is based on the core principle that the welfare of the child or young person is paramount, and emphasises the need for professionals to work together in accurately assessing the risk of significant harm when a child or young person is engaged in sexual activity.

All agencies, which have contact with children and young people, should use this protocol to develop and implement local guidance for their own staff.

1. Assessment

1.1 All young people, regardless of gender, or sexual orientation who are believed to be engaged in, or planning to be engaged in, sexual activity must have their needs for health education, support and/or protection assessed by the agency involved. This assessment must be carried out utilising the Framework for the Assessment of Children and their Families in accordance with information and guidance set out in;

- Pan Dorset Inter-agency Safeguarding Procedures;
- Department of Health Best Practice Guidance for Doctors and other Health Professionals on the provision of Advice and Treatment to Young People Under 16 On Contraception, Sexual, and Reproductive Health. (Appendix2)

1.2 In assessing the nature of any particular behaviour, it is essential to look at the facts of the actual relationship between those involved. Power imbalances are very important and can occur through differences in size, age and development and where gender, sexuality, race and levels of sexual knowledge are used to exert such power. (Of these, age may be a key indicator, eg a 15 year old and a 25 year old). There may also be an imbalance of power if the young person's sexual partner is in a position of trust in relation to them eg teacher, youth worker, carer etc. In the assessment, workers need to include the use of sex for favours eg exchanging sex for clothes, compact discs, trainers, alcohol, drugs, cigarettes etc. Young people could also have large amounts of money or other valuables which cannot be accounted for.

1.3 If the young person has a learning disability, mental disorder or other communication difficulty, they may not be able to communicate easily to someone that they are, or have been abused, or subjected to abusive behaviour. Staff need to be aware that the Sexual Offences Act 2003 recognises the rights of people with a mental disorder to a full life, including a sexual life. (Also Human Rights Act Chapter 3) However, there is a duty to protect them from abuse and exploitation. The Act includes 3 new categories of offences to provide additional protection (Appendix 1)

1.4 In order to determine whether the relationship presents a risk to the young person, the following factors should be considered. This list is not exhaustive and other factors may be needed to be taken into account (Pan Dorset Inter-agency Safeguarding Procedures, Chapter 3, Appendix 11)

- The age of the child. Sexual activity at a young age is a very strong indicator that there are risks to the welfare of the child (whether boy or girl) and, possibly, others
- The level of maturity and understanding of the child
- What is known about the child's living circumstances or background
- Age imbalance, in particular where there is a significant age difference
- Overt aggression or power imbalance
- Coercion or bribery
- Familial child sex offences
- Behaviour of the child i.e. withdrawn, anxious
- Whether the child's own behaviour, because of the misuse of substances places him/her at risk of harm so that he/she is unable to make an informed choice about any activity
- Whether any attempts to secure secrecy have been made by the sexual partner, beyond what would be considered usual in a teenage relationship
- Whether the child denies, minimises or accepts concerns
- Whether the sexual partner/s is known by one of the agencies
- Whether the young person's own behaviour, for example through misuse of substances, including alcohol, places them in a position where they are unable to make an informed choice about the activity
- If accompanied by an adult, does that relationship give any cause for concern?
- Whether methods used to secure compliance and/or secrecy by the sexual partner are consistent with behaviours considered to be 'grooming' (Appendix 1)
- Whether sex has been used to gain favours (eg swap sex for cigarettes, clothes, cds, trainers, alcohol, drugs etc.)
- The young person has a lot of money or other valuable things which cannot be accounted for
- Prostitution is a cause for concern (Working Together to Safeguard Children 2006 Chapter 6 para 6.2 and Appendix 5)

1.5 Workers should follow the Fraser guidelines when discussing personal or sexual matters with a young person under 16. The Fraser guidelines give guidance on providing advice and treatment to young people under 16 years of age. These hold that sexual health services can be offered without parental consent providing that

- The young person understands the advice that is being given
- The young person cannot be persuaded to inform or seek support from their parents, and will not allow the worker to inform the parents that contraceptive/protection, eg condom advice, is being given
- The young person is likely to begin or continue to have sexual intercourse without contraception or protection by a barrier method
- The young person's physical or mental health is likely to suffer unless they receive contraceptive advice or treatment
- It is in the young person's best interest to receive contraceptive/safe sex advice and treatment without parental consent

2. Process

2.1 In working with young people, it must always be made clear to them 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 young person may prove useful as a means of emphasising the gravity of some situations ensuring that the young person's thoughts, feelings and needs have been ascertained.

2.2 On each occasion that a young person is seen by an agency, consideration should be given as to whether their circumstances have changed or further information has been given which may lead to the need for referral or re-referral.

2.3 In some cases urgent action may need to be taken to safeguard the welfare of a young person. However, in most circumstances there will need to be a process of information sharing and discussion in order to formulate an appropriate plan. There should be time for reasoned consideration to define the best way forward. Anyone concerned about the sexual activity of a young person should initially discuss this with the person in their agency responsible for safeguarding children. There may then be a need for further consultation with the Team Manager, Assessment Team, Children's Services. All discussions should be recorded, giving reasons for action taken and who was spoken to.

It is important that where there are concerns all decision making is undertaken with full professional consultation, never by one person alone (agency procedures must include guidance on how this is to be undertaken within their own organisation).

2.4 If you have concerns that the young person may be at risk of sexual exploitation through prostitution, please refer to Children's Services by completion of a Multi Agency Referral process. If the situation is an emergency, Dorset Police should be contacted immediately.

2.5 When a referral is received by Children's Services, an enquiry as to whether the child has been the subject of a child protection plan will be made, and this may be followed by a strategy discussion with the police and partner agencies. This discussion should be informed by the assessment undertaken using this protocol and, in the majority of cases, may be largely for the purposes of consultation and information sharing.

In many cases, it will not be in the best interests of the young person for criminal or civil proceedings to be instigated. However, Dorset Police and Children's Services and other agencies may hold vital information that will assist in any clear assessment of risk.

2.6 Following any referral to Children's Services and after a strategy discussion with the Police and/or any other agencies there may be one of the following responses

- no further action deemed necessary
- following an initial assessment the young person may be identified as a child in need and additional services provided
- the young person may be identified as a child at risk of significant harm and in need of safeguarding
- the child may need to be the subject of a core assessment
- the outcome of the referral will be formally fed back to the referring agency (Inter-agency Safeguarding Procedures 2006 Chapter 2.46)

During this process agencies must continue to offer the service and support to the young person.

2.7 Any girl or a young person with learning/disabilities, who is pregnant, must be offered specialist support and guidance by the relevant services.

3. Children (taken out Young People) Under the Age of 13

3.1 Under the Sexual Offences Act 2003, a child under the age of 13 is not legally capable of consenting to sexual activity. Penetration of the vagina, mouth or anus of a child under 13, with a penis, is classified as rape. Any offence under the Sexual Offences Act 2003 involving a child under 13 is very serious and should be taken to indicate a risk of significant harm to the child. If you have concerns that the child may be at risk of sexual exploitation through prostitution, or engaged in penetrative sexual relationships or activity, this must be referred to Children's Services and Dorset Police. If the situation is an emergency, the Dorset Police should be contacted immediately.

Dorset Police must be notified as soon as possible when a criminal offence has been committed or is suspected of having been committed against a child unless there are exceptional reasons not to do so. (Recommendation 12 of Sir Michael Bichard's report – see list of hyperlinks)

3.2 In all cases where the sexually active child is under the age of 13, a full assessment must be undertaken, including checks with other agencies. Each case must be assessed individually. Where it is identified that there is a risk of significant harm or that it is known an offence has been committed a referral to Children's Services must be made. A strategy meeting will be held with Dorset Police and/or other relevant agencies to determine what action should be taken to safeguard the young person. In order for this to be meaningful, the child will need to be identified, as will their sexual partner if details are known.

3.3 A decision not to refer can only be made following a case discussion with the named or designated lead for child protection within the professional's employing authority. When a referral is not made, the professional and agency concerned is fully accountable for the decision and a good standard of record keeping must be made, including the reasons for not making a referral. **Again, all cases should be carefully documented including where a decision is taken not to share information.**

3.4 When a girl under 13 is found to be pregnant, a referral to the Children's Services must be made and they will hold a strategy discussion with the police and/or other agencies. At this stage a multi agency support package should be formulated.

4. Young People between 13 and 16

4.1 The Sexual Offences Act 2003 reinforces that, whilst mutually agreed, non-exploitative sexual activity between teenagers does take place and that often no harm comes from it, the age of consent should still remain at 16. This acknowledges that this group of young people is still vulnerable, even when they do not view themselves as such.

4.2 Sexually active young people in this age group will still have to have their needs assessed using this protocol. Discussion with Children's Services will depend on the level of risk/need assessed by those working with the young person. (see para 1.4 relating to risk factors)

4.3 This difference in procedure reflects the position that, whilst sexual activity under 16 remains illegal, young people under the age of 13 are not capable to give consent to such sexual activity.

4.4 In all cases where it is identified that there is a risk of significant harm or that an offence has been committed against a child or young person, a referral to Children's Services must be made following which a strategy meeting will be held which will involve a discussion with the Dorset Police. Any decision not to hold a strategy meeting should be clearly documented.

5. Young People between 17 - 18

5.1 Although sexual activity in itself is no longer an offence over the age of 16, young people under the age of 18 are still offered the protection of Safeguarding Procedures under the Children Act 1989. As with younger children, 16-17 year olds may also be particularly vulnerable to harm through abusive sexual relationships. Agencies and workers who become aware of this occurring need to assess the young person's wellbeing and safety and consider whether or not a referral should be made to Children's Services or Dorset Police. Consideration still needs to be given to issues of sexual exploitation through prostitution and abuse of power in circumstances outlined above. Young people, of course, can still be subject to offences of rape and assault and the circumstances of an incident may need to be explored with a young person. Young people over the age of 16 and under the age of 18 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 the Sexual Offences Act 2003.

6. Sharing Information With Parents and Carers

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

6.2 Determine what information from the strategy discussion will be shared with the family, unless such information sharing may place a child at increased risk of significant harm or jeopardise police investigations into any alleged offence(s). Pan Dorset Inter-agency Safeguarding Procedures 2006 Chapter 2 para 2.66 (*WT06 chapter 5 para 5.55*)

6.3 This protocol is written on the understanding that those working with this vulnerable group of young people will naturally want to do as much as they can to provide a safe, accessible and confidential service whilst remaining aware of their duty of care to safeguard them and promote their well being.

7. Reviewing Needs

Agency staff who continue to have continue to have contact with a young person, or receive information which may indicate the young person's circumstances have changed which indicates potential or actual risk of significant harm, must consider whether or not a referral or re-referral should be made to Children's Services or Dorset Police. Please refer to 1.4 above.

Appendix 1
Additional Information

DEFINITIONS

Sexual Grooming

Section 15 of the Sexual Offences Act 2003 makes it an offence for a person (A) aged 18 or over to meet intentionally, or to travel with the intention of meeting a child under 16 in any part of the world, if he has met or communicated with that child on at least two earlier occasions, and intends to commit a "relevant offence" against that child either at the time of the meeting or on a subsequent occasion. An offence is not committed if (A) reasonably believes the child to be 16 or over.

The section is intended to cover situations where an adult (A) establishes contact with a child through for example, meetings, conversations or communications on the internet and gains the child's trust and confidence so that he can arrange to meet the child for the purpose of committing a "relevant offence" against the child.

The course of conduct prior to the meeting that triggers the offence may have an explicitly sexual content, such as (A) entering into conversations with the child about sexual acts he wants to engage him/her in when they meet, or sending images of adult pornography. However, the prior meetings or communication need not have an explicitly sexual content and could for example simply be (A) giving swimming lessons or meeting him/her incidentally through a friend.

The offence will be complete either when, following the earlier communications, (A) meets the child or travels to meet the child with the intent to commit a relevant offence against the child. The intended offence does not have to take place.

The evidence of (A's) intent to commit an offence may be drawn from the communications between (A) and the child before the meeting or may be drawn from other circumstances, for example if (A) travels to the meeting with ropes, condoms and lubricants.

Subsection (2)(a) provides that (A's) previous meetings or communications with the child can have taken place in or across any part of the world. This would cover for example (A) emailing the child from abroad (A) and the child speaking on the telephone abroad, or (A) meeting the child abroad. The travel to the meeting itself must at least partly take place in England or Wales or Northern Ireland.

THE SEXUAL OFFENCES ACT 2003 www.opsi.gov.uk

The legal age for young people to consent to have sex is still 16, whether they are straight, gay or bisexual. The aim of the law is to protect the rights and interests of young people, and make it easier to prosecute people who pressure or force others into having sex they don't want.

For the purposes of the under 13 offences, whether the child consented to the relevant risk is irrelevant. A child under 13 does not, under any circumstances, have the legal capacity to consent to any form of sexual activity.

Protecting People with a mental disorder

The act has created three new categories of offences to provide additional protection with a mental disorder.

- The Act covers offences committed against those who, because of a profound mental disorder, lack the capacity to consent to sexual activity.

- The Act covers offences where a person with a mental disorder is induced, threatened or deceived into sexual activity.

- The Act makes it an offence for people providing care, assistance or services to someone in connection with a mental disorder to engage in sexual activity with that person.

CHILDREN AND FAMILIES: SAFER FROM SEXUAL CRIME – (The Sexual Offences Act 2003) www.homeoffice.gov.uk

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, condoms, pregnancy and abortion.

BICHARD INQUIRY - Recommendation Number 12 www.bichardinquiry.org.uk

"The government should reaffirm the guidance in 'Working Together to Safeguard Children' so that the Police are notified as soon as possible when a criminal offence has been committed, or is suspected of having been committed against a child - unless there are exceptional reasons not to do so".

WORKING TOGETHER TO SAFEGUARD CHILDREN (2006)
www.everychildmatters.gov.uk/workingtogether

Paragraph 2.103

'….The police should be notified as soon as possible by local authority Children's Services wherever a case referred to them involves a criminal offence committed, or is suspected of having been committed, against a child. Other agencies should consider sharing such information. (See paragraphs 5.17 onwards for detailed guidance on this point). This does not mean that in all such cases a full investigation will be required, or that there will necessarily be any further police involvement. It is important, however, that the police retain the opportunity to be informed and consulted, to ensure all relevant information can be taken into account before a final decision is made….'

Paragraph 5.18

'….Whenever other agencies, or the LA in its other roles, encounter concerns about a child's welfare which constitute, or may constitute, a criminal offence against a child, they must always consider sharing that information with local authority Children's Services or the police in order to protect the child or other children from the risk of significant harm. If a decision is taken not to share information, the reasons must be recorded….'

ADDITIONAL REFERENCES

- **Enabling young people to access contraceptive and sexual health information and advice: Legal and Policy Framework for Social Workers, Residential Social Workers, Foster Carers and other Social Care Practitioners.**
- (Department for Education and Skills Teenage Pregnancy Unit 2004) www.dfes.gov.uk/teenagepregnancy

- **Best practice guidance for doctors and health professionals on the provision of advice and treatment to young people under 16 on contraception, sexual and reproductive health.**
- (Department of Health July 2004) www.dh.gov.uk/PressReleases

- **What to do if you are worried a child is being abused Children's Services Guidance.**
- (Joint publication from the Department of Health, Home Office, Office of the Deputy Prime Minister, Lord Chancellor, Department of Education and Skills) www.teachernet.gov.uk

- **Handling Allegations of sexual offences against children.**
- (Local Authority Social Services Letter LASSL (2004) 21 August 2004) www.dh.gov.uk

- **Guidance on offences against children**.
- (Home Office Circular 16/2005) www.yjb.gov.uk/Publications/Resources/Downloads

Further Information Available From

The Home Office - www.homeoffice.gov.uk/sexualoffences/legislation/act.html
Teenage Pregnancy Unit - www.teenagepregnancyunit.gov.uk
Brook - www.brook.org.uk
Sex Education Unit - www.ncb.org.uk/sef
Cabinet Office - www.cabinetoffice,gov.uk
Department of Education and Skills - www.dfes.gov.uk
Department of Health - www.dh.gov.uk

Appendix 2

Best Practice Guidance for Doctors and other Health Professionals

Summary

This revised guidance replaces HC (86)1/HC (FP) (86)1/LAC (86)3 which is now cancelled.

Doctors and health professionals have a duty of care and a duty of confidentiality to all patients, including those under 16.

This guidance applies to the provision of advice and treatment on contraception, sexual and reproductive health, including abortion. Research has shown that more than a quarter of young people are sexually active before they reach 16.

Young people under 16 are the group least likely to use contraception and concern about confidentiality remains the biggest deterrent to seeking advice. Publicity about the right to confidentiality is an essential element of an effective contraception and sexual health service.

The Government's ten year Teenage Pregnancy Strategy, launched in 1999, set a goal to halve the under 18 conception rate by 2010. This is a Department for Education and Skills Public Service Agreement jointly held with the Department of Health. Progress towards meeting local under 18 conception rate reduction targets is one of the NHS Performance Indicators for Primary Care Trusts (PCT).

The contribution of PCTs to improving young people's access to contraceptive and sexual health advice is a key element of all local Teenage Pregnancy Strategies, linked to implementation of the Sexual Health and HIV Strategy, and is performance managed by Strategic Health Authorities.

The Sexual Offences Act 2003 does not affect the duty of care and confidentiality of health professionals to young people under 16.

1 Wellings, K., Nanchahal, K., Macdowall, W., McManus, S., Erens, R., et al. (2001) Sexual Behaviour in Britain: early heterosexual experience. Lancet 358: 1843-50

Action

- PCT commissioners and clinical governance leads should bring this guidance to the attention of all health professionals responsible for the care of young people in any setting via the Safeguarding Children & Young People Health Action Group of the Bournemouth & Poole Local Safeguarding Children Board and Dorset Local Safeguarding Children Board.

- All services providing contraceptive advice and treatment to young people should:

    - Produce an explicit confidentiality policy making clear that under 16s have the same right to confidentiality as adults;

    - Prominently advertise services as confidential for young people under 16, within the service and in community settings where young people meet.

- Health professionals who do not offer contraceptive services to under 16s should ensure that arrangements are in place for them to be seen urgently elsewhere.

- Children's Directors should ensure that social care professionals working with young people are aware of this guidance and the Teenage Pregnancy Unit guidance – '*Enabling young people to access contraception and sexual health information and advice: the legal and policy framework for social workers, foster carers and other social care practitioners'.*

Confidentiality

The duty of confidentiality owed to a person under 16, in any setting, is the same as that owed to any other person. This is enshrined in professional codes 2.

All services providing advice and treatment on contraception, sexual and reproductive health should produce an explicit confidentiality policy which reflects this guidance and makes clear that young people under 16 have the same right to confidentiality as adults.

Confidentiality policies should be prominently advertised, in partnership with health, education, youth and community services. Designated staff should be trained to answer questions. Local arrangements should provide for people whose first language is not English or who have communication difficulties.

Employers have a duty to ensure that all staff maintain confidentiality, including the patient's registration and attendance at a service. They should also organise effective training which will help fulfil information governance requirements

Deliberate breaches of confidentiality, other than as described below, should be serious disciplinary matters. Anyone discovering such breaches of confidentiality, however minor, including an inadvertent act, should directly inform a senior member of staff (eg the Caldicott Guardian) who should take appropriate action.

The duty of confidentiality is not, however, absolute. Where a health professional believes that there is a risk to the health, safety or welfare of a young person or others which is so serious as to outweigh the young person's right to privacy, they should follow locally agreed child protection protocols, as outlined in Pan Dorset Inter-agency Safeguarding Procedures 2006 Chapter 2 para 2.16. In these circumstances, the over-riding objective must be to safeguard the young person. If considering any disclosure of information to other agencies, including the police, staff should weigh up against the young person's right to privacy the degree of current or likely harm, what any such disclosure is intended to achieve and what the potential benefits are to the young person's well-being.

Any disclosure should be justifiable according to the particular facts of the case and legal advice should be sought in cases of doubt. Except in the most exceptional of circumstances, disclosure should only take place after consulting the young person and offering to support a voluntary disclosure.

Duty of Care

Doctors and other health professionals also have a duty of care, regardless of patient age.

A doctor or health professional is able to provide contraception, sexual and reproductive health advice and treatment, without parental knowledge or consent, to a young person aged under 16, provided that:

- She/he understands the advice provided and its implications;
- her/his physical or mental health would otherwise be likely to suffer and so provision of advice or treatment is in their best interest.

However, even if a decision is taken not to provide treatment, the duty of confidentiality applies, unless there are exceptional circumstances as referred to above.

The personal beliefs of a practitioner should not prejudice the care offered to a young person. Any health professional who is not prepared to offer a confidential contraceptive service to young people must make alternative arrangements for them.

Good practice in providing contraception and sexual health to young people under 16

It is considered good practice for doctors and other health professionals to consider the following issues when providing advice or treatment to young people under 16 on contraception, sexual and reproductive health.

If a request for contraception is made, doctors and other health professionals should establish rapport and give a young person support and time to make an informed choice by discussing:

- The emotional and physical implications of sexual activity, including the risks of pregnancy and sexually transmitted infections;
- whether the relationship is mutually agreed and whether there may be coercion or abuse;
- the benefits of informing their GP and the case for discussion with a parent or carer. Any refusal should be respected. In the case of abortion, where the young woman is competent to consent but cannot be persuaded to involve a parent, every effort should be made to help them find another adult to provide support, for example another family member or specialist youth worker;
- any additional counselling or support needs.

Additionally, it is considered good practice for doctors and other health professionals to follow the criteria outlined by Lord Fraser in 1985, in the House of Lords' ruling in the case of Victoria Gillick v West Norfolk and Wisbech Health Authority and Department of Health and Social Security. These are commonly known as the Fraser Guidelines:

- the young person understands the health professional's advice;
- the health professional cannot persuade the young person to inform his or her parents or allow the doctor to inform the parents that he or she is seeking contraceptive advice;
- the young person is very likely to begin or continue having intercourse with or without contraceptive treatment;
- unless he or she receives contraceptive advice or treatment, the young person's physical or mental health or both are likely to suffer;
- the young person's best interests require the health professional to give contraceptive advice, treatment or both without parental consent.

Sexual Offences Act 2003

The Sexual Offences Act 2003 does not affect the ability of health professionals and others working with young people to provide confidential advice or treatment on contraception, sexual and reproductive health to young people under 16.

The Act states that, a person is not guilty of aiding, abetting or counselling a sexual offence against a child where they are acting for the purpose of:

- Protecting a child from pregnancy or sexually transmitted infection;
- protecting the physical safety of a child;
- promoting child's emotional well-being by the giving of advice.

In all cases, the person must not be causing or encouraging the commission of an offence or a child's participation in it. Nor must the person be acting for the purpose of obtaining sexual gratification.

This exception, in statute, covers not only health professionals, but anyone who acts to protect a child, for example teachers, Connexions Personal Advisers, youth workers, social care practitioners and parents.

Guidance Note to Accompany the Flow Chart for Professionals Working with Sexually Active Under 18's

This Note, the Flow Chart and Prompts for Workers are one aspect of a wider Protocol for working with Sexually Active Young People.

Introduction

1. This process applies to any contact in Bournemouth, Poole and Dorset with a health professional, youth worker, Connexions advisor and voluntary agency worker, with someone who is sexually active and under 18, including requests in non-NHS settings for emergency contraception; chlamydia screening or repeat issuing of condoms. It does not apply to condom distribution campaigns where there is no one-to-one consultation, nor does it apply to the sale of condoms.

2. The Note and Flow Chart have been put together by a wide range of statutory agencies (education, health and police), and partners in the voluntary and community sectors. It is aimed at providing staff with guidance on how contact with sexually active under 18s should be managed. Its use MUST be in conjunction with local Safeguarding Procedures.

3. In designing the flow chart, the agencies are clear that at the centre of our contact with the young person is their health and well-being. We have a duty to ensure that we work together to minimise risks to potentially vulnerable young people and in so doing, we must respect an individual's legal rights to privacy and confidentiality.

The Process

4. The decision making process must consider the relationship between the professional and the young person, and seek to build trust as far as possible. The amount of information that will be forthcoming will vary from one setting to another, and will be affected by whether the professional has any prior knowledge of the young person. Therefore, a pharmacist issuing emergency contraception as a one-off will probably only gain some of the answers to the questions or prompts the guidance proposes. As a result, the threshold for discussions with a designated member of staff, Children's Services, or the police, may be lower than for a GP who is more confident they will see the young person again.

5. Some of the answers to these questions may be gained over the course of several consultations. It is up to the professional to use their judgement as to how much information they can seek each time.

6. Where a professional worker expects to discuss a case with Named/Designated staff, and/or also with the line manager, or to have an informal conversation outside the NHS thus breaching confidentiality, then this should be done in consultation with the young person, except where the professional believes it is not in their best interests to be informed, and also where advice is sought without disclosing the name of the individual.

7. Where a serious crime is suspected, advice should be sought from Dorset Police at the earliest opportunity to safeguard the child and minimise the risk of any evidence, such as e-mails or pictures, being destroyed before they can begin their investigation. All staff must be aware that the police must formally record contact made by an agency.

An incident will be recorded as a crime where on the balance of probability an offence defined by law has been committed and there is no evidence to the contrary

8. Any referral or potential referral should be discussed in the first instance with the young person. The organisation making the referral then has a **Duty of Care** to the individual to secure their physical and mental well-being and offer support during that time.

9. In law, children under 13 are deemed to be unable to give informed consent to sexual activity, so professionals working with such children need to ensure that they have taken all reasonable steps to protect the child's welfare and prevent them from harm, and that they have operated within the guidance issued by their organisation.

10. The degree of [Fraser] competence of a young person needs to be assessed on an individual basis and documented. This will vary with age, maturity and with the implications of the treatment or advice they are seeking. Young people under sixteen who are Fraser competent can consent to treatment. A child or young person can say they wish to withhold consent to their information being shared with another agency. A professional, however, may override this if they are of the firm view that not to do so may jeopardise the safety and welfare of the child or young person, or is in the wider public interest.

11. Where the young person is under 13 years of age, an assessment must be undertaken as to risk, and advice or guidance obtained from the organisation's Child Protection lead, the Designated/Named clinician, or line manager. The actions taken by the professional **MUST BE RECORDED**, the rationale for these actions clearly given, and the line manager informed.

12. Throughout the process it will be important to remember the perpetrator of abuse might be: the patient; male or female; of the same sex; in a caring role for the individual. Similarly not all abuse is recognised as such by the victim at the time, and this is notably the case where a young person is being groomed.

13. In accordance with guidance from the Department of Health, the health professional is responsible for deciding when a referral is or is not made. Where there is any uncertainty and a referral is not made, the reasons and rationale must be documented in the young person's notes at the time, and for all under 13s this must be recorded because the law treats them as unable to give informed consent to sex.

14. Wherever possible, informal discussions should be carried out in such a way as not to breach confidentiality.

15. Initiating a Safeguarding Procedure may involve discussion with a Named/Designated Doctor or Nurse. Where a Youth Worker, Connexions advisor or any other professional is working in a sexual health service for young people, as part of induction and ongoing training, staff should be made aware of the arrangements for confidentiality, and know who their named and designated professionals are in order to seek advice and support.

16. As part of inter-agency working, each agency must recognise that they only hold some pieces of the "jigsaw". For example, health professionals would not routinely have access to wider multi-agency intelligence about a young person, their partner, or their family, without making a referral.

17. It is important to recognise that any information passed to Children's Services, even in confidence, can be released by a Court Order by a judge in the Family Court. The same does not apply to the Police, who are entitled to withhold information under Public Interest Immunity. This should be considered when disclosing any information that could later put a patient or informant at risk.

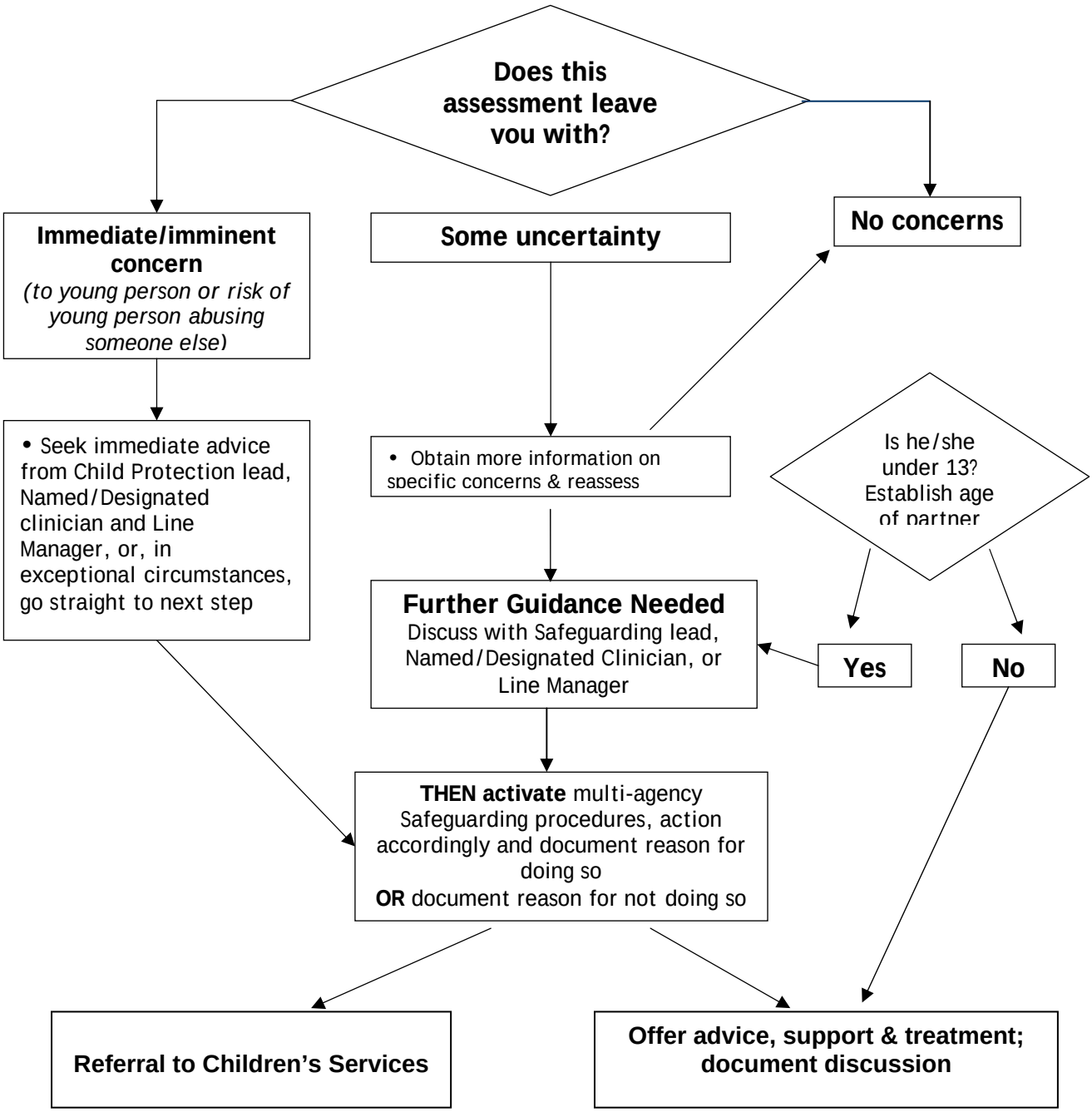
Flow Chart for Professionals Working With Sexually Active Under 18's

INITIAL OR ONGOING CONTACT WITH YOUNG PERSON PERSON

INITIAL ASSESSMENT OF RISK (based on information available)

Consider:

- The young person, (inc. whether they appear to be under 13 because the law treats under 13s differently)
- The context of the consultation (inc. who else is present)
- Any information known or forthcoming about their partner
- Give advice, support/treatment in line with Fraser competency
- Young person should be kept advised of actions being taken where this is appropriate to do so.
- Act in a timely way, avoiding and minimising delay, ensuring that at all stages you minimise risk of harm for both the young person and their sexual partner if she/he is **at risk of harm**



Prompts for workers/professional coming into contact with sexually active under18s
To only be used in conjunction with Guidance Note and flow chart, and relevant safeguarding guidance issued by your organisation

Context:	**General** **(Reasonable level of Trust established with the young person, you have confidence that the young person will be either returning to you for support/treatment, or that you can maintain contact with the young person after the face to face contact has ended)**	
	16/17 year olds	Under 16s
Initial prompts for workers	▪ Personal Information ▪ Health, social and sexual health history ▪ Do they understand the concept of informed consent? ▪ Is there informed consent between partners? ▪ In seeing the young person, is there anything untoward that gives you cause for concern?	As for 16 and 17 year olds, plus: ▪ Are they Fraser competent?
Issues to clarify if uncertain or concerned	▪ Who does the young person live with, is this a risk? ▪ Is there any concern about lifestyle issues ▪ Is there any sign of alcohol or substance misuse relating to the sexual activity? ▪ Are they still in touch with their peers ▪ Does the young person or their partner have a Social Worker or a Connexions Personal Advisor? ▪ Is the other partner present? If so, try to see the young person on their own. ▪ If not, are they willing to give details of their partner?	As for 16/17 year olds, plus: ▪ is the other partner present? If so, try to see young person on their own. (* note that legal age of consent = 16). ▪ What is the partner's occupation? Is this a position of power over the young person? ▪ Do they go to school?

	▪ Any age differential ▪ The relationship (e.g. family, or Position of Trust, such as teacher, youth worker etc.) ▪ Is there any evidence of coercion? What makes it coercive? ▪ Any evidence of gifts being used as an incentive to secure consent or secrecy? ▪ Any evidence of violence, threats, or attempts to gain secrecy? ▪ Any evidence of self-harm? ▪ Where did/do they meet? (e.g. internet)	▪ If they are under 13, you must ensure that you have sought advice from a Child Protection lead, Named/Designated Person and Line Manager
	Opportunistic (No significant trust established) Likely to be a one-off contact with young person, or where you are uncertain if you will see them again	
Initial prompts for workers	▪ Personal Information ▪ Maturity of the young person for their age	
Issues to clarify if uncertain or concerned	▪ Are they Fraser competent? ▪ In seeing the young person, is there anything untoward that gives you cause for concern (including their age) ? ▪ Are any peers present? ▪ Are they willing to give personal details? ▪ Do they understand the concept of consent? ▪ Lifestyle issues (e.g. domestic violence, drug or alcohol abuse etc.) ▪ Does the young person or their partner have a Social Worker or a Connexions Personal Advisor? ▪ Is there any sign of alcohol or substance misuse relating to the sexual activity? ▪ Any evidence of violence, threats, or attempts to gain secrecy? ▪ Is there anything else leading to a risk of significant harm? ▪ Any evidence of self-harm?	

Bournemouth & Poole Local Safeguarding Children Board

Dorset Safeguarding Children Board

PAN DORSET INTER-AGENCY SAFEGUARDING PROCEDURES

CHAPTER 3

3.5 SERIOUS CASE REVIEWS

Procedures Effective from: **March 2010**

Review Date: **October 2010**

If you have any comments or queries about the pan-Dorset procedures please contact your agency representative on the Pan Dorset Policy and Procedures Group or notify the LSCB using the following email addresses:

info@dorsetlscb.co.uk
info@bournemouth-poole-lscb.org.uk

Chapter 3.5 – Serious Case Reviews

This protocol should be read in conjunction with Chapter 8 of Working Together to Safeguard Children, revised in December 2009.

Contents

No	Item	Page No
1.	Introduction	2
2.	The purposes of serious case reviews	2
3.	Safeguarding siblings or other children	2
4.	When should a SCR be undertaken?	2
5.	When should a SCR be considered?	3
6.	Which LSCB should take lead responsibility?	4
7.	Instigating a Serious Case Review	4
	• Requesting a SCR	4
	• LSCB Chair role	4
	• Serious Case Review Sub-group	4
	• Serious Case Review Panel	5
	• Determining the scope and terms of reference of the review	5
	• Findings presented to LSCB Chair	7
	• Resolution of disagreements	7
8.	Timescales	7
9.	Agency responsibilities	8
10.	Involving the family/ongoing work	8
11.	Reviewing institutional abuse	8
12.	Confidentiality/information sharing	9
13.	Support for staff	9
14.	IMRs	9
15.	Overview Report	11
16.	Executive Summary	11
17.	The Case Synopsis	11
18.	LSCB action on receiving the SCR	11
19	Learning Lessons	12
Appendix 1	Request for consideration of Serious Case Review	12
Appendix 2	Serious Case Review process/Timeline	13
Appendix 3	IMRs	16
Appendix 4	Chronology	20
Appendix 5	The Overview Report	22
Appendix 6	The Executive Summary	24
Appendix 7	The Case Synopsis	25

1. Introduction

1.1 The prime purpose of a Serious Case Review (SCR) is for agencies and individuals to learn lessons to improve the way in which they work both individually and collectively to safeguard and promote the welfare of children.

1.2 Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 requires LSCBs to undertake reviews of serious cases. They should be undertaken in accordance with the revised statutory guidance contained in Chapter 8 of Working Together to Safeguard Children published in December 2009.The same criteria apply to all children, including those with a disability. The LSCB therefore has responsibility for undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

2. The purposes of serious case reviews

2.1 The purposes of SCRs are to:

- establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children;
- identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result; and
- improve intra- and inter-agency working and better safeguard and promote the welfare of children.

2.2 SCRs are not inquiries into how a child died or was seriously harmed, or into who is culpable. These are matters for coroners and criminal courts, respectively, to determine as appropriate.

2.3 SCRs are also not part of any disciplinary inquiry or process relating to individual practitioners.

3. Safeguarding siblings or other children

3.1 When a child dies or is seriously harmed, and abuse or neglect is known or suspected to be a factor, the first priority of local organisations should be to consider immediately whether there are other children who are suffering, or likely to suffer, significant harm and who require safeguarding (for example, siblings or other children in an institution where abuse is alleged).

3.2 Where there are concerns about the welfare of siblings or other children the guidance in Chapter 2 of these procedures (Managing individual cases in Bournemouth, Dorset and Poole) should be followed. Once the safety of the child and any other children has been established, organisations should consider whether there are any lessons to be learned about the ways in which they work individually and together to safeguard and promote the welfare of children.

4. When should a SCR be undertaken?

4.1 When a child dies (including death by suspected suicide) **AND** abuse or neglect is known or suspected to be a factor in the death, a SCR should ALWAYS be undertaken.

4.2 This is irrespective of whether Children's Services Social Care is, or has been, involved with the child or family.

4.3 These SCRs should include situations where a child has been killed by a parent, carer or close relative with a mental illness, known to misuse substances or to perpetrate domestic abuse. In addition, a SCR should always be carried out when a child dies in custody, either in police custody, on remand or following sentencing, in a Youth Offending Institution (YOI) or a Secure Training Centre (STC), or where the child was detained under the Mental Health Act 2005.

5. When should a SCR be considered?

5.1 Whenever a child has been seriously harmed in the following situations:

- a child sustains a potentially life-threatening injury or serious and permanent impairment of physical and/or mental health and development through abuse or neglect; **or**

- a child has been seriously harmed as a result of being subjected to sexual abuse; **or**

- a parent has been murdered and a domestic homicide review is being initiated under the Domestic Violence Act 2004; **or**

- a child has been seriously harmed following a violent assault perpetrated by another child or an adult;

5.2 **AND** the case gives rise to concerns about the way in which local professionals and services worked together to safeguard and promote the welfare of children. This includes inter-agency and/or inter-disciplinary working.

5.3 The following questions may also help in deciding whether a case should be the subject of a SCR. The answer 'yes' to one or more of these questions is likely to indicate that a SCR could yield useful lessons:

- Was there clear evidence of a child having suffered, or been likely to suffer, significant harm that was:

    - not recognised by organisations or professionals in contact with the child or perpetrator or
    - not shared with others or
    - not acted on appropriately?

- Was the child abused or neglected in an institutional setting (for example, school, nursery, children's or family centre, YOI, STC, immigration removal centre, mother and baby unit in a prison, children's home or Armed Services training establishment)?

- Was the child abused or neglected while being looked after by the local authority?

- Was the child a member of a family that has recently moved to the UK, for example as asylum seekers or temporary workers?

- Did the child suffer harm during an unauthorised absence from an institution, or having run away from home or other care setting?

- Does one or more agency or professional consider that its concerns about a child's welfare were not taken sufficiently seriously, or acted on appropriately, by another?

- Does the case indicate that there may be failings in one or more aspects of the local operation of formal safeguarding children procedures which go beyond the handling of this case?

- Was the child the subject of a child protection plan at the time of the incident, or had they previously been the subject of a plan or on the child protection register?

- Does the case appear to have implications for a range of agencies and/or professionals?

- Does the case suggest that the LSCB may need to change its local protocols or procedures, or that protocols and procedures are not being adequately communicated, understood or acted on?

- Are there any indications that the circumstances of the case may have national implications for systems or processes, or that it is in the public interest to undertake a SCR?

6. Which LSCB should take lead responsibility?

6.1 Where partner agencies of more than one LSCB have known about or have had contact with the child, the LSCB for the area in which the child is or was ordinarily resident should take lead responsibility for conducting the SCR. Any other LSCBs that have an interest or involvement in the case should co-operate as partners in jointly planning and undertaking the SCR. In the case of a looked after child, the local authority looking after the child should exercise lead responsibility for conducting the SCR, again involving other LSCBs with an interest or involvement.

7. Instigating a Serious Case Review

Requesting a SCR

7.1 When a professional in any LSCB agency identifies a cause for concern or that a case potentially meets the criteria for a SCR, they should initially discuss this with their line manager and agency safeguarding lead in order to agree a way forward. The LSCB agency representative should also normally be advised. Where the criteria for a SCR appear to be met, the professional should complete the *Request for SCR Proforma* **(Appendix 1)** and ensure this is counter-signed by the agency safeguarding lead. The proforma should then be submitted to the LSCB Chair for consideration via the LSCB administrator who will distribute it to relevant individuals.

LSCB Chair role

7.2 The LSCB Chair will consider whether the case appears to meet the criteria for a SCR, applying the criteria detailed in paras 4 and 5 above. Where the child has died, the LSCB Chair should also contact the Child Death Overview Panel Manager and use information from professionals involved in reviewing the child's death under the Child Death Review processes detailed in Chapter 3.7 of these procedures.

7.3 The LSCB chair has ultimate responsibility for deciding whether to conduct a SCR and should notify Ofsted as soon as this decision is reached. Ofsted will then pass this information to Government Office South West (GOSW) and the Department for Children, Schools and Families (DCSF). The PCT commissioners should ensure the Strategic Health Authority (SHA) and the Care Quality Commission (CQC) are notified. The police should also notify Her Majesty's Inspectorate of Constabulary (HMIC) and similarly the National Offender Management Service should notify Her Majesty's Inspectorate of Prisons (HMIP) and Her Majesty's Inspectorate of Probation (HMI Probation).

7.4 In all cases and at all stages in the SCR process from the first notification to Ofsted of a serious incident to the completion of the final SCR report, information relating to children, family members and professionals involved in the case (with the exception of the LSCB Chair, SCR Panel Chair and the overview report author) should be anonymised by the LSCB before being submitted to any external organisation or body (including Ofsted, GOSW and the DCSF). The LSCB administrator will be responsible for allocating the key for anonymising family and professional details.

Serious Case Review Sub-group (Bournemouth and Poole LSCB)/Serious Case Review Panel (Dorset)

7.5 Where the LSCB Chair considers, in a particular case, that the criteria for a SCR may be met, s/he should refer the case to the SCR Sub-group (in Bournemouth and Poole) or the SCR Panel (in Dorset).

7.1 The SCR Sub-group or Panel will consider the request for a SCR to take place, using the SCR proforma and relevant agency briefing reports, and make recommendations back to the LSCB Chair about whether a SCR should be conducted and if so, what the scope and terms of reference should be. As detailed in para 7.3 above, the Chair of the LSCB alone, has responsibility for deciding whether or not to conduct a SCR following receipt of the recommendation from the SCR sub-group or Panel. The chair is not required to follow the recommendation of the SCR sub-group or Panel.

7.2 In some cases, where the SCR Sub-group or Panel do not recommend a SCR, they may make other recommendations about how and whether the case should be considered in some alternative way e.g. a single Individual Management Review (IMR) rather than a full SCR (where there are lessons to be learned about the way in which staff worked within one agency rather than about how agencies worked together); a smaller scale audit of an individual case that gives rise to concern but does not meet the criteria for a SCR; a case de-brief meeting; any other kind of case review as appropriate. In such cases, arrangements will be made to share relevant findings with the SCR Sub-group and in Dorset the SCRP and QA Group (as appropriate) to ensure any lessons learned are disseminated and any actions arising are completed.

Serious Case Review Panel

7.8 Following a decision to conduct a Serious Case Review a Serious Case Review Panel will be convened comprising as a minimum of:

- Children's Services - Social Care
- Health (commissioning PCT and other partners as relevant)
- Education
- Police

7.9 Membership of the SCRP will be determined on a case by case basis, however the principle will be to seek the wider engagement of agencies to aid development of and promote a positive culture of critical challenge and learning through the process.

7.10 The Panel will be chaired by an independent person, identified by the Serious Case Review Sub-group or Panel, and commissioned by the Local Authority on behalf of the LSCB. Where the independent chair of the SCRP is **NOT** the chair of the LSCB, the SCRP Chair must, as soon as they are appointed, agree with the Chair of the LSCB the arrangements for regularly briefing him/her on the progress and timescales of the SCR and how any issues with regard to the quality will be progressed

Determining the scope and terms of reference of the review

7.11 The SCRP should consider, in the light of current information known in each case, the scope of the SCR and draw up clear terms of reference. The LSCB Chair should ensure that the terms of reference address the key issues in the case and approve them. Government Office South West Children and Learners Team will be able to assist the LSCB where policy advice on undertaking a SCR is required; they should also be consulted about the terms of reference. Where necessary the LSCB should also seek it's own legal advice. Relevant issues to consider include the following:

- What appear to be the most important issues to address in identifying the learning from this specific case? How can the relevant information best be obtained and analysed, including, for instance, information on the mental health of relevant adults?
- When should the SCR start, and by what date should it be completed, bearing in mind the timescales for completion set out below? Are there any relevant court cases or investigations pending which could influence progress or the timing of the publication of the executive summary?
- Over what time period should events in the child's life be reviewed, i.e. how far back should enquiries extend and what is the cut-off point? What family history/background information will help better to understand the recent past and the present?
- How should the child (where the review does not involve a death), surviving siblings, parents or other family members contribute to the SCR, and who should be responsible for facilitating their involvement? How will they be involved and contribute throughout the overall process?
- Are there any specific considerations around ethnicity, religion, diversity or equalities issues that may require special consideration?

- Did the family's immigration status have an impact on the child/children or on the parents' capacities to meet their needs?
- Which organisations and professionals should be asked to submit reports or otherwise contribute to the SCR including, where appropriate, for example, the proprietor of an independent school or a playgroup leader?
- Who will make the link with relevant interests outside the main statutory organisations, for example independent professionals, independent schools, independent healthcare providers or voluntary organisations?
- Is there a need to involve organisations/professionals working in other LSCB areas (see paragraph 6), and what should be the respective roles and responsibilities of the different LSCBs with an interest?
- Will the LSCB need to obtain independent legal advice about any aspect of the proposed SCR?
- What should the membership of the SCRP be – bearing in mind the minimum membership requirements as detailed in 7.4
- Who should be appointed as the independent chair of the SCRP
- Who should be appointed as the independent author for the overview report
- Might it help the SCR Panel to bring in an outside expert at any stage, to help understand crucial aspects of the case?
- Will the case give rise to other parallel investigations of practice, for example, into the health or adult social care provided or multi-disciplinary suicide reviews, a domestic homicide review where a parent has been killed, a Prisons and Probation Ombudsman (PPO) Fatal Incidents Investigation5 where the child has died in a custodial setting or a Serious Further Offence (SFO)6 or MAPPA Serious Case Review (MSCR)7 process where offenders are charged with serious further offences whilst subject to statutory supervision? And if so, how can a co-ordinated or jointly commissioned review process address all the relevant questions that need to be asked in the most effective way and with minimal delay? Arrangements should be agreed locally on how a NHS Serious Untoward Incident investigation into the provision of healthcare should be co-ordinated with a SCR.
- How will the SCR terms of reference and processes fit in with those for other types of reviews – for example, for homicide, mental health or prisons?
- How should the review process take account of a coroner's inquiry, any criminal investigations (if relevant), family or other civil court proceedings related to the case? How will it be best to liaise with the coroner8 and/or the Crown Prosecution Service (CPS) and to ensure that relevant information can be shared without incurring significant delay in the review process?
- How should the review process take account of relevant lessons learned from research (including the biennial overview reports of SCRs) and from SCRs which have been undertaken by the LSCB?
- How should any family, public and media interest be managed before, during and after the SCR? In particular, how should surviving children (where appropriate given their age and understanding) and family members be informed of the findings of the SCR?
- Set the dates for future SCRP meetings, including briefings for IMR authors

Some of these issues may need to be revisited by the SCR Panel as the review progresses and new information emerges. This reconsideration of the issues may in turn mean that the terms of reference will need to be revised and agreed by the SCRP and the LSCB Chair.

Findings presented to LSCB Chair

7.12 At the conclusion of the SCR, and before the review is presented for sign-off to the LSCB, the LSCB Chair should meet with the SCRP or the Chair of the SCRP to discuss the findings.

Resolution of disagreements

7.13 IMRs and Overview reports are based on a critical professional analysis and hence there may be occasions when there is a difference of opinion about the content or findings contained within the reports.

7.14 The IMR represents the agency's view of their involvement in the case and hence where there is disagreement between the IMR author and a professional within the agency about any aspect of the IMR, this should normally be resolved by discussion between the parties involving the agency safeguarding lead and senior mangers as appropriate. Where agreement cannot be reached, the professional involved may wish to put their comments in writing to the SCRP Chair for consideration by the SCRP and the Overview author.

7.15 Where there is any disagreement about the content or findings of an Overview report between for example, members of the SCRP and the Overview author, or the SCRP and the LSCB Chair, agreement should be reached about how these differences will be presented to the LSCB. As a minimum, the LSCB Chair should ensure that the members of the SCRP are present at the LSCB meeting which receives the SCR or where this is not possible that their written views are presented.

8. Timescales

8.1 Reviews vary widely in their breadth and complexity but, in all cases, **where lessons are able to be identified they should be acted upon as quickly as possible without necessarily waiting for the SCR to be completed.**

8.2 Within **one month** of a case coming to the attention of the LSCB Chair, s/he will decide, following a recommendation from the SCR sub-group or panel, whether a review should take place.

8.3 Serious case reviews should be completed **within six months** from the date of the decision to proceed. Sometimes the complexity of a case does not become apparent until the SCR is in progress. If it emerges that a SCR cannot be completed within six months of the LSCB Chair's decision to initiate it (perhaps because of judicial proceedings), the LSCB will revise its timetable and immediately consult GOSW in their capacity to provide advice, support and challenge.

8.4. The final version of the executive summary, and the date of its publication, should be submitted to Ofsted **within one month** of receipt of the SCR evaluation letter. The final version of the executive summary should be suitably anonymised and should be sent by email to SCR.SIN@ofsted.gov.uk .

8.5 A summary of the timelines in the SCR process are attached as **Appendix 2,** but the case specific timescales will be made clear to agencies involved in the SCR at the beginning of the process. IMR authors will be briefed at the second SCRP meeting and IMRs should normally be completed at least within **6 weeks** of this meeting. Health providers and agencies will each provide their own IMR (including GPs).In addition, a health overview report will be compiled by the designated health professional. The health overview report (which will constitute the IMR for the PCT as commissioners) should be completed within a further **2 weeks** of receipt of the health IMRs i.e. approximately at week 13 of the SCR process. (See para 13 for further details).

8.6 In some cases it may not be possible to finalise the IMRs and the overview report or to finalise and publish an executive summary until after coronial or criminal proceedings have been concluded, but this should not prevent early lessons learned from being acted upon.

8.7 SCRs should not be delayed as a matter of course because of outstanding family, civil or administrative court cases. The LSCB Chair will make these decisions on a case by case basis based on advice from the Chair of the SCR Panel and having consulted with the Local Authority where there are pending family cases. The LSCB Chair may also need to seek legal advice to assist in deciding how to proceed.

9. Agency responsibilities

9.1 The initial scoping of the SCR will identify those who should contribute, although it may emerge, as further information becomes available, that the involvement of others, such as those providing specialist adult services, would be useful.

9.2 Each relevant agency Chief Executive will be notified as soon as possible after the decision to conduct a SCR is made, giving the detail of the SCR including the scope and terms of reference and the timetable for completion of the agency's Individual Management Review (IMR).

9.3 Each relevant service should immediately secure the agency records relating to the case and identify an author for the IMR. (See **appendix 3**). The IMR should begin as soon as a decision is taken to proceed with a SCR, and even sooner if a case gives rise to concerns within the individual organisation. Each agency should ensure that the person compiling the IMR has sufficient experience, knowledge and skills to undertake the task and sufficient resources, including time, to complete the tasks required within the relevant timeframe. S/He should also normally have completed specific IMR training.

9.4 Where CAFCASS contributes to a review, the prior agreement of the courts will be sought by the SCRP so that the duty of confidentiality which the children's guardian has under the court rules can be waived to the degree necessary.

9.5 The IMR should be signed off by the Chief Executive of the agency concerned before the IMR is submitted to the SCRP who will also take responsibility for ensuring the quality of the report. On receipt of the agency's IMR the Chief Executive also has responsibility for ensuring that an action plan is devised which addresses the recommendations made in the IMR.

10. Involving the family/ongoing work

10.1 The family of the child who is the subject of the SCR often have key information that can aid the learning from the SCR. They should normally be involved in the process at the earliest opportunity. Decisions about when, how and who should be involved and contribute to the review should form part of the terms of reference of the SCR. There are some circumstances where it would not be appropriate to engage the family in the SCR process, e.g. where the Police have requested this because of criminal proceedings, and the reasons for this should be clearly documented including a plan about how and when the family will be involved.

10.2 Where there are surviving siblings and there is ongoing work with the family, those professionals involved should be consulted for advice based on their knowledge of the family and understanding of the family dynamics. In addition, any relevant early findings or information should be shared with those professionals to ensure that appropriate action is taken to safeguard the children.

11. Reviewing institutional abuse

11.1 When serious abuse takes place in an institution, or multiple abusers are involved, the same principles of review apply. SCRs in these circumstances are likely to be more complex, on a larger scale, and may require more time. Terms of reference for the SCR will need to be carefully constructed to take account of the complexity of the case.

11.2 There needs to be clarity over the interface between:

- the different processes of investigation (including criminal investigations);
- case management, including help for abused children and immediate measures to ensure that other children are safe;
- learning lessons from the SCR to reduce the chance of such events happening again.

11.3 These three different processes should inform each other. Any proposals for review should be agreed with those leading criminal investigations, to make sure that they do not prejudice possible criminal proceedings.

12. Confidentiality/Information sharing

12.1 The process of conducting an IMR requires access to records relevant to the child such as those from health bodies. The public interest served by this process warrants full disclosure of all relevant information within the child's own records. In some circumstances the person conducting the IMR may require access to information about third parties (for example, members of the child's immediate family or carers) that is either contained within the child's health records or in the health records of another person. While in most cases there will be a public interest in disclosing this information, the record holder(s) should ensure that any information they disclose about a third party is both necessary and proportionate.

12.2 All disclosures of information about third parties need to be considered on a case by case basis, and the reasoning for either disclosure or non-disclosure should be fully documented. This applies to all records of NHS-commissioned care, whether provided under the NHS or in the independent or voluntary sector.

13. Support for staff

13.1 The intense feelings that a serious case review can provoke for all staff involved must be carefully handled by both those undertaking the review and by line managers. Apart from the need for staff to have appropriate support, emotions (if not dealt with) can distort the outcome of a review through, for example, staff being defensive, looking for scapegoats, or denying organisational difficulties.

13.2 Staff should be aware of the need for a review of practice and work undertaken in the event of the death of a child or serious injury sustained due to abuse and should have a clear understanding of the purpose of a SCR. Being aware of the process and these procedures may help in the event of staff needing to be involved in an actual serious case review

13.3 When a serious case review or case audit is to be undertaken, the following issues need to be addressed:

- senior officers will need to keep staff who were involved in the case, trade unions, where applicable and/or professional associations, advised of the progress of the review, due to the potential impact of the review upon staff;

- staff, whether directly involved in the case or not, may be extremely distressed by the death or injury of a child and may require separate help and support;

- line managers or, where appropriate, another manager must be available to staff to discuss their concerns and feelings during the review process. Where necessary a counsellor should be made available who can offer an impartial and confidential service.

14. Individual Management Reviews

14.1 The aim of IMRs should be to look openly and critically at individual and organisational practice and at the context within which people were working to identify all good practice as well as whether the case indicates that improvements could and should be made. If so, the IMR should identify how those changes can be brought about. It is important that the SCR process supports an open, just and learning culture and is not perceived as a disciplinary-type process which may intimidate and undermine the confidence of staff.

14.2 All IMR authors involved in the SCR will have the opportunity of meeting with the SCRP for a briefing session. This is to enable them to be clear about what is required and address any issues or questions and to share information as appropriate between the IMR authors. At the end of the process, IMR authors will again be offered the opportunity to meet with the SCRP and the Overview report author to discuss the findings before the Overview report and executive summary are finalised.

14.3 The format for the IMR is detailed at **Appendix 3** and the chronology format is detailed at **Appendix 4**

14.4 The questions posed do not comprise a comprehensive checklist relevant to all situations. Each case may give rise to specific questions or issues that need to be explored, and the particular structure and format of the IMR and chronology will be

sent to IMR authors once agreed by the SCRP and will be covered in the IMR authors briefing session.

14.5 Where staff or others are interviewed by those preparing IMRs, a written record of such interviews should be made and this should be shared with the relevant interviewee. If the review finds that policies and procedures have not been followed, relevant staff or managers should be interviewed in order to understand the reasons for this.

14.6 The Chief Executive in the organisation which has commissioned the report will take responsibility for ensuring the quality of the IMR. S/he will counter-sign the IMR to indicate their satisfaction and that the findings are accepted. The Chief Executive will also be responsible for ensuring that the recommendations of the IMR, and where appropriate the overview report, are acted on.

14.7 On completion of each IMR report each agency will ensure a process of feedback and debriefing for the staff involved in the case, in advance of completion of the overview report. There should also be a follow-up feedback session with these staff once the SCR report has been completed and before the executive summary and synopsis of learning is published.

14.8 Designated safeguarding health professionals, on behalf of the PCT(s) as commissioners, should review and evaluate the practice of all involved health professionals, including GPs and providers commissioned by the PCT area. Where more than one PCT has commissioned services the PCTs will need to agree locally how they will work together. This may involve reviewing the involvement of individual practitioners and NHS Trusts, and advising named professionals and managers who are compiling reports for the review. The designated professionals should produce an integrated health chronology and a health overview report focusing on how health organisations have interacted together. This may generate additional recommendations for health organisations. The health overview report will constitute the IMR for the PCTs as commissioners.

15. Overview Report

15.1 The SCR Panel, on behalf of the LSCB, will commission an overview report and an executive summary from an accredited overview author that brings together and analyses the findings of the various IMRs from organisations and others, and that makes recommendations for future action.

15.2 The overview author will meet with the SCRP and the IMR authors at about week 12 of the SCR process to discuss, and where appropriate challenge, the content of the completed IMRs and identify any further information that may be required. Further SCRP meetings may be convened if required to facilitate a thorough and effective process but as a minimum they will meet again at the end of the process to discuss the findings of the overview author before the overview report and executive summary are finalised.

15.3 The format of the overview report will be produced according to the format detailed in **Appendix 5**, although as with IMRs, the precise format will depend on the features of the case.

16. Executive Summary

16.1 In all cases, the SCR overview report and the IMRs will be used to produce an executive summary that will be made public (via publication on the relevant LSCB website) and which accurately reflects the full overview report. The executive

summary will include information about the review process, key issues arising from the case, the recommendations and the action plan (including any actions that have been completed). The content of the executive summary will be suitably anonymised in order to protect the identity of children, relevant family members and others and to comply with the Data Protection Act 1998. The executive summary will, however, include the names of the LSCB Chair, SCR Panel Chair, the overview report author, and the job titles and employing organisations of all the SCR Panel members. (**See Appendix 6**)

17. The Case Synopsis

17.1 Since the prime purpose of a SCR is to learn lessons, a brief case synopsis will be produced for professionals that summarises the case details, the main issues identified and the main learning points. This will normally be disseminated to all front line practitioners to ensure the broadest possible opportunity for learning. All synopses of learning will be shared between the two LSCBs to ensure the widest possible learning. (**See Appendix 7**)

18. LSCB action on receiving the SCR

18.1 At the conclusion of the SCR, the IMRs, overview report, action plan, executive summary and synopsis of learning will be presented to the LSCB for formal sign-off. This will be the responsibility of the independent SCRP Chair who may involve the overview author in the presentation as appropriate.

18.2 Once the SCR process is complete and the review signed off by the LSCB, the LSCB will:

- provide an anonymised copy of the IMRs, overview report, executive summary and the individual and multi-agency action plans and chronologies to Ofsted, GOSW Children and Learners Team, the SHA and DCSF. All personal information relating to children, family members and professionals involved in the case (with the exception of the names of the LSCB and SCR Panel chairs and the overview report author) will be anonymised in all the SCR documentation submitted to Ofsted and GOSW. If the child died in a custodial setting, copies of the anonymised SCR will be made available to the YJB and copies of the executive summary should be provided to the PPO;

- make arrangements to provide feedback and debriefing to staff and the media as appropriate;

- disseminate the executive summary, key findings and synopsis of learning to relevant interested parties;

- publish only the SCR executive summary once the SCR has been completed;

- implement those actions for which the LSCB has lead responsibility and monitor the timely implementation of the SCR action plan. In Dorset this work is undertaken by the Quality Assurance group and in Bournemouth and Poole by the SCR sub-group;

- on receipt of the evaluation letter from Ofsted, take action as necessary to amend the action plan and/or the SCR report if the SCR executive summary has been published before receiving Ofsted's feedback; and

- formally conclude the review process when the action plan has been implemented and inform GOSW of this decision.

18.3 The LSCB, following recommendations from the SCRP, will decide on a case by case basis when to publish the executive summary and synopsis of learning.

19. Learning Lessons

19.1 As the purpose of SCRs is to learn lessons for improving both individual agency and inter-agency working, dissemination of the learning points is a key objective for both Bournemouth and Poole LSCB and Dorset SCB.

19.2 As far as possible, reviews will be conducted in a way that the process is a learning exercise in itself for all those who were involved in the case.

19.3 All LSCB agencies are committed to developing a positive learning culture and for each case which becomes the subject of either a SCR or a case audit under these procedures, a synopsis of learning will be produced and it will be the responsibility of each agency to ensure dissemination to all appropriate front line staff.

19.4 The Pan Dorset Safeguarding Through Training Group has responsibility for ensuring that the learning identified from any case review process including SCRs and case audits is shared between the two LSCBs and they will facilitate a bi-annual event focussed on learning from SCRs and case audits.

Appendix 1

Request for consideration of Serious Case Review

Name of person requesting the review **Designation** **Agency**

Name of family, family members, including dates of birth and address

Brief Family History

Outline of concerns leading to the request for a Review (continue on separate sheet if necessary)

Detail why a SCR is considered to be appropriate (i.e. what evidence there is to suggest the criteria in para.3 of this protocol appear to be met?)

Signed **Print Name** **Date**

Safeguarding Lead

Print Name

Signed

Date **Agency/Organisation**

Appendix 2

Serious Case Review process/Timeline

To be completed by at least by end of week….	Action
Week 0	*Request for a SCR Proforma* received for consideration of a SCR
Week 1	*Critical Incident Notification* completed and submitted to Ofsted
	Request for member agencies to check agency records and compile a briefing report
Week 2	Briefing reports submitted to LSCB Administrator
	Briefing Reports circulated prior to initial SCR panel meeting
Week 3	**SCR Working Group (B&P) or Panel (Dorset) Meeting 1** Meeting of the SCR Panel to: • consider *Request for a SCR Proforma* • consider agency briefing reports • make recommendation to LSCB chair • identify independent SCR Panel chair/overview author • draft terms of reference/scope of review • set key for anonymising case • set meeting dates for SCR
Week 4	LSCB Chair agrees SCR to be undertaken LSCB Chair notifies Ofsted, relevant agency notifies the SHA, CQC,HMIC, HMIP and MHI Probation of decision Commission independent Chair Commission independent Overview Author
Week 4	*Critical Incident Notification* submitted to Ofsted confirming SCR Letter requesting Individual Management Review (IMR) (appendix 7) sent to relevant agencies

Week 0	**SCR TIMELINE STARTS WITH DECISION OF LSCB CHAIR TO CONDUCT SCR**
Week 3	**SCR Panel Meeting 2** Meeting chaired by Independent Panel chair and attended by SCR Panel and IMR and Health overview authors to: • brief IMR authors on IMR expectations • share information between IMR agencies
Week 8	IMRs received and disseminated to SCR Panel for comment
Week 9	**SCR Panel Meeting 3** Meeting attended by SCR Panel, Independent Overview Author and IMR authors as necessary. Panel to: • discuss completed IMRs • request further work from IMR authors if required • instruct Independent Overview Author to initiate Overview Report
Week 11	Health Overview submitted to SCR Panel and Independent Overview Author
Week 12	If requested, IMRs re-submitted to the SCR Panel and Independent Overview Author and further information gathered if required
Week 18	Overview Report received and disseminated to SCRP
Week 19	**SCR Panel Meeting 4** • SCR Overview Report considered by SCR Panel • Detail of Executive Summary agreed • SCR Panel to draft an action plan
Week 20	Consultation exercise undertaken with IMR agencies on Overview Report and action plan with written feedback from agencies
Week 22	**SCR Panel Meeting 5** Overview author/IMR authors/SCR Panel undertake final sign off of the: • Overview Report • Executive Summary • Action Plan
Week 23	Synopsis of Learning produced

Week 24	Feedback and de-briefing of staff involved in case
Week 25	All reports to be presented to LSCB for sign off by Independent SCR Panel Chair including : • Individual Management Reviews • Independent Overview Report • Action Plan • Executive Summary • Synopsis of Learning
Week 26	SCR submitted to Ofsted/GOSW
Following Week 26	SCR Grading received from Ofsted – send the final version of the executive summary, and the date of its publication, to Ofsted **within one month** of receipt of the SCR evaluation letter. The final version of the executive summary should be suitably anonymised and should be sent by email to SCR.SIN@ofsted.gov.uk
	Report/findings/learning shared with the family
	Executive Summary and Synopsis of Learning published
	Individual agency and LSCB action plans monitored by SCR Working Group (B & P) and QA Group (Dorset)
	Advise GOSW when action plan has been implemented

IMRs

The IMR is a stand alone report which should contain sufficient detail that the reader can understand the context of the agency involvement. Any queries or concerns about the production of the IMR may be dealt with at the initial briefing meeting with the SCRP and IMR authors should expect to receive support if required from their agency safeguarding lead.

The IMR should normally be in the format detailed below and should contain a detailed chronology as an appendix. See appendix 4 for further details relating to chronologies. Details regarding both the IMR and the chronology will be confirmed to IMR authors in the briefing meeting.

1. FORMAT

1.1 Front sheet as attached at appendix 1a

1.2 Contents page
1.3 Details of qualifications and experience of IMR author and statement of independence from case mgt

1.3 Introduction (short summary of events leading up to the Serious Case Review)

1.4 Terms of reference of SCR (will be provided by SCRP)

1.5 Methodology (this section should set out what files you have read, who you have interviewed and / or consulted)

1.6. Family composition including genogram (format will be provided by SCRP)

1.7 What was the agency's involvement with this child and family?

Give a list of which parts of your service worked with whom in the family. Include here a succinct summary of the relevant involvement and work undertaken with the child and his/her family.

1.8 Analysis of involvement

In this section you should explain what the expected standard or best practice is in relation to the events and to what extent these were met. Where practice fell short of the expected standard this should be explained/commented on and it is of equal importance that good practice is identified.

Consider the events that occurred, the decisions made, and the actions taken or not taken. Where judgements were made, or actions taken, which indicate that practice or management could be improved, try to get an understanding not only of what happened but why something either did or did not happen. Consider specifically the following:

- Were practitioners aware of and sensitive to the needs of the children in their work, and knowledgeable both about potential indicators of abuse or neglect and about what to do if they had concerns about a child's welfare?
- When, and in what way, were the child (ren)'s wishes and feelings ascertained and taken account of when making decisions about the provision of children's services? Was this information recorded?
- Did the organisation have in place policies and procedures for safeguarding and promoting the welfare of children and acting on concerns about their welfare?

- What were the key relevant points/opportunities for assessment and decision making in this case in relation to the child and family? Do assessments and decisions appear to have been reached in an informed and professional way?
- Did actions accord with assessments and decisions made? Were appropriate services offered/provided or relevant enquiries made, in the light of assessments?
- Were there any issues, in communication, information sharing or service delivery, between those with responsibilities for work during normal office hours and others providing out of hours services?
- Where relevant, were appropriate child protection or care plans in place, and child protection and/or looked after reviewing processes complied with?
- Was practice sensitive to the racial, cultural, linguistic and religious identity and any issues of disability of the child and family, and were they explored and recorded?
- Were senior managers or other organisations and professionals involved at points in the case where they should have been?
- Was the work in this case consistent with each organisation's and the LSCB's policy and procedures for safeguarding and promoting the welfare of children, and with wider professional standards?
- Were there organisational difficulties being experienced within or between agencies? Were these due to a lack of capacity in one or more organisations? Was there an adequate number of staff in post? Did any resourcing issues such as vacant posts or staff on sick leave have an impact on the case?
- Was there sufficient management accountability for decision making?

1.9 What do we learn from this case?

- Are there lessons from this case for the way in which this organisation works to safeguard and promote the welfare of children?
- Is there good practice to highlight, as well as ways in which practice can be improved?
- Are there implications for ways of working; training (single and inter-agency); management and supervision; working in partnership with other organisations; resources?
- Are there implications for current policy and practice?

1.10 Recommendations for action

- What action should be taken by whom and when? What outcomes should these actions bring, and in what timescales, and how will the organisation evaluate whether they have been achieved?
- Are there any immediate statutory requirements for the notification of concerns and are there likely to be any media handling issues?
- focus recommendations on a small number of key areas, with Specific, Measurable, Achievable, Relevant and Timely proposals for change and intended outcomes;

N.B. The Chief Executive of the agency concerned should ensure the quality of the IMR and have signed it off before the report is submitted to the SCRP. The agency should also ensure that an action plan is drawn up and submitted to the SCRP which addresses the recommendations made in the IMR. This action plan should be submitted to the LSCB administrator by at least week 15 of the process and Chief Executives will be notified at the start of the process of the relevant date.

2. Interviewing staff as part of the IMR preparation

2.1 It is normally necessary and helpful to the review process to interview staff who are, or previously were, involved in the case. The individual management review process should involve staff being interviewed on an individual basis, to allow them the privacy to address the issues and share any concerns with the interviewer, though they can bring with them a supporter – normally this should not be their line manager.

2.2 Interviewees will find it helpful to have a copy of the outline questions to be put to them in advance and a chance to look at files or chronologies prior to and during any interview.

2.4 Areas to be covered with the interviewee could include:

- his/her knowledge of the history of the case; the child(ren) and family prior to the individual's involvement;
- his/her specific involvement in the case;
- his/her knowledge of the agency's policy and procedures in relation to child care and child protection;
- his/her knowledge of child development, identifying injuries in relation to abuse, understanding of the psychological effects of abuse upon a child, direct work techniques, and their role in relation to child protection conferences;
- the methods used to relate to and communicate with other professionals in the case;
- the interviewee record keeping;
- the supervision the interviewee received;
- the interviewee's feelings about the case, the parent, step-parent or child and how those feelings were dealt with in supervision;
- the range of training both within and outside the agency in the last two years;
- looking back; what the interviewee would now do differently;
- whether there were significant issues impacting on the person's work;
- what lessons the interviewee can learn from the experience;
- whether the interviewee thinks that the agency can learn lessons from the experience.

2.4 Staff should subsequently have a chance to read a draft of the individual management review report, or at least those sections which relate to them, for accuracy and comment. There should also be initial feedback to staff after individual management reviews have taken place, in advance of completion of the overview report, with further feedback when the overview report is completed.

FORMAT FOR IMRs

STYLE NOTES

- The IMR should be written in the third person
- Please use Arial, font size 11
- Please do not underline headings, put headings in bold and uppercase and to the left hand side of the page
- Please only use acronyms when absolutely necessary, and use in full the first time with the acronym bracketed by the side. At the bottom of the contents page (page 2) please put your glossary of acronyms
- Please use numbered paragraphs and please use automatic numbering – do not put the numbers in yourself and rely on the space bar
- Please apply automatic page numbering and for this to show at the bottom right hand corner
- Please start a new page for each chapter
- Please do not use colloquial language
- Refer to people by their full name and title. If an agency representative, then full name, title, and agency (these names, as well as the family names will be anonymised in the Overview Report)
- Don't forget to spell check

Please remember to send your IMR and chronology, password protected (using the password allocated by the SCRP) to the LSCB administrator for merging. It is the agency's responsibility to ensure the security of the report and chronology until it is in the possession of the LSCB administrator in line with own agency's security standards.

INDIVIDUAL MANAGEMENT REVIEW

UNDERTAKEN BY (Author's name and designation)
ON BEHALF OF (PUT AGENCY NAME HERE)

Regarding (as given by serious case review panel)

Individual Management Review in accordance with
Chapter 8 of Working Together To Safeguard Children 2006 (and as updated in December 2009)
And
Chapter 3.5 - Serious Case Review Protocol
Pan Dorset Inter-agency Safeguarding Procedures 2006
(updated Jan 2010)

Author Name *(please print)*	
Agency	
Date	
Signature	

Name of Chief Executive *(please print)*	
Date:	
Signature	

Appendix 4

Chronology

What constitutes a chronology?

1.1 There are different ways of interpreting what constitutes a comprehensive chronology. Three types of chronologies are detailed below. The Serious Case Review Panels (SCRP) of Bournemouth and Poole, and Dorset LSCBs will need to consider each review individually and decide upon the content of the chronology in each serious case review. The SCRP will define which format will be used, and the content of the chronologies.

Chronologies may consist of:

- **all** file entries;
- all significant events or changes in a case;
- all critical incidents.

1.2 Whilst the first type of chronology gives all of the information even details perceived as insignificant on the basis that they **may** become more significant once the wider picture has been established, this can be a very time consuming process. On the other hand, if the merged inter-agency chronology runs into hundreds of pages, this could be counter-productive, allowing important information to be missed, if staff have time constraints and other work pressures.

1.3 The latter two types can be expanded upon at a later point, with the possibility of **all** file entries being included should it become clear that this is necessary. Alternatively it may be deemed necessary to obtain any further details about a *specific* incident or period and further details can therefore be prepared for a defined period only. This might be particularly appropriate in cases spanning a number of years, but this in itself cannot be the reason for limiting the chronology in this way. Extra information, or a more detailed chronology or detailed section within it, can be requested by the author of the individual management review, the Overview author or by the SCRP.

1.4 The chronology should initially be prepared from written records. Each child and adult should, at least initially, have his/her own separate chronology.

1.5 It may be that not all discussions, exchange of information, or actions that have taken place have been fully recorded but it will be important to establish as far as possible what has happened, and why, within a case. Where records do not reflect accounts given in interviews, the reviewing person or team will need ultimately to use their judgements in balancing between the written and oral accounts available to them regarding significant issues.

1.6 Where there is a difference between individuals or agencies about significant events or actions, an attempt should be made to establish the facts in relation to key events or incidents, referencing any corroborating information. It may be appropriate, where incidents are key to understanding the working of the case, to include a summary of differing accounts of the situation, outlining areas of consensus and disagreement, where there is no other corroboration.

1.7 Events or actions, not recorded but identified later, should be added subsequently to the chronology. Such information may be from interviews or other sources and should clearly indicate within the later chronology if this is substantiated (and how) or unsubstantiated (and source). The Overview author or SCRP may need to give advice on this in relation to each case.

1.8 The SCRP will need to determine the specific requirements for the chronology in each case and will need to consider the following points:

- Clarify which children and adults should be included in the review and chronology (e.g. absent fathers, uncle living as part of household, previous partners);

- a Chronology format is attached for professionals to use for completion by their agency. The headings may be changed by the SCRP if required for certain types of cases/case audits (e.g. fabricated or induced illness). The Chronologies should be completed electronically following the instructions within the programme to enable merging.

- note specifically in the chronology each occasion on which the child was seen and the child's views and wishes sought or expressed;

- how to ensure that any alias and/or maiden names have been obtained in order to check records fully;

- how to differentiate within the chronology those entries from written records and those entered later from verbal accounts from staff interview, including any evidence regarding the reliability of these accounts;

- determine the method of each agency's chronology being merged for the overview stage and report.

1.9 The SCRP may differ in its expectations for a serious case review and a case audit. The SCRP may consider whether a summary of the chronology would be informative if contained in the summary report, to enable lessons to be better understood in the context of the specific case.

Format Chronology.xls

Appendix 5

The Overview Report

The SCR overview report should bring together, and draw overall conclusions from, the information and analysis contained in the IMRs, information from the child death review processes, where relevant, and reports commissioned from any other relevant interests. Overview reports should be produced according to the following outline format although, as with IMRs, the precise format will depend on the features of the case. This outline is most applicable to abuse or neglect that has taken place in a family setting. In certain circumstances, for example abuse in institutional settings or complex situations, the reviews are likely to be more complex.

The Overview report should use the same style type as the IMR reports and should address the points detailed in Chapter 8 of Working Together to Safeguard Children (revised Dec 2009) and which are reproduced here.

Introduction

- Summarise the circumstances that led to a SCR being undertaken in this case.
- State the terms of reference of the review.
- Record the methodology used including the documents reviewed, and whether the information was provided in an interview or through written evidence.
- List agencies or types of contributors to review and the nature of their contributions (for example, IMR by local authority, report through the PCT as commissioner from adult mental health service). List the names and roles/positions/job titles of the LSCB Chair, SCR Panel Chair, the author of the overview report and the job titles and employing organisations of all the SCR Panel members.
- List external investigations, if any, that are being conducted (for example the PPO investigation following the death of a child in custody or a mental health inquiry).

The facts

- Prepare an anonymised genogram showing membership of family, extended family and household.
- Compile an integrated chronology of involvement with the child and family on the part of all relevant organisations, professionals and others who have contributed to the review process. Note specifically in the chronology each occasion on which the child was seen, if the child was seen alone and whether the child's wishes and feelings were sought or expressed.
- Consider explicitly any relevant ethnic, cultural or other equalities issues and whether these are relevant to the behaviours and approach taken by the organisations and professionals involved.
- Summarise the relevant information that was known to the agencies and professionals involved about the parents/carers, any perpetrator and the home circumstances of the children.

Analysis

This part of the overview report should look at how and why events occurred, decisions were made and actions taken or not taken. This is the part of the report where reviewers can consider, with the benefit of hindsight, whether different decisions or actions may have led to an alternative course of events. It is important that this is objective and open, being clear where systems could improve. The analysis section is also where any examples of good practice should be highlighted. The findings from this SCR should be considered alongside learning from previous SCRs undertaken by the LSCB and findings from relevant research.

Conclusions and recommendations

This part of the report should summarise what lessons are to be drawn from the case, and how those lessons should be translated into recommendations for action, and to what timescales. Recommendations should include, but should not simply be limited to, the recommendations made in individual reports from each organisation. Recommendations should usually be few in number, focused and specific, and capable of being implemented. If there are lessons for national as well as local policy and practice, these should also be highlighted and the information sent to the relevant government department.

Appendix 6

The Executive Summary

In all cases, the SCR overview report and the IMRs should be used to produce an executive summary that should be made public and which accurately reflects the full overview report. The executive summary should include information about the review process, key issues arising from the case, the recommendations and the action plan (including any actions that have been completed). The content of the executive summary needs to be suitably anonymised in order to protect the identity of children, relevant family members and others and to comply with the Data Protection Act 1998. The executive summary should, however, include the names of the LSCB Chair, SCR Panel Chair, the overview report author, and the job titles and employing organisations of all the SCR Panel members.

The full text of the executive summary should be included at the beginning of the overview report.

Appendix 7

The Case Synopsis

The case synopsis should contain a brief narrative of the case sufficient to allow the reader to understand the context of the case.

It should detail the main issues identified in the SCR and the learning points identified. It should also contain a summary of the actions being taken by the LSCB agencies to address the concerns.

In order to be easy to read and therefore effective, the synopsis should not normally be longer than 2 sides of A4 type.

Bournemouth & Poole Local Safeguarding Children Board

Dorset Safeguarding Children Board

PAN DORSET INTER-AGENCY SAFEGUARDING PROCEDURES

CHAPTER 3

3.6 SUDDEN UNEXPECTED DEATHS IN CHILDHOOD

Procedures Effective from: **2006**

Review Date: **March 2011**

If you have any comments or queries about the pan-Dorset procedures please contact your agency representative on the Pan Dorset Policy and Procedures Group or notify the LSCB using the following email addresses:

info@dorsetlscb.co.uk
info@bournemouth-poole-lscb.org.uk

SUDDEN UNEXPECTED DEATHS IN CHILDHOOD

A joint agency protocol for investigation and management in Dorset

FOREWORD

The death of a child is a traumatic time for everyone involved. The family will be experiencing extreme grief, and where the death is unexpected (ie not anticipated as a significant possibility 24 hours before the death, or where there was a similarly unexpected collapse leading to or precipitating the events that led to the death), the family will also be in a state of shock. Professionals will need to support the family in understanding what has happened and why. The majority of unexpected child deaths occur as a result of natural causes or accidents. Nevertheless there is a need to identify where a parent or carer[1] may have been responsible for a child's death and to fully investigate the circumstances of such deaths. The interagency response, management and investigation of sudden unexpected deaths in childhood[2] should therefore keep a sensitive balance between the medical management, the care and support of the family and any investigation into the cause of death, including any forensic requirements.

This protocol

- relates to the county of Dorset, covered by Bournemouth and Poole and Dorset Local Safeguarding Children Boards (LSCBs), and as such is to be adhered to by all agencies;

- draws on a number of local and national initiatives including the Foundation for the Study of Infant Deaths (FSID), Confidential Enquiry into Maternal and Child health (CEMACH), South West Infant Sleep Study (SWISS) together with the current high standard of practice and multi-agency working within Dorset. This has provided the opportunity to establish good practice and working within clear management strategies, enabling a high quality of service to families;

- should be applied to all sudden unexpected deaths in infancy and childhood. This should include unexpected deaths within a hospital environment. It relates to infants from birth to children and young people under the age of 18 years old. Most sudden child deaths occur in infancy and much of the guidance relates specifically to infants. However, many of the principles of management apply equally to older children and the same protocols should therefore be followed;

- can be applied in other circumstances e.g. in dealing with a child who has suffered a life threatening injury.

1. **Footnote:** the term 'parent/s' is used throughout and is to mean parent/guardian/carer.
2. **Footnote:** for ease of reading Sudden Unexpected deaths in childhood will be referred to as "Sudden Child Death"

1. Introduction

1.1 The majority of sudden child deaths occur as a result of natural causes and are an unavoidable tragedy for any family.

1.2 This protocol outlines the responsibilities of agency staff in dealing with a tragic situation sensitively whilst taking correct action to differentiate between death from natural causes and suspicious deaths.

1.3 In situations where an accident is the cause of death, consideration needs to be given to whether the accident reflected inadequate care of a child. Where this appears to be the case enquiries of other agencies should be made by police to ensure that all relevant information is obtained, and, if appropriate, an inter-agency meeting is convened and this protocol is applied.

1.4 A sudden child death is a very difficult time for everyone. The time spent with the family may be brief but actions may greatly influence how the family experiences the bereavement for a long time afterwards. A sympathetic and supportive attitude whilst maintaining professionalism towards the investigation is essential. The following principles should always be applied:

- Sensitivity
- Open minded/balanced approach
- An inter-agency response
- Sharing of information
- Appropriate response to the circumstances
- Preservation of evidence
- Use of an appropriately skilled interpreter or communicator should always be considered where required

All items on this list are equal in importance.

1.5 In situations where there are other children in the household, and there is evidence indicating a suspicious death or concern arises that a child's death may be due to abuse or neglect, professionals will continue to follow these guidelines in conjunction with the guidance relating to Section 47 enquiries within Part 1 Chapter 2 of the Inter-agency Safeguarding Procedures for Bournemouth, Dorset and Poole December 2006.

2. Background

2.1 Since the early 1990's and the introduction of the 'Back to Sleep' campaign and similar initiatives, there has been a dramatic reduction in the incidence of Sudden Infant Death Syndrome (SIDS). Many of the key factors for SIDS have been identified and measures have been taken to reduce the risks. Further research is continuing to try to establish the cause(s) of SIDS, but at present the condition cannot be fully explained.

2.2 Medical research has become increasingly advanced so that most unexpected child deaths can be explained following a post mortem and other tests. The number of unexplained deaths in infancy and childhood has therefore gradually reduced.

2.3 Accident prevention strategies and awareness raising campaigns have been developed nationally and locally with great success, thereby reducing the incidence of children who die as a result of avoidable accidents. Whilst most accidents are preventable, it is important to establish whether the care and supervision of the child was what could have been reasonably expected.

2.4 It is likely that very few cases a year of sudden unexpected death will occur, but when they do, this protocol should always apply.

3. General guidance

Multi-Agencies involvement, Discussion and Assessment

3.1 All cases of sudden unexpected child death need to be referred to the coroner and the subsequent assessment and management will be carried out in close liaison with the coroner. The designated paediatrician for unexpected deaths in childhood should also be informed. The investigation and management of these cases should follow a multi-agency approach, as set out in this protocol. Where appropriate, a serious incident notification should be made to Ofsted at National Business Unit, 3rd Floor, Royal Exchange Buildings, St Ann's Square, Manchester M2 7LA.

3.2 In the aftermath of a sudden unexpected death, professionals may need to fulfil several roles. Those professionals involved (before or after the death) with a child who dies unexpectedly should come together to enquire into and evaluate the child's death. A balance must be kept between medical and forensic requirements and the need to support family members grieving for their child.

3.3 From the first point of contact with the child and/or family, each agency on becoming involved has a responsibility to assess whether the circumstances of the child's death should be considered in accordance with this protocol. In all situations of concern the police should be informed.

3.4 The sharing of information between relevant agencies at an early stage following the report of a sudden child death is vital. It will assist in assessing the level of any suspicions and in deciding upon the direction and level of investigation, practice, procedures, the timing and personnel involved in any home visits, ensuring appropriate support for the family, and in determining the overall strategy to be adopted.

3.5 Due to time constraints, initial information sharing and multi-agency discussions may have to take place over the telephone. Obviously not all relevant information will be available at this early stage and arrangements may have to be made for subsequent discussions following the obtaining of further information. Consideration should be given to further meetings in the light of information gathered; in order to re-evaluate and review decided actions.

3.6 The parents will be informed by the police at the earliest opportunity of the nature of information gathering and sharing and the multi-agency approach involving health, police and children's services and of the coroner's involvement.

3.7 Where there are issues relating to other children in the family, or there has been previous relevant children's service involvement or where there are suspicions requiring Section 47 enquiries, the children's services team will need to be more directly involved. Such concerns may be apparent at the outset, or may come to light at any stage during the investigation.

3.8 Where children's services have had no previous involvement with the child or family, and are not needed to be involved in the investigation, they should still be notified of the outcome for future file reference.

3.9 Where suspicious factors around the death have been identified and there are other children, there should be a formal child protection strategy meeting in relation to

the other children. The purpose of this meeting is to identify if there are concerns about the circumstances of the death, and the safety of the other children. This meeting should ideally be face to face, and will include a senior police officer from the Child Protection Investigation Unit; paediatrician; and a senior representative from the relevant children's services team or emergency duty team, and a children's services solicitor. It should also include health visitor and or school nurse/general practitioner, and education, if other child/ren is/are at school.

3.10 The child protection strategy meeting should decide, amongst other things:

- how Section 47 enquiries in relation to other children should proceed;
- what protective measures are required in the meantime;
- whether legal action is appropriate;
- whether an initial child protection conference should be convened;
- contingency plans in case the situation changes;
- what information is to be provided to parents and/or family members.

In the context of organisational responsibilities the child protection strategy meeting should also consider:

- notifying the Chair of the appropriate LSCB if abuse/neglect is suspected for consideration of the need for a Serious Case Review;
- notifying the Strategic Health Authority (SHA) as a requirement of the Serious Untoward Incident Reporting protocol;
- what information should be provided to which staff;
- whether the staff who previously dealt with the family or are to deal with them in future are likely to need additional support.

If necessary, further multi-agency meetings should be held with the same representatives to review the situation and plan accordingly.

3.11 Consideration should be given to the well being and any potential risks to the care of other children in the family. This may require a medical examination, and enquiries under Section 47 Children Act 1989, the children to be temporarily cared for by members of the family network or in extreme circumstances, the children to be looked after in foster care. Wherever possible however, children should remain with their family, recognising that this is a particularly traumatic time for all family members.

3.12 Where there is the need for a core assessment led by Children's Services, this should be carefully planned through the multi-agency meeting to ensure co-ordination with any police investigation and ongoing paediatric involvement.

3.13 When a baby or older child dies unexpectedly in a non-hospital setting, the senior investigating police officer or coroner's officer must contact the senior healthcare professional (usually the designated paediatrician for unexpected deaths in childhood or the consultant paediatrician on-call on behalf of the designated paediatrician for unexpected deaths) and children services to inform them of the circumstances.

3.14 They will make a decision about which other agencies should be included within an immediate multi-agency case discussion and whether a visit to the place where the child died should be undertaken. This visit should almost always take place for infants who die unexpectedly. Where a visit is to take place, a decision should also be made about how soon (within 24 hours) and who should attend. It is likely to be a senior investigating police officer and a healthcare professional experienced in responding to unexpected deaths. They may make this visit together or separately and then confer (see local child death review protocol). When such a visit is carried out this will be coordinated by the senior investigating police officer according to a protocol agreed with the local coronial services and the designated paediatrician for unexpected deaths in childhood.

3.15 After the visit described above the senior investigating police officer, visiting healthcare professional, GP, health visitor or school nurse and children's services representative should review whether there is any additional information that could raise concerns about the possibility of abuse or neglect having contributed to the child's death.

3.16 A multi-agency case discussion should be convened by the designated paediatrician for unexpected child deaths following the preliminary results of the post mortem examination. This will usually be a telephone discussion. This discussion usually takes place 5-7 days after the death and should involve the pathologist, police, LA children's services and the paediatrician, plus any other relevant healthcare professionals, to review any further information that has come to light.

3.17 The designated paediatrician for unexpected deaths in childhood should convene and usually chair a case discussion meeting following the final results of the post mortem examination. The timing of this meeting will vary and may be eight – twelve weeks after the death. The meeting should include professionals who knew the child and family and those involved in investigating the death. The collection of the core data set should be completed. The purpose of this meeting is to share information to identify the cause of death and / or those factors which may have contributed to the death, and then to plan future care for the family. Potential learning points may also be identified. The meeting may also inform any inquest being held.

3.18 If at any point in the investigation / assessment there are concerns about surviving children living in the household, the procedures set out in Part1 chapter 2 of the Bournemouth, Poole & Dorset interagency safeguarding procedures (or chapter 5 Working Together to safeguard Children 2006) should be followed. If there is evidence to suggest abuse or neglect as a possible cause of death, the police child protection investigation unit and the chair of the LSCB should be notified and the serious case review protocol followed.

3.19 The results of the post mortem examination should be discussed with the parents at the earliest opportunity, except in those cases where abuse is suspected or the police are conducting a criminal investigation. In these situations the paediatrician must discuss with LA children's services, the police and the pathologist what information should be shared and when.

3.20 An agreed record of the case discussion meeting and all reports should be sent to the coroner, if needed to take into consideration in the conduct of an inquest and in the cause of death notified to the Registrar of Births and Deaths.

3.21 The record of the case discussions and the core data set should also be made available to the local Child Death Overview Panel when the child dies away from their residential area (see 11.2)

Issues to Consider

3.22 It is important to remember that people are in the first stages of grief and may react in a variety of ways, such as shock, numbness, anger or hysteria. Allow the parents space and time to hold the child (see paragraph 3.15) to cry, to talk together and to comfort any other children. These early moments of grieving are very important.

3.23 It is normal and appropriate for a parent to want physical contact with their dead child. In all but exceptional circumstances, such as when crucial forensic evidence may be lost or interfered with, this should be allowed in the presence of a professional, who should carefully observe the contact and record the details, ensuring that the contact is supervised at all times. If the death is the subject of a police investigation, the child should not be changed or washed before approval by the senior investigating police officer.

3.24 The child should always be handled as if still alive, remembering to use their name at all times as a sign of respect and dignity. Under no circumstances should the child be referred to as 'it'.

3.25 All professionals need to take into account any religious and cultural beliefs that may have an impact on procedures. Such issues must be handled sensitively but the importance of the preservation of evidence and the elimination of any concerns about abuse or neglect should not be forgotten.

3.26 The parents should be allowed time to ask questions about practical issues. This includes telling them where their child will be taken and when they are likely to be able to see their child again.

3.27 The names and telephone numbers of relevant people should be given to parents in writing.

3.28 All sudden deaths need to be reported to the coroner immediately. The parents need to be informed of this and that there will be a need for a post mortem examination. The coroner may decide to hold an inquest. All investigations into the cause of death need to be conducted under the direction of the coroner.

3.29 Parents must be informed about the necessity to carry out all examinations and a post mortem. **Parental consent to a post mortem examination is not required, but parents should receive a sensitive explanation of what is involved.** This should usually be done by the senior doctor (consultant or registrar level in paediatrics and/or A&E. Following the post mortem, parents will have a say in what they would like to happen to any tissues / organs removed during the post mortem Consent from those with parental responsibility for the child is required for tissue / organs to be retained beyond the period required by the coroner(see 10.9)**.**

Obtaining and Recording Information

3.30 All professionals must record history and background information given by parents in as much detail as possible. The initial accounts about the circumstances, including timings, must be recorded verbatim.

3.31 Staff from all agencies need be aware that on occasions, in suspicious circumstances, the early arrest of the parents may be essential in order to secure and preserve evidence.

3.32 The coroner and/or police may require documentary information held by other agencies, which should be made available in the format agreed by individual agencies. Release of this information is permitted by Data Protection legislation for the prevention or detection of crime, or in pursuance of statutory functions. Professionals from all agencies must be prepared to provide statements of evidence promptly if required.

4. Factors which may arouse suspicion

4.1 Certain factors in the history or examination of the child may give rise to concern about the circumstances surrounding the death. When such factors are identified, it is important that the information is documented and shared with senior colleagues and relevant professionals in other key agencies involved in the investigation. The following list, whilst not exhaustive, provides guidance:

- *Previous Child Deaths*. Approximately 1 in 2000 children dies suddenly during infancy. Two sudden child deaths within the same family, whilst very unusual, may be the effect of a metabolic abnormality and does not necessarily signify child abuse.

- Previous child protection concerns within the family relating to this child or the siblings.

- Inappropriate delays in seeking medical help.

- *Inconsistent Explanations*. The account given by the parents of the circumstances of death should be recorded verbatim. Any inconsistencies in the story given on different occasions should arouse suspicions, although it is important to bear in mind that some inconsistencies may occur as a result of the shock and trauma caused by the death.

- *Evidence of drug/alcohol abuse* - particularly if the parents are still intoxicated. This is more often associated with accidental rather than non-accidental death.

- *Unexplained injury* e.g. unexplained bruising, burns, bite marks. However, it is very important to remember that a child may have serious internal injuries without any external evidence of trauma.

- *Presence of Blood*. The presence of blood must be very carefully noted and recorded. It is found occasionally in cases of natural death. A pinkish frothy residue around the nose or mouth is a normal finding in some children whose deaths are due to Sudden Infant Death Syndrome. Fresh blood from the nose or mouth is less common, but does occur in some natural deaths. Bleeding from other sites is very uncommon in natural deaths.

- *Neglect Issues*. Observations about the condition of the accommodation, general hygiene and cleanliness, the availability of food, adequacy of clothing, bedding, and temperature of the environment in which the child died are very important. This will include a level of supervision and/or care, below what would be reasonably expected. This will assist in determining whether there may be any underlying neglect issues to consider.

The following sections set out the procedures for key agencies involved in the investigation and management of sudden deaths in childhood. All who have contact with children and young people should refer to their own agency procedures for guidance in response to a sudden unexpected death of a child which occurs on their premises/site.

5. Ambulance Staff

5.1 The ambulance service must notify the police immediately when they are called to the scene of a sudden child death. Generally, this will be through the Emergency Medical Dispatch Centre making direct contact with the police control room.

5.2 The recording of the initial call to the ambulance services should be retained in case it is required for evidential purposes. Additionally, ambulance services must also retain bedding, equipment, and any disposable items e.g. tissues, used during the resuscitation, conveyance and treatment of the child.

5.3 Babies who die suddenly and unexpectedly at home should be taken to an A&E department unless this is inappropriate (e.g. the circumstances of the death require the body to remain at the scene for forensic examination). Resuscitation should always be initiated, unless clearly inappropriate and continued until an experienced doctor (usually the consultant on-call paediatrician) has made the decision to stop. Older children may also be taken to A&E unless this is inappropriate (e.g. the circumstances of the death require the body to remain at the scene for forensic examination).

5.4 Ambulance staff should follow the guidance laid down in the current Ambulance Training Manual as follows:

- Do not automatically assume that death has occurred. Clear the airway and if in any doubt about death, apply full Cardio Pulmonary Resuscitation. (CPR);
- inform the Accident and Emergency (A & E) department of estimated time of arrival and patient's condition;
- take note of how the body was found;
- pass on all relevant information to the A & E Department;
- ensure that any injury is compatible with history.

5.5 The first professional on the scene should note the position of the child, the clothing worn and the circumstances of how the child was found. Those remaining at the scene should be asked not to disturb or move items around where the child was found until he/she has been seen by the police. This can be extremely important in helping the family to understand why their child has died.

5.6 If the circumstances allow, note any comments made by the parents, any background history, any possible substance misuse and the conditions of the living accommodation. Any such information must be passed on to the receiving doctor and the police. Where this cannot be recorded at the scene, the ambulance crew must do so upon arrival at hospital and pass the information to the police/paediatrician before leaving the hospital.

5.7 Any suspicions should be reported directly to the police and to the receiving doctor at the hospital as soon as possible.

6. General Practitioners and Health Visitors

6.1 There are times when a general practitioner (GP) attends the scene first. In such circumstances, they should adhere to the same general principles as for the ambulance staff (see section 5).

6.2 It is important for the GP to contact the police or Coroner's Officer if they are the first on the scene (taking into account their primary responsibility of saving life/certifying death). The best route for this is to contact the police control room.

6.3 The professional confirming the fact of death should consult the designated paediatrician for unexpected deaths in childhood at an appropriate time.

6.4 Additional guidance can be obtained from the Foundation for Sudden Infant Death (FSID) publication "When a baby dies suddenly and unexpectedly". Whilst this booklet is written specifically for dealing with cot deaths, many of the principles will apply to other child deaths. Further information is available on the FSID website www.sids.org.uk

6.5 The primary care team plays a crucial role in supporting the family following an sudden child death. The GP or Health Visitor will undertake an initial home visit for support (see para 7.32). If this is not possible, a joint follow up visit will be arranged 1 - 3 days after the death.

6.6 Members of the primary care team may often be aware of wider background information on the family. This information may help to shed light on the circumstances of the death and may be important to the police in considering any criminal investigation and also any child protection enquiries if there are other children. GPs and health visitors should therefore be prepared to share information on the child and other family members with the paediatrician and with the Police Investigation team.

6.7 If a sudden death occurs at home the family may call the GP to the home, or more commonly, call an ambulance leading to the admission of the child to an A&E department. Separate agency guidelines are given to cover both possibilities.

7. Hospital Staff in Accident and Emergency

Immediate Action

7.1 On arrival in A&E, the child should be taken to an appropriate area either the resuscitation room or an area set-aside for such purposes. The senior paediatrician on call and the senior doctor in A&E should be notified immediately.

7.2 The family should be provided with privacy and should be kept informed at all times. Staff should be particularly sensitive to the parents' needs and should handle the child with care and respect and refer to the child by name.

7.3 A nurse should be allocated to look after the family. S/he should stay with the family at all times and keep them informed about what is happening.

7.4 The child should immediately be assessed and death confirmed or appropriate resuscitation started. Unless it is clear that the child has been dead for some time

(for example when rigor mortis or blood pooling are evident), resuscitation should always be initiated.

7.5 Subject to the approval of the medical staff involved, the parents should be given the option of being present during resuscitation. The allocated nurse should stay with them to explain what is going on, particularly procedures that may look alarming, such as cutting of clothes or intubation.

7.6 The doctor in charge whenever possible in consultation with the parents should decide how long it is appropriate for resuscitation to be continued. It is usual to discontinue resuscitation if there is still no detectable cardiac output after 30 minutes (including prior resuscitation by paramedics).

7.7 Immediate responsibility for informing and providing appropriate care and support to the family rests with the senior clinician (in the absence of a Paediatric Consultant/team or A&E Consultant). Whilst senior staff from the disciplines of emergency medicine and/or intensive care may have been involved in the resuscitation events, it is generally not appropriate that they should be responsible for continuing pastoral care of the family and liaison with the primary care team or other agencies.

Assessment and investigation

7.8 If the child is dead the police should be informed immediately and involved in any assessment though their involvement should not prevent any other necessary medical assessment or investigation. A senior doctor (consultant or registrar level in paediatrics or A&E) should take a careful history of events leading up to and following the death of the child. Consideration should be given as to whether it is feasible to perform a joint interview with the allocated police officer to obtain the history from the parent(s). The child should be carefully examined, in particular noting any evidence of injury and the state of nutrition and hygiene of the child. Any injuries or rashes should be documented on a body chart. A rectal temperature should be taken immediately on presentation, using a low reading thermometer if necessary. The site and route of any intervention in resuscitation, for example venepuncture or intra-osseous needle insertion, needs to be carefully recorded. Full growth measurements (length, weight and, for children aged 2 years or under, a head circumference) should be taken and plotted on centile charts. The mouth, genitalia and retina should be examined for any signs of injury.

7.9 If any laboratory investigation samples are taken during resuscitation, these should be clearly labelled and documented. Once death has been pronounced then further specimens should only be taken in accordance with local agency protocols agreed in advance with the coroner. Investigations should include the standard set for SUDI and standard sets for other types of death presentation as they are developed. Some further investigations, including a skeletal survey, will be carried out according to the post-mortem protocol by, or in consultation with, the pathologist.

7.10 It is usual practice for sudden unexpected deaths in infancy / very young children to take photographs of the child along with prints of the hand and foot and a small lock of hair as mementoes for the family. If this is done it must be with the consent of the parents and clearly documented in the notes.

7.11 Clothing can be left on the child. If removed, it should be placed in labelled evidence bags. Any other item such as bedding brought in with the child should be placed in labelled evidence bags to be given to the pathologist. The parents should be informed that this has been done. **No items should be returned to the parents without consultation with the Senior Investigating police officer involved.**

7.12 Arrangements for Children's Services to be contacted by telephone regarding information held including those children who are the subjects of Child Protection Plans will be made by the Senior Investigating Police Officer. This information will include anything known about all other members of the household. The fact that child and / or siblings' names are not known to Children's Services does not exclude the possibility of child protection concerns.

7.13 It is important to make detailed records of the history and examination of findings. As far as possible, accounts should be recorded verbatim. The identity of the people present and their relationship to the child should be documented. This record may be used in the legal proceedings. It should give the time as well as the date, and should be signed legibly.

7.14 In all cases presenting to the hospital, the consultant paediatrician on call should be notified.

Family Support

7.15 Consideration should be given to allowing the family as much time and privacy as they wish with the child. Professional presence is vital at all times, but should be discreet.

7.16 It is important that all staff are familiar with the principles and general guidance in Sections 1 and 3 of this period.

7.17 When the child has been pronounced dead, the paediatrician (if available) or the A&E Senior Clinician should break the news to the parents, having first reviewed all the available information. The interview should be in the privacy of an appropriate room. The allocated nurse should also be present.

7.18 Once the child has been pronounced dead, any IV cannula, ET tubes and other equipment may be removed from the child but this should be documented clearly in the notes. Hospital staff must retain bedding, clothing, equipment and any disposable items e.g. tissues, used during the resuscitation, conveyance and treatment of the child. It may be appropriate to take photographs prior to any cleaning of the child and this along with washing and re-dressing, should be discussed with the police and paediatrician. During all discussions with the parents, they should be allowed to hold their child if they so wish, under supervision.

7.19 The family should be informed that the death must be notified to the Coroner, and that a post mortem will be required. Unless there is an obvious cause of death, it is usually best to say that an opinion cannot be given until after the post-mortem examination. Explain to the family sensitively what a post mortem involves. Ensure that the family know where this will be done and that it is likely to be at a specialist centre, but that the child will be returned after the post mortem.

7.20 The family should be given copies of available and appropriate bereavement support leaflets, booklets and contact details e.g. the FSID booklet "When a baby dies suddenly and unexpectedly", the Department of Health leaflet "Guide to the post-mortem examination: brief notes for parents and families who have lost a baby in pregnancy or early infancy", and the FSID death helpline number (020 7222 8001). This information, together with contact details of local funeral directors, local religious leaders, and the different support agencies should be kept in a readily available folder in A&E.

7.21 The Allocated Nurse should ensure that the family knows where their child will be before they leave the hospital, and that they have the contact details to enable them to arrange a visit if they wish.

7.22 The family should be offered help in contacting other family members or close friends, employers, the hospital chaplain or other religious leader if the parents wish.

7.23 If the infant was a twin, it will normally be appropriate to admit the surviving twin to hospital for monitoring.

7.24 Whilst the death is being investigated, it is important that the nurse allocated to the family establishes that someone else is looking after any other young children in the family until concerns about possible abuse or neglect have been eliminated. This information should be passed to the Senior Investigating Police Officer.

7.25 Where there are other children in the household and there are indications that the circumstances surrounding the child's death are suspicious, these concerns must be conveyed to the Senior Investigating Police Officer whose responsibility will be to consider the safety of the other children in conjunction with Children's Services.

7.26 Consideration of family support by the Children's Services Department should be given when there are other children and when health professionals think it is appropriate.

Further Management

7.27 Previous medical records of the child (including A&E records) should be reviewed to identify any factors which may be important in the medical assessment In the case of infant deaths the mother's maternity/obstetric records should also be reviewed. Relevant information should then be shared with the investigating officer if obviously significant or at the strategy meeting.

7.28 The responsibility for the further management, support of the family and future medical risk assessments will usually rest with the paediatrician and primary care team.

7.29 The doctor who pronounces that the child has died must inform the Allocated Nurse and either the Coroner's officer or Police Officer making a record of who he/she told. The doctor should highlight any concerns about the death.

7.30 The Allocated Nurse should inform the GP and health visitor, and the child health department should be notified as soon as possible in accordance with their own procedures.

7.31 Where the death occurred in a hospital the NHS South West serious untoward incident policy and the Trust's serious incidents protocol should also be followed.

7.32 All families should be visited at home within 24-48 hours by the Health Visitor and/or General Practitioner or on some occasions the Paediatrician to assist the family in coping with the loss of a child. This visit will serve a different purpose to that of the home visit (see 7.33) carried out by the 'Rapid Response Team' in accordance with requirements of Chapter 7 of Working Together to Safeguard Children 2006. There must however be liaison with the senior investigating police officer prior to any contact to avoid duplicating visits and to ensure inappropriate questions are not asked about the circumstances of the child's death.

8. Police and Coroners Officers

8.1 The responsibility for investigating suspicious deaths is that of HQ CID. This will normally be the on-call Detective Chief Inspector or Inspector. If there are concerns identified which cause the Investigating Officer to believe that the death may be due to homicide or the Investigating Officer has other concerns, then he/she should contact the on-call Detective Superintendent.

8.2 It is important for Police Officers to remember that for most sudden deaths, the death has been the result of natural causes. Police action therefore needs to maintain a careful balance between consideration for the bereaved family and the potential of a crime having been committed.

8.3 In all cases the Coroner's Officer must be notified as soon as possible. As well as the usual functions they perform, their experience in dealing with sudden deaths and bereaved families will be invaluable in explaining to the parent what will happen to their child's body and why. It may be useful for the Coroners Officer to attend the scene, but it is not absolutely necessary. The Investigating officer and the Coroner's Officer should continue close liaison throughout the investigation.

8.4 If the police are the first professionals to attend the scene, they should request urgent medical assistance as the first priority, unless it is absolutely clear that the child has been dead for some time. If this is the case, the police will immediately call a doctor to pronounce death. If the paediatrician is able to attend immediately, he or she can pronounce death, usually however the police surgeon, GP or coroner's officer should be called.

8.5 Police should keep attendance to the minimum required. A single officer should have the lead responsibility for interviewing the parents, who should not be subjected to repeat questioning by different people about the same events. The Detective Inspector will determine this.

8.6 Police should exercise sensitivity in the use of personal radios and mobile phones etc. If possible, the officers speaking with the family, whilst not being out of contact, should have such equipment turned off.

8.7 When a sudden unexpected child death occurs at home the child may still be there when the police and other professionals attend. However, usually the child will already have been taken to the hospital. If this is the case, the principles remain the same. However, in such a situation, there may be two scenes and resources will need to be allocated accordingly. It is important to note that if the child has already been moved from the home, this does not negate the need for professionals to visit the home. All professionals should avoid referring to the home as the "death scene", or using other accusatory phrases, which might be misunderstood, or distressing to the family.

8.8 The senior detective attending will be responsible for deciding on whether to request the attendance of a Crime Scene Investigator. Certainly if items are to be removed or police photographs or a video are to be taken, their attendance will be essential.

8.9 The first officer at the scene must make a visual check of the child and his/her surroundings, noting any obvious signs of injury. The officer must establish whether

the body has been moved and record the current position of the infant. All other relevant matters should also be recorded. Consideration must be given to evidencing factors of neglect that may have contributed to the death such as temperature of scene, condition of accommodation, general hygiene and the availability of food/drink. The senior detective attending is responsible for ensuring that this is done.

8.10 An early record of events from the parent is essential, including details of the child's recent health. This should normally be collected jointly or in close collaboration with healthcare professionals. If death is pronounced at a hospital then consideration should be given to performing a joint interview of the parents with the senior doctor/clinician (usually paediatrician)

8.11 The preservation of the scene and the level of investigation will be relevant and appropriate to presenting factors. In addition to the normal procedures surrounding a suspicious death (e.g. scene log, general preservation, photographs etc.) and in consultation with the on call detective inspector, consideration must be given to:

- Retention of bedding and items such as the child's used bottles, cups, food, medication which may have been administered This may be influenced by obvious signs of forensic value such as blood, vomit or other residues. Items should be retained only after the scene has been assessed and recorded by the police

- The child's nappy and clothing should remain on the child but if removed arrangements should be made for them to be retained at the hospital

- Records of monitoring equipment used by the ambulance service which may be of evidential value; otherwise, this information may only be retained for 24 hours

8.12 The issues of continuity of identification must be considered. The child should be handled as if he/she were alive.

8.13 In general, avoid any disturbance of the environment around the place where the body was found until the Investigating Officer (as determined by the Detective Inspector on-call) has carefully assessed this. This will allow the best understanding of what may have happened and will also result, in those few cases where it is appropriate, in the preservation of the scene for forensic investigation. Non-forensic removal of bedding and other objects destroys the scene and prevents full investigation of what happened - both medical and forensic.

8.14 If it is considered necessary to remove items from the house, do so with consideration for the parents. Explain that it may help to find out why their child has died and that they will be returned later. Before returning the items, the parents must be asked if they actually want them back.

8.15 If articles have been kept for a while, try to ensure that they are presentable and that any official labels or wrappings are removed before return. Return any items as soon as possible after the Coroner's verdict or the conclusion of the investigation. The term investigation will include any possible trial or appeal process.

8.16 Consideration must be given to evidencing factors of neglect that may have contributed to the death such as temperature of scene, condition of accommodation, general hygiene and the availability of food/drink.

8.17 Police officers have to be aware of other professionals' responsibilities, i.e. resuscitation attempts, taking details from the parents, examination of the child who has died and looking after the welfare needs of the family. They may have to wait until some of these things have happened and take details from these professionals before introduction to the parents. It is not helpful and may be distressing if the same questions are asked repeatedly.

8.18 Paediatricians may have already collected health and childcare information at the hospital and may be better able to obtain important details of the medical aspects of what happened. It is best to ask who was present when the child was fed, vomited, fell, etc. All comments should be recorded. Any conflicting accounts should raise suspicion, but it must not be forgotten that any bereaved person is in a state of shock and possibly confused. Repeat questioning of the parent(s) by different police officers should be avoided at this stage. Joint working with other agencies is essential.

8.19 There may be other children at the scene and their health and wellbeing is of paramount importance. Where there are other children in the household and there is immediate information or later findings which indicate non accidental injuries to the dead child, the information must be conveyed as soon as practicable to the investigating police officer, whose responsibility would be to consider the safety of the other children in consultation with Children's Services. If alternative arrangements for the care of the other children are deemed appropriate and if no other suitable accommodation is available consideration should be given to using Police Protection Powers or, in consultation with Children's Services, an Emergency Protection Order. These decisions should not be taken lightly and consultation with the Child Protection Investigation Unit and other agencies is essential. An urgent discussion initiated by police within three to four hours to consider the information available should do this.

8.20 Police visits to the home should be kept to a minimum, and should be carried out by specially trained officers in plain clothes.

8.21 Where the death occurred in a custodial setting appropriate liaison should occur with the investigator from the Prisons and Probations Ombudsman.

9. Children's Services

9.1 In all cases of sudden unexpected child death, the children's services duty team will be contacted for any information they may hold about the child and/or family. A tripartite (health, children's services and police) discussion will always take place where there are other children of the family, or there is information concerning the family or child who has died held by children's services.

9.2 Children's services may become more directly involved either where there are specific support needs if there are other children in the family, which cannot be met by other services, and always where there are child protection concerns arising from the circumstances of the death.

9.3 Where children's services have had no previous involvement with the child or family, and are not needed to be involved in the investigation, they should still be notified of the outcome for future file reference.

9.4 Where suspicious factors around the death have been identified and there are other children, there should be a formal child protection strategy meeting in relation to the other children. This meeting should ideally be face to face, and will include a senior police officer from the Child Protection Investigation Unit; paediatrician; a

senior representative from the relevant children's services team or emergency duty team, and a children's services solicitor. It should also include health visitor and or school nurse/general practitioner, and education, if other child/ren is/are at school.

10. Coroner/Pathologist and Post Mortem

10.1 After the death is pronounced the Coroner has control of the body, mementoes and medical samples, other than those described in paragraphs 7.10 which should not be taken without prior consultation.

10.2 The pathologist is chosen by the coroner, in consultation with police and other relevant professionals, with the aim that it should be a specialist paediatric pathologist who will conduct the post mortem.

10.3 The post mortem together with ancillary or additional investigations that become appropriate during the procedure should be performed to the current Department of Health guidelines. If during the post mortem a paediatric pathologist becomes at all concerned that there may be suspicious circumstances, s/he must halt the post mortem and a Home Office Pathologist must be contacted.

10.4 If the Coroner has any concerns, having been made aware of all the facts, that the death may be of a suspicious nature, then the Home Office Pathologist will be used in conjunction with a Paediatric Pathologist. In such circumstances, the agreed protocol will be followed in addition to any necessary forensic investigations.

10.5 Both the Coroner and the Pathologist must be provided with a full history at the earliest possible stage. This will include a full medical history from the Paediatrician, any relevant background information concerning the child and the family and any concerns raised by any agency. The Investigating Officer is responsible for ensuring that this is done.

10.6 The Coroner's Officer must ensure that all relevant professionals are informed of the time and place that the post mortem will be conducted as soon as it is known. A Crime Scene Investigation officer must attend all post mortems conducted by a Home Office Pathologist. The Consultant Paediatrician should also be invited to attend.

10.7 The Pathologist in charge of the post mortem will arrange a number of investigations. These include a skeletal survey *and* the collection of samples for microbiology and metabolic investigations. If the paediatrician has arranged any similar investigations before death, the Coroner must be informed and the results forwarded.

10.8 All professionals must endeavour to conclude their investigations expeditiously. This should include the post mortem results such as histology. The funeral of the infant must not be delayed unless there is a forensic reason for doing so.

10.9 Parents must be informed that small tissue samples will be retained for further investigation. They should be given the choice of whether samples are retained or returned to them once the Coroner has concluded his investigation.

10.10 Immediately following the completion of a post mortem, the interim or final findings should be provided to the senior investigating officer and coroner. The interim result may well be "awaiting histology/virology/toxicology" etc.

10.11 The final result must be notified in writing to the Coroner as soon as it is known.

10.12 The investigating officer should ensure that a copy is sent to the Child Protection Investigation Unit who will retain it on their file.

10.13 The Consultant Paediatrician and GP responsible for the follow up will be sent a copy of the post mortem report and informed by the pathologist of the preliminary findings. The contents of the report may be shared with the family and other professionals unless criminal proceedings are continuing.

10.14 Any information from the radiologist or from other examination or tests e.g. toxicity, which indicates the possibility of child abuse, even if not conclusive, must be conveyed to the investigating police office immediately. This will allow the re-assessment of any potential risk to other children, in the light of this new information.

11. Child Death Overview Panel

11.1 An overview of all child deaths in Bournemouth, Poole & Dorset will be undertaken by the Pan Dorset Child Death Overview Panel (a working group of the LSCBs). This is a paper exercise, based on information available from those involved in the care of the child and other sources as appropriate.

11.2 The Panel should be informed of all deaths of children normally resident in its geographical area as well as deaths of children visiting the area.

11.3 The LSCB Chair should decide who will be the designated person to whom the death notification and other data on each death should be sent. The Chair of the Overview Panel is responsible for ensuring that this process operates effectively.

11.4 Deaths should be notified by the professional confirming the fact of the child's death. If the death of a child occurs in an area which is not the child's area of residence the designated person should inform their opposite number in the area where the child normally resides.

CONCLUSION

The following principles are reiterated and are all of equal importance:

- Sensitivity
- Open minded/balanced approach
- Sharing of information
- Appropriate response to the circumstances
- Preservation of evidence
- Use of an appropriately skilled interpreter or communicator should always be considered

It must be remembered that all staff across the agencies involved in these sad events could potentially be distressed; each agencies' own counselling and post traumatic incident policies should be followed.

Bournemouth & Poole Local Safeguarding Children Board

Dorset Safeguarding Children Board

PAN DORSET INTER-AGENCY SAFEGUARDING PROCEDURES

CHAPTER 3

3.7 CHILDREN WHO ARE SUBJECT TO PROTECTION PLANS WHO ARE LOOKED AFTER

Procedures Effective from: **2006**

Review Date: **2011**

If you have any comments or queries about the pan-Dorset procedures please contact your agency representative on the Pan Dorset Policy and Procedures Group or notify the LSCB using the following email addresses:

info@dorsetlscb.co.uk
info@bournemouth-poole-lscb.org.uk

CHILDREN WHO ARE SUBJECT OF A CHILD PROTECTION PLAN WHO ARE ALSO LOOKED AFTER

1. Background and purpose

1.1 This guidance is required to address concerns raised about the need for children who are looked after to also have a Child Protection Plan, whilst they were in fact safe because they were looked after by the local authority.

1.2 However, the guidance should be adopted in a flexible manner and the Child Protection Conference will still have autonomy about the need for a Child Protection Plan in accordance with the inter-agency safeguarding procedures.

1.3 This guidance is based on the premise that the planning and review process for looked after children is sufficiently robust to address issues of concern and provide adequate safeguarding arrangements for the child.

1.4 Children and young people should therefore generally not be subject of both the Child Protection Planning process and the Care Planning process.

2. Child subject of a Child Protection Plan

2.1 Where a child becomes looked after who is subject of a Child Protection Plan, it is likely that the threshold criteria will no longer be met. The child may be subject of a legal order or may be accommodated by agreement with the parent/s.

2.2 The first Child Protection Review Conference following accommodation of the child should, therefore, actively consider whether a Child Protection Plan is still required.

2.3 In addressing this issue, the following areas should be addressed at the Child Protection Conference, which will be informed by the Care Planning/LAC Review process:

- What is the care plan for the child, including timescales?
- What are the Child Protection needs and how are they met?
- What Child Protection needs, if any, arise through potential rehabilitation or contact?

2.4 Where appropriate, and if the Independent Reviewing Officer for the looked after child is not already a member of the Child Protection Conference, it may be appropriate to invite him/her.

3. Child not subject of a Child Protection Plan becomes looked after

3.1 Where a child becomes looked after as a response to concerns about risks of significant harm, and the child is not subject of a Child Protection Plan, consideration should be given to convening a Child Protection Conference.

3.2 The child may be subject of a legal order, removed under powers of Police Protection, or may be accommodated by agreement with the parent/s.

3.3 The decision about whether to convene a Child Protection Conference may usefully be considered at a specially convened legal planning meeting or, where children have been accommodated by voluntary agreement (Sec. 20), a multi-agency planning meeting.

3.4 In either case, it will be important to seek and record the views of the agencies involved and to construct a plan which specifically addresses the need for safeguarding. The plan should also detail in what circumstances a Child Protection Conference should be convened and consider the need for legal proceedings. In the event that there is no immediate prospect of rehabilitation and, rehabilitation is not under active consideration, it is likely that there will be no identified need for a Child Protection Conference.

3.5 Circumstances where a Child Protection Conference is likely to be required include:

(i) where the parents are unlikely to abide by the agreement to allow the child to remain accommodated until it is considered safe for the child to return home;

(ii) where needs have been identified and can be met through agreement with all parties but the level of parent/carer co-operation and their ability to work in partnership with the local authority to achieve such an agreement is adequate or unknown;

(iii) where the substitute carers may not be able to co-operate fully with the plan;

(iv) where the child has been removed on an Emergency Protection Order or through Powers of Police Protection, and legal advice suggests that any application for a legal order by the local authority is likely to be unsuccessful;

(v) where the agreement to accommodation is broken and the child is removed from substitute care, ie foster carers or family members/friends (unless a legal order has meanwhile been grant to ensure the child's safety).

(This list is illustrative only).

3.6 Where a Child Protection Conference is held, a decision should be reached on the most appropriate route to safeguard the welfare of the child, ie Child Protection and/or the Care Planning Process.

4. Child Looked After, where Rehabilitation is being considered, where Risks of Significant Harm previously existed

4.1 Where a Child Protection Plan for a child was discontinued because s/he became looked after (section 2) or where a child became looked after as a response to concerns about risks of significant harm (section 3), and

rehabilitation is being considered to the same situation which had led to the child, or another child, being in substitute care or subject of a Child Protection Plan, a Child Protection Conference should be seriously considered. Any decision not to proceed with a Child Protection Conference should be taken in accordance with current procedures.

4.2 This should apply to children who are subject to a legal order as well as children who are accommodated by agreement with their parent/s.

4.3 Clearly, decisions about the need for a Child Protection Plan will rest with the Child Protection Conference, but it will be important to view the development of a Child Protection Plan as a positive means of achieving children's rehabilitation, where concerns still exist but risks can be managed through such an inter-agency plan.

5. Contact Issues

5.1 Any perceived protection issues regarding contact should be addressed in a multi-agency forum and this will normally be via the Care Planning and Review process.

5.2 A decision will be required as to whether a Child Protection Conference should be convened and this should take account of the circumstances for discontinuing the Child Protection Plan which are contained in the Inter-agency Safeguarding Procedures.

- it is judged that the child is no longer at continuing risk of significant harm requiring safeguarding by means of a child protection plan (for example, the likelihood of harm has been reduced by action taken through the child protection plan; the child and family's circumstances have changed; or re-assessment of the child and family indicates that a child protection plan is not necessary). Under these circumstances, only a child protection review conference can decide that a child protection plan is no longer necessary;

- the child and family have moved permanently to another local authority area. In such cases, the receiving local authority should convene a child protection conference within 15 working days of being notified of the move, only after which event may the child protection plan be discontinued in respect of the original local authority's child protection plan;

- the child has reached 18 years of age, has died or has permanently left the UK.

Bournemouth & Poole Local Safeguarding Children Board

Dorset Safeguarding Children Board

PAN DORSET INTER-AGENCY SAFEGUARDING PROCEDURES

CHAPTER 3

3.8 JOINT MENTAL HEALTH, SUBSTANCE MISUSE AND CHILDCARE PROTOCOL

Procedures Effective from: **December 2010**

Review Date: **June 2011**

If you have any comments or queries about the pan-Dorset procedures please contact your agency representative on the Pan Dorset Policy and Procedures Group or notify the LSCB using the following email addresses:

info@dorsetlscb.co.uk
info@bournemouth-poole-lscb.org.uk

Safeguarding children whose parents/carers have mental health needs or who use drugs/alcohol

Contents

		Page
1.	**Part One: Introduction**	**4**
1.1.	Purpose	**4**
1.2.	Scope	**5**
1.3.	Background	**6**
1.4.	Equalities	**6**
1.5.	Confidentiality and Sharing Information	**6**
1.6.	Children's Services	**7**
1.7.	Adults Services	**8**
1.8.	Young Carers	**8**
1.9.	Child Protection Conferences	**9**
1.10.	Case Management	**9**
1.11.	Supervision	**10**
1.12.	Training	**10**
1.13	References and Biography	**11**
2.	**Part Two: Mental Health**	**12**
2.1.	Definition	**12**
2.2.	Effects on parenting	**12**
2.3.	Children's Services	**13**
2.4.	Partnership Working	**13**
2.5.	Implications of Mental Health for parenting	**15**
2.6.	Prenatal and Postnatal Period	**16**
2.7.	Dual Diagnosis	**16**
2.8.	Service Contact Details	**17**
2.9.	References and Biography	**18**
3.	**Part Three: Substance Misuse**	**19**
3.1.	Definitions	**20**
3.2.	Effects on parenting (drugs)	**21**
3.3.	Effects on parenting (alcohol)	**21**
3.4.	Expectations on practice for Adult Treatment Services	**22**
3.5	Expectations on practice for Children's Services	**22**
3.6.	Expectations on practice for Partnership working	**23**
3.7.	Implications of parental drug misuse	**24**
3.8.	Implications of parental alcohol misuse	**24**
3.9.	Pregnant women who misuse drugs and alcohol	**25**
3.10.	Dual Diagnosis	**25**
3.11.	Substance Misusing Offenders	**25**
3.12.	Service contact details	**26**
3.13.	References	

…./continued

4. Part Four: Appendices 27

Appendix 1	**Practice Guidelines – Mental Health**	**28**
Appendix 2	**Summary of Potential Impact on a Child of primary and secondary behaviours associated with parental psychiatric disorder**	**29**
Appendix 3	**JOINT WORKING PROTOCOL Safeguarding children whose parents/carers use drugs/ alcohol**	**30**
Appendix 4	**Summary of Potential Impact of Parental Drug Misuse**	**31-32**
Appendix 5	**Summary of Potential Impact of Parental Alcohol Misuse**	**33-35**
Appendix 6	**Summary of Protective Factors in relation to Parental Substance Misuse**	**36-37**
Appendix 7	**GLOSSARY Descriptions and categories of common mental disorders**	**38**

GLOSSARY Quick reference A - Z

Anorexia nervosa	**43**
Anxiety	**42**
Asperger's Syndrome	**43**
Bipolar affective disorder	**39**
Bulimia Nervosa	**43**
Delerium Tremens:	**44**
Depression in the Postnatal Period	**41**
Drug Induced Psychosis	**45**
Eating disorders	**42**
Obsessive-compulsive disorder	**42**
Personality Disorder: Emotionally Unstable	**43**
Phobias	**42**
The Postnatal Period up to 1 year	**41**
Prodrome	**45**
Puerperal Psychosis	**41-42**
Schizoaffective Disorder	**40**
Schizophrenia	**39**
Substance Dependence	**44**
Substance Misuse	**44**
Unipolar Depression (commonly known as 'clinical depression')	**40**

Safeguarding children whose parents/carers have mental health needs or who may use drugs/alcohol

1 Part One: Introduction (applicable to both mental health and substance misuse)

1.1 Purpose

1.1.1 - To safeguard and promote the welfare of children and young people (including young carers) whose lives are affected by parents/carers using drugs/alcohol or by parents/ carers with mental health needs;

- To promote effective communication between drugs/alcohol, mental health, primary health care and children's services;

- To promote the concept of '*Safeguarding Families'* recognising that by the nature of Mental Health and Substance Misuse problems, both adults and children may potentially become vulnerable and require services to promote the welfare of whole family.

- To set out good practice for the services involved to encourage working together in the assessment and care planning for families with problematic substance use and/ or mental health needs to enable their full participation in the process wherever possible.

NB In the context of this protocol 'parent' includes anyone who has care of the child, for example, members of the extended family.

1.2 Scope

1.2.1 These guidelines apply to and have been written for use by the many statutory, non-statutory, voluntary, independent sector and primary care services working with parents/carers with mental health and/or drug/alcohol problems within Dorset.

1.2.2 All practitioners will be expected to use this protocol when they come into contact with:

- an adult with drug/alcohol or mental health issues who is caring for, or has significant contact with, a child.

- a child whose life is affected by a parent or carer's use of drugs/alcohol or mental health needs.

NB Practitioners working with adults should identify at an early stage the adult's relationship with any children and apply the principles outlined within this guidance and any other locally derived protocols or procedures which support the delivery of this section.

1.2.3 All other services represented on the DSCB will be expected to know of the existence of this protocol and be able to recognise when it should be used.

1.3 Background

1.3.1 Local authorities have specific duties under the Children Act 1989 in respect of children in need (Section 17) and children at risk of significant harm (Section 47). Those working with adults and children with substance use/misuse and mental health needs in all health, social care and voluntary sector settings have a responsibility to safeguard children when they become aware of or identify a child at risk of harm, following Local Safeguarding Children Board (LSCB) procedures which are based on the Government Guidance *Working Together to Safeguard Children (WT)* (2010).

1.3.2 Working Together (WT) (2010) outline that "Children need to feel loved and valued and be supported by a network of reliable and affectionate relationships. If they are denied the opportunity and support they need to achieve these outcomes, children are at increased risk not only of an impoverished childhood, but also of disadvantage and social exclusion in adulthood. Abuse and neglect pose particular problems (*WT* section 1.3).

1.3.3 Patterns of family life vary and there is no one perfect way to bring up children. Good parenting involves caring for the children's basic needs, keeping them safe, showing them warmth and love and providing stimulation needed for their development and to help them achieve their potential, within a stable environment where they experience consistent guidance and boundaries" (section 1.4).

1.3.3 The government guidance *Working Together* (2010), places the responsibility for the safety and welfare of children with the local authority (*WT* section 2.18), but expects *all* health professionals working with children to ensure that safeguarding and the welfare of children is an integrated part of the care they offer. There is an expectation that health professionals that come into contact with children, parents and carers in the course of their work are aware of their responsibilities to safeguard and promote the welfare of children and young people (*WT* sections 2.67 to 2.77). The same expectation relates to those working in the field of substance misuse (*WT* sections 2.102-2.207).

1.3.5 All agencies involved in the care of such adults or children are expected to work closely together, share information and thoroughly assess to promote the welfare of a child or to protect a child from significant harm.

1.3.6 Although not addressed within this protocol the impact of Domestic Violence also needs to be considered, as this may be a factor which professionals working with adults who misuse substances or who have mental health issues, will need to assess and identify the risks to both the children and adults involved. (Ref LSCB DV Protocol)

1.3.7 Working Together (WT 2010) states "Domestic Violence rarely exists in isolation. Many parents also misuse drugs or alcohol, experience poor physical and mental health and have a history of poor childhood experiences themselves. The co-morbidity of issues compounds the difficulties parents experience in meeting the needs of their children, and increases the likelihood that the child will experience abuse and /or neglect." (WT 9.19)

1.3.8 Building on former publications around Hidden Harm (2003) and (2006), aiming to address the impact of substance use on children and young people, Think Family guidance: DCSF, DH and NTA joint guidance for adult, children's, and drug and alcohol treatment services http://www.dcsf.gov.uk/everychildmatters/resources-and-practice/ig00637/ was published during the Autumn of 2009 requiring Drug and Alcohol Action Team partnerships to have in place joint protocols addressing parenting and substance use. For Dorset, Bournemouth and Poole, this has constituted a review

and revision to the previous version of Section 3.8 which is this document. The Department for Education and the National Treatment Agency for substance misuse are monitoring progress made by partnerships.

1.4 Equality and Diversity

1.4.1 This protocol applies in all situations irrespective of the race, gender, age, sexual orientation, class, cultural and religious beliefs or disability of those involved.

1.4.2 In order to make sensitive and informed professional judgments about a child's needs, and the capacity of parents/carers to respond to those needs, professionals should be sensitive to differing family patterns, lifestyles and child-rearing practices which can vary across different racial, ethnic and cultural groups. **However, all professionals must be clear that child abuse or neglect, caused deliberately or otherwise, cannot be condoned for religious or cultural reasons.**

1.4.3 All professionals will be aware of stereotypes and prejudices which exist about adults who use drugs/alcohol or have mental health needs. It is essential that these do not influence assessments. Any assessment should be thorough, based on observation of the parent/s involved and should be undertaken jointly, or a least discussed with relevant specialist workers, whose views should be taken into account.

1.5 Confidentiality and Sharing Information

1.5.1 Confidentiality can never be an absolute principle and it is generally accepted that where children need protecting, their needs are paramount and information may be shared without their parents'/carers' permission. It is critical that **all practitioners** working with adults, children and young people are in no doubt that where they have reasonable cause to suspect that a child or young person may be suffering significant harm or **may be at risk of suffering significant harm**, they should always consider referring their concerns to social care. Practitioners should seek to discuss any concerns with the family and, where possible, seek their agreement to making referrals to children's social care.

This should only be done where such discussion and agreement seeking will not place a child at increased risk of significant harm. The child's interest must be the overriding consideration in making any such decisions.

Where a child is not suffering significant harm, parental permission is still needed for the sharing of information. This should be raised with parents at the beginning of professional involvement following agency guidelines, with emphasis on the help and support which can be accessed by the family as a result of sharing information with other agencies. In the process of finding out what is happening to the child, it is important to take into consideration their wishes and feelings.

The Overarching Information Sharing Protocol (OAISP) for the Pan-Dorset area and other Information Sharing Protocols may also give a framework to support this.

1.5.2 Each agency/organisation will have its own system with regards to undertaking an assessment using the Common Assessment Framework (CAF). Parents should be asked if one has already been done and if so, it will mean that they have agreed to information being shared.

1.5.3 Practitioners should be aware of any protection plan around family members e.g. MAPPA, Child Protection Plans, MARAC, and identify the need to be involved in those processes. These should be clearly documented with in the adults or child's records.

1.5.4 Practitioners should always be mindful of Risk and any Risk Assessment process and documentation should always be continually reviewed and updated to ensure that the information is always current and live.

1.6 Children's Services

1.6.1 Children's Services will, throughout their involvement:

- employ a policy of openness with families where information from other agencies impacts on planning for the child.
- seek consent from family members to share information with other agencies in the best interests of the child (but bear in mind this should only be done if the discussion and agreement-seeking will not place a child at increased risk of significant harm - see *Working Together to Safeguard Children* 2010 Para 5.18)
- be clear whether an assessment using the Common Assessment Framework (CAF) has been or needs to be undertaken and, if so, what the outcomes were/are.
- assess the unborn child's needs and identify desired outcomes for the child.
- assess the child's needs and identify desired outcomes for the child.
- provide a child-focused service to families with whom they are involved.
- ensure that the wishes and feelings of child/ren are ascertained.
- ensure the child is given the opportunity to be seen/heard on their own.
- check with Substance Misuse teams where parents are using drugs particularly where there is an unborn or very young child and make sure that the assessment to include both partners, not just the mother. Risk Assessment documentation must be kept up to date and monitored at regular intervals to ensure risk information is *live* and current
- consult with primary and secondary mental health services and with Substance Misuse teams where applicable for information to support assessment of parenting capacity, and for realistic assessment of any risk even where there are no apparent safeguarding issues, undertaking joint assessment where possible.
- invite representatives from mental health and substance misuse services to Child Protection Conferences where they are involved with the family with the maximum timescales as possible to facilitate attendance and provide reports.
- provide a representative to attend Care Programme Approach meetings where at all possible.
- share assessments, verbally and in writing, with parents and, with parental permission, practitioners working in mental health and/or drugs and alcohol teams.
- identify and address any caring responsibilities a child or young person is undertaking with the parent/carer.
- together with relevant agencies, identify roles and responsibilities for any ongoing work with the family: a meeting is preferable where decisions need to be made and owned.

1.7 Adult Services

1.7.1 Parental mental health needs/substance misuse do not automatically indicate that their child is at risk of abuse or neglect, although it is necessary for workers to recognise that these issues can impact on their ability to parent and therefore, this is where an assessment needs to focus.

1.7.2 Adult Services will, throughout their involvement ensure that when assessing adults needs that any support parents or individuals with parental responsibility may need with parenting is taken into account.

1.7.3 Local authorities are also the lead agency for safeguarding adults.

Services do not always neatly divide into those for adults and those for children, and there will be circumstances when adult services can make a contribution to the safeguarding of children and circumstances when staff in adult services may be aware of the risk of harm to children which should be disclosed, and vice versa.

There will also be circumstances when safeguarding children and adults can and should be done jointly as part of addressing the needs of the Family. For all these reasons children and adult services should be aware of each other's roles and responsibilities, underpinned with effective communication.

Services and workforce planning should take account of the family and neighbourhood context in which safeguarding work is carried out.

extracted from Working Together 2010 Section 2.28

1.7.4 The sharing of information between adult and children's services is of paramount importance , particularly when there are children involved who potentially are at risk of significant harm through adult behaviour.

1.8 Young Carers

1.8.1 For services to provide effective support for young carers and their families, it is vital that all members of staff working with them begin with an inclusive, wide-ranging and holistic approach that considers the needs of:

- The adult or child in need of personal care
- The child who may be caring and
- The family

1.8.2 Children Act 2004 – Young Carers are an "at risk" group and need support.

1.8.3 Carers (Equal Opportunities) Act 2004 - Identification of young carers can be problematic. Many children live with family members with stigmatized conditions such as mental illness or/and drug and alcohol problems. In many cases, families fear what professional intervention may lead to if they are identified. Some families may also have concerns about stigmatisation of being assessed under children's legislation

1.8.4 Carers (Recognition and Services) Act 1995 – young carers are entitled to an assessment of their needs separate from the needs of the person for whom they are caring.

1.8.5 Under Section 17 of the Children Act 1989, a young carer may be regarded as a child in need if "he is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development".

1.8.6 Carers and Disabled Children Act 2000 – assessments of need must be given when requested by people of 16+ who are in a caring role.

1.8.7 The Children's Plan (DfES 2007) states that: for young carers – services should adopt a *whole family* approach. This means that children's and adult services must have arrangements in place to ensure that no young person's life is unnecessarily restricted because they are providing significant care to an adult with an identifiable community care need.

1.8.8 In a system that 'Thinks Family', both adults' and children's services join up around the needs of the family and sets out what this system would look like to families on the ground. Where young people take on caring roles, work to ensure, they receive adequate support and services that safeguard their childhood and aspirations as children and young people.

1.8.9 Young carers, parents and their families: Key Principles of Practice (Frank, McLarnon, 2008) are a vital resource for policy makers and practitioners when developing and providing services and can be used to measure success across departments and agencies. The Whole Family pathway (Leadbitter 2008) is a free online resource which will help practitioners achieve the Key principles of practice and promote whole family working.

1.9 Child Protection Conferences

1.9.1 Child Protection Conferences will be conducted in line with LSCB child protection procedures. It is expected that representatives from the appropriate statutory and voluntary agencies will attend, and if they cannot, that they will provide the conference with a written report or send a well briefed representative to speak to the report.

1.9.2 Parents are encouraged to attend conferences. They may be excluded however, if they are under the influence of substances at the time of the conference to such an extent that they are unable to participate effectively.

1.9.3 They are invited to bring someone to support them or an advocate to the conference. Their worker from the Drug/Alcohol Service will always be invited to attend by the social worker. They will be part of the professional network and will be expected to contribute to the decision making.

1.9.4 If a decision is made that a child protection plan is required, this will be followed by the development of such a plan including the establishment of a core group. It is necessary for members of this group to be clear about their role and that of others.

1.10 Case Management

1.10.1 Effective inter-agency communication and multi-agency co-operation is **crucial** to the management of on-going work with people with mental health needs/substance users and their families. When workers receive new information that is likely to affect a previous assessment of the impact on mental health/substance use problems upon parenting, they must pass this information on to the other agencies involved, so that, if necessary, a reassessment of the situation can be undertaken. It may be necessary to arrange a meeting of professionals to discuss the new information and how it will impact on the family/ies. There must be clarity with regard to the different roles and responsibilities undertaken by different workers and a decision made regarding coordination, so that this is not left to the parent.

Where a child is the subject of a child protection plan, or is identified as a child in need, it is important to maintain a continuous dialogue between Primary Care, Mental Health Services/Drug/Alcohol Services and Children's Services Teams regarding treatment objectives. Professionals working directly with such families are expected to participate in child protection core groups, where these are set up to monitor the progress of Child Protection Plans, and to be clear about their role and responsibility.

1.11 Supervision

1.11.1 It is crucial that all agencies establish a clear framework for supervision as staff need to feel, and be properly supported to make their safeguarding practice effective. Those supervising staff working with adults should always ask about the care of children in the family and vice versa. Those managing child care cases should always ask about collaboration with adult workers if there are substance misuse or mental health issues affecting parents.

1.12 Training

1.12.1 All professionals who have substantial involvement with children, and pregnant substance users **and their partners** should receive basic awareness training on mental health and substance misuse issues as they relate to safeguarding children, and ways to access resources.

1.12.2 **Voluntary organisations have an important role to play in offering services to people with mental health needs and drug/alcohol users, so it is essential that workers from these agencies and other specialist health services are included in training related to child safeguarding, and are aware of their responsibilities and appropriate responses under their local systems.**

1.13 References and Biography

DfES (2006) *Working Together to Safeguard Children. A guide to inter-agency working to safeguard and promote the welfare of children.* London: The Stationary Office.

DfES (2007) *The Children's Plan. Building brighter futures* accessed at: http://www.dfes.gov.uk/publications/childrensplan

Frank J and McLarnon J (2008) *Young Carers, Parents and their Families: Key Principles of Practice.* The Children's Society

Leadbitter, H (2007) *Whole Family Pathway – A whole family working resource for practitioners.* The Children's Society.

Social Exclusion Task Force (2008) *Think Family: Improving the Life Chances of Families at Risk.*

2. Part Two: Mental Health

The guidelines refer to people with mental health needs, from brief interventions to severe and enduring mental ill health. It is important that all workers should be aware that the term 'mental health need' covers a range of needs some requiring brief intervention in primary care, while others require referral to specialist mental health services.

2.1 Definition

2.1.1 For the purposes of safeguarding children the mental health or mental illness of the parent or carer should be considered in the context of the impact of the illness on the care provided to the child.

2.2 Effect on parenting

2.2.1 All parents find parenting challenging at times, and those with a mental health need often show considerable inner strengths in adequately parenting their child. Being a parent with a mental health need however, may be particularly challenging. Many parents are painfully aware that their disorder affects their children even if they do not fully understand the complexities. (Royal College of Psychiatrist 2002, Falkov 1998).

2.2.2 All children even young children are sensitive to the environment around them. Thus their parents' state of mind can have an effect on even the youngest child. In this context, all children are vulnerable when a parent has a mental illness but children may be helped considerably where the parent is aware of this. (Stanley et al 2003).

2.2.3 The lack of capacity to parent well may not be the only reason for poor outcomes for children whose parents have mental illness. Factors such as the effects of poor housing, financial difficulties, domestic violence or hostile neighbourhoods may be a significant factor in parental stress and illness. (Stanley et al. (2003).

2.2.4 Strengths in the family, such as the ameliorating effects of another adult, can minimise the effects on children of the mental illness of a parent.

2.2.5 Questions about childcare and parenting issues are clearly sensitive and can have important implications for people with mental health needs. The stigma associated with mental illness may make parents reluctant to ask for help, as they fear their child or young person may be removed.

2.2.6 Families may struggle for a long time with a high level of stress, delaying seeking help until a crisis situation; thus leaving little opportunity for preventative intervention. Children in this situation may fear being removed. Balancing the rights and needs of both children and adults in families can pose difficult dilemmas. It is government policy to promote the well being of children through timely and appropriate support. (Children Act 2004).

2.2.7 Assessment of the impact of these stresses on the child is an important factor in the care plan for the child and the care plan for the parent and reinforces the need to see mental health needs of parents/carers in the context of family life and functioning.

2.2.8 It is essential that an appropriate assessment of the parent/carer's needs is undertaken to access the impact on any child involved with the family. Children have a right to have their own needs assessed, receive appropriate services and to be heard in their own right so that risk factors can be identified and minimised and protective factors promoted. In this way, children can be enabled to achieve their full potential.

2.3 Children's Services

2.3.1 When a referral is accepted by Children's Services an assessment will be undertaken. Where information gathered indicates the potential risk of significant harm to the child, child protection procedures must be initiated and the assessment conducted in accordance with these procedures.

2.3.2 Where Children's Services are already involved with a family where the parent or person with significant caring responsibility for children appears to have mental health needs, the practitioner should discuss with the parent whether they are receiving any support from either the Primary Health Care team (via their GP) or from Adult Mental Health Services, or any other service, and whether they will consent to have information shared with other practitioners. The benefits to the family of sharing information should be explained.

2.3.3 If there are concerns relating to the parent's needs, and no other services are involved, the parent's GP should be contacted, by the Children's Services practitioner, in the first instance for his/her view of the family situation. Whether a referral for primary or secondary mental health services is required should be discussed. This is particularly important where there is an unborn or very young child. Where nursing or midwifery services are being used, they should also be involved.

2.3.4 If the parent is receiving support from Adult Mental Health Services, the Children's Services practitioner should contact the person involved, and use their expertise and experience to help assess, or review, the parent's current and potential capacity to meet the child's needs, taking into account the support received from the mental health practitioner.

2.3.5 The referral pathway to Children's Services will vary between authorities; each agency should ensure that they are familiar with their local authority's process.

2.3.6 **NB This protocol is relevant as long as concerns about the parent's capacity to meet the needs of the child/children are at a level where the child is not suffering or not likely to suffer significant harm. If the concerns are about neglect, or harm, whether emotional, physical or sexual, to the child, the Local Safeguarding Children Board child protection procedures should be followed without delay.** https://www.dorsetlscb.co.uk or www.bournemouth-poole-lscb.org.uk

2.3.7 When a referral is accepted by Children's Services, an assessment will be undertaken. The assessment should be planned jointly with other involved professionals, unless the concerns are so urgent that immediate action needs to be taken by the Children's Services social worker to ensure the child's safety. In this case the mental health practitioner should be fully informed and be part of the child protection strategy planning.

2.4 Partnership Working

2.4.1 Safeguarding and promoting the welfare of children, and in particular protecting them from significant harm, depends upon effective communication and joint working.

2.4.2 Sharing information is essential to enable early identification to help children young people and families who need additional services to achieve positive outcomes. (See *What to do if you're worried a child is being abused* 2006).

2.4.3 Joint working should be conducted within the boundaries of confidentiality, however the emphasis should be on working collaboratively with parents and other professionals to maximize the care of children and protect them from harm. The duty of confidentiality to parents is not absolute and must not be allowed to stand in the way of a vulnerable child or adult. .

2.4.3 The National Service Framework (DoH 2004) recognises that many children have contact with a variety of professionals. If during an assessment, concerns arise that may require support from another agency, it is important for the professionals involved to work in partnership and to share relevant information as required in accordance with confidentiality obligations. (*Working Together to Safeguard Children* 2006 para 2.81).

2.4.5 Close collaboration and liaison between Adult Mental Health Services and Children's Services are essential in the interests of children. This may require sharing information to safeguard and promote the welfare of children or to protect a child from significant harm. Systems should be in place to ensure that:-

- Managers working with adults can monitor those cases which involve dependent children.

- There is regular, formal and recorded consideration of such cases with Children's (Social Care) staff.

- If Adult and Children's Services are providing services to a family, staff communicate and agree interventions.

(Pan-Dorset Safeguarding Children Procedures 2007: https://www.dorsetlscb.co.uk or www.bournemouth-poole-lscb.org.uk

2.4.6 In order to safeguard children of parents with whom they are working, mental health practitioners should routinely record details of parents' responsibilities in relation to children and consider the support needs of parents and of their children in all aspects of their work. (*Working Together to Safeguard Children* 2010 para 2.103-4).

2.4.7 Joint working should be conducted within the boundaries of confidentiality, however the emphasis should be on working collaboratively with parents and other professionals to maximize the care of children and protect them from harm. The duty of confidentiality to parents is not absolute.

2.4.8 As part of the assessment process, mental health and primary care practitioners will offer professional assessments on the impact of the mental health need upon the parenting capacity of the person/s involved and childcare practitioners will offer professional assessments on the child. This information will assist in the construction of a plan that ensures the child's/children's safety, whilst also taking into consideration the needs of the parent/carer.

2.4.9 Practitioners will input into the decision making process of professional meetings and child protection conferences. Practitioners attend to offer professional assessments and not as advocates of the parent.

2.4.10 Should a practitioner feel that their role with the parent is being compromised, they should consider engaging the services of an advocate who can support and advise the parent and therefore free the practitioner to fulfil their responsibilities to the child protection conference.

2.4.11 It is not possible to give guidance to cover every circumstance in which sharing of information without consent will be justified. Practitioners must make a judgment on the facts of each case. Where there is clear risk of significant harm to the child, or serious harm to the adult, the public interest test will almost certainly be satisfied. However, there will be other cases where practitioners will be justified in sharing some confidential information in order to make decisions on sharing further information or taking action; the information shared should be proportionate. (*What to do if you're worried a child is being abused* 2006. para 3.11).

2.5 Implications of Mental Health for parenting

2.5.1 The Royal College of Psychiatrists (2002) states that the links between mental illness and adverse outcomes for children is well established. For parents with mental health needs, difficulties, usually beyond their control, can create problems in parenting or in being the parents they would wish to be.

2.5.2 The failure of any parent to meet a child's basic needs will have an impact on all aspects of that child's health, growth and development.

2.5.3 The Royal College of Psychiatrists (2002) states *the effect of parental psychiatric disorder on children's psychological welfare is determined by the social and relational consequences of the parent's' disorder. It is the parental behaviour that creates the risk to the children. A parent who is self pre-occupied or emotionally and practically unavailable is more likely to neglect their children's health and well-being whereas a parent suffering from irritability or over-reaction to stress that accompanies anxiety, depression or psychosis may resort to over chastisement or physical abuse of the child'*

.

2.5.4 Where a child becomes incorporated into a parents paranoid or threatening delusions, this may pose a significant risk to the child. In their review of 35 child death cases, Reder and Duncan (1999) found that 43% of the parents were suffering from active mental health needs at the time the child died.

2.5.4 Parental personality factors (pre-existing and/or exacerbated by the illness) may mean parents have difficulty controlling their emotions, have an inability to cope or be self-preoccupied. Violent, irrational and withdrawn behaviour can frighten children

2.5.6. Poor compliance with treatment and problematic relationships with professionals are factors that influence parent's ability to be effective in the care of their children. (Royal College of Psychiatrist 2002).

2.5.7 Unmet mental health needs can lead to the child taking on responsibilities beyond their years because of their parent's incapacity. This may include becoming a carer for the parent and/or other children or family members.

2.5.8 The effects of parental mental ill health may be minimised and ameliorated by a caring adult who is available and cognisant of the fluctuating needs of the parents and can step in to provide a supportive stable environment for the child/young person.

2.5.9 Children may understand when things are not right and if their needs are not being met. They may not be able to, or want to say anything about it, or there may be no-one to tell; they may just get on with it by taking on inappropriate caring roles for their families.

2.5.10 The needs of the child in his own right should be assessed by the children's services social worker within a child plan which identifies the presence of another significant adult while the needs of the parent should be assessed and addressed by the mental health worker in order to support the parenting role (McDonald 2005 in Taylor and Daniel).

2.5.11 Fear of a child being removed from the parent is considered an obstacle to a parent seeking help for mental health needs.

2.6 Prenatal and Postnatal Period

2.6.1 Specific concerns apply to the pre- and post- natal periods. It is vital that there is joint working between the General Practice, Midwifery, Health Visiting and if involved, specialist Mental Health Services. It is essential to identify needs, assess and prepare safeguarding plans for both mother and child.

2.6.2 Post-natal depression (PND) is very common among new parents and may affect as many as one in six new mothers, typically in the first three months after delivery, sometimes lasting for six months or up to a year if left untreated. Maternal post-natal depression can be significantly harmful to young infants particularly between the ages of six to eighteen months of age with increased incidence of insecure attachment. The depression itself does not cause the damage it is the effect of the mother: child interaction and non-availability to the child that does the damage leading to emotional and cognitive difficulties, social withdrawal, negativity and distress. (Cox et al 1987, Murray et al 1996).

2.6.3 Women in the postpartum period have a greater risk of becoming psychotic. Puerperal psychosis affects two percent of the general population but affect 30 – 50% of woman with a previous significant history of mental illness. Relapse signature can predict onset and nature of illness.

2.7 Dual Diagnosis

2.7.1 Substance misusing parents may have mental health problems. It is important, therefore, to maintain effective links between the agencies involved. *Pathway to care for individuals with substance misuse and mental health needs are indicated in local guidance.*

2.7.2 Workers should consider the impact, especially with chronic severe mental illness with co-morbid disorders such a substance misuse or a personality disorder will have on parenting capability. Those with a dual diagnosis of mental health needs and learning disability may require extra support.

2.7 Services Contact Details (Mental Health)

Dorset HealthCare University NHS Foundation Trust HQ

11 Shelley Road
Boscombe
Bournemouth
BH1 4JQ

Tel: 01202 303400
Fax: 01202 701462

WWW.dorsethealthcare.nhs.uk

Dorset Community Health Services

Forston Clinic
Herrison
Dorchester
DT2 9TB

Tel: 01305 361300
Fax: 01305 361300

www.dorset-pct.nhs.uk/health_services/dorset_community_health_services/index.asp

2.9 References and Biography

Browne K, Douglas J, Hamilton-Giachritsis C and Hegart J (2006). *A community Health Approach to the Assessment of Infants and their Parents: The Care Programme*. Chichester: John Wiley & Sons Ltd.

Cassell, D. and Coleman, R (1995) Parents with psychiatric problems, in P. Reder and C Lucey (eds) *Assessment of Parenting: Assessment of Parenting: Psychiatric and Psychological Contributions*, London: Routledge, pp169-49.

Commission for Social Care Inspection (2006) *Supporting parents, safeguarding children*, London: CSCI.

Cox A.D, Puckering. C. Pound. A, AND Mills, M (1987) The impact of maternal depression in young children. Child Psychology and Psychiatry, vol 22, no 6, pp917-28.

DfES (2004) *Every Child Matters. Change for Children*. London: The Stationary Office.

DfES (2004) *National Service Framework for Children, Young People and Maternity Services*. London: The Stationery Office.

DfES (2006) *Working Together to Safeguard Children. A guide to inter-agency working to safeguard and promote the welfare of children*. London: The Stationery Office.

DoH and DfES (2004) *National Service Framework for Children, Young People and Maternity Services*. London: Department of Health. Website: www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/ChildrenServices/ChildrenServicesInformation/fs/en

Falkov A (ed) (1998) Crossing Bridges: Training recourses for working with mentally ill parents and their children. Brighton: Pavilion Publishing

Joyce L (2003) *Report of an Independent Inquiry into the Care and Treatment of Dasha Emson M.B.B.S, MRCPPsych, MSc and her Daughter Freya*. London: North East London NHS Strategic Health Authority.

Leadbitter, H. (2007) *Whole Family Pathway – A whole family working resource for practitioners*. The Children's Society.

Murray, L. Hipwell, A. and Hooper, R (1996) *Cognitive development of 5 year old children of postnatally depressed mothers. Child Psychology and Psychiatry*. Vol 37, no 8, pp927-35.

Quinton and Rutter (1985) *Family psychology and child psychiatric disorder: a four year study. In A>R> Nicol (ed) Longtudinal Studies in child psychology and psychiatry*. Chichester. John Wiley, pp91-134.

Reader P and Duncan S (1999) *Lost Innocents a Follow-up Study of Fatal Child Abuse.* London and New York Routledge.

Royal College of Psychiatrist (2002) *Patients as Parents: Addressing the needs, including the safety of children whose parents have mental illness*.
London: Royal College of Psychiatrist CR 105.

Royal College of Psychiatrist (2004) *Child Abuse and Neglect: The role of Mental Health Services*. London: Royal College of Psychiatrist CR 120.

Stanley N, Penhale B, Riorden D, Barbour RS and Holden S (2003)
Child Protection and Mental Health Services: Inter-professional responses to the needs of mothers. Bristol: The Policy Press.

3. Part Three: Drugs and Alcohol

Parental misuse of drugs or alcohol becomes relevant to child protection when the misuse of the substances impacts on the care provided to their child/ren.

Foreword

'all drug-misusing parents with treatment needs to have ready access to treatment, with all problem drug user parents whose children are at risk having prompt access to treatment, with assessments taking account of family needs'.

Drugs: protecting families and communities
(Home Office, 2008)

By taking a whole family approach and by working closely together, drug and alcohol services, dedicated young carer services and children, parenting and family services can meet the needs of parents whose substance misuse is adversely affecting the whole family.

These guidelines have been written for use by all services working with drug or alcohol misusers who are parents or carers of children. There are many voluntary and statutory agencies providing services for drug and alcohol users and their families. All these agencies must recognise the importance of working together, particularly in assessing the needs of children of parents/carers who use substances.

Further sub-protocols may need to be developed within the respective Dorset, Poole and Bournemouth areas and possibly between services within these areas as required to underpin the implementation.

Pan Dorset overarching protocol **(this document)**		
Dorset *Sub-protocol(s) as required*	**Poole** *Sub-protocol(s) as required*	**Bournemouth** *Sub-protocol(s) as required*

In implementing this protocol, services will need to consider whether their local protocol will impact differentially on the groups and communities that are being supported and take steps to address any issues identified. This should include an evaluation using the Local Authority or NHS Equality Impact Assessment process to further inform the protocol development.

3.1 Definitions

3.1.1 **Substances**

'Substance' is used to refer to any psychotropic substance (capable of affecting the mind – changing the way we feel, think and or behave) including alcohol, tobacco, drugs sold as 'legal highs', illegal drugs, illicit use of prescription drugs and volatile substances such as solvents (gases, lighter and other fuel) some plants and fungi (magic mushrooms); over-the-counter and prescribed medicines that are used for recreational rather than medical purposes.

3.1.2 **Substance Use**

Substance use is drug taking which requires a lower level of intervention than treatment. Harm may still occur through substance use, whether through intoxication, illegality or health problems, even though it may not be immediately apparent. Substance use requires the appropriate provision of interventions such as education and advice, targeted prevention and brief interventions to reduce the potential for harm.

3.1.3 **Substance Misuse**

Substance misuse is where substance taking harms health or social functioning. It may cause dependency (physical or psychological). Drug taking in this context may also be part of a wider spectrum of problematic behaviour. Substance misuse will require treatment.

3.1.4 Substance use/misuse by parents/carers does not, on its own, automatically mean that children are at risk of abuse or neglect, but workers must recognize that children of substance misusers are a high-risk group. Furthermore, adults who misuse substances may be faced with multiple problems, including homelessness, accommodation or financial difficulties, difficult or damaging relationships, lack of effective social and support systems, issues relating to criminal activities and poor physical/and or mental health. Parents or carers who experience domestic abuse may use or misuse substances as a coping mechanism. Substance misuse may cause or exacerbate abuse within a relationship. Assessment of the impact of these stresses on the child is as important as the direct impact of substance misuse. It reinforces the need to see substance misuse by parents/carers in the context of family life and functioning, and not purely as an indicator or predictor of child abuse and neglect.

3.1.5 Questions about childcare and parenting issues are clearly sensitive and can have important implications for substance misusing parents. The need to gain information must be balanced against deterring substance users from accessing appropriate treatment. Whilst parents have the right to confidentiality in most circumstances, society has a duty to protect children who cannot advocate for themselves. While a professional's primary relationship may be with the parent, where there is cause for concern, information must to be shared on a 'need to know' basis with the appropriate children's services. This should be conducted within the boundaries of confidentiality. The emphasis should be on working collaboratively with parents and other professionals to optimize the care of children and protect them from harm or risk of harm.

3.1.6 It is important that all workers should be aware that the term 'substance misuse' covers a range of usage, from minor recreational through to more serious use and physical addiction. In common usage then, not all 'substance misuse' by parents leads to risk of significant harm to their children. All cases should be assessed on their individual circumstances.

3.2 Effects on Parenting (drugs)

3.2.1 In some cases drug misuse can become a higher priority for the parent than buying basic essentials for the family.

3.2.2 Parent's behaviour may result in basic standards of hygiene being neglected.

3.2.3 Drug misuse may result in some parents having difficulty organising their lives. This may result in inconsistent and ineffective parenting.

3.2.4 Drug misuse may mean parents have difficulty controlling their emotions. Violent, irrational and withdrawn behaviour can frighten children.

3.2.5 The extreme nature of their parents' drug misuse may cause the child's life to revolve around it, and lead to the child taking on responsibilities beyond their years because of their parent's incapacity.

3.2.6 Drug misuse may result in the parent placing their own needs before those of their children, and lead them to being cared for by a large number of other people. There may also be reduced vigilance by the parent leaving children vulnerable to abuse by visitors to the home.

3.2.7 Parenting is most likely to be negatively affected where drug misuse is uncontrolled or chaotic, and the parent/carer swings between states of severe intoxication and withdrawal, particularly when substances are mixed.

3.2.8 Drug misuse may result in a parent/carer becoming unconscious or incapable while looking after the child, or failing to notice or get treatment for a child when s/he is ill or has had an accident.

3.2.9 Drug misuse may lead to violence toward a child, or domestic violence towards a partner, accompanied by its adverse impact on the child's emotional well-being.

3.2.10 Drug misuse may lead to the parent becoming intensely worried about obtaining their next fix, with the result that the child is left alone, or, alternatively, taken to places which are unsuitable or unsafe.

3.2.11 The drug-misusing parent may be driven to committing crimes or resorting to prostitution to finance their habit, with the result that the child is left alone, or alternatively taken to places which are unsuitable or unsafe, or ultimately separation from their child by a prison sentence.

3.2.12 Parental drug misuse may lead to the disruption of relationships with the extended family, and as a result, make it less available to the child as a protective factor.

3.2.13 Drug misuse may lead to parents being careless about the safe storage of their methadone/other drugs, needles and syringes.

3.3 Effect on Parenting (alcohol)

3.3.1 Parental alcohol use may lead parents to neglect their own needs and those of their children.

3.3.2 Drinking may lead parents to lack awareness of their surroundings and even loss of consciousness, increasing the risk to children's health and safety.

3.3.3 Problem drinking can result in a parent being emotionally unavailable, inconsistent and unpredictable: swinging from 'caring, loving and entertaining to violent, argumentative, and withdrawn'. This may cause parents to behave in a way that frightens their children.

3.3.4 Children's attachments to their parents may be disrupted as parent's problem drinking can lead to them to be impassive, angry and critical of their children. Also, if a parent's attachment is primarily to alcohol this can result in children feeling loss and abandonment.

3.3.5 Parental alcohol misuse can make it harder for parents to manage their lives, which can lead to inconsistent and ineffective parenting.

3.4 Expectations on practice for Adult Treatment Services

3.4.1 Adult treatment services will routinely screen clients for childcare responsibilities at the triage/comprehensive assessment stage and as an ongoing process throughout their treatment journey and monitored by service managers via supervision.

3.4.2 Where a drug/alcohol using client has responsibility for the care of child(ren), the appropriate risk assessment should have been undertaken and indicated the level of intervention required. Local guidance on the use of the Common Assessment Framework (Pre-CAF and CAF) should be followed which may result in a referral to Children's Services. Should the level of risk/harm not meet the threshold for referral to children's social care services it may nevertheless be required to develop some level of intervention. Resulting actions identified must be recorded within the Risk Assessment Plan. A locally recognised *Capacity to Parent* tool may helpful when making decisions.

3.5 Expectations on practice for Children's Services

3.5.1 When a referral is accepted by Children's Services an assessment will be undertaken. Where information gathered indicates the potential risk of significant harm to the child, child protection procedures must be initiated and the assessment conducted in accordance with these procedures.

3.5.2 Where Children's Services are involved with a family where the parent or person with significant caring responsibility for children appears to be using drugs or alcohol in a way which may affect their parenting, the practitioner should discuss with the parent whether they are receiving any support from any other service relating to their drugs/alcohol use, and whether they will consent to have information shared with other practitioners. The benefits to the family of sharing information should be explained.

3.5.3 If there are concerns relating to the parent's needs, and no other services are involved, the parent's GP should be contacted, by the Children's services practitioner, in the first instance for his/her view of the family situation. Whether a referral for primary or secondary substance misuse services is required should be discussed. This is particularly important where there is an unborn or very young child. Where nursing or midwifery services are being used, they should also be involved.

3.5.4 If the parent is receiving support from substance misuse services, the Children's Services practitioner should contact the person involved, and use their expertise and experience to help assess, or review, the parent's current and potential capacity to meet the child's needs, taking into account the support received from the mental health practitioner.

3.5.5 The referral pathway to Children's Services will vary between authorities, each agency should ensure that they are familiar with their local authority's process.

3.5.6 **NB This protocol is relevant as long as concerns about the parent's capacity to meet the needs of the child/children are at a level where the child is not suffering harm. If the concerns are about neglect, or harm, whether emotional, physical or sexual, to the child, the Local Safeguarding Children Board child protection procedures should be followed without delay.**

3.5.7 When a referral is accepted by Children's Services and an assessment undertaken, the assessment should be planned jointly with other involved professionals, unless the concerns are so urgent that immediate action needs to be taken by the Children's Services social worker to ensure the child's safety. In this case the substance misuse practitioner should be fully informed and be part of the child protection strategy planning.

3.6 Expectations on practice for partnership working

3.6.1 **Effective joint working** is essential to safeguarding and promoting the welfare of children, and in particular protecting them from significant harm.

3.6.2 **Sharing information** is essential to enable early identification to help children young people and families who need additional services to achieve positive outcomes. (See *What to do if you're worried a child is being abused* 2006)

3.6.3 **Joint working** should be conducted within the boundaries of confidentiality, however the emphasis should be on working collaboratively with parents and other professionals to maximize the care of children and protect them from harm or risk from harm. The duty of confidentiality to parents is not absolute.

3.6.4 The National Service Framework (DoH 2004) recognises that many children have contact with a variety of professionals. If during an assessment, concerns arise that may require support from another agency, it is important for the professionals involved to work in partnership and to share relevant information as required in accordance with confidentiality obligations. (*Working Together to Safeguard Children* 2006. para 2.81).

3.6.5 **Close collaboration and liaison** between drugs and alcohol services and children's services are essential in the interests of children. This may require sharing information to safeguard and promote the welfare of children or to protect a child from significant harm. Systems should be in place to ensure that

- Managers working with adults can monitor those cases which involve dependent children.
- There is regular, formal and recorded consideration of such cases with Children's Services (Social Care) staff.
- If Adult and Children's Services are providing services to a family, staff communicate and agree interventions.

3.6.6 To safeguard children of parents with whom they are working, drug and alcohol practitioners should routinely record details of parents' responsibilities in relation to children and consider the support needs of parents and of their children in all aspects of their work. (*Working Together to Safeguard Children* 2006 paras 2.93-4)

3.6.7 As part of the assessment process, drug and alcohol practitioners will offer professional assessments on the impact of the substance misuse problem upon the parenting capacity of the person/s involved and childcare practitioners will offer professional assessments on the child. This information will assist in the construction of a plan that ensures the child/ren's safety, whilst also taking into consideration the needs of the parent/carer.

3.6.8 Substance misuse practitioners will input into the decision making process of professional meetings and child protection conferences. Practitioners attend to offer professional assessments and not as advocates of the parent.

3.6.9 It is not possible to give guidance to cover every circumstance in which sharing of information without consent will be justified. Practitioners must make a judgment on the facts of each case. Where there is clear risk of significant harm to the child, or serious harm to the adult, the public interest test will almost certainly be satisfied. However, there will be other cases where practitioners will be justified in sharing some confidential information in order to make decisions on sharing further information or taking action; the information shared should be proportionate. (*What to do if you're worried a child is being abused* 2006.para 3.11)

3.6.10 **See Appendix 3 for an example of a Joint Working Protocol Pathway**

3.7 Implications of parental drug misuse

3.7.1 Any failure of drug misusing parents to meet a child's basic needs will have an impact on all aspects of that child's health, growth and development, resulting in a failure to thrive.

3.7.2 The worker must also be aware of the possibility that the parents may be feeding the child substances on a regular basis.

3.7.3 **See Appendices 4a – 4b for the Summary of Potential Impact of Parental Drug use on Developmental Stages and Appendix 6a - 6b Summary of Protective Factors in relation to Parental Substance Misuse**

3.8 Implications of parental alcohol misuse

3.8.1 Alcohol misuse may have significant adverse effects on parenting including inconsistency, emotional detachment and neglect. Family life can become characterized by chaos and lack of routine, and in some cases unpredictable behaviour associated with mental health needs and violence. Many parents struggle to meet their children's basic care needs or provide adequate emotional support, and children may have to rely on their own coping strategies or resilience or the support of others to get by.

3.8.2 **See Appendices 5 for Summary of Potential Impact of Parental Alcohol use on Development Stages and Appendix 6a- 6b Summary of Protective Factors in relation to Parental Substance Misuse**

3.9 Pregnant women who misuse drugs and alcohol

3.9.1 This protocol is intended to reflect a clear and consistent policy for those working with pregnant women and their partners who use substances, with a view to encouraging their co-operation with the relevant agencies. The overall objective is to ensure the physical well being of both the mother and child, and enable the baby to be safely discharged from the hospital to the care of the mother/partner wherever possible.
The pre – discharge meeting should include an assessment of the partner and consideration should be given to the resources needed to support the family following hospital discharge.

3.9.2 The pregnant women, and or her partner who are substance user/misusers are likely to feel guilty about the harm they may be causing to the baby, and fearful of the judgment of others. As soon as any agency comes into contact with a pregnant woman or a partner who is misusing substances, they should offer reassurance that all agencies will work with the family to enable them to care for the baby, and that the baby will not automatically be removed or become the subject of a Child Protection Conference because of substance misuse. Where available, a written guide to the policy should be provided and explained to women and their partners. It is important that policies and expectations should be as explicit as possible.

3.9.3 The woman's consent is not required in order to share information within a single agency, i.e. health professionals need to be able to liaise with each other in order to deliver a client needs led service. The same applies to children services teams. Where teams are integrated across agencies this will aid timely and effective information sharing across professional groups.

3.9.4 Ongoing use of substances through pregnancy is particularly damaging in the second trimester of pregnancy (14 - 26 weeks), especially if using 'street drugs' which maybe impure and mixed with various substances.

3.9.5 Failure to address the issues early in pregnancy will not encourage attendance at antenatal appointments, engagement with substance misusing services, or modification of lifestyle.

3.9.6 Clear plans will be made from agency meetings in respect of the expectations of the parents to engage with and attend appropriate services.

3.9.7 Planning will enable early involvement and monitoring and should prevent a reactive service occurring late in pregnancy.

3.10 Dual Diagnosis

3.10.1 Many substance misusing parents suffer from mental health needs. It is important, therefore, to maintain effective links between the agencies involved. (*Pathway to care for individuals with substance misuse and mental health needs are indicated in local guidance.)*

3.11 Substance Misusing Offenders

3.11.1 In August 2007, the Home office Drug Interventions Programme (DIP) published *"Around Arrest, Beyond Release"* which explored the experiences and needs of families (including children) of drug misusing offenders, particularly at arrest and on release. Some of the suggestions for future practice which practitioners might wish to explore and may help further safeguard these children include:

- Establishing prior to a planned raid on a domestic property whether children are likely to be present and if so ensuring attendance of a child or family welfare professional when possible. Children should also be able to have supervised access to a familiar carer during searches on domestic properties.

- Following their arrest, there should be prompt identification of those arrestees who have caring responsibilities for children so that alternative care arrangements can be made.

- Assessment of family circumstances, including any immediate needs for children, both at arrest and prior to release of drug misusing offenders.

- The need for all family members (including children and young people) to receive support in their own right.

3.12 Service Contact Details (Drugs and alcohol)

Please use the following links to find the latest information on service contact details

Dorset	*Tel: 01305 224100*
	http://www.dorsetforyou.com/drugsandalcohol
Poole	*Tel: 01202 633635*
	http://www.poole.gov.uk/adult_social_services_commissioning/services/ref:S46487D4332C83/aka:Drug+Action+Team/
Bournemouth	*Tel: 01202 458705*
	http://www.bournemouth.gov.uk/daat/

4. Part Four: Appendices

Appendix 1 - Practice Guidelines

The Royal College of Psychiatrist (2002) suggest the following practice guidelines:

Some factors that need to be considered in assessing if there is a risk to children where a parent has mental health needs are:

- the impact of the illness on the adult (being a parent and having a mental illness), especially chronic severe illness with co-morbid disorders, such as episodes of mental illness complicated by substance misuse or the presence of a personality disorder.
- poor compliance with treatment, problematic relationships with professionals and diagnostic uncertainty.
- parental personality factors (pre-existing and/or exacerbated by the illness, e.g. irritability, hostility, inability to cope, self-preoccupation, etc).
- a history of overdose and self-harm (prior to and especially since having children), especially when there has been more than one such action.
- a parent's own experience of severe childhood trauma and adversity, including discontinuities in carers and experience of abuse and being 'looked after' (in care).
- a history of violence (as a perpetrator or a victim) with unstable, discordant parental relationships.
- environmental stressors outweighing support and protective factors – for example, poor quality support and social isolation in association with multiple adversities such as discrimination (on grounds of gender, ethnic minority status and mental illness), material deprivation and poverty.
- parents with a learning disability.

Children who adapt well to a parent's mental illness will typically exhibit at least some of the following:

- older age at the time of the onset of their parent's illness (because of reduced opportunities for exposure to difficulties and development of a greater range of potential coping resources).
- being more sociable and able to form positive relationships (having an easier temperament).
- greater intelligence.
- a parent who has discrete episodes of mental illness with a good return of skills and abilities between episodes.
- alternative support from adults with whom the child has a positive, trusting relationship
- success outside of the home (e.g. at school, in sport).

Royal College of Psychiatrists (2002) *Patients as Parents: Addressing the needs, including the safety of children whose parents have mental illness.* London: Royal College of Psychiatrist CR 105.

Appendix 2

Summary of Potential Impact on a Child of primary and secondary behaviours associated with parental psychiatric disorder

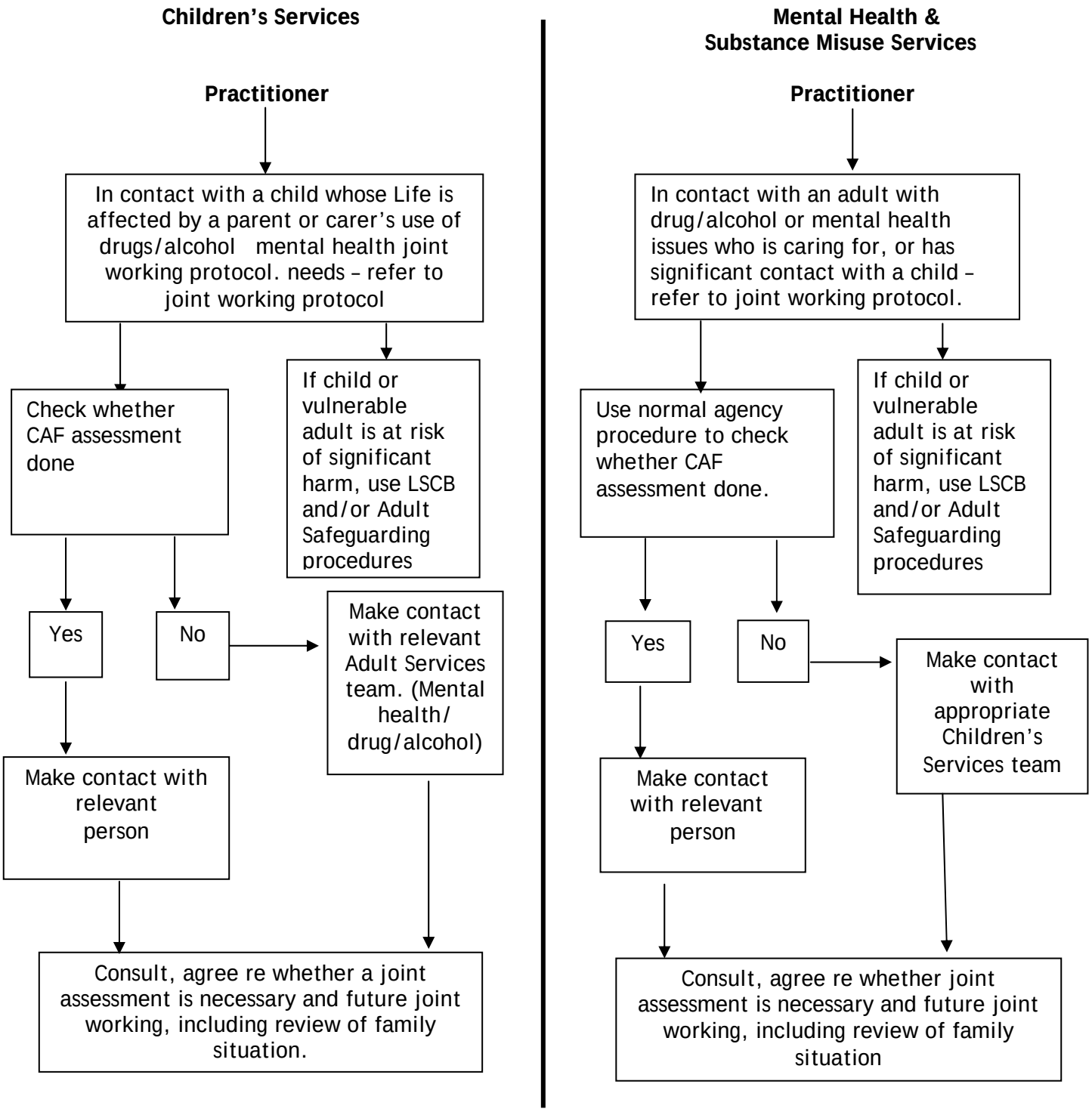
PARENTAL BEHAVIOUR	POTENTIAL IMPACT ON CHILD (in addition to attachment problems)
Self pre-occupation	Neglected
Emotional unavailability	Depressed, anxious, neglected
Practical unavailability	Out of control, self-reliant, neglected, exposed to danger
Frequent separations	Anxious, perplexed, angry, neglected
Threats of abandonment	Anxious, inhibited, self-blame
Unpredictable/chaotic planning	Anxious, inhibited, neglected
Irritability/over-reactions	Inhibited, physically abused
Distorted expressions of	Anxious, confused reality
Strange behaviour/beliefs	Embroiled in behaviour, shame, perplexed, physically abused
Dependency	Caretaker role
Pessimism/blames self	Caretaker role, depressed, low self esteem
Blames child	Emotionally abused, physically abused, guilt
Unsuccessful limit-setting	Behaviour problem
Marital discord and hostility	Behaviour problem , anxiety, self-blame
Social deterioration	Neglect, shame

Source: Reder, P., McClure, M. & Jolley, A. (2000) *Family Interfaces Between Child Matters and Adult Mental Health*

Appendix 3

JOINT WORKING PROTOCOL

Safeguarding children whose parents/carers use drugs/alcohol



Appendix 4a Summary of Potential Impact of Parental Drug Misuse

Age (years)	Health	Education and Cognitive Ability	Relationships and Identity	Emotional and Behavioural Development
0 – 2	Substance misuse during pregnancy may result in symptoms of withdrawal	Cognitive development of the infant may be delayed through parents' inconsistent, under-stimulating and neglectful behaviour.	Care of children by different strangers at different times can lead to insecure attachments and safeguarding concerns.	A lack of commitment and increased unhappiness, tension and irritability in parents may result in inappropriate responses and emotional insecurity in the child.
3 – 4	Children may be placed in physical danger by excessive parental drug misuse, *and by the presence of drugs in the home.* Children's physical needs may be neglected.	Lack of stimulation. Nursery or pre-school attendance may be irregular.	Children may take on responsibilities beyond their years because of parental incapacity.	Children may be at risk because they are unable to tell anyone of their distress.
5 – 9	School medicals and dental appointments missed. Psychosomatic symptoms e.g. sleep problems, bedwetting	Academic attainments may be negatively affected and children's behaviour in school may become problematic.	Children may develop poor self-esteem, and may blame themselves for their parents' problems. Because they feel shame and embarrassment over their parents' behaviour, children may curtail friendships and social interactions.	Conduct disorders with boys e.g. hyperactivity, inattention. Depression and anxiety in girls Children may be in denial of their own needs and feelings

Appendix 4b Summary of Potential Impact of Parental Drug Misuse - *continued*

Age (years)	Health	Education and Cognitive Ability	Relationships and Identity	Emotional and Behavioural Development
10 – 14	Little or no support during puberty because of parental emotional withdrawal. Early experimentation with substances more likely.	Continued poor academic performance due to caring for siblings or parents. Higher risk of school Exclusion.	Restricted friendships. Poor self image and low self esteem.	Children are at increased risk of emotional disturbance and conduct disorders, including bullying. They are also at risk of becoming drug misusers themselves.
15 +	Increased risk of problem substance misuse. Risk of pregnancy, STIs and failed relationships.	Poor life chances due to poor school attainment or exclusion because of behavioural problems.	Lack of appropriate role Models.	Emotional problems may result from self-blame and guilt, and lead to increased risk of suicidal behaviour and vulnerability to crime.

Appendix 5a Summary of Potential Impact of Parental Alcohol Misuse

Age (years)	Health	Education and Cognitive Ability	Relationships and Identity	Emotional and Behavioural Development
0 – 2	Health risks to children include direct physical harm, including risk of serious injury or death by overlaying parents failing to ensure that the environment is safe and harm caused by impaired physical concentration, can lead to problems completing breastfeeding or nappy changing.	Possible delay in cognitive development due to lack of appropriate and consistent stimulation.	Attachments to parents may be problematic or insecure because of inconsistent and chaotic behaviour and emotional withdrawal. Children can feel loss and abandonment if drinking behaviour is placed above child's needs.	Infants may have unsuitable clothing and poor hygiene. Indifference and despair that can accompany problem drinking can mean parents do not respond to or reassure their child in appropriate and positive manner – may lead to child to believe they are unloved and unlovable.
3 – 4	When a parent is intoxicated the ability to care for children can decline, and children can be a t risk from both direct physical harm and neglect. Children may be left home alone or with unsuitable carers if parents place their drinking behaviour above child's needs.	Child may have cognitive deficit due to insufficient emotional stimulation and interaction. Nursery or preschool attendance may be irregular since problem drinking often results in parents being disorganised or inactive.	Children commonly blame themselves for family's problems and attempt to put things right in vain attempt to make their environment better able to support them.	Children may be more at risk of emotional disturbance as they cannot easily articulate emotions. The level of this disturbance may be missed as child's behaviour does not always reflect their mental state.

Appendix 5b Summary of Potential Impact of Parental Alcohol Misuse - *continued*

Age (years)	Health	Education and Cognitive Ability	Relationships and Identity	Emotional and Behavioural Development
5 – 9	Children may experience head and stomach aches, allergies, sleeping problems and bed-wetting	Academic performance may be negatively affected with school attendance, punctuality, preparation and concentration also potentially affected. In contrast, some children may immerse themselves in their studies and attain well.	Children may suffer from low self-esteem and feel that they are not in control of events in their life. They may find it harder to see themselves as an individual separate to the family problems.	Girls may internalise the depression, fear, anxiety and stress caused by their parent's inconsistent and chaotic behaviour, by withdrawing into make-believe. Boys may externalise the distress, resulting in conduct problems, hyperactivity and lack of concentration
10 – 14	Children may receive no support through puberty because of parental emotional withdrawal. They may have difficulty in developing healthy and balanced attitudes to alcohol as a result of parental alcohol use – experimentation with alcohol and other drugs may be more likely	Academic performance may be negatively affected due to children's concern about parental problem drinking, which can lead to children staying at home to care for family.	If parents' lives revolve around drinking, children may develop low self-esteem and blame themselves for the drinking. If income is directed primarily at parents' drinking, children may find it hard to maintain an acceptable appearance, causing them to be highly self-conscious, and may lose friendships as a result.	Children may externalize the distress caused by parental drinking problems, resulting in conduct problems. These ways of externalizing/ internalising difficult feelings can lead to children being labelled or identified as ' the problem' by their families and others.

Appendix 5c Summary of Potential Impact of Parental Alcohol Misuse - *continued*

Age (years)	Health	Education and Cognitive Ability	Relationships and Identity	Emotional and Behavioural Development
15 +	Can lead to teenagers to drinking extremes, either mirroring their parents' problem drinking or abstaining. Risk of pregnancy, STIs and failed relationships are higher if parents, who may be emotionally withdrawn, do not discuss these issues with teenagers.	Caring responsibilities can impact negatively on a teenager's education, and their future employability. If excluded from school, parents may be incapable of getting children back into school or supporting their continued learning.	If parents' behaviour is inconsistent and chaotic, children may have low self esteem, feel rejected, isolated, unable to control events in their life.	Teenagers may show extremes of behaviour that are beyond parental control. Adolescents may resort to stealing when income is spent on parental drinking, and this criminal and antisocial behaviour may bring them into contact with the Criminal Justice System.

Appendix 6a Summary of Protective Factors in relation to Parental Substance Misuse

Age (years)	Health	Education and Cognitive Ability	Relationships and Identity	Emotional and Behavioural Development
0 – 5	Good regular ante-natal care Support for the expectant mother of at least one caring adult. Medicines and illicit drugs are safely stored. Sufficient income and good physical living standards.	Regular supportive help from primary health care team and Children & Families.	The presence of a caring adult who responds appropriately to the child's needs.	The presence of a caring adult who responds appropriately to the child's needs.
6 – 9	Attendance at school Medicals.	Regular attendance at school. Sympathetic, empathetic and vigilant teachers.	A supportive older sibling. Children who have at least one mutual friend have higher self-worth and are less lonely than those without. Social networks outside the family, especially with a sympathetic adult of the same sex. Belonging to organised out of school activities Being taught different ways of coping and knowing what to do when parents are Incapacitated.	The presence of an alternative, consistent, caring adult who responds appropriately to the child's cognitive and emotional needs.

Appendix 6b Summary of Protective Factors in relation to Parental Substance Misuse - *continued*

Age (years)	Health	Education and Cognitive Ability	Relationships and Identity	Emotional and Behavioural Development
10 – 15 +	Factual information about puberty, sex and contraception.	Regular school attendance. Sympathetic, empathetic and vigilant teachers. A champion who acts vigorously on behalf of the child. For those longer in school, a job.	A mentor or trusted adult to whom the child can discuss sensitive issues. Practical and domestic help.	A mutual friend. Unstigmatised support of relevant professionals. The ability to separate themselves either psychologically or physically from stressful family situations.

Appendix 7 GLOSSARY DESCRIPTIONS AND CATEGORIES OF COMMON MENTAL DISORDERS

It should be noted that categories and descriptions of mental disorders vary across time and within different cultures. The important point is how the symptoms impinge on the life of the individual as a parent in terms of their parenting capacity and the impact the symptoms have on their children.

Quick reference	Page
Anorexia nervosa	42
Anxiety	41
Asperger's Syndrome	42
Bipolar affective disorder	38
Bulimia Nervosa	42
Delerium Tremens:	43
Depression in the Postnatal Period	40
Drug Induced Psychosis	44
Eating disorders	41
Obsessive-compulsive disorder	41
Personality Disorder: Emotionally Unstable	42
Phobias	41
The Postnatal Period up to 1 year	40
Prodrome	44
Puerperal Psychosis	40-1
Schizoaffective Disorder	39
Schizophrenia	38
Substance Dependence	43
Substance Misuse	43
Unipolar Depression (commonly known as 'clinical depression')	39

DEFINITIONS

Schizophrenia

Schizophrenia affects one person in a 100. It is a debilitating and enduring disorder but can often be effectively controlled with medication. The individual may describe:

- Distorted thinking and perception which can lead to behavior that is chaotic or out of character;
- intimate thoughts, feelings and acts are felt to be shared by others.
- hallucinations: Seeing, hearing, feeling or smelling something that doesn't exist;
- delusions which are false beliefs: for example believing they are famous, someone is controlling their thoughts, they have special powers, they are being followed by secret agents;
- thought disorder where thoughts don't link up correctly and the speech as a consequence is muddled and often difficult to comprehend;
- loss of feelings or emotions so the individual presents in a flat detached way;
- loss of energy and interest so the individual presents as unmotivated or lazy.

Bipolar affective disorder

Bipolar disorder is characterized by significant mood swings lasting usually weeks or months. Often a period of mania is followed by depression prior to the mood state normalising. It is an enduring disorder but can be controlled by medication. During manic episodes, a person will:

- Sleep very little;
- have all sorts of new ideas and plans;
- their activity level will dramatically increase;
- they may loose touch with reality and experience grandiose false beliefs and even hallucinations;
- they may become disinhibited putting themselves at risk;
- they may spend excessively or give away money resulting in large debts;
- they may overindulge in alcohol, smoke excessively and use illicit substances;
- they frequently come to the attention of the police creating a public disturbance or driving too fast.

During a depressive phase a person will experience many of the following:

- Low mood which may fluctuate;
- a sense of hopelessness and despair which can lead to thoughts and plans of suicide;
- loss of energy and concentration;
- a desire to withdraw from people leading to isolation;
- a lack of motivation which may impede everyday activities such as eating, sleeping and generally looking after themselves and their families;
- feelings of low self esteem and vulnerability.

Schizoaffective Disorder
An individual is diagnosed with schizoaffective disorder when schizophrenic symptoms present in combination with marked mood swings. It is not always easy to differentiate between schizophrenia, bipolar affective disorder and schizoaffective disorder. Treatment of schizoaffective disorder usually consists of antipsychotic and mood stabilizing medication.

Unipolar Depression (commonly known as 'clinical depression')
Unipolar depression although sharing similarities to bipolar depression is a separate disorder that can be effectively treated with a combination of antidepressant medication and psychological interventions.
Typically an individual will present with:

- Sleep disturbance and early morning wakening;
- low mood often associated with anxiety and frequently worse in the mornings.
- Loss of appetite with marked weight loss; occasionally the opposite is seen with comfort eating and weight gain;
- poor concentration;
- repetitive depressive thoughts or worries;
- low self esteem;
- inappropriate feelings of guilt and self blame.

As the depression deepens individuals become increasingly withdrawn and hopeless.
Their thinking becomes delusional. They may experience suicidal ideation and start to make plans to kill themselves.

The Postnatal Period up to 1 year
At least 10% of all women following the birth of their baby will be become mentally ill during the first year. Illnesses range in severity from puerperal psychosis to all degrees of postnatal depression.

Depression in the Postnatal Period
Can be mild, moderate or severe with or without biological symptoms and can be combined with prominent symptoms of anxiety, panic and obsessional phenomena. At the most severe end it can merge with puerperal psychosis:

- The majority of cases present 8- 12 weeks after delivery: the most severe cases tend to present earlier at 4-6 weeks;
- Severe depressive illness with biological features affects at least 3% of all delivered women;
- Women with a previous history of severe postnatal depressive illness or severe depression at other times or a family history of the condition are at increased risk of relapse;
- Post natal and other depressive illnesses adversely affect family structure and functioning leading to unwanted divorce or separation. (Cox 1999 – Weir & Douglas 'Child Protection & Adult Mental Health' (1999) Butterworth Heinemann.)

Puerperal Psychosis
The most severe form of postpartum disorder:

- Leads to 2 per 1000 women being admitted to a psychiatric hospital following childbirth, mostly in the first few weeks
- Most women will have been previously well
- Risk factors emerging consistently from the literature are a past psychiatric history, poor social support, a first baby and to a lesser extent a previous stillbirth
- Its onset is early and acute, frequently presenting in the first 14 days post delivery. Rarely within 48 hours of delivery most commonly suddenly between days 3 and 7
- The earliest signs tend to be perplexity, fear or terror and restless agitation associated with insomnia. Other signs include purposeless activity, uncharacteristic behaviour, disinhibition, irritation, fleeting anger and resistive behaviour
- Presentation is variable throughout the day with elation, grandiosity, suspiciousness, paranoia, depression and unspeakable ideas of horror
- Concentration is grossly impaired and the mother's ability to care for her own basic needs and those of her baby are usually grossly impaired

Anxiety
Pathological anxiety is constant and unrealistic worry about daily life. It can affect the person's ability to concentrate, leading to restlessness and disturbed sleep patterns. It may also give rise to physical symptoms such as rapid heartbeat, digestive upsets, tensions in muscles giving rise to aches and pains. Psychological interventions are first line treatment for this disorder.

Phobias
A phobia is an unreasonable fear of a situation or object. It can cause disruption to a person's life if it imposes restrictions on the way they live. For example agoraphobia, a fear of going out into open spaces can result in a person becoming isolated in their own home unable to work, shop or socialize. Alternatively claustrophobia, a fear of enclosed spaces can affect activities such as shopping, or going to the cinema or anywhere that is crowded. Other phobias include fear of animals, heights or flying.

Obsessive-compulsive disorder
Obsessive-compulsive disorder (OCD) is characterized by the presence of obsessions or compulsions, but commonly both.

- Often the people affected have tended to be perfectionists but it can be triggered by major life events or start during a period of depression
- Frequently the disorder starts at an early age, 92% develop OCD before the age of 40 years some in childhood
- On average it takes people 12 years to ask for help
- 11% of all people have OC symptoms and about 2 % develop OCD sometime in their lives

OCD causes marked distress, consumes time and interferes with ones daily routine, ability to work, relationships and family life.

Eating disorders
Eating disorders are characterized by an extreme preoccupation with food or calories and bodyweight and shape. The person with an eating disorder often has a distorted body image, believing they are overweight when they are extremely underweight. They may also have rituals around food and its preparation and have difficulty eating in the company of others.
There are two main types of eating disorder; anorexia nervosa and bulimia nervosa.

Anorexia nervosa
In anorexia nervosa the person restricts their eating and loses weight. The restriction is often accompanied by a sense of triumph over being in control and able to manage without food. In reality the control quickly gives way to an overriding fear of food. Restriction of food intake gives rise to physical symptoms, for example cold extremities and weakness. In women periods cease and, in extreme cases, the starvation can be life threatening. People with anorexia may also exercise compulsively as a means of controlling shape and weight.

Bulimia Nervosa

In bulimia nervosa, while still preoccupied by food and body weight and shape, the person has episodes of overeating when they will feel out of control. These are referred to as binges; in extreme cases the sufferer may eat anything and everything they can get their hands on. A binge may be followed by vomiting, taking laxatives or occasionally diuretics as a means of getting rid of the calories. As in anorexia, they may also exercise compulsively. Binges can alternate with periods of restricting food intake. Often there is denial of symptoms and body weight may be in the normal range.

The aetiology is complex for both disorders. In some individuals it will relate to poor or frankly abusive parenting of the individual. In others there may have been a past history of unsuccessful dieting for weight problems. Psychological therapies are the mainstay of treatment for mild to moderate disorders. At the more severe end of the spectrum admission to specialised units with structured re-feeding is required.

Asperger's Syndrome

This condition occurs predominantly in men of normal intelligence. It is a developmental disorder. There is poor appreciation of socio-emotional cues leading to odd social behaviors that can be construed as cold or rude.

Routines tend to be ritualistic, for instance meals tend to be of certain foods which have to be set out on the plate in specific patterns. Interests are frequently novel and pursued for a prolonged period in an obsessional way, for instance collecting rucksacks and solving mathematical puzzles.

Personality Disorder: Emotionally Unstable

- Typically the individual has had a deprived and abusive childhood
- Personality disorders are diagnosed from late adolescence
- Mood is dysregulated sometimes swinging violently from hour to hour
- Behavior is impulsive and may be risky
- When prevented from behaving impulsively in ways that puts them or others at risk, often they respond by becoming violent and aggressive
- There is a tendency to become involved in unstable relationships which lead to emotional crises
- There is a tendency towards repeated episodes of self harm by overdoses or cutting, sometimes leading to suicide
- Frequently behaviors are exacerbated by the use of alcohol and illicit substances

Substance Misuse

This is a term which refers to the harmful use of any substance, such as alcohol, a street drug, a prescribed drug or over the counter medication resulting in any or all of the following:

- Excessive use;
- Repeated use;
- A harmful effect on the persons life;
- inability to fulfil life responsibilities

Increased usage results in

Substance Dependence which is characterised by:

- Craving
- Loss of control of use of the substance
- Physical dependence with the need to keep repeating the dose to avoid withdrawal symptoms
- Increasing tolerance and the need for more of the substance to feel its effect
- Social, criminal justice and professional consequences.

Delerium Tremens:

- Withdrawal state from alcohol complicated by delirium
- Can be life threatening
- Short lived

Prodrome:

- Insomnia, tremor and fear

Followed by:

- Clouding of consciousness
- Confusion
- Vivid hallucinations and illusions in any sensory modality
- Tremor
- Insomnia
- Agitation
- Autonomic over activity

Drug Induced Psychosis:

A cluster of psychotic phenomena that occur during or immediately after illicit substance misuse, characterised by:

- Vivid hallucinations often auditory
- Misidentifications
- Delusions and/or ideas of reference often paranoid or persecutory
- Abnormal affect ranging from fear to ecstasy
- Often mild confusion
- Usually resolves within a month

Bournemouth & Poole Local Safeguarding Children Board

Dorset Safeguarding Children Board

PAN DORSET INTER-AGENCY SAFEGUARDING PROCEDURES

CHAPTER 3

3.9 MANAGING ALLEGATIONS AGAINST PEOPLE WHO WORK WITH CHILDREN

Procedures Effective from: **2006**

Review Date: **December 2010**

If you have any comments or queries about the pan-Dorset procedures please contact your agency representative on the Pan Dorset Policy and Procedures Group or notify the LSCB using the following email addresses:

info@dorsetlscb.co.uk
info@bournemouth-poole-lscb.org.uk

Managing allegations against people who work with children

CONTENTS

Section	Title	Page
1.	Introduction	2
2.	Scope	2
3.	Roles & responsibilities	3
4.	Initial action by person receiving or identifying an allegation or concern	4
5.	Initial action by the designated senior manager	5
6.	Initial considerations by the senior manager and the Local Authority Designated Officer (LADO)	6
7.	Strategy/Initial Evaluation discussion/meeting and Post Allegation Investigation Meeting	7
8.	Confidentiality considerations	11
9.	Allegations against staff in their personal life	12
10.	Disciplinary Process	12
11.	Sharing information for disciplinary purposes	14
12.	Record keeping	14
13.	Unsubstantiated, unfounded and malicious allegations	15
14.	Procedures in specific organisations	15
15.	Support	15
16.	Suspension	16
17.	Resignations and 'compromise agreements'	16
18.	Organised and historical abuse	17
19.	Whistle-blowing	17
20.	Timescales	17
Appendix 1	Contact details for LADOs	19

1. Introduction

1.1 The Bichard enquiry identified a number of recommendations designed to help ensure that those who come into contact with children through their work are safe and appropriate.

1.2 Despite all efforts to recruit safely and to ensure people who work with children do so in a way that safeguards and promotes their welfare, there will still be occasions when allegations of abuse or concerns about individuals are raised.

1.3 This procedure is provided to give guidance on managing allegations against people who work with children, and should be seen as part of a raft of measures to safeguard children which include robust recruitment policies; staff codes of practice and the creation of safer activities and environments.

2. Scope

2.1 These procedures apply to a wider range of allegations than those in which there is reasonable cause to believe a child is suffering, or likely to suffer, significant harm. They also apply in cases where allegations indicate someone is unsuitable to continue to work or volunteer with children in his/her present position, or in any capacity. These procedures should be used when there is an allegation or concern that any person who works with children, in connection with his/her employment or voluntary activity, has:

- behaved in a way that has harmed a child, or may have harmed a child;
- possibly committed a criminal offence against or related to a child; or
- behaved towards a child or children in a way that indicates s/he is unsuitable to work with children.

2.2 These behaviours should be considered within the context of the four categories of abuse (i.e. physical, sexual and emotional abuse and neglect). These include concerns relating to inappropriate relationships between members of staff and children or young people, e.g.:

- Having a sexual relationship with a child under 18 if in a position of trust in respect of that child, even if consensual[1];
- 'Grooming'[2] (i.e. meeting a child under 16 with intent to commit a relevant offence);
- Other 'grooming' behaviour giving rise to concerns of a broader child protection nature (e.g. inappropriate text / e-mail messages or images, gifts, socializing etc);
- Possession of indecent photographs / pseudo-photographs of children.

[1] Sections 16-19 Sexual Offences Act 2003
[2] Section 15 Sexual Offences Act 2003

2.3 In addition, these procedures apply to an individual who works with children but the allegation or concern arises in his/her personal life which indicates he/she may be unsuitable to work in their present position, or any capacity. (For example when a person assaults his/her own child). Similarly, the allegation might relate to the spouse or partner of the person who works with children, whose response or attitude to this suggests that his/her ability to fulfil his/her work role might be compromised. (See Para 9)

3. Roles and responsibilities

3.1 Each LSCB member organisation should identify a named senior officer with overall responsibility for:

- ensuring that the organisation deals with allegations in accordance with these procedures;
- resolving any inter-agency issues;
- liaising with the appropriate LSCB on the subject.

3.2 Bournemouth, Dorset and Poole local authorities each have designated officer(s) (LADO) to:

- be involved in the management and oversight of individual cases which meet the threshold set out at 2.1;
- provide advice and guidance to employers and voluntary organisations;
- liaise with the police and other agencies;
- monitor the progress of cases to ensure that they are dealt with as quickly as possible, consistent with a thorough and fair process.

In Bournemouth the LADO role is fulfilled by the Principal Education Welfare Officer and the Service Manager for Quality Assurance and Children's Review.

In Dorset the LADO role is undertaken by a number of Children's Services Staff. Any contacts with the LADO should therefore be made via the Children's Services Safeguarding Unit who will identify the appropriate LADO and ensure urgent contact with the referrer/employer.
In Poole the LADO role is fulfilled by the Safeguarding and Quality Assurance Manager.

Contact details are included in Appendix 1

3.3 All employers should designate:

- a senior manager to whom allegations or concerns should be reported;
- a deputy to whom reports should be made in the absence of the designated senior manager or where that person is the subject of the allegation or concern.

3.4 The Police Detective Chief Inspector will:

- have strategic oversight of the local police arrangements for managing allegations against staff and volunteers;
- liaise with the relevant DSCB on the issue;
- ensure compliance.

3.5 The police also have a designated detective sergeant in each Child Protection Investigation Unit to:

- liaise with the relevant local authority designated officer;
- take part in strategy discussions;
- review the progress of cases in which there is a police investigation;
- share information as appropriate, on completion of an investigation or related prosecution.

4. Initial action by person receiving or identifying an allegation or concern

4.1 An allegation against a member of staff/volunteer may arise from a number of sources (e.g. a report from a child, a concern raised by another adult in the organisation, or a complaint by a parent).

4.2 The person to whom an allegation or concern is first reported should treat the matter seriously and keep an open mind.

4.3 S/he should not:

- Investigate or ask leading questions if seeking clarification;
- Make assumptions or offer alternative explanations;
- Promise confidentiality, but give assurance that the information will only be shared on a 'need to know' basis.

4.4 S/he should:

- Immediately report the matter to the designated senior manager, or deputy in his/her absence, or where the senior manager is the subject of the allegation.
- As soon as possible make a written record of the information (where possible in the child / adult's own words), including the time, date and place of incident(s), persons present and what was said;
- Sign and date the written record;

5. Initial action by the designated senior manager

5.1 When informed of a concern or allegation, the senior manager should not investigate the matter or interview the member of staff, the child concerned or any potential witnesses. He / she should:

- Obtain written details of the concern / allegation, signed and dated by the person receiving (not from the child / adult making the allegation);
- Countersign and date the written details;
- Record any information about times, dates and location of incident(s) and names of any potential witnesses;
- Record discussions about the child and/or member of staff, any decisions made, and the reasons for those decisions.

5.2 If the allegation meets the criteria in paragraph 2.1, the designated senior manager should report it to the Local Authority Designated Officer (LADO) promptly, at least within 1 working day. If there is any doubt regarding whether the allegation meets the criteria, advice should be sought from the LADO. Referral should not be delayed in order to gather information. Any failure to follow procedures is a potential disciplinary matter.

5.3 If an allegation requires immediate attention, but is received outside normal office hours, the senior manager should consult the LA Children's Services emergency duty team (tel: 01202 45800) or local police and inform the LADO as soon as possible.

5.4 If a police officer receives an allegation, s/he should, without delay, report it to the designated detective sergeant on the Child Protection Investigation Unit (CPIU). The detective sergeant should then immediately inform the LADO.

5.5 Similarly, an allegation made to LA Children's Services should be immediately reported to the relevant LADO.

6. Initial considerations by the senior manager and the Local Authority Designated Officer (LADO)

6.1 There are up to three strands in the consideration of an allegation:

- a police investigation of a possible criminal offence;
- enquiries and assessment by Children's Services about whether a child is in need of protection or in need of services;
- consideration by an employer of disciplinary action.

6.2 The LADO and designated senior manager should consider first whether further details are needed and whether there is evidence or information that establishes that the allegation is false or unfounded. Care should be taken to

ensure that the child is not confused as to dates, times, locations or identity of the member of staff.

6.3 If the allegation is not demonstrably false and there is cause to suspect that a child is suffering or is likely to suffer significant harm, the LADO will immediately refer to Children's Services and ask them to convene an immediate *strategy discussion*. Wherever possible this should take the form of a meeting and the LADO and senior manager should normally attend.

6.4 If the threshold for significant harm is not reached, but a criminal offence might have been committed and/or the accused person may have behaved in a way that indicates s/he is unsuitable to work with children, the LADO should immediately inform the police CPIU and convene a similar discussion, an *initial evaluation discussion*, to evaluate the allegation and decide how it should be dealt with including whether a police investigation is needed. That discussion should wherever possible take the form of a meeting, and involve the employer and other agencies involved with the child.

NB. Where a referral has been made to Children's Services and a strategy meeting convened, the initial evaluation meeting will not be held separately. All issues relating to the person who works with children should be addressed within the strategy meeting (see paragraph 7)

6.5 If there is no cause to suspect significant harm is an issue and there is nothing to suggest a criminal offence has been committed but the initial considerations indicate a need for the employer to take some action through their disciplinary procedures, the LADO will check with children's social care and the police (Child Protection Investigation Unit) whether they have any relevant information about the accused person.

6.6 It is anticipated that the LADO and senior manager will be in agreement in respect of action to be taken. If agreement cannot be reached or the senior manager does not follow the LADO's advice, the matter will be referred to the named senior officer who sits on the relevant LSCB for resolution.

7. Strategy/Initial Evaluation discussion/meeting and Post Allegation Investigation Meeting

7.1 Strategy Discussion/meeting

7.1.1 Wherever possible, a strategy discussion should take the form of a meeting. However, on occasions a telephone discussion may be justified. The following is a list of possible participants:

- Children's Services care manager to convene and chair (if a strategy meeting);
- Local Authority Designated Officer;
- Relevant social worker;
- Detective Sergeant from the CPIU (or nominated officer in his/her absence);

- Designated senior manager for the employer concerned;
- Human resources representative, where appropriate;
- Legal adviser where appropriate;
- Senior representative of the employment agency or voluntary organisation if applicable;
- Manager from the fostering service provider when an allegation is made against a foster carer;
- Supervising social worker when an allegation is made against a foster carer;
- Those responsible for regulation and inspection where applicable (e.g. Health Care Commission or Ofsted);
- Consultant paediatrician or designated or named professional as appropriate;
- Where a child is placed or resident in the area of another authority, representative(s) of relevant agencies in that area;
- Complaints officer if the concern has arisen from a complaint.

7.1.2 The strategy discussion should:

- Fulfil the usual tasks of a strategy discussion in relation to protecting individual children (see Inter-agency safeguarding procedures part 1 Ch 2 paragraph 2.71);
- Consider whether any parallel disciplinary process can take place and agree protocols for sharing information;
- Consider the current allegation in the context of any previous allegations or concerns;
- Where appropriate, note any entitlement by staff to use reasonable force to control or restrain children;
- Consider whether a complex abuse investigation is applicable;
- Plan enquiries if needed, allocate tasks and set timescales;
- Decide what information can be shared, with whom and when.

7.1.3 The strategy discussion should also:

- Ensure that arrangements are made to protect the child/ren involved and any other child/ren affected, including taking emergency action where needed; consideration should be given to the needs of any child who was

previously in the care of the adult, or was known to them in their personal lives;

- Consider what support should be provided to all children who may be affected;
- Consider what support should be provided to the member of staff and others who may be affected. This includes consideration of those who may be witnesses to the situation ;
- Ensure that investigations are sufficiently independent;
- Make recommendations where appropriate regarding suspension, or alternatives to suspension;
- Identify a lead contact manager within each agency responsible for coordinating, liaison and feedback;
- Agree protocols for reviewing investigations and monitoring progress by the LADO, having regard to the target timescales (see paragraph 20);
- Consider/plan for media interest;
- Consider risk assessments to inform the employer's safeguarding arrangements;

Agree dates for future discussions/reviews of progress, as appropriate.

7.2 Initial evaluation discussion/meeting

7.2.1 Wherever possible the initial evaluation discussion should take the form of a meeting. However, on occasions a telephone discussion may be justified. The following is a list of possible participants:

- The Local Authority Designated Officer should normally convene and chair the meeting
- Designated senior manager for the employer concerned;
- Human resources representative, where appropriate;
- Legal adviser where appropriate;
- Senior representative of the employment agency or voluntary organisation if applicable;
- Manager from the fostering service provider when an allegation is made against a foster carer;
- Supervising social worker when an allegation is made against a foster carer;
- Those responsible for regulation and inspection where applicable (e.g. Health Care Commission or Ofsted);

- Consultant paediatrician or designated or named professional as appropriate;
- Where a child is placed or resident in the area of another authority, representative(s) of relevant agencies in that area;

- Complaints officer if the concern has arisen from a complaint.

7.2.2 The initial evaluation meeting should:

- Consider the current allegation or concern in the context of any previous allegations or concerns:

- Where appropriate, note any entitlement by staff to use reasonable force to control or restrain children;

- Plan enquiries if needed, allocate tasks and set timescales;

- Decide what information can be shared, with whom and when;

- Ensure that arrangements are made to protect the child/ren involved and any other child/ren affected, including taking emergency action where needed; consideration should be given to the needs of any child who was previously in the care of the adult, or was known to them in their personal lives;

- Consider what support should be provided to all children who may be affected;

- Consider what support should be provided to the member of staff and others who may be affected. This includes consideration of those who may be witnesses to the situation;

- Ensure that investigations are sufficiently independent;

- Make recommendations where appropriate regarding suspension, or alternatives to suspension;

- Identify a lead contact manager within each agency responsible for coordinating, liaison and feedback;

- Agree protocols for reviewing investigations and monitoring progress by the LADO, having regard to the target timescales (see paragraph 20)**;**

- Consider/plan for media interest;

- Consider risk assessments to inform the employer's safeguarding arrangements;

Agree dates for future discussions/meetings as appropriate

7.3 The post allegation investigation meeting

7.4 At the conclusion of the child protection enquiry and/or police enquiry, a further meeting (post allegation investigation meeting should be held to:

- share findings of the investigation;
- outline any further actions required, include completion of the police investigation and any potential media interest;
- decide whether an individual who has been suspended can return to work and if so how s/he can be supported;
- review the circumstances of the case to determine whether any changes/improvements should be made to the employer's (or any other agency's) procedures or practice;
- Consider reports to relevant regulatory body and/or POCA/POVA/List 99 (The independent Safeguarding Authority from autumn 2008.
- Consider whether notification under the "people posing a risk " protocol is required (see inter-agency safeguarding procedures Part 1 Appendix 1

8. Confidentiality Considerations

8.1 In managing allegations against people who work with children, the following general considerations should be taken into account:

- Parents and carers of a child/ren involved should normally be told about the allegation as soon as possible. The decision about how and by whom they should be informed, should be agreed between the senior manager and the LADO. In cases where the Police and/or Children's Services may need to be involved the LADO should first discuss and agree the most appropriate course of action with those colleagues.
- The Senior Manager should, as soon as possible, inform the accused person about the allegation and how enquiries will be conducted after consulting and agreeing this with the LADO. In some cases, the police and/or social care will want to impose restrictions on the information that can be provided. The LADO and/or Senior Manager will need to reach an agreement with those colleagues about the disclosure of any information.
- Every effort should be made to maintain confidentiality and guard against publicity whilst an allegation is being investigated or considered. Apart from keeping the child, parents and accused person up-to-date with the progress of the case, information sharing should be restricted to those who have a need to know in order to;
  - protect children
  - facilitate enquiries
  - manage related disciplinary, capability or suitability processes
- The fact that a person tenders his/her resignation, or ceases to provide services, must not prevent an allegation being followed up in accordance with these procedures and it is important to reach and record a

conclusion. By the same token, "compromise agreements" by which an employer agrees not to pursue disciplinary action, and both parties agree a form of words to be used in any future reference, must not be used in these cases.

- In accordance with ACPO guidance, the police do not normally provide any information to the press that might identify an individual who is under investigation unless and until the person is charged with an offence. In exceptional cases, where the police might depart from that rule (e.g. an appeal to trace a suspect) the reasons should be documented and partner agencies consulted beforehand.

9. Allegations against staff in their personal lives

9.1 If an allegation or concern arises about a member of staff, outside of his / her work with children, and this may present a risk of harm to child/ren for whom the member of staff is responsible, the general principles outlined in these procedures will still apply.

9.2 The strategy /initial evaluation discussion should decide whether the concern justifies:

- Approaching the member of staff's employer for further information, in order to assess the level of risk of harm; and/or

- Inviting the employer to a further strategy discussion about dealing with the possible risk of harm.

9.3 If the member of staff lives in a different authority area to that which covers his / her workplace, liaison should take place between the relevant agencies in both areas and a joint strategy discussion convened.

9.4 In some cases, an allegation of abuse against someone closely associated with a member of staff (e.g. partner, member of the family or other household member) may present a risk of harm to child/ren for whom the member of staff is responsible. In these circumstances, a strategy discussion should be convened to consider:

- The ability and/or willingness of the member of staff to adequately protect the child/ren;

- Whether measures need to be put in place to ensure their protection;

- Whether the role of the member of staff is compromised.

10. Disciplinary process

10.1 The LADO and the designated senior manager should discuss whether disciplinary action is appropriate in all cases where:

- It is clear at the outset or decided by a strategy discussion that a police investigation or LA Children's Services enquiry is not necessary; or

- The employer or LADO is informed by the police or the Crown Prosecution Service that a criminal investigation and any subsequent trial is complete, or that an investigation is to be closed without charge, or a prosecution discontinued.

10.2 The discussion should consider any potential misconduct or gross misconduct on the part of the member of staff, and take into account:

- Information provided by the police and/or LA Children's Services;
- The result of any investigation or trial;
- The different standard of proof in disciplinary and criminal proceedings.

10.3 In the case of supply, contract and volunteer workers, normal disciplinary procedures may not apply. In these circumstances, the local authority designated officer and employer should act jointly with the providing agency, if any, in deciding whether to continue to use the person's services, or provide future work with children, and if not, whether to make a report for consideration of barring or other action.

10.4 If formal disciplinary action is not required, the employer should institute appropriate action within three working days. If a disciplinary hearing is required, and further investigation is not required, it should be held within 15 working days.

10.5 If further investigation is needed to decide upon disciplinary action, the employer and the LADO should discuss whether the employer has appropriate resources or whether the employer should commission an independent investigation because of the nature and/or complexity of the case and in order to ensure objectivity. The investigation should not be conducted by a relative or friend of the member of staff.

10.6 The aim of any disciplinary investigation is to obtain, as far as possible, a fair, balanced and accurate record in order to consider the appropriateness of disciplinary action and/or the individual's suitability to work with children. Its purpose is not to prove or disprove the allegation.

10.7 If, at any stage, new information emerges that requires a child protection referral, the disciplinary investigation should be held in abeyance and only resumed if agreed with LA Children's Services and the police. Consideration should again be given as to whether suspension is appropriate in light of the new information

10.8 The investigating officer should aim to provide a report within ten working days.

10.9 On receipt of the report the employer should decide, within two working days, whether a disciplinary hearing is needed. If a hearing is required, it should be held within 15 working days.

11. Sharing information for disciplinary purposes

11.1 Wherever possible, police and LA Children's Services should, during the course of their investigations and enquiries, obtain consent from witnesses or those interviewed to provide the employer and/or regulatory body with statements and evidence for disciplinary purposes. The witness/interviewee should be advised that it may be necessary to disclose information in order to safeguard other children, even if consent is not given.

11.2 If the police or CPS decide not to charge, or decide to administer a caution, or the person is acquitted, the police should pass all relevant information to the employer without delay.

11.3 If the person is convicted, the police should inform the employer straight away so that appropriate action can be taken.

12. Record Keeping

12.1 Employers should keep a clear and comprehensive summary of the case record on a person's confidential personnel file and give a copy to the individual. The record should include details of how the allegation was followed up and resolved, the decisions reached and the action taken. It should be kept at least until the person reaches normal retirement age or for ten years if longer. It should be retained even if the individual leaves their employment.

12.2 This enables accurate information to be given in response to any future request for a reference and will help to provide clarity where a future CRB check reveals police information that an allegation was made but did not result in a prosecution or conviction. Such a record also serves to protect the employee from unnecessary re-investigation if allegations resurface after a period of time.

12.3 The LADO should keep a copy of all relevant records, assessments and papers. S/He will keep comprehensive records in order to ensure that each case is being dealt with expeditiously and that there are no undue delays. The records will also assist the DSCBs to monitor and evaluate the effectiveness of the procedures for managing allegations and provide statistical information to the DCSF as required.

12.4 Where a s47 investigation has been undertaken, any record of sensitive personal information relating to the accused adult should be kept in a confidential section of the child's case record.

13. Unsubstantiated, unfounded and malicious allegations

13.1 Where it is concluded that there is insufficient evidence to substantiate an allegation, the Chair of the strategy or initial evaluation discussion (or the allocated social worker or a person delegated this task) should prepare a separate report of the enquiry and forward this to the designated senior manager of the employer to enable her/him to consider what further action, if any, should be taken.

13.2 An allegation would be unfounded where it can be evidenced that the person making the allegation misinterpreted the incident or was mistaken about what they saw. Alternatively, they may not have been aware of all the

circumstances. If an allegation by a child is determined to be unfounded, the employer should refer the matter to Children's Services to determine whether the child is in need of services or may have been abused by someone else.

13.3 Malicious allegations are rare; in order to be classed as malicious, there needs to be clear evidence there was a deliberate intention to deceive. In such cases the police should be asked to consider whether any action might be appropriate against the person responsible.

14. Procedures in specific organisations

14.1 It is recognised that many organisations will have their own procedures in place, some of which may need to take into account particular regulations and guidance (e.g. schools and registered child care providers). Where organisations do have specific procedures, they should be compatible with these procedures and additionally provide the contact details for:

- The designated senior manager to whom all allegations should be reported;
- The person to whom all allegations should be reported in the absence of the designated senior manager or where that person is the subject of the allegation;
- The local authority designated officer.

15. Support

15.1 The organisation, together with LA Children's Services and/or police, where they are involved, should consider the impact on the child concerned and provide support as appropriate. Liaison between the agencies should take place in order to ensure that the child's needs are addressed.

15.2 As soon as possible after an allegation has been received, the accused member of staff should be advised to contact his/her union or professional association. Human resources should be consulted at the earliest opportunity in order that appropriate support can be provided via the organisation's occupational health or employee welfare arrangements.

16. Suspension

16.1 Suspension is a neutral act and it should not be automatic. It should be considered in any case where:

- there is cause to suspect a child is at risk of significant harm; or
- the allegation warrants investigation by the police; or
- the allegation is so serious that it might be grounds for dismissal.

16.2 The possible risk of harm to children posed by the accused person should be evaluated and managed effectively – in respect of the child/ren involved in the allegations and any other children in the accused member of staff's home, work or community life.

16.3 The senior manager should advise the LADO what action has already been taken to remove the accused person from duties where such action has been taken. Any informal action should be strictly time limited until a considered decision on suspension has been reached, which should normally be made no later than ONE DAY after the strategy/initial evaluation discussion. If a strategy discussion is to be held or if LA children's social care or the police are to make enquiries, the LADO should canvass their views on suspension and inform the employer. Only the employer, however, has the power to suspend an accused employee and they cannot be required to do so by a local authority or Police.

16.4 If a suspended person is to return to work, the employer should consider what help and support might be appropriate (e.g. a phased return to work and/or provision of a mentor), and also how best to manage the member of staff's contact with the child concerned, if still in the workplace.

17. Resignations and 'compromise agreements'

17.1 Every effort should be made to reach a conclusion in all cases even if:

- the individual refuses to cooperate, having been given a full opportunity to answer the allegation and make representations;
- it may not be possible to apply any disciplinary sanctions if a person's period of notice expires before the process is complete.

17.2 'Compromise agreements' must not be used (i.e. where a member of staff agrees to resign provided that disciplinary action is not taken and that a future reference is agreed). (see Para 9)

18. Organised and historical abuse

18.1 Investigators should be alert to signs of organised or widespread abuse and/or the involvement of other perpetrators or institutions. They should consider whether the matter should be dealt with in accordance with complex abuse procedures which, if applicable, will take priority.
This guidance is available at: http://police.homeoffice.gov.uk/news-and-publications/publication/operational-policing/child_abuse_guidance.pdf?view=Binary.

18.2 Historical allegations should be responded to in the same way as contemporary concerns. It will be important to ascertain if the person is currently working with or has contact with children and if that is the case, to consider whether the current employer should be informed.

19. Whistle-blowing

19.1 All staff should be made aware of their organisation's whistle-blowing policy and feel confident to voice concerns about the attitude or actions of colleagues.

19.2 If a member of staff believes that a reported allegation or concern is not being dealt with appropriately by their organisation, s/he should report the matter to the LADO.

20. Timescales

20.1 It is in everyone's interest for cases to be dealt with expeditiously, fairly and thoroughly and for unnecessary delays to be avoided. The target timescales detailed below are realistic in most cases, but some cases will take longer because of their specific nature or complexity.

20.2 If any allegation or concern meets the criteria set out in Para 2.1 the employer should normally report it to the LADO immediately but always at least within one working day
The LADO will regularly monitor the progress of cases, either via review discussions or by liaising with the police and/or children's services or the employer as appropriate. Such reviews should take place at **monthly or fortnightly** intervals depending on the complexity of the case. Where the target timescales cannot be met the LADO should record the reasons. The LADO should keep comprehensive records in order to ensure that each case is being dealt with expeditiously and that there are no undue delays. The records will also assist the DSCB to monitor and evaluate the effectiveness of the procedures for managing allegations and provide statistical information to the DfES as required.

20.3 Similarly the police should review the progress of investigations and consult with the Crown prosecution Service (CPS) wherever possible no later than **4 weeks** after the initial action meeting. Dates for subsequent reviews, at **fortnightly or monthly** intervals, should be set at the meeting if the investigation continues.

20.4 Where the initial evaluation decides that the allegation does not involve a possible criminal offence, it is dealt with by the employer. In such cases, if the nature of the allegation does not require formal disciplinary action, appropriate action should be instituted within three working days. If a disciplinary hearing is required and can be held without further investigation, the hearing should be held within 15 working days.

20.5 Where further investigation is required to inform consideration of disciplinary action, the employer should discuss who will undertake that with the LA designated officer. In some settings and circumstances, it may be appropriate for the disciplinary investigation to be conducted by a person who is independent of the employer or the person's line management to ensure objectivity. In any case, the investigating officer should aim to provide a report to the employer within 10 working days.

20.6 On receipt of the report of the disciplinary investigation, the employer should decide whether a disciplinary hearing is needed within two working days, and if a hearing is needed it should be held within 15 working days.

20.7 If the allegation is substantiated, and on conclusion of the case the employer dismisses the person or ceases to use the person's services, or the person ceases to provide his/her services, the employer should consult the LA designated officer about whether a referral to the PoCA list and/or to a professional or regulatory body is required. If a referral is appropriate, the report should be made within one month.

Appendix 1

Contact details for LADO's

Bournemouth:

Chris Harvey
Principal Education Welfare Officer
Dorset House
20-22 Christchurch Road
Bournemouth
Dorset BH1 3NL
Tel.: 01202 456134
Email: Chris.Harvey@Bournemouth.gov.uk

Jean Haslett
Service Manager for Quality Assurance and Children's Review
ChildCare & Family Support
9 Madeira Road
Bournemouth
Dorset BH1 1QN
Tel.: 01202 458039
Email: Martin.Taylor@Bournemouth.gov.uk

Dorset:

c/o Tanya Foley
Children's Safeguarding Unit
2nd Floor The Old House
Monkton Park
Winterbourne Monkton
Dorchester
Dorset DT2 9PS
Tel.: 01305 221122
Email: safeguardingunit@dorsetcc.gov.uk

Poole:

Wendy Manning
Safeguarding and Quality Assurance Manager
Strategy, Quality & Improvement
Borough of Poole
Civic Centre
Poole
Dorset, BH15 2RU
Tel.: 01202 714747
Email: w.manning@poole.gov.uk

Bournemouth & Poole Local Safeguarding Children Board

Dorset Safeguarding Children Board

PAN DORSET INTER-AGENCY SAFEGUARDING PROCEDURES

CHAPTER 3

3.10 CHILDREN AND YOUNG PEOPLE WHO RUN AWAY OR GO MISSING FROM HOME OR CARE

Procedures Effective from: **December 2010**

Review Date: **2012**

If you have any comments or queries about the pan-Dorset procedures please contact your agency representative on the Pan Dorset Policy and Procedures Group or notify the LSCB using the following email addresses:

info@dorsetlscb.co.uk
info@bournemouth-poole-lscb.org.uk

Contents

Introduction 3
Contact Information 4
1. Background 5
2. Definitions 6
3. Legislation 7
4. Scope 8
5. Principles 9
6. Procedures for a child missing from home 10
Flow chart for a child missing from home 10
6.1 Responsibility of parents/carers 11
6.2 All Agencies/Members of the public 11
6.3 Role of the Police 11
6.4 Recording 12
6.5 Sharing Information 12
6.6 Review of continued absence 12
6.7 Return of the child 12
6.8 The Return Interview 13
6.9 Planning to reduce risks 14
7. Procedures for a child looked after 16
Flow chart for Child Looked After 16
7.1 On Admission to the placement 17
7.2 If the Child Looked After goes missing. 17
7.3 Unauthorised absence 19
7.4 Missing 20
7.5 Absconding 21
7.6 Roles and Responsibilities 21
7.7 Review of Continued Absence 22
7.8 Return of the Child Looked After 22
7.9 The Return Interview 23
7.10 Planning to reduce risks 24
8. The role of the Out of Hours Services 25
9. Police Powers 26
10. Prevention Strategy 26

Introduction

This Protocol is important for the safeguarding of children and families across Dorset, or those using services in the area. It should be read and implemented, where necessary, by all practitioners and managers working with children or young people (hereafter referred to as 'children') who are at risk of going missing from home or care or who are already doing so. It does not cover children who go missing with family members.

The Protocol will be available to members of the public on the Dorset Local Safeguarding Children Board and the Bournemouth and Poole Local Safeguarding Children Board websites.

The Procedural sections are divided into children going missing from home and children going missing from care. Readers should only need to refer to the section appropriate to an individual child's situation.

It is intended that this protocol will assist in developing robust responses to children who go missing which mirror the good practice already established across Dorset with regards to children at risk of sexual exploitation and or any other abuse. It should be used to engage partner agencies in developing preventative services for children and young people who are at risk of going missing. It is vital all involved with missing children use their professional judgement and take positive action to deal with the issues raised.

It has been compiled jointly by Dorset County Council, Dorset Police, Bournemouth Borough Council and the Borough of Poole in consultation with other statutory and independent organisations. Dorset Local Safeguarding Children Board and the Bournemouth and Poole Local Safeguarding Children Board will be responsible for ensuring an annual review of the effectiveness of all aspects of the protocol.

The most effective practice comes from good information sharing, joint assessments of need and risk, joint planning, professional trust within the interagency network and joint action in partnership with families.

The Local Safeguarding Children Boards expects all agencies working with children or young people who are missing from home or care to implement this Protocol and ensure that all relevant staff are aware of it and how to use it.

Contact Information

If you believe that a child is at immediate risk, this should be reported without delay to the police service; for emergencies use 999, or for urgent/immediate reporting 01202 222222 as well as making contact with Children's Services:

Bournemouth: 01202 458000
Poole: 01202 735046
Dorset: 01305 221000

Out of Hours Services: 01202 668123.

1. Background

1.1 Across Bournemouth, Poole and Dorset there were 1130[1] reports of missing people in 2009. Of these, 667 were reports of missing children, either from home or from care. This includes children who go missing on more than one occasion.

1.2 The Children's Society through its research has identified the following risk factors[2] that can precede a missing incident:

- Arguments and conflicts
- Conflict within a placement
- Poor family relationships
- Physical and emotional abuse
- Boundaries and control
- Step parent issues
- Domestic Violence

The immediate risks associated with going missing include:

- No means of support or legitimate income – leading to high risk activities
- Involvement in criminal activities
- Victim of abuse
- Victim of crime, for example through sexual assault and exploitation
- Alcohol/substance misuse
- Deterioration of physical and mental health
- Missing out on schooling and education
- Increased vulnerability

Longer-term risks include:

- Long-term drug dependency / alcohol dependency
- Crime
- Homelessness
- Disengagement from education
- Child sexual exploitation
- Poor physical and/or mental health

1.3 In July 2009 the Department of Children, Schools and Families issued Statutory guidance on children who run away and go missing from home or care.

1.4 There is a duty on Local Authorities to Report against the National Indicator NI71 which monitors multi-agency response to the needs of missing children.

[1] Figures from Dorset Police

[2] Still Running: Children on the Streets in the UK, The Children's Society, 1999.

2. Definitions

2.1 The following definitions apply to this protocol and relate to children who go, or have gone missing. The definition of running away is taken from the Social Exclusion Unit Young Runaways report (2002) and includes reference to young people who self-define running away as being forced to leave because, for example, they do not believe they have any alternative.

Child: A child or young person under the age of eighteen years.

Missing: is anyone whose whereabouts are unknown, whatever the circumstances of disappearance. They will be considered missing until located and their well being, or otherwise, established. This will include children who run away.

Child Looked After: A child is looked after by the local authority if they are "in care" by reason of a court order, or if they are provided with accommodation for more than 24 hours by agreement with their parents or with the child if they are aged 16 or more.
A child in a private fostering arrangement is not looked after.

Unauthorised absence from care: Absent for a short period of time and after a careful and thorough risk assessment the absence does not raise concern for their immediate safety or that of the public. This period of absence should not **exceed 6 hours**.

Absconded: When a missing child is subject to a court order, such as curfew or bail conditions, police **must** be made aware of the order and the expiry date in order for the child to be classified as an absconder. If the expiry date of the order is not known, the child will be classified as a "missing person" **NOT** an absconder.

3. Legislation

3.1 The legal parameters within which missing person enquires are conducted can be found in common law, international law and the provisions of the European Convention of Human Rights (ECHR). Some of the provisions of the ECHR have been given legal effect within the United Kingdom by virtue of the Human Rights Act 1998.

3.2 Data protection legislation places certain conditions on the 'processing' of information classed as personal data. Adherence to this Agreement will therefore ensure compliance with the Data Protection Act 1998 and Data Protection policies. Data Protection legislation does not prevent the police and local authority working together to ensure the safe return of a missing child. Both organisations are registered for the purpose of protecting people and therefore for disclosing information for that purpose.

3.3 Statutory guidance on children who runaway and go missing from home or care (Department for Children, Schools and Families) 2009.

3.4 Working Together to safeguard children (HM Government, 2010) Supplementary guidance Safeguarding children and young people from sexual exploitation.

4. Scope

4.1 The protocol is designed for:

- all children living in the boundaries of Dorset, Poole and Bournemouth.
- children looked after by the Local Authority placed within Children's homes or foster homes (either Local Authority or independent) within the Local Authority boundaries.
- children looked after by the Local Authority who are subject to a care order and who are living with parents or relatives.

The Local Authority retains responsibility for children looked after who are placed outside the Local Authority boundaries. In these cases the Local Authority will require the placement provider to comply with these protocols as well as protocols local to their area.

Other Local Authorities placing children within the Bournemouth, Poole and Dorset boundary will be informed of this protocol.

4.2 Within this context, "Children Looked After" refers to children accommodated under Section 20 of the Children Act 1989, children subject to Care Orders including Interim Care Orders, Section 31 and 38 Children Act 1989, and children who are otherwise provided with accommodation by Section 21 Children Act 1989.

5. Principles

5.1 This protocol cannot anticipate every situation. Anyone working with children in a professional capacity should use their judgement to take whatever action is deemed necessary including information sharing to protect and safeguard the child, based on an assessment of risk for each individual.

5.2 Our joint aim is to reduce the incidence of children going missing. Children who go missing may place themselves and others at risk and each missing episode is potentially serious. The reasons for their absence are often varied and complex and cannot be viewed in isolation from their home circumstances or their experiences of care. Every 'missing' episode should attract proper attention from the professionals involved, who must collaborate to ensure a consistent and coherent response is given to the child on his/her return.

5.3 When a child does go missing our joint aim is to prevent that child suffering harm and to recover the child to safety as soon as possible. We do this by partnership working, information sharing, risk identification, risk assessment, risk management, action planning and performance management.

5.4 Interventions are important in attempting to address repeat missing episodes. Interventions for Child Looked After must be informed by and reflected in the placement information and the care plan. Effective return interviews will inform practice and children's views and concerns will be taken seriously.

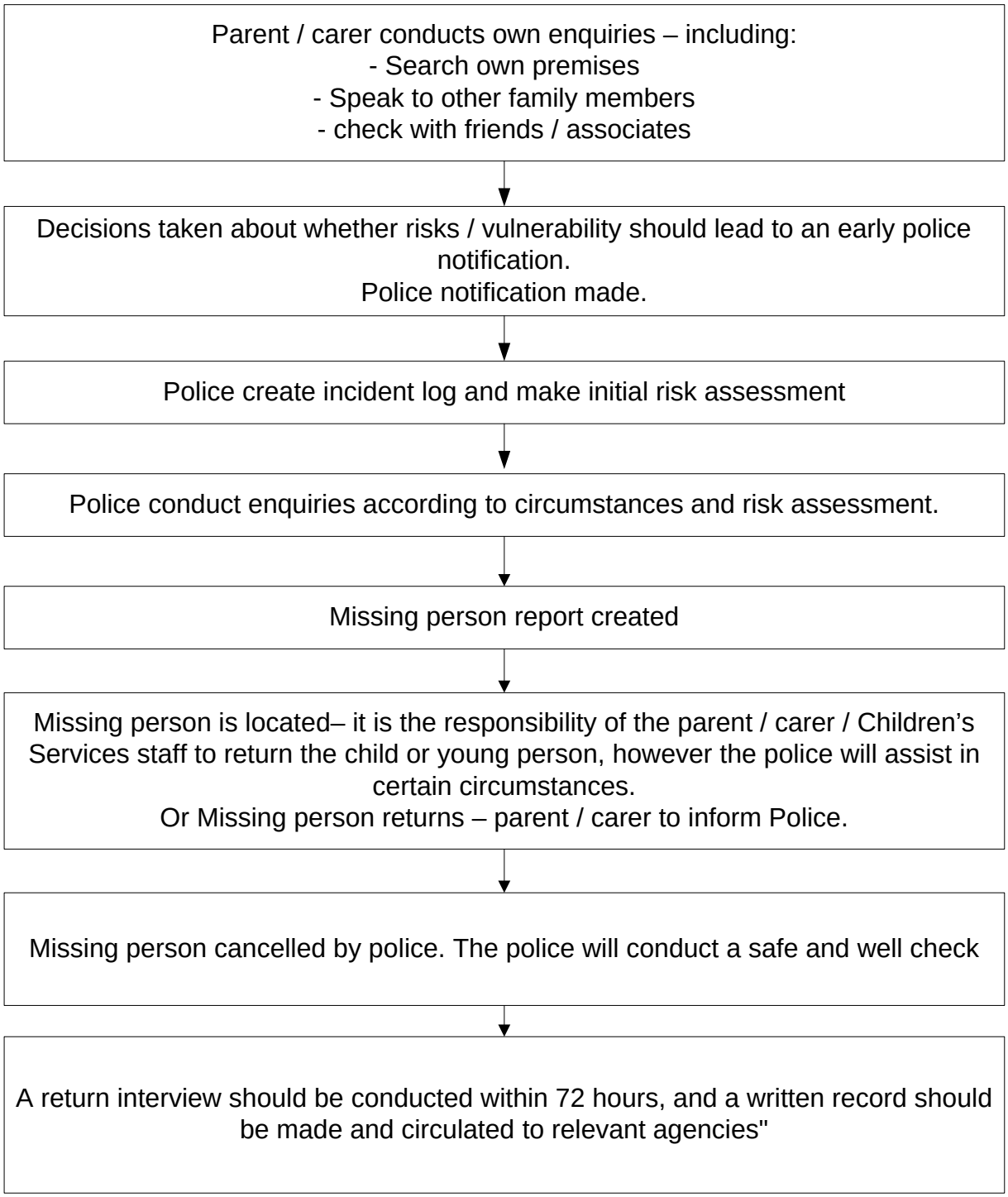
5.5 Interventions may be focused on the individual child, the child's home, or by targeting 'pull' factors in the community.

5.6 The Local Authority and the police will monitor compliance with the protocol and monitor outcomes jointly via Quarterly Performance Reports.

6. Procedures for a child missing from home

Please note section 7 covers procedures for a child missing from care.

Flow chart for a child missing from home



6.1 Responsibility of parents/carers

6.1.1 Parents and those with parental responsibility are expected to undertake the following basic measures to try to locate the missing child if it is considered safe to do so. Anyone else who has care of a child without parental responsibility should take all reasonable steps to locate the child and ascertain their safety.
It is expected that the police will be informed *without delay* when a child goes missing. However, before a child is reported missing the following actions should be undertaken:

- search bedroom/ accommodation/outbuildings/ vehicles
- contact known friends and relatives where child may be
- visit locations that the child is known to frequent, if it is possible

6.1.2 A person who has care of a child without parental knowledge or agreement should also do what is reasonable to safeguard and promote the child's welfare. In these circumstances, they should inform the police, Children's Services and the parents of the child's whereabouts and safety. If this is not complied with, the police should consider advice or warning under the Child Abduction Act 1984, if it is appropriate.

6.1.3 A person who 'takes or detains' a runaway under 16 years old without lawful authority may be prosecuted under Section 2 of the Child Abduction Act 1984.

6.1.4 Children under the age of 16 years are not legally considered as being able to live independently. For children over the age of 16 years, consideration should be given to their legal status, physical and emotional needs when making a judgement as to whether they can live independently.

6.2 All Agencies/Members of the public

6.2.1 If it comes to the attention of any agency that a child is missing, they must advise the parent/carer to report this matter to the police. They also need to advise the parent of the agency's duty to ensure that the matter is reported to the police.

6.3 Role of the Police

6.3.1 Upon receiving a report of a child being missing from home, the police will carry out enquiries (which are proportionate to the perceived risk) aimed at locating the child as soon as possible.

6.3.2 A risk assessment will be carried out for each individual on every separate occasion they are reported missing to the police. This Risk Assessment, usually conducted by the Initial Investigating Officer, and subsequently confirmed or revised by a supervising officer will form the basis for the subsequent investigation into the child's disappearance.

6.3.3 Children who have gone missing may come to the attention of the police in a variety of circumstances. Where the police locate a child who they believe may be missing, although not officially reported, assessment and enquiries based on the child's account of the circumstances will be made. These should include checks of National and Local Police Databases as well as enquiries at the home address. In the event that a missing child has not been reported by

parents/carers this should trigger further enquiries and assessment by the Police and other relevant agencies in accordance with safeguarding procedures.

6.3.4 If enquiries identify risk factors at the home address safeguarding procedures will be implemented. If the Police decide not to return the child to the home address options should be discussed with Children's Services to identify suitable responsible adult(s) and/or accommodation. (Out of hours to be contacted after office hours). Police databases should also be checked.

6.4 Recording

6.4.1 An incident log should be opened and a risk assessment conducted on all occasions when a child is reported to the police. The log should remain open until the missing person report is opened or the child has been located. A missing person report must be created by the investigating officer for all missing children.

6.4.2 Missing person reports should be submitted as soon as possible, as the submission of the report now triggers Police National Computer circulation.

6.5 Sharing Information

6.5.1 The police will receive reports about children missing and record them in accordance with locally agreed police procedures.

6.5.2 It is acknowledged that for some children who go missing there are concerns about home circumstances and good sharing of information will ensure that assessments and decisions about the return of the child are well-informed.

6.5.3 The police will notify the relevant Children's Services by completing a C112. This will be sent to the Local Authority within 72 hours. The Children's Service will make an assessment of the information shared by the Safeguarding and Referral Unit by the C112 and decide what action they will take.

6.5.4 The relevant officer/supervisor or control room supervisor for the area will also notify the relevant manager in Children's Services if there is further information on a particular case or they have concerns that need further assessment.

6.6 Review of continued absence

6.6.1 Throughout the missing episode, the police are responsible for ongoing enquiries, risk assessment and proportionate actions and reviews.

6.6.2 In the event of a continuing missing episode good communication and close co-operation is essential to ensure that any significant concerns are identified and appropriate safeguarding action is taken. When a child has been absent for a period of 48 hours the police should update the Local Authority. Any significant developments should be reported at least every 5 days, or earlier if deemed appropriate.

6.7 Return of the child

6.7.1 It is the responsibility of the parent or carer to contact the police and confirm that the missing child has returned.

6.7.2 If the whereabouts are known or suspected, it is the responsibility of the parents or carers to arrange for the child's return. In exceptional circumstances, in the interests of the safe and speedy return of the child, the police may agree to requests from parents or carers to assist. The police should not unreasonably withhold assistance in cases involving local recovery and transport missions for vulnerable children.

6.7.3 Once the child has been located, the police will carry out a police 'safe and well check'. It will not be conducted over the telephone. The purpose is: to confirm that it is safe for the child to return home; to check for any indications that the child has suffered harm; where and with whom they have been; and to give them an opportunity to disclose any offending by, or against, them. This will lead to the police closing the missing person report, and the case being cancelled on the Police National Computer. This is NOT a return interview. The police will notify the Local Authority of the return of the child and any relevant information.

6.7.4 If it is apparent, on the return of the child, that they have been the victim of a crime whilst absent, or that they may be in danger or at risk from any person arising out of circumstances that have occurred whilst they were absent then the police will instigate further enquiries. This is vital for the protection of the child and for the speedy recovery of evidence.

6.7.5 In such circumstances, the missing child's clothing, mobile phone and trace evidence from their body, fingernails or hair may be crucial. In cases of sexual abuse the child should be discouraged from washing and immediate advice sought from the police. The Police should advise parents or carers that if they become aware of the location of a scene of any crime committed against the child, or of the location of any crucial evidence they must notify the police without delay. This will enable the police to take steps to secure and preserve evidence.

6.7.6 Additionally, in matters of sexual exploitation, or any other situation which indicates that the child may have been subject to, or at risk of, significant harm, a referral must be made to the Local Authority in accordance with Local Safeguarding Procedures.

6.8 The Return Interview

6.8.1 'Return Interview' is the term applied to the safety, needs and risk assessment carried out by Children's Services and/or their partners (not the police). It should include an exploration of the reason the child left their home, what risks they were exposed to whilst missing, and what can be done to reduce the risk of future missing episodes. The 'Return Interview' is distinct from the police 'Safe and Well' check.

6.8.2 If one or more of the following factors apply, a return interview should be undertaken (with the agreement of the child and parent as appropriate).

- The child has been missing for over 24 hours.
- The child has been missing on two or more occasions in the last 3 months.
- The child has been engaged (or is believed to have been engaged) in criminal activities during their absence.
- The child has been hurt or harmed (or is believed to have been hurt or harmed) during their absence.
- The child has known mental health issues.

- The child is at a known risk of sexual exploitation or has had contact with persons posing a risk to children.

6.8.3 Appropriate Safeguarding procedures should be followed where there are safeguarding concerns.

6.8.4 If during a return interview a child discloses that a crime may have taken place, this should be referred to the police.

6.8.5 It is acknowledged that a returning child may well share different parts of their experience with different people. It is the responsibility of all agencies therefore, to attend to issues of immediate safety, future support and safeguarding needs, and information shared in a way that respects and safeguards children and young people.

6.8.6 The return interview should be conducted by a professional who is trained to carry out these interviews and is able to follow up any actions that emerge. It may be helpful to arrange for someone independent from those currently working with the child to undertake the interview. Account should also be taken of any preference the child has for the conducting of the return interview. The interview should be conducted within 72 hours, or as soon as possible after this.

6.8.7 The purpose of the interview is:

- to better understand the reasons why the child went missing.
- to explore the circumstances which led to the missing episode(s).
- to inform future prevention strategies.
- to inform any future missing person investigation should that child go missing again.
- to learn of the activities, associates, risks and victimisation involved in the missing episode, and where possible to address those risks with appropriate and proactive strategies such as the use of the harbouring warning notices under the Child Abduction Act.
- to identify and address any harm that the child has suffered – including harm that may have not already been disclosed as part of the safe and well check.

6.8.8 A written record should be made of the return interview, which should be circulated to relevant agencies.

6.8.9 The outcome of the return interview will inform whether a planning meeting involving family and professionals is needed

6.9 Planning to reduce risks

6.9.1 The following are examples of reasons to initiate a planning meeting:

- Any case where the risks involved in even a single future missing episode are very high.
- Cases where it has been identified that immediate action is necessary to ensure the well being of the child.

6.9.2 The agency that convenes the meeting will be responsible for Chairing and minuting the meeting. The meeting MUST produce a clear Action Plan, including timescales for action, named lead professionals, risk/contingency planning and timescale for review.

6.9.3 The meeting should try to identify any 'push' or 'pull' factors in the case. Where 'pull' factors are identified it may be necessary to target those in the community who harbour the missing child or exploit them with regard to crime, sex or drugs.

6.9.4 The notes of the meeting should be copied to all professionals invited.

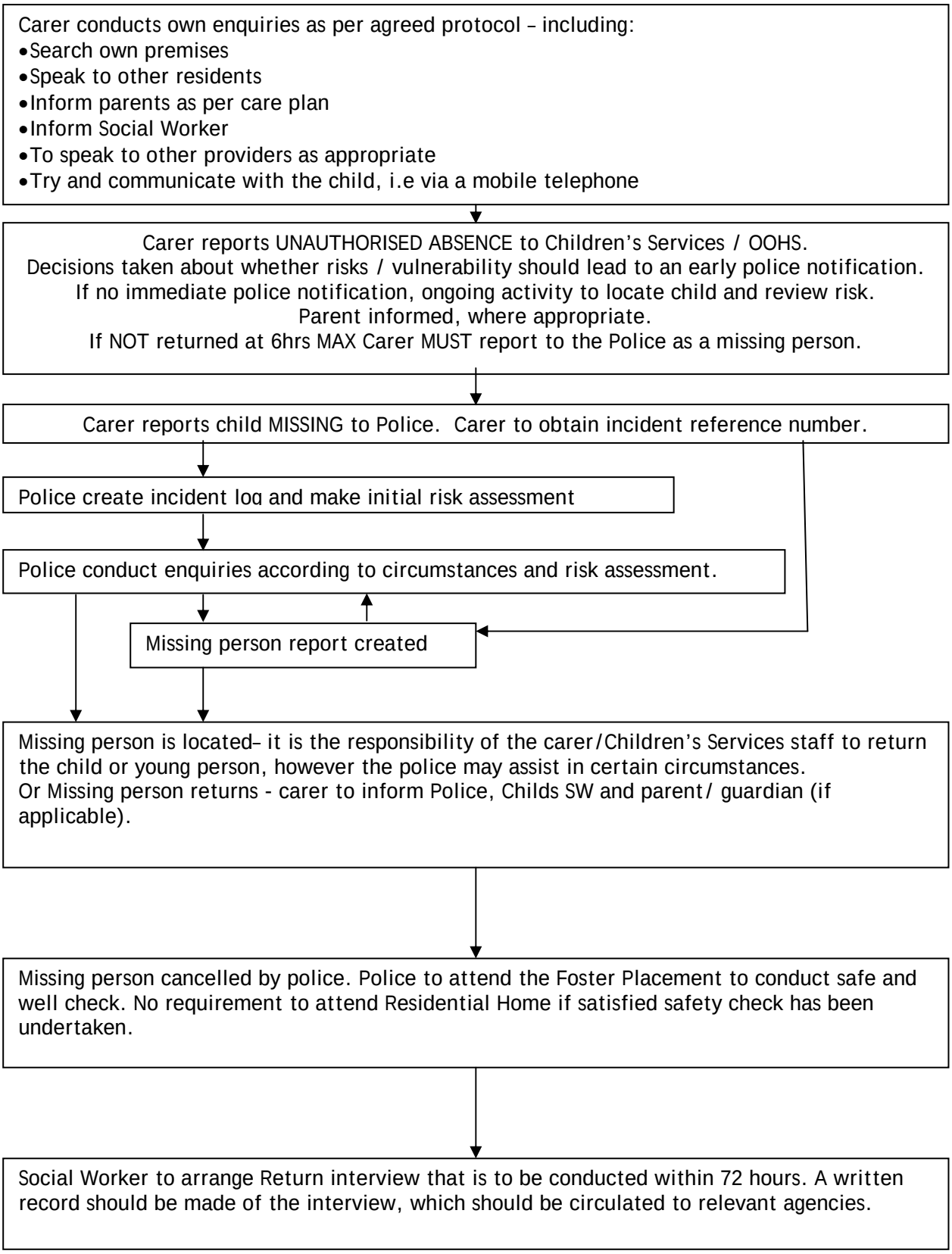
6.9.5 Review of the plans to reduce the risk of running away will continue until the child is no longer running away. At each meeting, or in the planning for meetings the level of risk will be considered to ensure that the level of meeting and the attendees is appropriate to address the concerns.

6.9.6 Some cases will meet the threshold for the monthly meetings of missing children causing greatest concern, chaired by the Police or other appropriate agency (see section 10).

6.9.7 If any one agency or professional has concerns for a child's wellbeing or safety then they may ask Children's Services to consider a strategy meeting (under safeguarding procedures) at any time, regardless of the number of missing episodes. The Common Assessment Framework (CAF) process can be initiated, or a referral to Children's Services can be made where relevant.

7. Procedures for a child looked after

Flow chart for Child Looked After



7.1 On Admission to the placement

7.1.1 Each child looked after has a care plan based on a full assessment of the child's current and future needs, including potential risk to self or others. The care plan will therefore take account of any risk that the child may go missing in the future and any factors which may increase the risk to the child should they go missing. Children's carers should contribute to this assessment. All information should be included in the placement plan and in the child's care plan. As part of this assessment it may be appropriate for the Local Authority to consult with the police to share information that may be of relevance.

7.1.2 The care plan will remain in the possession of the Local Authority. It is not a public document. It is not envisaged that the police will need to view the care plan at any time. However, there may well be circumstances when it is necessary to involve the police in aspects of the care planning process to safeguard the child.

7.1.3 Carers and the Local Authority should have up-to-date photographs of children who are looked after. If a child goes missing it is vital to the safe recovery of the child that a recent photograph of the child is made available. The photograph must be a good likeness of the child. Most commonly the photograph will be used by local police officers to help them recognise the child when patrolling or when actively looking for the child at relevant locations. In very serious cases, where the child is believed to be at severe risk, the police and local authority may decide to use the photograph more widely and even release the photograph to national or local media.

7.1.4 The Local Authority will ensure that sufficient knowledge and information about the child is recorded to enable carers to have immediate access to the information they would need to make a referral to the police should the child go missing.

7.1.5 The residential unit manager/ foster carer should consider the most appropriate ways to hold the relevant information and whether it is necessary and appropriate to discuss the risks of going missing with the child.

7.2 If the Child Looked After goes missing.

7.2.1 Categories of absence have been agreed between the Police and Local Authority. If a Child is absent from care the Local Authority will decide which of the three categories the absence will fit; **unauthorised absence** (see section 7.3), **missing** (see section 7.4) **or absconding** (see section 7.5).

7.2.2 In deciding the category of absence, all staff must consider the circumstances of the child and their absence. This will include detailed consideration of:

- the circumstances of the absence.
- the child's care plan.
- the age of the child.
- the maturity of the child.
- any physical or cognitive disability of the child.
- any continuing or urgent need for the child to have medication or other medical treatment.
- the legal status of the child.
- the child's previous behaviour/ history .

- danger posed by the child to themselves or others.
- general vulnerability of the child.
- the child's tendency to drug/substance abuse.
- whether the child is perceived as running to, or running from, someone or something.
- any circumstances within the placement, say with carers or other residents that may be relevant to the absence.
- the risk of offending.
- the influence of peer groups, families or friends.
- predatory influences on the child- may relate to others wanting to use the child for crime, sex or drugs.
- any known risk of abduction.
- environmental factors including weather, time of year, community events or tensions.

7.2.3 Children who are absent from their placement can be a matter of considerable concern to their carers and there is a need to locate them and ensure they are safe. The children can be thought of as being on a continuum, with there being little cause for concern at one end, and significant cause for concern at the other. Children who are a few minutes late home from school would not normally give rise to concerns.

It is not helpful to consider any short absence as warranting a formal missing person report.

7.2.4 However, at some point, depending upon the child and the circumstances, the child's absence will give rise to justifiable concern and require a formal missing person report to the police. Whilst there can be no substitute for a considered judgement, based on a sound assessment of the child and the circumstances, it is the purpose of this framework to assist carers to structure their thinking with regard to the three categories of absence. This decision should not be taken in isolation, residential staff should consult with the senior member on duty and foster carers should liaise with the child's social worker or Out of Hours Services (OOHS) staff. The situation should be kept under constant review and changes in circumstances be taken into account. If the Child is receiving support from Child and Adolescent Mental Health Service professionals, Educational Psychologists and so on, it may be advisable to discuss the case with them. However, if they are not readily available a decision must be made on the basis of the best available information. In cases of doubt it may also be appropriate to discuss the case with a local police supervisor.

7.2.5 Each case must be decided on merit and a formal missing person report to the police may be actioned earlier in some circumstances than in others.
For a small number of vulnerable children it may be appropriate to immediately report them as a missing person. Normally this will have been previously agreed as part of the Care Plan.

7.2.6 If the child has gone missing before, this does not reduce the risk. In fact, children who repeatedly go missing are often being enticed away from their placement by activities that they see as exciting or by predatory influences. Furthermore, short absences may be as risky as lengthy ones.

7.3 Unauthorised absence

7.3.1 Some children absent themselves for a short period and then return, with their whereabouts known to the carer. Sometimes children stay out longer than agreed, either on purpose to test boundaries, or accidentally. Examples of situations where unauthorised absence will apply are:

- Running away after a dispute.
- Failing to return on time.
- Staying at a known location with a friend.

7.3.2 If the carer assesses that the child is at risk due to any factor/s known to the carer, then the child should be reported as missing without delay and the perceived risk communicated to the Police. If the assessment of the carer is that there is **no apparent risk** for their immediate safety but they are away from home without permission it is still important that staff/ carers record these incidences as unauthorised absences in the child's record. In addition to this staff/carers should always start a dated/timed record of their contacts, risk assessment and decisions throughout the episode from the point that they are aware of the child's absence, in case the level of risk changes and decisions are auditable.

7.3.3 **A period of 6 hours should normally be regarded as the absolute maximum for any child whose whereabouts are not known** and who cannot be contacted, to remain categorised as unauthorised absent, rather than being formally reported as missing; in many cases a shorter period will be appropriate. It will not be appropriate for any child whose whereabouts are not known and who cannot be contacted, to remain out overnight, without being formally reported as missing.

7.3.4 If the child's whereabouts are known or suspected, the Local Authority staff will decide whether to allow the child to remain at that location, albeit temporarily, or to arrange for their return. If the decision is to arrange their return and there is reason to believe that there may be public order difficulties, the police may be asked to assist. Police assistance in these circumstances does not mean that the child is categorised as missing. Each such occurrence needs to be evaluated based upon the factors mentioned in paragraph 7.2.2 and upon other information gleaned from the child, friends, family and associates.

7.3.5 It is expected that the first response by carers along with any relevant staff from the child's responsible authority, will be to take all steps a responsible parent would take, to try to locate the child and to make a careful assessment in accordance with paragraph 7.2.2.

7.3.6 **The responsibility for managing unauthorised absence lies with the carer and the Local Authority.** It is not the responsibility of the police to influence or determine the decision of whether a person is missing or unauthorised absence.

7.3.7 A clear assessment needs to be made by the carer in each individual case as to the length of time that elapses before a child who is unauthorised absent becomes categorised as missing. An unauthorised absence must be kept under regular review by the appropriate carer. It is important to consider whether the circumstances of the disappearance would now render the child at risk of harm, for example:

- the child requires medication at a set time (consider impact of not taking medication); or

- weather conditions have severely deteriorated.

7.4 Missing

7.4.1 Missing is where the child's location or reason for absence is unknown and/or due to the circumstances, there is cause for concern for the child or potential danger to the public.

7.4.2 Reporting a young person missing involves providing detailed information to the police. It is important that the carer makes it clear to the police that they are reporting the child as **missing**. The carer should always ask for and record a police log reference number. This will cause the police to record the case as a Missing person on the command and control system. It will lead to a proactive police investigation managed locally by the police on the computer system. Moreover, the individual's details will be circulated nationwide via the Police National Computer System. (See also paragraph 7.5 if the child is an absconder).

7.4.3 When receiving a missing person report the police will tailor their response to the circumstances. If information is available to suggest a possible location of the missing child, and this gives rise to concerns about the safety of the child, the police response will be to immediately address those concerns, perhaps postponing the administrative recording duties for a short time in favour of safeguarding.

7.4.4 Premises Search:
For a child reported missing from a residential home, the Police will ask for verification that a thorough premises search has been undertaken by family/carer/care staff.

7.4.5 Information provided by the carer will inform the risk assessment undertake by the Police.

7.4.6 The carer and the Local Authority will provide information about risk factors in the case. After considering this and other information the police will decide the risk level to be assigned to the case. This will be **High, Medium or Standard.**

Risk	Definition
High	The risk posed is immediate and there are substantial grounds for believing that the child is in danger through their own vulnerability, or may have been the victim of a serious crime, or the risk posed is immediate and there are substantial grounds for believing that the public is in danger.
Medium	The risk posed is likely to place the child in danger, or they are a threat to themselves or others.
Standard	There is no apparent risk of danger to either the child or the public. *No child aged 15 or under is ever considered to be at standard risk 16 and 17 year olds rarely could be classed as standard risk.*

7.4.7 Carers must also inform without delay:
- The social worker or the accountable team manager or the Out of Hours Services if outside of office hours.
- The parents/those who have parental responsibility (unless indicated otherwise on the care plan).

7.5 Absconding

7.5.1 An absconder is a child who is absent from the placement without permission and who is subject to an order or requirement resulting from the criminal justice process (e.g. remands, curfews, tagging, conditions of residence, other bail conditions, PACE detention or ASBO's), or a secure order made in either civil or criminal proceedings. A child in this category must be reported to the police without delay.

7.5.2 If an absconder is under the age of 16 years, or if the absconding does not involve a power of arrest, the police will treat the case as BOTH a missing child case AND an absconder. This means that it will be necessary to provide detailed information to the police on the missing child form.

7.5.3 This will lead to a proactive police investigation managed locally by the police on the computer system. Moreover, the individual's details will be circulated nationwide via the Police National Computer system. When the child is traced however, it is likely that they will also be arrested or dealt with by the police in relation to any offence or breach. **It is essential however, that they are also viewed as a child in need of protection and safeguarding, and any risks they have been exposed to during their absence must be reviewed fully.**

7.5.4 If an absconder is aged 16 or over and is liable to arrest the police will the treat them solely as an absconder and not as a missing child, unless there are grounds to suspect that factors other than the absconder's desire to evade justice are involved. If the police treat the case solely as one of absconding they will actively seek the absconder for arrest. Absconders in this category must also be reported to the police without delay.

7.6 Roles and Responsibilities

7.6.1 After reporting a child missing, Children's Services remain responsible for the child in their care. This responsibility is not absolved when the child has been reported missing to the police.

7.6.2 Once a child is reported missing to the police, the police will have primacy in respect of the investigation to trace the child.

7.6.3 Carers and the child's social worker will be responsible for liaising with the police, taking an active interest in the investigation and passing on all information, which may help to inform the investigation and assist in protecting the child while absent.

7.6.4 Carers and the child's social worker should continue to make appropriate enquiries with other residents or others who may be able to assist with the investigation unless they are requested not to do so by the police. All information gleaned from these enquiries should be passed to the police.

7.6.5 The police will normally conduct all physical enquiries away from the premises from which the child is absent.

7.6.6 In certain circumstances the police may need to revisit the duties initially performed by carers. When necessary they will do so in liaison with appropriate

children's services staff and will do so sensitively, causing as little disruption as possible to the establishment and residents.

7.6.7 Throughout the process in this protocol, carers and social workers must keep a full record of all actions taken and messages received and given. Police will likewise keep a record of all aspects of the investigation on the Missing Person Case Management System.

7.6.8 Media Strategy: In some cases, particularly where a missing child is felt to be especially vulnerable or where they have been missing for a long period of time, it may be necessary to publicise the case via the media. Such an approach is not routine but is usually a response to very serious concerns for the child's safety. Either carers or the police may suggest such an approach. Normally, such decisions to publicise will be jointly made, and where appropriate, in consultation with parents and Children's Services. However, for operational reasons primacy over such decisions must lie with the police.

The Police may also utilise the website facility of the Missing Persons Bureau (MPB) (www.missingkids.co.uk) to publicise the absence of the child.

7.6.9 If the case falls within the criteria for 'Child Rescue Alert' then any decision to publicise the case is likely to be urgent. It will be made in accordance with nationally agreed procedures by a police officer of the rank of Detective Superintendent.

7.7 Review of Continued Absence

7.7.1 When a child has been absent for a period of 48 hours the social worker should inform the relevant senior manager as per the local authority protocols via the usual line management route.

7.7.2 Throughout the missing episode, carers, Children's Services and the police will continually review the case. After the Child has been missing for 5 days, **or earlier, if deemed appropriate,** an urgent planning meeting will be held. This will involve carers, police and Children's Services and any other professional involved in the care of the child.

The meeting will review:

- What action has been taken so far by the police and professionals.
- What action needs to be taken by the police and professionals.
- Decide whether the Child should return to the same placement when located.
- Consider any other relevant information.
- Minutes will be taken and distributed by the agency that has convened the meeting.

Further such reviews will take place at least monthly for the first 6 months and there after as deemed appropriate.

7.8 Return of the Child Looked After

7.8.1 If the whereabouts are known or suspected, it is the responsibility of the Local Authority to arrange for the child's return.

7.8.2 However, there will be circumstances when, in the interests of the safe and speedy return of the child, the police may agree to requests from the Local Authority to assist. The police should not unreasonably withhold assistance in cases involving local recovery and transport missions for vulnerable children. However, the police will not agree to requests to provide escorts for children, which would unreasonably involve officers leaving their normal areas of patrol.

7.8.3 It is the responsibility of the carer to contact the police by telephone and to confirm when a missing child has returned. For children in residential placements, the police will accept confirmation from care professionals without the need for an officer to attend the home and visit the returnee. This will lead to the police closing the missing person investigation and the case being cancelled on the Police National Computer. **For children in foster placements, the police will verify the child's safe return in person.**

7.8.4 If it is apparent, upon the return of a child, that they have been the victim of a crime whilst absent, or that they may be in danger or at risk from any person arising out of circumstances that have occurred whilst they were absent, the police must be called and asked to attend without delay. This is vital for the protection of the child and for the speedy recovery of evidence. In such circumstances, the child's clothing, mobile phone and trace evidence from their body, fingernails or hair may be crucial.

In cases of sexual abuse the child should be discouraged from washing and immediate advice sought from the police.

7.8.5 If carers become aware of the location of the scene of any crime committed against the child, or of the location of any crucial evidence, they must notify the police without delay. This will enable the police to take steps to secure and preserve evidence.

7.8.6 Additionally, in matters of sexual exploitation, or any other situation which indicates that the child may have been subject to, or at risk of, significant harm, referral must be made under the Local Safeguarding Children's Board Policy Guidance and Procedures.

It should be noted that if any one agency or professional has increased or serious concerns for a child's well-being or safety then they may call a multi-agency strategy meeting at any time, regardless of the number of missing episodes.

7.9 The Return Interview

7.9.1 'Return Interview' is the term applied to the safety, needs and risk assessment carried out by statutory Children's Services and/or their partners. It should include an exploration of the reason the child left their placement, what risks they were exposed to whilst missing, and what can be done to reduce the risk of future missing episodes. The 'Return Interview' is distinct from the police 'Safe and Well' check.

7.9.2 A return interview should be offered following every instance where a child looked after goes missing.

7.9.3 Appropriate Safeguarding procedures should be followed where there are Safeguarding concerns. If during a return interview a child discloses that they have been abused, the child should be referred to Children's Services without delay.

7.9.4 If during a return interview a child discloses that a crime may have taken place, this should be referred to the police.

7.9.5 It is acknowledged that a returning child may well share different parts of their experience with different people. It is the responsibility of all agencies therefore, to attend to issues of immediate safety, future support and safeguarding needs, and information sharing in a way which respects and safeguards children and young people.

7.9.6 The return interview should be conducted by a professional who is trained to carry out these interviews and is able to follow up any actions that emerge.

This may be the child's social worker, residential social worker, or another suitable professional. It may be helpful to arrange for someone independent of Children's Services to undertake the interview. The interview should only be conducted by the child's immediate carer if it would not otherwise take place. Account should also be taken of any preference the child has for the conducting of the return interview. The child's social worker is responsible for ensuring that the return interview takes place. The interview should be conducted within 72 hours, or as soon as possible after this.

7.9.7 The purpose of the return interview is;

- to better understand the reasons why the child went missing.
- to explore the circumstances which led to the missing episode(s).
- to inform future prevention strategies.
- to inform any future missing person investigation should that child go missing again.
- to learn of the activities, associates, risks and victimisation involved in the missing episode, and where possible to address those risks with appropriate and proactive strategies such as the use of the harbouring warning notices under the Child Abduction Act.
- to identify and address any harm that the child has suffered – including harm that may have not already been disclosed as part of the safe and well check.

7.9.8 A written record should be made of the return interview, which should be signed off by the Team Manager. The record should be circulated to relevant agencies.

7.9.9 The outcome of the return interview will inform whether a meeting involving family and professionals is needed.

7.10 Planning to reduce risks

7.10.1 The following are examples of reasons to initiate a planning meeting:

- Any case where the risks involved in even a single future missing episode are very high.
- Cases where it has been identified that immediate action is necessary to ensure the well being of the child.

7.10.2 The meeting should be minuited and MUST produce a clear Action Plan, including timescales for action, named lead professionals, risk/contingency planning and timescale for review.

7.10.3 The meeting should try to identify any 'push' or 'pull' factors in the case. Where 'pull' factors are identified it may be necessary to target those in the community who harbour the missing child or exploit them with regard to crime, sex or drugs.

7.10.4 Review of the plans to reduce the risk of running away will continue until the child is no longer running away. At each meeting, or in the planning for meetings the level of risk will be considered to ensure that the level of meeting and the attendees is appropriate to address the concerns.

7.10.5 The notes of the meeting should be copied to all professionals invited.

7.10.6 In cases of a child going missing from an out-of-authority placement the responsibility for arranging the meeting lies with the local authority responsible for the child. They will involve the relevant organisations from the host authority, to determine action, and to ensure change.

7.10.7 When a child who has a history of going missing is moved to an out-of-authority placement, the host authority should be informed of the risk, and as part of the placement agreement, appropriate details should be shared to support the local authority to manage the risks to inform care planning for the individual child.

8. The role of the Out of Hours Services

8.1 The OOHS provides emergency services when the Local Authority Children's Services Offices are shut, overnight, at weekends and bank Holidays. The OOHS will

- assist Police in work to assess risks to young people by accessing children's services records,
- take part in discussions and risk assessment of where a child or young person who is found should be returned to, and in some cases OOHS may need to find appropriate short-term accommodation for them.
- play a part in the assessment of the welfare of a child or young person found out of hours.

8.2 The first point of reference for Foster Carers/Residential Homes outside of office hours should be the OOHS Services. There needs to be a discussion in respect of the unauthorised absence regarding the risks and vulnerability of the child and a decision taken whether to report to the police as a missing child. If there is no immediate police notification there should be ongoing activity to locate the child and review the risks. If the child has not returned within a maximum of 6 hours the carer MUST report to the police as a missing person.

8.3 The OOHS has a particular role in working with carers of children who are looked after when they go missing.

8.4 Where emergency accommodation is used for a child or young person, OOHS will use foster carers or residential placements in preference to B&B accommodation and no child aged under 16 will be placed in B&B unaccompanied.

8.5 Without prejudice to the welfare of any child, the Local Authority will support the police in taking appropriate action against those who commit crimes against children and/or involve children in their offending behaviour.

9. Police Powers

9.1 The police have significant powers to safeguard vulnerable children. These include powers to enter premises to preserve life. Additional Police powers can be obtained through the Court with the use of warrants.

9.2 If a missing child is found or known to have been in the company of another person during any missing period and a criminal offence has been committed positive steps will be taken against any perpetrators. Examples of offences are child abuse, sexual offence, drug offence, assault, aid, abet, counsel or procuring child to commit an offence. The primary concern is always the safety of the child and also to hold the perpetrators accountable for their actions and deal with them appropriately.

9.3 It is recognised that children who have been the victim of a serious offence may not always see themselves as victims or be willing to assist in the investigation, particularly in the early stages. Likewise those whom others have used for criminal purposes may not be willing to assist the police. A complaint from a victim is not required to make an arrest. Usually reasonable suspicion is enough to arrest. When such an offence has occurred and a power of arrest exists, the offender should normally be arrested. An officer should be prepared to justify a decision not to arrest in these circumstances.

10. Prevention Strategy

10.1 The LSCBs expect all agencies and professionals working with children who are missing from home or care, or at risk of being missing from home or care, to implement this protocol, and ensure that all staff are aware of it and how to use it. It should be considered by professionals and agencies in all new and existing contacts with children. Together we will take steps to raise awareness, ensure improved responses and practice thereby delivering better outcomes for children.

10.2 It is intended that this protocol will assist in developing robust responses to children who go missing, which mirror good practice already established across Dorset. It should be used to engage partner agencies in developing preventative services for children and young people who are at risk of going missing.

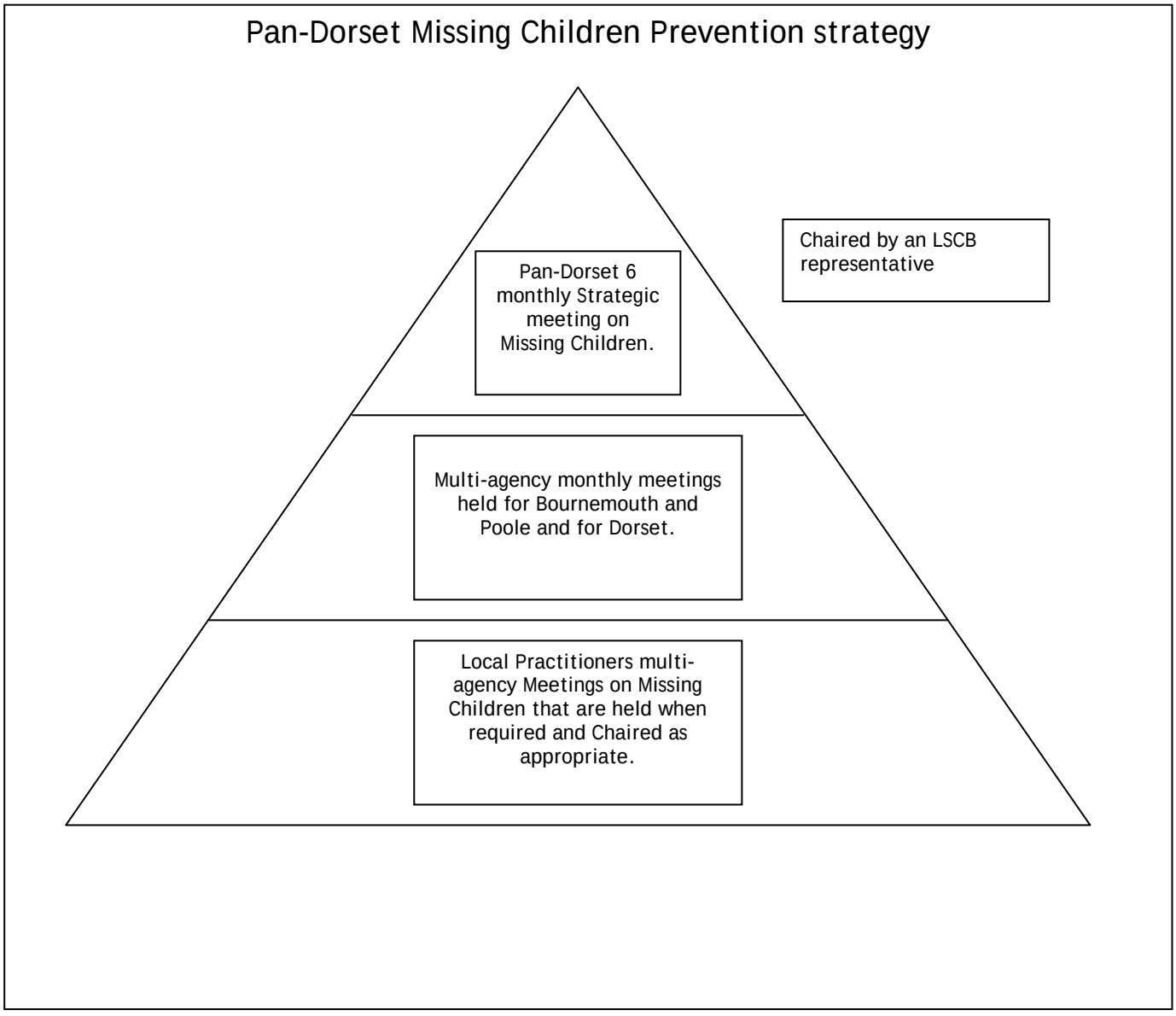
10.3 The Local Authority and police will monitor the missing episodes of all children. This will be presented in an annual report to the LSCB. Good practice would indicate that this should be a standing item on the agenda of the LSCB Executive Board (Working Together 2010).

10.4 Dorset Police and the Local Authority will operate an escalating system of interventions to reduce the likelihood of a child repeatedly going missing. Strategically, the meeting cycle shown below operates across the three pan-Dorset authorities, to maximise prevention opportunities and monitor multi-agency trends of children causing concern.

10.5 LSCBs will undertake a local needs analysis to identify specific local prevention measures to support the working protocol. Local Safeguarding Children Boards are charged with ensuring children and young people 'stay safe from harm' (Children Act (2004) Section 11.)

10.6 The Local Authority and police will monitor the missing episodes of all children. This will be presented in a quarterly performance report to the LSCB.

10.7 Dorset Police and the Local Authority will operate an escalating system of interventions to reduce the likelihood of a child repeatedly going missing. Strategically, the meeting cycle shown below operates across the three pan-Dorset authorities, to maximise prevention opportunities and monitor multi-agency trends of children causing concern.



Bournemouth & Poole Local Safeguarding Children Board

Dorset Safeguarding Children Board

PAN DORSET INTER-AGENCY SAFEGUARDING PROCEDURES

CHAPTER 3

3.11 MANAGING INDIVIDUALS WHO MAY POSE A RISK OF HARM TO CHILDREN

Procedures Effective from: **December 2010**

Review Date: **2012**

If you have any comments or queries about the pan-Dorset procedures please contact your agency representative on the Pan Dorset Policy and Procedures Group or notify the LSCB using the following email addresses:

info@dorsetlscb.co.uk
info@bournemouth-poole-lscb.org.uk

MANAGING INDIVIDUALS WHO POSE A RISK OF HARM TO CHILDREN

INDEX

1. Introduction

2. Multi-agency public protection arrangements

3. Children and young people with sexually harmful behaviour

4. People presenting a risk, or potential risk, of harm to children including notification process

5. Guidance on the disclosure to third parties of information about sex offenders and others without convictions who may present a risk to children

6. Checks with the CRB, Police Disclosure Unit and Child Abuse Investigation Team

7. Other processes and mechanisms

PART 1

INTRODUCTION

This section provides practice guidance and information about a range of mechanisms that are available when managing people who have been identified as presenting a risk, or potential risk, of harm to children.

The Children Act 1989 recognised that the identification and investigation of child abuse, together with the protection and support of victims and their families, requires multi-agency collaboration. As part of that protection, action has been taken, usually by the police and Children's Services, to prosecute known offenders or control their access to vulnerable children.

The Sexual Offences Act 2003 introduced a number of new offences to deal with those who abuse and exploit children in this way. (See www.opsi.gov.uk)
The term 'schedule one offender' should no longer be used for anyone convicted of a crime against a child. The focus should be on whether the individual poses a 'risk of harm to children'.

Part 2 of this guidance deals with the **multi-agency public protection arrangements** provided by the national framework for the assessment and management of risks posed by serious and violent offenders. Details of the referral, purpose and process of MAPPA are contained in this section.

Part 3 Children and young people who pose a risk to children may also be considered within the MAPPA but this part of the guidance sets out the policy and procedures to be followed when a **child or young person is behaving in ways that are sexually harmful**.

Part 4 details of the process to be followed for the **assessment and notification** of any individual who may pose a 'risk of harm to children'.

Part 5 describes the procedure for **disclosing information to third parties** about those who present a risk to children.

Part 6 clarifies **checks** and which Police unit should be contacted for information relating to specific individuals about whom there may be concerns or information is required.

Part 7 details the **other processes and mechanisms** for working with and monitoring people who present a risk to children.

PART 2

A JOINT AGENCY PROTOCOL FOR ASSESSMENT AND MANAGEMENT IN DORSET OF SEXUAL AND VIOLENT OFFENDERS OR OTHER OFFENDERS WHO MAY CAUSE SERIOUS HARM TO THE PUBLIC "CONVICTED" AND "UNCONVICTED, POTENTIAL OFFENDERS"

Foreword:

1. Introduction
2. Relevant Sexual and Violent Offenders
3. Risk Assessment
4. Child Protection Conferences
5. Organisational levels of Decision Making
6. Level 2 Multi-agency Public Protection Panel (MAPPP)
7. Management of Level 2 MAPPP
8. Level 3 Multi-agency Public Protection Panel
9. Management of Level 3 MAPPP
10. Wider Issues arising from Level 2/Level 3 MAPPPs
11. Defensible Multi-agency Decision Making
12. Roles and Requirements of Individual Agencies
13. Children's Services
14. Young Offenders – General
15. Young Offenders – Looked After by the Local Authority
16. Youth Offending Teams
17. Education
18. Mental Health Services
19. Housing
20. NSPCC
21. Crown Prosecution Service
22. Unconvicted Potential Offenders

Appendices:

Appendix 1 MAPPA Panel Criteria Checklist
Appendix 2 MAPPA Monthly Schedule
Appendix 3 Report to Level 2/3 MAPPP
Appendix 4 Level 2/3 MAPPP Minutes & Initial Risk/Review Assessment Meeting

1. INTRODUCTION

1.1 This protocol supersedes the previous Protocol on Potentially Dangerous Offenders Conferences.

1.2 A Joint Policy Statement and a full document entitled Operational Guidelines for Dorset Police, the National Probation Service Dorset area and the Prison Service is with the management of each agency.

1.3 Each agency will be aware of its own operational guidelines and reference documents and care should be taken to refer to those where appropriate.

1.4 The Criminal Justice Act 2003 Section 325 seeks to increase public protection by building upon the existing inter-agency arrangements.

The Act places a statutory duty on Police, Probation and the Prison Service as the 'responsible authorities' to make joint arrangements for the assessment and management of the risks posed by sexual and violent offenders, and other offenders who, by reason of offences committed by them, are considered to be persons who may cause serious harm to the public. These arrangements are known as the Multi-Agency Public Protection Arrangements (MAPPA).

1.5 In addition to the statutory responsibilities that Children's Services, Police, Probation and the Prison Service have there are a number of statutory and voluntary agencies that have an important role to play in effective public protection, these agencies have a duty to co-operate. This will include the National Health Service (including local Mental Health Services), Education, Local Authority Housing, Youth Offending Teams, NSPCC and a range of other agencies including the independent sector. In the County of Dorset, the aim of the Police, Probation and Prison Service will be to achieve agreement across agencies to put in place arrangements that will better protect the public.

1.6 Under S326 of the Act, there is a statutory requirement on the Police, Probation and the Prison Service to produce an annual report on the work carried out under the arrangements. It will be a clear and accessible document that informs and reassures the public about the work taking place for their protection. It will summarise the roles and responsibilities of all agencies involved.

2. RELEVANT SEXUAL AND VIOLENT OFFENDERS

2.1 The Police, Probation and the Prison Service have a responsibility to implement joint arrangements for the assessment and management of the risks posed by sexual and violent offenders, and other offenders who may cause serious harm to the public.

2.2 A person is a relevant sexual or violent offender if s/he falls within one or more of the categories set out in S327 of the Act, as follows:-

Category 1

S/he is subject to the notification requirements of Part 2 of the Sex Offenders Act 2003. See Operational Guidelines for Dorset Police, Prison Service and the National Probation Service Dorset Area.

Category 2

S/he is convicted by a court in England or Wales of a murder, or an offence specified in Schedule 15 of the Criminal Justice Act, (See Operational Guidelines for Dorset Police and the National Probation Service Dorset area) and one of the following sentences is imposed:

- a term of imprisonment of 12 months or more;
- detention in a Young Offender Institution for a term of 12 months or more;
- detention during Her Majesty's pleasure;
- a sentence of detention for public protection under S226 of the Act;
- detention for a period of 12 months or more under Section 91 of the Powers of Criminal Courts (Sentencing) Act 2000 (offenders under 18 convicted of certain serious offences);
- detention under S228 of the Act;
- detention and training order for a term of 12 months or more;
- a Hospital or Guardianship Order within the meaning of the Mental Health Act 1983;
- this category also includes persons found not guilty of murder or an offence specified in Schedule 15 of the Act by reason of insanity or under a disability and done the act charged against them in respect of the offence and one of the following orders is made:-

(i) an order that s/he be admitted to hospital; or

(ii) a Guardianship Order within the meaning of the Mental Health Act 1983.

("Court" does not include a Court-Martial or the Courts-Martial Appeal Court.)

Category 3

Other offenders: These offenders must have been convicted/formally cautioned or in the case of juveniles, reprimanded or warned for an offence that indicates that he/she is capable of causing serious harm to the public and the Responsible Authority considers that they may pose a risk of serious harm to the public which requires active multi-agency management.

Agencies that operate an Integrated Care Programme Approach (ICPA) should consider and risk assess via that system first. Agencies or individuals concerned about people posing a risk of serious harm should raise those concerns with the MAPPA coordinator who will discuss with the Detective Inspector or Detective Chief Inspector (as appropriate) to determine which individuals may pose a risk and whether they have any relevant criminal history.

INITIALLY ALL ISSUES MUST BE RAISED WITH A LINE MANAGER

3. RISK ASSESSMENT

3.1 Risk assessment is an ongoing process. All agencies involved must remain sensitive to factors that could indicate a change in the level of risk. Concerns must be acted upon through liaison, consultation and either a Level 2 or Level 3 Multi-Agency Public Protection Panel, if applicable.

4. CHILD PROTECTION CONFERENCE (CPC)

4.1 When it is apparent there is a risk of abuse from a convicted offender to an individual child which may not be alleviated by the management of the risk related to that person, a child protection conference will be required.

4.2 This child protection conference will be held separately from any Level 2/3 MAPPP. Where the only identified risk posed by an offender who is under the supervision of the Probation Service is to an identified child (ren) and there is a robust risk management plan that includes arrangements for good information sharing and attendance by the Offender Manager at Child Protection Conferences it will not be necessary to hold a separate MAPPA level 2 or 3 meeting. This will be decided by the MAPPA co-ordinator and Detective Inspector/ Detective Chief Inspector in consultation with the offender manager and social worker/independent conference chair. – in all other cases when the concern about an individual child is evident, it will be essential for Children's Services, and any other agency relevant to the circumstance, to attend the Level 2/3 MAPPP and relevant agencies to attend the CPC.

5. ORGANISATIONAL LEVELS OF DECISION MAKING

5.1 There are three levels of Conference decision making:-

Category 1, 2 or 3 offenders can be managed at Level 1, 2 or 3.

5.2 LEVEL 1 ORDINARY RISK MANAGEMENT

Is the level used in most cases where the risks posed by the offender can be managed by the agency responsible for supervision/case management of the offender. This does not mean that other agencies will not be involved only that it is not considered necessary to refer the case to a level 2/3 meeting. It is essential that good information sharing takes place and there are multi-agency case management meetings where necessary. This level can only be used for Category 1 and 2 offenders because by definition Category 3 cases require active multi-agency management.

If multi-agency meetings are required at Level 2 or 3 then the MAPPA Panel Criteria Checklist (Appendix 1) should be completed and countersigned by a manager before being sent to the MAPPA co-ordinator.

6. LEVEL 2 – MULTI-AGENCY PUBLIC PROTECTION PANEL – (MAPPP)

6.1 The criteria for referring a case to the Level 2 MAPPP are defined as those in which the offender:

Is assessed under OASys or Risk Matrix 2000 or other validated Risk Tool as being a high or very high risk of causing serious harm

and

Active multi-agency management of risk is required (in addition to Police and Probation)

6.2 Consultation must take place between the MAPPA co-ordinator and Detective Inspector to confirm that the criteria are met in Category 3 cases but for Category 1 and 2 cases the decision of the manager is sufficient to refer to Level 2.

6.3 The role of the Level 2 MAPPP is to:

- share information on those offenders referred to;
- identify the likelihood of re-offending
- Identify serious risk of harm issues and their imminence
- recommend the action necessary to manage the risk including any contingencies;
- Consider whether disclosure needs to take place
- Undertake a review of the risk management plan and ensure implementation of the agreed action(s) and revise if necessary;
- Review the risk level and decide if the case still needs to be managed at the current level.

7. MANAGEMENT OF THE LEVEL 2 MAPPP

7.1 Level 2 MAPPP will be convened on days as set out in the MAPPA timetable Appendix 2.

7.2 Category 1 offender's panels will be chaired by a Detective Inspector, a Senior Probation Officer or the MAPPA co-ordinator.

Category 2 offender's panels will be chaired by a Senior Probation Officer; a Detective Inspector, or the MAPPA co-ordinator.

Category 3 offender's panels will be chaired by a Senior Probation Officer if current to the Probation Service but otherwise will be chaired by a Detective Inspector or the MAPPA co-ordinator.

7.3 The MAPPA co-ordinator will determine who will be panel members. The MAPPA Secretary will book a room for the panel meeting.

7.4 Other agencies may be invited on the basis of current involvement or the need for likely involvement.

7.5 Staff directly involved in the case and their immediate line managers will be required to attend as will the Victim Liaison Officer, if appropriate.

7.6 Attendees are required to provide a written summary and submit key information and/or documents to the Chair on the day of the Panel Meeting. The papers will be photocopied and then distributed with the minutes. The format is as MAPPA 3. (Appendix 3)

7.7 The meeting will follow the Standing Agenda MAPPA 5. (Appendix 4)

7.8 A Level 2 MAPPP that concludes that a person meets the criteria for a Level 3 MAPPP must be referred to a Level 3 MAPPP via the MAPPA Co-ordinator.

7.9 Detailed draft minutes of the meeting will be made by the MAPPA secretary and distributed to the attendees.

7.10 The chair of the meeting will be asked to confirm that the minute is a correct record or to identify any necessary amendments. This should be done by the conference Chair within 5 working days of receipt.

7.11 If there are any amendments these will be made by the Chair and the amended minutes distributed by secure email or hard copy together with the reports

7.12 It is the responsibility of each attendee and agency to keep these minutes confidential and secure within their own file retention policy. They should not be shared with any other party without the permission of the chair of the meeting.

8. LEVEL 3 - MULTI-AGENCY PUBLIC PROTECTION PANEL

8.1 The criteria for referring a case to the Level 3 MAPPP are defined as those in which the offender:

(a) is assessed under OASys or Risk Matrix 2000, or other validated Risk Tool as being a high or very high risk of causing serious harm

AND

(b) presents risks that can **only** be managed by a plan which requires close multi-agency (in addition to police/probation) co-operation at a senior level due to the complexity of the case and/or because of the unusual resource commitments it requires

OR

(c) although not assessed as a high or very high risk, the case is exceptional because the likelihood of media scrutiny and/or public interest in the management of the case is very high and there is a need to ensure that public confidence in the criminal justice system is sustained.

Although these cases are not exclusively those assessed as high or very high risks, in almost all cases they will be. Also, while most will be offenders being released from prison, they may also include:

- an offender on discharge from detention under a hospital order;
- an offender returning from overseas (whether immediately following their release from custody or not);

- an offender who having been managed as a medium or even a low risk in the community comes to present a high or very high risk as the result of a significant change of circumstances.

8.2 Agencies attending Level 3 will, at a minimum, be Police and Probation Services, but may - and often should - also include Prison Service (Senior Probation Officer and Governor grades), Children's Services, Health, Local Authority Housing departments, YOTS, Victim Liaison and other statutory and voluntary agencies. Agencies should be represented at a senior level where an allocation of extra resources may be required to effectively assess and manage the risks.

8.3 The role of the Level 3, at a minimum, is to:

- share information on those offenders referred to it;
- identify the level of risk of serious harm posed by the offender and the likelihood of reoffending;
- recommend the action necessary to manage the risk including any contingencies;
- monitor and ensure implementation of the agreed action;
- review the level of risk and the action plan in the light of changes in circumstances or behaviour;
- consider and manage necessary resources;
- consider the need for disclosure and other community issues;
- agree a media strategy where appropriate;
- Set a date for the review (4-6 weeks for those in the community);

9. MANAGEMENT OF THE LEVEL 3 MAPPP

9.1 When a Level 3 MAPPP case has been identified the decision to convene a meeting will be taken by the Assistant Chief Officer (Probation) and the Detective Chief Inspector.

9.2 The Assistant Chief Officer (Probation) and Detective Chief Inspector will agree arrangements for convening a Level 3.

9.3 The conference will be chaired by the MAPPA Co-ordinator, a Detective Chief Inspector or the Assistant Chief Officer (Probation). It will be held on the days set out in the MAPPA calendar unless extenuating circumstances dictate otherwise.

9.4 The MAPPA co-ordinator will determine who will be panel members and set a date for the MAPPP meeting. (Usually the date set out in the MAPPA calendar) The MAPPA Secretary will book a room for the panel meeting.

9.5 The panel will include representation from agencies determined as relevant to the case by the Assistant Chief Officer (Probation) and Detective Chief Inspector.

9.6 Consideration will always be given to requesting the attendance of managers from the Prison Service (Governor grades), NSPCC, Health, Children's Services and Housing who have the authority and are in a position to commit resources.

9.7 Other agencies' senior managers who have the authority and are in a position to commit resources may be invited on the basis of current involvement or the need for likely involvement.

9.8 Staff directly involved in the case and their immediate line managers will be required to attend as will the Victim Liaison Officer, if appropriate.

9.9 Attendees are required to provide a written summary and submit key information and/or documents to the Chair on the day of the Panel Meeting. The papers will be photocopied and then distributed with the minutes. The format is as MAPPA 3 and will be sent out with the MAPPA invitations.

9.10 The meeting will follow the Standing Agenda. (MAPPA 5) Appendix 4

9.11 Detailed draft minutes of the meeting will be made by the MAPPA secretary and distributed to the attendees and as determined by the Chair.

9.12 If there are any amendments these will be made by the Chair and the amended minutes distributed by secure email or hard copy together with the reports presented.

It is the responsibility of each attendee and agency to keep these minutes confidential and secure within their own file retention policy. They should not be shared with any other party without the permission of the chair of the meeting.

10. WIDER ISSUES ARISING FROM LEVEL 2 AND LEVEL 3 MAPPPs

10.1 As a part of the MAPPA process the Chairs of Level 2 and Level 3 meetings must consider issues which arise from the cases specifically considered, but which have a wider significance or where difficulties occur with the local provision of services to assist in the management of risk.

10.2 The MAPPA Co-ordinator needs to be made aware of these issues by Chairs in order that the MAPPA Strategic Management Board can consider the issue if necessary.

11. DEFENSIBLE MULTI-AGENCY DECISION MAKING

11.1 All agencies need to be aware that Multi-agency Public Protection Panels (Level 2 or Level 3) should be able to demonstrate:

- Ensure decisions are grounded in the evidence.
- Use reliable risk assessment tools.
- Collect, verify and thoroughly evaluate information.
- Record and account for your decision making.
- Communicate with relevant others, seek information you do not have.
- Stay within agency policies and procedures.
- Take all reasonable steps.
- Match risk management interventions to risk factors.
- Maintain contact with offender at a level commensurate with the level of risk of harm.
- Respond to escalating risk, deteriorating behaviour, and non-compliance.

11.2 An audit programme is in place conducted by the MAPPA Coordinator and Lay Advisor.

11.3 Probation MAPPA lead, quarterly, to identify any areas of weakness.

12. ROLES AND REQUIREMENTS OF INDIVIDUAL AGENCIES

12.1 Duty to Co-operate**.**

12.2 Section 325(3) of the Criminal Justice Act 2003 imposes on specific organisations which provide public services a 'Duty to Co-operate' with the MAPPA Responsible Authority in the fulfillment of its obligation to establish arrangements for the purposes of assessing and managing risks posed by MAPPA offenders. A reciprocal duty is imposed on the responsible authority to act in co-operation with those organisations.

12.3 The Act requires external organisations to co-operate only in so far as this is compatible with their existing statutory responsibilities. It does not therefore impose on them a duty to do anything operationally beyond what they are already required to do. They are, however, required to carry out their responsibilities where these relate to MAPPA offenders, collaboratively with the responsible authority and the other organisations on whom a duty is imposed.

12.4 The purposes of co-operation are:

(a) to co-ordinate the involvement of different agencies in assessing and managing risk;

(b) to enable every agency, which has a legitimate interest, to contribute as fully as its existing statutory role and functions require in a way that complements the work of other agencies.

Co-operation depends upon respect for the different role each agency performs and the boundaries which define it. Unless clarity about authority is maintained, responsibility and accountability will become clouded and Duty to Co-operate agencies may misunderstand the basis upon which they co-operate. In turn, this may cause representatives of those agencies to feel dis-empowered or professionally compromised – a result which the statutory basis of the duty is explicitly designed to prevent. Without this clarity, agencies may assume that a referral of a case to either a level 2 or

level 3 meeting somehow diminishes or even absolves them of any continuing responsibility, which is not the case.

Successful engagement of an agency's co-operation is therefore dependent upon:

(a) Identifying that an agency has a legitimate interest or specific responsibility;
(b) advising about how best it can become involved, and,
(c) helping it to co-ordinate its involvement with that of other agencies.

13. CHILDREN'S SERVICES

13.1 Children's Services receive notifications from the police on adults and young people arrested for offences against children and young people under 18 years. Notifications of convictions can be received from the Court, penal establishments, the Probation Service, the Youth Offending Team and other local authorities and may relate to custodial and non-custodial sentences.

13.2 Notification is received from the Police Sex Offender Unit about convicted sexual offenders who have to register their address with the Police as part of the requirements of the Sexual Offences Act 2003. Included are those cautioned for sexual offences, who are also required to register their address with the Police. This is using form C202 forwarded to the Safeguarding Manager, Dorset County Council, who will in turn forward the details to Poole/Bournemouth Unitary Authorities. Where there is an identified risk to a child(ren), a referral will be also be made to Children's Services under Inter-agency Safeguarding Procedures.

13.3 When a notification is received Children's Services will make initial checks including checking their database and record the information. If as a result concerns are identified these will be responded to in accordance with safeguarding procedures. (For further information see Inter-agency safeguarding procedures Chapter 3.11 part 4.)

13.4 The information obtained on offenders convicted of offences against children will be retained by Children's Services and referred to as and when need arises.

13.5 When a child is considered to be at risk, a child protection conference will be required (LSCB Inter-Agency Child Protection Procedures apply) unless the risk is immediately alleviated by the intervention of Children's Services and it is evident there is no continuing risk.

13.6 Transition protocols must be adhered to in respect of young people who are moving from Children's Services to Adult's Services, where it is identified that they may cause serious harm to the public or themselves.

13.7 As part of the MAPPA, Children's Services will be invited to attend MAPPP's as appropriate.

14. YOUNG OFFENDERS - GENERAL

14.1 The Act includes sexual offenders who are under 18 years of age when convicted or cautioned for a relevant sexual offence. The differences for young people are:

Registration Period

The duration of the registration period is halved unless the conviction is for an indefinite period.

Penalties for not Registering

An offender under 18 years who fails to register has committed an offence - the liability, if convicted, is a fine rather than imprisonment.

Responsibility for Notification

When a young person is sentenced to custody, the court may direct that an individual having parental responsibility for him or her complies with the provisions of the Act on behalf of the young person until the age of 18 has been reached.

Additional policy and procedures in relation to children and young people with sexually harmful behaviour can be found in Bournemouth, Dorset and Poole's Inter-agency Safeguarding Procedures.

15. YOUNG OFFENDERS – LOOKED AFTER BY THE LOCAL AUTHORITY

15.1 Children's Services also have a specific role when:

- a child who is looked after by the Authority is convicted of an offence under the Sexual Offences Act 2003.

15.2 When a looked after young person is cautioned for a relevant sexual offence, it is the young person's responsibility to comply with notification requirements. The Police will notify the nominated person in Children's Services of any such cautions. The nominated person will pass the information to the supervising social worker.

15.3 In the case of both convictions and cautions, the social worker will need to:

- ensure all written notifications are placed on the young person's file;
- inform those with day-to-day care of the young person of the registration requirements;
- assist the young person to comply with notification requirements;
- ensure the young person is reminded of the requirement to notify the Police every time a move occurs, until the young person ceases to be looked after;
- ensure that any new day-to-day carers are informed of the registration requirements;
- ensure that the nominated Education representative is notified that the young person is a pupil at a school (including a 6th Form) or a student at a college.

16. YOUTH OFFENDING TEAMS

16.1 YOT Risk Assessment.

16.2 The Youth Offending Teams work with all young offenders aged 10 to 17. The teams follow the procedures outlined in this document. In this protocol for this age group of offenders references to "Probation Officer" can be replaced by "YOT Officer".

16.3 The Probation Officers seconded to the teams are used as link points.

16.4 The Youth Offending Teams complete a standard assessment process, the "ASSET" form, on all young offenders with whom they carry out any interventions. This is a nationally implemented form issued by the Youth Justice Board.

16.5 ASSET is completed at the beginning, middle and end of an intervention.

16.6 ASSET creates a risk score, which can then be used to inform the assessment of likelihood of harm and risk to the public and others. Where significant risk of harm is identified in the core ASSET then a Risk of Serious Harm ASSET would be completed.

16.7 Following this assessment when appropriate the YOT would follow the MAPPA procedures.

17. EDUCATION

17.1 Schools and other educational establishments will have a direct interest and involvement if a convicted offender is:

- A young person of compulsory school age or student in a school 6th Form/or a student at a college.
- Known to have connections with the school, living near the school or loitering in the vicinity of a school.

17.2 Reference will be made to the nominated Education representative:

- Where the above is known to apply and where a Level 2 or Level 3 Multi-Agency Public Protection Panel is scheduled, contact should be made initially with a nominated person in the relevant authority;
- the nominated Education representative will consider the implications and will arrange for a relevant person to attend the Level 2/3 panel;
- discussion related to concerns, in advance of a Level 2/3 panel being scheduled, will be with the nominated person from Education, as above;
- if a Level 2/Level 3 occurs within which there are implications for Education, but where there was no recognition in advance of such issues, a sub-group of the main panel will be identified to initiate contact with the nominated Education representative as above. This sub-group will then meet with the person identified by the nominated

Education representative, to formulate an action plan to take account of the factors arising from the Level 2/3 panel;

- where the concern is initiated in a school or other educational establishment, the Head or other relevant person should seek advice from the person nominated by their Education Authority. As a result this nominated person will make contact with the local Probation office or Police as appropriate, or will agree who from the school staff will undertake this action;

- following a Level 2/3 panel, if the required action is continuing, then a method of updating/reviewing the progress will be identified.

18. MENTAL HEALTH SERVICES

18.1 Specialist Mental Health services are provided by two Trusts across Dorset: Dorset Healthcare NHS Foundation Trust (DHFT) for East Dorset and North Dorset Primary Care Trust (NDPCT) for West Dorset. These two Trusts have arrangements with Local Authority Children's Services to provide integrated Community Mental Health Teams to undertake the following in respect of MAPPA and mentally disordered offenders (MDO) to whom they provide care:-

- To identify MDOs considered suitable for Level 2 and 3 MAPPPs;
- to refer such individuals into MAPPA;
- to disclose only the necessary information required to assess and manage the risks presented working as closely as possible within the Trusts' policy on confidentiality;
- clinicians and managers involved in the case are to attend all panels and present reports as required;
- to amalgamate risk management plans into the Integrated Care Programme Approach of the individual who is the subject of the MAPPA.

18.2 DHFT provide the Dorset Forensic Services (DFS) which is a pan Dorset service for offenders with more severe disorders and higher levels of risk. Staff from DFS will attend all Level 2 and 3 MAPPPs called on their patients. This service will also provide the Health Service representation on the Dorset Strategic Management Board for MAPPA.

Sex Offenders Detained in Hospital or Subject to Guardianship Orders under the Mental Health Act 1983.

18.3 A hospital manager's referral of an offender who is detained in hospital or subject to guardianship under the Mental Health Act 1983 following sentencing or cautioning for a relevant offence, on receipt of notification:-

- should ensure that the patients' records are endorsed; and
- if necessary, inform the new hospital managers, prison or local Children's Services authority if the patient is transferred to another hospital, back to prison or guardianship.

18.4 The hospital manager must remind the patient of the registration requirements when they leave hospital on discharge or long term leave in the community.

18.5 Hospital detention in these cases is likely to be at one of the special hospitals and, although there are no special hospitals in Dorset, both the main psychiatric

hospitals at Forston Clinic, Dorchester and St Ann's Hospital, Poole have the potential to receive such patients in their care. If staff are unsure whether the person they are supervising comes under the provisions of the Mental Health Act 1983, they should discuss the position with the relevant manager. If there are immediate child protection concerns reference should be made to the named nurse for child protection advice, followed as applicable by referral without delay to the relevant Children's Services children services team.

Patients Subject to Guardianship

18.6 Children's Services are not required to take any special action in respect of people subject to guardianship who are served with notice to register under the Sexual Offences Act 2003. However, as a matter of good practice a supervising social worker should discuss registration requirements with the person concerned and assist them to comply.

18.7 When a person subject to the provisions of the Act is discharged from guardianship or is transferred to another local authority area, the information regarding the address of the person, which is held by the Police, should be updated. Social workers should explain this to the person and ask their permission to disclose the information. If consent is refused the relevant senior manager will be informed, so that there can be a discussion about the risk posed by the person and a decision made on the basis of public interest and whether this justifies overriding the refusal of the person to have the information passed to the Police. This discussion should be recorded and signed.

18.8 Any information about change of address will be passed to the Police Sex Offender Unit in the area where the sex offender will become resident.

Disclosure of Information: Sex Offences/Other Potentially Dangerous Offences

18.9 Where it is important and relevant for staff and agencies to share information or have information disclosed to them regarding the offender, this will be on a strictly confidential basis.

18.10 Consideration of the need to make disclosure to protect victims, potential victims, staff and other persons in the community will be undertaken at every Level 2 and 3 MAPPP meeting and a plan identifying necessary action will be agreed if appropriate. The meeting will identify who needs to receive disclosure, what information needs to be disclosed, who will make that disclosure and where and when it will take place. The minutes of the meeting will clearly record those decisions. Disclosure to third parties will also include advice on how that information is to be used and where the recipients(s) may seek additional support and guidance. (See also Inter-agency safeguarding procedures Chapter 3.11 Part 5)

18.11 The authority to disclose information is contained within section 115 Crime and Disorder Act.

19. HOUSING

19.1 Housing Authorities/Associations may have a role in connection with:

- Housing applicants/tenants who have been/are convicted of sexual offences or other dangerous offences;

- housing applicants/tenants who live in proximity to a person convicted of a sexual offence or other dangerous offence;

- applications from persons convicted of sexual offences or who are deemed to be dangerous offenders.

19.2 When these factors arise, the Housing Authority should expect to be invited to the Level 2/3 panels, or if a concern becomes apparent, they should make contact with the local Probation office to provide relevant information.

Implications for Housing Policy and Practice

19.3 Where a person who is required to register as a sexual offender, or who is a dangerous offender, has a housing need and requires re-housing then the relevant housing authority should be invited to send a representative to the Level 2/3 panel. Identified concern relating to housing need should be included fully in the action plan. Where this need was not apparent in advance and the relevant housing authority was not represented at the conference, there should be a further conference or, if more applicable, a sub-group should be identified to share the matter in full with the relevant housing authority.

19.4 A secure Council/Housing Association tenant who is a sexual offender might apply for an urgent transfer after experiencing harassment/threats of violence as a consequence of the offence(s) committed or of the disclosure of information.

19.5 If an offender who is a tenant is considered to be at risk of violence following the disclosure of information, an urgent transfer should be considered if that is what the tenant wants. Similarly, if following a risk assessment the police ask for a transfer of an offender who is a tenant - and providing a transfer would assist in the management of risk - the housing authority will endeavour to comply with this request. Normally this could occur only if the tenant agrees to the transfer.

19.6 Tenants may apply for an urgent transfer because they believe they are at risk from a sexual offender or another dangerous offender in their area following the disclosure of information.

19.7 Tenants will not normally be granted an urgent transfer unless there is a specific risk to them from the sexual offender/dangerous offender. A more general risk to a local community (for example to all of those with young children) will not normally be considered cause to grant urgent transfers to all or part of the community.

19.8 A specific risk might be present for example:

- if a tenant or a member of the household is a previous victim of the offender;
- if a tenant is particularly vulnerable (for example people who have previously been the victim of a similar offence to the one committed by the offender, young care leavers, people with a mental illness or disability);
- due to of the location of the tenancy and the nature of the offence committed (for example an elderly woman sharing communal facilities with an offender who has been convicted of the rape or assault of an elderly woman).

- In all cases, the individual circumstances of a transfer applicant will be taken into account in reaching a decision about whether to grant an urgent transfer or other method of re-housing.

19.9 The families of sexual offenders or other dangerous offenders may be the victims of harassment/threats of violence following disclosure of information. Such families will be supported, advised and given practical assistance by the housing authority. The practical assistance offered will depend on the needs of the family and could include increasing the urgency of any arrangement for a mutual exchange, supporting a move to another area or accepting the family as homeless and re-housing them in another part of the district.

19.10 Sexual offenders or other dangerous offenders may become homeless as a direct or indirect consequence of the offence(s) committed or the disclosure of information, for example following release from prison/discharge from hospital or after being forced by harassment or threats of violence to leave accommodation either in this area or another part of the country.

19.11 Homeless applications from sexual offenders must be assessed in accordance with the terms of Part VII of the Housing Act 1996. If a duty to provide accommodation exists, neither the nature of the crime committed nor any difficulty in providing accommodation without risk to others negates that duty. To protect victims it is often necessary to ensure that dangerous offenders do not return to their original locality. In such cases Local Authorities should not insist upon a local connection before accepting the referral. In cases where the offender has no local connection anywhere (other than the locality of their original offence to which they cannot return), Local Authorities should not insist upon a local connection before accepting the referral. As far as possible in other cases Local Authorities should interpret any local connection with the Dorset area as being sufficient to accept a referral, even if a stronger connection exists elsewhere. It should be noted that residence in a Bail Hostel does not create a local connection. The duty must be discharged in a flexible and appropriate manner, to include the support of other agencies.

19.12 Housing Authorities have a statutory duty to consider whether an applicant has made themselves intentionally homeless as a result of their actions. If such a decision is made the local authority will actively work with Gateway to find an alternative housing solution in the private sector or elsewhere. Referrals will not be turned down as intentionally homeless solely on the grounds that they have perpetrated acts that have caused them to be imprisoned.

19.13 Homelessness applications might be received from people who believe they are at risk from a sexual offender or other dangerous offender in their area following disclosure of information.

19.14 A homeless applicant will not normally be considered homeless in these circumstances unless there is a specific risk to them from the offender. A more general risk to a local community will not normally result in a decision that all or part of that community is homeless.

19.15 A specific risk might be present, for example:

- If the homeless applicant or a member of the household was a previous victim of the offender;

- if the homeless applicant was particularly vulnerable (for example young care leavers, people with a mental illness or disability, people who have previously been the victim of similar offence to the one committed by the offender);

- because of the location of the homeless applicant and the nature of the offence committed.

19.16 In these circumstances, the homeless applicant may be considered homeless. However, the individual circumstances of the homeless applicant will always be taken into account in reaching a decision.

19.17 There may be considerable difficulty in managing risk where there is a duty to provide temporary or permanent accommodation for a sex offender or other dangerous offender.

19.18 If the housing authority has a legal duty to provide accommodation under the terms of Part VI (Allocation of Housing) or Part VII (Homelessness) Housing Act 1996, convictions for sexual or other dangerous offences do not negate this duty. In reaching decisions about the type and location of accommodation the following should be taken into account:

- Location of any victims of the sex/dangerous offender;

- the nature of the offences committed and the offending pattern;

- advice from other agencies on minimising risk. In particular, it is expected that the Police will give advice and guidance on what action is required to be taken following disclosure of information;

- those who are most at risk from the offender (children/frail/elderly/vulnerable adults/women/men).

19.19 It may be the case that an offender is harassed or threatened with violence by a tenant following disclosure of information. Such behaviour is anti-social and may breach the tenancy conditions. Action to evict a tenant in such circumstances could be considered.

19.20 Tenants who are convicted of offences during the course of their tenancy, where the victim is a person living in the locality, may be in breach of their tenancy conditions. This will constitute a ground for eviction if it is an arrestable offence committed in the locality of the property. The legislation does not define locality but this will depend on the circumstances.

20. NSPCC

20.1 In partnership with Dorset Children's Services, Bournemouth Children's Services, Poole Children's Services, and Dorset Probation area – the NSPCC undertakes to provide an Assessment and Treatment Service for convicted sexual offenders and an Assessment and limited treatment programme for unconvicted offenders within the county across Dorset, Poole and Bournemouth.

20.2 The NSPCC will work with such offenders where a primary risk to children is identified. As such, offenders will be offered group work within the Home Office accredited Thames Valley Sex Offender Programme if they meet the criteria.

20.3 The NSPCC will accept referrals from the above agencies where potential risk from an adult has been identified, or where an adult has been sentenced by the court and received a valid Treatment Order.

20.4 As part of this process, the NSPCC will liaise with the Police, Probation, and Children's Services departments and other relevant agencies, making their assessment/treatment reports available as necessary. The NSPCC will share their final report from the Thames Valley Sex Offender Group programme with Dorset Police and Dorset Probation Area so that they are better informed to manage the risk. Wherever possible, the NSPCC will attend level 2/3 panels as requested and appropriate, in order to share information.

20.5 During the course of their work, if it comes to the NSPCC's attention that concerns are present which suggest risk to a child/ren, the NSPCC will liaise immediately with the relevant agencies and share this information.

20.6 The NSPCC also have a role in undertaking assessment and intervention work with young people aged ten to seventeen who pose a sexual risk to other children/young people. These may be within or outside the criminal justice system and subject to the same NSPCC checks and procedures as those which apply to adult abusers.

20.7 The NSPCC will inform the referring agency (and any other relevant agency) of new child protection concerns relating to a young person with whom they are working, as soon as this becomes apparent. All reports written by the NSPCC about a young person will be made available to multi-agency assessment meetings upon request. This is a condition of the NSPCC's contact with young persons.

21. CROWN PROSECUTION SERVICE (CPS)

21.1 The CPS will take account as necessary of a MAPPP's information with regard to an offender in the Criminal Justice System. Liaison with CPS will usually be via the Police or Probation service.

22. POTENTIALLY DANGEROUS PERSONS (PDP)/ASSESSMENT OF RISK MEETINGS (ARM)

22.1 The statutory MAPPA guidelines relate to convicted persons only and require that an individual must have been subject to some form of criminal justice disposal before inclusion in the MAPPA process.

22.2 There are a number of individuals that are potentially dangerous that pose a risk of sexual, violent or other serious harm to the public who are unconvicted. These are classed as Potentially Dangerous Persons.

22.3 The agency managing the individual will usually be the first to identify that a case involving an unconvicted person would benefit from a multi-agency assessment of risk meeting. Any agency can request this multi agency meeting to

facilitate effective information-sharing in order to reduce the risk of harm to the public (refer to Inter-agency safeguarding procedures Chapter 3.11 Part 5)

22.4 The requesting agency is responsible for the arrangements for such a meeting including; inviting relevant professionals providing secretarial support and Chairing.

22.5 The MAPPA guidelines and MAPPA minutes form Appendix 4 can be used by any agency to document a PDP conference. In ALL cases the conference must be minuted. This ensures accurate recording and defensible decision-making with regard to an unconvicted person who poses a risk of sexual, violent or other harm to the public.

22.6 When requesting an ARM meeting consultation should take place via the Detective Chief Inspector or Detective Inspector responsible for MAPPA. This is in order to provide support for the process and to set clear expectations.

22.7 All documentation relating to an ARM meeting must be stored according to MAPPA guidelines. Records must be stored in the secure confidential section of files.

APPENDIX 1

Integrity | Professionalism | Fairness | Respect

RESTRICTED (When completed)

DORSET MULTI-AGENCY PUBLIC PROTECTION ARRANGEMENTS

MAPPA CRITERIA CHECKLIST AND REFERRAL FORM

REFERER DETAILS	
Name:	
Agency:	
Address:	
Telephone:	
Date Completed:	

OFFENDER DETAILS	
ViSOR reference:	
Family name:	
First name:	
Middle name:	
Alternative name/s:	
Date of birth:	

PART 1 IDENTIFICATION*

Category 1 ☐ Registered Sex Offender
Category 2 ☐ Violent or Sex Offender (non registerable)
Category 3 ☐ Other Dangerous Offenders

Relevant conviction/ caution/ reprimand or warning

Offence(s)	
Date of sentence	
Sentencing Court	
Sentence	

* Please refer to the National MAPPA Guidance V2.0 summary on page 6 for definitions of categories

PART 2 RISK MANAGEMENT LEVEL

1.Risk of Serious Harm Assessment

Risk Matrix 2000 Score: Very High

Relevant OASys risk assessment:

Children:	Not applicable
Public:	Not applicable
Known Adult:	Not applicable
Staff:	Not applicable
Prisoners:	Not applicable

Other validated risk tool:	
Assessment of risk:	
Completed by:	
Agency:	
Date of assessment	

2. Management Level

Level 3

Assessed under OASys or Risk Matrix 2000 or other validated risk assessment tool as being a high or very high risk of causing serious harm;

AND

Presents risk that can only be managed by a plan which requires close multi-agency (in addition to Police and Probation) co-operation at a senior level due to the complexity of the case and/or because of the unusual resource commitments it requires;

OR

Although not assessed as a high or very high risk, the case is exceptional because the likelihood of media scrutiny and/or public interest in the management of the case is very high and there is a need to ensure that public confidence in the criminal justice system is sustained.

CRITERIA: MET

If criteria are met then the following WILL APPLY:-

- Complete Part 3 – referral to MAPPA level 2 or 3 meeting
- Pass completed form to line manager for countersignature
- Line Manager will pass form to the MAPPA co-ordinator and MAPPA secretary as per referral process
- MAPPA co-ordinator will seek agreement of the Detective Chief Inspector for MAPPA and the Assistant Chief Officer for Probation

Line manager countersignature:	
Line manager Comments:	
Date	

Decision: (to be completed by the MAPPA co-ordinator)

Level 2

Assessed under OASys or Risk Matrix 2000 or other validated risk assessment tool as being a high or very high risk of causing serious harm;

AND

Active multi-agency management of risk is required (in addition to Police and Probation).

CRITERIA: MET

If the criteria are met then the following WILL APPLY:-

- Complete Part 3 – referral to MAPPA level 2 or 3 meeting
- Pass form to line manager for countersignature
- Line Manager will pass form to the MAPPA co-ordinator and MAPPA secretary as per referral process

Line manager countersignature:	
Line manager Comments:	
Date	

If Criteria for level 3 or 2 is not met and/ or Risk of Serious Harm is Medium or Low the case will be managed at Level 1

Level 1:

Line manager countersignature:	
Line manager Comments:	
Date	

If assessed under OASys or RM2000 as being a high or very high risk of causing serious harm but criteria for Level 2 or 3 not met the police officer or probation officer should refer to the MAPPA Operational Guidance for Police and Probation: Chapter 5: The Management of MAPPA Offenders.

PART 3 REFERRAL TO MAPPA LEVEL 3 OR 2 MULTI - AGENCY MEETING

Offender details	
Gender:	
Ethnicity:	
Disability/diversity considerations:	
NI number:	
Prison number	
PNC number:	
CRO number:	
Agency unique reference:	
Current address:	
Postcode:	
Proposed discharge/ release address:	

Relevant Dates	
Parole Eligibility Date:	
Non Parole Date:	
Conditional Release Date:	
Automatic Release Date:	
End of Custody Licence Date:	
Licence End Date:	
Sentence End date:	
Sex Offender Registration:	
Sex Offender Prevention Order:	
Mental Health Tribunal Date:	

Victim Liaison	
VLO involvement:	
VLO Name:	
VLO address:	
VLO telephone No:	

Details of other agency involvement

Name	Agency and address	Telephone Number

MAPPA co-ordinator and MAPPA secretary can be contacted at:

Dorset Probation Area
Forelle House
Marshes End
Upton Road
Poole
BH17 7AG

Tel: 01202 664085 (MAPPA co-ordinator)
01202 664086 (MAPPA Secretary)

Fax: 01202 664061

Category 1 Offenders: Registered Sexual Offenders (RSOs)

This Category includes offenders required to comply with the notification requirements (often referred to as registration requirements) set out in Part 2, Sexual Offences Act (2003). These offenders are often referred to as being on the 'Sexual Offender Register'. A person convicted of, cautioned for, or in respect of whom a finding is made in relation to an offence listed in Schedule 3 to the Sexual Offenders Act (2003) will become subject to the notification requirements of Part 2 of that Act.

Category 2 Offenders: Violent and Other Sexual Offenders

This category refers to those that are convicted of a serious offence as set out in Schedule 15 Criminal Justice Act **AND currently subject to one of the following:**

- A term of imprisonment of 12 months or more;
- A Suspended Sentence where the term of imprisonment is 12 months or more
- Detention in a Young Offenders Institution for a term of 12 months or more;
- Detention and Training Order for 12 months or more
- Detention under Section 91 of the Powers of Criminal Courts (Sentencing) Act 2000 for 12 months or more (offenders aged under 18 years)
- Life imprisonment or an indeterminate sentence under public protection……
- Hospital or Guardianship Orders within the meaning of the Mental Health Act 1983
- He/ She is found guilty of a sexual or violent offence by reason of insanity or a disability but is considered to have done the act charged against him/ her and was sentenced by way of a Hospital or Guardianship Order within the meaning of the Mental Health Act.

Category 3 Offenders: Other

This category is comprised of offenders, not in either Category 1 or 2 but who are considered by the responsible Authority to pose a risk of serious harm to the public which requires active multi- agency management. The inclusion of offenders in this category is determined by the Responsible Authority. Unlike categories 1 and 2 identification is not determined by the sentence or other disposal of the court.

- Establish that the person has committed an offence which indicates that he/she is capable of causing serious harm to the public. This is not limited to those that are convicted by the courts, rather it includes adults who have been formally cautioned and juveniles who have been reprimanded or warned. This is because all of those processes require an admission of guilt in relation to an offence.

AND

- The responsible Authority must reasonably consider that the offender may cause serious harm to the public

AND

- A multi-agency approach at level 2 or 3 is necessary to manage the risk. This means the offender should present a high risk of serious harm.

APPENDIX 2

Integrity | Professionalism | Fairness | Respect

DORSET MULTI-AGENCY
PUBLIC PROTECTION ARRANGEMENTS

NATIONAL PROBATION SERVICE

MAPPA CALENDAR

Level 2 West Week 1 (Thur – Weymth[2])	Level 2 East Week 2 (Tues – Bmth[1])	Level 2 West Week 3 (Tues- Weymth[2])	Level 2 East Week 4 (Thu – Bmth[1])

Potential Level 2 Day "Overflow" Week 4 (Tues – Poole[3])	Level 3 Week 3 (Wed – Poole[3])	SMB (Fri – Poole[3])
		January April July October

[1] Bournemouth = Probation Office, Madeira Road, Bournemouth, BH1 1QL

[2] Weymouth = Meeting Room, Child Protection Unit, Dorset Police Western Division HQ, Radipole Lane, Weymouth, DT4 9WN

[3] Poole = Probation Office, 63 Commercial Road, Parkstone, Poole, BH14 0JB

APPENDIX 3

Integrity Professionalism Fairness Respect

NATIONAL PROBATION SERVICE

DORSET MULTI-AGENCY
PUBLIC PROTECTION ARRANGEMENTS

REPORT TO MAPPA

DATE OF MEETING:	

NAME OF OFFENDER:	
DOB:	
AKA/ALIAS:	
ADDRESS:	
POSTCODE:	

REPORT BY:	
AGENCY:	
ADDRESS:	
COMPLETED:	

Authority of information request

The Criminal Justice Act 2003, the Data Protection Act 1998, the European Convention on Human Rights and common law, all place a duty on the Responsible Authority and Duty to Co-operate agencies to share and disclose information to ensure essential and effective public protection.

This request is made under section 115 of the Crime and Disorder Act 1998 (CDA) which confers on any person a power to pass information to certain authorities (including police, probation, prison, health and local authorities) if necessary to help implement the provisions of the Act.

I understand that any information supplied is confidential in its nature and I confirm that it will be used for specified purposes only. I understand I must not pass on any information supplied at the MAPP meeting to any other agency or individual without the express permission of the MAPP Chair at the MAPP meeting.

CARE SHOULD BE TAKEN TO DISTINGUISH BETWEEN FACT, OBSERVATION, ALLEGATION AND OPINION.

Report:

Risk Management Plan:

SIGNED……

DATE……/……/……

Please ensure you bring two copies of this report to the meeting – one to read to those present and one to be attached to the minutes

APPENDIX 4

Dorset Police

Integrity | Professionalism | Fairness | Respect

NATIONAL PROBATION SERVICE

Multi-Agency Public Protection Arrangements
Initial / Review MAPPA Meeting Minutes

1. Introduction by Chair

MAPPA Meeting Chair:	
Minutes completed by:	

2. Confidentiality Statement

In working with offenders, victims and other members of the public all agencies have agreed boundaries of confidentiality.

The information contained in these MAPP meetings respects those boundaries of confidentiality and is shared under an understanding that:

1) The meeting is called in circumstances where it is felt that the risk presented by the offender is so great that issues of public or individual safety outweighs those rights of confidentiality.

2) These minutes are closed under the Freedom of Information Act 2000 under one or more of the following reasons:

a) Investigations and proceedings by Public Authorities (S.30(1)(B))

b) Health and safety (S.38)
c) Personal information (S.40)
d) Information provided in confidence (S.41)

3) The discussions and decisions of the meeting take account of Article 8.2 European Court of Human Rights, with particular reference to:

a) Public safety
b) The prevention of crime and disorder
c) The protection of health and morals
d) The protection of the rights and freedom of others

All documentation will be marked RESTRICTED.

These minutes should not be photocopied or the contents shared outside of the meeting without the agreement of the Chair. Minutes should be kept in the RESTRICTED or CONFIDENTIAL section of agency files.

If further disclosure within your agency is felt essential, permission should be sought from the Chair of this MAPP meeting and a decision will be made (share on a need-to-know basis, share information which is proportionate and necessary) as to what information can be shared.

3. Offender Information

ViSOR reference:	
Family name:	
First name:	
Middle name:	
Alternative name/s:	
Date of birth:	

Date of meeting:	
Time of meeting:	
Venue of meeting:	

4. Attendee introductions and apologies

Attendees:	
Apologies with reports:	
Apologies:	
Invited and did not attend:	

5. Subject's Legal and MAPPA status

Category 1 ☐ Registered Sex Offender
Category 2 ☐ Violent or Sex Offender (non registerable)
Category 3 ☐ Other Dangerous Offenders

Relevant conviction/ caution/ reprimand or warning

Offence(s)	
Date of sentence	
Sentencing Court	
Sentence	

5a. Case Summary

6. Summary of referral Information

6a. MAPPA Risk Management Plan review		
Who	**What**	**When by**

7. Additional Information from other agencies

8. Risk to Victims

9. Diversity Considerations

10. Risk Assessment Summary

11. Disclosure Decision	
Was disclosure considered?	**Yes**
Will disclosure take place?	**Yes**
Reasons and details – what will be disclosed, who to, by whom, when by	

12. Communication: media and press handling

13. MAPPA Risk Management and Decision		
Risk Management Plan decision		
Planned actions to be taken		
Who	**What**	**When**

Does this case require on going management at level 2/3	**Yes**
14. Human Rights Act validation	
15. Update to ViSOR	
16. Issues for reporting to the MAPPA SMB	
17. Review Meeting Date:	

MAPPA secretary,
Forelle House,
Marshes End,
Upton Road,
Poole,
BH17 7AG

Tel: 01202 664086
Fax: 01202 664061
Email: nikki.sanderson@dorset.probation.gsi.gov.uk

PART 3

PROTOCOL FOR WORKING WITH CHILDREN AND YOUNG PEOPLE WITH SEXUALLY HARMFUL BEHAVIOUR

1. Purpose

1.1 This document sets out Bournemouth, Dorset and Poole's Inter-Agency policy and procedures to be followed when there are concerns about a child behaving in ways that are sexually harmful.

2. Policy

2.1 Our policy is to work with service users, the wider community and partner agencies and organisations to protect and promote the welfare of children in need, recognising that children and young people who present with sexually harmful behaviour are children in need, who may also pose a risk to others. The aim is to improve their life chances through providing or commissioning services which:

- support the upbringing of children in their own families and, where this is not possible, provide stable, safe and effective alternative care at the right time and for the right length of time;
- are responsive to individual needs, circumstances and choice and are based on evidence of what works for service users;
- recognise and are sensitive to the ethnic and cultural needs of the child/young person;
- are child-centred.

2.2 In respect of children and young people who exhibit sexually harmful behaviour our policy is to ensure that a multi-agency assessment of concerns and strengths takes place to ensure that the child/young person's needs are clearly identified, a multi-agency plan is agreed and risk to others minimised, utilising the services and expertise of those other agencies who have skills in assessment and treatment.

3. Race, Culture, Ethnicity

3.1 Throughout the assessment process issues relating to ethnicity will be identified and consideration given to the use of interpreter services. Cultural tradition and religious beliefs alone neither explain nor condone acts of commission or omission which place a child or young person at risk of significant harm.

4. Definitions

4.1 In the absence of a nationally agreed single definition the following will be adopted for the purposes of this policy as a broad definition of behaviours that are sexually harmful and/or abusive.

Young people (below the age of eighteen years) who engage in any form of sexual activity with another individual, over whom they have power by virtue of age, emotional maturity, gender, physical strength or intellect and where the victim in this relationship has suffered sexual exploitation and betrayal of trust. Sexual activity includes sexual intercourse (oral, anal or vaginal), sexual touching, exposure of sexual organs, showing pornographic material, exhibitionism, voyeurism, obscene communication, frottage, fetishism and talking in a sexualised way. We should also include any form of sexual activity with an animal and where a young person sexually abuses an adult.

[This definition is taken from: CALDER, M.C. with HANKS, H., EPPS. K, J., PRINT, B., MORRISON. T. and HENNIKER, J. (2001). *Juveniles and Children who Sexually Abuse.* Second edition, Lyme Regis: Russell House Publishing. P.5.]

4.2 Evidence suggests that young people 'take on' and internalise labels, and therefore to describe a young person only as a 'sex offender' or 'young abuser' may impact on their motivation and responsiveness in both assessment and treatment, leaving them feeling they cannot change.

4.3 Although cumbersome, the term *children and young people with sexually harmful behaviour* recognises that this client group are children first; is more developmentally sensitive; is not unduly punitive; describes behaviour and defines the young person holistically. This behaviour is not the entirety of who they are.

5. Procedure

5.1 Context

5.2 In research it is thought that children and young people commit between a quarter to a third of all child sexual abuse. *(Derwent Initiative /Leisure Watch 2000/Glasgow et al 1994.)* Work with adult abusers has shown that many of them begin committing abusive acts during childhood or adolescence and that significant numbers of them have been subjected to abuse themselves. Early intervention with children and young people may therefore play an important part in protecting the public by preventing the continuation or escalation of abusive behaviour.

5.3 The revised edition of *Working Together* (2006) allocates lead responsibility for the management of children and young people who sexually abuse to the Dorset Safeguarding Children Board (DSCB), Bournemouth & Poole Local Safeguarding Children Board (LSCB) and the Youth Offending Team (YOT). However, they should be dealt with outside of the child protection system unless there is clear evidence that they are themselves the victims of abuse and continue to be at risk. The Department of Health *Framework for the*

Assessment of Children in Need is the assessment tool Children's Services Departments are required to use.

5.4 A Section 47 Child Protection Investigation (Children Act 1989) will be undertaken in respect of the child victim(s) of sexual abuse when the alleged perpetrator is under the age of 18.

6. Key Principles

6.1 The complex nature of this client group requires a co-ordinated multi-disciplinary approach to address:

- issues of child and public protection;
- an assessment of the child/young person's needs including their psychiatric and psychological needs;
- the roles and responsibilities of child welfare and criminal justice agencies.

Within this context the following key aims and principles will apply:

- The primary objective of intervention is the protection of victims and potential victims and the avoidance of repetition of the abusive behaviour;
- The needs of the child/young person with sexually harmful behaviour should be considered separately from those of their victim(s);
- Children and young people who abuse others should be held responsible for their abusive behaviour, whilst being identified and responded to in a way which meets their needs as well as protecting others.
- Children and young people with sexually harmful behaviour are in need of help and are entitled to appropriate services;
- The assessment will address the specific concerns and assess the child/young person's needs; this will include identifying strengths to address their offending behaviour;
- Wherever possible, children/young people have a right to be consulted and involved in all matters and decisions that affect their lives. The parent(s)/carers have a right to information, respect and participation in matters that concern their family.

7. Children's Services

7.1 When a referral is made to Children's Services about a child or young person who is exhibiting sexually harmful behaviour, an initial assessment will normally be undertaken within 7 days. The exception to this is if it is apparent from the outset that behaviours are healthy/age-appropriate, in which case there may be no further action or advice only given. (See Appendix 1)

7.2 The initial assessment may conclude:

i) no further action,

ii) no ongoing role for Children's Services but onward referral to another agency,

iii) ongoing involvement of Children's Services

7.3 In making an initial assessment relevant considerations include:

- The relative chronological and developmental age of the two children (the greater the difference the more likely the behaviour should be defined as abusive)
- A differential in power or authority
- The actual behaviour (both physical and verbal factors must be considered) including duration and frequency
- Whether the behaviour could be described as age appropriate or involves inappropriate sexual knowledge or motivation
- Whether physical aggression, bullying, bribery or coercion was involved
- The possibility the abuser is or was also a victim
- Attempts to ensure secrecy
- Whether a particular type of victim appears to be targeted
- Whether the alleged abuser acknowledges the problem; denies, minimises or accepts concerns
- Whether substance misuse is a feature
- Whether parents/carers are in a position to control the behaviour
- Whether learning disability, conduct disorder or mental health issues are present

7.4 Expert opinion may be needed, for example from those providing specialist treatment services for young people who sexually harm others.

7.5 If the initial assessment concludes that the child or young person does exhibit sexually harmful behaviour (see definition in paragraph 7.1), Children's Services will convene and chair a multi-agency meeting – see paragraph 11 for details.

7.6 Where there are concerns that the alleged abuser is also a victim of abuse child protection procedures will be followed. This may include convening a Child Protection Conference if the young person is deemed to be at continuing risk of significant harm.

7.7 Where a child protection conference is convened the multi-agency meeting should be incorporated into it to avoid repeat meetings. The child protection conference will therefore need to address the needs of the child/young person both as an abuser and as a victim, and this should be made clear at the outset.

7.8 In cases where the threshold is met, the meeting should be convened under the Multi-Agency Public Protection Arrangements (see this procedure, Part 2).

7.9 Work with a child or young person who has been abused by another young person will be undertaken separately to the work with the perpetrator.

7.10 A decision will need to be taken at the Multi-agency Risk Assessment Meeting on how best to undertake this work. It will be essential to ensure the child/young person's safety and determine whether the parents can be proactive in this respect, especially if both young people are in the same family/household.

7.11 An assessment of the victim's circumstances will be key to identifying what actions, strategies and services need to be put place to ensure protection from further abuse.

8. Response by Youth Offending Teams (YOT)

8.1 The YOT's role in working with children and young people who sexually abuse, is to ensure their offending behaviour is addressed and to work with other agencies to assess and manage the risk they present to the community.

8.2 The YOT may become involved with those accused of sexual offences at the very earliest stage by acting as appropriate adult. However, this is usually a one-off involvement often undertaken by sessional workers.

8.3 Children/young people who are subsequently charged and given police bail may be supported by the YOT, where this is agreed with the child/young person and their family. Where a case is adjourned, for whatever reason, YOT will also be involved if a bail supervision order is made.

8.4 If the young person is pleading not guilty, YOTs may have no contact with that young person or their family until after a finding of guilt at Court. However, where a multi-agency meeting is convened by Children's Services, the appropriate YOT team manager should attend in order to play their part in risk management.

8.5 Where a child or young person is charged with an offence and admits their guilt, or is subsequently found guilty, it is the YOTs responsibility to co-ordinate an assessment of the risk of harm. In Dorset, though not in Bournemouth or Poole, the YOT have a Service Level Agreement with the NSPCC, who carry out assessments on behalf of the YOT jointly or in consultation with the allocated YOT officer.

8.6 There will be occasions when the child/young person receives an order from the court and is not known to either YOT or Children's Services; or known only to the YOT. In these cases the YOT team manager should convene and chair the multi-agency meeting.

8.7 It is acknowledged that the child/young person order from court may expire before the work with him/her is completed, thus ending the role of the YOT. A multi-agency meeting should be convened before any order expires and an agreement reached about which agency will assume the key worker role until work with the child/young person is completed.

9. NSPCC

9.1 Bournemouth, Dorset and Poole Children's Services and Dorset YOT, have Service Level Agreements with the NSPCC to provide assessments and treatment services to children and young people with sexually harmful behaviour.

9.2 A possible outcome of the initial/core assessment and Children in Need/Risk Assessment Meeting might be a recommendation that further specialist assessment is required. In such cases a referral to the NSPCC should be considered and the NSPCC should normally attend the meeting. The NSPCC undertake specialist assessments using AIM (Assessment Intervention and Moving-On).

9.3 The AIM assessment findings and recommendations can be added as a supplementary section to the Initial/Core Assessment paperwork, or recorded as a stand-alone report. As stated earlier, *Working Together* highlights the importance of a multi-agency response to the needs of and concerns presented by this client group. Therefore the outcomes of the AIM Assessment(s) will be presented to the review Children in Need/Risk Assessment Meeting.

10. CAMHS/HEALTH

10.1 Dorset HealthCare NHS Foundation Trust/Dorset County Hospital NHS Foundation Trust is fully committed to working with partner agencies where young people with problematic, inappropriate and or criminal sexual behaviour are concerned.

10.2 Where a young person (Under 18 years of age) is referred to or is already an active case within Child and Adolescent Mental Health Services and it becomes apparent that such behaviours are being exhibited, an immediate referral will be made to the appropriate Children's Services.

10.3 CAMHS will attend all initial multi-agency meetings for children/young people with sexually harmful behaviour, whether or not the child/young person is known to them.

10.4 A referral may be made to CAMHS, either directly by another agency or via the multi-agency meeting. Such referrals will be prioritized in recognition of the high potential for harm to themselves and also to other children/young people.

10.5 Such referrals may be for an assessment of underlying mental disorders and/or therapeutic work with the child/young person where they themselves have been abused. Depending on the identified need, work may be undertaken before, during or after the offence-focused work.

11. Multi-Agency Meeting

11.1 The child/young person who is the subject of a multi-agency meeting will need to have his/her needs considered and an action plan devised to meet those needs. However, where the meeting concerns a child/young person

with sexually harmful behaviour, the action plan will additionally need to address any risk he/she may present to the community.

11.2 Needs are likely to be significant in this group of children and young people, so it is important that relevant agencies co-operate to ensure appropriate services are provided in a reasonable timescale. To this end, agency representatives invited to the multi-agency meeting should prioritize their attendance, and be prepared to commit resources to ensure the child or young person's needs can be appropriately met and that the risk to the community can be minimized and managed effectively.

11.3 The following suggestions give additional general guidance about multi-agency meetings for children/young people with sexually harmful behaviour, but professional judgement will clearly be required in individual cases.

Who should be invited?

- The meeting should be convened and chaired by a Children's Services Manager or a YOT Manager. In some cases it may be appropriate for an Independent Reviewing Officer/Conference Chair to chair the meeting e.g. where the case is particularly complex or where there are significant differences of opinion about how the case should be managed.
- Children's Services (where the meeting is being convened by the YOT)
- YOT – Where the child/young person is already known to the YOT or where a criminal prosecution is likely or where the child/young person has been charged
- CAMHS – invitation to the initial meeting should be sent to the appropriate Team Leader (Tier 3)
- Education/School
- Health
- NSPCC
- Police – where appropriate
- The child/young person (where appropriate) and their parent/ carer – the social worker or youth offending officer should ensure that the child/young person is adequately prepared for the meeting
- Representatives from the other local authority where the child/young person is placed outside the originating authority
- Adult Services – where the child/young person is likely to require services beyond their 18th birthday
- Any other professional who has significant involvement with the child/young person and/or their family

When should the meeting be held/reviewed?

- The meeting should be held as soon as possible after the need for such a meeting is identified, and at least within 15 days.
- The action plan developed should be reviewed within one month and thereafter at not less than three-monthly intervals.

- A review meeting should be held prior to the expiry of any court order

Links to other meetings

- Where the threshold is met, the meeting should be convened under the Multi- Agency Public Protection Arrangements
- Where a Child Protection Conference is convened in respect of the child/young person, the additional issues that would have been addressed via the multi-agency meeting should be covered in the Child Protection Conference. The Child Protection Conference should therefore address the needs of the child/young person both as a victim and as an abuser, and this dual function should be stated clearly at the outset.
- Where the child/young person is Looked After, an initial multi-agency meeting will be needed to develop the plan. However, the review of the multi-agency meeting plan may be combined with the statutory review process where possible, to avoid duplication of meetings.

What additional areas should be covered in the multi-agency meeting where the child/young person exhibits sexually harmful behaviour?

- What further enquiries should be made?
- What further assessments are required?
- Should a meeting be convened under MAPPA or CP procedures?
- What are the risks to the community?
- How can these be managed?
- What are the risks in school and how can these be managed. (NB a risk assessment tool for use in schools is currently being developed and school staff should contact their relevant local authority child protection adviser for further information).
- What information should be shared with whom, and who will do this? Including distribution of meeting minutes and action plan.
- Should the review of the Child in Need Meeting be combined with any other meeting already being held in relation to the child/young person? (eg: statutory review of Child Looked After).

BIBLIOGRAPHY

- Children Act 1989
- Bournemouth, Dorset & Poole ACPC Inter-agency Safeguarding Procedures 2006
- Working Together to Safeguard Children 2006
- Childhood Lost, DM Overview Report
- Framework for the Assessment of Children in Need and their Families - 2000
- AIM Project – Guidelines for Identifying & Managing Sexually Problematic/Abusive Behaviour in Schools and Nurseries – 2002

APPENDIX 1

AGE APPROPRIATE SEXUAL BEHAVIOURS

The table below gives a brief overview of age appropriate sexual behaviours.

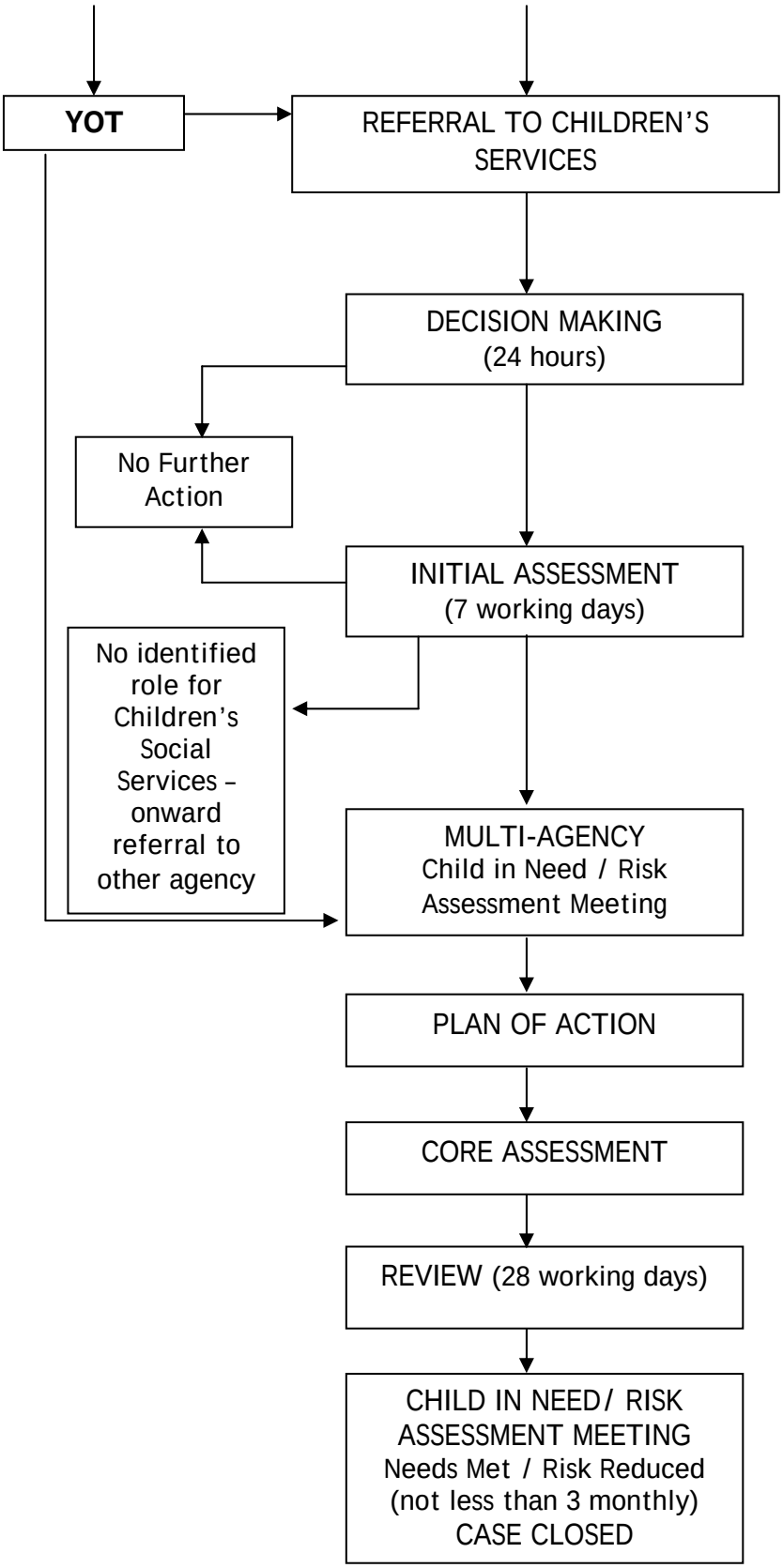
AGE APPROPRIATE SEXUAL BEHAVIOURS [reproduced from 'Child's Play?' a STOP IT NOW leaflet]		
	They commonly…..	**They rarely…..**
Pre-school Children [0-5]	• Use childish 'sexual' language to talk about body parts • Ask how babies are made and where they come from. • Touch or rub their own genitals • Show and look at private body parts	• Discuss sexual acts or use sexually explicit language • Have physical sexual contact with other children • Show adult-like sexual behaviour or knowledge
School-age [6-12]	• Ask questions about menstruation, pregnancy and sexual behaviour • Experiment with other children, often during games, kissing, touching, showing and role-playing e.g. mums and dads or doctors and nurses • Masturbate in private [Older children in this age range are also more likely than pre-school children to use sexual words and discuss sexual acts, particularly with their friends]	• Masturbate in public • Show adult-like sexual behaviour or knowledge
Adolescents [13-16]	• Ask questions about relationships and sexual behaviour • Use sexual language and talk about sex acts between themselves • Masturbate in private • Experiment sexually with adolescents of similar age [NB About one-third of adolescents have sexual intercourse before the age of sixteen]	• Masturbate in public • Have sexual contact with much younger children or adults

(Further information and guidelines for identifying and managing sexually problematic/abusive behaviour in schools and nurseries can be obtained from the Aim Project, Building Three, Quays Reach, South Langworthy Road, Salford, Manchester, M50 2PW. Tel: 0161 743 4665. E-mail: aimproject@msn.com – © Carol Carson & AIM Project 2002)

APPENDIX 2

CHILDREN AND YOUNG PEOPLE WITH SEXUALLY HARMFUL BEHAVIOUR

FLOWCHART



NB

- *CONSIDER CPC FOR VICTIMS/OTHER CHILDREN IN HOUSEHOLD*
- *CONSIDER CPC FOR C/YP WITH SEXUALLY HARMFUL BEHAVIOUR ONLY IF THEY ARE ALSO BELIEVED TO BE A VICTIM OF ABUSE AND AT CONTINUING RISK OF SIGNIFICANT HARM (IE : FOLLOWING A S47 ENQUIRY)*
- *CONSIDER AMALGAMATING REVIEW PROCESSES IF C/YP WITH SEXUALLY HARMFUL BEHAVIOUR IS ALSO LOOKED AFTER*
- *CONSIDER MAPPA IF CRITERIA MET*

Part 4

NOTIFICATION REGARDING ADULTS AND YOUNG PEOPLE WHO POSE A RISK OR A POTENTIAL RISK TO CHILDREN

1. INTRODUCTION

1.1 This protocol is intended to apply when agencies need to notify Children's Services about adults and young people who pose a risk or a potential risk to children (RTC).

1.2 The Children and Young Persons Act 1933 was intended to protect children of school age from "cruelty and exposure to moral and physical danger". Schedule 1 of the Act laid out a set of offences against children and young people to which particular provisions of the Act applied. The term "Schedule 1 offender" subsequently came into general use across agencies, as a means of identifying anyone convicted of an offence against a child.

1.3 The term "Schedule 1 offender" is a label that lasts for life with no review procedure. It does not take into consideration the circumstances of the offence, or any assessment of ongoing risk that the individual may pose. Thus a child involved in a playground fight, for example, may find themselves subject to scrutiny from child protection agencies for life with no opportunity to challenge that scrutiny.

1.4 The term "Schedule 1 offender" is ill-defined and thus often unhelpful since it defines people by their offending history rather than the ongoing risks they pose; therefore the term should no longer be used, but instead, where applicable, should be replaced with "a person posing or potentially posing a risk to children".

1.5 In order to protect children effectively, good information sharing between agencies is essential. To date, agencies have notified Children's Services of any adult/young person charged with or convicted of an offence against a child. Children's Services in turn have recorded the basic details in an electronic system. Further detailed information that may later be required to complete an assessment is therefore not always available. This protocol aims to ensure that the best possible information available is shared between agencies, at the point of notification, and ensures that only those who pose a risk or a potential risk to children are recorded as such.

2. REGISTRATION OF RTCs

2.1 RTCs may only be registered on Children's Services electronic systems upon receipt of written notification by another agency such as:

- Probation Service
- Police
- Courts
- Youth Offending Team
- NSPCC
- Prison Service

2.2 RTCs are only registered by Children's Services if:

- the RTC resides in the Authority's geographical area and/or
- the RTC will not give an address or states "no fixed abode"
- the victim(s) resides in the Authority's geographical area and/or
- the offence was committed in the Authority's geographical area

2.3 The information held by Children's Services will be held securely and may only be accessed by professionals undertaking assessments of risk to children - this will primarily be social workers in relation to individual cases. Information will be held in accordance with Children's Services file retention policies.

3. ACTIONS TO BE TAKEN

3.1 Police - where a person is being investigated for an offence against a child (see Appendix 1 for details of relevant offences - this list is not exhaustive) the police will need to make a judgement about whether the person poses a risk or a potential risk to children. The points to consider in reaching this judgement are contained in Appendix 2.

3.2 In cases where an arrest is made - the Police custody system will automatically generate a record for all arrests for sexual or violent offences where the victim is or is perceived to be under 18 years of age. This notification will be raised for the attention of the Detective Sergeant in the Police Safeguarding Referral Unit (SRU) and it will be the responsibility of this officer to assess the potential risk to children. At the same time the custody system will generate a C112 for the Officer in the case to complete in respect of the victim.

3.3 If the police consider that the individual poses or potentially poses a risk to children, Children's Services should be notified using form C202 (see flowcharts in Appendix 3).

3.4 If the case does not proceed to prosecution, or if the prosecution is unsuccessful, Children's Services will liaise with the police to agree which documentation should be copied to Children's Services. e.g. MG5, discontinuance letter.

3.5 Police - Sex Offenders Unit: where there is a new registration of a sex offender or a change of address of a registered sex offender, the sex offender unit need to make a judgement about whether the registered sex offender (RSO) poses or potentially poses a risk to children. The points to consider in reaching this judgement are detailed in Appendix 2.

3.6 If the RSO is judged to pose such a risk, Children's Services should be notified using form C202 and enclosing the relevant papers where these have not been previously supplied. See Appendix 3 for flowchart.

3.7 Probation: when notifying Children's Services about the court hearing or the outcome of a court hearing of a person charged with an offence against a child, the probation officer will firstly need to make a judgement about whether the individual poses or potentially poses a risk to children. The points to consider in reaching this judgement are detailed in Appendix 2.

3.8 If the probation officer considers that the individual poses or potentially poses a risk to children, Children's Services should be notified, using form Prob 129, and enclosing the relevant papers. (See flowchart - Appendix 3).

3.9 Where an offender, convicted of an offence against a child, and judged to pose or potentially pose a risk to children, is supervised by the Probation Service, the probation officer should:

- liaise with the relevant Children's Services fieldwork team, where there is a suspected or known risk to an individual child/ren.
- forward a copy of any assessment completed to Children's Services at the end of the supervisory period.

(See flowchart in Appendix 3).

3.10 Probation - prisons: wherever a prisoner, convicted of an offence against a child is to be released:

- To Dorset;
- To an unknown destination

the prison probation officer needs to make a judgement about whether the individual poses or potentially poses a risk to children. The points to consider in reaching this judgement are detailed in Appendix 2.

3.11 Where the individual is judged to pose or potentially pose a risk to children, the prison probation officer should notify Children's Services using form Prob 129, and enclosing the relevant papers (see flowchart at Appendix 3)

3.12 Youth Offending Team (YOT)
Where the YOT become aware of/are working with a young person who has been cautioned/convicted for an offence against a child (see Appendix 1) the YOT officer will need to make a judgement about whether the young person poses or potentially poses a risk to children. The points to consider in reaching this judgement are contained at Appendix 2.

3.13 If the YOT officer considers the young person to pose or potentially pose a risk to children, Children's Services should be notified using form CC8029 and enclosing the relevant papers (see flowchart at Appendix 3b).

APPENDIX 1

List of offences (chronological)

Offence	Section	Act
Murder	Common Law	
Manslaughter	Common Law	
Infanticide	Common Law	
Kidnapping	Common Law	
False Imprisonment	Common Law	
Assault or battery	Common Law	
Indecent exposure	Section 4	Vagrancy Act 1824
Indecent exposure	Section 28	Town Police Clauses Act 1847
Conspiring or soliciting to commit murder	Section 4	Offences Against the Person Act 1861
Administering poison, or wounding, with intent to murder	Section 11	Offences Against the Person Act 1861
Threats to kill	Section 16	Offences Against the Person Act 1861
Wounding and causing grievous bodily harm: Wounding with intent	Section 18	Offences Against the Person Act 1861
Wounding and causing grievous bodily harm: Inflicting bodily injury	Section 20	Offences Against the Person Act 1861
Maliciously administering poison	Section 23	Offences Against the Person Act 1861
Abandonment of children under two	Section 27	Offences Against the Person Act 1861
Assault occasioning actual bodily harm	Section 47	Offences Against the Person Act 1861
Child stealing	Section 56	Offences Against the Person Act 1861
Drunk in charge of a child under 7 years	Section 2	Licensing Act 1902
Cruelty to children	Section 1	Children and Young Persons Act 1933
Allowing persons under 16 to be in brothels	Section 3	Children and Young Persons Act 1933
Causing or allowing persons under 16 to be used for begging	Section 4	Children and Young Persons Act 1933
Give / cause to be given intoxicating liquor to a child under 5 years	Section 5	Children and Young Persons Act 1933
Exposing children under seven to risk of burning	Section 11	Children and Young Persons Act 1933
Prohibition against persons under 16 taking part in performances endangering life and limb	Section 23	Children and Young Persons Act 1933
Infanticide	Section 1	Infanticide Act 1938
Aiding, abetting, counselling or procuring the suicide of a child or young person.	Section 2	Suicide Act 1961
Burglary (by entering a building or part of a building with intent to rape a child)	Section 9	Theft Act 1968
Supplying or offering to supply a Class A drug to a child, being concerned in the supplying of such a drug to a child, or being concerned in the making to a child of an offer to supply such a drug.	Section 4	Misuse of Drugs Act 1971

Offence	Section	Act
Indecent photographs of children	Section 1	Protection of Children Act 1978
Offence of abduction of a child by parent	Section 1	Child Abduction Act 1984
Offence of abduction of child by other persons	Section 2	Child Abduction Act 1984
Possession of indecent photographs of children	Section 160	Criminal Justice Act 1988
Abduction of Child in Care/ Police Protection... take away/induce away/assist to run away/ keep away	Section 49	Children Act 1989
Recovery of missing or unlawfully held children	Section 50	Children Act 1989
Rape	Section 1	Sexual Offences Act 2003
Assault by penetration	Section 2	Sexual Offences Act 2003
Sexual assault	Section 3	Sexual Offences Act 2003
Causing a person to engage in sexual activity without consent.	Section 4	Sexual Offences Act 2003
Rape of a child under 13	Section 5	Sexual Offences Act 2003
Assault of a child under 13 by penetration	Section 6	Sexual Offences Act 2003
Sexual assault of a child under 13	Section 7	Sexual Offences Act 2003
Causing or inciting a child under 13 to engage in sexual activity	Section 8	Sexual Offences Act 2003
Sexual Activity with a Child	Section 9	Sexual Offences Act 2003
Causing or inciting a child to engage in sexual activity	Section 10	Sexual Offences Act 2003
Engaging in sexual activity in the presence of a child	Section 11	Sexual Offences Act 2003
Causing a child to watch a sexual act	Section 12	Sexual Offences Act 2003
Child sex offences committed by a children or young persons	Section 13	Sexual Offences Act 2003
Arranging or facilitating commission of a child sex offence	Section 14	Sexual Offences Act 2003
Meeting a child following sexual grooming etc.	Section 15	Sexual Offences Act 2003
Abuse of position of trust: sexual activity with a child	Section 16	Sexual Offences Act 2003
Abuse of position of trust: causing or inciting a child to engage in sexual activity	Section 17	Sexual Offences Act 2003
Abuse of position of trust: sexual activity in the presence of a child	Section 18	Sexual Offences Act 2003
Abuse of position of trust: causing a child to watch a sexual act	Section 19	Sexual Offences Act 2003
Sexual activity with a child family member	Section 25	Sexual Offences Act 2003
Inciting a child family member to engage in sexual activity	Section 26	Sexual Offences Act 2003
Sexual activity with a person with a mental disorder impeding choice	Section 30	Sexual Offences Act 2003
Causing or inciting a person, with a mental disorder impeding choice, to engage in sexual activity	Section 31	Sexual Offences Act 2003
Engaging in sexual activity in the presence of a person with a mental disorder impeding choice	Section 32	Sexual Offences Act 2003
Causing a person, with a mental disorder impeding choice, to watch a sexual act	Section 33	Sexual Offences Act 2003
Inducement, threat or deception to procure sexual activity with a person with a mental	Section 34	Sexual Offences Act 2003

Offence	Section	Act
disorder		
Causing a person with a mental disorder to engage in or agree to engage in sexual activity by inducement, threat or deception	Section 35	Sexual Offences Act 2003
Engaging in sexual activity in the presence, procured by inducement, threat or deception, of a person with a mental disorder	Section 36	Sexual Offences Act 2003
Causing a person with a mental disorder to watch a sexual act by inducement, threat or deception	Section 37	Sexual Offences Act 2003
Care workers: sexual activity with a person with a mental disorder	Section 38	Sexual Offences Act 2003
Care workers: causing or inciting sexual activity	Section 39	Sexual Offences Act 2003
Care workers: sexual activity in the presence of a person with a mental disorder	Section 40	Sexual Offences Act 2003
Care workers: causing a person with a mental disorder to watch a sexual act	Section 41	Sexual Offences Act 2003
Paying for the sexual services of a child	Section 47	Sexual Offences Act 2003
Causing or inciting child prostitution or pornography	Section 48	Sexual Offences Act 2003
Controlling a child prostitute or a child involved in pornography	Section 49	Sexual Offences Act 2003
Arranging or facilitating child prostitution or pornography	Section 50	Sexual Offences Act 2003
Causing or inciting prostitution for gain	Section 52	Sexual Offences Act 2003
Controlling prostitution for gain	Section 53	Sexual Offences Act 2003
Trafficking into the UK for sexual exploitation	Section 57	Sexual Offences Act 2003
Trafficking within the UK for sexual exploitation	Section 58	Sexual Offences Act 2003
Trafficking out of the UK for sexual exploitation	Section 59	Sexual Offences Act 2003
Administering a substance with intent	Section 61	Sexual Offences Act 2003
Committing an offence with intent to commit a sexual offence (in a case where the intended offence was an offence against a child)	Section 62	Sexual Offences Act 2003
Trespass with intent to commit a sexual offence (in a case where the intended offence was an offence against a child)	Section 63	Sexual Offences Act 2003
Exposure	Section 66	Sexual Offences Act 2003
Voyeurism	Section 67	Sexual Offences Act 2003
Trafficking people for exploitation	Section 4	Asylum and Immigration (Treatment of Claimants, etc)

A reference to an offence in this list includes:
a reference to an attempt, conspiracy or incitement to commit that offence, and
a reference to aiding, abetting, counselling or procuring the commission of that offence.
Unless stated otherwise, the victim of the offences listed above will be under 18

APPENDIX 2

Points to consider include (NB. this list is not exhaustive):

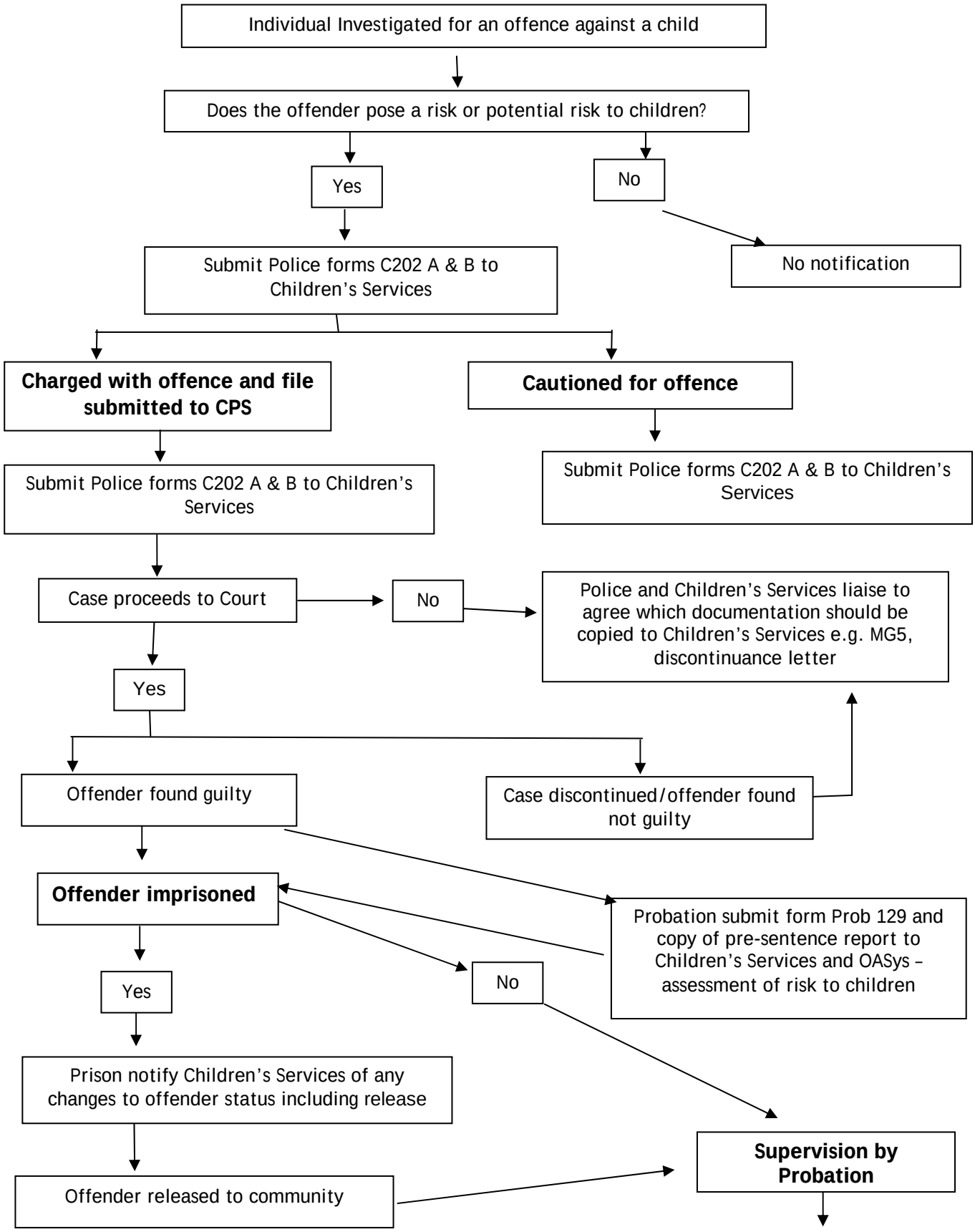
- any known background history including previous offending history
- relevant information about the offence e.g. context/age of victim/difference in relative age of victim and offender/evidence of planning/evidence of involvement or sharing information with other offenders
- relationship, if any, between the victim and the offender
- attitude towards the victim
- degree of personal responsibility shown for offence
- any past or current substance misuse
- current personal situation – who s/he lives with/has contact with – including through employment or social contacts e.g. Church, youth/social clubs

In the case of young people, additional points for consideration should include:

- difference in the level of physical maturity/capability between victim and offender
- differential in the levels of emotional maturity
- differential in the levels of intellectual capability which is of significance
- was victim particularly vulnerable?
- any power differential with the offender taking unfair advantage of the victim
- where the offence was of a sexual nature, was there an age/power differential? Was it abusive/coercive/consensual?

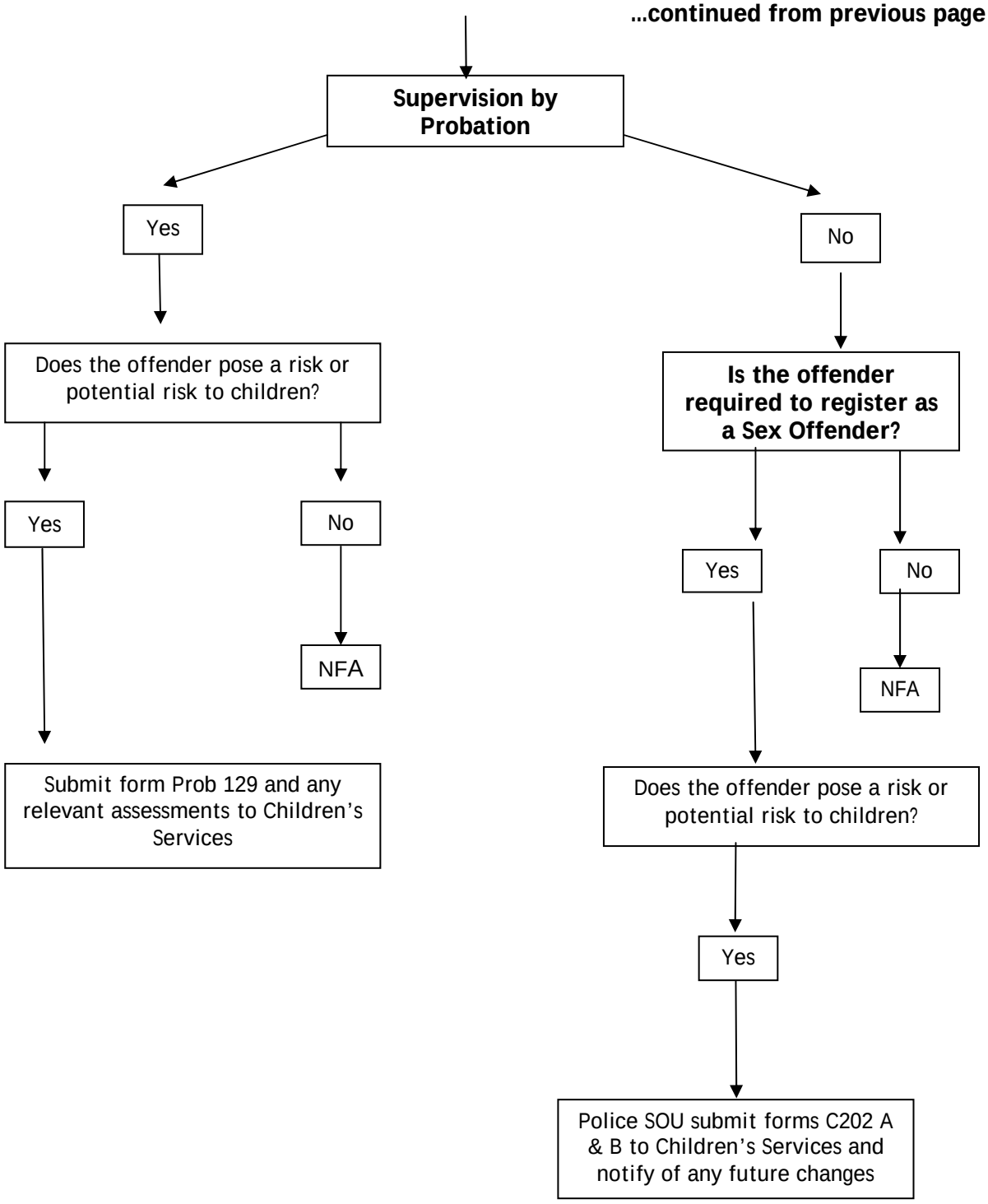
APPENDIX 3a

ADULT OFFENDER FLOWCHART



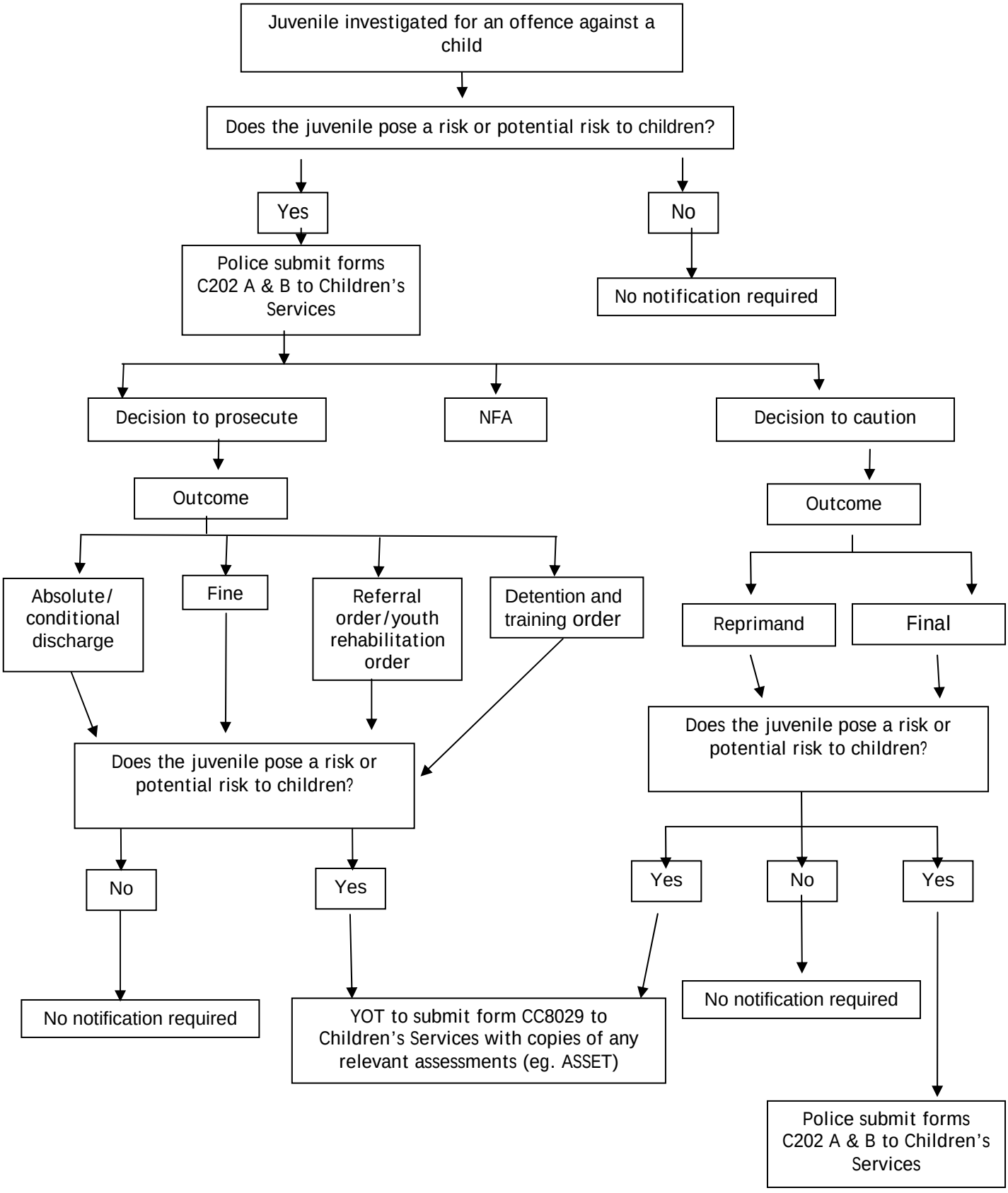
…continued on next page

...continued from previous page



APPENDIX 3b

JUVENILE OFFENDER FLOWCHART



C202A

NOTIFICATION OF PERSON POSING OR POTENTIALLY POSING A RISK TO CHILDREN REQUIRED TO REGISTER/REGISTERED WITH POLICE UNDER SEXUAL OFFENCES ACT 2003 BY POLICE SEX OFFENDERS UNIT

To: Safeguarding Manager, Children's Services, Dorset County Council

1.

To advise:	**tick as appropriate ✓**
Violent Offender/Sex Offender – **please delete**	
New registration	
Sex offender cautioned by police/sentenced to less than 12 months imprisonment	
Transfer of sex offender into Dorset	
Transfer of sex offender to another force	
Sex offender – change of address within Dorset	
Sex offender – change of name	
Additional information	
Other (please specify)	

2.

Offender Details:			
Full name on conviction		Date of Birth	
AKA/alias			
Current address (including post code)			
Previous address (including post code)			

3.

Offence Details/Results/Details of Transfer/Additional Information

4.

Child(ren)/Victim(s)			
Name		Date of Birth	
Current address (including post code)			
Name		Date of Birth	
Current address (including post code)			

I confirm that the person named above poses a risk or a potential risk to children	
Signed	
Print Name	
Job Title	
Contact Tel. Number	
Date	

NB. IF THERE IS A CONCERN FOR A SPECIFIC CHILD, REFERRAL SHOULD BE MADE TO THE RELEVANT CHILDREN'S SERVICES TEAM.

CAUTION

Data Protection – This personal data is supplied to you for the agreed purpose. As the recipient of this data you should protect it against loss or unauthorised access. Destroy after use

NOTIFICATION OF PERSON POSING OR POTENTIALLY POSING A RISK TO CHILDREN REQUIRED TO REGISTER/REGISTERED WITH POLICE UNDER SEXUAL OFFENCES ACT 2003 BY POLICE SEX OFFENDERS UNIT

1.

Offender Details:			
Full name on conviction		Date of Birth	
AKA/alias			
Current address (including post code)			
Previous address (including post code)			

2.

Offence Details/Results/Details of Transfer/Additional Information

3.

Child(ren) in the household			
Child's name		Date of Birth	
Child's name		Date of Birth	
Child's name		Date of Birth	
Child's name		Date of Birth	

4.

Child(ren) with whom alleged offender may have contact			
Child's name		Date of Birth	
Address (including post code)			
Child's name		Date of Birth	
Address (including post code)			
Child's name		Date of Birth	
Address (including post code)			

5. **Is the alleged offender or any other person in the family in a position of trust e.g. employed or working as a volunteer in a capacity that brings them into contact with children/young people?**

YES / NO (delete where applicable) **If yes, please complete details below**.

Name		Date of Birth	
Address (including post code)			
Relationship to alleged offender			
Capacity in which they have contact			

IF YES – HAS THE LOCAL AUTHORITY DESIGNATED OFFICER BEEN INFORMED?

YES / NO (delete where applicable)

(See Managing Allegations Against People who Work with Children – Inter-Agency Safeguarding Procedures Part 1)

I confirm that the person named above poses a risk or a potential risk to children	
Signed	
Print Name	
Job Title	
Contact Tel. Number	
Date	

NB. IF THERE IS A CONCERN FOR A SPECIFIC CHILD, REFERRAL SHOULD BE MADE TO THE RELEVANT CHILDREN'S SERVICES TEAM.

CAUTION

Data Protection – This personal data is supplied to you for the agreed purpose. As the recipient of this data you should protect it against loss or unauthorised

CC8029

NOTIFICATION OF A CHILD/YOUNG PERSON POSING A RISK, OR POTENTIAL RISK TO CHILDREN (RTC) BY YOUTH OFFENDING TEAM

To: Safeguarding Manager, Children's Services, Dorset County Council

1.

To Advise:	
Final warning	
Court appearance	
Supervision	
Custody	
Other (please specify)	

2

Details Regarding Above:		
Date	Location	Other information

3.

Child/Young Person (RTC)	
Name	
Date of Birth	
Address (including post code)	
LOCI Number	

4.

Offence Details

5.

Child(ren) Victim(s)			
Name		Date of Birth	
Current Address (including post code)			
LOCI Number			

6. **Is the Child/Young Person (RTC) or any other person in the family in a position of trust e.g. employed or working as a volunteer in a capacity that brings them into contact with children/young people?**

YES / NO (delete where applicable) If **yes, please complete details below.**

7.

Name		Date of Birth	
Address (including post code)			
Relationship to Child/Young Person			
Capacity in which they have contact			

IF YES – HAS THE LOCAL AUTHORITY DESIGNATED OFFICER BEEN INFORMED?

YES / NO (delete where applicable)

(See Managing Allegations Against People who Work with Children – Inter-Agency Safeguarding Procedures Part 1)

8.

Please attach relevant assessments/reports to this form and indicate those which are attached (tick if attached)	
Pre-sentence report	
ASSET	

9.

I confirm that the Child/Young Person named above poses a risk or a potential risk to children	
Signed	
Print name	
Designation	Youth Offending Team Worker
Contact Tel. Number:	
Date	

I confirm that the Child/Young Person named above poses a risk or a potential risk to children	
Signed	
Print name	
Designation	Youth Offending Team Manager
Contact Tel. Number:	
Date	

NB. IF THERE IS A CONCERN FOR A SPECIFIC CHILD, REFERRAL SHOULD BE MADE TO THE RELEVANT CHILDREN'S SERVICES TEAM.

CAUTION

Data Protection – This personal data is supplied to you for the agreed purpose. As the recipient of this data you should protect it against loss or unauthorised access. Destroy after use.

PROB 129

NOTIFICATION OF PERSON POSING OR POTENTIALLY POSING A RISK TO CHILDREN BY PROBATION SERVICE

To: Safeguarding Manager, Children's Services, Dorset County Council

1.

To advise:	**tick as appropriate ✓**
Initial Court Hearing	
Subsequent Court hearing	
Result of Final Court Hearing	
End of Supervision by Probation	
Other (please specify)	

2.

Offender Details:			
Full name		Date of Birth	
AKA/alias			
Home address (including post code)			
Current address if different (including post code)			

3.

Offence Details

4.

Child(ren)/Victim(s)			
Name		Date of Birth	
Current address (including post code)			
Name		Date of Birth	
Current address (including post code)			

5.

Child(ren) in the household			
Child's name		Date of Birth	
Child's name		Date of Birth	
Child's name		Date of Birth	
Child's name		Date of Birth	

6.

Child(ren) with whom alleged offender may have contacted			
Child's name		Date of Birth	
Address (including post code)			
Child's name		Date of Birth	
Address (including post code)			

7.

Is the alleged offender or any other person in the family in a position of trust e.g. employed or working as a volunteer in a capacity that brings them into contact with children/young people? **YES / NO** (delete where applicable) **If yes, please complete details below.**			
Name		Date of Birth	
Address (including post code)			
Relationship to alleged offender			
Capacity in which they have contact			

IF YES – HAS THE LOCAL AUTHORITY DESIGNATED OFFICER BEEN INFORMED?

YES / NO (delete where applicable)

(See Managing Allegations Against People who Work with Children – Inter-Agency Safeguarding Procedures Part 1)

8.

Next Court appearance if applicable	
Date	
Location	

9.

Result of Final Hearing	
Outcome	
Date	
If Prison, location address	

10.

Please attach relevant assessments/reports to this form and indicate those which are attached (tick if attached)	
Pre-sentence Report	
OAsys	
Other (Please specify)	

11.

I confirm that the person named above poses a risk or a potential risk to children	
Signed	
Print Name	
Job Title	
Contact Tel. Number	
Date	

NB. IF THERE IS A CONCERN FOR A SPECIFIC CHILD, REFERRAL SHOULD BE MADE TO THE RELEVANT CHILDREN'S SERVICES TEAM.

CAUTION
Data Protection – This personal data is supplied to you for the agreed purpose. As the recipient of this data you should protect it against loss or unauthorised access. Destroy after us

PART 5

GUIDANCE ON THE DISCLOSURE TO THIRD PARTIES OF INFORMATION ABOUT SEX OFFENDERS AND OTHERS WITHOUT CONVICTIONS WHO MAY PRESENT A RISK TO CHILDREN

1 PURPOSE

This document provides guidance to employees of the relevant agencies (Police, Probation, and Children's Services) on the management of the disclosure of information to third parties about sex offenders and others without convictions who may pose a risk to children and vulnerable adults. The guidance applies to disclosures about adults and young people.

2 INTRODUCTION

The principles underpinning disclosure to third parties are the same as for information sharing, but inevitably introduce greater sensitivities given that disclosure may be to individual members of the public. Because of this, great caution should be exercised before making any such disclosure. It should be seen as an exceptional measure and part of an overall risk management plan.

3 SCOPE

3.1 This guidance relates to disclosing information to third parties about:

a) those persons who have been convicted of, cautioned for, or otherwise dealt with by the courts (including those convicted abroad) for a sexual offence and;
b) those who are believed to have abused a child but who do not have a conviction.

AND/OR

c) who are considered by the relevant agencies to present a risk to children or others.

Third Parties

'Third Parties' are persons or bodies **other than** agencies having a responsibility for the assessment, monitoring and management of sex offenders in the community. Examples of third parties are child protection charities, partners of offenders, employers, head teachers, housing providers and voluntary organisations. In exceptional circumstances it may include parents whose children may come into contact with a person convicted of sex offences or believed to pose a risk of such abuse, but without a conviction, or carers of vulnerable adults.

3.2 This guidance does not cover;

disclosure of information from criminal records for employment and related purposes,

OR

the sharing of information between agencies (Police, Probation, Children's Services, Health) which is covered in other protocols.

4 DISCLOSURE OF INFORMATION TO THIRD PARTIES

General Rules

- Where an agency considers that a sex offender, or in some instances a person without convictions, may pose a sexual risk to children or vulnerable adults, a risk assessment should be conducted which will establish whether or not there should be a disclosure of information to a third party. This risk assessment will be conducted in accordance with local protocols depending upon the status of the subject of the proposed disclosure. (See 'Processes' below)

- The general presumption is that information should not normally be disclosed.

- Each case must be considered carefully on its particular facts.

- A decision to disclose to third parties will always need to be justified carefully on both legal and moral grounds, and should be taken only as part of a carefully managed process. (See 'Processes' below)

- Agencies should act only in accordance with agreed protocols.

- Those involved in the decision making process will have to consider carefully the *purpose* of disclosing information to a third party. Such a decision should normally be taken within the context of a plan for a named individual who poses a risk and/or child/vulnerable adult.

- The offender, or person suspected of posing a risk, should always be informed that a disclosure about him/her is going to be made unless there are exceptional circumstances eg. To inform the individual would present an increased risk of harm to a child. Where practicable, s/he should have the opportunity to challenge the information on which the decision was based (R v North Wales Police *ex parte* (AB & CD).

- Where appropriate the offender or person who is thought to pose a risk should be given the opportunity to make the disclosure her/himself in a supervised and/or properly managed scenario; where the individual agrees to disclose the information to the third party, checks should then take place to ensure that the correct information has been disclosed. (See Appendices A & B)

- The decision to disclose - or not disclose - and the reason for this decision should always be recorded in writing by the decision-maker.

5 PROCESSES

The 'managed process' that should be followed (see above) will depend upon the status of the offender or the subject of the proposed disclosure.

5.1 Multi Agency Public Protection Arrangements

If an offender is recognised as posing a serious risk, s/he will be dealt with in accordance with the Multi Agency Public Protection Arrangements (MAPPA). This will consist of Multi-Agency Public Protection Panels (MAPPPs). The protocol relating to MAPPA is entitled 'Protocol for Agencies on the Assessment and Management of Sexual and Violent Offenders or other offenders who may cause serious harm to the public'. It outlines the relevant risk assessment process that should be followed and provides clear guidance for those parties involved. This protocol is currently being updated (Part 2 of these procedures).

If a decision is made by the MAPPP meeting that disclosure should take place, the process for physically carrying that out is contained with Appendix A.

The Police will take responsibility for this as lead agency in making the decision and disclosure. A recommendation to disclose must be passed for decision making by the relevant superintendent.

If the police superintendent refuses permission for disclosure, other agencies may wish to consider disclosing this information but should do so only in accordance with Appendix B and they should take account of their own legal advice.

5.2 Registered Sex Offenders

If a person is a registered sex offender s/he will be dealt with in accordance with the Dorset Police policy on the Sex Offenders Act 1997. That policy provides clear guidelines on the management of registered sex offenders including advice on assessing the risk of disclosure to third parties. The management of registered sex offenders is essentially police business. In instances where there is a risk to a specific child, police will generally liaise with Children's Services and other appropriate agencies about disclosure of information, convening a meeting where necessary.

The Police will take responsibility for this as lead agency in making the decision and disclosure. A recommendation to disclose must be passed for decision making by the relevant superintendent.

If a decision is made that a disclosure should take place, this will be managed by the police.

5.3 People with convictions against child/ren

If a situation occurs where a police officer or social worker consider that a person with a conviction against a child/ren, poses a risk to a child, but does not meet the criteria for a MAPPP, that person should arrange a risk assessment meeting to take place to consider whether there should be disclosure of information to a third party. The decision about who should be involved in such a risk assessment will depend on the circumstances of the case, but it must include as a minimum a manager from both Dorset Police and Children's Services.

The police will take responsibility for this as lead agency in making the decision and disclosure. A recommendation to disclose must be passed for decision making by the relevant superintendent.

If a decision is made that disclosure should take place the process for carrying this out, is contained within Appendix B. If the police superintendent refuses permission for disclosure, other agencies may wish to consider disclosing this information but should do so only in accordance with Appendix B and they should take account of their own legal advice.

5.4 **Persons believed to pose a risk but without convictions**

The same process as outlined under 3 above will apply to those persons who are believed to pose a risk but have no convictions. This will include persons against whom credible allegations have been made but not pursued through a criminal prosecution. This may also include those who have been found not guilty or whose cases have been discontinued, but where a serious risk is still believed to exist. If the police superintendent refuses permission for disclosure, other agencies may wish to consider disclosing this information but should do so only in accordance with Appendix B and they should take account of their own legal advice.

6 MAKING THE DISCLOSURE

The question of which agency should physically carry out the act of disclosure to third parties will depend upon the particular circumstances of the case. This will normally be the Police, but will be decided upon during the risk assessment discussion. In situations relating to specific children it is likely to be most appropriate that Children's Services will work jointly with the police in ensuring that the disclosure takes place properly.

Disclosure should be made in person.

The person making the disclosure should explain that it is made in confidence and ensure that the recipient understands the reasons for having been given the information, what use they are to make of it, and any restrictions applying to its further dissemination.

Disclosure of information should always be accompanied by the offer of appropriate professional support and guidance both to the person to whom the information is disclosed, and the person about whom the information is being shared.

7 EXAMPLES OF DISCLOSURE TO THIRD PARTIES

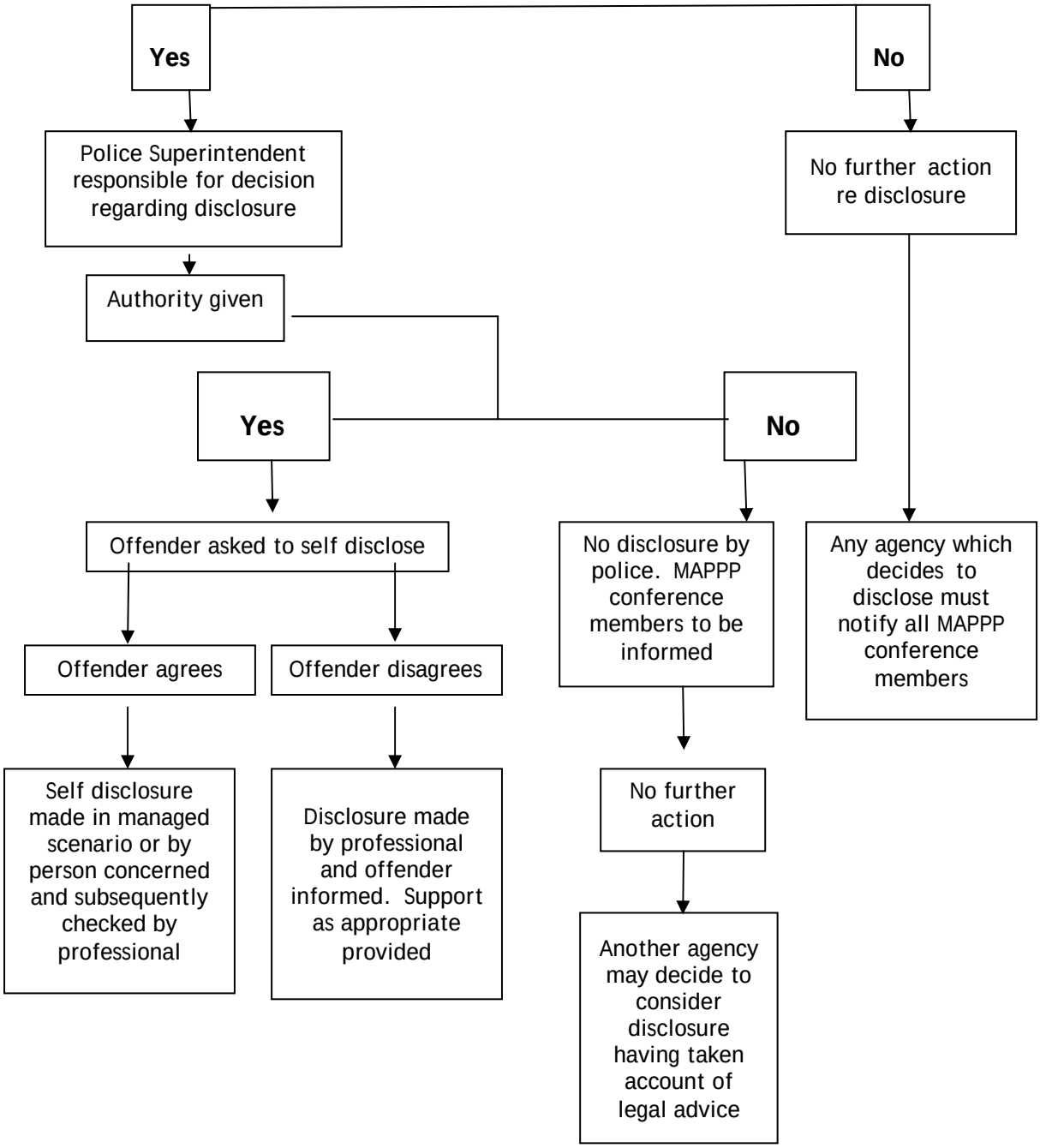
It is not possible to identify all the circumstances in which disclosure to third parties may need to be considered. However, the examples in Appendix C may help to illustrate when disclosure may be appropriate. These examples were contained within the original guidance from the Home Office in 1999.

Appendix A

DISCLOSURE TO THIRD PARTIES

MAPPA

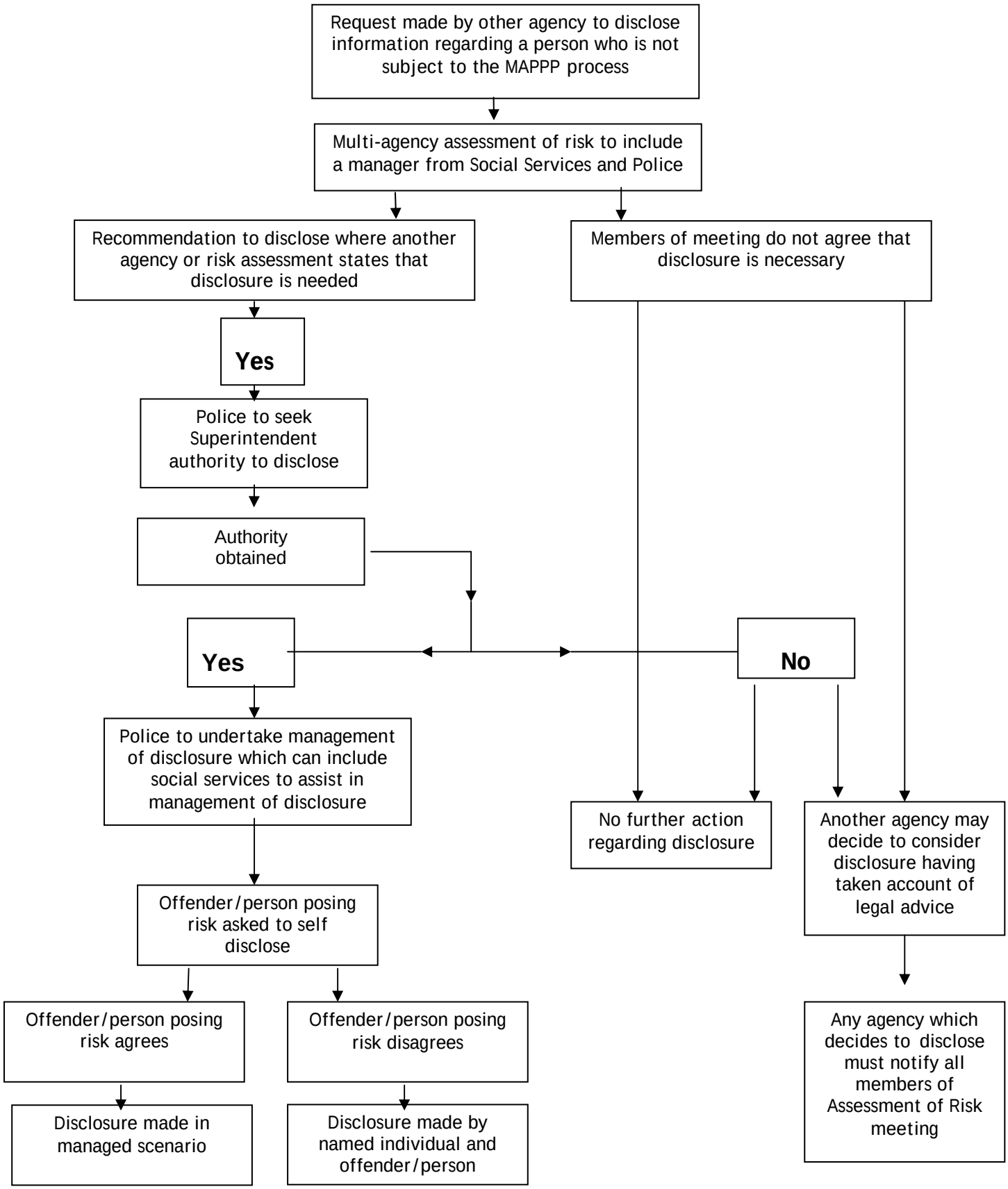
MAPPP CONFERENCE RECOMMENDS DISCLOSURE



Appendix B

DISCLOSURE TO THIRD PARTIES

ASSESSMENT OF RISK MEETING (NOT MAPPP)



APPENDIX C

ILLUSTRATIVE EXAMPLES OF WHEN IT MAY BE APPROPRIATE TO DISCLOSE TO THIRD PARTIES

Housing

Where an offender is seeking social housing (housing owned by a local housing authority or a registered social landlord) the landlord should be advised where it is considered that the offender should be accommodated away from areas frequented by unaccompanied children or where he may come into contact with children, e.g. – schools, nurseries or playgrounds. Disclosure should be made to a nominated officer in accordance with a protocol agreed between the agencies concerned and the landlord. In such cases, the landlord should also be advised of the level of risk attached to the offender and the arrangements for supervision.

The Workplace

Circumstances might arise in which a risk of offending comes about because of opportunities for access to children through the individual's work or voluntary activities. The employer ought to be aware of the position in order to consider whether the risks are manageable or could be made so.
Account should be taken of the guidance in the Inter-Agency Safeguarding Procedures, Part 1, Chapter 3.9.

Schools and Playgrounds

Agencies may receive information that an offender is living near or has been seen in the vicinity of a school, day nursery, play group or similar organisation. Following a risk assessment involving the appropriate agencies, and having considered the vulnerability of the children in that place, it might be thought necessary to inform the head teacher, playgroup leader, etc. of the risk. On receipt of this information, head teachers will need advice from the police or Children's Services department about disclosing to other staff, and the desirability of informing parents, and perhaps pupils, in general terms of the risk. The police or Children's Services department should ensure that clear advice is given to head teachers on these issues.

Youth Groups

There may be circumstances where an offender has secured an official or unofficial role in helping children or vulnerable adults, for example in helping to run a youth club or society; acting as an advocate; befriender, etc., and if the risk assessment is such as to indicate that there is a risk of offending arising from the situation the police will need to identify those to whom any disclosure should be made, e.g. to the church authorities or other relevant governing bodies. It is recommended that local protocols are established with the organisations concerned, to make it easier to implement decisions to disclose information.

Family Relationships

It may come to the notice of the Police, Children's Services or Probation that an offender has begun a new relationship, where the partner has children or a relative of a vulnerable disposition (for example, an elderly or disabled relative living in the home). Where a decision is taken to disclose the history of the offender to the new partner, this will need very careful handling given the close relationship between the offender and the recipient of the information. Children's Services departments should take a full part in these discussions, and it may be appropriate for a social worker to make the disclosure, or to be present when the disclosure is made. A

decision on this should only be reached following consultation with the relevant police force.

Some cases will require additional care in handling, for example where the offender is young, has a mental health problem, or severe learning difficulties. In these cases, it will be particularly important to ensure that the appropriate bodies are consulted before any decision is taken to disclose.

People with learning disabilities

Particular care will be needed when handling cases involving people with learning disabilities. It will be important to ensure that all offenders with learning disabilities understand the reasons for, and implications of, disclosure, and that their rights to confidentiality are taken into account. Decisions on risk and risk management will need to be informed by expertise in the learning disabilities area.

Young Sex Offenders

There could be a case for a distinction to be drawn between adults and juveniles: juveniles may be more amenable to techniques for changing their behaviour; they could be more profoundly affected by being labelled a sex offender; and it will be important to ensure that treatment at an early stage for the offenders' own problems (which may have led to his/her offending behaviour) should not be inhibited. Where young sex offenders (i.e. those under the age of 18) are concerned, those who have parental responsibility for them or who have day to day care, will need to be consulted before any decision is taken to disclose, unless the young person is deemed to be of sufficient capacity to give consent him or himself. Where a young sex offender is being looked after or accommodated by the local authority, the guidance in LAC (88)17 will have to be taken into account by the local authority. Where the young offender is in education, the education authority will also have to be consulted.

Juvenile sex offenders looked after by local authorities: placement decisions

Local authorities looking after children who are sex offenders will need to develop clear policy and practice guidelines for the appropriate placement of the child. This will involve undertaking a risk assessment of the placement and ensuring that carers, in residential or foster care settings, are made fully aware of the child's background and that no other children or at-risk adults will be placed in a vulnerable position by the placement.

An important aspect of meeting the needs of abusing children will be access to psychological services to reduce offending behaviour. On a strategic cross-agency level management information should be sought on the numbers of abusing children, so that planning can incorporate their special needs.

PART 6

CHECKS WITH THE CRB, POLICE DISCLOSURE UNIT AND POLICE SAFEGUARDING REFERRAL UNIT

This section gives guidance about which process should be used by Children's Services to complete information/background checks with the Police. This document should be read in conjunction with the Inter-Agency Safeguarding Procedures part 1, chapter 3.1.

Introduction

A number of recommendations were made by Sir Michael Bichard following his enquiry into the Soham murders and the trial and conviction of Ian Huntley. The recommendations were aimed at creating an environment where information is used efficiently and fairly to minimize risk of harm to the most vulnerable members of society. The Police have developed systems which improve the way information is shared and managed by forces across the Country, and there is a commitment to sharing information between agencies for the protection of children.

Process

The following table describes which section of the Police information should be sought from in normal circumstances; however, it is not possible to give guidance to cover every circumstance.
Practitioners must make a judgment on the facts of the individual situation, and where there is a conflict of views; resolution should be sought via the respective line managers in the agencies concerned.

	Reason why information is being sought	Contact
1	As part of s47 enquiries	Police Safeguarding Referral Unit (SRU)
2	Immediate placement of child(ren) (i.e. Within 24 hours and consents obtained)	SRU
3	All other placements of children (including privately fostered children/kinship placements AND consents obtained) **BEFORE** child placed	Criminal Records Bureau (CRB)
4	All other placements as in 3 above where child **ALREADY** placed (at point of notification to social care)	SRU **followed by** CRB
5	Application to adopt/foster	CRB
6	Application for employment	CRB
7	Urgent staff safety issue where visit required within 24 hours	SRU
8	All other staff visiting issues	Police Disclosure Unit
9	Allegations against people who work with children – contact via Local Authority Designated Officer	SRU
10	Child subject to a Child Protection Plan	SRU

All requests for disclosure to the S.R.U. should be made by telephone- 01202 222777 or by e mail using the secure cjsm system.

All requests for disclosure to the Police Disclosure Unit should be made using Police form A148, a copy of which is attached as Appendix 1.

All requests for disclosure to the CRB should be made in accordance with current CRB procedures.

Appendix 1

Non-Urgent Request to Dorset Police For Information

Originating Social Services Authority: *i.e Dorset, Poole, Bournemouth*

Address: *office address*

Social Worker: *name of social worker*

Social Worker Contact Number: *telephone number*

Reason/Event/Circumstances that give rise to the request

Background into family circumstances and events that brought the child to social services and/or police notice.

Current family situation and how this is relevant to your request to the police to release any information they may have.

"the child is on the at risk register" is not a satisfactory response.

What has happened to make you request information from the police and how will that information enhance your investigation.

This is your opportunity to set the scene and how relevant information from the police will help protect the child.

Information Required

If you need to know if a person has convictions for sex offences then ask for any conviction history in relation to sex offences.

You are not entitled to all conviction data if it is irrelevant to the case in hand and therefore you will not automatically receive a full disclosure printout unless you justify why you require details of all convictions.

The same principal applies to intelligence. If you ask for information relating to drugs then drug information is what will be disclosed and not all intelligence held unless you can justify why you need it.

Details of Person to be Checked

Full Name: *name of person that you require information on*
(include details of maiden and other names used)

Date of Birth: *self explanatory*

Place of Birth: *self explanatory*

Last 5 years' address history:

With out this and the above details then a thorough search can not be carried out.

To put just the name or name and partial address will not help the police to locate any/all relevant information and significant details may go undisclosed to you.

Partner Details (if applicable)
Complete in all cases – outline relationship

Full Name:
(include details of maiden and other names used)

Date of Birth:

Place of Birth:

Last 5 years' address history:

Although your request may not be for information on the partner often partner details will help the police to assess if information held on the partner is relevant to the case in hand and therefore will also be disclosed.

Child/Children Details

Full Name:
(include details of maiden and other names used)

Date of Birth:

Place of Birth:

This information will confirm the details of the child to which the case and your request refers

Last 5 years' address history:
Details of any other person relevant to future welfare of child/children in this case who require police checks

Complete in all cases – outline relationship

This is the section where, for example, details of the child's extended family are provided, particularly if they are frequent visitors or would like to have the child stay over.

Social Worker Signature .....

Date .....

Team Manager's Signature .....

Date .....

Fax to 01202 223414

PART 7

OTHER PROCESSES AND MECHANISMS

7. Offending Behaviour Programmes

7.1 Rehabilitation of offenders is the best guarantee of long-term public protection. A range of treatment programmes have been 'tried and tested' at a national level, which have been developed or commissioned by the prison and probation service. Examples include, Sex Offender Treatment Programmes, programmes for offenders convicted of Internet sexually related offences, and for perpetrators of domestic abuse.
In partnership with Bournemouth, Dorset and Poole Children's Services and Dorset Probation, the NSPCC undertakes to provide an assessment and treatment service for both convicted and unconvicted Sex offenders.

Disqualification from Working with Children

7.2 The Criminal Justice and Court Services Act 2000 (CJCSA), as amended by the Criminal Justice Act 2003, provides for people to be disqualified from working with children. A person is disqualified by either:

- a Disqualification Order, made by the Crown Court when a person is convicted for an offence against a child (under 18) listed in Schedule 4 to the CJCSA. Schedule 4 includes sexual offences, violent offences and offences of selling Class A drugs to a child; or

- being included in a permanent capacity on the list of people who are unsuitable to work with children that is kept under s1 of the Protection of Children Act 1999 (see paragraph 7.8 below); or,

- being included on DFES List 99 on the ground of being unsuitable to work with children (see paragraph 7.12 below).

7.3 When making a Disqualification Order the court applies different provisions depending on the age of the offender and the sentence received:

- **Adult offender who receives a qualifying sentence** (12 months or more or equivalent) or relevant order for a specified offence: a Disqualification Order *must* be made *unless* the court is satisfied that it is *unlikely* that the individual will commit any further offence against a child.

- **Juvenile offender who receives a qualifying sentence or relevant order:** a Disqualification Order *must* be made *if* the court is satisfied the individual is *likely* to commit a further offence against a child.

- **Adult or Juvenile offender who does not receive a qualifying sentence or relevant order:** a Disqualification Order *may* be made *if* the court is satisfied that the offender is *likely* to commit a further offence against a child.

7.4 A disqualification order is of indefinite duration (i.e. for life) but application can be made for an order to be reviewed by the Care Standards Tribunal after 10 years (or 5 years in the case of a juvenile).

7.5 Disqualification orders are made as part of the sentence and, therefore, cannot be made on application. However, the Criminal Justice Act 2003 allows the Crown Prosecution Service to refer cases back to the courts where it appears that the court should have considered making a disqualification order but failed to do so. Therefore, if an offender is identified who it seems should have been made subject to a disqualification order the case should be discussed with other MAPPA agencies and the Crown Prosecutions Service.

7.6 People who are disqualified from working with children are prohibited from applying for, offering to do, accepting, or doing, any work in a "regulated position". The positions covered are specified in s.36 of the CJCSA and are broadly defined. They includes working with children in paid or unpaid positions whose normal duties involve caring for, training, supervising or being in sole charge of children, and positions whose normal duties involve unsupervised contact with children under arrangements made by a responsible person, for example, a parent, and include a broad range of work with children from babysitting to working as a schoolteacher and from working in a local authority education or social services department to voluntary work at a boys' football club. School governor is a regulated position, as are other positions whose normal duties include the supervision or management of another individual who works in a regulated position.

7.7 A person who is disqualified commits an offence if he/she knowingly applies for, offers to do, accepts, or does, any work with children. It is also an offence for an individual knowingly to offer work with children to, or procure work with children for, an individual who is disqualified from working with children, or to allow such an individual to continue in such work. The Police should be contacted if such an offence is committed. The maximum penalty for breach is 5 years imprisonment.

Protocol for Managing Allegations against People who work with Children

There is an agreed multi-agency procedure for managing allegations against people who work with children in Bournemouth, Dorset & Poole. This is contained in Chapter 2, Part 3.9 of the Inter-agency Safeguarding Procedures and is based on current DfES guidance.

The Protection of Children Act List

7.8 This Act gives the Secretary of State power to keep a list of people who are unsuitable to work with children in childcare positions. Child care organisations in the regulated sector are required to make a report to the Secretary of State in specified circumstances, principally if they dismiss a person for misconduct which has harmed a child or put a child at risk of harm, or if a person resigns in circumstances where s/he might have been dismissed for that reason. Other organisations that employ childcare workers can also make reports in those circumstances, but do not have to.

7.9 Reports should normally be made with advice from the relevant HR department and agencies wishing to make such a report should follow their own agency procedures.

7.10 If there appear to be grounds for including the person on the List his/her name will be added provisionally while further enquiries are made, and the person will be given the opportunity to make written observations about the case. If, at the end of that process the Secretary of State is of the opinion that:

- the referring organisation reasonably believed that the person was guilty of misconduct that harmed a child, or put a child at risk of harm; and,
- the person is unsuitable to work with children,
- the person will be added to the List on a permanent basis.

7.11 Anyone who is included on the List on a permanent basis can appeal to an independent tribunal, the Care Standards Tribunal, within 3 months of the decision.

7.12 Childcare organisations must check the List (and List 99) before employing someone in a childcare position.

DFES List 99

7.13 List 99 is a confidential list of people who the Secretary of State has directed may not be employed by Local Education Authorities (LEAs), schools (including independent schools) or Further Education (FE) institutions as a teacher or in work involving regular contact with children under 18 years of age The List also includes details of people the Secretary of State has directed can only be employed subject to specific conditions. Employers in the education sector are under a duty not to use a person who is subject to a direction in contravention of that direction.

7.14 LEAs, schools, FE institutions and other employers have a statutory duty to make reports to DfES if they cease to use a person's services on grounds of misconduct or unsuitability to work with children, or someone leaves in circumstances where the employer might have ceased to use their services on one of those grounds. The Police also make reports to DfES if a teacher or other member of staff at a school is convicted of a criminal offence.

7.15 People who are convicted of one of a number of sexual or violent offences against a child under 16 years of age, or is some cases against an adult, are automatically deemed unsuitable to work with children and included on List 99. Those subject to a disqualification order and those permanently included on the Protection of Children Act List are also included on List 99 automatically. In other cases the Secretary of State, advised by a panel of experts who must consider the circumstances of the individual case and give the person concerned an opportunity to make representations before reaching a decision, has power to direct that a person be prohibited from employment and added to the List.

7.16 People included on List 99, other than those included automatically, can appeal to the Care Standards Tribunal against the decision within 3 months of the decision

Criminal Records Bureau (CRB)

7.17 The Criminal Records Bureau (CRB) is an executive agency of the Home Office. The CRB's disclosure service aims to help employers make safer recruitment decisions by identifying candidates who may be unsuitable for certain types of work. Employers should ask successful candidates to apply to the CRB for a standard or enhanced disclosure, depending on the duties of the particular position or job involved. In addition to information about a person's criminal record, disclosures supplied in connection with work with children will contain details of whether a person is included on List 99, the Protection of Children Act List, or is disqualified by the courts from all work with children. Enhanced disclosures may contain details of acquittals or other non-conviction information held on local Police records, relevant to the position or post for which the person has been selected and the Police may also provide additional information to employers in a separate letter. Further information, including details of how to apply for disclosures, is available at http://www.crb.gov.uk.

The Sex Offenders Register

7.18 The notification requirements of Part 2 of the Sexual Offences Act 2003 (known as the Sex Offenders Register) are an automatic requirement on offenders who receive a conviction or caution for certain sexual offences. The notification requirements are intended to ensure that the Police are informed of the whereabouts of offenders in the community. The notification requirements do not bar offenders from certain types of employment, from being alone with children etc.

7.19 Offenders must notify the Police of certain personal details within three days of their conviction or caution for a relevant sexual offence (or, if they are in prison on this date, within three days of their release.)

7.20 Such an offender must then notify the Police, within three days, of any change to the notified details and whenever they spend 7 days or more at another address.

7.21 All offenders must reconfirm their details at least once every twelve months and notify the Police, 7 days in advance of any travel overseas for a period of 3 days or more.

7.22 The period of time that an offender must comply with these requirements depends on whether they received a conviction or caution for their offence and, where appropriate, the sentence they received.

7.23 Failure to comply with these requirements is a criminal offence with a maximum penalty of 5 years' imprisonment. The Police should be contacted if such an offence is committed.

Notification Orders

7.24 Notification Orders are intended to ensure that British citizens or residents, as well as foreign nationals, can be made subject to the notification requirements (the Sex Offenders Register) in the UK if they receive convictions or cautions for sexual offences overseas.

7.25 Notification Orders are made on application from the Police to a Magistrates' Court. Therefore, if an offender is identified who has received a conviction or caution for a sexual offence overseas the case should be referred to the local Police for action.

7.26 If a Notification Order is in force then the offender becomes subject to the requirements of Sex Offender Registration (see above).

7.27 For example: a Notification Order could ensure that the notification requirements will apply to a British man who, while on holiday in South East Asia, received a caution for a sexual offence on a child.

7.28 Any information that an individual has received a conviction or caution for a sexual offence overseas should, where appropriate, be shared with the Police.

Sexual Offences Prevention Orders (SOPOs)

7.29 Introduced by the Sexual Offences Act 2003, SOPOs are civil preventative orders designed to protect the public from serious sexual harm. A court may make a SOPO when it deals with an offender who has received a conviction for an offence listed at Schedule 3 (sexual offences), or Schedule 5 (violent and other offences), to the Act who is assessed as posing a risk of serious sexual harm. Also, the Police can apply for a SOPO to a Magistrates' court in respect of an offender who has a previous conviction or caution for a Schedule 3 or 5 offence who poses a risk of serious sexual harm.

7.30 SOPOs include such prohibitions, as the court considers appropriate. For example, a child Sex Offender who poses a risk of serious sexual harm could be prohibited from loitering near schools or playgrounds. The offender will also, if s/he isn't already, become subject to the notification requirements for the duration of the order.

7.31 SOPOs can be made on application from the Police, so any violent or Sex Offender who poses a risk of serious sexual harm should be referred to MAPPA agencies and the Police in particular. In an application for an order the Police can set out the prohibitions they would like the court to consider.

7.32 Breach of any of the prohibitions in a SOPO is a criminal offence with a maximum punishment of 5 years' imprisonment. Therefore, the Police should be contacted whenever a SOPO is breached.

7.33 SOPO's can be particularly helpful in the management of Sex Offenders who are assessed as continuing to pose a high risk of harm but are no longer subject to statutory supervision.

Risk of Sexual Harm Orders (RSHOs)

7.34 Introduced by the Sexual Offences Act 2003, RSHOs are civil preventative orders used to protect children from the risks posed by individuals who do not necessarily have a previous conviction for a sexual or violent offence but who have, on at least two occasions, engaged in sexually explicit conduct or communication with a child or children and who pose a risk of further such harm. For a RSHO to be made it is not necessary for there to be a risk that the defendant will commit a sexual offence against a child – the risk may be that s/he intends to communicate with children in a sexually explicit way. The RSHO can contain such prohibitions, as the court considers necessary. For example, an adult could be found regularly communicating with young children in a sexual way in Internet chat rooms. A RSHO could be used to prohibit the person from using the Internet in order to stop him/her from such harmful activity.

7.35 RSHOs are made on application from the Police, so any person who is thought to pose a risk of sexual harm to children should be referred to the Police. In an application for an order the Police can set out the prohibitions they would like the court to consider.

7.36 Breach of any of the prohibitions in a RSHO is a criminal offence with a maximum punishment of 5 years' imprisonment. It is also an offence, which makes the offender subject to the notification requirements (see above). The Police should be contacted whenever a RSHO is breached.

Bournemouth & Poole Local Safeguarding Children Board

Dorset Safeguarding Children Board

PAN DORSET INTER-AGENCY SAFEGUARDING PROCEDURES

CHAPTER 3

3.12 NOTIFICATIONS AND TRANSFERRING INFORMATION

Procedures Effective from: **2006**

Review Date: **December 2010**

If you have any comments or queries about the pan-Dorset procedures please contact your agency representative on the Pan Dorset Policy and Procedures Group or notify the LSCB using the following email addresses:

info@dorsetlscb.co.uk
info@bournemouth-poole-lscb.org.uk

Notifications and Transferring Information & Records

Introduction

All agencies agree that the effective and timely sharing of information is required to safeguard and promote the welfare of all children. This applies not only to those who are subject to a child protection plan or are looked after but also to those for whom welfare concerns or needs have been identified.

Each agency will have its own records and transfer protocols and procedures and practitioners should refer to their own agency guidance where this is not attached to this guidance. This procedure sets out the principles and expectations for the efficient and effective notification and transfer of information between agencies and across authorities in order to safeguard children and all agencies should ensure that their own agency guidance incorporates these expectations and principles.

Key actions for all agencies and organisations:

- On receiving information that a child or their family, who is currently known, is moving or has moved, that professional is responsible for informing other involved agencies within a timescale commensurate with the level of concern for the child, but at least within 5 working days

- Where a professional has reason to suspect that a child and their family have moved and their whereabouts is either not known or concealed, they have a duty to follow up with other involved agencies as soon as possible, to see if their whereabouts can be verified or agree action commensurate with the level of perceived need or concern.

- Other Inter-Agency Safeguarding protocols regarding children who are missing or missing education should be followed.

- Where immediate notification of a child/family's move is made verbally to another agency this must be confirmed in writing within 2 working days.

- There should be a discussion, at the appropriate level of management, with the receiving area agency regarding continuing or relinquishing responsibility for the child / family. Where agreement cannot be reached the matter should be referred to a senior manager for resolution.

- Comprehensive information (written documents e.g. assessments, plans) should be sent to the receiving authority as appropriate to the case in accordance with own agency guidelines on information sharing and transferring records. Information should be sent within timescales commensurate with the level of concern for the child in accordance with own agency guidelines and at least within 10 working days of informing the receiving agency.

- There is a presumption that the service user's (child and family) consent will be sought in accordance with the Inter-agency Safeguarding Procedures Chapter 3. 1

INDIVIDUAL AGENCY PROCEDURES

Appendix 1
Children's Social Care:

Appendix 1

Children's Services responsibilities in relation to children/young people who move between Local Authority Areas

To facilitate a process whereby children/young people who move between local authority areas can be safeguarded the following guidance should be followed, in addition to the key actions detailed in chapter 3.12 of the inter-agency safeguarding procedures – Notifications and transferring information and records.

1. **Children/young people for whom welfare needs have been identified but no concerns**

   Whenever a child/young person, for whom ongoing needs are identified following an initial assessment, moves to another authority area, it is the responsibility of the originating authority to:

   - seek and obtain the consent of the parent/carer, and the young person, where appropriate to share information for the purpose of making a referral to the receiving authority and having achieved this
   - confirm in writing any referral to the receiving authority, within 10 working days ,including a copy of the initial assessment, chronology and any plan as appropriate and
   - seek and obtain written confirmation of receipt of the referral information from the receiving authority.

2. **Children/young people about whom there are welfare concerns**

   (i) It is important to note that Section 47 (12) of the Children Act 1989 stipulates that "where a local authority is making enquiries under this section (S47 (1)(b)) with respect to a child who appears to them to be ordinarily resident within the area of another authority they shall consult that other authority who may undertake the necessary enquiries in their place".

   (ii) Whenever there are concerns about the welfare of a child/young person, at any stage:

   - following receipt of a referral and/or
   - during subsequent enquiries, and/or
   - whilst services are being offered to the child/young person/family **and**

   that child/young person/family moves from one authority area to another, it is the responsibility of the authority where the

children/young person is physically present, regardless of where s/he actually lives, to:

- initiate a strategy discussion to decide whether there is evidence to support commencing Section 47 enquiries or to apply for an emergency protection order
- continue with enquiries and/or an assessment
- provide services as appropriate

unless appropriate alternative arrangements have been made with Children's Services in the authority area where the child originates.

(iii) In these circumstances who takes lead responsibility will depend on a number of factors, such as where the child is going to continue to be living in the near future, practical issues such as distance between authority areas, and whether the allegations relate to a person living or working in the same area as the child is living.

(iv) Following completion of any necessary enquiries/assessments by an authority where a child/young person is physically present, a transfer of statutory responsibility to the child's originating authority, where this is appropriate, should be negotiated at the time the child returns and agreement reached between the authorities as to how the case will be managed before lead responsibility is relinquished. Such action should be endorsed by a team manager and confirmed in writing with the authority where the child is ordinarily resident and written confirmation of receipt obtained.

(v) **Where the receiving authority cannot be identified/is unknown**

In a small number of cases, children/young people and their families about whom there are concerns, move between local authority areas, and few or no details of their intended location/future address are known to the agencies. This is particularly likely to occur with travelling families.

In these circumstances a strategy discussion/meeting should be held in the originating authority, which in addition to the tasks and purpose of strategy discussions/meetings as set out in Chapter 2.66 and 3.2 of the Inter Agency Safeguarding Procedures should:

- collate information about the current and potential concerns for the child/young person
- determine the degree of concern/potential future risk to the child/young person and as a result
- agree a plan of action setting out:

- what attempts should be made to establish the location of the child/young person and their family via the tracking of transferred school/health records

- to whom the information about the fact the child/young person/family are missing is circulated

- whether a plan to actively trace the child/young person/family should be put in place with the police.

(vi) **In all cases**

The originating local authority should:

- Confirm the referral in writing to the receiving authority as soon as possible and at least within 10 working days of notifying the receiving authority of the move
- Enclose copies of all relevant information and documents including; the initial and core assessment, the chronology, any plan for the child and any other relevant documentation.

3. **Movement of Children/Young People subject of a Child Protection Plan between authority areas where the move is considered to be permanent**
(to be read in conjunction with Chapter 2.181 of the Inter Agency Safeguarding Procedures)

The prevailing principle is when a child/young person subject of a Child Protection Plan moves into the area of a different authority, on being informed:

- the receiving authority has the immediate duty to make enquiries, followed by any necessary action, to satisfy itself that the child is adequately safeguarded in their new situation

- to hold a child protection conference within 15 working days

Source: Bournemouth Dorset & Poole Safeguarding Procedures

(i) **Children/young people subject of a Child Protection Plan moving into Bournemouth, Dorset or Poole**

Whenever Children's Services receive information that a child subject of a Child Protection Plan of another authority area has moved into their area, they should:

- ensure there is an exchange of information, including written information, with Children's Services in the child's originating authority area;

- enter the child/family details on the RAISE system;

- assist with any enquiries about protecting the child which need to be made;

- make any enquiries as necessary to satisfy themselves that the child is adequately safeguarded in his/her new situation;

- make contact with the child/parent as applicable;

- assist with any requirement to protect the child;

- notify the Child Protection Administrator so that the child's details can be added (In Dorset an LSCB 5 should be receipt e-mailed or faxed to the Safeguarding Unit as soon as possible and normally within one working day, and a hard copy sent by post);

- confirm in writing with the social worker/team manager in the originating authority area, agreed actions and clarify key worker responsibilities and monitoring arrangements between authorities;

- ensure all necessary arrangements are made for relevant agencies to be informed of the move;

- convene and prepare for a transfer-in child protection conference within 15 working days of being notified of the move by:

- seeking the attendance of the originating authority at the transfer-in child protection conference

- obtaining a report for the conference from the originating authority

- where the latter is not available prepare a report for the conference setting out the previous concerns and new information

- prepare a report in respect of any new information received following the move to the receiving authority

- following the transfer-in child protection conference implement the recommendations as set out in the child protection plan/action plan agreed at the conference.

(ii) **Children/young people subject of a Child Protection Plan moving to another local authority area from Bournemouth, Dorset or Poole**

When a child, subject of a Child Protection Plan in Bournemouth, Dorset or Poole, moves to another authority area the key worker should:

- make contact with Children's Services in the area where the child has moved and ensure that all information in relation to the child and their family is exchanged, including written material(this should include as a minimum a copy of the

initial and core assessment, a copy of the most recent child protection conference minutes and the child protection plan and any other relevant documentation;

- clarify with the social worker/team manager in the receiving authority any action which needs to be taken to protect the child, including who is responsible for the action;

- confirm in writing responsibility for any protective action and expectations regarding the management of the case pending the transfer-in child protection conference;

- obtain written confirmation of the receiving authority's acceptance of responsibility for the management of the case;

- notify other professionals and agencies in Dorset who have contact with the child, in order for them to ensure that they notify their colleagues in the receiving area of the child's move;

- notify the Child Protection Administrator of the move in order for a request to be made to the receiving authority for the child's name to be included on that authority's child protection register (In Dorset an LSCB 5 should be receipt e-mailed or faxed to the Safeguarding Unit as soon as possible and normally within one working day, and a hard copy sent by post);

- assist as appropriate in the preparation for a transfer-in child protection conference in the receiving area, including the provision of written reports as appropriate;

- attend the transfer-in child protection conference as appropriate;

- contribute to the decision making process in the receiving authority and in the originating authority in relation to continued registration/de-registration.

A child's child protection plan may be discontinued:

- As a result of a child protection review conference deciding that the child is no longer in need of safeguarding via a child protection plan;

- If the child and family have moved permanently to another authority area. In such cases, the receiving authority should convene a transfer-in child protection conference within 15 working days of being notified of the move and

discontinuance of the child protection plan should only take place after a decision by this conference;

- When the child has reached 18 years of age, has died, or has permanently left the UK.

4. **Movement of children/young people subject of a Child Protection Plan between local authority areas where the move is considered to be temporary**

(i) There are occasions when a child/young person subject of a Child Protection Plan moves temporarily into another local authority area, and it is anticipated at the outset that the duration of their stay in the receiving authority area will be short term i.e. move to bed and breakfast accommodation, holiday, Looked After Child placement, placement in a refuge.

(ii) In these circumstances it is the duty of the originating authority to:

- inform the receiving authority of the move
- make any necessary enquiries to ascertain whether the child/young person in the new location is safeguarded
- advise the receiving authority of the outcome of those enquiries and
- advise what action/response if any is required by the receiving authority.

The receiving authority has a legal duty to undertake enquiries and any action required to protect the child/young person, satisfying themselves that the child is adequately safeguarded.

(iii) It is the responsibility of the receiving authority to record on their system that the child is subject of a child protection plan for the duration of the child's stay.

(iv) In circumstances where there is a perceived risk to the child/young person in the receiving authority area, the receiving authority should follow the procedures set out in paragraphs 3.3(i) of this procedure.

(v) The decision in respect of which authority will have responsibility for the management of the case and whether to hold a transfer-in conference will be the subject of negotiation between the originating and receiving authorities based on good practice. Such discussions will need to take into account:

- the particular circumstances of the child/young person/family
- the plan

- the anticipated duration of their stay in the receiving authority area and

- the practicalities of ongoing involvement by the originating authority.

(vi) Where it is deemed unnecessary to hold a transfer-in child protection conference because there is no perceived risk to the child/young person, the decision should be taken in accordance with each authority's agreed decision making procedures.

5. **In All Cases**

- A child may remain subject of a child protection plan in more than one authority area where there is a perceived risk in each of these areas.

- A move out of an authority area does not discontinue the child protection plan for that child. The child will remain the subject of a child protection plan in the originating authority area at least until the transfer-in child protection conference in the area to which the child has moved has been held.

- In circumstances where a child(ren) subject of a Child Protection Plan moves to another authority area within practical travelling distance of the child's originating authority the requirement set out above in relation to the receiving authority satisfying itself that the child is safeguarded remains. A child protection conference in the receiving authority may not be recommended if the originating authority has accepted responsibility for the management of the case and has joined all relevant agencies in the receiving area into the protection plan and child protection conferences.

- The responsible team managers in each authority must confirm expectations and agreements about the monitoring, management and reviewing of cases in writing. This would also apply in cases where the stay in another authority area is expected to be of limited duration.

- Where it is felt that a transfer-in conference is inappropriate the relevant manager for the receiving social work team, in consultation with their counterpart in the originating authority, must record this decision on the case file.

- Where agreement cannot be reached between team managers of two authority areas as to:

  - whether a child is safeguarded in their new/changed situation

  - the adequacy of the arrangements to safeguard the child

  - the need to convene a child protection conference

the concerns must be passed to a senior manager for resolution with senior managers in the other authority.

- In circumstances where a child is both looked after and subject of a Child Protection Plan, the originating authority retains responsibility for the looked after status. However, the receiving authority should determine whether there may be child protection issues in the receiving authority and where this is the case a transfer-in child protection conference should be convened.

6. **Children/young people who have lived overseas**

Social workers should seek information from relevant services if the child and family have spent time abroad. Professionals from such agencies as Health, Children's Services or the Police should request this information from their equivalent agencies in the country(ies) in which the child has lived. Information about who to contact can be obtained via the Foreign and Commonwealth Office on 020 7008 1500 or the appropriate Embassy or Consulate based in London (you can obtain contact information about all the Embassies in London - the London Diplomatic List, ISBN 0 11 591772 1 - from the Stationery Office on 0870 600 5522 or from the FCO Website www.fco.gov.uk).

Glossary

Originating authority - the authority area where the child is ordinarily resident
Receiving authority - the authority area to which the child is moving

Bournemouth & Poole Local Safeguarding Children Board

Dorset Safeguarding Children Board

PAN DORSET INTER-AGENCY SAFEGUARDING PROCEDURES

CHAPTER 3

3.13 SAFEGUARDING CHILDREN WHO MAY BE TRAFFICKED

Procedures Effective from: **2008**

Review Date: **October 2010**

If you have any comments or queries about the pan-Dorset procedures please contact your agency representative on the Pan Dorset Policy and Procedures Group or notify the LSCB using the following email addresses:

info@dorsetlscb.co.uk
info@bournemouth-poole-lscb.org.uk

SAFEGUARDING CHILDREN WHO MAY HAVE BEEN TRAFFICKED

1. Introduction

This protocol is intended to help agencies and staff safeguard and promote the welfare of children and young people who may have been trafficked. It is supplementary to and should be used in conjunction with the individual management of cases as set out in Chapter 2 of the Dorset, Bournemouth & Poole Inter-Agency procedures and other supplementary protocols in Chapter 3.

Definition

Trafficking of persons has been defined as

"**the act of** *recruitment, transportation, transfer, harbouring or receipt of person,* **by means of**, *the threat of or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or control over another person,* **for the purpose of** *exploitation*

Exploitation *includes, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs"*

(Ref: Article 3, Palermo Protocol, UN Convention, 2000 – ratified by the UK in 2006)

Any child or young person who has been transported for exploitative reasons, whether or not they have been forced or deceived, is considered to be a trafficking victim. That is, they cannot consent to any of the above activities even if they appear to submit willingly believing that this is the will of their parents or accompanying adults.

2. Prevalence and reasons for trafficking

As it is a clandestine activity, the extent of trafficking in children is not know but is believed to be increasing as more cases come to light. It is estimated that globally each year around 1.2 million children are victims of human trafficking. A Child Exploitation and Online Protection Centre report (2007) identified 330 potential child victims in the UK. Operation Pentameter, a national police led anti-trafficking operation during a 3 month period in 2006 found 12 child victims of trafficking who were being sexually exploited.

The local situation is not known but as checks have improved at the larger ports of entry more regional airports and sea ports are being used. Dorset has three such ports of entry, Bournemouth International Airport and the cross-channel ferry ports at Poole and Weymouth. In addition the secluded coast-line and facilities for small craft, together with the transitory holiday population and accommodation make it potentially an attractive alternative to traffickers.

There is no single explanation for how and why children might be abused and exploited. Statistics show that both the country from which children are taken and the reason for being brought to the UK vary widely.

Most children are trafficked for financial gain. They may be used for any of the following:

- sexual exploitation
- domestic servitude
- sweatshop, restaurant and other catering work
- credit card fraud
- begging or pick pocketing or other forms of petty criminal activity
- agricultural labour, including tending plants in illegal cannabis farms
- benefit fraud
- drug mules, drug dealing or decoys for adult drug traffickers
- illegal inter-country adoption

Younger children are sometimes trafficked to become beggars and thieves or for benefit fraud. Teenagers are often trafficked for domestic servitude or sexual exploitation

Reasons which contribute to why children and young people become vulnerable to being trafficked.

- Poverty: often the root case with the promise of a better life and financial gain
- Lack of education: traffickers promise education to parents
- Discrimination: both on gender, girls being seen as more of a financial burden and ethnicity where the child comes from a minority community
- Cultural attitudes to the rights of children and customary expectations regarding child labour
- Grooming
- Dysfunctional families, where children chose to leave home due to abuse and neglect
- Political conflict and economic transitions leading to displacement and loss of social protection
- Inadequate local laws and regulations; not all countries have laws against exploiting child labour and trafficking. Enforcement of existing laws may be hampered by lack of prioritisation, corruption and ignorance.

Children and young people may enter the UK either accompanied by a parent or other adult or may arrive alone seeking asylum. Where accompanied by an adult who is not a parent the child or young person may be particularly vulnerable, especially where there is little evidence of a pre-existing relationship or evidence of parental permission for the child/young person to travel to the UK.

Many children travel on false documents or even if genuine, they may not have access to them as this is a means to control that the traffickers may hold over them.

Missing children and young people are particularly vulnerable to exploitation. There is increasing evidence of children and young people, both UK and other citizenship, being internally trafficked.

3. Recognition

There is no exhaustive list of the signs of trafficking. The risk factors that have been identified in some cases may not all be applicable in others and there may well be others, especially given that children are trafficked for a variety of different purposes. General signs and symptoms of abuse and neglect coexist with specific indicators of sexual exploitation and / or trafficking and issues of concern relating to a child/young person's immigration status. (See Appendix 1)

Even children/young people who understand what has happened may still appear to submit willingly, through fear for themselves or their family, or because they believe their parents have agreed to the situation, or sometimes because of bribes.

4. Impact of trafficking on children's health and welfare

Trafficked children are not only deprived of their right to freedom but also to health care and access to education. The creation of a false identity and implied criminality, together with the loss of family and community, may seriously undermine their sense of self-worth.

As a result of the nature of trafficking and exploitation children and young people may suffer significant harm for the following reasons

Physical abuse may include,

- beatings
- being subdued with drugs leading to a drug dependency
- alcohol addiction
- physical symptoms such as skin problems, headaches, backache which are as a result of mistreatment
- forms of harm linked to a belief in spirit possession (see *Safeguarding Children from Abuse Linked to a Belief in Spirit Possession,2007*)

Emotional and psychological abuse may include

- feeling disorientated and a loss of identity
- being kept isolated away from local community and school because they cannot speak English
- fear of adults who have control over them and the threat of being reported to immigration authorities or police
- loss of trust in adults
- low self-esteem, feeling experiences have ruined them for life; depression and suicidal thoughts
- worrying about what family and community will think and being afraid to go home
- feeling like criminals and long term consequences for adult life
- distress at their sense of powerlessness, particularly where violence or the threat of violence has been used, including where extreme, symptoms of post traumatic stress disorder
- dependent relationships with abusers
- flashbacks, nightmares, anxiety attacks, irritability and other symptoms of stress
- loss of ability to concentrate

- becoming antisocial, aggressive and angry, and / or fearful and nervous, finding social and family relationships difficult

Sexual abuse is an integral part of sexual exploitation. Children and young people who are sexually exploited are at risk of

- sexually transmitted infections, including HIV/AIDS
- unwanted pregnancies
- possible damage to sexual and reproductive health

Neglect may be the result of

- lack of routine health care or emergency medical attention (due to lack of care or the need for secrecy regarding their circumstances)
- Physical, sensory and food deprivation

5. Individual Agencies Roles and Responsibilities

In addition to responsibilities under the statutory functions and expertise of each agency, and the overall duty to work together to safeguard and promote the welfare of all children, the following specific roles should be undertaken where a child or young person may be potentially a victim of trafficking.

Children and young people who belong to communities that are traditionally mobile e.g. Gypsy/Roma traveller or other migrant families, may be known for being missing from settled addresses or from education. Specific procedures for these and other Missing Children should be followed once it is clear that trafficking has been discounted.

5.1 Children's Social Care

There is a duty to safeguard and promote the welfare of all children irrespective of their immigration status. Where a child or young person is referred because of potential trafficking concerns the usual decision making timescales apply. A decision must be made within 24 hours regarding undertaking an initial assessment to determine whether the child is in need or, if the threshold is met for a strategy discussion to decide whether to initiate a section 47 enquiry.

5.2 Schools and other Education Services

Trafficked children may be registered at a school for a term or longer before being moved to another part of the UK or abroad. A pattern of registration and de-registration may indicate that a child or young person is being trafficked. Where concerned a member of school staff should inform the senior member of staff with designated safeguarding responsibilities who should ensure that the police or children's social care are contacted immediately.

When a school place is being requested for a child or young person who was previously living abroad, particular attention should be given to the documentation being presented to the school at the point of admission. It is not acceptable to be told that the passport or other paperwork is missing. It is extremely unlikely that adults do not know where their paperwork/official documentation is.

In addition to the above, it is vitally important to check the document photograph against the child (like for like comparison). If there is any doubt about this, contact the local UK Border Agency forgery officer who can offer assistance.

The named contact or team responsible for identifying children missing from education should be aware of the issue of trafficking and should contact children's social care or the police immediately following the same procedures used for all children.

5.3 Health Services

Trafficked children and young people may be seen at a number of health settings – GPs, Accident & Emergency, Genito-Urinary Medicine (GUM) clinics, community health and contraceptive services, at pharmacies, through school nurses etc. Practitioners should be alert to potential signs of abuse and trafficking particularly where there are,

- inconsistencies in addresses
- vagueness by either the child/young person or the carers regarding the details of next of kin, names, telephone numbers or other personal details

If normal residency is given as outside the UK the current holiday addresses should recorded as well as the home address abroad. Health staff should be alert to patterns arising in the same local holiday address being given by different children or young people who do not appear to be related, or which suggest large numbers of children moving in and out of the same address.

5.4 Youth Offending Teams

Staff working with young offenders may find young people who have been trafficked are reluctant to disclose circumstances of their exploitation or arrival in the UK for fear of reprisals by the adults on whom they depend or out of misplaced loyalty. Parents or carers may be reluctant to engage in assessments and may be implicated in the trafficking process. Age verification may be required. YOT workers should follow safeguarding procedures where they suspect a young person may have been trafficked.

5.5 Police

The police are a lead agency in the investigation of trafficking there being a number of specialist teams across the UK. In most cases external intelligence will be received by the Police via the Force Intelligence Unit who will act as a point of contact for these specialist teams. The Child Abuse Investigation Teams are likely to receive local information direct from these teams. The local child protection officer will refer any suspected trafficked child or young person to the appropriate children's social care team immediately.

Police officers investigating any offences committed by children and young people should be aware of and recognise indicators of trafficking, referring to their child protection colleagues.

Operation Pentameter 2 is a nationwide operation to identify victims in human trafficking. Where a child is identified within the Dorset area the lead officer for

the specialist team will contact the Force Intelligence Unit and advise them of the information. The Police will then ensure that the designated LA lead professional is informed and an initial planning meeting to agree action under the inter-agency safeguarding procedures (Chapter 2) should be convened. If an urgent response is required then action to remove the child to a place of safety should be the first priority and a multi-agency meeting can be convened once the child is safe. As police operations may occur out of office hours, the Out of Hours Service must be contacted and briefed on agreed plans/action taken as soon as practicable.

Part of the initial considerations will be whether there is a need to take emergency action either under the Police Powers of Protection or by the LA applying for an emergency protection order.

See also section **5** regarding Police responsibility for informing the National Advocate

5.6 Crown Prosecution Service

Under the Code for Crown Prosecutions, when making decisions regarding prosecution the CPS should ensure that young people are not inappropriately criminalised. The use of a child or young person in a criminal enterprise is a form of child abuse. Children and young people who are the victims of trafficking may have been coerced into criminal activity. The prosecutor should consider whether or not the coercion amount to a defence of duress. Children and young people may also be witnesses in the prosecution of adults and should be given appropriate support.

5.7 United Kingdom Border Agency (UKBA)

Under the UK Borders Act 2007, UKBA officials are required to have regard for the "Keeping Children Safe from Harm" code of practice when dealing with any child identified as being at risk of harm at a port of entry. They should refer to the appropriate LA children's social care team and/or local police.

When interviewing a child, every effort must be made to identify their sponsor and any other adult who comes to collect them, ensuring that they are legitimately able to do so and that they do not pose a threat to the child or young person's welfare. The UKBA will endeavour to seek evidence and reassurances that the accompanying adult, if not a parent or blood relative, is caring for the child/young person with the parent's consent.

Immigration officers are empowered to refer children and young people to LA children's social care in the area the port of entry is located, if their immigration documentation is incorrect or the officer has concerns about their welfare. However, officers have very limited opportunity to assess the child or young person's welfare, and adults bringing children into the country illegally are adept at concealing irregularities in their relationship with the child, including using threats to ensure that the child or young person presents appropriately.

Where it appears that a private fostering arrangement has been made, and there is no evidence that the Local Authority has been notified of or inspected the arrangements, the UKBA will notify the relevant Children's Social Care.

UKBA caseworkers will not only be a source of referral to children's social care or the police but may assist with developing child protection and care plans.

5.8 Community, including Faith groups and Voluntary Sector

Community groups, faith groups and voluntary organisations play an important role in identifying children and young people who may have been trafficked. They also play an important part in working with and supporting young people. It is important that a good working relationship and trust is established between statutory agencies and these groups.

6. Support and Advice Services

Specialist support services can provide specific guidance and support. These are,

UK Human Trafficking Centre: www.ukht.org. Tel: 0114 252 3891

Child Exploitation and Online Protection Centre: www.ceop.gov.uk

NSPCC 24 hour helpline: 020 7825 2802 (specific for the duration of Operation Pentameter 2)

NSPCC Child Trafficking Advice and Information Line: 0800 170 7057

Refugee Council Children's Panel:
www.refugeecouncil.org.uk/howwehelp/directly/children Tel: 020 7346 1134

A card which includes details of these and other support services are available and will be given to children and young people who are recovered by the police through **Operation Pentameter 2**

National Advocate: If recovered through Operation Pentameter 2, the police led co-ordinating group (Gold Command Victim Care Group) will identify an advocate for the child/young person who will provide support and advice to children's social care regarding appropriate care. The advocate will also contact the young person directly once they give their permission. The National Advocate will be expected to have an overview of the young person's circumstances and needs and will be able to prompt and help inform a response by police forces if the young person goes missing after being identified. Responsibility for informing the National Advocate and passing on information is the responsibility of the police

7. Responding to Concerns

The LA children's social care team should follow inter-agency procedures as set out in Chapter 2 but with the following additional issues in mind.

Where a child/young person is recovered by police as a result of Operation Pentameter, it will be important to ensure their immediate safety as well as protecting from harm in the longer term. In these circumstances children's social care should consider commencing care proceedings.

For guidance on the recognition of potential indicators, see appendix 1

7.1 Initial information and referral

- Obtain as much information as possible from the referrer including accessing information from abroad as soon as possible
- Clarify the basis for concerns about possible trafficking and request that these are put in writing
- A decision regarding action must be made within 24 hours in order to act before the child goes missing

7.2 On completion of the initial referral information gathering, the LA children's social care should consider one of four ways forward

- An initial assessment to gather more information.
- Accommodation of the child under s20 *Children Act 1989* if
    - The child/young person is lost or abandoned, or there is no person exercising parental responsibility
    - The person who has been accommodating the child is prevented, for whatever reason, from providing suitable accommodation or care
    - There is reasonable cause to believe that the child is suffering or likely to suffer significant harm, an emergency protection order may be sought
- Immediate emergency protection may be necessary using the Police powers of protection
- A strategy discussion agrees that a section 47 enquiry and core assessment is necessary in line with procedures outlined in Chapter 2
- No further action

The LA children's social care team must advise the referrer which action is to be taken and make clear to them what information, if any at this stage, can be shared with the child/young person and any accompanying adult

8. Assessments

- Where trafficking is suspected the initial assessment must be led by a qualified and suitably experienced social worker
- It must be carefully planned with all relevant agencies contributing, including agreeing the timing of the different assessment activities
- Consideration must be given as to what information is to be given to the parents or carers
- Initial assessments should involve seeing and speaking to the child and family members (see below interviews). The services of an independent, CRB checked, interpreter should be used where English is not the child/young person's preferred language
- All relevant information should be taken into account, particularly historical information and details of family addresses abroad and dates of movement between countries
- All documentation held by the child/young person, parents and other agencies should be checked for discrepancies. This should include (if available) passport, Home Office papers, birth certificate and proof of guardianship

- Attention should be given to details in the passport, verifying the date of issue; length of visa; whether the picture resembles the child/young person; whether the name in the passport is the same as the alleged mother/father and if not, why not; whether this appears to be an original and taking copies to ensure further checks can be made if necessary
- Take copies of all documents to ensure further checks can be made as necessary
- Age Dispute: a young person may be told to lie about their age e.g. to say they are over 18 years if working in a brothel. If there is any concern that the young person may be under 18, until there is information to the contrary, they should be treated as a child.

9. Interviewing as part of section 47 enquiries

Once a decision has been made at a strategy discussion to conduct a joint interview under no circumstances should the child or young person be interviewed with any family member or carer present and, wherever possible, in a safe environment. The family member or sponsor should **never** be asked to act as an interpreter.

The interview should focus on the following areas:

- family composition, brothers, sister, ages
- parent's employment
- tasks done around the home
- length of time in this country
- where they lived in their country of origin
- where they went to school in their country of origin
- who cared for them in their country of origin
- travel history – how did they travel to the UK and who accompanied them, etc.

The adult of the family should be interviewed separately covering the same areas. A comparison can then be made and discrepancies highlighted. These should then be followed up for an explanation and where possible verified through an independent source.

All documents must be seen and checked. This should include (if available) passport, Home Office papers, birth certificate and proof of guardianship, visas, utility bills, tenancy agreements.

On completion of the section 47 enquiries a meeting should be held will the social worker, their manager, police, other relevant agencies and the referring agency as appropriate to decide on future action. Unless emergency action is required, further action should not be taken until this meeting has been held and multi-agency agreement obtained to the proposed plan.

Where it is found that the child or young person is not family member and is not related to any other person in this country, further consideration needs to be given to whether this is a viable private fostering arrangement or whether the child/young person needs to be removed from the household and/or legal advice sought on making a separate application for immigration status.

10. Issues for professionals to consider when working with trafficked children and young people

The child or young person is likely to need:

- Safe accommodation if they are victims of an organised trafficking operation
- Their whereabouts to be kept confidential
- Contrary to good practice, contact arrangements with family, friends or other people (by telephone, text etc or in person) to be severely restricted and/or supervised.
- Access to advocacy and legal advice about their rights and immigration status
- Access to health and education
- Discretion and caution to be used in tracing families
- A risk assessment to be made into the danger they may face if they are repatriated
- Support and protection against reprisals if acting as a witness against adults in criminal proceedings

For additional guidance see "*Safeguarding children who may have been trafficked*" HM Government, 2007

11. Particularly vulnerable groups

Children and young people who are in particular groups may be more at risk of exploitation by trafficking. These groups are,

- **Inter-country adoptions:** Those involved in facilitating inter-country adoptions may be doing so for significant financial gain. At no point should profit be made from the process.

- **Private Fostering:** It is thought that many private fostering arrangements are not known to the local authority for a variety of reasons. Children and young people in private fostering arrangements are vulnerable to being exploited in domestic servitude, other forms of forced labour or even sexual exploitation

- **Children who are in Care:** LAs have a duty to assess and accommodate all unaccompanied asylum seeking children (UASC), developing a care plan that becomes a pathway plan. The assessment of needs should include additional areas of enquiry for children and young people who may have been trafficked e.g. relevant background information, reasons for coming to the UK, vulnerability to the continuing influence/control of adults sponsoring their arrival. Establishing trust and a sense of safety/security is essential.

The identity and legitimacy of any adult enquiring about the young person must be established before whereabouts is divulged. The relationship to the young person

of any person claiming to be a potential carer/family member/friend must be verified and a risk assessment made prior to reunification.

Foster carers/residential workers should be vigilant about anything unusual e.g. cars waiting outside the premises and telephone enquiries

- **Missing Children:** There is a likely risk that trafficked children and young people will go missing from local authority care and this should be taken into account in planning that child's care. This should include a contingency plan in the event that the child/young person goes missing. The Inter-Agency Missing Children procedures should be followed as soon as the child/young person fails to return to their placement. Schools should be made aware of the risks of possible enticement and/or abduction and should not release a child to an unknown adult.

APPENDIX 1

Possible indicators that a child or young person may have been trafficked

There is no exhaustive list of the signs of trafficking. These indicators are in addition to general concerns and indicators of abuse and neglect:

At the Port of Entry	Whilst Resident	At risk of internal trafficking
• has entered country illegally or with parents on genuine visas, then abandoned and forced to claim asylum • has no passport or other ID • has false documents • possess goods / money not accounted for • is malnourished • unable to confirm the name and address of the person meeting them • has had their journey or visa arranged by someone other than their family • is accompanied by an adult who insists on remaining with them at all times • is withdrawn / refuses to talk or appears afraid to talk to a person in authority • has a prepared story that is very similar to those given by other children • excessive maturity / confidence for their age • has no money but has a mobile phone • unable / reluctant to give details of accommodation The Sponsor: • has made previous multiple visa applications for other children • has acted as a guarantor for other visitors who have not returned to their country of origin once the visa expired	As for the Port of Entry but additionally, • receives unexplained phone calls • possess money / goods not accounted for • has a history with missing links and unexplained moves • has gone missing from care or is missing for periods without plausible explanation • appears required to earn a minimum amount of money every day • works in various locations • has limited freedom of movement • is known to beg • performs excessive housework and rarely leaves the residence • is being cared for by adults who are not their parents and the quality of the relationship is not good • is one among a number of unrelated children at the same address • is not registered with a GP • has not been enrolled in school • has to pay off large debts • is deprived of large part of their earnings • is excessively afraid of being deported • signs of physical/sexual abuse; contracted sexually transmitted disease; unwanted pregnancy	Additional indicators include, • reliable sources suggest the likelihood of involvement in sexual exploitation • reported seen in places known to be used for sexual exploitation • evidence of drug, alcohol or substance misuse • leaving home / care setting in unusual clothes compared to usual attire, or inappropriate for age including borrowing from older people • adults loitering outside residence • significantly older boyfriend • social activities have no plausible funding source • returning after being missing looking well cared for • acquisition of expensive clothes / goods without plausible explanation • having keys to premises other than those known about • entering or leaving vehicles driven by unknown adults • being found in areas where they have no known links • inappropriate use of the internet and forming on-line relationships, particularly with adults

Bournemouth & Poole Local Safeguarding Children Board

Dorset Safeguarding Children Board

PAN DORSET INTER-AGENCY SAFEGUARDING PROCEDURES

CHAPTER 3

3.14 DOMESTIC VIOLENCE

Procedures Effective from: **2010**

Review Date: **July 2011**

If you have any comments or queries about the pan-Dorset procedures please contact your agency representative on the Pan Dorset Policy and Procedures Group or notify the LSCB using the following email addresses:

info@dorsetlscb.co.uk
info@bournemouth-poole-lscb.org.uk

Bournemouth, Poole & Dorset Safeguarding Children Boards

Safeguarding Children Domestic Violence & Abuse Procedures, Policy & Practice Guidance

1. INTRODUCTION

The issue of children living with domestic violence and abuse is now recognised as a matter for concern in its own right by both Government and key Children's Services agencies. Domestic violence and abuse has been recognised nationally as having a significant impact on both individuals and families, including affecting a parent's ability to care for his/her children. Domestic violence and abuse has a direct and indirect impact on the lives of children and young people and the links between domestic violence and abuse and child protection are well documented:

- A study published in 2006 by the NSPCC and the Body Shop estimated that nearly a million children in the UK are living with domestic violence Among victims of child abuse, 40% report domestic violence in the home (UNICEF 2006)
- In 25% of cases of domestic violence the male partner is also violent to the children
- Two thirds of the refuge population in England are children. At least 20,000 children stay in refuges each year and half of these are aged under 5
- Domestic violence is a significant factor in serious case reviews. In the 2003-05 study, two thirds of cases considered had domestic violence, mental health or substance misuse as a significant factor. In the 2007-08 study, 30% of the cases studied had domestic violence as a significant factor (Study of Serious Case Reviews & Child Deaths 2008)
- Nearly three quarters of children (over 750,000) on local "at risk" registers live in households where domestic violence occurs (DOH 2003/Women's Aid)
- Domestic violence is a factor in two thirds of cases where children have been killed or seriously injured (Analysis of Serious Case Reviews 2003-05). 29 children in 13 families in England and Wales were killed by abusive fathers during contact visits between 1994 and 2004 (Women's Aid 2004)

From January 2005, the legal definition of harm to children was extended to include the impairment suffered from seeing or hearing the ill treatment of another (S120 Adoption and Children Act 2002). This amendment was in response to evidence that children can suffer serious long term damage through living in a household where domestic violence and abuse takes place, even though they themselves have never been directly harmed. From October 2006, statutory guidance was issued which included this definition as part of the emotional abuse category where a child is suffering or likely to suffer significant harm.

2. PURPOSE

The purpose of this Procedure, Policy & Practice Guidance on domestic violence and abuse is to:

- Raise awareness amongst professionals in Dorset, Bournemouth and Poole about domestic violence and abuse in relation to safeguarding children.
- Set out single agency and interagency roles and responsibilities when working with families where there is domestic violence and abuse.
- Ensure that there is an appropriate and safe response to children and their non abusing parent by professionals involved in safeguarding children.

This guidance should be read in conjunction with Chapter 2 of the Inter-agency Safeguarding Procedures – Managing Individual Cases in Bournemouth, Dorset and Poole.

3. UNDERLYING PRINCIPLES

The underlying principles of any intervention for children living with domestic violence and abuse, which all professionals are expected to adhere to, are that:

3.1 The child's safety is paramount:

In situations of domestic violence and abuse where the child's needs are in conflict with the wishes of the adult victim, protecting the child/ren is paramount. Child protection enquiries in such cases must include an analysis of the possible reasons for this conflict from the adult victim's perspective, which may be the result of threats from the abuser or a difficulty in acknowledging the gravity of the situation. However the child's safety should not be compromised by these enquiries.

3.2 Children should be protected and supported:

It is important that support for children is made available in order for them to recover from their experiences. Both individual and group work with children living with domestic violence and abuse and its aftermath can help children understand what has happened to them and their carers, to overcome the negative impact of living with abuse, and to move on with their lives. There are support services available for children via the refuges but these are neither comprehensive nor securely funded. However support for older children presents particular risks as they may not be able to access refuge support services as readily as younger children. Referrals to CAMHS will be made in accordance with locally agreed protocols. CAMHS provide consultation and support to other professionals, including refuge staff.

3.3 The non abusing parent should be supported to protect themselves and their child/ren:

When there are concerns about the safety of children, supporting the victim is important in order to prevent further harm to them and the child/ren. Professionals should utilise those times when the abuser is in custody/prison or out of the home to engage and work with the family, as this may be an important opportunity for the victim and any children involved to reassess the situation and change the direction of their lives. This is a period when sustained work should be attempted, not a period of withdrawal. However, professionals need to be able to judge any potential risks that such interventions may produce: i.e. be aware if the perpetrator's return to the home is imminent and also bear in mind that it is not unknown for perpetrators to hide within the home when professionals are visiting.

With the exception of the provision of safety, the most valuable task for agency workers in response to domestic violence and abuse is to provide the victim with information. Victims should be informed about risks, how to contact local services, including outreach and refuge and the Police Domestic Abuse Units. Provision of leaflets, cards or bookmarks should be made routinely and practitioners should have these available in their individual workplaces. (Local and national information is attached at appendix 1)

Where the non abusing parent is identified as being at high risk of harm using the CAADA DASH risk assessment a referral to the MARAC should be made (appendix 2)

In any work with the non-abusing parent, professionals should be aware of vulnerable adult protection policies and services (see 7.8)

3.4 The abusive partner should be held accountable for their violence and be provided with opportunities to change:

Where an abusive male partner is willing to acknowledge his violent behaviour and seeks help to change, this should be encouraged and affirmed. Such men should be referred to appropriate programmes, which work to address the cognitive structures that underpin controlling behaviours, where these are available and meet Respect (the national association for professionals working with people to end their abusive behaviour www.respect.org) standards. Professionals should avoid referring to anger management, as this approach does not challenge the factors that underpin the abusive partner's use of power and control. (Details on local perpetrator programmes available are in appendix 3)

3.5 Information should be shared safely and appropriately to protect children:

Practitioners need to be aware of the need for confidentiality and sensitive handling of victims' personal information. Practitioners should take every precaution to ensure that information is not shared inappropriately to cause further harm, distress or abuse to the victim. Ideally the victim's consent should be obtained before any information is passed on. However, there may be situations where gaining consent is not appropriate or safe. There will also

be situations, e.g. where a child's safety is involved where information has to be shared without the consent of the victim.

The need to share information about children in need of protection overrides confidentiality. Although families living with domestic violence and abuse have a right and a need to expect confidentiality from professionals, this will be compromised where there are children involved as all agencies have a statutory duty to pass on information regarding their safety to Children's Services-Social Care. (Section 11, Children Act 2004- Duty to co-operate and share information).

The specific circumstances and living situation of the non abusing parent and children need to be considered. Professionals receiving information about domestic violence and abuse should ensure that the child/ren and their non abusing parent's safety are not compromised. The dangers associated with breaches of confidentiality can be extreme. Practitioners should be aware that perpetrators often go to elaborate lengths to track victims down e.g. obtain information on the whereabouts and movements of ex-partners who have left them, including impersonating social workers and police officers, and care should be taken to avoid inadvertently passing on information which could compromise the safety of a victim or their children e.g. a contact telephone number or address. Information on high risk victims should be shared through the MARAC process see appendix 2) Consideration should also be given as to whether a shielding request within ContactPoint is appropriate.

Accurate documentation and record keeping have an important role in responding to domestic violence and abuse and may provide cumulative evidence of abuse. It is therefore imperative that all agencies record their contact and any allegations made and any injuries seen. If abuse is suspected but not disclosed/admitted by the victim any injuries seen and the account for them should also be recorded.

3.6 Professionals dealing with children are appropriately informed and trained:

Raising awareness about domestic violence and abuse is a first step towards its prevention. Professionals working with all families, children and young people need to be alert to signs of domestic violence and abuse and have the appropriate level of knowledge, understanding, skills and abilities to deal with it. When any assessment is being undertaken the possibility of domestic violence and abuse should be considered. Early intervention and preventative work should always be initiated and this may be facilitated by the CAF process. Professionals have a responsibility to consult with colleagues in other agencies if they have concerns and to make a referral where appropriate. (Information about training available can be found at appendix 4)

4. CONTEXT

4.1 Definition

Domestic violence or abuse is not a specific criminal offence and there is no statutory definition of it. It is a general term to describe a range of abusive behaviour, which may be criminal or non-criminal. The cross-government

definition based on that developed by the Association of Chief Police Officers (ACPO) is:

"any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults, aged 18 and over, who are or have been intimate partners or family members, regardless of gender and sexuality" (family members are defined as mother, father, son, daughter, brother, sister and grandparents, whether directly related, in-laws or step-family)

This definition incorporates abuse between family members as well as adults in intimate relationships. It also includes abuse that may result from the actions taken (criminal or non-criminal behaviour) by the members of a family to protect the perceived standing of the family within the community (so called honour based violence (HBV), as well as forced marriage and female genital mutilation.

Anyone can experience domestic violence and abuse and people can suffer regardless of their social group, class, age, race, religion, disability, sex or sexuality. Domestic violence and abuse occurs in a wide range of relationships and does not always involve physical violence. It is acknowledged that domestic violence and abuse can occur in both heterosexual and same-sex relationships but research confirms the gender bias of abuse towards women, particularly in relation to high risk victims.

Domestic violence and abuse is typified by the perpetrator exercising some form of control or misuse of power over the victim and by the escalation in severity of behaviour and effects over time. It is recognised that the long term effects of emotional abuse or psychological violence may be more damaging than physical violence alone. Whatever forms the violence or abuse takes, the effects can be devastating and costly not just for the victim but their children, work colleagues, family and friends. Long-term and repeated violence, abuse and victimisation can have serious and long lasting effects on the victim's mental and physical health, including loss of self-esteem, anxiety, guilt, stress, depression and death (from suicide or murder). The cumulative effects of domestic violence and abuse can be severely debilitating, lead to drug and alcohol misuse and can adversely affect a woman's ability to care for her children.

4.2 Terminology

The terms domestic violence and domestic abuse are used jointly throughout the Procedures, Policy & Practice Guidance to reflect the fact that abusive behaviour can be more than physical violence and encompass mental, financial, sexual, emotional and psychological abuse as well.

The term non abusing parent is used to reflect the fact that men can be abused and in same cases may be the parent caring for the children.

4.3 Impact on Children

Domestic violence and abuse is also identified within the Every Child Matters outcome framework as a cause of vulnerability in children which has a negative

impact on children's ability to achieve their full potential across all five outcomes. The majority of victims of domestic violence and abuse are women aged between16 and 35 and they frequently have children living with them. Research evidence shows that children experiencing domestic violence and abuse can be negatively affected in every aspect of their functioning, safety, physical and mental health and well being, school attendance and achievement, economic wellbeing and emotional development. The effects may continue into adulthood affecting their ability to form peer friendships and healthy partner relationships of their own. In the most extreme cases, children are at risk of serious injury or death as a result of domestic violence.

For many children experience of living with domestic violence and abuse is often the underlying factor in other needs for which they come to the notice of services and individual organisations and many have domestic violence and abuse as one feature in chaotic lives. Involvement with crime, antisocial behaviour and prostitution in later life can be an outcome.

Domestic violence and abuse is an important indicator of risk of harm to children. Children are likely to be at risk of actual physical, sexual and/or emotional abuse from perpetrators of domestic violence and abuse. Witnessing violence can have a detrimental impact on children, tantamount to emotional abuse or psychological maltreatment. Children can 'witness' domestic violence and abuse in a number of ways other than seeing and hearing incidents and experience some or all of the following:

- Hearing the perpetrator verbally abuse, humiliate, intimidate and threaten violence
- Hearing the adult victim's screams and pleas for help
- Observing bruises and injuries sustained by the adult victim
- Witnessing the adult victim being taken to hospital by ambulance
- Experiencing unexpected and/or frequent moves due to the adult victim's attempt to secure safety for themselves and their children
- Trauma from loss of their homes, friends, toys, personal belongings and pets if forced to move house
- Observing the perpetrator being removed and taken into police custody
- Being used as pawns or spies by the perpetrator in attempts to control the adult victim
- Being forced to participate in the abuse and degradation by the perpetrator
- Being physically injured as a result of intervening in an assault or by being accidentally hurt whilst present during a violent assault
- Being directly abused by the perpetrator as part of the abuse of their carer
- Older children may assume, or have to assume, an increased responsibility in attempts to protect or shield mother/father-if victim and/or siblings
- Developing a belief that the violence is their fault or feeling to blame
- Loss of self esteem
- Fear, distress and isolation

There is also recognition that young people can be involved in their own abusive relationships (NSPCC report 2009 – Partner Exploitation and Violence in Teenage

Intimate Relationships) and an increasing awareness of young people (particularly males) perpetrating domestic abuse on their parents.

4.4 The impact of domestic violence and abuse on unborn children

It is estimated that 30% of domestic violence and abuse begins or escalates during pregnancy and this presents clear risks to both the health of the mother and that of the unborn child. Domestic violence and abuse has also been identified as a prime cause of miscarriage or still-birth, premature birth, foetal psychological damage from the effect of abuse on the mother's hormone levels, foetal physical injury and foetal death. In addition the mother may be prevented from seeking or receiving proper ante-natal or post-natal care. If the mother is being abused this may affect her attachment to her child, more so if the pregnancy is a result of rape by her partner.

4.5 Diversity & Equality

Domestic violence and abuse occurs across all boundaries, regardless of age, gender, race, ethnicity, sexuality, social class, HIV status, nationality, or disability. Practitioners should recognise and understand the diverse needs of victims, some of whom may already be marginalised in society.

Consideration should be given to the provision of specialist information about the needs of victims with disabilities and also those for whom English is not their first language. Provision of information on tape, in Braille or in other languages should be enabled if possible. It is also helpful to signpost victims to websites and other support information (see appendix 1).

4.6 Forced Marriage & Honour Based Violence (HBV)

Children and young people can be subjected to domestic abuse perpetrated in order to force them into marriage or to 'punish' them for 'bringing dishonour on the family' within some cultural groups. Whilst honour based violence can culminate in the death of the victim, this is not always the case. The child or young person may be subjected over a long period to a variety of different abusive behaviours ranging in severity. The abuse is often carried out by several members of a family and may, therefore, increase the child's sense of powerlessness and be harder for professionals to identify and respond to.

5. FAMILIES WITH ADDITIONAL VULNERABILITIES

Domestic violence and abuse is a complex problem often involving the interrelationship of factors such as:

- Child abuse
- Mental health issues
- Deprivation and social exclusion
- Alcohol and/or substance misuse
- Homelessness and housing issues

It is crucial that there is a multi agency approach to safeguarding children whose welfare is at risk through domestic violence and abuse, as outlined in Working Together (2010 para 9.17 – 9.26)

All professionals should understand the following issues that children and their non abusing parent may face, and take these into consideration when trying to help them:

5.1 Culture

The culture amongst some communities means that it is often more difficult for women to admit to having marital problems. This is because a failed marriage is often seen as being the woman's fault, and she will be blamed for letting down the family's honour. In some cultures, a woman may not be in a position to divorce her husband. If the husband does not want to comply with this, he can prevent giving a religious divorce to his wife (see section on honour based violence and forced marriage).

5.2 Immigration Status

Children and their mothers may have an uncertain immigration status, which could prevent them from accessing services. The mother may also be hesitant to take action against her partner for fear of losing her right to remain in the UK. In some cases, women have received threats of deportation from their partner or extended family if they report domestic violence and abuse and have had their passports taken from them. Similarly, children may have had their passports taken away from them and may fear that they and/or their mother could be deported if they disclose domestic violence and abuse in the family.

5.3 Language / Literacy

Children and their non abusing parent may face the additional challenge to engaging with services if English is not their first language. Where interpreters are needed, care should be taken to ensure that the interpreter chosen is acceptable to the victim. When working with these children and families professionals should use professional interpreters who have a clear CRB check; it is not acceptable to use a family member or friend, and members of the extended community network should also be avoided wherever possible.

5.4 Temporary Accommodation

Many families live in temporary accommodation including refuges. When a family moves frequently, they may be facing chronic poverty, social isolation, racism or other forms of discrimination and the problems associated with living in disadvantaged areas or in temporary accommodation. These families can become disengaged from, or may have not been able to become engaged with, health, education, social care, welfare and personal social support systems or access to employment.

5.5 Disability

Children and/or non abusing parents with disabilities may be especially vulnerable in situations where the abuser is also their primary carer, and some refuges may lack appropriate facilities to respond to their particular needs. The British Crime Survey and research by Women's Aid (2009) consistently shows that disabled people (and in particular women) are much more likely to experience domestic violence and abuse than non disabled people.

5.6 Social Exclusion

Children and their families may also face additional vulnerabilities as a result of social exclusion. The British Crime Survey indicates that people who are currently on a low income and/or not owning their own home are more likely than those on a higher income and/or homeowners to have experienced incidents of domestic violence and abuse. This can include women with no recourse to public funds. Lesbian, gay, bisexual and transgender people may also be especially vulnerable, and issues such as shame, stigma, mistrust of authority (particularly the police), fear of having children taken away because of incorrect stereotyping, "outing" etc can lead to the abuse or violence being hidden and unreported. There are also issues around safe havens for transgender people and their children, and some women's refuges may not accept men who have not fully transitioned.

5.7 Substance misuse and mental ill health

Mothers who experience domestic violence are more likely to use prescription drugs, alcohol and illegal substances as a means of coping with the abuse they have suffered. For a mother experiencing domestic violence, alcohol and drugs can represent a wide range of coping and safety strategies. Mothers may have started using legal drugs prescribed to alleviate symptoms of a violent relationship. Mothers may turn to alcohol and drugs as a form of self-medication and relief from the pain, fear, isolation and guilt that are associated with domestic violence and abuse. Alcohol and drug use can help eliminate or reduce these feelings and therefore become part of how she copes with the abuse.

Mothers can also be coerced and manipulated into alcohol and drug use. Abusers may often introduce their partner to alcohol or drug use to increase her dependence on him and to control her behaviour. Furthermore, any attempts by the mother to stop her alcohol or drug use are threatening to the controlling partner and some abusive men will actively encourage mothers to leave treatment. The double stigma associated with being both a victim of domestic violence as well as having a substance use problem may compound the difficulties of help-seeking, particularly for black and minority ethnic mothers.

Mental health problems such as depression, trauma symptoms, suicide attempts and self-harm are frequently 'symptoms of abuse' and need to be addressed alongside the issues of substance use and domestic violence and abuse. The relationship between a mother's alcohol and drug use and/or mental health problems and her experiences of domestic violence and abuse may not (or not all) be linked. Assessment and interventions for these mothers therefore need to be conducted separately, although as part of the same care plan, and at the same time.

Men who abuse may use their own or their partners' alcohol or drug use as an excuse for their violence. An abusive partner may threaten to expose a mother (or teenage girl)'s use. He may be her supplier and he may increase her dependence on him by increasing her dependence on drugs. Despite the fact that alcohol, drugs and violence to women often coexist, there is no evidence to suggest a causal link. In addition, no evidence exists to support a "loss of control caused by intoxication" explanation for violence - research and case examples show that abusive partners exert a huge amount of power and control

regardless of intoxication. Even when physical assaults are only committed whilst intoxicated, abusive partners are likely to be committing non-physical forms of abuse when sober. It should never be assumed that by working with an abusive partner's substance use the violent behaviour will also be reduced. In fact, the violence may increase when substance use is treated. Similarly, it should not be assumed that treating a domestic abuser's mental ill health will necessarily reduce their violent behaviour – again, the violence may increase. Therefore, work with an abusive partner should comprise separate assessments and interventions for violence, substance misuse and/or mental ill health. The intervention outcomes are more likely to be positive if the violence, substance use and/or mental ill health are addressed at the same time.

5.8 Sexual Exploitation

Mothers in abusive relationships are also at risk of sexual exploitation. Mothers working in prostitution may be subjected to domestic violence and abuse through their relationship with their 'pimps'; these relationships will invariably be based on power, control or the use of violence.

Procedure

6. Multi Agency responses

Professionals will work with many women who are experiencing domestic violence and who have not yet disclosed. Research suggests that women usually experience an average of 35 incidents before reporting it to the police. It is recognised good practice that professionals should offer all children and women, accompanied or not, the opportunity of being seen alone (including in all assessments) with a female practitioner, and asked whether they are experiencing or have previously experienced domestic violence. However, it is acknowledged that locally this can be difficult to achieve.

Professionals in all agencies are in a position to identify or receive a disclosure about domestic violence. Professionals should be alert to the signs that a child or mother may be experiencing domestic violence, or that a father / partner may be perpetrating domestic violence.

Professionals should never assume that somebody else will take care of the domestic violence issues. This may be the child, mother or abusing partner's first or only disclosure or contact with services in circumstances which allow for safeguarding action.

Professionals must ensure that their attempts to identify domestic violence and their response to recognition or disclosure of domestic violence do not trigger an escalation of violence.

In particular, professionals should keep in mind that:

- The issue of domestic violence should only ever be raised with a child or mother when they are safely on their own and in a private place; and separation does not ensure safety, it often at least temporarily increases the risk to the child/ren or mother.

If there is concern about the risk of significant harm to child/ren, then every professional's overriding duty is to protect the child/ren. This may include a referral to Children's Services-Social Care which should follow the guidance in Chapter 2 of the Bournemouth, Dorset & Poole Interagency Safeguarding Procedures.

Information from the public, family or community members must be taken sufficiently seriously by professionals in statutory and voluntary agencies. Recent research evidence indicates that failure to do so has been a contributory factor in a significant number of cases where a child has been seriously harmed or died.

Risk of violence towards professionals should be considered by all agencies who work in the area of domestic violence and abuse and assessments of risk undertaken. It is acknowledged that intimidatory or threatening behaviour towards professionals may inhibit the professional's ability to work effectively. Thus the importance of effective supervision and management is highlighted and agencies should take account of the impact or potential impact on professionals in planning their involvement in situations of domestic violence and abuse.

7. SINGLE AGENCY REPONSES

7.1 Police

When a police officer deals with a domestic incident where children are present or normally reside in the household, a copy of the domestic violence form (DV/1) is completed in all cases. All information and relevant history must be recorded fully on the DV/1 by the attending officer and passed to the domestic abuse office before the end of the tour of duty. The Police attending the incident will inform the adults involved that as children are (or normally are) residing or spend significant time there on contact/other visits, information relating to the incident will be forwarded to the appropriate Children's Services-Social Care Department (in Bournemouth and Poole this information is also passed to education and health). The police officer must document on the DV/1 that the adults are aware of this process. The domestic abuse office will inform the Children's Services-Social Care office within 24 hours, or the first working day of receiving the DV/1. The CAADA DASH risk assessment is completed with the victim at the scene or time of reporting to the police. The police will look to share this information and that on the DV/1 with other agencies. In the case of very high-risk victims, the police will make a referral to the MARAC.

The Police must take all reasonable steps to safeguard the welfare of the adult victim and children. Removing the abuser from the home should be considered, unless the safest option is to assist the victim and child/ren to a place of safety. Dorset Police Force policy (2006) requires that an attending officer must take positive action when responding to and investigating incidents of domestic violence and abuse. This means that where a criminal offence is disclosed and the power of arrest exists, then that power should normally be exercised. Officers must be prepared to account for their actions if they do not make an arrest in those circumstances.

The officer will record visible injuries and encourage the victims to seek medical assistance. Digital photographs of injuries (with due regard to cultural sensitivities and the dignity of the individual) and the scene of an incident are to be obtained. Evidence gathered at the scene is vital and good quality photographs are an essential part of any prosecution. They would also help in the assessment of risk posed to any children. Police officers will also provide victims with information about help available to them.

At Child Protection Conferences the police will provide information about all reported domestic violence and abuse incidents.

7.2 Children's Social Care

Referral procedures under existing **Pan Dorset Interagency Safeguarding Children Procedures** apply and Children's Social Care must consistently record and **actively consider** all notifications of incidents involving domestic violence and abuse.

Emergencies or incidents of domestic violence and abuse where children are present in the household will often involve the police, and the police will complete a Children & Young Person at risk form DV/1 and CAADA DASH risk assessment. Children's Services-Social Care may already have been alerted to the incident where there are immediate concerns for any children. This includes

the Out of Hours Service. On notification of an incident, the minimum response must be to consult existing social care records and check whether a CAF has been completed and to consider what else is known about the family where other professionals are known to be involved from universal or targeted services

A decision about the most appropriate course of action must be made by the manager, according to locally agreed agency protocols.

The evaluation will be based on a consideration of information and factors such as:

- The degree of injury sustained to the adult
- Where the victim is pregnant and there is a risk of injury to the unborn child
- Whether a child is injured
- Whether a child is involved and not injured
- Whether a child is in the house
- The emotional impact on the child / adult
- The age of the child / children
- The number of previous incidents and their severity
- Previous MARAC's with current or previous partner
- Whether parties involved are separated or separating
- Whether there are any other attributing or associated factors e.g. substance misuse, mental health, vulnerability (parent or child)
- Police information regarding significant offending history of the adults e.g. previous assaults, use of weapons, drug and alcohol related offences.

Following a consideration of the initial information against agency protocols, a decision may be taken to record the incident in the client record system (RAISE/ICS) as a contact only. The decision in this case may therefore be no further action.

Where the threshold for taking a referral is met, further information will be gathered and this may include contacting the victim, where appropriate, and liaising with the Police domestic abuse teams. Advice maybe given to the victim regarding services.

Within 24 hours of the receipt of the referral a decision will be made on the basis of the information gathered whether to proceed to an initial assessment. Each case will be considered on its own merit, using the risk factors outlined and any other agency protocols. Referrers to Children's Services- Social Care should not automatically expect that there will be an initial assessment but Children's Services- Social Care must inform the agency / professional making the referral of the decision. Where the threshold for an initial assessment is met this will be undertaken in accordance with the "Framework for Assessment of Children in Need and their Families" (2000). The Child must be seen and if of sufficient age must be spoken to.

If earlier notifications have not led to an initial assessment, on receipt of the third DV/1 within a 12-month period contact will be made with other agencies (e.g. police, education, health) to discuss their involvement and to consider an appropriate course of action. Generally, an initial assessment will be undertaken. However if each conflict is verbal, and of a minor nature the

Children's Services social care assessment team may decide not to proceed to an Initial Assessment. The responsible manager must clearly record on the case file the reasons why an initial assessment was not undertaken. In these cases any of the agencies consulted may request further discussion or a review of this decision.

Contact with a family for the purposes of completing any assessment should be done with care and sensitivity in order to avoid exposing the non-abusing adult and the children to the risk of further harm-especially when that contact is not face to face. This includes checking with the referrer and / or agencies that are working with the family about the best way to contact them and when the alleged abuser is most likely to be absent. When any contact is made with the adult victim, information concerning support services and legal options must be offered and be available.

As part of an Initial Assessment a child/ren must always be seen and where the age of the child is appropriate the views of the child must also be sought. Reasons for not obtaining the child's views must be discussed with a manager and the reasons recorded.

If during the initial assessment more information is obtained, which raises concerns which reach the threshold for child protection, a strategy discussion must be held and where the outcome is that a s.47 enquiry should commence, a core assessment must be started.

Where the initial assessment identifies complex or additional needs a core assessment may be required. Where a Core Assessment and S.17 response is made, a Child In Need Plan should be agreed and actioned.

Consideration must be given to working with the perpetrator, in line with the child in need/child protection plan, challenging the behaviour and assessing their understanding of the impact of their behaviour on the children. It is critical that the implications for the social worker's personal safety and for that of the victim are considered within risk assessments.

Factors which are likely to suggest that a Section 47 (Child Protection Enquiry): should be considered are:

- Previous child protection concerns
- A child/ren witnessing serious assault
- A significant domestic violence incident involving a child/ren – either child threatened (at risk of injury from violence) or directly injured
- A repeated pattern of referrals / escalation of domestic violence and abuse incidents where there is significant risk harm to the child/children
- Previous MARAC with current or previous partners (whether victim or perpetrator)
- Clear injury to a child would automatically instigate a Section 47 Enquiry and core assessment, unless the child is no longer at risk.

The Child protection Conference

The following are additional procedures to be followed in conjunction with Chapter 2 of the Inter-Agency Safeguarding Procedures

Where a Child Protection Conference is to be held the Police Domestic Abuse Coordinators (Community Safety / Public Protection Unit) should be asked to provide all information of reported domestic violence incidents in relation to the family in question. All regular pre-conference checks should be carried out in line with procedures i.e. Schools, Probation Service, Education Welfare, Health / GP and any other agency known to be involved with either the children or adults.

All professionals involved with the family, including adult services, probation, health, advocates and voluntary sector services, should be invited to the initial child protection conference. If unable to attend, they should be asked to provide a report.

A CAADA DASH risk assessment should have been completed and any additional assessments must be undertaken regarding risks posed by the abuser/ offender to the child/ren and any risks that their attendance at the conference might pose to the non-abusing parent children and professionals present.

It is the responsibility of the allocated social worker to discuss the reasons for the conference and the conference process with the non-abusing parent and ascertain their views regarding the participation of the abusing adult.

The social worker must discuss with the Chair of the Conference, in advance of the conference, if the working process of a Child Protection Conference is likely to be compromised because the non-abusing parent feels unable to share information or participate, or has safety fears. Consideration must be given to excluding the abusing parent from all or part of a meeting. This decision is the responsibility of the Chair of the Conference, who will record the reason in the conference record. The Chair of the Conference will also consider how the views of the adult perpetrator will be sought regarding the children for whom they have parental responsibility, and will make arrangements for the abusing adult to be informed of the outcome of the conference.

The Family Law Act 1996 gives greater powers to permit, in certain circumstances, removing the abuser from the home in order to protect children and this should be considered as part of the of a Child Protection Plan, or before this point if necessary. Consultation with the legal department to use these powers or other orders will be necessary

7.3 Health

The Department of Health (Domestic Violence: A resource manual for Health Professionals, 2000 – updated Dec 2005) states that 'all health care professionals have the opportunity and responsibility to identify people who are experiencing domestic violence and abuse and to take steps to empower those women to get help and support. Early intervention can prevent an abusive situation becoming worse and the level of violence becoming more intense'.

The specific health consequences of domestic violence are numerous. They can range from psychological effects to physical injury and death. Domestic violence and abuse often starts or escalates during pregnancy.

Living with domestic violence and abuse also has a psychological impact on those involved, and has been compared to living under hostage/terrorism

situations. There is a clear link between domestic violence and abuse and mental ill health, with most researchers suggesting that abuse – both in childhood or adult life – is often a precursor of and a causal factor in the development of mental health issues, including depression, post-traumatic stress disorder and self-harming behaviour. This association also appears to hold cross culturally. Additionally, a variety of negative coping strategies may be employed, including alcohol and substance misuse.

The health service has a dual role when dealing with domestic violence. Firstly, it is the source of care for many of the injuries of victims and survivors, providing both immediate and long-term care. Secondly, since there is near universal contact with the Health Service, the NHS provides a key route to identification, risk assessment and appropriate health and other support for those experiencing domestic violence and abuse, including their children.

If Health professionals, including GPs, Midwifery, Practice Nurses, Health Visitors (HV) and School Nurses (SN), Paediatricians Accident & Emergency Staff, become aware of domestic violence and abuse within a family they should listen to the victim and take them seriously. The safety of any children in the household and the implications of domestic violence and abuse for them should be discussed. Any injuries should be logged, (photographed if possible, by medical photography or forensic photography but NOT with a mobile phone) and questions should be sensitively asked about how they were received.

The need to safeguard the welfare of the child/ren is paramount. Where child/ren are in the household the Health professional should establish how/where the child/ren were and how they are affected. The emotional impact on children may be difficult to assess but may manifest as adjustment problems resulting in withdrawal, depression, anxiety, difficult behaviour, parent child conflict, low self esteem, attachment problems etc. Where children are involved the parent/carer should be informed that the matter will be discussed with the Safeguarding Children Adviser (Health) and their advice sought. If the child/ren are considered to be suffering, or are likely to suffer, significant harm a referral will be made to Children's Social Care (formerly SSD). If domestic abuse is suspected but denied any injuries should be recorded and consideration should be given to a referral to Children's Social Care.

GPs have a responsibility to alert other health professionals and /or social care where an adult patient who is a parent/carer/partner raises concerns in relation to domestic violence and abuse. As a minimum GPs should check whether the adult patient has children or children who visit the home and where a decision is made NOT to make a referral to Children's Social Care, the reasons for this should be recorded on the patient record and cross referenced onto the child's record. Additionally, GPs should consider whether a referral may be appropriate under the Protection of Vulnerable Adults Guidance (see 7.8)

In Bournemouth and Poole only

The police will distribute DV1 forms to health professionals via the B&P Community Health Service Safeguarding Children department who will alert other Health Professionals and other health trusts in the area as appropriate.

Upon receipt, the DV1 form will be read, assessed and passed on to health visitors. If they are assessed as 'high' staff will be contacted by phone. Health visitors will share the referral with GPs, school nurses and midwives as appropriate.

Health professionals will transfer this information to the child and family records. Any concerns will be discussed with their Safeguarding Children Supervisor and appropriate action agreed. This includes considering a referral to Children's Services-Social Care.

If it is decided that a support visit is needed then contact will be made with other agencies to ascertain their level of intervention and to consider joint visits if appropriate, or to agree who will undertake a support visit in order to avoid duplication of intervention. Following a visit any outcomes or actions taken will be passed to the relevant agencies.

The health professional will discuss the information with all other health professionals' including the GP who may be involved with the child. The GP should ensure this information is recorded on the notes of the non abusive parent and child and that this information is also recorded in a safe and coded manner on the perpetrator's notes (ie this information may be significant if the perpetrator establishes another relationship).

If the health professional is aware that a child involved is being seen in a secondary or tertiary care setting and that the information could be relevant to the secondary care management they should ensure that the information is passed on to whoever is providing secondary or tertiary care.

7.4 Probation

Dorset Probation Area (DPA) should follow their Domestic Abuse Policy and Guidelines for staff as far as it aligns to national instructions / policy for NOMS.

Offenders known to the Probation Service are assessed as to whether they pose a risk of causing serious harm to others. The likelihood of domestic abuse is an important aspect of this assessment. If any offender presents a risk of serious harm a referral will be made for consideration under the MAPPA, MARAC or the DVLA and a multi agency meeting may be convened.

Some offenders may, themselves, be victims of domestic violence and abuse and they should be assisted to protect themselves and any dependents.

Perpetrators under the supervision of DPA are monitored, their behaviour is challenged and they will be referred to the Integrated Domestic Abuse Programme (IDAP) as appropriate. The focus of supervision is protecting the victim and any dependents, preventing further offending and changing established patterns of thinking and behaviour.

Those perpetrators required to attend the IDAP will be required to provide details of partners so that the Women Safety Worker can make contact with partners. WSW support to victims is a key part of the Probation's public protection remit. The WSW will liaise directly with police, offender managers,

programme staff and Children Services in order to provide safety planning options and manage the risk to partners.

Probation offender managers will liaise with the relevant Children's Services-Social Care (through the assessment team if appropriate) where it is known that there are children in the family of an offender and offenders are known to be perpetrators of domestic abuse.

In addition to the usual child protection procedures, where a convicted domestic violence and abuse perpetrator is attending the IDAP programme and is living with or having regular contact with children, the Probation Offender manager will send a notification form to Children's Services-Social Care assessment team. The purpose of the notification should be made clear e.g., notification only, information seeking, or making a referral.

7.5 Youth Offending Teams

When working with young offenders, the Youth Offending Worker must check the Children's Services-Social Care Department IT systems to access to any information that would have a bearing on the work that is carried out with the young person.

7.6 Children and Family Court Advisory and Support Service (CAFCASS)

Where a Family Court Adviser is asked for a welfare report under section 7 of the 1989 Children Act in relation to a disputed application for contact and/or residence in a household or family in which domestic violence and abuse is a feature, an assessment must be made regarding the harm the child/ren have suffered or are at risk of suffering if contact is ordered. The report should include an assessment of whether the child/ren and resident parent's safety can be secured, before, during and after contact. Particular efforts should be made to ascertain the wishes and feelings of the child/ren in the light of domestic violence and abuse allegations. In each case, children should be interviewed in a manner consistent with their age, developmental needs and understanding.

Family Court Advisers should be informed by the court prior to their assessment if a Finding of Fact concerning domestic violence has been made. It may be advisable for reporters to confirm this in such cases. In addition, Family Court Advisers have a duty to advise the Court if they believe that a Finding of Fact Hearing would be appropriate because of allegations of domestic violence and abuse.

Where allegations of domestic violence and abuse are involved and the whereabouts of the child/ren and resident parent are not known to the parent seeking contact, but are known to the court and the Family Court Adviser, it is vital that the court makes directions designed to ensure that the welfare report does not reveal their whereabouts, either directly or indirectly. In addition, CAFCASS has a general duty to respect this. It may also be appropriate for responsibility for a welfare report to be allocated to an office away from the area where the children and the resident parent are living in order to avoid detection of their whereabouts.

In deciding whether to recommend contact in their report to court, the family court adviser should take into account the welfare checklist in section (1) (3) of the 1989 Children Act. The court, when considering whether or not to grant contact, will take into account details on whether or not it will be supervised/supported, by whom and how. Any contact must minimise the risk of harm to the child/ren and ensure the safety of the child/ren and resident parent, before, during and after contact. In making an assessment, the Family Court Adviser will make appropriate use of the CAFCASS Domestic Violence Toolkit and safety planning documents. In cases where there is agreement between the parties and there is a background of domestic violence the Family Court Adviser will act to carefully scrutinize the agreement in terms of safety and protection.

All referrals to CAFCASS will initially be screened by a Service Manager in terms of possible safeguarding issues. In all Private Law cases where there are allegations of domestic abuse the Local Authority will be notified that CAFCASS is involved with the family. Where the arrangements for the child/ren currently prevent the risk of exposure to harm, or that risk is being managed during the course of CAFCASS' work, no formal referral will be made at that stage. Where the outcome of the court application results in contact and residence arrangements that resolve issues satisfactorily, excluding the risk of future exposure to harm as a result of witnessing or experiencing domestic abuse, the Local Authority will be notified that CAFCASS' involvement is at an end and no referral is being made. Where ongoing concerns remain and the child/ren require assessment as to services needed then a formal referral will be made, usually accompanied by a CAF. If the child/ren have suffered harm or are considered to remain at risk of harm a Child Protection referral will be made. The court, the children where appropriate and their families will be informed of the steps CAFCASS will take. In cases of Child Protection referrals there may be specific reasons not to do this although the Court will always be informed of actions taken.

Whenever a Court requires a Section 7 Report and the Local Authority Children's Services-Social Care are working with the child/ren and their family, the Local Authority shall ordinarily undertake the reporting requirement in order to avoid agency duplication.

In Section 31 applications, Adoption Proceedings and any other Public Law Proceedings the Family Court Adviser must be aware of any relevant Domestic Violence issues in their assessment.

7.7 Schools and Education Support Services

Education support services and schools have no statutory responsibility for protecting adults who have experienced or are experiencing domestic violence and abuse. However, they do have a duty under the Children Act to assist Children's Services-Social Care (formerly SSD) acting on behalf of children in need or enquiries into allegations of child abuse. Further, Section 175 of the Education Act 2002 placed a statutory duty on Local Authorities, schools and further education institutions to make arrangements for carrying out their functions with a view to safeguarding and promoting the welfare of children. The same duty is imposed on Independent Schools through s157 of the Education Act 2002

Every school is required to have a child protection policy in place and a named Senior Designated Person within the school that has specific responsibility for child protection issues. Many children and young people in schools and youth settings will be experiencing or witnessing domestic violence and abuse within their immediate family. Many young people may be in relationships where they are already experiencing violence or abuse.

Staff in the Education Service who have direct contact with children and families should be aware of the significance of domestic violence and abuse on the lives of children and young people. Staff should not only be alert to signs of physical abuse but also the emotional impact on children. Schools and educational establishments are a major point of contact for children and their parents/carers. Schools can have more contact with school-aged children than any other professional or agency. Schools also have a role to play in reminding the community that domestic violence and abuse is a crime and can display information about sources of help available locally for women and children.

Where Children's Services social care are undertaking an initial assessment or undertaking a child protection investigation, the social worker will communicate with the school's designated member of staff and a named representative within education.

If child protection concerns are raised then a referral should be made to the appropriate. See Chapter 2 – Bournemouth, Dorset & Poole Interagency Safeguarding Procedures.

If a child/ren has transferred schools due to the family experiencing domestic violence and abuse, care should be taken in relation to revealing the new location of the school to the perpetrator. However relevant information about the child should be shared by the school's Designated Senior Person with the appropriate figure in the new school to ensure the overall well-being of the child is safe-guarded. If the whereabouts of the child and adult victim of abuse are not known, the Education Welfare Officer/ education Social Worker should be notified and agreement reached about attempts to establish where the child is and how information will be passed onto the relevant local authority and or school. In cases where families move areas due to domestic violence and have difficulty in securing a school place the Education Welfare Officer should intervene to ensure that these children have access to education.

In Bournemouth and Poole only

The Police will forward a copy of the DV form to named persons in Children and Young Peoples Integrated Services (CYPIS) Poole and Childrens Learning and Engagement (CLE) Bournemouth. The information will be flagged on the respective data bases so that all education professionals are aware of the DV. CYPIS/CLE will share this information with the Designated Senior Person for child protection and also the Head Teacher (where s/he is not the DSP) No-one from the school should speak with the child or young person unless this is agreed with the parent or as part of an agreed multi agency plan. SCHOOL TO BE ADVISED TO BE AWARE OF NEED FOR CONFIDENTIALTY AROUND THE DETAILS ON THE DV FORM – ADDRESSES MAY NEED TO BE KEPT CONFIDENTIAL

7.8 Adults Services

A significant finding described in "Analysing child deaths and serious injury through abuse and neglect: what can we learn?" DCSF 2008 is that where domestic violence prevailed in cases subject of a serious case review, this very often coexisted with other problems in the family such as substance misuse and mental health. The conclusion being that this continues to be a major challenge for (Adult) provider services in terms of early identification and that agencies who have contact with the adult members of the family have a key role to play. Therefore this protocol should be read in conjunction with the Adult Mental Health, Substance Misuse and Child Care Protocol. Therefore when practitioners are working with adults who have a child caring responsibilities they need to ensure that the children are included in any holistic assessment when the adult mentions as part of history gathering:

- History of domestic violence or convictions for violent offences
- Disordered thinking about partner
- Obsessive/controlling behaviour towards partner and/or children
- Expressing fears or intent to harm partner and/or children
- Known use of or availability of weapons (carries a knife /owns or access to guns)
- Describing behaviours which could suggest harassment or stalking
- The heightened risk to a pregnant partner or a partner who is threatening to or has recently left the family home

Therefore it is essential that a client's relationship with their partner is explored as part of the professional assessment and intervention.

Adult Protection:

In respect of Domestic Violence, consideration should also be given to the level of vulnerability of the Adult experiencing domestic violence. Currently the definition of Vulnerable Adult is a follows:

"The individual is or may be in need of *Community Care Services* by reason of mental or other disability, age or illness
And
Is or may be unable to take care of himself or herself
Or
Is unable to protect themselves against significant harm or serious exploitation"
("Who Decides" - Lord Chancellor's Office, 1997 and *"No Secrets"*, 2000*)*

If it is felt that the person experiencing Domestic Violence does or may fall in line with this definition then a referral to Adult Social Services should be made under the Pan Dorset Adult Protection Policy to raise an "alert". This will then be further screened and acted upon in line with the policy. Work will be undertaken in liaison with all relevant parties with the intention of safeguarding where possible this adult against significant harm, abuse or neglect.

7.9 Housing Departments

There follows general references to housing law and policy relating to victims of domestic violence and abuse. Local policies and priorities may differ.

Many victims do not leave their violent partners because they believe there is nowhere else to go**.** They may also return to violent partners due to inadequate housing arrangements. There are, in fact, several options available and they can:

- Obtain a court order "Occupation Order" under the Family Law Act 1996 to remove the perpetrator. Women who are concerned about their immigration status should seek advice from the Immigration Advisory Service before taking legal proceedings.

- Staying with family or friends – the Council should be informed immediately that this has resulted in homelessness. Migrants to Britain should contact the Immigration Advisory Service before contacting the housing department.

- Women's Refuge – referrals can be made via Samaritans, CAB, the Police, Children's Services-Social Care or Women's Aid, and some accept self referrals.

- Privately rented or bought accommodation – the victim should be eligible to claim Housing Benefit for rented housing.

- Traveller Liaison Officers within Housing Departments can be contacted for advice and availability of caravan sites within the area. This may include information on private sites renting caravans or private letting agencies. Rented caravan accommodation qualifies for housing benefit.

Councils have a duty to arrange housing for anyone who is homeless, in priority need and is not intentionally homeless (Housing act 1996, Part VII, as amended by Homelessness Act 2002). Local councils have a duty to advise/assist the homeless and provide temporary accommodation.

Homelessness applies when:

- A person tries to live in their accommodation they may be at risk of violence from someone living in it.

- The person has no accommodation they can lawfully occupy.

- The person's family members who normally live with them are forced to live separately from them because they have no accommodation they can occupy together.

- The person has accommodation but cannot occupy it i.e. illegally evicted or is forcibly prevented from occupying it.

- Priority needs which may apply in the domestic violence and abuse context.

- The person is vulnerable as a result of fleeing violence.

- The person has children living with them or who would normally live with them.

- The person is pregnant or has someone living with them who is pregnant.

- The person is 16 or 17yrs old who is not a relevant child or a child in need to whom the LA owes a duty under S20 of the Children Act 1989

- The person or anyone who lives with them is vulnerable due to old age, or mental or physical disability. Councils sometimes accept that single women fleeing violence are in priority need if they are vulnerable.

Housing Associations have no legal duty to house the homeless, but may be able to offer a tenancy earlier than the local authority.

The Department of Environment Code of Guidance on Homelessness states that local authorities should respond sympathetically to situations where violence has not yet occurred, but it is feared. If a woman is living in a refuge, she should be treated as homeless. If she has gone to stay with friends or relatives, she may still be regarded as homeless.

Where a local authority has reason to believe the victim may be homeless and may have a priority need, they have a duty to offer temporary accommodation whilst investigating the case. Homeless victims are entitled to apply to any council, irrespective of any local connection. The council may refer the victim to an authority where there has been a previous connection. However, such a referral should not be made if a move to that area would renew the risk of domestic violence and abuse.

Professionals should advise victims to record the violence experienced before going to the Housing Department, or in the event of literacy difficulties assist the victim to do this, as it may be difficult to remember details in an interview. If victims have supporting evidence such as a social worker's/doctor's report or letter, an occupation order, an injunction or a Police report, they should take these with them when applying to the Housing Department.

If a Housing Officer has received information to suggest that either an adult or a child maybe vulnerable due to domestic abuse they should consult with Children's Services - social care or Adult Services in line with inter-agency safeguarding procedures and adult protection procedures

Appendix 1

Appendices

SOURCES OF HELP AND SUPPORT FOR VICTIMS

Specialist Domestic Violence Services

Outreach

Dorset Women's Outreach Project (DWOP) covers the West of Dorset County Freephone 0800 5877480

Bournemouth Women's Helpline 01202-547755. Confidential 24hour Helpline with refuge and outreach facilities for women and families.

Poole Domestic Violence Project 01202-710777.
Dorset new countywide service to be added (starts 1 July 2010)

Refuges

Bournemouth 01202 547755
Poole 01202 748488 (can take male victims)
West Dorset 01305 262444
North Dorset 01747 858555

Dorset Police Domestic Abuse Teams

Weymouth	01305 226547
Ferndown	01202 226089
Bournemouth	01202 222046
Poole	01202 227835

Dorset Police non emergency contact number 01202/01305 222222
For an emergency response the police should always be contacted via 999.

Other Services

There is also a range of other organisations in Dorset who will be able to support victims as part of their work. These include:

Victim Support 01202 606200
Relate (Bournemouth, Poole & Christchurch) 01202 311231
Relate (Dorchester) 01305 262285
Rape Crisis Line 01202-547445. 24 hour answer phone line offering confidential support to woman and girls who have been raped or sexually abused.
Family Matters 01202 311231

Social Services (Bournemouth, Poole & Dorset) out of hours 01202 657279

Borough of Poole: Children and Families
14A Commercial Road, Poole, BH14 0JW Tel:01202-735046

Borough of Bournemouth: Children's Services-Social Care

New Century House, 24 Christchurch Road, Bournemouth, BH1 3NL Tel: 01202 458000

Dorset County Children's Services-Social Care

Bridport:	01308 422234	Purbeck:	01929 553456
Christchurch:	01202 474106	Dorchester:	01305 221450
Ferndown:	01202 877445	North Dorset:	01258 472652
Weymouth/Portland:	01305 760139		

You Trust Dorset First Point

First Point is a Dorset County floating support service which aims to prevent homelessness and provide support to vulnerable people aged 16-65. Referrals can be made by agencies including Social Services, Housing, CAB and drug and alcohol services.
Contact: 0845 310 6843

StoP – Supports mothers of children who have been sexually abused

PO Box 4493, Boscombe, Bournemouth, BH1 4YZ Tel: 01202 773667
(24 hour answer phone, answered Monday and Tuesday 10.30-12.30)

National Support

24 Hour Helplines

National Domestic Violence Helpline 0808 2000 247
The Men's Advice Line 0808 801 0327 (male victims)
Respect (for perpetrators) 0845 1228609
The National Centre for Domestic Violence (NCDV) (free legal advice & help with obtaining injunctions) 0844 8044 999

Childline 0800 1111

Useful national websites can be found at
http://www.dorsetforyou.com/index.jsp?articleid=337063

Appendix 2

Multi-Agency Risk Assessment Conferences (MARAC)

MARACs deal with the adult domestic violence victims identified as being at highest risk of serious harm. The risk assessment process, MARAC procedures (including referral) and standards for operating MARAC meetings have been developed by CAADA (Coordinated Action Against Domestic Abuse) which is a national organisation supported by the Home Office. Issues relating to children e.g. conflict over child contact; pregnancy and perception of harm to children are key indicators of risk in the CAADA risk assessment process. Thus a substantial number of victims who become MARAC cases have children (although many do not).

The aim of the MARAC is to:

- Share information to increase the safety, health and well-being of victims and their children.
- Determine whether the perpetrator poses a significant risk to any particular individual or the general community.
- Construct and implement a risk management plan that provides professional support to all those at risk and that reduces the risk of harm.
- Reduce repeat victimisation.
- Improve agency accountability.
- Improve support for staff involved in high risk domestic violence cases.

The responsibility to take appropriate action rests with the individual agencies – the MARAC is the process through which information is shared.

Independent Domestic Violence Advisors (IDVAs)

MARACs are adult victim centred and intended to reduce risk and prevent murder. Victims referred to the MARAC are supported by IDVAs. The IDVA's role is to:

- Work only with very high risk victims identified by the police
- Represent the victim at the MARAC
- Offer the victim practical, legal and emotional support to guide them through their options
- Support victim through the criminal justice process, including attending the Specialist Domestic Violence Court (SDVC) if required
- Work with other agencies to ensure that actions agreed at the MARAC are carried out through the MARAC action plan

In Dorset County there are two full time IDVAs and a 30 hours per week project leader provided by Bournemouth Churches Housing Association (BCHA).
Bournemouth & Poole IDVA service details to be added

Risk Assessment & How to Refer to the MARAC

Any agency can refer a victim's case to the MARAC by following the procedure below:

1. Complete the CAADA DASH risk assessment form. 14 ticks or more meets the MARAC threshold and the case should be referred.
2. Complete the MARAC referral form.
3. Send the risk assessment form and MARAC referral form (by secure fax or secure E mail) to the MARAC coordinator

If the case does not meet the MARAC threshold consider other support you may need to give the victim and signpost to other specialist services.

It should be noted that DASH isn't a full risk assessment for children and doesn't replace any safeguarding processes already in place

Dorset MARAC Contact Details

Contact details for help, advice and guidance on the MARAC process including making a referral are listed below.

Chair DI Kevin Lansdale Kevin.lansdale@dorset.pnn.police.uk (01305 226510)

Coordinator ElaineTaylor Elaine.taylor@dorset.pnn.police.uk

Advice DS Nigel Cullis Nigel.cullis@dorset.pnn.police.uk (01202 226186)

Bournemouth MARAC Contact Details TBC

Poole MARAC Contact Details TBC

General Information About the MARAC & Risk Assessment

CAADA has produced a very good toolkit which contains more detailed information on the MARAC. A copy of this has been supplied on the training.

For more information please visit the CAADA website www.caada.org.uk

The MARAC DASH risk assessment form and referral form along with links to the CAADA website can be found at http://www.dorsetforyou.com/index.jsp?articleid=1002591

Appendix 3

Perpetrator Treatment Programmes

There are currently no established perpetrator programmes, other than those for high risk convicted offenders via the Probation Integrated Domestic Abuse Programme.

Dorset Change in conjunction with NSPCC are currently (as at May 2010) running a pilot treatment programme for male perpetrators of domestic violence and abuse for Dorset cases. Continuation or development of this programme will depend on the evaluation and further funding becoming available.

Appendix 4

Training Courses

1. Domestic Violence Awareness (full day)

For details of awareness courses in Dorset County contact Nicola Pengelly (n.pengelly@dorsetcc.gov.uk). Dates and course details can be found on http://www.dorsetforyou.com/index.jsp?articleid=357222
Awareness courses provide a short input on the impacts of domestic violence and abuse on children but do not cover the subject in any detail

2. Safeguarding Children/Child Protection Matters (two day)

A short input on domestic violence and children is included on the courses running in Bournemouth, Poole and Dorset

3. MARAC Awareness (half day)

For details of MARAC awareness training courses in Dorset County contact Nicola Pengelly (n.pengelly@dorsetcc.gov.uk).

Appendix 5

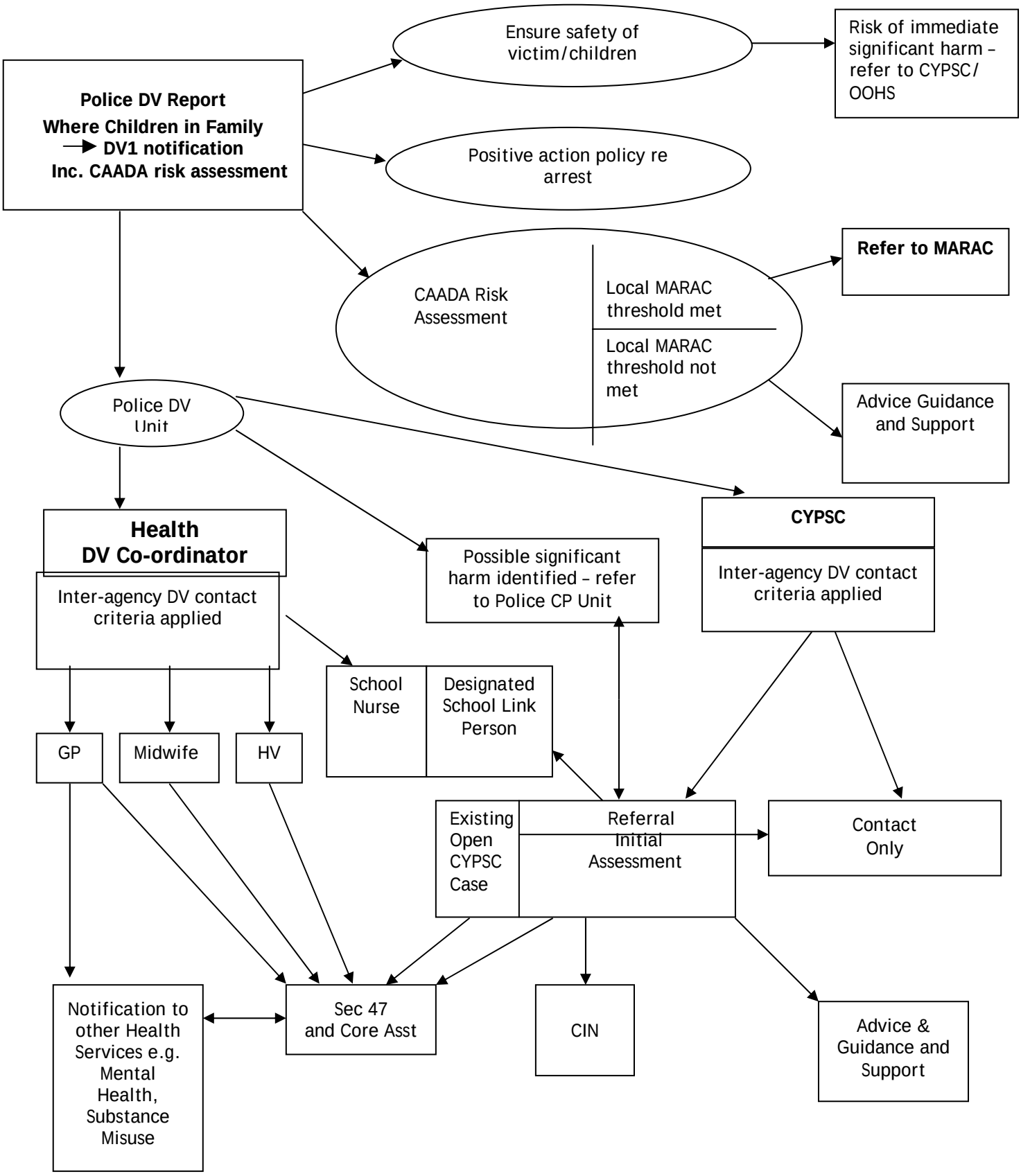
ACRONYNMS	
MARAC	Multi Agency Risk Assessment Conference
CAADA	Coordinated Action Against Domestic Abuse
LSCB	Local Safeguarding Children Board
CPS	Crown Prosecution Service
CAF	Common Assessment Framework
DPA	Dorset Probation Area
NOMS	National Offender Management Service
MAPPA	Multi Agency Public Protection Arrangements
DVLA	Domestic Violence Liaison Arrangements
IDAP	Integrated Domestic Abuse programme
WSW	Women's Safety Worker for IDAP
YOT	Youth Offending Team
YISP	Youth Inclusion Support Panel
CAFCASS	Children & Family Court Advisory & Support Service

Appendix 6

INTER-AGENCY DOMESTIC VIOLENCE POLICE REPORT (DV1)

SAFEGUARDING CHILDREN NOTIFICATION PATHWAY BOURNEMOUTH & POOLE

(This pathway relates to Bournemouth & Poole only, Dorset will develop their own)



Bournemouth & Poole Local Safeguarding Children Board

Dorset Safeguarding Children Board

PAN DORSET INTER-AGENCY SAFEGUARDING PROCEDURES

CHAPTER 4

4.1 SAFER RECRUITMENT

Procedures Effective from:

Review Date:

If you have any comments or queries about the pan-Dorset procedures please contact your agency representative on the Pan Dorset Policy and Procedures Group or notify the LSCB using the following email addresses:

info@dorsetlscb.co.uk
info@bournemouth-poole-lscb.org.uk

PAN-DORSET SAFER RECRUITMENT GOOD PRACTICE GUIDANCE

Contents

Section	Title
1	Introduction
2	Scope
3	Contractors
4	Volunteers
5	Training
6	Process – Elements of safer practice
7	Planning and Advertising
8	Application Form
9	Job Description
10	Person Specification
11	Information Pack for Candidates
12	Scrutinising and Short listing
13	References
14	Other Checks before Interview
15	Involving Children and Young People
16	Interviews
17	Invitation to Interview
18	Interview Panel
19	Scope of the Interview
20	Offer of Appointment
21	List 99/ PoCA or PoVA List and CRB Checks on Overseas staff
22	Post Appointment Induction
23	Maintaining a Safer Culture
24	Monitoring
Appendix 1	Checklist for Safer Recruitment Process
Appendix 2	Suggested Questions for Inclusion in Reference Requests

1 Introduction

1.1 Experience shows the importance of organisations that provide services to children, operating recruitment and selection procedures and other Human Resources (HR) management processes that help deter, reject or identify people who might abuse children, or who are otherwise unsuited to work with them. Making safeguarding and promoting the welfare of children an integral factor in HR management is an essential part of creating safe environments for children and young people.

This guidance sets out best recruitment practice and is compliant with the safe recruitment recommendations of the Bichard Inquiry.

2 Scope

2.1 All organisations which employ staff or volunteers to work with children should adopt a consistent and thorough process of safer recruitment in order that those recruited are suitable.

2.2 The measures described in this guidance should therefore be applied to:

- everyone who works (as an employee, volunteer or is a contractor) with children.
- those who regularly work in a setting where children are present (e.g. School, Leisure Centre, family homes) who may not have direct contact with children as a result of their job, but nevertheless will be seen as safe and trustworthy because of their regular presence. This includes staff not on the payroll, e.g. Contractors and volunteers.

3 Contractors

3.1 The principles of safe recruitment should be included in the terms of any contract (or Service Level Agreement) drawn up between the organisation and contractors or agencies that provide services for, or adults to work with, children for whom the organisation is responsible. The organisation should also monitor compliance with the contract which should include a requirement that the provider will not sub-contract to any personnel who have not been part of a safe recruitment process.

4 Volunteers

4.1 Volunteers are also seen by children as safe and trustworthy adults and thus any organisation which is considering recruiting volunteers should normally adopt the same rigour in recruitment measures as it would for paid staff. However, the procedure may be streamlined where, for example, a parent who is well known, is approached to take on a particular role, i.e.:

- seek references (usually from a person who knows the volunteer in a professional capacity)
- checking whether others in the organisations community know of concerns, and can make a positive recommendation
- Conduct an informal interview
- Undertake relevant checks e.g. CRB, List 99, and PoCA etc.
- Ensuring the volunteer is aware of and committed to safe practice in other circumstance e.g. Where a volunteer's role will be one-off, such as accompanying children and paid staff on a day outing or helping at an event, measures will normally be unnecessary provided that the person is not left alone with or unsupervised in charge of children.

4.2 Where volunteers recruited by another organisation work with or in a setting where children are present, the organisation responsible for those children should obtain assurance from the other organisation that the person has been properly vetted (including details of the vetting procedures undertaken.

5 Training for staff involved in the recruitment and selection process

5.1 All organisations involved in the selection of adults to work with children should ensure that designated staff are appropriately trained in safer recruitment and are familiar with and apply the procedure contained in this guidance.

6 Process - Elements of Safer Practice

6.1 Safer practice in recruitment means thinking about and including issues to do with child protection and safeguarding and promoting the welfare of children at every stage of the process.

6.2 It starts with the process of planning the recruitment exercise and, where the post is advertised, ensuring that the advertisement makes clear the

organisations commitment to safeguarding and promoting the welfare of children.

6.3 It also requires a consistent and thorough process of obtaining, collating, analysing and evaluating information from and about applicants.

6.4 Main elements of the process include:

- ensuring the job description makes reference to the responsibility for safeguarding and promoting the welfare of children;
- ensuring that the person specification includes specific reference to suitability to work with children;
- obtaining and scrutinising comprehensive information from applicants, and taking up and satisfactorily resolving any discrepancies or anomalies;
- obtaining independent professional, personal and character references that answer specific questions to help assess an applicant's suitability to work with children and following up any concerns;
- a face to face interview that explores the candidate's suitability to work with children as well as his/her suitability for the post;
- verifying the successful applicant's identity;
- verifying that the successful applicant has any academic or vocational qualifications claimed;
- checking his/her previous employment history and experience;
- verifying that s/he has the health and physical capacity for the job;
- appropriate mandatory checks of List 99, Protection of Children Act, (PoCA) & Protection of Vulnerable Adults, (PoVA) List; Independent Safeguarding Authority Vetting and Barring Scheme (from Autumn 2008)
- enhanced criminal record check via the CRB for all relevant posts.

Note:
Enhanced CRB checks, inclusive of List 99, PoCA and PoVA checks cannot be solely relied on to screen out unsuitable applicants. This is why it is critical to ensure that all other elements of the process as detailed above are undertaken. Criminal records and the 'list' checks will identify individuals:

- who have been convicted or cautioned
- who have been placed on Lists 99, PoCA, or PoVA; and
- about whom relevant police intelligence information is held (NB. who has responsibility to lead on enhanced disclosure information needs to be agreed with the Police and employing agency).

There will therefore be some individuals who may be unsuitable to work with children who will not be known to the police and who are not on any of the 'lists'.

A checklist for safer recruitment is included at appendix 1.

7 Planning and Advertising

7.1 Planning is vital to successful recruitment and will minimise the risk of making an unsuitable appointment.

7.2 The elements which should be considered as part of good planning are:

- Identify who should be involved, assigning responsibilities and set aside sufficient time for the work needed at each stage of the recruitment process so that safeguards are not skimped or overlooked.
- Be clear about what mix of qualities, qualifications and experience a successful candidate will need to demonstrate. Whether there are any particular matters that need to be mentioned in the advertisement for the post in order to prevent unwanted applications.
- Person specification will need careful thought and drafting, including essential criteria which can be measured/assessed;
- Ensure all other material, e.g. the application form, job description, information and guidance that will form part of the recruitment pack sent to prospective applicants is up-to-date. Ensure that the information clearly sets out the extent of the relationships and contact with children and the degree of responsibility for children that the person will have in the position applied for. (All people who work with children or in settings where children are present have a responsibility to safeguard children, although the way in which this responsibility is discharged will vary according to the nature of the post).
- References should normally be obtained on short-listed candidates prior to the interview and should ask both specific and open questions about the candidate in relation to safeguarding and child protection. See section 12, page 8, for further information about references.
- The advertisement for the post should include a statement about the employer's commitment to safeguarding and promoting the welfare of children and where appropriate that the successful applicant will be asked undertake an enhanced criminal record check via the CRB. E.g. This organisation is committed to safeguarding and promoting the welfare of children and young people and expects all staff and volunteers to share this commitment. Rigorous checks will be undertaken of the successful applicant's background credentials including an enhanced CRB check.

8 Application Form

8.1 Employers should use an application form to obtain a common set of core data from all applicants. It is not good practice to accept curriculum vitae drawn up by applicants in place of an application form because these will only contain the information the applicant wishes to present and may omit relevant details.

8.2 The form should obtain:

- Full identifying details of the applicant including current and former names, current address, and National Insurance number.
- A statement of any academic and/or vocational qualifications the applicant has obtained that are relevant to the position for which s/he is applying with details of the awarding body and date of award.
- A full history in chronological order since leaving secondary education, including periods of any post-secondary education/training, part-time and voluntary work as well as full time employment, with start and end dates, explanations for periods not in employment or education/training and reasons for leaving employment.
- A declaration of any family or close relationship to existing employees or employers (including councillors and governors).
- Details of referees. One referee should be the applicant's current or most recent employer and normally two referees should be sufficient. N.B. where an applicant who is not currently working with children has done so in the past, in a paid or voluntary capacity, it is important that a reference is also obtained from the employer by whom the person was most recently employed in this work. This situation may particularly apply where people have not worked for a number of years or those who are entering the job market for the first time. The form should make it clear that references will not be accepted from relatives or from people writing solely in the capacity of friends with the exception of recruitment for fostering and adoption applicants.
- A statement of the personal qualities and experience that the applicant believes are relevant to his/her suitability for the post advertised and how s/he meets the person specification.
- An explanation that the post is exempt from the Rehabilitation of Offenders Act 1974 and therefore that all convictions, cautions and bind-overs including those regarded as 'spent', must be declared.
- It should require a signed statement that the person is not included on List 99 or PoVA or (from Autumn 2008) barred by the Independent Safeguarding Authority; or disqualified from work with children; subject to sanctions imposed by a regulatory body, e.g. the General Teaching Council (GTC) or General Social Care Council (GSCC) and either has no convictions, cautions, or bind-overs, or has attached details of their record in a sealed envelope marked confidential.

8.3 It should record that:

- Where appropriate the successful applicant will be required to provide a Disclosure from the CRB at the appropriate level for the post (posts involving work with children are exempt from the Rehabilitation of Offenders Act 1974);
- The prospective employer will normally seek references on short-listed candidates, and may approach previous employers for information to verify particular experience or qualifications, before interview;
- If the applicant has or is currently working with children, on either a paid or voluntary basis, his/her current or previous employer will be asked about disciplinary offences relating to children, including any in which the penalty is "time expired" (where a warning could no longer be taken into account in any new disciplinary hearing for example) and whether the applicant has been the subject of any child protection concerns or allegations and if so, the outcome of any enquiry or disciplinary procedure.
- providing false information is an offence and could result in the application being rejected or summary dismissal if the applicant has been selected and a possible referral to the police.
- applicants holding any relevant professional registration will be asked to provide their reference number

Explanatory notes and/or instructions for completing the form should be included in the candidate's information pack.

9 Job Description

9.1 This should clearly state:

- the main duties and responsibilities of the post
- the individual's responsibility for promoting and safeguarding the welfare of children and young persons s/he is responsible for, or comes into contact with.

10 Person Specification

10.1 This should include:

- qualifications, experience and any other requirements needed to perform the role in relation to working with children, young people;

- the competences and qualities that the successful candidate should be able to demonstrate; and,
- explain how these requirements will be tested and assessed during the selection process.

10.2 For example:

"In addition to candidates' ability to perform the duties of the post, the interview will also explore issues relating to safeguarding and promoting the welfare of children and young people including:

- *motivation to work with children and young people;*
- *ability to form and maintain appropriate relationships and personal boundaries with children and young people;*
- *emotional resilience in working with challenging behaviours and attitudes to the use of authority and maintaining discipline"; and*
- *explain that if the applicant is short listed any relevant issues arising from his/her references will be taken up at interview."*

11 Information Pack for Candidates

11.1 The pack should include a copy of:

- the application form and explanatory notes about completing the form;
- the job description and person specification;
- any relevant information about the organisation and the recruitment process and relevant policies such as the organisation's policy about equal opportunities, the recruitment of ex-offenders, management of allegations against staff, etc.
- the organisation's Child Protection/Safeguarding Policy Statement;
- the organisation's code of practice;
- a statement of the terms and conditions relating to the post.

12 Scrutinising and Short listing

12.1 All applications forms should be scrutinised to ensure that they are fully and properly completed. The organisation should:

- check the information provided is consistent and does not contain any discrepancies
- refuse incomplete applications
- note any anomalies, discrepancies or gaps in employment identified so that they can be taken up as part of the consideration of whether to short list the applicant. As well as reasons for obvious gaps in

employment, the reasons for a history of repeated changes of employment without any clear career or salary progression, or a mid career move from a permanent post to supply or temporary work, also need to be explored and verified.

- assess all candidates equally against the criteria contained in the person specification without exception or variation.

13 References

13.1 The purpose of seeking references is to obtain objective and factual information to support appointment decisions. They should always be sought and obtained directly from the referee. Employers should not rely on references or testimonials provided by the candidate, or on open references and testimonials, i.e. "To Whom It May Concern". There have been instances of candidates forging references, also open references/testimonials might be the result of a "compromise agreement" and are unlikely to include any adverse comments.

13.2 References should be sought on all short listed candidates, including internal ones, and should normally be obtained before interview so that any issues of concern they raise can be explored further with the referee, and taken up with the candidate at interview. In exceptional circumstances it might not be possible to obtain references prior to interview, either because of delay on the part of the referee, or because a candidate strongly objects to their current employer being approached at that stage, but that should be the aim in all cases.

13.3 It is up to the person conducting the recruitment to decide whether to accede to a candidate's request to approach his/her current employer only if s/he is the preferred candidate after the interview, but it is not recommended as good practice.

13.4 It is acknowledged that many employers do not take up references prior to interview. However, in any case where a reference has not been obtained on the preferred candidate before interview, the prospective employer must ensure that it is received and scrutinised and any concerns are resolved satisfactorily, before the person's appointment is confirmed.

13.5 All requests for references should seek objective verifiable information and not subjective opinion, the use of reference pro-formas can help achieve that. A copy of the job description and person specification for the post for which the person is applying should be included with all requests.

Some suggested questions for inclusion in a reference request are included at appendix 2.

13.6 On receipt references should be checked to ensure that all specific questions have been answered satisfactorily and if all questions have not been answered or the reference is vague or unspecific, the referee should be telephoned and asked to provide written answers or amplification as appropriate.

13.7 Written references for candidates applying for positions within fostering and adoption services must also be followed up by telephone enquiries. This is a specific recommendation for these regulated services and evidence of these telephone enquiries must be attached to the personnel record.

13.8 The information given in the reference should also be compared with the application form to ensure that the information provided about the candidate and his/her previous employment by the referee is consistent with the information provided by the applicant on the form. Any discrepancy in the information should be taken up with the applicant and/or the referee.

13.9 Any information about past disciplinary action or allegations should be considered in the circumstances of the individual case.

13.10 Cases in which an issue was satisfactorily resolved some time ago or an allegation was determined to be unfounded or did not require formal disciplinary sanctions and in which no further issues have been raised, are less likely to cause concern than more serious or recent concerns, or issues that were not resolved satisfactorily. A history of repeated concerns or allegations over time is also likely to give cause for concern.

14 Other Checks before Interview

14.1 If a short listed applicant claims to have some specific qualification or previous experience that is particularly relevant to the post for which s/he is applying that will not be verified by a reference, it is good practice to verify the facts before interview so that any discrepancy can be explored at interview. The qualification or experience can usually be verified quickly by telephoning the relevant qualification body or previous employer and asking for written confirmation of the facts.

15 Involving Children and Young People and their families

15.1 Involving children and young people in the recruitment and selection process in some way, or observing short listed candidates' interaction with

children and young people is common, and recognised as good practice. There are different ways of doing this.

- E.g. having a child(ren)/young person(s) as part of the interview panel; having a separate panel of children and young people; observation of the candidate's interaction with children/young people whilst being shown around the organisation's workplace by a senior member of staff.

Organisations should refer to their own agency policy/procedure for involving service users, including children and young people in their recruitment and selection.

In some instances it may be appropriate to involve parents in the selection process (eg. where they are the main recipients of the service).

16 Interviews

16.1 The interview should assess the merits of each candidate against the job requirements, and explore their suitability to work with children. The selection process should always include a face-to-face interview even if there is only one candidate.

17 Invitation to Interview

17.1 In addition to the arrangements for interviews - time and place, directions to the venue, membership of the interview panel - the invitation should also;

- remind candidates about how the interview will be conducted and the areas it will explore including suitability to work with children (enclosing a copy of the person specification can usefully draw attention to the relevant information).
- stress that the identity of the successful candidate will need to be checked thoroughly to ensure the person is who he or she claims to be and that where a CRB check is appropriate the person will be required to complete an application for a CRB Disclosure straight away. Consequently all candidates should be instructed to bring with them documentary evidence of their identity that will satisfy CRB requirements.
- Ask candidates to bring documents confirming any educational and professional qualifications that are necessary or relevant for the post, e.g. the original or a certified copy of a certificate, or diploma, or a letter of confirmation from the awarding body. N.B. If the successful

candidate cannot produce original documents or certified copies written confirmation of his/her relevant qualifications must be obtained from the awarding body. A copy of the documents used to verify the successful candidate's identity and qualifications must be kept for the personnel file.

18 Interview Panel

18.1 Interviews should normally be conducted by a minimum of two interviewers (male and female), and in some cases, e.g. for senior or specialist posts, a larger panel might be appropriate.
A panel of at least two people allows one member to observe and assess the candidate and make notes; while the candidate is talking to the other. It also reduces the possibility of any dispute about what was said or asked during the interview.

18.2 The members of the panel should:

- have the necessary authority to make decisions about appointment;
- be appropriately trained in interview processes,
- meet before the interviews to: -
  - i. reach a consensus about the required standard for the job to which they are appointing;
  - ii. consider the issues to be explored with each candidate and who on the panel will ask about each of those;
  - iii. agree the assessment criteria in accordance with the person specification.

18.3 The panel cannot agree in advance a list of questions for each candidate that they will not deviate from but they can agree a set of questions they will ask all candidates relating to the requirements of the post and the issues they will explore with each candidate based on the information provided in the candidate's application and references (if available). A candidate's response to a question about an issue will determine whether and how that is followed up.
Where possible it is best to avoid hypothetical questions because they allow theoretical answers. It is better to ask competence based questions that ask a candidate to relate how s/he has responded to, or dealt with, an actual situation, or questions that test a candidate's attitudes and understanding of issues.

19 Scope of the Interview

19.1 In addition to assessing and evaluating the applicant's suitability for the particular post, the interview panel should also explore:

- the candidate's attitude toward children and young people;
- his/her ability to support the organisation's agenda for safeguarding and promoting the welfare of children;
- gaps in the candidate's employment history;
- concerns or discrepancies arising from the information provided by the candidate and/or a referee; and,
- whether the candidate wishes to declare anything in light of the requirement for a CRB check.

19.2 If, for whatever reason, references are not obtained before the interview, the candidate should also be asked at interview if there is anything s/he wishes to declare/discuss in light of the questions that have been (or will be) put to his/her referees. (And it is vital that the references are obtained and scrutinised before a person's appointment is confirmed and before s/he starts work.)

20 Offer of Appointment

20.1 Pre Appointment Checks

A formal offer of appointment to the successful candidate should not be made until:

- at least two satisfactory references have been received (if those have not already been received);
- the candidate's identity has been verified (if that could not be verified straight after the interview)
- appropriate checks with List 99/PoCA/PoVA/CRB and from Autumn 2008 Independent Safeguarding Authority have been made and are satisfactory enhanced disclosure information will not be on the return CRB disclosure sent to the applicant, therefore conditional offers subject to CRB clearance can provide problems if there is no policy for disclosure with the Police;
- the candidate's medical fitness to undertake the role is verified;
- qualifications claimed have been verified (if not verified after the interview);
- professional status where required is verified e.g. GTC or GSCC registration, QTS status etc (unless properly exempted), NPQH;

20.2 All checks should be:

- confirmed in writing;
- documented and retained on the personnel file, (subject to certain restrictions on the retention of information imposed by CRB regulations); and,
- followed up where they are unsatisfactory or there are discrepancies in the information provided.

20.3 Where:

- the candidate is found to be on List 99 or the PoCA or PoVA List, or the CRB Disclosure shows s/he has been disqualified from working with children by a Court; or the candidate is barred (by the Independent Safeguarding Authority from Autumn 2008); or,
- an applicant has provided false information in, or in support of, his/her application; or,
- there are serious concerns about an applicant's suitability to work with children;

The facts should be reported to the police and/or the appropriate department within the Department for Children Schools and families.

20.4 In addition, the organisation should seek advice from its HR or Personnel services provider and follow relevant CRB guidance if a Disclosure reveals information that a candidate has not disclosed in course of the selection process.

21 List 99/ PoCA or PoVA List and CRB Checks on Overseas staff

21.1 Where appropriate, List 99/PoCA/PoVA List (and the Independent Safeguarding Authority from autumn 2008) and CRB checks should be completed on staff from overseas unless it is verified that the applicant has not previously lived in the UK.

21.2 In addition, criminal records information should be sought from Countries where individuals have worked or lived. The CRB provides an overseas information service and further information can be obtained from: http://www.crb.gov.uk/services_overseas.asp, or by telephoning the CRB enquiry line on 08700 100 450.

21.3 In cases where a criminal record check is not possible, particular care should be taken with the other required checks, especially those of identity and qualifications, and to obtain satisfactory references.

22 Post Appointment Induction

22.1 There should be an induction program for all staff and volunteers newly appointed in an organisation, regardless of previous experience.

22.2 The content and nature of the induction process will vary according to the role and previous experience of the new member of staff or volunteer and the organisation. However, in addition to the usual purposes of induction, the need to Safeguard and promote the welfare of children must be included and the induction programme should include information about and written statements of:

- policies and procedures in relation to safeguarding and promoting welfare e.g. child protection/safeguarding procedures, anti bullying, anti racism, physical intervention/restraint, intimate care, internet safety;
- safe practice and the standards of conduct and behaviour expected of staff, users and pupils in the service/establishment;
- how and with whom any concerns about those issues should be raised; and,
- other relevant personnel procedures e.g. disciplinary, capability and whistle-blowing.

The program should also include attendance at child protection training and any other training appropriate to the person's role.

23 Maintaining a Safer Culture

23.1 It is important that all staff in any organisation have appropriate training and induction so that they understand their roles and responsibilities and are confident about carrying them out. Also that volunteers, staff, users, parents and carers feel confident that they can raise issues/concerns about the safety or welfare of children and that they will be listened to and taken seriously. That can be achieved by maintaining an ethos of safeguarding and promoting the welfare of children and young people and protecting staff which is supported by:

- a clear written statement of the standards of behaviour
- the boundaries of appropriate behaviour expected of volunteers, staff and users and that is understood and endorsed by all;
- appropriate induction and training;
- regular briefing and discussion of relevant issues.

24 Monitoring

24.1 Monitoring of both the recruitment process and induction arrangements will allow for future recruitment practices to be better informed. It should cover:

- staff turnover and reasons for leaving;
- exit interviews; and, attendance of new recruits at child protection and safeguarding training.

Appendix 1

Checklist for Safer Recruitment Process

Planning	✓
Timetable sufficient time for effective process	
Person specification – specific reference to suitability to work with children	
Job description – clear reference to the responsibility for safeguarding and promoting the welfare of children	
Information pack includes Child Protection/Safeguarding Policy/code of conduct	
Application form seeks all relevant information and includes relevant statements about checks/references	

Advertisement	✓
Include statement about the organisations commitment to safeguarding and promoting the welfare of children	
Include need for satisfactory CRB clearance pre-appointment	

Shortlisting	✓
Rigorously scrutinise application – check for gaps, inconsistencies, discrepancies and note to explore during interview	
Refuse incomplete application forms	

References	✓
Seek directly from referee and follow up if necessary	
Ask specific questions (see appendix 2)	
On receipt check against information on application and take up and discrepancy with applicant	

Interviews	✓
At least 2 panel members and plan interview	
Involve children and young people in process	
At interview, explore any gaps, discrepancies, inconsistencies	
Verify applicants identify and qualifications (Scrutinise originals and keep copies)	
Explore applicants suitability for work with children	

Offer of Appointment Offer is conditional on satisfactory completion of checks which include:	✓
References (if not previously obtained)	
Identity (if not previously obtained)	
Qualifications (if not previously obtained)	
Permission to work in the UK if required	
List 99/PoCA/PoVA/CRB as appropriate and from autumn 2008 Independent Safeguarding Authority	
Health	
Any professional status/registration as appropriate e.g. General Teaching Council, General Social Care Council	
All above confirmed in writing and include on HR file	

Induction	✓
Include need to safeguard and promote the welfare of children	
Provide written information about: - Child Protection/Safeguarding Procedures - Safe Practice - Code of Conduct etc	
Plan and monitor attendance at child protection training appropriate to level of post	

Suggested Questions for Inclusion in Reference Requests

1. How long and in what capacity have you known the applicant?

2. Given the job description and personal specification for the post, are you satisfied that the applicant has the ability and is suitable for the post? Please provide specific comments which support your views.

3. Do you have any concerns at all about the candidate's suitability to work with children/in a setting where children are present?
   Yes/No – If yes please provide specific details of your concerns and the reasons why you believe the applicant may not be suitable.

4. Please provide details of the applicant's post with your organisation including salary.

5. What is the candidate's sickness absence record?

6. Please give details of the candidate's performance history and conduct.

7. Has the applicant ever been the subject of any disciplinary action whether the sanction is current or not?
   If so, please give details.

8. Has the applicant ever been the subject of any allegation or concern that relates to the safety and welfare of children and young people or behaviour or attitude towards children and young people?
   If so, please give details including the outcome of concern.

NB. Please be reminded that you have a responsibility to ensure that all information contained in this reference is accurate, and that it does not contain any material misstatement or omission. The factual content of this reference may be discussed with the applicant.

Bournemouth & Poole Local Safeguarding Children Board

Dorset Safeguarding Children Board

PAN DORSET INTER-AGENCY SAFEGUARDING PROCEDURES

CHAPTER 4

4.2 SAFE PRACTICE

Procedures Effective from: **January 2009**

Review Date: **2011**

If you have any comments or queries about the pan-Dorset procedures please contact your agency representative on the Pan Dorset Policy and Procedures Group or notify the LSCB using the following email addresses:

info@dorsetlscb.co.uk
info@bournemouth-poole-lscb.org.uk

Government Offices
for the English Regions

Guidance for Safer Working Practice for Adults who Work with Children and Young People.

Updated
January 2009

AMA network established by

department for
children, schools and families

This guidance is based upon an original IRSC [1]document - 'Guidance *for Safe Working Practice for the Protection of Children and Adults in Education Settings*, [2]commissioned by DfES[3].

[1] Investigation Referral and Support Co-ordinators network
[2] September 2006. This document is still in use and has relevance for those working in education settings
[3] Department for Education and Skills. now known as Department for Children, Schools and Families (DCSF)

Contents

Section 1 Overview

1.1 Background……. 5

1.2 What to do if you are worried a child is being abused…….. 6

Section 2 Using the Guidance

2.1 Status of Document……. 7

2.2 Purpose of the Guidance…….. 7

2.3 Underlying Principles…….. 7

2.4 Definitions……. 8

2.5 How to Use the Document…….. 8

Section 3 Guidance for Safer Working Practices

1 Context……. 11

2 'Unsuitability'……. 11

3 Duty of Care 11

4 Confidentiality 12

5 Making a Professional Judgement 13

6 Power and Positions of Trust 13

7 Propriety and Behaviour 14

8 Dress and Appearance…….. 14

9 Personal Living Space……. 14

10 Gifts, Rewards and Favouritism……. 15

11 Infatuations..... 15

12 Communication with Children and Young People *(including Use of Technology)*…….. 16

13 Social Contact 16

14 Sexual Contact……. 17

15 Physical Contact…….. 18

16 Other Activities that Require Physical Contact 19

17 Behaviour Management 20

18 Use of Physical Intervention 20

19 Children and Young People in Distress……... 21

20 Intimate Care……. 22

21 Personal Care 22

22 First Aid and Administration of Medication…….. 22

23 One to One Situations……. 23

24 Home Visits…….. 24

25 Transporting Children and Young People..... 25
26 Trips and Outings…… 25
27 Photography and Video 26
28 Access to Inappropriate Images and Internet Usage..... 26
29 Whistle Blowing……..…. 27
30 Sharing Concerns and Recording Incidents 27

Appendices 29

For further information, please contact the Allegation Management Adviser or Safeguarding Adviser at your local Government Office or the Safeguarding Policy team at Mowden Hall, Staindrop Road Darlington DL3 9BG Tel: 870012345

Section 1: Overview

1.1. Background

All adults who come into contact with children and young people in their work have a duty of care[4] to safeguard and promote their welfare.

The Children Act 2004, through the Stay Safe outcome of the Every Child Matters Change for Children programme[5], places a duty on organisations to safeguard[6] and promote the well-being of children and young people. This includes the need to ensure that all adults who work with or on behalf of children and young people in these organisations are competent, confident and safe to do so.

The vast majority of adults who work with children act professionally and aim to provide a safe and supportive environment which secures the well-being and very best outcomes for children and young people in their care. However, it is recognised that in this area of work tensions and misunderstandings can occur. It is here that the behaviour of adults can give rise to allegations of abuse being made against them. Allegations may be malicious or misplaced. They may arise from differing perceptions of the same event, but when they occur, they are inevitably distressing and difficult for all concerned. Equally, it must be recognised that some allegations will be genuine and there are adults who will deliberately seek out, create or exploit opportunities to abuse children. It is therefore essential that all possible steps are taken to safeguard children and young people and ensure that the adults working with them are safe to do so.

Some concerns have been raised about the potential vulnerability of adults in this area of work. It has been suggested that there is a need for clearer advice about what constitutes illegal behaviour and what might be considered as misconduct. This document has been produced in response to these concerns and provides practical guidance for anyone who works with, or on behalf of children and young people regardless of their role, responsibilities or status. It seeks to ensure that the duty to promote and safeguard the wellbeing of children is in part**,** achieved by raising awareness of illegal, unsafe and inappropriate behaviours.

Whilst every attempt has been made to cover a wide range of situations, it is recognised that this guidance cannot cover all eventualities. There may be times when professional judgements are made in situations not covered by this document, or which directly contravene the guidance given by their employer. It is expected that in these circumstances adults will always advise their senior colleagues of the justification for any such action already taken or proposed.

It is also recognised that not all adults who work with children and young people work as paid or contracted employees. The principles and guidance outlined in

---

[4] The duty which rests upon an individual to ensure that all reasonable steps are taken to ensure the safety of a child or young person involved in any activity, or interaction for which that individual is responsible. Any person in charge of, or working with children and young people in any capacity is considered, both legally and morally, to owe them a duty of care

[5] www.everychildmatters.gov.uk

[6] Process of protecting children from abuse or neglect, preventing impairment of their health and development, and ensuring they are growing up in circumstances consistent with the provision of safe and effective care that enables them to have optimum life chances… Working Together to Safeguard Children: 2006 HM Government

this document still apply and should be followed by an adult whose work brings them into contact with children and young people.

The guidance contained in this document has due regard to current legislation and statutory guidance.

1.2. What to do if you are worried a child is being abused[7]

Everyone working with children and young people should be familiar with local procedures and protocols for safeguarding the welfare of children and young people. Adults have a duty to report any child protection or welfare concerns to a designated member of staff in their organisation and/or report any concerns to the local social care office. Anyone who has concerns or is in doubt should refer to the document '**What To Do If You're Worried a Child Is Being Abused"** and follow that guidance.

[7] What to do If You are Worried a Child is Being Abused HM Government 2006

Section 2: Using the Guidance

2.1. Status of Document

This guidance document has been commissioned by the Department for Children, Schools and Families. (DCSF). It does not replace or take priority over advice or codes of conduct produced by employers or national bodies.

It is a generic document that should complement existing professional procedures, protocols and guidance which relate to specific roles, responsibilities or professional practices.

2.2. Purpose of Guidance

It is important that all adults working with children understand that the nature of their work and the responsibilities related to it, place them in a position of trust. This practice guidance provides clear advice on appropriate and safe behaviours for all adults working with children in paid or unpaid capacities, in all settings and in all contexts. The guidance aims to:

- keep children safe by clarifying which behaviours constitute safe practice and which behaviours should be avoided;
- assist adults working with children to work safely and responsibly and to monitor their own standards and practice;
- support managers and employers in setting clear expectations of behaviour and/or codes of practice relevant to the services being provided;
- support employers in giving a clear message that unlawful or unsafe behaviour is unacceptable and that, where appropriate, disciplinary or legal action will be taken;
- support safer recruitment practice;
- minimise the risk of misplaced or malicious allegations made against adults who work with children and young people;
- reduce the incidence of positions of trust being abused or misused.

Employers should be familiar with, and know how to access, their Local Safeguarding Children's Board's policy and procedures for managing allegations against staff.

2.3. Underpinning Principles

- The welfare of the child is paramount.[8]

- It is the responsibility of all adults to safeguard and promote the welfare of children and young people. This responsibility extends to a duty of care for those adults employed, commissioned or contracted to work with children and young people.

- Adults who work with children are responsible for their own actions and behaviour and should avoid any conduct which would lead any reasonable

[8] Children Act 1989

person to question their motivation and intentions.

- Adults should work and be seen to work, in an open and transparent way.
- The same professional standards should always be applied regardless of culture, disability, gender, language, racial origin, religious belief and/or sexual identity.
- Adults should continually monitor and review their practice and ensure they follow the guidance contained in this document.

2.4. Definitions

Children and Young People: Throughout this document references are made to "children and young people". These terms are interchangeable and refer to children who have not yet reached their 18th birthday. This guidance, however also has value for those working with vulnerable adults.

Adults: References to 'adults' or 'volunteers' refer to any adult who is employed, commissioned or contracted to work with or on behalf of, children and young people, in either a paid or unpaid capacity.

Manager: The term 'manager' refers to those adults who have responsibility for managing services including the supervision of employees and/or volunteers at any level.

Employer: The term 'employer' refers to the organisation which employs, or contracts to use the services of individuals in pursuit of the goals of that organisation. In the context of this document, the term 'employer' is also taken to include 'employing' the unpaid services of volunteers.

Safeguarding: Process of protecting children from abuse or neglect, preventing impairment of their health and development, and ensuring they are growing up in circumstances consistent with the provision of safe and effective care that enables children to have optimum life chances and enter childhood successfully[9].

Duty of Care: The duty which rests upon an individual or organisation to ensure that all reasonable steps are taken to ensure the safety of a child or young person involved in any activity or interaction for which that individual or organisation is responsible. Any person in charge of, or working with children and young people in any capacity is considered, both legally and morally to owe them a duty of care.

2.5. How to Use the Document

This document is relevant to both individuals and organisations working with or on behalf of children and young people. Where an individual works independently and does not work as part of an organisation references made to the 'senior manager' should be taken to refer to parents or those with parenting responsibilities.

Each section provides general guidance about a particular aspect of work undertaken

[9] Working Together to Safeguard Children 2006. HM Government (WT 2006)

with children and young people with, in the right hand column, specific guidance about which behaviours should be avoided and which are recommended. Some organisations may need to adapt or add to the guidance to meet their specific practices or contexts, The document has however, been written for a generic audience and most, if not all of the content, is applicable to all adults who work with children and young people. The diagram in Appendix 1 illustrates how the guidance could be used as a basis for developing specific agency guidance. Appendix 2 provides a visual framework for understanding how the document fits with safer recruitment and selection and procedures and those which relate to disciplinary proceedings.

It is recommended that organisations and settings who provide services for children and young people use this guidance to develop and promote safer working practice by ensuring that all employees and volunteers are made aware of its contents and have access to it.

Incorporating the use of this document in recruitment and selection processes will help to prevent and deter unsuitable people from working with children and young people. Providing employees and volunteers with clear guidance on appointment and revisiting this through induction, supervision, performance management, training programmes etc, will also help to ensure a safer children's workforce. Employers and managers will be better placed to deal with unsuitable or inappropriate behaviour if their expectations have been made clear and reinforced throughout a person's employment and there is evidence that this has been done.

Individuals should follow this guidance in their day to day practice. It should also be referred to when taking on new work, different duties or additional responsibilities.

Section 3: Guidance for Safe Working Practice

1. Context

All adults who work with children and young people have a crucial role to play in shaping their lives. They have a unique opportunity to interact with children and young people in ways that are both affirming and inspiring. This guidance has been produced to help adults working in all settings to establish safe and responsive environments which safeguard young people and reduce the risk of adults being unjustly accused of improper or unprofessional conduct.

This means that these guidelines:

- *apply to **all** adults working in all settings whatever their position, role, or responsibilities*
- *may provide guidance where an individual's suitability to work with children and young people has been called into question.*

2. 'Unsuitability' [10]

The guidance contained in this document is an attempt to identify what behaviours are expected of adults who work with children and young people. Adults whose practice deviates from this guidance and/or their professional or employment-related code of conduct may bring into question their suitability to work with pupils or children and young people in any capacity.

This means that adults should:

- *have a clear understanding about the nature and content of this document*
- *discuss any uncertainties or confusion with their line manager*
- *understand what behaviours may call into question their suitability to continue to work with children and young people*

3. Duty of Care

All adults who work with, and on behalf of children are accountable for the way in which they exercise authority; manage risk; use resources; and safeguard children and young people.

Whether working in a paid or voluntary capacity, these adults have a duty to keep children and young people safe and to protect them from sexual, physical and emotional harm. Children and young people have a right to be treated with respect and dignity. It follows that trusted adults are expected to take reasonable steps to ensure the safety and well-being of children and young people. Failure to do so may be regarded as neglect[11].

This means that adults should:

- *understand the responsibilities, which are part of their employment or role, and be aware that sanctions will be applied if these provisions are breached*
- *always act, and be seen to act, in the child's best interests*
- *avoid any conduct which would lead any reasonable person to question their motivation and intentions*
- *take responsibility for their own actions and behaviour*

The duty of care is in part, exercised through the development of respectful and caring relationships between adults and children and young people. It is also exercised

This means that employers should:

- *ensure that appropriate safeguarding and child protection polices and*

[10] WT 2006 Chapter 6, page 153. See also AMA document on 'Unsuitability' available Dec 07 from Allegation Management Advisers in Government Offices.
[11] WT 2006 page Chapter 1 page 38
[12] Health and Safety at Work Act 1974 Part I, Section. 2 (1) and (2)
[13] Health and Safety at Work Act 1974 Part I, Section.7

through the behaviour of the adult, which at all times should demonstrate integrity, maturity and good judgement.

Everyone expects high standards of behaviour from adults who work with children and young people. When individuals accept such work, they need to understand and acknowledge the responsibilities and trust inherent in that role.

Employers also have a duty of care towards their employees, both paid and unpaid, under the Health and Safety at Work Act 1974[12]. This requires them to provide a safe working environment for adults and provide guidance about safe working practices. Employers also have a duty of care for the well-being of employees and to ensure that employees are treated fairly and reasonably in all circumstances. The Human Rights Act 1998 sets out important principles regarding protection of individuals from abuse by state organisations or people working for those institutions**.** Adults who are subject to an allegation should therefore be supported and the principles of natural justice applied.

The Health and Safety Act 1974 also imposes a duty on employees[13] to take care of themselves and anyone else who may be affected by their actions or failings. An employer's duty of care and the adult's duty of care towards children should not conflict. This 'duty' can be demonstrated through the use and implementation of these guidelines.

procedures are adopted, implemented and monitored

- *ensure that codes of conduct/practices are continually monitored and reviewed*
- *ensure that, where services or activities are provided by another body, the body concerned has appropriate safeguarding polices and procedures*
- *foster a culture of openness and support*
- *ensure that systems are in place for concerns to be raised*
- *ensure that adults are not placed in situations which render them particularly vulnerable*
- *ensure all adults have access to and understand this guidance and related, policies and procedures*
- *ensure that all job descriptions and person specifications clearly identify the competences necessary to fulfil the duty of care*

4. Confidentiality

Adults may have access to confidential information about children and young people in order to undertake their responsibilities. In some circumstances they may have access to or be given highly sensitive or private information. These details must be kept confidential at all times and only shared when it is in interests of the child to do so. Such information must not be used to intimidate, humiliate, or embarrass the child or young person concerned.

If an adult who works with children is in any doubt about whether to share information or keep it confidential he or she should seek guidance from a senior member of staff or nominated child protection person. Any actions should be in line with locally agreed information sharing protocols.

The storing and processing of personal information about children and young people is governed by the Data Protection Act 1998. Employers should provide clear advice to adults about their responsibilities under this legislation.

Whilst adults need to be aware of the need to listen and support children and young people, they must also understand the importance of not promising to keep secrets. Neither should they request this of a child young person under any circumstances.

This means that adults:

- *be clear about when information can be shared and in what circumstances it is appropriate to do so*
- *are expected to treat information they receive about children and young people in a discreet and confidential manner*
- *should seek advice from a senior member of staff if they are in any doubt about sharing information they hold or which has been requested of them*
- *need to know to whom any concerns or allegations should be reported*

Additionally, concerns and allegations about adults should be treated as confidential and passed to a senior manager without delay.

5. Making a Professional Judgement

This guidance cannot provide a complete checklist of what is, or is not appropriate behaviour for adults in all circumstances. There may be occasions and circumstances in which adults have to make decisions or take action in the best interests of the child or young person which could contravene this guidance or where no guidance exists. Individuals are expected to make judgements about their behaviour in order to secure the best interests and welfare of the children in their charge. Such judgements, in these circumstances, should always be recorded and shared with a senior manager or if the adult does not work for an organisation, with the parent or carer. In undertaking these actions individuals will be seen to be acting reasonably.

Adults should always consider whether their actions are warranted, proportionate and safe and applied equitably.

This means that where no specific guidance exists adults should:

- *discuss the circumstances that informed their action, or their proposed action, with a senior manager, or with the parent/carer if not working for an organisation*
- *report any actions which could be mis-interpreted to their senior manager*
- *always discuss any misunderstanding, accidents or threats with a senior manager*
- *always record discussions and reasons why actions were taken.*
- *record any areas of disagreement about course of action taken and if necessary referred to a higher authority*
- *ensure they have had copies of records which confirm decisions, discussions and reasons why actions were taken*

6. Power and Positions of Trust

As a result of their knowledge, position and/or the authority invested in their role, all adults working with children and young people are in positions of trust in relation to the young people in their care. Broadly speaking, a relationship of trust can be described as one in which one party is in a position of power or influence over the other by virtue of their work or the nature of their activity. It is vital for all those in positions of trust to understand the power this can give them over those they care for and the responsibility they must exercise as a consequence of this relationship.[14]

A relationship between an adult and a child or young person cannot be a relationship between equals. There is potential for exploitation and harm of vulnerable young people. Adults have a responsibility to ensure that an unequal balance of power is not used for personal advantage or gratification.

Adults should always maintain appropriate professional boundaries and avoid behaviour which might be misinterpreted by others. They should report and record any incident with this potential.

This means that adults should not:

- *use their position to gain access to information for their own or others' advantage*
- *use their position to intimidate, bully, humiliate, threaten, coerce or undermine children or young people*
- *use their status and standing to form or promote relationships which are of a sexual nature, or which may become so*

[14] Caring for Young People and the Vulnerable. Guidance for Preventing Abuse of Trust Home Office

Where a person aged 18 or over is in a specified position of trust[15] with a child under 18, it is an offence for that person to engage in sexual activity with or in the presence of that child, or to cause or incite that child to engage in or watch sexual activity.

7. Propriety and Behaviour

All adults working with children and young people have a responsibility to maintain public confidence in their ability to safeguard the welfare and best interests of children and young people. It is therefore expected that they will adopt high standards of personal conduct in order to maintain the confidence and respect of the public in general and all those with whom they work.

There may be times, for example, when an adult's behaviour or actions in their personal life come under scrutiny from local communities, the media or public authorities. This could be because their behaviour is considered to compromise their position in their workplace or indicate an unsuitability to work with children or young people. Misuse of drugs, alcohol or acts of violence would be examples of such behaviour.

Adults in contact with children and young people should therefore understand and be aware, that safe practice also involves using judgement and integrity about behaviours in places other than the work setting.

The behaviour of an adult's partner or other family members may raise similar concerns and require careful consideration by an employer as to whether there may be a potential risk to children and young people in the workplace.

This means that adults should not:

- *behave in a manner which would lead any reasonable person to question their suitability to work with children or act as a role model.*
- *make, or encourage others to make, unprofessional personal comments which scapegoat, demean or humiliate, or which might be interpreted as such*

This means that adults should:

- *be aware that behaviour in their personal lives may impact upon their work with children and young people*
- *follow any codes of conduct deemed appropriate by their organisation*
- *understand that the behaviour and actions of their partner (or other family members) may raise questions about their suitability to work with children and young people*

8. Dress and Appearance

A person's dress and appearance are matters of personal choice and self-expression. However adults should dress in ways which are appropriate to their role and this may need to be different to how they dress when not at work.

Adults who work with children and young people should ensure they take care to ensure they are dressed appropriately for the tasks and the work they undertake.

Those who dress in a manner which could be considered as inappropriate could render themselves vulnerable to criticism or allegations.

This means that adults should wear clothing which:

- *is appropriate to their role*
- *is not likely to be viewed as offensive, revealing, or sexually provocative*
- *does not distract, cause embarrassment or give rise to misunderstanding*
- *is absent of any political or otherwise contentious slogans*
- *is not considered to be discriminatory and is culturally sensitive*

[15] Sexual Offences Act 2003.Sect 16-19 re-enacts and amends offence of abuse of position of trust

9. The use of Personal Living Space

No child or young person should be in or invited into, the home[16] of an adult who works with them, unless the reason for this has been firmly established and agreed with parents/ carers and senior managers or the home has been designated by the organisation or regulatory body as a work place e.g. childminders, foster carers.

It is not appropriate for any other organisations to expect or request that private living space be used for work with children and young people.

Under no circumstances should children or young people assist with chores or tasks in the home of an adult who works with them. Neither should they be asked to do so by friends or family of that adult.

This means that adults should:

- *be vigilant in maintaining their privacy and mindful of the need to avoid placing themselves in vulnerable situations*
- *challenge any request for their accommodation to be used as an additional resource for the organisation*
- *be mindful of the need to maintain professional boundaries*
- *refrain from asking children and young people to undertake personal jobs or errands*

10. Gifts, Rewards and Favouritism

The giving of gifts or rewards to children or young people should be part of an agreed policy for supporting positive behaviour or recognising particular achievements. In some situations, the giving of gifts as rewards may be accepted practice for a group of children, whilst in other situations the giving of a gift to an individual child or young person will be part of an agreed plan, recorded and discussed with senior manager and the parent or carer.

It is acknowledged that there are specific occasions when adults may wish to give a child or young person a personal gift. This is only acceptable practice where, in line with the agreed policy, the adult has first discussed the giving of the gift and the reason for it, with the senior manager and/or parent or carer and the action is recorded. Any gifts should be given openly and not be based on favouritism. Adults need to be aware however, that the giving of gifts can be misinterpreted by others as a gesture either to bribe or groom[17] a young person.

Adults should exercise care when selecting children and/or young people for specific activities or privileges to avoid perceptions of favouritism or unfairness. Methods and criteria for selection should always be transparent and subject to scrutiny.

Care should also be taken to ensure that adults do not accept any gift that might be construed as a bribe by others, or lead the giver to expect preferential treatment.

This means that adults should:

- *be aware of their organisation's policy on the giving and receiving of gifts*
- *ensure that gifts received or given in situations which may be misconstrued are declared*
- *generally, only give gifts to an individual young person as part of an agreed reward system*
- *where giving gifts other than as above, ensure that these are of insignificant value*
- *ensure that all selection processes which concern children and young people are fair and that wherever practicable these are undertaken and agreed by more than one member of staff*

[16] This includes any home or domestic settings used or frequented by the adult

[17] grooming' – the act of gaining the trust of a child so that sexual abuse can take place.

There are occasions when children, young people or parents wish to pass small tokens of appreciation to adults e.g. on special occasions or as a thank-you and this is acceptable. However, it is unacceptable to receive gifts on a regular basis or of any significant value.

11. Infatuations

Occasionally, a child or young person may develop an infatuation with an adult who works with them. These adults should deal with these situations sensitively and appropriately to maintain the dignity and safety of all concerned. They should remain aware, however, that such infatuations carry a high risk of words or actions being misinterpreted and should therefore make every effort to ensure that their own behaviour is above reproach.

An adult, who becomes aware that a child or young person is developing an infatuation, should discuss this at the earliest opportunity with a senior manager or parent/carer so appropriate action can be taken to avoid any hurt, distress or embarrassment.

This means that adults should:

- *report and record any incidents or indications (verbal, written or physical) that suggest a child or young person may have developed an infatuation with an adult in the workplace*
- *always acknowledge and maintain professional boundaries*

12. Communication with Children and Young People *(including the Use of Technology)*

In order to make best use of the many educational and social benefits of new technologies, children and young people need opportunities to use and explore the digital world, using multiple devices from multiple locations. It is now recognised that e.safety risks are posed more by behaviours and values than the technology itself. Adults working in this area must therefore ensure that they establish safe and responsible online behaviours. This means working to local and national guidelines on acceptable user policies. These detail the way in which new and emerging technologies may and may not be used and identify the sanctions for misuse. Learning platforms are now widely established and clear agreement by all parties about acceptable and responsible use is essential.

Communication between children and adults, by whatever method, should take place within clear and explicit professional boundaries. This includes the wider use of technology such as mobile phones text messaging, e-mails, digital cameras, videos, web-cams, websites and blogs. Adults should not share any personal information with a child or young person. They should not request, or respond to, any personal information from the child/young person, other than that which might be appropriate as part of their professional role. Adults should ensure that all communications are transparent and open to scrutiny.

Adults should also be circumspect in their communications with children so as to avoid any possible misinterpretation of

This means that the organisation should:

- *have a communication policy which specifies acceptable and permissible modes of communication*

This means that adults should:

- *not give their personal contact details to children or young people, including their mobile telephone number*
- *only use equipment e.g. mobile phones, provided by organisation to communicate with children, making sure that parents have given permission for this form of communication to be used*
- *only make contact with children for professional reasons and in accordance with any organisation policy*
- *recognise that text messaging is rarely an appropriate response to a child in a crisis situation or at risk of harm. It should only be used as a last resort when other forms of communication are not possible*
- *not use internet or web-based communication channels to send personal messages to a child/young*

their motives or any behaviour which could be construed as grooming. They should not give their personal contact details to children and young people including e-mail, home or mobile telephone numbers, unless the need to do so is agreed with senior management and parents/carers. E-mail or text communications between an adult and a child young person outside agreed protocols may lead to disciplinary and/or criminal investigations. This also includes communications through internet based web sites.

Internal e-mail systems should only be used in accordance with the organisation's policy.

person

- *ensure that if a social networking site is used, details are not shared with children and young people and privacy settings are set at maximum.*

13. Social Contact

Adults who work with children and young people should not seek to have social contact them or their families, unless the reason for this contact has been firmly established and agreed with senior managers, or where an adult does not work for an organisation, the parent or carers. If a child or parent seeks to establish social contact, or if this occurs coincidentally, the adult should exercise her/his professional judgement in making a response but should always discuss the situation with their manager or with the parent of the child or young person. Adults should be aware that social contact in certain situations can be misconstrued as grooming.

Where social contact is an integral part of work duties, e.g. pastoral work in the community, care should be taken to maintain appropriate personal and professional boundaries. This also applies to social contacts made through interests outside of work or through the adult's own family or personal networks.

It is recognised that some adults may support a parent who may be in particular difficulty. Care needs to be exercised in those situations where the parent comes to depend upon the adult for support outside their professional role. This situation should be discussed with senior management and where necessary referrals made to the appropriate support agency.

This means that adults should:

- *have no secret social contact with children and young people or their parents*
- *consider the appropriateness of the social contact according to their role and nature of their work*
- *always approve any planned social contact with children or parents with senior colleagues,*
- *advise senior management of any social contact they have with a child or a parent with who whom they work, which may give rise to concern*
- *report and record any situation, which may place a child at risk or which may compromise the organisation or their own professional standing*
- *be aware that the sending of personal communications such as birthday or faith cards should always be recorded and/or discussed with line manager.*
- *Understand that some communications may be called into question and need to be justified.*

14. Sexual Contact

All adults should clearly understand the need to maintain appropriate boundaries in their contacts with children and young people. Intimate or sexual relationships between children/young people and the adults who work with them will be regarded as a grave breach of trust. Allowing or encouraging a relationship to develop in a way which might lead to a sexual relationship is also unacceptable.

This means that adults should not:

- *have sexual relationships with children and young people*
- *have any form of communication with a child or young person which could be interpreted as sexually suggestive or provocative i.e. verbal comments, letters, notes, electronic mail, phone*

[18] Working Together to Safeguard Children .A guide to interagency working to safeguard and promote the welfare of children HM Government 2006

Any sexual activity between an adult and the child or young person with whom they work may be regarded as a criminal offence and will always be a matter for disciplinary action.

Children and young people are protected by specific legal provisions regardless of whether the child or young person consents or not. The sexual activity referred to does not just involve physical contact including penetrative and non-penetrative acts. It may also include non-contact activities, such as causing children to engage in or watch sexual activity or the production of pornographic material. 'Working Together to Safeguard Children'[18], defines sexual abuse as "forcing or enticing a child or young person to take part in sexual activities, whether or not the child is aware of what is happening".

There are occasions when adults embark on a course of behaviour known as 'grooming' where the sole purpose is to gain the trust of a child, and manipulate that relationship so sexual abuse can take place. Adults should be aware that consistently conferring inappropriate special attention and favour upon a child might be construed as being part of a 'grooming' process and as such will give rise to concerns about their behaviour.

calls, texts, physical contact
- *make sexual remarks to, or about, a child/young person*
- *discuss their own sexual relationships with or in the presence of children or young people*

This means that adults should:

- *ensure that their relationships with children and young people clearly take place within the boundaries of a respectful professional relationship*
- *take care that their language or conduct does not give rise to comment or speculation. Attitudes, demeanour and language all require care and thought, particularly when members of staff are dealing with adolescent boys and girls.*

15. Physical Contact

Many jobs within the children's workforce require physical contact with children as part of their role. There are also occasions when it is entirely appropriate for other adults to have some physical contact with the child or young person with whom they are working. However, it is crucial that in all circumstances, adults should only touch children in ways which are appropriate to their professional or agreed role and responsibilities.

Not all children and young people feel comfortable about physical contact, and adults should not make the assumption that it is acceptable practice to use touch as a means of communication. Permission should be sought from a child or young person before physical contact is made. Where the child is very young, there should be a discussion with the parent or carer about what physical contact is acceptable and/or necessary.

When physical contact is made with a child this should be in response to their needs at the time, of limited duration and appropriate to their age, stage of development, gender, ethnicity and background. It is not possible to be specific about the appropriateness of each physical contact, since an action that is appropriate with one child in one set of circumstances may be inappropriate in another, or with a different child. Adults, nevertheless, should use their professional judgement at all times, observe and take note of the child's reaction or feelings and – so far as is possible -

This means that adults should:

- *be aware that even well intentioned physical contact may be misconstrued by the child, an observer or by anyone to whom this action is described*
- *never touch a child in a way which may be considered indecent*
- *always be prepared to report and explain actions and accept that all physical contact be open to scrutiny*
- *not indulge in horseplay*
- *always encourage children, where possible, to undertake self-care tasks independently*
- *work within Health and Safety regulations*
- *be aware of cultural or religious views about touching and always be sensitive to issues of gender*
- *understand that physical contact in some circumstances can be easily misinterpreted*

This means that organisations should:

- *ensure they have a system in place for recording incidents and the means by which information about incidents and outcomes can be easily accessed by senior*

use a level of contact and/or form of communication which is acceptable to the child for the minimum time necessary.
.
Physical contact which occurs regularly with an individual child or young person is likely to raise questions unless there is explicit agreement on the need for, and nature of, that contact. This would then be part of a formally agreed plan or within the parameters of established, agreed and legal professional protocols on physical contact e.g. sport activities or medical procedures. Any such arrangements should be understood and agreed by all concerned, justified in terms of the child's needs, consistently applied and open to scrutiny.

Physical contact should never be secretive, or for the gratification of the adult, or represent a misuse of authority. If an adult believes that their action could be misinterpreted, or if an action is observed by another as being inappropriate or possibly abusive, the incident and circumstances should be reported to the senior manager outlined in the procedures for handling allegations and an appropriate record made. Parents/carers should also be informed in such circumstances.

Where a child seeks or initiates inappropriate physical contact with an adult, the situation should be handled sensitively and care taken to ensure that contact is not exploited in any way. Careful consideration must be given to the needs of the child and advice and support given to the adult concerned.

It is recognised that some children who have experienced abuse may seek inappropriate physical contact. Adults should be particularly aware of this when it is known that a child has suffered previous abuse or neglect. In the child's view, physical contact might be associated with such experiences and lead to some actions being misinterpreted. In all circumstances where a child or young person initiates inappropriate physical contact, it is the responsibility of the adult to sensitively deter the child and help them understand the importance of personal boundaries. Such circumstances must always be reported and discussed with a senior manager and the parent/carer.

16. Other Activities that require Physical Contact

Adults who work in certain settings, for example sports drama or outdoor activities will have to initiate some physical contact with children, for example to demonstrate technique in the use of a particular piece of equipment, adjust posture, or perhaps to support a child so they can perform an activity safely or prevent injury. Such activities should be carried out in accordance with existing codes of conduct, regulations and best practice.

management

- *make adults aware of relevant professional or organisational guidance in respect of physical contact with children and meeting medical needs of children and young people where appropriate*
- *be explicit about what physical contact is appropriate for adults working in their setting*

This means that adults should:

- *treat children with dignity and respect and avoid contact with intimate parts of the body*
- *always explain to a child the reason why contact is necessary and what form that contact will take*
- *seek consent of parents where a child or young person is unable to do*

Physical contact should take place only when it is necessary in relation to a particular activity. It should take place in a safe and open environment i.e. one easily observed by others and last for the minimum time necessary. The extent of the contact should be made clear to the parent/carer and once agreed, should be undertaken with the permission of the child/young person. Contact should be relevant to their age or understanding and adults should remain sensitive to any discomfort expressed verbally or non-verbally by the child.

Guidance and protocols around safe and appropriate physical contact are provided by national organisations, for example sports governing bodies or major arts organisations, or the employing organisation and should be understood and applied consistently. Any incidents of physical contact that cause concern or fall outside of these protocols and guidance should be reported to the senior manager and parent or carer.

It is good practice if all parties clearly understand at the outset, what physical contact is necessary and appropriate in undertaking specific activities. Keeping parents/carers, children and young people informed of the extent and nature of any physical contact may also prevent allegations of misconduct or abuse arising.

so because of a disability.

- *consider alternatives, where it is anticipated that a child might misinterpret any such contact,*
- *be familiar with and follow recommended guidance and protocols*
- *conduct activities where they can be seen by others*
- *be aware of gender, cultural or religious issues that may need to be considered prior to initiating physical contact*

This means that organisations should:

- *have up to date guidance and protocols on appropriate physical contact in place that promote safe practice and include clear expectations of behaviour and conduct.*
- *ensure that staff are made aware of this guidance and that safe practice is continually promoted through supervision and training.*

17. Behaviour Management

All children and young people have a right to be treated with respect and dignity even in those circumstances where they display difficult or challenging behaviour.

Adults should not use any form of degrading treatment to punish a child. The use of sarcasm, demeaning or insensitive comments towards children and young people is not acceptable in any situation. Any sanctions or rewards used should be part of a behaviour management policy which is widely publicised and regularly reviewed.

The use of corporal punishment is not acceptable and whilst there may a legal defence for parents who physically chastise their children, this does not extend, in any circumstances, to those adults who work with or on behalf of children and young people.

Where children display difficult or challenging behaviour, adults must follow the behaviour policy outlined by their place of work, and use strategies appropriate to the circumstance and situation. The use of physical intervention can only be justified in exceptional circumstances and must be used as a last resort when other behaviour management strategies have failed.

This means that adults should:

- *not use force as a form of punishment*
- *try to defuse situations before they escalate*
- *inform parents of any behaviour management techniques used*
- *adhere to the organisation's behaviour management policy*
- *be mindful of factors which may impact upon a child or young person's behaviour e.g. bullying, abuse and where necessary take appropriate action*

This means that organisations should:

- *have in place appropriate behaviour management policies*
- *where appropriate, develop positive handling plans in respect of an individual child or young person.*

Where a child has specific needs in respect of particularly challenging behaviour, a positive handling plan may be drawn up and agreed by all parties. Only in these circumstances should an adult deviate from the behaviour management policy of the organisation.

18. Use of Control and Physical Intervention

There are circumstances in which adults working with children displaying extreme behaviours can legitimately intervene by using either non-restrictive or restrictive physical interventions. This is a complex area and adults and organisations must have regard to government guidance and legislation in the development and implementation of their own policies and practice.

The use of physical intervention should, wherever possible, be avoided. It should only be used to manage a child or young person's behaviour if it is necessary to prevent personal injury to the child, other children or an adult, to prevent serious damage to property or in what would reasonably be regarded as exceptional circumstances. When physical intervention is used it should be undertaken in such a way that maintains the safety and dignity of all concerned

The scale and nature of any physical intervention must be proportionate to both the behaviour of the individual to be controlled and the nature of the harm they may cause. The minimum necessary force should be used and the techniques deployed in line with recommended policy and practice.

Under no circumstances should physical force or intervention be used as a form of punishment. The duty of care which applies to all adults and organisations working with children and young people requires that reasonable measures are taken to prevent children being harmed. The use of unwarranted physical force is likely to constitute a criminal offence.

In settings where restrictive physical interventions may need to be employed regularly, i.e. where adults are working with children with extreme behaviours associated with learning disability or autistic spectrum disorders, the employer should have a policy on the use of such intervention, as part of a wider behaviour management policy. Individual care plans, drawn up in consultation with parents/carers and where appropriate, the child, should set out the strategies and techniques to be used and those which should be avoided. Risk assessments should be carried out where it is foreseeable that restrictive physical intervention may be required.

In all cases where physical intervention is employed the incident and subsequent actions should be documented and

This means that adults should:

- *adhere to the organisation's physical intervention policy*
- *always seek to defuse situations*
- *always use minimum force for the shortest period necessary*
- *record and report as soon as possible after the event any incident where physical intervention has been used.*

This means that organisations should:

- *have a policy on the use of physical intervention in place that complies with government guidance and legislation and describes the context in which it is appropriate to use*

  physical intervention
- *ensure that an effective recording system is pace which allows for incidents to be tracked and monitored*
- *ensure adults are familiar with the above*
- *ensure that staff are appropriately trained*

reported. This should include written and signed accounts of all those involved, including the child or young person. The parents/carers should be informed the same day.

19. Children and Young People in Distress

There are some settings, where adults are involved in managing significant or regular occurrences of distress and emotional upset in children, for example in mental health services, residential care provision etc. In these circumstances professional guidance should be followed and adults should be aware of what is and what is not acceptable behaviour when comforting a child or diffusing a situation. This is particularly important when working on a one-to-one basis.

For all other adults working with children there will be occasions when a distressed child needs comfort and reassurance and this may involve physical contact. Young children, in particular, may need immediate physical comfort, for example after a fall, separation from parent etc. Adults should use their professional judgement to comfort or reassure a child in an age-appropriate way whilst maintaining clear professional boundaries.

Where an adult has a particular concern about the need to provide this type of care and reassurance, or is concerned that an action may be misinterpreted, this should be reported and discussed with a senior manager and parents/carers.

This means the adult should:

- *consider the way in which they offer comfort and reassurance to a distressed child and do it in an age-appropriate way*
- *be circumspect in offering reassurance in one to one situations, but always record such actions in these circumstances*
- *follow professional guidance or code of practice where available*
- *never touch a child in a way which may be considered indecent*
- *record and report situations which may give rise to concern from either party*
- *not assume that all children seek physical comfort if they are distressed*

20. Intimate Care

Some job responsibilities necessitate intimate physical contact with children on a regular basis, for example assisting young children with toileting, providing intimate care for children with disabilities or in the provision of medical care. The nature, circumstances and context of such contact should comply with professional codes of practice or guidance and/or be part of a formally agreed plan, which is regularly reviewed. The additional vulnerabilities that may arise from a physical or learning disability should be taken into account and be recorded as part of an agreed care plan. The emotional responses of any child to intimate care should be carefully and sensitively observed, and where necessary, any concerns passed to senior managers and/or parents/carers.

All children have a right to safety, privacy and dignity when contact of a physical or intimate nature is required and depending on their abilities, age and maturity should be encouraged to act as independently as possible.

The views of the child should be actively sought, wherever possible, when drawing up and reviewing formal

This means that adults should:

- *adhere to the organisation's intimate care guidelines or code of practice*
- *make other staff aware of the task being undertaken*
- *explain to the child what is happening*
- *consult with senior managers and parents/carers where any variation from agreed procedure/care plan is necessary*
- *record the justification for any variations to the agreed procedure/care plan and share this information with parents*
- *ensure that any changes to the agreed care plan are discussed, agreed and recorded.*

arrangements. As with all individual arrangements for intimate care needs, agreements between the child, parents/carers and the organisation must be negotiated and recorded.

21. Personal Care

Young people are entitled to respect and privacy at all times and especially when in a state of undress, changing clothes, bathing or undertaking any form of personal care. There are occasions where there will be a need for an appropriate level of supervision in order to safeguard young people and/or satisfy health and safety considerations. This supervision should be appropriate to the needs and age of the young people concerned and sensitive to the potential for embarrassment.

Adults need to be vigilant about their own behaviour, ensure they follow agreed guidelines and be mindful of the needs of the children and young people with whom they work.

This means that adults should:

- *avoid any physical contact when children are in a state of undress*
- *avoid any visually intrusive behaviour*
- *where there are changing rooms announce their intention of entering*

This means that adults should not:

- *change in the same place as children*
- *shower or bathe with children*
- *assist with any personal care task which a child or young person can undertake by themselves*

22. First Aid and Administration of Medication

Health and safety legislation places duties on all employers to ensure appropriate health and safety policies and equipment are in place and an appropriate person is appointed to take charge of first-aid arrangements. Any employee may volunteer to undertake this task but it is not a contractual requirement and appropriate training should be given before an individual takes on a role which may require administering first aid or medication.

It is expected that adults working with children and young people should be aware of basic first aid techniques. It is not however, a contractual requirement and whilst adults may volunteer to undertake such tasks, they should be suitably trained and qualified before administering first aid and/or any agreed medication.

When administering first aid, wherever possible, adults should ensure that another adult is aware of the action being taken. Parents should always be informed when first aid has been administered.

In circumstances where children need medication regularly a health care plan should have been established to ensure the safety and protection of children and the adults who are working with them. Depending upon the age and understanding of the child, they should where appropriate, be encouraged to self administer medication or treatment including, for example any ointment, use of inhalers.

This means that organisations should:

- *ensure staff understand the extent and limitations of their role in applying basic care and hygiene tasks for minor abrasions and understand where an injury requires more experienced intervention*
- *ensure there are trained and named individuals to undertake first aid responsibilities*
- *ensure training is regularly monitored and updated*
- *always ensure that arrangements are in place to obtain parental consent for the administration of first aid or medication*

This means that adults should:

- *adhere to the organisation's policy for administering first aid or medication*
- *comply with the necessary reporting requirements*
- *make other adults aware of the task being undertaken*
- *explain to the child what is happening.*
- *always act and be seen to act in the child's best interests*
- *report and record any administration of first aid or medication*

- *have regard to any health plan which is in place*
- *always ensure that an appropriate health/risk assessment is undertaken prior to undertaking certain activities*

23. One to One Situations

All organisations working with or on behalf of children and young people should consider one to one situations when drawing up their policies.

It is not realistic to state that one to one situations should never take place. It is however, appropriate to state that where there is a need, agreed with a senior manager and/or parents/carers, for an adult to be alone with a child or young person, certain procedures and explicit safeguards must be in place. This also applies to those adults who do not work as part of an agency or organisation but owe a duty of care to the child or young person because of the nature of their work.

Adults should be offered training and guidance for the use of any areas of the workplace which may place themselves or children in vulnerable situations. This would include those situations where adults work directly with children and young people in unsupervised settings and/or isolated areas within community settings or in street-based projects for example.

One to one situations have the potential to make child/young person more vulnerable to harm by those who seek to exploit their position of trust. Adults working in one to one settings with children and young people may also be more vulnerable to unjust or unfounded allegations being made against them. Both possibilities should be recognised so that when one to one situations are unavoidable, reasonable and sensible precautions are taken. Every attempt should be made to ensure the safety and security of children and young people and the adults who work with them.

There are occasions where managers will need to undertake a risk assessment in relation to the specific nature and implications of one to one work. These assessments should take into account the individual needs of the child/young person and the individual worker and any arrangements should be reviewed on a regular basis.

Meetings with children and young people outside agreed working arrangements should not take place without the agreement of senior managers and parents or carers.

This means that adults should:

- *ensure that when lone working is an integral part of their role, full and appropriate risk assessments have been conducted and agreed.*
- *avoid meetings with a child or young person in remote, secluded areas,*
- *always inform other colleagues and/or parents/carers about the contact(s) beforehand, assessing the need to have them present or close by*
- *avoid use of 'engaged' or equivalent signs wherever possible. Such signs may create an opportunity for secrecy or the interpretation of secrecy*
- *always report any situation where a child becomes distressed or angry to a senior colleague*
- *carefully consider the needs and circumstances of the child/children when in one to one situations*

24. Home Visits

There are workers for whom home visits are an integral part of their work. In these circumstances it is essential that appropriate policies and related risk assessments are in

These means that adults should:

place to safeguard children and young people and the adults who work with them.

A risk assessment should include an evaluation of any known factors regarding the child/young person, parents and others living in the household. Risk factors such as hostility, child protection concerns, complaints or grievances can make adults more vulnerable to an allegation. Specific consideration should be given to visits outside of 'office hours' or in remote or secluded locations. Following an assessment, appropriate risk management measures should be in place before visits are agreed. Where little or no information is available, visits should not be made alone. There will be occasions where risk assessments are not possible or not available, e.g. when emergency services are used. In these circumstances, a record must always be made of the circumstances and outcome of the home visit. Such records must always be available for scrutiny.

Under no circumstances should an adult visit a child in their home outside agreed work arrangements or invite a child to their own home or that of a family member, colleague or friend. If in an emergency, such a one -off arrangement is required, the adult must have a prior discussion with a senior manager and the parents or carers and a clear justification for such arrangement is agreed and recorded.

- *agree the purpose for any home visit with senior management, unless this is an acknowledged and integral part of their role e.g. social workers*
- *adhere to agreed risk management strategies*
- *always make detailed records including times of arrival and departure and work undertaken*
- *ensure any behaviour or situation which gives rise to concern is discussed with their manager and, where appropriate action is taken*

This means that employers should:

- *ensure that they have home visit and lone-working policies of which all adults are made aware. These should include arrangements for risk assessment and management*
- *ensure that all visits are justified and recorded*
- *ensure that adults are not exposed to unacceptable risk*
- *ensure that adults have access to a mobile telephone and an emergency contact person*

25. Transporting Children and Young People

There will be occasions when adults are expected or asked to transport children as part of their duties. Adults, who are expected to use their own vehicles for transporting children should ensure that the vehicle is roadworthy, appropriately insured and that the maximum capacity is not exceeded.

It is a legal requirement that all passengers should wear seat belts and it is the responsibility of the staff member to ensure that this requirement is met. Adults should also be aware of current legislation and adhere to the use of car seats for younger children. Where adults transport children in a vehicle which requires a specialist license/insurance e.g. PCV or LGV[19]- staff should ensure that they have an appropriate licence and insurance to drive such a vehicle.

It is inappropriate for adults to offer lifts to a child or young person outside their normal working duties, unless this has been brought to the attention of the line manager and has been agreed with the parents/carers.

There may be occasions where the child or young person requires transport in an emergency situation or where not to give a lift may place a child at risk. Such circumstances must always be recorded and reported to a senior manager and parents/carers.

This means that all organisations:

- *should have appropriate policies for transporting children and young people*

This means that adults should:

- *ensure they are fit to drive and free from any drugs, alcohol or medicine which is likely to impair judgement and/ or ability to drive*
- *be aware that the safety and welfare of the child is their responsibility until they are safely passed over to a parent/carer*
- *record details of the journey in accordance with agreed procedures*
- *ensure that their behaviour is appropriate at all times*
- *ensure that there are proper arrangements in place to ensure vehicle, passenger and driver safety. This includes having proper and appropriate insurance for the type of vehicle being driven*
- *ensure that any impromptu or emergency arrangements of lifts are recorded and can be justified if questioned*

26. Trips and Outings

Adults should take particular care when supervising children and young people on trips and outings, where the setting is less formal than the usual workplace. Adults remain in a position of trust and need to ensure that their behaviour remains professional at all times and stays within clearly defined professional boundaries. .

Where activities include overnight stays, careful consideration needs to be given to sleeping arrangements. Children, young people, adults and parents should be informed of these prior to the start of the trip. In all circumstances, those organising trips and outings must pay careful attention to ensuring safe staff/child ratios and to the

This means that adults should:

- *always have another adult present in out of workplace activities, unless otherwise agreed with a senior manager*
- *undertake risk assessments in line with their organisation's policy where applicable*
- *have parental consent to the activity*
- *ensure that their behaviour remains professional at all times(see section 7)*
- *never share beds with a*

[19] For further information see www.dvla.gov.uk

gender mix of staff especially on overnight stays.

Health and Safety arrangements require members of staff to keep colleagues/employers aware of their whereabouts, especially when involved in activities outside the usual workplace.

child/children or young people.

- *not share bedrooms unless it involves a dormitory situation and the arrangements have been previously discussed with senior manager, parents and children and young people.*

27. Photography and Videos

Working with children and young people may involve the taking or recording of images. Any such work should take place with due regard to the law and the need to safeguard the privacy, dignity, safety and well being of children and young people. Informed written consent from parents or carers and agreement, where possible, from the child or young person, should always be sought before an image is taken for any purpose.

Careful consideration should be given as to how activities involving the taking of images are organised and undertaken. Care should be taken to ensure that all parties understand the implications of the image being taken especially if it is to be used for any publicity purposes or published in the media, or on the Internet. There also needs to be an agreement as to whether the images will be destroyed or retained for further use, where these will be stored and who will have access to them.

Adults need to remain sensitive to any children who appear uncomfortable, for whatever reason, and should recognise the potential for such activities to raise concerns or lead to misunderstandings.

It is not appropriate for adults to take photographs of children for their personal use.

This means that adults should:

- *be clear about the purpose of the activity and about what will happen to the images when the activity is concluded*
- *be able to justify images of children in their possession*
- *avoid making images in one to one situations or which show a single child with no surrounding context*
- *ensure the child/young person understands why the images are being taken and has agreed to the activity and that they are appropriately dressed.*
- *only use equipment provided or authorised by the organisation*
- *report any concerns about any inappropriate or intrusive photographs found*
- *always ensure they have parental permission to take and/or display photographs*

This means that adults should not:

- *display or distribute images of children unless they have consent to do so from parents/carers*
- *use images which may cause distress*
- *use mobile telephones to take images of children*
- *take images 'in secret', or taking images in situations that may be construed as being secretive.*

28. Access to Inappropriate Images and Internet Usage

There are no circumstances that will justify adults possessing indecent images of children. Adults who access and possess links to such websites will be viewed as a significant and potential threat to children. Accessing, making and storing indecent images of children on the internet is illegal. This will lead to criminal investigation and the individual being barred from working with children and young people, if proven.

Adults should not use equipment belonging to their organisation to access adult pornography; neither should personal equipment containing these images or links to them be brought into the workplace. This will raise serious concerns about the suitability of the adult to continue to work with children.

Adults should ensure that children and young people are not exposed to any inappropriate images or web links. Organisations and adults need to ensure that internet equipment used by children have the appropriate controls with regards to access. e.g. personal passwords should be kept confidential.

Where indecent images of children or other unsuitable material are found, the police and Local Authority Designated Officer (LADO) should be immediately informed. Adults should not attempt to investigate the matter or evaluate the material themselves, as this may lead to evidence being contaminated which in itself can lead to a criminal prosecution.

This means that organisations should

- *have clear e-safety policies in place about access to and use of the internet*
- *make guidance available to both adults and children and young people about appropriate usage.*

This means that adults should:

- *follow their organisation's guidance on the use of IT equipment*
- *ensure that children are not exposed to unsuitable material on the internet*
- *ensure that any films or material shown to children and young people are age appropriate*

29. Whistle blowing

Whistle blowing is the mechanism by which adults can voice their concerns, made in good faith, without fear of repercussion. Each employer should have a clear and accessible whistle blowing policy that meets the terms of the Public Interest Disclosure Act 1998. Adults who use whistleblowing procedure should be made aware that their employment rights are protected.

Adults should acknowledge their individual responsibilities to bring matters of concern to the attention of senior management and/or relevant external agencies. This is particularly important where the welfare of children may be at risk.

This means that organisations should:

- *ensure they have appropriate whistle-blowing policies in place*
- *ensure that they have clear procedures for dealing with allegations against staff which are in line with their Local Safeguarding Children Board's procedures.*

This means that adults should:

- *report any behaviour by colleagues that raises concern regardless of source*

30. Sharing Concerns and Recording Incidents

Individuals should be aware of their organisation's child

This means that adults:

protection procedures, including procedures for dealing with allegations against adults. All allegations must be taken seriously and properly investigated in accordance with local procedures and statutory guidance. Adults who are the subject of allegations are advised to contact their professional association.

In the event of any allegation being made, to someone other than a manager, information should be clearly and promptly recorded and reported to a senior manager without delay.

Adults should always feel able to discuss with their line manager any difficulties or problems that may affect their relationship with children and young people so that appropriate support can be provided or action can be taken.

It is essential that accurate and comprehensive records are maintained wherever concerns are raised about the conduct or actions of adults working with or on behalf of children and young people.

- *should be familiar with their organisation's system for recording concerns*
- *should take responsibility for recording any incident, and passing on that information where they have concerns about any matter pertaining to the welfare of an individual in the workplace*

This means that organisations:

- *should have an effective, transparent and accessible system for recording and managing concerns raised by any individual in the workplace*

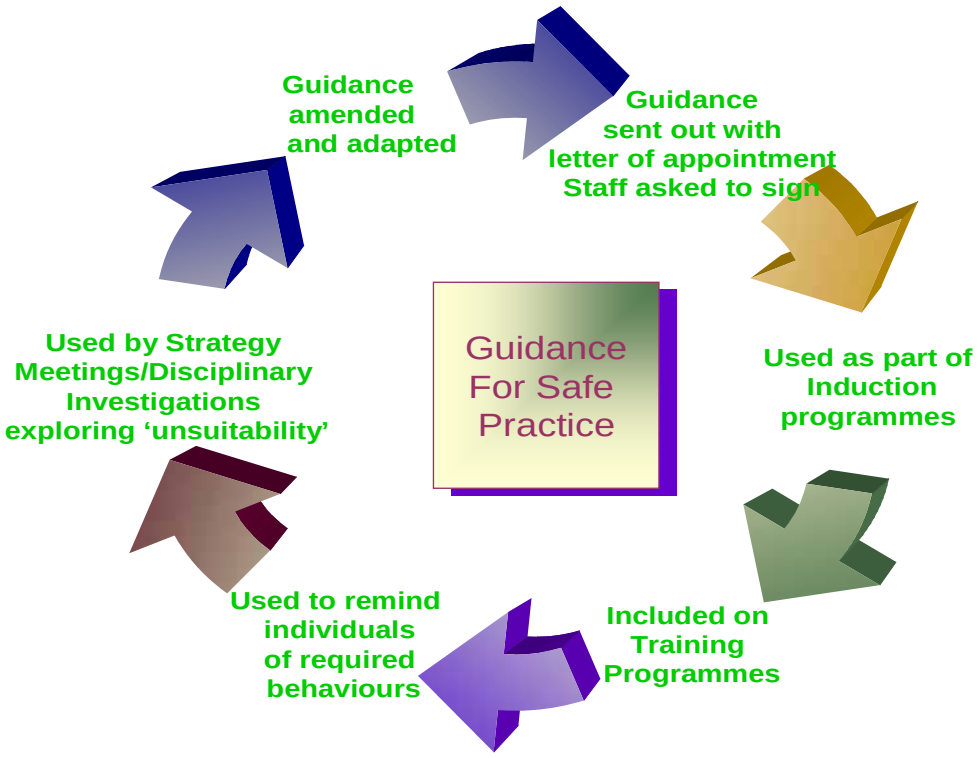
APPENDIX 1

This generic document can be used as a base upon which other disciplines/agencies develop specific guidance for adults working in specialised areas.

A March 2009 Education Version of this document is available from the LADO in your council.

APPENDIX 2

This generic document can be used to support safer recruitment and selection practices, induction and on-going training programmes and where necessary, disciplinary and child protection procedures.



Bournemouth & Poole Local Safeguarding Children Board

Dorset Safeguarding Children Board

PAN DORSET INTER-AGENCY SAFEGUARDING PROCEDURES

CHAPTER 4

4.3 CHILD PERFORMANCE WORKING PRACTICE GUIDANCE

Procedures Effective from:

Review Date:

If you have any comments or queries about the pan-Dorset procedures please contact your agency representative on the Pan Dorset Policy and Procedures Group or notify the LSCB using the following email addresses:

info@dorsetlscb.co.uk
info@bournemouth-poole-lscb.org.uk

PAN DORSET CHILD PERFORMANCE WORKING PRACTICE POLICY
BOURNEMOUTH, DORSET AND POOLE LOCAL AUTHORITIES

1. A child may have up to three days **absence from school** in order to take part in a performance without the need for a license if no payment is made to the child or any other person. If a performance lasts for more than 3 days a performance license will be required to authorise further absence from school.

2. The **issuing of a license** allows the school to authorise the school absence incurred. The school and the producer can be assured that all the necessary checks have been made by a local authority officer during the production to ensure compliance.

3. A Child Performance License may be obtained from the Child Performance Licensing Officer for Bournemouth at www.bournemouth.gov.uk 'Children and Learning' and then 'Child Employment etc'.

4. A Child Performance License may be obtained from the Child Performance Licensing Officer in Poole on 01202 261937.

5. A Child Performance License may be obtained from the Child Performance Licensing Officer for Dorset, who can be contacted on 01305 224832.

6. If no performance license is required, there is no need to use an approved chaperone. However, it is recommended that producers of short-lived voluntary or amateur productions are advised by the local authority of the importance of devising and implementing an approved **child protection policy.**

7. A chaperone may only be approved in connection with a performance or performances where child licenses are required. Their registration will be restricted to productions in connection with a specified dance or drama group, and will be for a maximum period of a year. Approval of chaperones will require an Enhanced Level CRB check, an interview and relevant references. Good practice dictates that the local authority will offer regular training sessions on the role and responsibilities of a chaperone, including child protection training.

8. Child performance licenses may be issued for a maximum number of days over a specified **six month period** in connection with long-running film or television productions. However, the license will only be valid if the producer has notified the local authority of exact dates and locations beforehand.

9. The three named local authorities, together with Hampshire County Council, are in the process of developing clear guidelines to enable them to grant **Approved Body** status to local groups. This will be relevant to those groups who regularly produce short-lived amateur shows and have a proven record of good practice. Approval will be given for one year maximum (renewable).

Bournemouth & Poole Local Safeguarding Children Board

Dorset Safeguarding Children Board

PAN DORSET INTER-AGENCY SAFEGUARDING PROCEDURES

CHAPTER 4

4.4 GUIDELINES FOR TEXT MESSAGING AND E MAILING

Procedures Effective from: 2008

Review Date:

If you have any comments or queries about the pan-Dorset procedures please contact your agency representative on the Pan Dorset Policy and Procedures Group or notify the LSCB using the following email addresses:

info@dorsetlscb.co.uk
info@bournemouth-poole-lscb.org.uk

GUIDELINES FOR COMMUNICATIONS WITH CHILDREN & YOUNG PEOPLE.

These Guidelines for Text Messaging, e mailing and e safety are produced to complement the Guidance for Safer Working Practice for Adults who Work with Children and Young People. (Nov 2007). The guidance document was commissioned by the Department for Children, Schools and Families. (DCSF). It does not replace or take priority over advice or codes of conduct produced by employers or national bodies.

It is a generic document that should complement existing professional procedures, protocols and guidance which relate to specific roles, responsibilities or professional practices.

The section that applies to technology is paragraph 12.

Paragraph 12 of Guidance for Safer Working Practice for Adults who Work with Children and Young People. (Nov 2007)

12. Communication with Children and Young People (including the Use of Technology)

Communication between children and adults, by whatever method, should take place within clear and explicit professional boundaries. This includes the wider use of technology such as mobile phones text messaging, e-mails, digital cameras, videos, web-cams, websites and blogs. Adults should not share any personal information with a child or young person. They should not request, or respond to, any personal information from the child/young person, other than that which might be appropriate as part of their professional role. Adults should ensure that all communications are transparent and open to scrutiny.

This means that the organisation should:

- *have a communication policy which specifies acceptable and permissible modes of communication.*

Adults should also be circumspect in their communications with children so as to avoid any possible misinterpretation of their motives or any behaviour which could be construed as grooming. They should not give their personal contact details to children and young people including e-mail, home or mobile telephone numbers, unless the need to do so is agreed with senior management and parents/carers. E-mail or text communications between an adult and a child young person outside agreed protocols may lead to disciplinary and/or criminal investigations. This also includes communications through internet based web sites.
Internal e-mail systems should only be used in accordance with the organisation's policy.

This means that adults should:

- *not give their personal contact details to children or young people, including their mobile telephone number (unless agreed as part of your organizations policy*
- *only use equipment e.g. mobile phones, provided by organisation to communicate with children, making sure that parents have given permission for this form of communication to be used*
- *only make contact with children for professional reasons and in accordance with any organisation policy*
- *recognise that text messaging is rarely an appropriate response to a child in a crisis situation or at risk of harm. It should only be used as a last resort when other forms of communication are not possible*
- *not use internet or web-based communication channels to send personal messages to a child/young person*

GUIDELINES FOR TEXT MESSAGING AND E MAILING

Whilst these guidelines refer specifically to text/email communication, all staff should be aware of the need for appropriate professional recording and boundaries in ALL communication with children and young people, whether written or oral.

1. TEXT MESSAGING

1.1 A written record should be made of all calls from/to a mobile phone in the same way as calls from a landline, according to agency/service procedure.

1.2 It is good practice to make a specific note of any mobile phone contact outside of normal working hours.

1.3 Work mobile numbers should only be given out to children/young people in accordance with agency/service protocols and policies. Line managers should be informed of all occasions when a number is given.

1.4 The use of texting is accepted as an essential tool of social contact for young people. Adult users must be aware of this. **It is recognised that texting is increasingly becoming a 'normal' professional tool of communication between adults and young people alongside meetings, telephone calls and letters.**

1.5 Texting should only contain information of a professional nature and written plain, unambiguous language, reflecting dialogue that would occur face to face. The language used should be professional and appropriate to the service/agency. It would not be appropriate to use 'text language' in a professional communication.

1.6 Texting should only be used if previously agreed by the child/young person e.g. for a specific agreed reason or purpose. The reason should be noted in the case record.

1.7 Texting should not normally be used as third party communication i.e. to ask

one service user to pass on a message to another service user.

1.8 All texts sent/received must recorded by being transcribed and put in the case file, timed and dated when recorded.

1.9 It is not recommended that personal home or mobile numbers are given to children or young people (or any service user). This should only happen where a service/agency policy specifically allows it and should be agreed with the line manager.

1.10 Any texts/calls of an abusive, threatening or nuisance calls should be recorded and reported to line manager.

1.11 Agencies/services should be clear about when a work mobile should be switched on or off. A nuisance call received out of work hours can be very distressing. If the phone is off no nuisance call can be received.

1.12 The law is very clear about the use of mobile phones when driving, all users have a responsibility to comply with the law. Some agencies/authorities instruct that all mobiles are switched off when driving.

1.13 It is possible for mobile phones with Bluetooth capability to receive unsolicited material, including images. Any such images received should be reported to line manager and then deleted. Please be aware that the Bluetooth issue is a complex one, all phones differ. Mobile phones can be configured to prevent unsolicited material. Please contact your provider to clarify this.

2. POLICE ADVICE REGARDING INDECENT VIDEO, FILM OR STILL IMAGES TRANSMITTED BY MOBILE PHONE

2.1 No young person should be asked to forward any material by staff as this is inadvertently asking the young person to commit an offence of distributing indecent images.

2.2 If a young person is volunteering the images for a member of staff to view the staff member should get the young person's permission to hold on to the phone and contact the police to see if they want to view the images.

2.3 If a staff member has an image received on their phone they should contact their Headteacher/Line Manger/Head of Service immediately so that a manager is aware that the image has been received. The police can then be contacted and the image viewed by them if necessary and then deleted

2.4 If a young person refuses to give their phone to a member of staff the young person should be advised to delete the material and a record of such kept on the agency file. The same advice should be given to staff.

2.5 SCHOOL STAFF SHOULD NEVER DOWNLOAD ANY INDECENT MAGES BUT IF IN DOUBT OF THE CONTENT, CONTACT THE POLICE SRU (Safeguarding Referral

unit), OR DESIGNATED MEMBER OF STAFF FOR SAFEGUARDING WITHIN THE LOCAL AUTHORITY.

3. E MAIL COMMUNICATION

3.1 Many young people and children have a personal e mail address.

3.2 Any adult working with children or young people should only use a work email address, as defined by service or agency.

3.3 Any communication by e mail must be compliant with any individual service/agency protocol and guidance.

3.4 All communication should be for clear professional reasons and the content must reflect this.

3.5 E mail communication should only be used as part of an agreed strategy or plan with the child/young person and parent/carer should be aware of this, according to age of young person and agency/service protocol and guidance. Any e mail communication without parent/carer knowledge should only happen with the agreement of a line manager and the decision recorded

3.6 **A record of all e mails sent/received should be kept as part of the agency add 'or service' record, printed off or copied into a computer system.**

4. SOCIAL NETWORKING SITES

4.1 It is not recommended that adults working with children/young people correspond through social networking sites.

4.2 If you become aware of a social networking site which contains any personal information about activities of concern about a young person known to you, this should be recorded and the line manager should be informed.

4.3 Staff should be aware of possible implications when entering any personal details on any gaming or social networking site e.g. you tube, my space, facebook etc.

PART 2

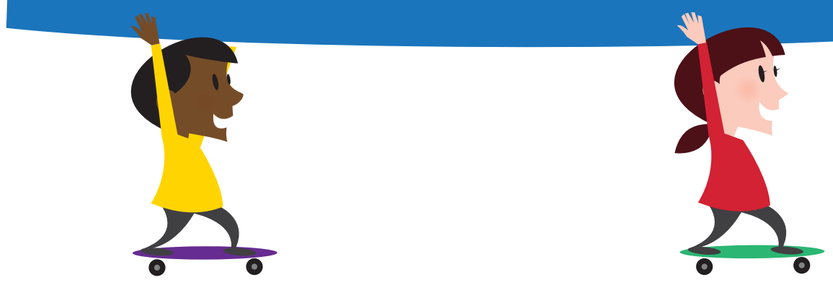
4. WORKING TOGETHER TO SAFEGUARD CHILDREN DCSF 2010

It was agreed that Bournemouth & Poole Local Safeguarding Children Board and Dorset Local Safeguarding Children Board would adopt Working Together To Safeguard Children 2010, in its entirety, as the Bournemouth, Dorset and Poole Inter-agency Safeguarding Procedures.

HM Government

Working Together to Safeguard Children

A guide to inter-agency working to safeguard and promote the welfare of children



department for
children, schools and families

March 2010

HM Government

Working Together to Safeguard Children

A guide to inter-agency working to safeguard and promote the welfare of children

March 2010

Contents

Working Together to Safeguard Children: Executive Summary 7
- Introduction 7
- Part 1: Statutory guidance 8
- Part 2: Non-statutory practice guidance 18

Preface 22
- Introduction 22
- Purpose of the document and who should read it 22
- Content of this guidance 24
- Other related guidance 24
- Status of the document as statutory guidance 25
- When does the guidance apply? 26

Glossary 27

Part 1: Statutory Guidance 28

Chapter 1 – Introduction: working together to safeguard and promote the welfare of children and families 29
- Supporting children and families 29
- Parenting, family life and services 29
- Lord Laming's progress report 30
- The Government's response 30
- An integrated approach 31
- A shared responsibility 31
- The child in focus 32
- Key definitions 34

Chapter 2 – Roles and responsibilities 40
- Introduction 40
- The statutory framework within which organisations operate 40
- Infrastructure and governance to deliver safeguarding responsibilities 42
- Information sharing 43
- ContactPoint 44
- Common Assessment Framework (CAF) 44
- Local authorities that are children's services authorities 45
- Other local authority roles 48
- Health services 51

Health organisations 52
Roles of different health services 60
Health professionals 67
Criminal justice organisations 70
Schools and further education institutions 78
Early years services 80
Children and Family Court Advisory and Support Service (Cafcass) 81
The armed services 82
The voluntary and private sectors 84
Faith communities 86

Chapter 3 – Local Safeguarding Children Boards 88
LSCB role 88
Scope of the LSCB 89
LSCB functions 90
Other policies and procedures 93
LSCB governance and operational arrangements 99
Membership of an LSCB 102

Chapter 4 – Training, development and supervision for inter-agency working 113
Introduction and definitions 113
Purpose 114
Roles and responsibilities 114
Content, audiences and values 118
Planning, organisation, delivery and evaluation 121
Effective support and supervision 123
Table 1: Suggested training for different target groups 126

Chapter 5 – Managing individual cases where there are concerns about a child's safety and welfare 133
Introduction 133
Working with children when there are concerns about their safety and welfare 133
Principles underpinning work to safeguard and promote the welfare of children 134
The processes for safeguarding and promoting the welfare of children 137
The welfare of unborn children 140
Referrals to local authority children's social care where there are concerns about a child's safety or welfare 140
Response of local authority children's social care to a referral 144
Initial assessment 146

Next steps – child in need but no suspected actual or likely significant harm 150
Next steps – suspicion that a child is suffering, or is likely to suffer, significant harm 151
Immediate protection 152
Strategy discussion 153
Section 47 enquiries and core assessment 155
Child Assessment Orders 158
The impact of section 47 enquiries on the family and child 159
The outcome of section 47 enquiries 159
Concerns are not substantiated 160
Concerns are substantiated, but the child is not judged to be continuing to, or be likely to, suffer significant harm 160
Concerns are substantiated and the child is judged to be continuing to, or be likely to, suffer significant harm 162
The initial child protection conference 162
Action following the initial child protection conference 172
Completion of the core assessment 174
The child protection plan 175
Intervention 176
The child protection review conference 179
Discontinuing the child protection plan 180
Children looked after by the local authority 181
Pre-birth child protection conferences and reviews 182
Recording that a child is the subject of a child protection plan 182
Managing and providing information about a child 183
Recording in individual case records 184
Request for a change of worker 185

Chapter 6 – Supplementary guidance on safeguarding and promoting the welfare of children 191

Introduction 191
Sexually exploited children 191
Children affected by gang activity 192
Fabricated or induced illness (FII) 192
Investigating complex (organised or multiple) abuse 194
Female genital mutilation 195
Forced marriage and honour-based violence 196
Allegations of abuse made against a person who works with children 199
Abuse of disabled children 201
Child abuse linked to belief in 'spirit possession' 204
Child victims of trafficking 204

Chapter 7 – Child death review processes 208

Introduction 208
Overall principles 209
Involvement of parents and family members (for all child deaths) 209
The Regulations relating to child deaths 210
Supply of information about child deaths by registrars 211
Duty and powers of coroners to share information 212
Duty and powers of Medical Examiners (MEs) to share information 212
Definition of an unexpected death of a child 212
Definition of preventable child deaths 213
LSCB responsibilities for the child death review processes 213
Procedures to be followed by the local Child Death Overview Panel (for all child deaths) 215
The process to be followed by Child Death Overview Panels (for all child deaths) 217
Roles and responsibilities when responding rapidly to an unexpected death of a child 220
Other related processes 221
Processes for a rapid response from professionals to all unexpected deaths of children (0–18 years) 223
Use of child death information to prevent future deaths 231

Chapter 8 – Serious case reviews 233

Reviewing and investigative functions of Local Safeguarding Children Boards 233
The purposes of Serious Case Reviews 234
Safeguarding siblings or other children 234
When should a LSCB undertake a Serious Case Review? 235
When should a LSCB consider undertaking a Serious Case Review? 235
Which LSCB should take lead responsibility? 237
Membership of SCR sub-committees and SCR Panels 237
Instigating a Serious Case Review 238
Timescales for initiating and undertaking a Serious Case Review 241
Who should be involved in the Serious Case Review? 242
Individual management reviews – general principles 243
The Serious Case Review overview report 247
SCR Panel responsibilities for the overview report 248
The executive summary 249
LSCB action on receiving the Serious Case Review report 251
Reviewing institutional abuse 252
Accountability and disclosure 253
Learning lessons locally 254
Learning lessons nationally 255

Part 2: Non-statutory practice guidance 257

Chapter 9 – Lessons from research 258
Introduction 258
The impact of maltreatment on children 258
Physical abuse 259
Emotional abuse 260
Sexual abuse 260
Neglect 260
Sources of stress for children and families 261
Social exclusion 262
Domestic violence 262
Mental illness of a parent or carer 265
Parental problem drug use 269
Parental problem alcohol use 274
Parents with a Learning Disability 278

Chapter 10 – Implementing the principles on working with children and their families 284
Introduction 284
Family group conferences 284
Support, advice and advocacy to children and families 285
Communication and information 286
Race, ethnicity and culture 286
Children in 'Families at risk' having very poor outcomes 287
Think Family practice 288
Effectiveness of parenting and family interventions 289
Working with fathers 290
Family Intervention Projects 290
Family Nurse Partnership 291

Chapter 11 – Safeguarding and promoting the welfare of children who may be particularly vulnerable 292
Introduction 292
Children living away from home 292
Abuse by children and young people 302
Children whose behaviour indicates a lack of parental control 307
Race and racism 308
Violent extremism 309
Domestic violence 310
Child abuse and information communication technology (ICT) 315
Children with families whose whereabouts are unknown 316

Children who go missing 316
Children who go missing from education 317
Children of families living in temporary accommodation 319
Migrant children 319
Unaccompanied asylum-seeking children (UASC) 319

Chapter 12 – Managing individuals who pose a risk of harm to children 322

Introduction 322
Collaborative working 322
Use of the term 'Schedule One offender' 322
New offences targeted at those who sexually exploit children and young people 324
Multi-Agency Public Protection Arrangements (MAPPA) 324
Other processes and mechanisms 328

Appendices

Appendix 1 – Statutory framework 336
Appendix 2 – Framework for the Assessment of Children in Need 344
Appendix 3 – Using standardised assessment tools to evidence assessment and decision making 350
Appendix 4 – MOD child protection contacts 353
Appendix 5 – Procedures for managing allegations against people who work with children 356
Appendix 6 – Faith community contacts and resources 366
Appendix 7 – A guide to acronyms in the document 368
References and internet links 371

Working Together to Safeguard Children: Executive Summary

Introduction

Working Together sets out how organisations and individuals should work together to safeguard and promote the welfare of children and young people in accordance with the Children Act 1989 and the Children Act 2004. It is important that all practitioners working to safeguard children and young people understand fully their responsibilities and duties as set out in primary legislation and associated regulations and guidance.

This guidance was most recently updated in 2006. This latest revision follows the publication of Lord Laming's report, *The Protection of Children in England: A Progress Report*, in March 2009, the acceptance by the Government of all of his recommendations and the Government's detailed response and action plan published in May 2009. Many of Lord Laming's recommendations are reflected in or given effect by this revised guidance. It has also been updated to reflect developments in legislation, policy and practice relating to safeguarding children.

Working Together is addressed to practitioners and frontline managers who have particular responsibilities for safeguarding and promoting the welfare of children, and to senior and operational managers in:

- organisations that are responsible for commissioning or providing services to children, young people, and adults who are parents/carers; and
- organisations that have a particular responsibility for safeguarding and promoting the welfare of children and young people.

Part 1 of the document comprises Chapters 1 to 8, which are issued as statutory guidance. Practitioners and agencies will have different responsibilities that apply to different areas of the guidance and should consult the preface for a fuller explanation of their statutory duties. Part 2 of the document incorporates Chapters 9 to 12 and is issued as non-statutory practice guidance.

This executive summary is not guidance in itself. It aims to help readers gain an overview of the document, and of main changes made to the 2006 version.

Over time Working Together has become a lengthy document containing a good deal of material in addition to the core statutory guidance. The Department for Children, Schools and Families will:

- produce an easily navigable web-based version of this document, with hyperlinks to relevant supporting guidance;
- produce in partnership with stakeholders a short practitioner guide; and
- work with stakeholders to identify what might be done to present the document more effectively to ensure that the statutory requirements to safeguard and promote the welfare of children and young people are not inadvertently obscured by non-statutory guidance.

Part 1: Statutory guidance

Chapter 1 – Introduction: working together to safeguard and promote the welfare of children and families

Chapter 1 sets the context for the revised guidance by discussing the reasons for the changes in safeguarding policy and practice since 2006. It also outlines the key definitions and concepts used in the guidance.

The publication of the *Every Child Matters* Green Paper in 2003 alongside the formal response to the Inquiry into the death of Victoria Climbié, and followed by the Children Act 2004, set out 'being safe' as one of five important outcomes for children and young people. In this context, three key provisions were:

- the creation of Children's Trusts under the duty to co-operate[1];
- the setting up of Local Safeguarding Children Boards (LSCBs); and
- the duty on all agencies to make arrangements to safeguard and promote the welfare of children.

Lord Laming's progress report, *The Protection of Children in England: A Progress Report*, made 58 recommendations relating to: leadership and accountability, support for children, inter-agency working, children's workforce, improvement and challenge, organisation and finance and the legal framework. The Government's detailed response to Lord Laming's recommendations was published in May 2009. Twenty-three of these recommendations have been addressed by this revised guidance.

Protecting children from harm and promoting their welfare depends on a shared responsibility and effective joint working between different agencies. This in turn relies on constructive relationships between individual practitioners, promoted and supported by:

- the commitment of senior managers to safeguard and promote the welfare of children; and
- clear lines of accountability.

1 This has now been strengthened by placing Children's Trust Boards on a statutory footing from 1 April 2010.

Chapter 2 – Roles and responsibilities

Chapter 2 explains the roles, responsibilities and duties of the different people and organisations that work directly with, and whose work affects, children and young people. It states that all organisations that provide services or work with children and young people should:

- have senior managers who are committed to children's and young people's welfare and safety;
- be clear about people's responsibilities to safeguard and promote children's and young people's welfare;
- check that there are no known reasons or information available that would prevent staff and volunteers from working with children and young people;
- have procedures for dealing with allegations of abuse against members of staff and volunteers;
- make sure staff get training that helps them do their job well;
- have procedures about how to safeguard and promote the welfare of young people; and
- have agreements about working with other organisations.

Section 11 of the Children Act 2004, section 175 of the Education Act 2002 and section 55 of the Borders, Citizenship and Immigration Act 2009 place duties on organisations and individuals to ensure that their functions are discharged with regard to the need to safeguard and promote the welfare of children. An overview of these duties and the structure of children's services under the Children Act 2004 are set out in the preface to this guidance and in Appendix 1.

Safeguarding and promoting the welfare of children is the responsibility of the local authority, working in partnership with other public organisations, the voluntary sector, children and young people, parents and carers, and the wider community. A key objective for local authorities is to ensure that children are protected from harm. Other functions of local authorities that make an important contribution to safeguarding are housing, sport, culture and leisure services, and youth services.

Health professionals and organisations have a key role to play in safeguarding and promoting the welfare of children. The general principles they should apply are:

- to aim to ensure that all affected children receive appropriate and timely preventative and therapeutic interventions;

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

All health professionals working directly with children and young people should ensure that safeguarding and promoting their welfare forms an integral part of all elements of the care they offer.

The police also have a key role in safeguarding children. They recognise the fundamental importance of inter-agency working in combating child abuse, as illustrated by well-established arrangements for joint training involving police and social work colleagues. All forces have child abuse investigation units and while they normally take responsibility for investigating such cases, safeguarding children is a fundamental part of the duties of all police officers.

The police are committed to sharing information and intelligence with other organisations and should be notified as soon as possible where a criminal offence has been, or is suspected of, being committed. LSCBs should have in place a protocol agreed between the local authority and the police, to guide both organisations in deciding how section 47 enquiries should be conducted, and in which circumstances joint enquiries are appropriate.

Probation services supervise offenders with the aim of reducing re-offending and protecting the public. By working with offenders who are parents/carers, Offender Managers can safeguard and promote the welfare of children. Probation areas/Trusts will also:

- provide a statutory victim contact scheme to the victims of violent and sexual offences;
- deliver unpaid work requirements to 16- and 17-year olds;
- fulfil their role as statutory partner of YOTs; and
- ensure support for victims, and indirectly children in the family, of convicted perpetrators of domestic abuse participating in accredited domestic abuse programmes.

Offender Managers should also ensure there is clarity and communication between risk management processes; these are described in greater detail in Chapter 12.

Governors/Directors of all prison establishments should have in place arrangements that protect the public from prisoners in their care. All prisoners who have been identified as presenting a risk of harm to children will not be allowed contact with them unless a favourable risk assessment has been undertaken by the police, probation, prison and children's social care services. Governors/Directors of women's establishments with Mother and Baby Units need to ensure that staff working on duty are prioritised for child protection training.

Governors/Directors of Young Offender Institutions (YOIs) are required to adhere to the policies, agreed by the Prison Service and the Youth Justice Board, for safeguarding and promoting the welfare of children held in custody.

Secure Training Centres (STCs) house vulnerable, sentenced and remanded young people aged between 12 and 17 years. Each STC has a duty to safeguard and promote the welfare of the children in its custody.

Youth Offending Teams are responsible for the supervision of children and young people subject to pre-court interventions and statutory court disposals. YOTs have a duty to make arrangements to ensure that their functions are discharged with regard to the need to safeguard and promote the welfare of children.

Schools (including independent and non-maintained schools) and further education institutions have a duty to safeguard and promote the welfare of pupils under the Education Act 2002. They should create and maintain a safe learning environment for children and young people, and identify where there are child welfare concerns and take action to address them, in partnership with other organisations where appropriate.

Early years services – children's centres, nurseries, childminders, pre-schools, playgroups, and holiday and out-of-school schemes – all play an important part in the lives of large numbers of children. Everyone working in early years services should know how to recognise and respond to the possible abuse and neglect of a child. The Early Years Foundation Stage makes it clear that all registered providers, except childminders, must have a practitioner who is designated to take lead responsibility for safeguarding children within each early years setting and who should liaise with local statutory children's services agencies as appropriate.

In care and related proceedings under the Children Act 1989, the responsibility of the Children and Family Court Advisory and Support Service (Cafcass) is to safeguard and promote the welfare of individual children who are the subject of family proceedings by providing independent social work advice to the court.

Under section 55 of the Borders, Citizenship and Immigration Act 2009 the UKBA has a duty to ensure that its functions are discharged with regard to the need to safeguard and promote the welfare of children.

Looking after under 18 year olds in the armed forces comes under the Ministry of Defence's comprehensive welfare arrangements, which apply to all members of the armed forces. There is already a responsibility on children's social care services to monitor the welfare of care leavers, and those joining the armed forces have unrestricted access to local authority social care services staff.

The voluntary sector is active in working to safeguard the children and young people with whom they work, and plays a key role in providing information and resources to the wider public about the needs of children.

Faith communities provide a wide range of activities for children and, as such, should have appropriate arrangements in place to safeguard and promote their welfare.

Chapter 3 – Local Safeguarding Children Boards

Chapter 3 explains the role, functions, governance and operation of Local Safeguarding Children Boards.

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

The scope of the LSCB role falls into three categories: firstly, they engage in activities that safeguard all children and aim to identify and prevent maltreatment, or impairment of health or development, and to ensure that children are growing up in circumstances consistent with safe and effective care; secondly, they lead and co-ordinate proactive work that aims to target particular groups; and thirdly, they lead and co-ordinate arrangements for responsive work to protect children who are suffering, or likely to suffer, significant harm.

The core functions of an LSCB are set out in regulations and are:

- developing policies and procedures including those on:
  - action taken where there are concerns about the safety and welfare of a child, including thresholds for intervention;
  - training of people who work with children or in services affecting the safety and welfare of children;
  - recruitment and supervision of people who work with children;

  - investigation of allegations concerning people who work with children;
  - safety and welfare of children who are privately fostered; and
  - co-operation with neighbouring children's services authorities (i.e. local authorities) and their LSCB partners.
- communicating and raising awareness;
- monitoring and evaluation;
- participating in planning and commissioning;
- reviewing the deaths of all children in their areas; and
- undertaking Serious Case Reviews.

County-level and unitary local authorities are responsible for establishing an LSCB in their area and ensuring that it is run effectively. LSCBs should have a clear and distinct identity within local Children's Trust governance arrangements. It is the responsibility of the local authority, after consultation with Board partners, to appoint the Chair of the LSCB.

Membership of the LSCB is made up of senior managers from different services and agencies in a local area, including the independent and voluntary sector. In addition, the Board receives input from experts – for example, the designated nurse or doctor.

To function effectively, LSCBs need to be supported by their member organisations with adequate and reliable resources. The budget for each LSCB and the contribution made by each member organisation should be agreed locally.

LSCBs should ensure the effectiveness of work undertaken by member organisations through a variety of mechanisms including peer review, self-evaluation, performance indicators and joint audit.

Key changes to Chapter 3 since 2006 include the requirement for LSCBs to produce and publish an annual report on the effectiveness of safeguarding in the local area, the appointment of two representatives of the local community to each LSCB, statutory representation on the LSCB of schools and, subject to the passage of the Children Schools and Families Bill, a provision to ensure appropriate information is disclosed to the LSCB in order to assist it in the exercise of its functions.

The revised chapter also provides further clarity over the complementary roles of the LSCB and the Children's Trust Board and makes clear that the Chair of the LSCB should be someone independent of the local agencies. Taken together, these changes aim to strengthen transparency and accountability of LSCBs.

Chapter 4 – Training, development and supervision for inter-agency working

Chapter 4 covers training, development and supervision to enable those working with children to develop the necessary skills, judgement and confidence. Training for multi- and inter-agency working means training that will equip people to work effectively with those from other professions and agencies.

Employers are responsible for ensuring their employees are confident and competent in carrying out their responsibilities, and for ensuring employees are aware of how to recognise and respond to safeguarding concerns. Employers should also identify adequate resources and support for inter-agency training.

Through their work on the local Children and Young People's Plan, Children's Trust Boards are responsible for ensuring that workforce strategies are developed in their local areas. An LSCB should contribute to, and work within, the framework of the local workforce strategy. The LSCB is responsible for developing local policies for the training of people who work with children or in services affecting the safety and welfare of children. This includes training in relation to child death review processes and Serious Case Reviews. LSCBs should review and evaluate the provision and availability of single and inter-agency training to ensure training reaches all relevant staff.

All training in safeguarding and promoting the welfare of children should create an ethos that:

- is child-centred;
- promotes the participation of children and families in the processes;
- values working collaboratively;
- respects diversity; and
- promotes equality.

The Common Core of Skills and Knowledge for the Children's Workforce (2010)[2] sets out the six areas of expertise that everyone working with children, young people and families should be able to demonstrate. These include safeguarding and promoting the welfare of children.

Training and development for inter-agency work at the appropriate level should be targeted at practitioners in voluntary, statutory and independent agencies who:

- are in regular contact with children and young people;

2 www.dcsf.gov.uk/everychildmatters/strategy/deliveringservices1/commoncore/commoncoreofskillsandknowledge/

- work regularly with children and young people, and with adults who are parents or carers, and who may be asked to contribute to assessments of children in need; or
- have particular responsibility for safeguarding children.

Training and development is also relevant to operational managers and those with strategic responsibility for services, in particular LSCB members.

Effective supervision is important in promoting good standards of practice, and supervisors should be available to practitioners as an important source of advice and expertise.

Chapter 5 – Managing individual cases where there are concerns about a child's safety and welfare

Chapter 5 provides guidance on what should happen if somebody has concerns about the welfare of a child (including those living away from home) and, in particular, concerns that a child may be suffering, or likely to suffer, significant harm. It also sets out the principles underpinning work to safeguard and promote the welfare of children.

The chapter is structured according to the four key processes that underpin work with children and families: assessment, planning, intervention and reviewing. The *Framework for the Assessment of Children in Need and their Families* (2000) should be followed when undertaking assessments of children in need and their families.

The chapter sets out in detail the processes to be followed when safeguarding and promoting the welfare of children. These include:

- responding to concerns about the welfare of a child and making a referral to a statutory organisation (children's social care, the police or the NSPCC) that can take action to safeguard and promote the welfare of children;
- undertaking an initial assessment of the child's situation and deciding what to do next;
- taking urgent action to protect the child from harm, if necessary;
- holding a strategy discussion where there are suspicions that a child may be suffering significant harm and, where appropriate, convening a child protection conference; and
- undertaking a core assessment as part of the section 47 enquiries to decide whether a child is continuing to be likely to suffer significant harm and therefore should be the subject of a child protection plan, implementing the plan and reviewing it at regular intervals.

The key changes to Chapter 5 include emphasising the importance of keeping the focus on the child and his or her safety and welfare, understanding the daily life experience of the child, seeing the child alone where appropriate and using information about the family's history and functioning to inform decision making. It also stresses the importance of analysing the inter-relationships between strengths and protective factors and vulnerabilities and risk factors when deciding whether a child is suffering or likely to suffer significant harm, and of the accurate recording of actions.

The chapter clarifies the relationship between the common assessment, referral to children's social care and an initial assessment. It also sets out that a referrer should be able to discuss their concerns with a qualified social worker.

The guidance extends the timescale for the completion of an initial assessment from seven to ten working days with effect from 1 April 2010. It makes it clear that the planning and reviewing processes for looked after children who are also the subject of a child protection plan should be integrated into one process during the coming year. This change is also reflected in the Care Planning, Placement and Case Review (England) Regulations 2010 and accompanying statutory guidance *Putting Care into Practice*.

Chapter 6 – Supplementary guidance on safeguarding and promoting the welfare of children

Chapter 6 summarises the supplementary guidance to Working Together. This guidance includes:

- Home Office, Department of Health (2002). Complex Child Abuse Investigations: Inter-agency issues;
- Home Office (2004). Home Office Circular 10/2004 on The Female Genital Mutilation Act 2003;
- DCSF (2007). Safeguarding Children for Abuse Linked to a Belief in Spirit Possession;
- DCSF and Home Office (2007). Safeguarding Children who may have been trafficked;
- HM Government (2008). Safeguarding Children in whom Illness is Fabricated or Induced;
- DCSF (2009). Safeguarding Disabled Children – Practice Guidance;
- HM Government (2009). The Right to Choose: Multi-agency statutory guidance for dealing with Forced Marriage, and HM Government (2009) Multi-agency practice guidelines: handling cases of forced marriage;

- HM Government (2009). Safeguarding Children and Young People from Sexual Exploitation;
- HM Government (2010). Safeguarding Children and Young People who may be affected by Gang Activity; and
- Guidance on allegations of abuse made against a person who works with children, which can be found in Appendix 5 of this document.

This chapter has been updated to reflect new or revised guidance which relates to Working Together and has been issued since 2006.

Chapter 7 – Child death review processes

Chapter 7 sets out the processes to be followed when a child dies in the LSCB area(s) covered by a Child Death Overview Panel.

There are two inter-related processes for reviewing child deaths:

- a rapid response by a group of key professionals who come together for the purpose of enquiring into and evaluating each unexpected death of a child; and
- an overview of all child deaths in the area, undertaken by a panel.

Either of these processes can identify cases requiring a Serious Case Review (covered in Chapter 8).

The key changes to Chapter 7 include revised definitions of preventable child deaths and unexpected deaths, and clarity on the roles of coroners and registrars and on how to respond appropriately to the deaths of children with life limiting illnesses. An additional section has been included on parents and family members which clarifies the level of involvement parents and family members should have and the type of support they will need.

Chapter 8 – Serious Case Reviews

Chapter 8 sets out the processes LSCBs should follow when undertaking a Serious Case Review (SCR). The purposes of SCRs are to:

- establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children;
- identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result; and

- improve intra- and inter-agency working and better safeguard and promote the welfare of children.

When a child dies (including death by suspected suicide), and abuse or neglect are known or suspected to be a factor in the death, the LSCB should always conduct a SCR. A SCR should also always be carried out when a child dies in custody, either in police custody, on remand or following sentencing, in a YOI, a STC, or a secure children's home or where the child was detained under the Mental Health Act 2005. LSCBs should always consider whether a SCR should be conducted in other circumstances where a child has been harmed. These circumstances are set out in the guidance.

The SCR should look into the involvement of organisations and professionals in the lives of the child and family, irrespective of whether local authority children's social care is, or has been, involved with the child or family As the prime purpose of SCRs is to learn lessons for improving both individual agency and inter-agency working, it is important that their recommendations are acted on promptly and effectively.

A revised version of Chapter 8 was published in December 2009. It made clear that the prime purpose of a SCR is to learn lessons both at an individual and inter-agency/LSCB level; extended the time scale for completing a SCR from four to six months; strengthened the requirements in relation to executive summaries, and made clear that the Chair of the SCR Panel should be independent.

Further changes have now been incorporated, in particular the inclusion of a template for SCR executive summaries and a flow chart providing an overview of the SCR process. In parallel, Chapter 3 makes clear that LSCBs will need to include in their annual reports progress updates on the actions that have been taken in response to current and recent SCRs.

Part 2: Non-statutory practice guidance

Chapter 9 – Lessons from research

Chapter 9 summarises the impact of maltreatment on children's health and developmental progress, and sets out some of the key messages from research and inspection that have informed this guidance.

The maltreatment of children – physically, emotionally, sexually or through neglect – can have major long-term effects on all aspects of a child's health, development and wellbeing.

Professionals must take special care to help safeguard and promote the welfare of children and young people who may be living in particularly stressful circumstances. These include families:

- living in poverty;
- where there is domestic violence;
- where a parent has a mental illness;
- where a parent is misusing drugs or alcohol;
- where a parent has a learning disability;
- that face racism and other forms of social isolation; and
- living in areas with a lot of crime, poor housing and high unemployment.

The research evidence in Chapter 9 has been updated since the 2006 edition.

Chapter 10 – Implementing the principles on working with children and their families

Chapter 10 sets out in more detail specific aspects of working with children, young people and families.

Family Group Conferences (FGCs) may be appropriate in a number of contexts where there is a plan or decision to be made. The family is the primary planning group in the process. Where there are plans to use FGCs in situations where there are concerns about possible harm to a child, they should be developed and implemented under the auspices of LSCB. FGCs should not replace or remove the need for child protection conferences.

Children and families may be supported through their involvement in safeguarding processes by advice and advocacy services, and they should always be informed of services that exist locally and nationally.

Local authorities have a responsibility to ensure that children and adults understand the processes that will be followed when there are concerns about the child. Information should be made available in the family's preferred language.

Children from all cultures may be subject to abuse and neglect, and while professionals should be sensitive to differing family patterns and lifestyles, they must be clear that child abuse cannot be condoned for religious or cultural reasons.

Chapter 11 – Safeguarding and promoting the welfare of children who may be particularly vulnerable

This chapter outlines the circumstances of children who may be particularly vulnerable. It is intended to help inform the practice that underpins the procedures in Chapter 5, which set out the basic framework within which action should be taken when a parent, professional or any other person has concerns about the welfare of a child.

The chapter gives advice to organisations and individuals on safeguarding in the context of:

- children living away from home;
- abuse by children and young people;
- bullying;
- children whose behaviour indicates a lack of parental control;
- race and racism;
- violent extremism;
- domestic violence;
- child abuse and information communication technology (ICT);
- children with families whose whereabouts are unknown;
- children who go missing;
- children who go missing from education;
- children of families living in temporary accommodation;
- migrant children; and
- unaccompanied asylum-seeking children (UASC).

Chapter 12 – Managing individuals who pose a risk of harm to children

Chapter 12 provides practice guidance and information about a range of mechanisms that are available when managing people who have been identified as presenting a risk, or potential risk, of harm to children.

The Children Act 1989 recognised that the identification and investigation of child abuse, together with the protection and support of victims and their families, requires multi-agency collaboration. As part of that protection, action has been taken, usually by the police and social services, to prosecute known offenders or control their access to vulnerable children. The Sexual Offences Act 2003 introduced a number of new offences to deal with those who abuse and exploit children in this way.

The term 'Schedule One offender' should no longer be used for anyone convicted of a crime against a child. The focus should be on whether the individual poses a 'risk of harm to children'. Home Office guidance explains how these people who present a potential risk of harm to children should be identified. Practitioners should use the new list of offences as a 'trigger' to further assessments.

Where the offender is given a community sentence, Offender Managers monitor their risk to others and liaise with partner agencies. Prison establishments undertake a similar responsibility where the offender has been sentenced to a period of custody.

The Multi-Agency Public Protection Arrangements (MAPPA) provide a national framework for the assessment and management of risks posed by serious and violent offenders. The Responsible Authorities need to ensure that strategies to address risk are identified, and plans developed, implemented and reviewed on a regular basis. The MAPPA framework identifies three separate but connected levels at which risk is managed:

- ordinary risk management;
- local inter-agency risk management; and
- Multi Agency Public Protection Panels (MAPPP).

There are other processes and mechanisms for working with and monitoring people who may present a risk to children. For example, the Vetting and Barring Scheme (VBS) aims to ensure that unsuitable people do not work with children, whether in paid employment or on a voluntary basis. Since October 2009, the duties to refer concerns regarding individuals under List 99 and the Protection of Children Act 1999 have been replaced with a duty to provide information to the Independent Safeguarding Authority. As another example, people placed on the sex offender list are served with a notification that ensures the police are informed of their whereabouts in the community.

Preface

Introduction

Working Together to Safeguard Children has evolved through several revisions. It contains detailed procedural guidance on safeguarding and promoting the welfare of children and families. The parts of the document that are statutory guidance for particular organisations are set out below. It is not necessary for all practitioners to read every part of Working Together to understand the principles and perform their roles effectively; Table 1 sets out for reference which parts of the document are particularly relevant to different roles. But the rest of the document contains information that may also be useful.

Over time, Working Together has become a lengthy document containing a good deal of material on the roles of different organisations and how to safeguard children in different situations. The Department for Children, Schools and Families (DCSF) will be working with stakeholders on what might be done to present the document more effectively to ensure that the statutory requirements on safeguarding and promoting the welfare of children are not inadvertently obscured by non-statutory guidance. It will also work in partnership with stakeholders to produce a short practitioner guide. In the shorter term, the Department intends to produce an easily navigable web-based version of this document, with hyperlinks to relevant supporting guidance.

This revision of Working Together is being published at around the same time as new guidance on *Children's Trusts: Statutory guidance on co-operation arrangements, including the Children's Trust Board and the Children and Young People's Plan*. The purpose of the Children's Trust Board is to bring all partners with a role in improving outcomes for children together to agree a common strategy on how they will co-operate to improve children's wellbeing and to help embed partnership in partners' routine delivery of their own functions. It is therefore essential that Children's Trust Boards and Local Safeguarding Children Boards – the latter responsible for co-ordinating work to safeguard and promote the welfare of children – work closely together. This is addressed in Chapter 3 of this guidance.

Purpose of the document and who should read it

This document sets out how organisations and individuals should work together to safeguard and promote the welfare of children.

It is addressed to practitioners and front line managers who have particular responsibilities for safeguarding and promoting the welfare of children, and to senior and operational managers, in organisations that:

- are responsible for commissioning or providing services to children, young people, and adults who are parents/carers; or
- have a particular responsibility for safeguarding and promoting the welfare of children.

Table 1 can be used as a guide to navigate the document. All practitioners and managers may be required to read chapters that are not listed as necessary under their job function in particular circumstances.

Table 1: How to use this document

Practitioners	Chapters it is necessary to read	Chapters it is advisable to read
Those with a strategic and managerial responsibility for commissioning and delivering services for children and families	1, 2, 3, 4, 5	6, 9, 10
Operational managers within organisations employing staff to work with children and families, or with responsibility for commissioning and delivering services	1, 2 (relevant section), 5	3, 4, 6, 9, 10, 11, 12
Those with a particular responsibility for safeguarding children, such as designated health and education professionals, police, social workers	1, 2, 3, 4, 5, 7, 8, 10, 11	6, 9, 12
Those who work regularly with children and young people and adults who are carers and who may be asked to contribute to assessments of children in need	1, 2 (relevant section), 5, 11	6, 8, 9, 10, 12
Others in contact with children and young people and parents who are carers	It is not necessary for others to read this document. Instead read the summary guide *What to do if you're worried a child is being abused*	1, 2 (relevant section), 5, 10

For more detail on which practitioners come under which group, see paragraph 4.30.

Content of this guidance

This guidance reflects the principles contained within the United Nations Convention on the Rights of the Child, ratified by the UK Government in 1991. It takes into account the European Convention of Human Rights, in particular Articles 6 and 8. It also takes account of other relevant legislation at the time of publication. It is particularly informed by the requirements of the Children Act 1989, which provides a comprehensive framework for the care and protection of children, and the Children Act 2004, which underpins the *Every Child Matters* reforms and includes the provisions on Local Safeguarding Children Boards.

Other related guidance

This document is one of a suite of documents that gives guidance on the governance, strategic planning and delivery of children's services, and on the cross-cutting issue of safeguarding and promoting the welfare of children[3].

The documents support provisions in the Children Act 2004, which underpin *Every Child Matters*. These include the creation of duties on local agencies in relation to children and young people's 'wellbeing' and 'welfare'.

- *Children's Trusts: Statutory guidance on co-operation arrangements, including the Children's Trust Board and the Children and Young People's Plan* brings together statutory guidance on Children's Trust co-operation arrangements, and the procedures and functions of the Children's Trust Board, including the Board's role in preparing, reviewing and monitoring the local Children and Young People's Plan. It replaces *Children's Trusts: statutory guidance on inter-agency co-operation to improve well-being of children, young people and their families* (2008) and *Children and Young People's Plan Guidance* (2009).
- S*tatutory guidance on the Duty to Make arrangements to Safeguard and Promote the Welfare of Children* sets out the key arrangements agencies should make to safeguard and promote the welfare of children in the course of discharging their normal functions.
- Guidance on the governance, leadership and structures required within the new strategic framework is provided in *The Roles and Responsibilities of the Director of Children's Services and the Lead Member for Children's Services* and the chapter on Local Safeguarding Children Boards within this revised version of *Working Together to Safeguard Children*.

3 All documents referred to are available at: www.dcsf.gov.uk/everychildmatters/

These core documents should be used alongside other key policy and planning documents relating to *Every Child Matters*. These include:

- *The National Service Framework for Children, Young People and Maternity Services*, which sets out a 10-year programme to stimulate long-term and sustained improvement in children's health and wellbeing. This guidance will help health and social care organisations to meet Standard Five on safeguarding and promoting the welfare of children and young people.
- The revised Care Planning, Placement and Case Review Regulations (England) 2010 and accompanying statutory guidance *Putting Care into Practice*, which describe how local authorities should exercise these functions for looked after children.
- *Information Sharing: Guidance for practitioners and managers* and the supporting materials, which are for everyone who works with children and young people, and explain when and how information can be shared legally and professionally.
- The *Common Assessment Framework (CAF) guides for managers and practitioners,* which are for all strategic and operational managers across all children's services who have responsibility for implementing the CAF and for all practitioners who want to know about the CAF and how to use it.

A number of other documents focus directly on integrated front line delivery and the processes that support it[4]. Appendix 1 sets out the statutory framework for safeguarding and promoting children's welfare.

Status of the document as statutory guidance

This document is intended to provide a national framework within which agencies and professionals at local level – individually and jointly – draw up and agree on their own ways of working together to safeguard and promote the welfare of children. It applies to England.

This guidance replaces the previous version of *Working Together to Safeguard Children*, which was published in 2006. Chapter 8 of this guidance replaces the previous version of Chapter 8 that was published in December 2009.

Part 1 of this document is statutory guidance. Part 2 is non-statutory practice guidance.

The whole of Part 1 is issued as guidance under **section 7 of the Local Authority Social Services Act 1970**, which requires local authorities in their social services functions to act under the general guidance of the Secretary of State. It should be complied with by local

4 These can be found at: www.dcsf.gov.uk/everychildmatters/

authorities carrying out their social services functions, unless local circumstances indicate exceptional reasons that justify a variation.

Chapters 3, 4, 7 and 8 are issued under **section 16 of the Children Act 2004**, which states that Children's Services Authorities (county-level and unitary local authorities) and each of the statutory partners must, in exercising their functions relating to a Local Safeguarding Children Board (LSCB), have regard to any guidance given to them for the purpose by the Secretary of State. This means that they must take the guidance into account and, if they decide to depart from it, have clear reasons for doing so. A full list of statutory LSCB partners is given in Chapter 3 and summarised in Table A in Appendix 1.

Where this document is not statutory guidance for a particular organisation, it still represents a standard of good practice and will help organisations fulfil other duties in co-operation with partners. For example, managers and staff with a particular responsibility in the organisations covered by the duty to safeguard and promote the welfare of children in section 11 of the Children Act 2004 are encouraged to read this document and follow it in conjunction with the guidance on that duty.

The same principle applies to educational institutions with duties in this area under the Education Act 2002, sections 157 and 175, early years providers with a duty in this area under section 40 of the Childcare Act 2006, the Children and Family Court Advisory and Support Service (Cafcass) which has a duty in this area under section 12(1) of the Criminal Justice and Court Services Act 2000, and the UK Border Agency which has a duty under section 55 of the Borders, Citizenship and Immigration Act 2009.

When does the guidance apply?

The guidance comes into force upon publication with two exceptions. The timescale for initial assessments being undertaken within 10 working days comes into force on 1 April 2010.

Where a looked after child is also the subject of a child protection plan, this guidance sets out that the child protection plan should be reviewed as part of the overarching care plan. The revised Care Planning, Placement and Case Review Regulations (England) 2010 and accompanying statutory guidance *Putting Care into Practice* will come into force on 1 April 2011. Local authorities will wish to use the intervening period between the issuing of this guidance and 1 April 2011 to integrate the two reviewing systems appropriately.

Glossary

Terminology in this area is complex, and changes as services are reshaped. This glossary sets out what is meant in the document by some key terms.

Term used in this document	Meaning
Abuse and neglect	Forms of maltreatment of a child – see paragraph 1.32 for details
Child	Anyone who has not yet reached their 18th birthday – see paragraph 1.19
Child protection	Process of protecting individual children identified as either suffering, or likely to suffer, significant harm as a result of abuse or neglect – see paragraphs 1.23, 1.24 and Chapter 5
'Children's social care' or 'local authority children's social care'	The work of local authorities exercising their social services functions with regard to children. This is not meant to imply a separate 'children's social services' department
Local authorities	In this guidance, this generally means top tier local authorities. These local authorities are responsible for social services and education. In England these authorities are defined as: a county council; a metropolitan district council; a non-metropolitan district council for an area where there is no county council; a London borough council; the Common Council of the City of London and the Council of the Isles of Scilly
Safeguarding and promoting the welfare of children	The process of protecting children from abuse or neglect, preventing impairment of their health and development, and ensuring they are growing up in circumstances consistent with the provision of safe and effective care that enables children to have optimum life chances and enter adulthood successfully. See paragraphs 1.20–1.22
Wellbeing	Section 10 of the Children Act 2004 requires local authorities and other specified agencies to co-operate with a view to improving the wellbeing of children in relation to the five outcomes first set out in *Every Child Matters* – see paragraph 1.1

Part 1: Statutory Guidance

Chapter 1 – Introduction: working together to safeguard and promote the welfare of children and families

Supporting children and families

1.1 All children deserve the opportunity to achieve their full potential. In 2003, the Government published the *Every Child Matters* Green Paper alongside the formal response to the report into the death of Victoria Climbié. The Green Paper set out five outcomes that are key to children and young people's wellbeing:

- be healthy;
- stay safe;
- enjoy and achieve;
- make a positive contribution; and
- achieve economic wellbeing.

1.2 The Children Act 2004 subsequently became law and set out these outcomes in statute. The publication of the Children's Plan in 2007, which was developed having regard to the principles and articles of the UN Convention on the Rights of the Child, further set out the role of Government and a wide range of agencies and professionals in improving children's lives.

1.3 To achieve the five *Every Child Matters* outcomes, children need to feel loved and valued, and be supported by a network of reliable and affectionate relationships. They need to feel they are respected and understood as individual people and to have their wishes and feelings consistently taken into account. If they are denied the opportunity and support they need to achieve these outcomes, children are at increased risk not only of an impoverished childhood, but also of disadvantage and social exclusion in adulthood. Abuse and neglect pose particular problems.

Parenting, family life and services

1.4 Patterns of family life vary and there is no single, perfect way to bring up children. Good parenting involves caring for children's basic needs, keeping them safe and protected, being attentive and showing them warmth and love, encouraging them

to express their views and consistently taking these views into account, and providing the stimulation needed for their development and to help them achieve their potential, within a stable environment where they experience consistent guidance and boundaries.

1.5 Parenting can be challenging. Parents themselves require and deserve support. Asking for help should be seen as a sign of responsibility rather than as a parenting failure.

1.6 A wide range of services and professionals provide support to families in bringing up children. Sometimes children will seek out and ask for help and advice themselves. However, in the great majority of cases, it will be the decision of parents when to ask for help and advice on their children's care and upbringing. As well as being responsive to children's direct requests for help and advice, professionals also need to engage with parents at the earliest opportunity when doing so may prevent problems or difficulties becoming worse. Only in exceptional cases should there be compulsory intervention in family life – for example, where this is necessary to safeguard a child from significant harm. Such intervention should – provided this is consistent with the safety and welfare of the child – support families in making their own plans for the welfare and protection of their children.

Lord Laming's progress report

1.7 On 12 November 2008 the Secretary of State for Children, Schools and Families asked Lord Laming to provide an urgent report on the progress being made across the country to implement effective arrangements for safeguarding children. Lord Laming published *The Protection of Children in England: A Progress Report*[5] on 12 March 2009. He confirmed that robust legislative, structural and policy foundations are in place but commented that although 'a great deal of progress has been made' in protecting children from harm, 'much more needs to be done to ensure that … services are as effective as possible at working together to achieve positive outcomes for children'.

1.8 Lord Laming made 58 recommendations relating to: leadership and accountability, support for children, inter-agency working, children's workforce, improvement and challenge, organisation and finance and the legal framework.

The Government's response

1.9 The Government immediately accepted all of Lord Laming's recommendations and, in May 2009 published *The Protection of Children in England: Action Plan*[6]. This set out

5 http://publications.everychildmatters.gov.uk/eOrderingDownload/HC-330.pdf
6 http://publications.dcsf.gov.uk/eOrderingDownload/DCSF-Laming.pdf

the Government's detailed response to Lord Laming's recommendations and made a number of commitments for future action. Progress has already been made to address a number of the recommendations and to fulfil many of the commitments made in the Government's action plan. The publication of this updated and revised version of *Working Together to Safeguard Children* guidance addresses a further 23 of Lord Laming's recommendations.

An integrated approach

1.10 Children have varying needs that change over time. Judgements on how best to intervene when there are concerns about harm to a child will often, and unavoidably, entail an element of risk – at the extreme, of leaving a child for too long in a dangerous situation or of removing a child unnecessarily from his or her family. The way to proceed in the face of uncertainty is through competent professional judgements, based on a sound assessment of the child's needs and the parents' capacity to respond to these – including their capacity to keep the child safe from significant harm – and the wider family circumstances.

1.11 Effective measures to safeguard children are those that also promote their welfare. They should not be seen in isolation from the wider range of support and services already provided and available to meet the needs of children and families:

- enquiries under section 47 of the Children Act 1989 may reveal significant unmet needs for support and services among children and families. These should always be explicitly considered, even where concerns are not substantiated about significant harm to a child, if the child and/or their family so wishes; and
- if processes for managing concerns about individual children are to result in improved outcomes for children, then effective plans for safeguarding and promoting children's welfare should be based on a wide-ranging assessment of the needs of the child, including the child's wishes and feelings, whether they are suffering or likely to suffer significant harm, parental capacity and their family circumstances.

A shared responsibility

1.12 Safeguarding and promoting the welfare of children – and in particular protecting them from significant harm – depends on effective joint working between agencies and professionals that have different roles and expertise. Individual children, especially some of the most vulnerable children and those at greatest risk of suffering harm and social exclusion, will need co-ordinated help from health, education, early years, children's social care, the voluntary sector and other agencies, including youth justice services.

1.13 In order to achieve this joint working, there needs to be constructive relationships between individual workers, promoted and supported by:

- a strong lead from elected or appointed authority members, and the commitment of chief officers in all agencies – in particular, the Director of Children's Services and Lead Member for Children's Services[7] in each local authority; and
- effective local co-ordination by the Local Safeguarding Children Board in each area.

1.14 For those children who are suffering, or likely to suffer, significant harm, joint working is essential to safeguard and promote their welfare and, where necessary, to help bring to justice the perpetrators of crimes against children. All agencies and professionals should:

- be alert to potential indicators of abuse or neglect;
- be alert to the risks of harm that individual abusers, or potential abusers, may pose to children;
- prioritise direct communication and positive and respectful relationships with children, ensuring the child's wishes and feelings underpin assessments and any safeguarding activities;
- share and help to analyse information so that an assessment can be made of whether the child is suffering or is likely to suffer harm, their needs and circumstances;
- contribute to whatever actions are needed to safeguard and promote the child's welfare;
- take part in regularly reviewing the outcomes for the child against specific plans; and
- work co-operatively with parents, unless this is inconsistent with ensuring the child's safety.

The child in focus

1.15 Lord Laming reiterated the importance of frontline professionals getting to know children as individual people and, as a matter of routine, considering how their situation feels to them. Ofsted's evaluation of 50 Serious Case Reviews conducted

7 Guidance on the roles and responsibilities of the Director of Children's Services and Lead Member for children's services, updated in July 2009, can be downloaded from: http://publications.everychildmatters.gov.uk/default.aspx?PageFunction=productdetails&PageMode=publications&ProductId=DCSF-00686-2009

between 1 April 2007 and 31 March 2008 highlighted 'the failure of all professionals to see the situation from the child's perspective and experience; to see and speak to the children; to listen to what they said, to observe how they were and to take serious account of their views in supporting their needs as probably the single most consistent failure in safeguarding work with children.'

1.16 Since 2005, local authorities have been under a duty under the Children Act 1989 (as amended by section 53 of the Children Act 2004) to ascertain the child's wishes and feelings and give due regard to their age and understanding when determining what (if any) services to provide under section 17 of the Children Act 1989, and before making decisions about action to be taken to protect individual children under section 47 of the Children Act 1989. These duties complemented existing requirements relating to the wishes and feelings of children who are, or may be, looked after (section 22(4) Children Act 1989), those being provided accommodation (section 20(6) Children Act 1989) and children taken into police protection (section 46(3)(d)).

1.17 In discharging their duties under these sections, the local authority must give due consideration to the child's 'wishes and feelings' so far as is reasonably practicable and consistent with the child's welfare and giving due regard to the child's age and understanding. There will be occasions when it is not possible to ascertain the child's wishes and feelings. In these circumstances, professionals should record in writing why it was not reasonably practicable or consistent with the child's welfare to elicit his or her wishes and feelings.

1.18 Effective ongoing action to keep the child in focus includes:

- developing a direct relationship with the child;
- obtaining information from the child about his or her situation and needs;
- eliciting the child's wishes and feelings – about their situation now as well as plans and hopes for the future;
- providing children with honest and accurate information about the current situation, as seen by professionals, and future possible actions and interventions;
- involving the child in key decision-making;
- providing appropriate information to the child about his or her right to protection and assistance;
- inviting children to make recommendations about the services and assistance they need and/or are available to them;

- ensuring children have access to independent advice and support (for example, through advocates or children's rights officers) to be able to express their views and influence decision-making; and
- the importance of eliciting and responding to the views and experiences of children is a defining feature of staff recruitment, professional supervision, performance management and the organisation's broader aims and development.

Key definitions

Children

1.19 In this document, as in the Children Acts 1989 and 2004 respectively, **a child** is anyone who has not yet reached their 18th birthday. 'Children' therefore means 'children and young people' throughout. The fact that a child has reached 16 years of age, is living independently or is in further education, is a member of the armed forces, is in hospital or in custody in the secure estate for children and young people, does not change his or her status or entitlement to services or protection under the Children Act 1989.

Safeguarding and promoting welfare and child protection

1.20 **Safeguarding and promoting the welfare of children** is defined for the purposes of this guidance as:

- protecting children from maltreatment;
- preventing impairment of children's health or development;
- ensuring that children are growing up in circumstances consistent with the provision of safe and effective care;

and undertaking that role so as to enable those children to have optimum life chances and to enter adulthood successfully.

1.21 Protecting children from maltreatment is important in preventing the impairment of health or development though that in itself may be insufficient to ensure that children are growing up in circumstances consistent with the provision of safe and effective care. These aspects of safeguarding and promoting welfare are cumulative, and all contribute to the outcomes set out in paragraph 1.1.

1.22 Young people at serious risk of harm from community based violence such as gang, group and knife crime are likely to have significant needs. Agencies and professionals need to ensure that the safeguarding process responds effectively to the needs of children at risk of suffering violence within the community. This may involve both the perpetrators and victims of violent activity.

1.23 **Child protection** is a part of safeguarding and promoting welfare. This refers to the activity that is undertaken to protect specific children who are suffering, or are likely to suffer, significant harm.

1.24 Effective child protection is essential as part of wider work to safeguard and promote the welfare of children. However, all agencies and individuals should aim to proactively safeguard and promote the welfare of children so that the need for action to protect children from harm is reduced.

Children in need

1.25 Children who are defined as being 'in need', under section 17 of the Children Act 1989, are those whose vulnerability is such that they are unlikely to reach or maintain a satisfactory level of health or development, or their health and development will be significantly impaired, without the provision of services (section 17(10) of the Children Act 1989), plus those who are disabled. The critical factors to be taken into account in deciding whether a child is in need under the Children Act 1989 are:

- what will happen to a child's health or development without services being provided; and
- the likely effect the services will have on the child's standard of health and development.

Local authorities have a duty to safeguard and promote the welfare of children in need.

The concept of significant harm

1.26 Some children are in need because they are suffering, or likely to suffer, significant harm. The Children Act 1989 introduced the concept of significant harm as the threshold that justifies compulsory intervention in family life in the best interests of children, and gives local authorities a duty to make enquiries to decide whether they should take action to safeguard or promote the welfare of a child who is suffering, or likely to suffer, significant harm.

1.27 A court may make a care order (committing the child to the care of the local authority) or supervision order (putting the child under the supervision of a social worker or a probation officer) in respect of a child if it is satisfied that:

- the child is suffering, or is likely to suffer, significant harm; and
- the harm, or likelihood of harm, is attributable to a lack of adequate parental care or control (section 31).

1.28 There are no absolute criteria on which to rely when judging what constitutes significant harm. Consideration of the severity of ill-treatment may include the degree and the extent of physical harm, the duration and frequency of abuse and neglect, the extent of premeditation, and the presence or degree of threat, coercion, sadism and bizarre or unusual elements. Each of these elements has been associated with more severe effects on the child, and/or relatively greater difficulty in helping the child overcome the adverse impact of the maltreatment. Sometimes, a single traumatic event may constitute significant harm, for example, a violent assault, suffocation or poisoning. More often, significant harm is a compilation of significant events, both acute and long-standing, which interrupt, change or damage the child's physical and psychological development. Some children live in family and social circumstances where their health and development are neglected. For them, it is the corrosiveness of long-term emotional, physical or sexual abuse that causes impairment to the extent of constituting significant harm. In each case, it is necessary to consider any maltreatment alongside the child's own assessment of his or her safety and welfare, the family's strengths and supports[8], as well as an assessment of the likelihood and capacity for change and improvements in parenting and the care of children and young people.

Under section 31(9) of the Children Act 1989 as amended by the Adoption and Children Act 2002:

'harm' means ill-treatment or the impairment of health or development, including, for example, impairment suffered from seeing or hearing the ill-treatment of another;

'development' means physical, intellectual, emotional, social or behavioural development;

'health' means physical or mental health; and

'ill treatment' includes sexual abuse and forms of ill-treatment which are not physical.

Under section 31(10) of the Act:

Where the question of whether harm suffered by a child is significant turns on the child's health and development, his health or development shall be compared with that which could reasonably be expected of a similar child.

8 For more details see Adcock, M. and White, R. (1998). *Significant Harm: its management and outcome*. Surrey: Significant Publications.

1.29 To understand and identify significant harm, it is necessary to consider:

- the nature of harm, in terms of maltreatment or failure to provide adequate care;
- the impact on the child's health and development;
- the child's development within the context of their family and wider environment;
- any special needs, such as a medical condition, communication impairment or disability, that may affect the child's development and care within the family;
- the capacity of parents to meet adequately the child's needs; and
- the wider and environmental family context.

1.30 The child's reactions, his or her perceptions, and wishes and feelings should be ascertained and the local authority should give them due consideration, so far as is reasonably practicable and consistent with the child's welfare and having regard to the child's age and understanding[9].

1.31 To do this depends on communicating effectively with children and young people, including those who find it difficult to do so because of their age, an impairment, or their particular psychological or social situation. This may involve using interpreters and drawing upon the expertise of early years workers or those working with disabled children. It is necessary to create the right atmosphere when meeting and communicating with children, to help them feel at ease and reduce any pressure from parents, carers or others. Children will need reassurance that they will not be victimised for sharing information or asking for help or protection; this applies to children living in families as well as those in institutional settings, including custody. It is essential that any accounts of adverse experiences coming from children are as accurate and complete as possible. Accuracy is key, for without it effective decisions cannot be made and, equally, inaccurate accounts can lead to children remaining unsafe, or to the possibility of wrongful actions being taken that affect children and adults[10].

What is abuse and neglect?

1.32 Abuse and neglect are forms of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may

9 Section 53 of the Children Act 2004 amended section 17 and section 47 of the Children Act 1989, so that before determining what, if any, services to provide to a child in need under section 17, or action to take with respect to a child under section 47, the wishes and feelings of the child should be ascertained as far as is reasonable and given due consideration.

10 Jones, D. P. H. (2003). *Communicating with Vulnerable Children: a Guide for Practitioners*, pp.1-2. London: Gaskell.

be abused in a family or in an institutional or community setting, by those known to them or, more rarely, by a stranger for example, via the internet. They may be abused by an adult or adults, or another child or children.

Physical abuse

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

Emotional abuse

1.34 Emotional abuse is the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may include not giving the child opportunities to express their views, deliberately silencing them or 'making fun' of what they say or how they communicate. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond the child's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction. It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying (including cyberbullying), causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.

Sexual abuse

1.35 Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet). Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.

Neglect

1.36 Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to:

- provide adequate food, clothing and shelter (including exclusion from home or abandonment);
- protect a child from physical and emotional harm or danger;
- ensure adequate supervision (including the use of inadequate care-givers); or
- ensure access to appropriate medical care or treatment.

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

Chapter 2 – Roles and responsibilities

Introduction

2.1 Everyone shares responsibility for safeguarding and promoting the welfare of children and young people, irrespective of individual roles. Nevertheless, in order that organisations and practitioners collaborate effectively, it is vital that all partners who work with children – including local authorities, the police, the health service, the courts, professionals, the voluntary sector and individual members of local communities – are aware of, and appreciate, the role that each of them play in this area.

The statutory framework within which organisations operate

2.2 Although all organisations that work with children and young people share a commitment to safeguard and promote their welfare, many organisations have specific roles and responsibilities to do so that are underpinned by a statutory duty or duties.

2.3 Local authorities that are children's services authorities[11] have a number of specific duties to organise and plan services and to safeguard and promote the welfare of children. These duties fall within the remit of the Director of Children's Services (DCS) under section 18 of the Children Act 2004. It is essential that the DCS, or senior managers reporting to the DCS, have relevant skills and experience in, and knowledge of, safeguarding and child protection, and that they provide high quality leadership in this area as part of the delivery of effective children's social care services as a whole.

2.4 Local authorities – along with district councils, NHS bodies (Strategic Health Authorities (SHAs), designated Special Health Authorities, Primary Care Trusts (PCTs), NHS trusts, and NHS foundation trusts), the Police (including the British Transport Police), probation and prison services (under the National Offender Management Service (NOMS) structure), Youth Offending Teams (YOTs), secure training centres and Connexions – also have a duty under section 11 of the Children Act 2004 to ensure that their functions are discharged with regard to the need to safeguard and promote the welfare of children. Guidance for these organisations

11 These are top tier local authorities, defined in England as a county council; a metropolitan district council; a non-metropolitan district council for areas for which there is no county council; a London borough council; the Common Council of the City of London; and the Council of the Isles of Scilly. See Glossary.

about their duty under section 11 is contained in *Making Arrangements to Safeguard and Promote the Welfare of Children* (HM Government, 2007)[12].

2.5 Local authorities in the exercise of their education functions also have a duty under section 175 of the Education Act 2002 to carry out those functions with a view to safeguarding and promoting the welfare of children. In addition, maintained (state) schools and Further Education (FE) institutions, including sixth-form colleges, have a duty under section 175 to exercise their functions with a view to safeguarding and promoting the welfare of their pupils (students under 18 years of age in the case of FE institutions). The statutory guidance to local authorities, maintained schools, and FE institutions about these duties is in *Safeguarding Children and Safer Recruitment in Education*[13], which is due to be updated and reissued in 2010. Regulations under section 157 of the Education Act 2002 prescribe as a standard for independent schools, including academies and technology colleges, that they should draw up and implement effectively a written policy to safeguard and promote the welfare of children who are pupils at the school which complies with *Safeguarding Children and Safer Recruitment in Education*. In addition, under section 87 of the Children Act 1989, independent schools that provide accommodation for children also have a duty to safeguard and promote the welfare of those pupils. Boarding schools, residential special schools, and FE institutions that provide accommodation for children under 18 must have regard to the respective National Minimum Standards[14] for their establishment.

2.6 Early years providers have a duty under section 40 of the Childcare Act 2006 to comply with the welfare requirements of the Early Years Foundation Stage, under which providers are required to take necessary steps to safeguard and promote the welfare of young children.

2.7 Safeguarding is a key function of the Children and Family Court Advisory and Support Service (Cafcass). Section 12(1) of the Criminal Justice and Court Services Act 2000 sets out Cafcass's duty to safeguard and promote the welfare of children involved in family proceedings in which their welfare is, or may be, in question.

2.8 The United Kingdom Border Agency (UKBA) is required under section 55 of the Borders, Citizenship and Immigration Act 2009 to carry out its functions having regard to the need to safeguard and promote the welfare of children who are in the UK. The UKBA instruction *Arrangements to Safeguard and Promote Children's Welfare in the United Kingdom Border Agency*[15] sets out the key principles to be taken into account in all Agency activities. Section 55 is intended to have the same effect as

12 www.everychildmatters.gov.uk/resources-and-practice/IG00042/
13 www.dcsf.gov.uk/everychildmatters/resources-and-practice/IG00175/
14 www.dh.gov.uk/en/PublicationsAndStatistics/Legislation/ActsAndBills/DH_4001911
15 www.ukba.homeoffice.gov.uk/sitecontent/documents/policyandlaw/legislation/bci-act1/

section 11 of the Children Act 2004. Statutory guidance on this duty, which mirrors the statutory guidance to other agencies, has been issued to the UKBA jointly by the Home Office and the DCSF[16].

2.9 All organisations must ensure they have in place safe recruitment policies and practices, including enhanced Criminal Records Bureau (CRB) checks for all staff, including agency staff, students and volunteers, working with children. It is an offence knowingly to employ a person who has been barred by the Independent Safeguarding Authority (ISA) from working in posts which involve caring for or treating children. Information about whether a person is barred will be given on an enhanced CRB check. From 26 July 2010, staff can register under the new Vetting and Barring Scheme[17] and from November 2010 registration will be compulsory for new entrants to the workforce.

2.10 An overview of the duties mentioned above and the structure of children's services under the Children Act 2004 are set out in the Preface to this guidance and Appendix 1.

Infrastructure and governance to deliver safeguarding responsibilities

2.11 To fulfil their commitment to safeguard and promote the welfare of children and young people all organisations that provide services for children, parents or families, or work with children, should have in place:

- clear priorities for safeguarding and promoting the welfare of children explicitly stated in key policy documents and commissioning strategies;
- a clear commitment by senior management to the importance of safeguarding and promoting children's welfare through both the commissioning and the provision of services;
- a culture of listening to and engaging in dialogue with children – seeking their views in ways appropriate to their age and understanding, and taking account of those both in individual decisions and the establishment or development and improvement of services;
- a clear line of accountability and governance within and across organisations for the commissioning and provision of services designed to safeguard and promote the welfare of children and young people;
- recruitment and human resources management procedures and commissioning processes, including contractual arrangements, that take account of the need to

16 www.dcsf.gov.uk/everychildmatters/12870

17 For more information on the Vetting and Barring Scheme see: www.isa-gov.org.uk

safeguard and promote the welfare of children and young people, including arrangements for appropriate checks on new staff and volunteers and adoption of best practice in the recruitment of new staff and volunteers;

- a clear understanding of how to work together to help keep children and young people safe online by being adequately equipped to understand, identify and mitigate the risks of new technology;
- procedures for dealing with allegations of abuse against members of staff and volunteers (see paragraphs 6.32–6.42) or, for commissioners, contractual arrangements with providers that ensure these procedures are in place;
- arrangements to ensure that all staff undertake appropriate training to equip them to carry out their responsibilities effectively, and keep this up to date by refresher training at regular intervals; and that all staff, including temporary staff and volunteers who work with children, are made aware of both the establishment's arrangements and their responsibilities for safeguarding and promoting the welfare of children;
- policies for safeguarding and promoting the welfare of children (for example, pupils/students), including a child protection policy, effective complaints procedures and procedures that are in accordance with guidance from the local authority and locally agreed inter-agency procedures;
- arrangements to work effectively with other organisations to safeguard and promote the welfare of children, including arrangements for sharing information (see paragraph 2.12); and
- appropriate whistle blowing procedures and a culture that enables issues about safeguarding and promoting the welfare of children to be addressed.

Information sharing

2.12 Effective information sharing underpins integrated working and is a vital element of both early intervention and safeguarding. The cross-government guidance *Information Sharing: Guidance for practitioners and managers* and associated training materials[18] provides advice on when and how frontline practitioners can share information legally and professionally. The guidance also covers how organisations can support practitioners and build their confidence in making information sharing decisions. It is intended for practitioners and managers who have to make decisions about sharing personal information on a case by case basis in all services and sectors, whether they are working with children, young people, adults or families. It is also for those who support these practitioners and managers and for others with

18 See www.dcsf.gov.uk/ecm/informationsharing

responsibility of information governance. It should be read in conjunction with any specific organisational or professional guidance.

2.13 Every Children's Trust Board should assure themselves that all partners consistently apply the Information Sharing Guidance. This should mean that:

- all practitioners are aware of, and have access to, the information sharing guidance and training, and are confident in making decisions about information sharing; and
- the organisational and cultural aspects that are required to embed information sharing have been, or are being, addressed.

2.14 The *Embedding information sharing toolkit*[19] focuses on the organisation and cultural aspects of information sharing. It describes activities that are specifically designed to address the key barriers and drivers of effective information sharing and presents real examples of these activities from local areas.

ContactPoint

2.15 ContactPoint[20] provides a quick way for people working with children to find out who else is working with the same child. It includes basic information[21] about every child in England from birth to their 18th birthday (over 18 in certain circumstances) and contact details for parents or carers and practitioners or other services working with that child. ContactPoint is subject to stringent security controls with access limited only to people with the appropriate training who have undergone security checks and who need to use it professionally.

Common Assessment Framework (CAF)

2.16 The CAF is a tool to enable early and effective assessment of children and young people who need additional services or support from more than one agency. It is a holistic consent-based needs assessment framework which records, in a single place and in a structured and consistent way, every aspect of a child's life, family and environment. National eCAF[22], still being developed, will be a secure IT system for storing and accessing information captured through the CAF process. Practitioners will only be given access to information on national eCAF for a child or young

19 Available at: www.dcsf.gov.uk/ecm/informationsharing
20 Information on ContactPoint is available at: www.dcsf.gov.uk/ecm/Contactpoint
21 The Children Act 2004 Information Database (England) Regulations 2007 available at www.opsi.gov.uk/si/si2007/uksi_20072182_en_1
22 Information on National eCAF is available at: www.dcsf.gov.uk/everychildmatters/strategy/deliveringservices1/caf/ecaf/ecaf/

person with whom they are working and then only with the specific consent of the child or young person (or parent/carer as appropriate).

2.17 The Children's Trust Board should have clear arrangements in place for implementing the CAF locally. This includes ensuring that the whole children and young people's workforce are aware of it and how it is used, and that there are enough people in the local area with the necessary skills, training and support to undertake a CAF. These arrangements should reflect that **the CAF form is not a referral form, although it may be used to support a referral or specialist assessment**. The absence of a CAF should not be a barrier to accessing services.

Local authorities that are children's services authorities

2.18 The safety and welfare of children and young people is the responsibility of the local authority, working in partnership with other public organisations, the private and third sector, and service users and carers. Integrating the delivery of these services at the frontline can help to maximise their effectiveness. An integrated and preferably co-located workforce that includes active partners from the police, health visiting services and other relevant health services, can enable these services to be provided both more effectively and more efficiently. Local authorities should work with partners to ensure that all services are working together effectively at an operational level, for example by meeting regularly to help build and develop positive professional relationships, share information, discuss issues and improve working practices. Local authorities, together with their Children's Trust partners, should look closely at any opportunity to integrate and co-locate services, taking into account specific local needs and circumstances.

2.19 As part of exercising statutory responsibilities, and in order to ensure that specialist services are commissioned effectively, it is important that local authorities work through the Children's Trust Board and wider co-operation arrangements to agree, in consultation with the LSCB:

- governance arrangements and systems to support commissioning of specialist services between relevant partners;
- a strategic approach to understanding needs, including a sophisticated analysis of data and effective engagement with children, young people and families;
- a strategic approach to understanding the effectiveness of current services, and identifying priorities for change – including where services need to be improved, reshaped or developed;
- integrated and effective arrangements for ensuring that priorities for change are delivered through the Children and Young People's Plan by the Children's Trust partners; and

- integrated and effective approaches to understanding the impact of specialist services on outcomes for children, young people and families, and using this understanding to constructively challenge progress and drive further improvement.

2.20 All services that are commissioned and/or delivered by the local authority will have an impact on the lives of children and families, and local authorities have a particular responsibility towards those children and families most at risk of social exclusion.

2.21 Local authorities have responsibilities for ensuring appropriate arrangements to safeguard and promote the welfare of children are in place for all children residing within their area, including:

- children excluded from school/receiving alternative provision;
- home educated children; and
- those placed in custody[23].

2.22 In order to ensure that children are protected from harm, local authorities commission, and may themselves provide a wide range of care and support for:

- adults, who may in turn be parents or carers of children and young people;
- children and families, including those groups whose needs may not be immediately obvious such as disabled children, children involved in gangs, unaccompanied asylum-seeking children and children within the immigration system;
- older people;
- people with physical or learning disabilities;
- people with mental health problems;
- people with substance misuse problems;
- ex-offenders and young offenders, including those in custody and their families;
- families, especially where children have special needs, and/or where children are growing up in special circumstances as set out in the *National Service Framework for Children Young People and Maternity Services*[24] and families experiencing multiple and complex problems;

---

23 The home local authority of a child or young person in custody retains continuing responsibility for safeguarding them and promoting their welfare.

24 www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4089101

- adults and children affected by domestic violence;
- children who need to be looked after by the local authority, through fostering or residential care; and
- children who are placed for adoption.

Local authorities also have a duty under section 17 of the Crime and Disorder Act 1998 to do all they reasonably can to prevent crime and disorder in the exercise of their functions.

2.23 Local authorities have specific duties in respect of children under the Children Acts 1989 and 2004. They have a general duty to safeguard and promote the welfare of children in need in their area and, provided that this is consistent with the child's safety and welfare, to promote the upbringing of such children by their families by providing services appropriate to the child's needs. They should do this in partnership with parents, in a way that is sensitive to the child's race, religion, culture and language and that takes account of the child's wishes and feelings. Services might include childcare for young children, after-school care for school children, counselling, short breaks, family centre services, practical help in the home or targeted parenting and family support.

2.24 Within local authorities, children's social care staff act as the principal point of contact for children about whom there are welfare concerns. They may be contacted directly by children, parents or family members seeking help, by concerned friends and neighbours, or by professionals and others from statutory and voluntary organisations. The need for family support should be considered at the first sign of difficulties, as early support can prevent more serious problems developing. Contact details need to be clearly signposted, including on local authority websites, on notice boards in schools, health centres, public libraries and leisure centres, and in telephone directories. Specific consideration should be given as to how children and young people will be made aware of whom they can contact if they require advice and/or support: this includes children living away from home in educational, health or custodial settings, for example. Good practice in information sharing and processes such as the CAF and the lead professional role should be fully embedded throughout the Children's Trust co-operation arrangements.

2.25 Local authorities, with the help of other organisations as appropriate, also have a duty to make enquiries if they have reason to suspect that a child in their area is suffering, or likely to suffer, significant harm, to enable them to decide whether they should take any action to safeguard and promote the child's welfare (see Chapter 5).

2.26 Where a child or young person is suffering or likely to suffer significant harm, children's social care staff have lead responsibility for undertaking an assessment of the child's needs, the parents' capacity to meet these needs and to keep the child safe and promote his or her welfare, and of the wider family and environmental circumstances. The child's own account of their needs, concerns, the capacity of their parents to protect them and promote their welfare, as well as other factors, should be taken into account as part of the assessment and subsequent interventions.

2.27 A well-supported workforce is essential to the effective and safe delivery of these functions. It is important that local authorities ensure that high quality, experienced social workers undertake key management and supervisory roles in intake/duty teams and receive high quality, specialist training in these roles.

Other local authority roles

Adult social services

2.28 Local authorities are also the lead agency for safeguarding adults. Services do not always neatly divide into those for adults and those for children, and there will be circumstances when adult services can make a contribution to the safeguarding of children, and circumstances when staff in adult services may become aware of risks of harm to children which should be disclosed, and vice versa. There will also be circumstances when safeguarding children and adults can and should be done jointly. For all these reasons children and adult services should be aware of each other's roles and responsibilities, and service and workforce planning should take account of the family and neighbourhood context in which safeguarding work is carried out.

Housing authorities and registered social landlords

2.29 As outlined in the section 11 guidance[25], housing and homelessness staff in local authorities, and others with a front line role such as environmental health officers, can play an important role in safeguarding and promoting the welfare of children as part of their day-to-day work – recognising child welfare issues, sharing information, making referrals and subsequently managing or reducing risks of harm.

2.30 In many areas, local authorities do not directly own and manage housing, having transferred these responsibilities to one or more registered social landlords (RSLs). Housing authorities remain responsible for assessing the needs of families, under homelessness legislation, and for managing nominations to RSLs who provide housing in their area. They continue to have an important role in safeguarding

25 www.everychildmatters.gov.uk/resources-and-practice/IG00042/

children because of their contact with families as part of the assessment of need, and because of the influence they have designing and managing prioritisation, assessment and allocation of housing.

2.31 From 1 April 2010, the Tenant Services Authority (TSA) will regulate the whole social housing sector using its new regulatory framework[26]. The TSA has been consulting tenants and landlords on proposed regulatory standards for social landlords; the final standards will be issued shortly. Under the TSA's proposals, all social housing providers would be expected to understand and respond to the particular needs of their tenants and co-operate with other partners at a local level, including local authorities, to promote social, environmental and economic wellbeing in those areas.

2.32 A number of RSLs across the country provide specialist supported housing schemes specifically for young people at risk and/or young people leaving care and pregnant teenagers. These schemes cater for 16- and 17-year-olds. Housing authorities and children's services should refer to the forthcoming joint DCSF and CLG guidance about their duties under Part III of the Children Act 1989 and Part 7 of the Housing act 1996 to secure or provide accommodation for homeless 16- and 17-year-old children.

Sport, culture and leisure services

2.33 Sport and cultural services designed for children and families – such as libraries, play schemes and play facilities, parks and gardens, sport and leisure centres, events and attractions, museums and arts centres – are directly provided, purchased or grant-aided by local authorities, the commercial sector, and by community and voluntary organisations. Staff, volunteers and contractors who provide these services have various degrees of contact with children who use them, and appropriate arrangements need to be in place. These should include:

- procedures for staff and others to report concerns they may have, about the children they meet, which are in line with *What to do if you're worried a child is being abused*[27] and LSCB procedures, as well as arrangements such as those described above; and
- appropriate codes of practice for staff, particularly sports coaches, such as the codes of practice issued by national governing bodies of sport, the Health and Safety Executive or the local authority.

26 Expected to be published in March 2010
27 www.dcsf.gov.uk/everychildmatters/resources-and-practice/IG00182/

Sports organisations can also seek advice on child protection issues from the Child Protection in Sport Unit (CPSU), while third sector organisations can also seek advice from the Safe Network (see paragraph 2.188).

Youth services

2.34 Youth and community workers (YCWs) have close contact with children and young people and should be alert to signs of abuse and neglect, and know how to act on concerns about a child's welfare. Increasingly, Youth Services form part of targeted rather than universal services and thus are dealing with a higher proportion of vulnerable young people. Local authority youth services (LAYS) should give written instructions, consistent with *What to do if you're worried a child is being abused* and LSCB procedures, on when YCWs should consult colleagues, line managers and other statutory authorities about concerns they may have about a child or young person. The LAYS instructions should emphasise the importance of safeguarding the welfare of children and young people, should make the YCW aware of Working Together guidance and should assist the YCW in balancing the desire to maintain confidentiality between the young person and the YCW and the duty to safeguard and promote the welfare of the young person and others. Volunteers within the youth service are subject to the same requirement.

2.35 Where the local authority commissions local voluntary youth organisations or other providers through grant or contract arrangements, the authority should ensure that proper arrangements to safeguard children and young people are in place (for example, this might form part of the agreement for the grant or contract). The organisations might get advice on how to do so from their national bodies or the LSCB.

Services provided under s114 of the Learning and Skills Act 2000 (The Connexions Service)

2.36 In April 2008 local authorities were given responsibility for Connexions and the ability to decide how best information, advice and guidance services should be delivered. Connexions has a substantial workforce working directly with young people including professionally qualified personal advisers and other delivery staff working under their supervision. Connexions is centred on young people and, as such, safeguarding and promoting the welfare of young people is a primary concern. Connexions staff should take account of and respond to behaviour that is likely to damage the overall wellbeing of young people and should address their welfare and safety needs in a holistic manner.

2.37 Local authorities should ensure that their Connexions service:

- identifies, keeps in touch with and provides the necessary support to young people in their geographical area. The needs of young people from vulnerable groups such as teenage mothers, care leavers, young people supervised by YOTs, young people in custody and young people with learning difficulties and/or disabilities are a particular priority as is ensuring support and planning for young people in custody and their resettlement back into the community;
- identifies young people who may be being abused or neglected and, in these cases, alerts the appropriate authority. Staff should be aware of the agencies and contacts to use to refer young people whom they suspect are suffering harm, and should be aware of the way in which these concerns will be followed up;
- minimises risk to the safety of young people on premises for which they are responsible and maintains the necessary capacity to carry out relevant risk assessments;
- minimises the risk that organisations to which they signpost young people, such as those providing employment and training opportunities, pose a threat to the moral development and physical and psychological wellbeing of young people;
- complies with current vetting regulations in the recruitment of all staff (including volunteers); and
- makes staff aware of risks to the welfare of young people so that they can exercise their legal, ethical, operational and professional obligations to safeguard them from these risks.

2.38 Connexions should work closely with other agencies concerned with child safety and welfare to analyse rigorously the nature and distribution of risk within the cohort of young people, and to use this information to design services, allocate resources and otherwise take action to address both cause and effect.

Health services

General principles for all health services

2.39 The safety and the health of a child are intertwined aspects of their wellbeing. Many 'health' interventions also equip a child to 'stay safe'[28].

2.40 All organisations commissioning or providing healthcare, whether in the NHS or third sector, independent healthcare sector or social enterprises, should ensure there is board level focus on the needs of children and that safeguarding children is an integral part of their governance systems.

28 'Staying safe' is a key outcome of *Every Child Matters*

2.41 All healthcare staff involved in working with children should attend training in safeguarding and promoting the welfare of children, and have regular updates as part of continuing professional development. See Chapter 4 for details of inter-agency training.

Health organisations

The Care Quality Commission and registration requirements

2.42 The Care Quality Commission (CQC) is the independent regulator of safety and quality for all health services. From April 2010, NHS trusts and NHS foundation trusts need to be registered with the CQC[29]. The Commission has a range of statutory independent enforcement actions to use where care does not meet the essential levels of safety and quality that users are entitled to expect.

2.43 GP practices and high street dental practices will be required to register with the CQC, regardless of whether they provide wholly private or wholly NHS services, or a mix of both and will be subject to a consistent set of quality standards. Registration of primary dental care providers will start from 2011 and primary medical care providers from 2012.

2.44 Any enforcement action being considered by the CQC, including possible deregistration, should include, where appropriate, arrangements in partnership with the relevant PCT to re-provide services for children as quickly and safely as possible.

Monitor

2.45 NHS foundation trusts are regulated by Monitor, an independent regulator, which has authority to hold them to account for meeting their responsibilities under the Children Acts. This is unlike NHS trusts, which are overseen by Strategic Health Authorities. However, NHS foundation trusts are assessed by the CQC in the same way as other providers.

Strategic Health Authorities

2.46 SHAs are the regional headquarters of the NHS. Each SHA is responsible for ensuring that patients have access to high-quality services in its area. SHAs oversee the performance of PCTs and NHS trusts and hold PCTs to account, including for safeguarding and promoting the welfare of children. SHAs are themselves directly accountable to the Department of Health and safeguarding is considered by the Department of Health as part of their SHA assurance process.

29 www.cqc.org.uk

2.47 SHAs should consider individual organisations' arrangements for, and contribution to, safeguarding children as an integral part of their governance system. Their performance and management of the healthcare system should be informed by information such as existing national data collections, LSCB audit, progress against action plans and/or child death and Serious Case Review recommendations and regulatory/inspection findings where appropriate. Bespoke local surveys and data gathering should be avoided unless there is a clear business need in order to minimise duplication and burden of reporting.

2.48 SHAs membership of LSCBs (see paragraph 3.70) will enable them to oversee the health contribution to safeguarding children at local level. Further advice on how SHAs should engage with LSCBs is set out in Annex D of the *Local Safeguarding Children Boards: A Review of Progress* report[30].

Primary Care Trust commissioners

2.49 PCTs are responsible for improving the health and wellbeing of their local population, including children and young people. To achieve this, they are under a legal duty to work with the local authority to assess what kind of health services people need.

2.50 PCTs can commission services from a range of different organisations and generally hold the providers of these services to account via contracts. PCTs can ask the regulators to step in if the providers are not meeting the expected standards. PCTs should have a collaborative, multi-agency approach to commissioning and should work with local authorities to commission and provide co-ordinated and, wherever possible, integrated services, in particular through Children's Trust co-operation arrangements.

2.51 PCTs should identify a senior lead for children and young people[31] to ensure that their needs are at the forefront of local planning and service delivery. PCTs should also identify a board executive lead for safeguarding children who takes responsibility for governance, systems and organisational focus on safeguarding children. This might be the same person.

2.52 Designated professionals should work closely with, and be performance managed and supported in their role by, this board executive lead as part of the board lead's portfolio of responsibilities. If this person is not the board level lead for clinical governance and clinical professional leadership, the designated professional will also need to work closely with this lead person (see paragraphs 2.109–2.123).

30 www.dcsf.gov.uk/everychildmatters/_download/?id=3082
31 NSF Core Standards 3 – Markers of good practice

2.53 There should be a named public health professional who addresses issues related to children in need as well as children in need of protection. The Joint Strategic Needs Assessment should include these needs which in turn should inform the Children and Young People's Plan and the LSCB business plan. When considering commissioning services for the health and wellbeing of children in need in their area, PCTs should ensure this includes those who are temporarily resident in the area, such as children held in secure settings.

2.54 PCT Chief Executives have responsibility for ensuring that the health contribution to safeguarding and promoting the welfare of children is discharged effectively across the whole local health economy through the PCTs' commissioning arrangements. PCTs should ensure that all their staff are alert to the need to safeguard and promote the welfare of children. Each PCT is responsible for identifying a senior paediatrician and senior nurse to undertake the role of designated professionals for safeguarding children in commissioning services across the health economy (see paragraphs 2.109–2.123).

2.55 PCTs should ensure that all providers from whom they commission services – including organisations in the public sector, independent sector, third sector and social enterprises – have comprehensive and effective single and multi-agency policies and procedures to safeguard and promote the welfare of children. These should be in line with, and informed by, LSCB procedures, and easily accessible for staff at all levels within each organisation.

2.56 PCTs are expected to ensure that safeguarding and promoting the welfare of children are integral to clinical governance and audit arrangements. Service specifications drawn up by PCT commissioners should include clear service standards for safeguarding and promoting the welfare of children, consistent with LSCB procedures. Section 4A and schedule 11 part 5 of the national contracts provide the means to prescribe the requirements for safeguarding children. By monitoring the service standards of all providers, PCTs will assure themselves that the required safeguarding standards are being met. Where practice-based commissioners undertake commissioning of services, this should be done in partnership with PCTs, who need to ensure their safeguarding duties are fulfilled.

2.57 PCTs should ensure GP practices and staff have robust systems and practices in place to ensure they can fulfil their role in safeguarding and promoting the welfare of children. PCTs will wish to consider how they support GP practices, for instance by assistance with protected time for, and access to, training in child protection.

2.58 PCTs are responsible for planning integrated GP out-of-hours services in their local area, and staff working within these services should know how to access advice from designated and named professionals within the PCT and LSCB. Each GP and

member of the Primary Health Care Team should have access to a copy of the LSCB's procedures.

2.59 PCTs are encouraged to bring together commissioning expertise on sexual violence services, to form a local Sexual Assault Referral Services (SARS) care pathway for children and young people. All SARS for children and young people, including services provided through Sexual Assault Referral Centres (SARCs), should comply with the standards for paediatric forensic medical services *Service Specification for the Clinical Evaluation of Children and Young People who may have been sexually abused* (RCPCH, 2009), the *Children's NSF*[32] and the *You're Welcome quality criteria: Making health services young people friendly*[33]. PCTs should ensure that staff know their local services and be clear about the different agencies' roles and responsibilities, so that they are not hesitant about responding appropriately. *A Resource for Developing Sexual Assault Referral Centres*[34], jointly published by the Department of Health, Home Office and the Association of Chief Police Officers (ACPO) in October 2009, sets out the minimum elements essential for providing high quality SARCs services for adults and children who are victims of sexual assault.

2.60 PCTs must co-operate with the local authority in the establishment and operation of the LSCB and, as partners, must share responsibility for the effective discharge of its functions in safeguarding and promoting the welfare of children. Representation on the Board should be at an appropriate level of seniority. PCTs are also responsible for providing and/or ensuring the availability of appropriate expertise and advice and support to the LSCB, in respect of a range of specialist health functions – for example, primary care, mental health (adult, adolescent and child) and sexual health – and for co-ordinating the health component of Serious Case Reviews (see Chapter 8). They should notify the SHA and the CQC of all Serious Case Reviews. The PCT must also ensure that all health organisations, including those in the third sector, independent healthcare sector and social enterprises with whom they have commissioning arrangements, have links with a specific LSCB and are aware of LSCB policies and procedures. This is particularly important where providers' boundaries/ catchment areas (including Ambulance Trusts and NHS Direct services[35]) are different from those of LSCBs. The PCT should also ensure that health agencies work in partnership in accordance with their agreed LSCB plan, including in secure settings such as Young Offenders Institutions, Secure Children's Homes/Training Centres (where relevant) and Youth Offending Teams in the community.

32 www.dh.gov.uk/en/Healthcare/Children/DH_4089111

33 www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4121564.pdf

34 www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/@sta/@perf/documents/digitalasset/dh_108350.pdf

35 NHS Direct is a national service staffed by nurses and health advisors providing 24 hour health advice and information through a national telephone number (0845 46 47), the NHS Choices website (www.nhs.uk) and a digital TV service

General principles for all provider services

2.61 These principles apply to all NHS health services and health service providers in both the NHS and independent healthcare settings. The aim is to ensure that all children and young people receive appropriate and timely early intervention and therapeutic interventions.

2.62 All health professionals working directly with children and young people should ensure that safeguarding and promoting their welfare forms an integral part of all elements of the care they offer. Other health professionals who come into contact with children, parents and carers in the course of their work also need to be fully informed about their responsibility to safeguard and promote the welfare of children and young people. This is important as even though a health professional may not be working directly with a child, they may be seeing their parent, carer or other significant adult and have knowledge which is relevant to a child's safety and welfare. A National Institute for Health and Clinical Excellence (NICE) clinical guideline, *When to suspect child maltreatment*[36], is a resource to help healthcare practitioners who are not specialists in child protection.

2.63 All health professionals who work with children, young people and families should be able to:

- understand risk factors and recognise children and young people in need of support and/or safeguarding;
- recognise the needs of parents who may need extra help in bringing up their children, and know where to refer for help and use the CAF to access support as appropriate for them;
- recognise the risks of abuse or neglect to an unborn child;
- communicate effectively with children and young people and stay focused on the child's safety and welfare;
- liaise closely with other agencies, including other health professionals, and share information as appropriate;
- assess the needs of children and the capacity of parents/carers to meet their children's needs, including the needs of children who display sexually harmful behaviours;
- plan and respond to the needs of children and their families, particularly those who are vulnerable;

36 www.nice.org.uk/nicemedia/pdf/CG89FullGuideline.pdf

- contribute to child protection conferences, family group conferences and strategy discussions;
- contribute to planning and commissioning support for children who are suffering, or likely to suffer, significant harm, for example, children living in households with domestic violence or parental substance misuse;
- help ensure that children who have been abused or neglected and parents under stress have access to services to support them;
- be alert to the strong links between adult domestic violence and substance misuse and child abuse and recognise when a child is in need of help, services or at potential risk of suffering significant harm;
- where appropriate, play an active part, through the child protection plan, in keeping the child safe;
- as part of generally safeguarding children and young people, provide ongoing promotional and preventative support, through proactive work with children, families and expectant parents; and
- contribute to child death and Serious Case Reviews and implementation of the lessons learned (see Chapters 7 and 8).

2.64 The above should all be undertaken with reference to the core processes set out in this document (summarised in *What to do if you're worried a child is being abused*), *Responding to domestic abuse: A handbook for health professionals*[37], *Improving safety, Reducing Harm: Children, young people and domestic violence; a practical toolkit for front line practitioners*[38] and LSCB procedures. It is essential that all health professionals and their teams have access to advice and support from named and designated child safeguarding professionals, clinical supervision and undertake regular safeguarding training and updating (see paragraphs 2.109–2.123).

2.65 All health professionals working with children will commonly complete CAFs, which should be the responsibility of all concerned with child welfare. This includes GPs, health visitors, school nurses and other community health professionals and should not be dependent on grade or position, but rather on competence and degree of involvement with, and knowledge of, the child or young person.

2.66 The cross-government guidance *Information Sharing: Guidance for practitioners and managers* and associated training materials provides advice on when and how

37 www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4126619.pdf

38 www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_108697

practitioners can share information legally and professionally (see paragraphs 2.12–2.14).

NHS trusts, NHS foundation trusts and PCT provider services

2.67 NHS trusts, NHS foundation trusts and PCT provider services are responsible for providing health services in hospital and community settings. They must co-operate with the local authority in the establishment and operation of the LSCB and, as statutory partners, share responsibility for the effective discharge of its functions in safeguarding and promoting the welfare of children. They should have a board executive lead for safeguarding children who takes responsibility for governance, systems and organisational focus on safeguarding children and works closely with the named health professionals.

2.68 Representation on the LSCB should be at an appropriate level of seniority. A wide range of their staff will come into contact with children and parents in the course of their normal duties. All these staff should be trained in how to safeguard and promote the welfare of children, be alert to potential indicators of abuse or neglect in children, and know how to act on their concerns in line with LSCB procedures.

2.69 All NHS trusts, NHS foundation trusts and PCT provider services should identify a named doctor and a named nurse – and a named midwife where they provide maternity services – for child protection (see paragraph 2.109).

2.70 Staff working in urgent care settings should be able to recognise abuse or neglect and have a thorough knowledge of local procedures for making enquiries to find out whether a child is the subject of a child protection plan. Staff in urgent care settings should also be alert to the need to safeguard the welfare of children when treating parents or carers of children, and be alert to parents and carers who seek medical care from a number of sources in order to conceal the repeated nature of a child's injuries. Specialist paediatric advice should be available at all times to A&E departments and all units where children receive care. If a child – or children from the same household – presents repeatedly, even with slight injuries, in a way that doctors, nurses or other staff find worrying, they should act upon their concerns in accordance with Chapter 5 of this guidance (the key processes are summarised in *What to do if you're worried a child is being abused*). Children and families should be actively and appropriately involved in these processes, unless this could result in an increased risk of harm to the child.

2.71 In most circumstances, the relevant child's GP should be notified of visits by children to all urgent care settings. Children and young people or, where they lack competency, their parents, should be informed about this information sharing; where they object, and clinicians agree that it would not be in their best interests for

information to be shared with their GP (for example, where a young person is seeking contraceptives) then a disclosure should not take place.

2.72 Where the child or young person is not registered with a GP, the appropriate contact in the PCT is to be notified for arranging registration. Consent should be sought from the child, young person or their family, as appropriate, for relevant information to be disclosed to the PCT, health visitor, school nurse or other health professional. It is important to strike an appropriate balance between protecting the confidentiality of individuals and allowing appropriate information sharing between professionals; any decision to share information without seeking consent or to override a refusal to provide consent should therefore only take place when it is in the public interest to do so. Where there is a clear risk either of a child suffering significant harm, or serious harm to an adult, the public interest test will almost certainly be satisfied. There will be other cases where practitioners will be justified in sharing some confidential information in order to make decisions on sharing further information or taking action. In these cases the information shared should be proportionate. All decisions to share or not share information about a child or young person should be fully documented, and information sharing should be explained to the child, young person or family, as appropriate, unless this could increase the risk of harm to the child.

2.73 In addition to the accountability arrangements for NHS foundation trusts set out in paragraph 2.46, NHS foundation trusts are accountable to the PCTs that commission services from them and to their local populations through a board of governors. National standards and the legal framework for the NHS apply to NHS foundation trusts just as they do to other parts of the NHS.

Ambulance trusts and NHS Direct sites

2.74 The staff working in these health services will have access (by phone or in person) to family homes and be involved with individuals in a time of crisis. They may therefore be in a position to identify initial concerns regarding a child's welfare and be able to alert children's social care, the GP or other appropriate health professional in line with locally agreed procedures. Ambulance trusts and NHS Direct sites should have a named professional for safeguarding children (see paragraph 2.109 for more detail). All staff should be aware of local procedures in line with LSCB policies and be appropriately trained.

Independent sector, third sector and social enterprises

2.75 Independent sector, third sector and social enterprise providers contracted to provide NHS services should comply with the requirements in this document with respect to safeguarding and promoting the welfare of children, including the

requirement to notify the local authority of children who are, or are likely to be, accommodated for at least three months (see paragraph 11.30)[39]. This will be included in their contract with the commissioning PCT, and PCTs should ensure that they apply the same standards and requirements as for NHS providers.

2.76 All providers of healthcare, whether operating in the NHS or independently are subject to registration requirements set out under the Health and Social Care Act 2008 and administered by the CQC. Independent, third sector and social enterprise providers should enable access for staff to regular safeguarding training and supervision as appropriate, and should have proportionate coverage of named professionals (see paragraphs 2.109–2.123), and access to designated professionals for complex issues or where concerns may have to be escalated and involve social services. Clinical networks[40] can provide a further opportunity for sharing highly specialised resources across teams and geographical areas and PCTs should facilitate these where appropriate.

GP practices

2.77 The family doctor or general practitioner (GP) is the first point of contact with the health service for most people. Most people are registered with a GP practice and have an ongoing relationship with that practice. In addition to maintaining their own professional skills in safeguarding and promoting the welfare of children, GPs have an important role to play as employers in ensuring staff whom they employ are trained in safeguarding and promoting the welfare of children (see Chapter 4).

Roles of different health services

Universal services

2.78 Universal child and family health services are provided by a range of professionals and their teams working within general practice or other provider organisations. There are many common responsibilities although specific arrangements may be different within community health services to those within general practice. While GPs and other health practitioners have responsibilities to all their patients, children may be particularly vulnerable and their welfare is paramount.

2.79 The Healthy Child Programme[41], 0-5 years and 5-19 years, provides a framework to ensure the promotion of the health and wellbeing of children and young people.

---

39 Section 85, Children Act 1989

40 A Guide to Promote a Shared Understanding of the Benefits of Managed Local Networks (Department of Health, 2005)

41 www.dh.gov.uk/en/Healthcare/Children/Maternity/index.htm

It is delivered by multi-agency support services involved with children and young people.

2.80 As part of the Programme, regular health reviews are undertaken which provide the opportunity to identify risk factors that make children more likely to experience poorer outcomes later in life, including family and environmental factors. This enables professionals to put together a package of support or referral to specialist services to address the issues raised. All professionals need to be alert to concerns and the requirements to safeguard children. More support should be targeted to children and families who are vulnerable or those with complex needs.

2.81 If concerns arise during an assessment that may require support from another agency it will be important for the professionals involved to work in partnership and share relevant information as required, in accordance with the Government's information sharing guidance.

2.82 All professionals delivering universal services have key roles to play both in the identification of children who may have been abused or neglected and those who are likely to be; and in subsequent intervention and protection from harm. Surgery consultations, home visits, treatment room sessions, child health clinic attendance, drop-in centres and information from staff such as health visitors, midwives, children's centre staff, school health team staff and practice nurses may all help to build up a picture of the child's situation and can alert the appropriate professional if there is a concern.

2.83 All professionals delivering primary care should know when it is appropriate to refer a child or young person to children's social care for help as a 'child in need', and know how to act on concerns that a child may be suffering, or likely to suffer, significant harm through abuse or neglect.

2.84 GPs, their staff and community health practitioners such as health visitors and school nurses are also well placed to recognise when a parent or other adult has problems that may affect their capacity as a parent or carer, or that may mean they pose a risk of harm to a child. When GPs and other health professionals have concerns that an adult's illness or behaviour may be causing, or putting a child at risk of, suffering significant harm, they should follow the procedures set out in Chapter 5 of this guidance (summarised in *What to do if you're worried a child is being abused)*.

2.85 GPs, practice staff, and other community health practitioners have an important role in all stages of the child protection process and should have a clear means of identifying in records those children (together with their parents and siblings) who are the subject of a child protection plan. This will enable them to be recognised by

the partners of the practice and any other doctor, nurse or health visitor who may be involved in the care of those children. There should be good communication between GPs, health visitors, school nurses (and the wider School Health Team), practice nurses and midwives in respect of all children and their families about whom there are concerns.

2.86 GPs and other community health practitioners, such as health visitors and school nurses, have key roles in appropriate information sharing with children's social care when enquiries are being made about a child. They will also contribute to assessments and be involved in a child protection plan, as appropriate. GPs, community health practitioners, other primary care professionals and practice staff should make available to child protection conferences relevant information about a child and family, whether or not they are able to attend.

General practitioners

2.87 All GPs have a duty to maintain their skills in the recognition of abuse and neglect, and to be familiar with the procedures to be followed if abuse or neglect is suspected. GPs should take part in training about safeguarding and promoting the welfare of children, and have regular updates as part of their post-graduate educational programme[42].

Health visitors

2.88 The specialist skills of the health visitor are crucially important in protecting children. Health visitors contribute to all stages of the child protection process, including Serious Case Reviews. They support the work of the LSCB through the delivery of multi-agency training programmes and membership of working and task sub-groups.

2.89 Health visitors are trained to recognise risk factors, triggers of concern and signs of abuse and neglect. Through their preventative work, they are frequently the first to recognise children who are being or are likely to be abused or neglected and therefore when safeguarding procedures need to be initiated. Knowledge of the family and their circumstances, as well as the child, probably gathered during home visits, enables the health visitor to recognise signs and symptoms of a worsening environment, lack of progress to improve the child's circumstances, or actual harm being suffered by the child.

2.90 Health visitors must have time to maintain effective contact with the child and family, to establish and develop a successful working relationship so they can

42 Good Medical Practice (GMC). www.gmc-uk.org/GMC_Good_Medical_Practise_1209.pdf_30373048.pdf

consider the situation objectively. Where formal safeguarding procedures are in place, health visitors need ongoing contact with families so that they continue to receive preventative health interventions both during the crisis, and in the future.

2.91 Health visitors should liaise with other professionals and agencies so that a full picture of risk factors and progress is obtained. A recurring theme in Serious Case Reviews has been inadequate sharing of information about vulnerable children. Health visitors should use professional judgement about what, and when, information is shared with others such as children's social care services, police and children's centres.

2.92 Health visitors should also consider the competence of those in their team, guiding them and ensuring they understand their own roles, responsibilities and relevant policies and procedures, as well as the legislative framework for safeguarding and promoting the welfare of children. Health visitors must have access to regular proactive child protection supervision to ensure good practice (see Chapter 4).

School nurses[43]

2.93 School nurses have a crucial role to play in safeguarding. They have regular contact with children aged 5-19 who spend a significant proportion of their time in school and are commonly the lead professional for CAFs. School nurses are educated in child health and development and have a prominent role in delivering the Healthy Child Programme. They have opportunities for periodic, anticipatory health assessments of this group of children as part of universal services. They lead public health actions, implement health education programmes and deliver enhanced services according to assessment of individual or group needs. They may be the first to identify the needs of specific children and instigate preventative interventions, and/or safeguarding procedures.

2.94 In their care and treatment of vulnerable children, school nurses may work with parents or carers, referring to, and liaising with specialists and can be instrumental in securing extra resources or support for families to increase their capacity for appropriate parenting.

2.95 The position of school nurses at the heart of caring about health and wellbeing within the school environment, alongside the personal care they offer, enables them to establish trusting relationships with children so they are the frequent recipient of confidences, which can lead to earlier intervention.

43 Nurses working in schools are often called 'school health advisers' or 'health advisers'

Maternity services

2.96 The Healthy Child Programme starts in pregnancy. Midwives are the primary health professionals likely to be working with and supporting women and their families throughout pregnancy. However, other health professionals – including maternity support workers, health visitors and, where applicable, specialist key workers – may also be directly engaged in providing support. The close relationship they foster with their clients provides an opportunity to observe attitudes towards the developing baby and identify potential problems during pregnancy, birth and the child's early care.

2.97 It is estimated that a third of domestic violence starts or escalates during pregnancy (see paragraphs 11.79–11.92). All health professionals working with pregnant women should understand that vulnerable women are more likely to delay seeking care, to fail to attend antenatal clinics regularly and to deny and minimise abuse. It is important to provide a supportive and enabling environment, where the issue of abuse is raised with every pregnant woman, with the provision of information about specialist agencies, thus enabling disclosure should a woman so choose (Maternity Section Children's NSF, 2004). The Department of Health issued revised guidance, *Responding to Domestic Violence: a Handbook for Health Professionals*[44], in 2006.

Child and Adolescent Mental Health Services (CAMHS)

2.98 Standard 9 of the NSF is devoted to the 'Mental Health and Psychological Wellbeing of Children and Young People'. The importance of effective partnership working is emphasised, and this is especially applicable to children and young people who have mental health problems as a result of abuse and/or neglect. Some forms of emotional distress may, however, fall short of being an identifiable mental health issue. It is also important that the more general need to promote emotional wellbeing among children and young people is not neglected as an essential component of safeguarding.

2.99 In the course of their work, child and adolescent mental health professionals will therefore want to identify as part of assessment and care planning whether child abuse or neglect, or domestic violence, are factors in a child's mental health problems, and ensure that this is addressed appropriately in their treatment and care. If they think a child is currently affected, they should follow local child protection procedures. Consultation, supervision and training resources should be available and accessible in each service (see Chapter 4).

2.100 Child and adolescent mental health professionals have a role in the initial assessment process in circumstances where their specific skills and knowledge are

44 www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/DH_4126161

helpful. In addition, assessment and treatment services may need to be provided to young people with mental health problems or with other emotional difficulties who offend. The assessment of children with significant learning difficulties, a disability or sensory and communication difficulties may require the expertise of a specialist learning disability service or CAMHS.

2.101 CAMHS also have a role in the provision of a range of psychiatric and psychological assessment and treatment services for children and families. Services that may be provided, in liaison with local authority children's social care services, include the provision of reports for court, and direct work with children, parents and families. Services may be provided either within general or specialist multi-disciplinary teams, depending on the severity and complexity of the problem. In addition, consultation and training may be offered to services in the community – including, for example, social care schools, primary healthcare professionals and nurseries.

Adult Mental Health Services

2.102 Adult mental health services – including those providing general adult and community, forensic, psychotherapy, alcohol and substance misuse and learning disability services – have a responsibility in safeguarding children when they become aware of, or identify, a child suffering or likely to suffer significant harm. This may be as a result of a service's direct work with those who may be mentally ill, a parent, a parent-to-be, or a non-related abuser, or in response to a request for the assessment of an adult perceived to represent a potential or actual risk to a child or young person. Adult mental health staff need to be especially aware of the risk of neglect, emotional abuse and domestic abuse to children. Staff should be able to consider the needs of any child in the family of their patient or client and to refer to other services or support for the family as necessary and appropriate, in line with local child protection procedures. Consultation, supervision and training resources should be available and accessible in each service.

2.103 In order to safeguard children of patients, mental health practitioners should routinely record details of patients' responsibilities in relation to children, and consider the support needs of patients who are parents and of their children, in all aspects of their work, using the Care Programme Approach. Mental health practitioners should refer to Royal College of Psychiatrists policy documents, including *Patients as Parents*[45] and *Child Abuse and Neglect: the Role of Mental Health Services*[46] and SCIE Guide 30[47].

45 www.rcpsych.ac.uk/files/pdfversion/cr105.pdf

46 www.rcpsych.ac.uk/files/pdfversion/cr120.pdf

47 Think child, think parent, think family: a guide to parental mental health and child welfare, 2009 SCIE Guide 30. www.scie.org.uk/publications/guides/guide30/index.asp

2.104 Close collaboration and liaison between adult mental health services and children's social care services are essential in the interests of children. It is similarly important that adult mental health liaise with other health providers, such as health visitors and general practitioners. This may require sharing information to safeguard and promote the welfare of children or to protect a child from significant harm. The expertise of substance misuse services and learning disability services may also be required. The assessment of parents with significant learning difficulties, a disability, or sensory and communication difficulties, may require the expertise of a specialist psychiatrist or clinical psychologist from a learning disability service or adult mental health service.

2.105 From April 2010, under section 131A of the Mental Health Act 1983, there is a duty on hospital managers to ensure that if a child or young person under the age of 18 is admitted to hospital for mental health treatment, the environment in the hospital is suitable having regard to their age. Managers of adult services must consult with a person who can provide appropriate advice on CAMHS who would need to be involved in decisions about accommodation, care and facilities for education in hospital.

Visiting of psychiatric patients by children

2.106 All inpatient mental health services must have policies and procedures relating to children visiting inpatients, as set out in the *Guidance on the Visiting of Psychiatric Patients by Children* to NHS trusts[48]. Additional guidance has been provided for high-security hospitals. Mental health practitioners must consider the needs of children whose parent or relative is an inpatient – whether formal or informal – in a mental health unit, and make appropriate arrangements for them to visit if this is in the child's best interests.

Alcohol and drug services

2.107 A range of services are provided, in particular by health and voluntary organisations, to respond to the needs of adults (who may have parental or caring responsibilities) and children who misuse drugs and alcohol. These services are linked to the relevant agencies at local level through Drug Action Teams, which comprise, as a minimum, health, social care, education and police representatives. It is important that arrangements are in place to enable children's social care services and substance misuse (including alcohol) services referrals to be made in relevant cases. Where children may be suffering significant harm because of their own substance misuse, or where parental substance misuse may be causing such harm, referrals need to be made by Drug Action Teams or alcohol services, in accordance with LSCB

48 www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4012658.pdf

procedures. Where children are not suffering significant harm, referral arrangements also need to be in place to enable children's broader needs to be assessed and responded to. Further information can be found in the DCSF/DH Joint Guidance on *Development of Local Protocols between Drug and Alcohol Treatment Services and Local Safeguarding and Family Services*[49].

Health professionals

Designated and named professionals

2.108 The terms 'designated professionals' and 'named professionals' denote professionals with specific roles and responsibilities for safeguarding children. As commissioners, all PCTs should have a designated doctor and nurse to take a strategic, professional lead on all aspects of the health service contribution to safeguarding children across the PCT area, which includes all providers. PCTs should ensure establishment levels of designated and named professionals are proportionate to the local resident populations and to the complexity of provider arrangements. For large PCTs, NHS trusts and foundation trusts which may have a number of sites, a team approach can enhance the ability to provide 24-hour advice and provide mutual support for those carrying out the designated and named professional role. If this approach is taken, it is important to ensure that the leadership and accountability arrangements are clear.

2.109 Designated and named professional roles should always be explicitly defined in job descriptions, and sufficient time, funding, supervision and support should be allowed to fulfil their child safeguarding responsibilities effectively. Further information can be found in the intercollegiate document *Safeguarding Children and Young People: Roles and Competencies for Health Care Staff*[50].

Designated professionals

2.110 Designated professionals are a vital source of professional advice on safeguarding children matters to the PCT, health professionals, particularly named safeguarding health professionals, local authority children's services departments and the LSCB. Appointment as a designated professional may be a full-time role employed as part of the PCT commissioning arm or the person may be employed by a provider organisation with certain time dedicated to the designated role. If the person is not employed by the PCT commissioning arm a clear service level agreement should be in place.

49 www.nta.nhs.uk/publications/documents/yp_drug_alcohol_treatment_protocol_1109.pdf
50 www.rcpch.ac.uk/doc.aspx?id_Resource=1535. This document is currently being updated

2.111 Designated professionals:

- provide advice to ensure the range of services commissioned by the PCT take account of the need to safeguard and promote the welfare of children;
- provide advice on the monitoring of the safeguarding aspects of PCT contracts;
- provide advice, support and clinical supervision to the named professionals in each provider organisation;
- provide skilled advice to the LSCB on health issues;
- play an important role in promoting, influencing and developing relevant training, on both a single and inter-agency basis, to ensure the training needs of health staff are addressed;
- provide skilled professional involvement in child safeguarding processes in line with LSCB procedures; and
- review and evaluate the practice and learning from all involved health professionals and providers commissioned by the PCT, as part of Serious Case Reviews (see paragraph 8.30).

Named professionals

2.112 All NHS trusts, NHS foundation trusts, and public, third sector, independent sector, social enterprises and PCTs providing services for children should identify a named doctor and a named nurse – and a named midwife if the organisation provides maternity services – for safeguarding. In the case of NHS Direct, Ambulance trusts and independent providers, this should be a named professional. The focus for the named professional's role is safeguarding children within their own organisation and they should work closely with the board safeguarding children lead to ensure all services are aware of their responsibilities (see paragraphs 2.61–2.65).

2.113 Named professionals have a key role in promoting good professional practice within their organisation, and provide advice and expertise for fellow professionals. They should have specific expertise in children's health and development, child maltreatment and local arrangements for safeguarding and promoting the welfare of children.

2.114 Named professionals should support the organisation in its clinical governance role, by ensuring that audits on safeguarding are undertaken and that safeguarding issues are part of the Trust's clinical governance system. They also have a key role in ensuring a safeguarding training strategy is in place and is delivered within their organisation.

2.115 Named professionals are usually responsible for conducting the organisation's internal management reviews, except when they have had personal involvement in the case when it will be more appropriate for the designated professional to conduct the review. Named professionals should be of sufficient standing and seniority in the organisation to ensure that the resulting action plan is followed up.

Paediatricians

2.116 Paediatricians, wherever they work, will come into contact with child abuse or neglect in the course of their work. All paediatricians need to maintain their skills in the recognition of abuse, and be familiar with the procedures to be followed if abuse and neglect is suspected. Consultant paediatricians, in particular, may be involved in difficult diagnostic situations, differentiating those where abnormalities may have been caused by abuse from those that have a medical cause. In their contacts with children and families, they should be sensitive to clues suggesting the need for additional support or enquiries.

2.117 Where paediatricians undertake forensic medical examination, they must ensure they are competent to do so, or work together with a colleague, such as a forensic medical examiner, who has the necessary complementary skills[51].

2.118 Paediatricians are sometimes required to provide reports for child protection investigations, civil and criminal proceedings, and to appear as witnesses to give oral evidence. They must always act in accordance with guidance from the General Medical Council (GMC)[52] and professional bodies, ensuring their evidence is accurate. The Academy of Royal Colleges also issued guidance for those undertaking expert witness work in 2005[53].

Dental practitioners and dental care professionals (DCPs)

2.119 Dental practitioners and dental care professionals (dental therapists, dental hygienists, dental nurses, etc.) may see vulnerable children, both within healthcare settings and when undertaking domiciliary visits. They are likely to identify injuries to the head, neck, face, mouth and teeth, as well as potentially identifying other child welfare concerns. From April 2011, primary dental practitioners will be required to register with the CQC and comply with the regulations for safeguarding.

---

51 The core and case-dependent skills required are outlined in detail in Guidance on Paediatric Forensic Examinations in Relation to Possible Child Sexual Abuse (2004), produced by the Royal College of Paediatrics and Child Health and the Association of Forensic Physicians. See: www.rcpch.ac.uk/doc.aspx?id_Resource=1750

52 Acting as an expert witness. See: www.gmc-uk.org/guidance/ethical_guidance/expert_witness_guidance.asp. This guidance also lists other sources of information and advice.

53 *Medical Expert Witness: Guidance from the Academy of Medical Royal Colleges* (2005) www.aomrc.org.uk

2.120 The dental team, irrespective of the healthcare setting in which they work, should therefore be included within the child protection systems and training within the local trust. *Child protection and the Dental Team – an introduction to safeguarding children in dental practice* is available[54] as guidance for all dental practice staff. Dentists should have access to a copy of the LSCB's procedures.

2.121 The dental team should have the knowledge and skills to identify concerns regarding a child's welfare. They should know how to refer to children's social care and who to contact for further advice, including the local named and designated professionals.

Other health professionals

2.122 All other health professionals, including those not specifically covered in the preceding sections, and staff who provide help and support to promote children's health and development should have knowledge of the LSCB procedures and how to contact named professionals for advice and support. They should receive the training and supervision they need to recognise and act on child welfare concerns and to respond to the needs of children.

Criminal justice organisations

The police

2.123 The main roles of the police are to uphold the law, prevent crime and disorder and protect citizens. Children, like all citizens, have the right to the full protection offered by the criminal law. Under section 11 of the Children Act 2004, the police authority and chief officer of police for a police area in England must ensure that their functions are discharged having regard to the need to safeguard and promote the welfare of children. Offences committed against children can be particularly sensitive, and often require the police to work with other organisations, such as children's social care, in the conduct of any investigation.

2.124 The police recognise the fundamental importance of inter-agency working in combating child abuse, as illustrated by well-established arrangements for joint training involving police and social care colleagues. The police also have specialist training in investigating child abuse cases. The second edition of *Investigating Child Abuse and Safeguarding Children* was published by ACPO and the National Police Improvement Agency in 2009[55]. This sets out the investigative doctrine, training courses and terms of reference for police forces' child abuse investigation units (CAIUs).

54 www.cpdt.org.uk/
55 www.npia.police.uk/en/docs/Investigating_Child_Abuse_WEBSITE.pdf

2.125 All police forces have CAIUs and, despite variations in their structures and staffing levels, they normally take primary responsibility for investigating child abuse cases. All CAIUs have access to the national IMPACT Nominal Index (INI) which enables them to quickly check which forces hold information on a particular individual. The INI capability draws on a number of police databases, including child protection, domestic violence, crime, custody and intelligence. Police forces are in the process of migrating to the Police National Database (PND) which will continue to provide and enhance this facility.

2.126 Safeguarding children is not solely the role of CAIU officers – it is a fundamental part of the duties of all police officers. Patrol officers attending domestic violence incidents, for example, should be aware of the effect of such violence on any children normally resident within the household. The police also maintain relevant UK-wide databases such as VISOR – a database for the management of individuals who pose a serious risk of harm to the public[56]. Through the Safeguarding Vulnerable Groups Act 2006, the Government has established a new integrated Vetting and Barring Scheme, regulating all those who work with children (and vulnerable adults), which relies on regularly updated police information. Separate guidance is available to help the police carry out this responsibility, and officers engaged in, for example, community safety partnerships, Drug Action Teams, Multi Agency Risk Assessment Conference (MARAC) and Multi Agency Public Protection Arrangements (MAPPA) must keep in mind the needs of children in their area.

2.127 Children and young people also come into contact with the police as part of the criminal justice process, when arrested or taken to a police station for questioning or when asked to give evidence as a witness. The police have a duty to safeguard and promote the welfare of children in their care/custody at all stages of the process and ensure full compliance with the requirements of the Police and Criminal Evidence Act (PACE). Criminal and youth justice agencies and local authority children's services should have protocols in place to ensure that young people are not detained in police cells overnight and to ensure adequate safeguarding of young people in court settings and during escort to the secure estate.

2.128 The police hold important information about children who may be suffering, or likely to suffer significant harm, as well as those who cause such harm, which they should share with other organisations where this is necessary to protect children for example, the family court. This includes a responsibility to ensure that those officers representing the police at a child protection conference are fully informed about the case, as well as being trained and experienced in risk assessment and the decision-making process. Similarly, they can expect other organisations to share

56 VISOR has been developed jointly between the police and the probation service to assist management of offenders in the community

with them information and intelligence they hold to enable the police to carry out their duties.

2.129 Any evidence gathered by the police or other agencies in criminal investigations may be of use to local authority solicitors who are preparing for civil proceedings to protect the victim. The Crown Prosecution Service (CPS) should be consulted, so that they may decide on the issue of sharing evidence in the best interests of the child and in the interests of justice.

2.130 The police must be notified as soon as possible by local authority children's social care whenever a case referred to them involves a criminal offence committed, or suspected of having been committed, against a child. Other agencies should also consider sharing such information (see paragraphs 5.20 onwards). This does not mean that in all such cases a full investigation is required, or that there will necessarily be any further police involvement. It is important, however, that the police retain the opportunity to be informed and consulted, to ensure all relevant information can be taken into account before a final decision is made.

2.131 LSCBs should have in place a protocol, agreed between the local authority and the police, to guide both organisations in deciding how section 47 enquiries should be conducted and, in particular, the circumstances in which joint enquiries are appropriate.

2.132 In addition to their duty to investigate criminal offences, the police have emergency powers to enter premises and ensure the immediate protection of children believed to be suffering, or likely to suffer, significant harm. In such circumstances, the police should inform the child (if he or she appears competent to understand) and take such steps as are reasonably practicable to ascertain the child's wishes and feelings. Police emergency powers should be used only when necessary, the principle being that, wherever possible, the decision to remove a child from a parent or carer should be made by a court. Home Office Circular 017/2008[57] gives detailed guidance on this.

Probation

2.133 The Probation Service supervises offenders with the aim of reducing re-offending and protecting the public. As part of their main responsibility to supervise offenders in the community, offender managers are in contact with, or supervising, a number of offenders who have been identified as presenting a risk, or potential risk, of harm to children. They also supervise offenders who are parents or carers of children and these children may be at heightened risk of involvement in (or exposure to) criminal or anti-social behaviour and of other poor outcomes. By working with these offenders to change their lifestyles and to enable them to change their behaviour,

57 www.homeoffice.gov.uk/about-us/publications/home-office-circulars/circulars-2008/017-2008/

offender managers safeguard and promote the welfare of offenders' children. In addition, Probation Areas/Trusts provide a direct service to children by:

- providing a statutory victim contact scheme to the victims of violent and sexual offences, including children and young people (where the victim is aged under 17, their parent or guardian is also entitled to services);
- delivering unpaid work requirements to 16- and 17-year-olds;
- fulfilling their role as statutory partner of YOTs; and
- ensuring support for victims, and indirectly children in the family, of convicted perpetrators of domestic abuse participating in accredited domestic abuse programmes.

2.134 Offender managers should also ensure that there is clarity and communication between MAPPA and other risk management processes – for example, in the case of safeguarding children, procedures covering registered sex offenders, domestic abuse management meetings, child protection procedures and procedures for the assessment of people identified as presenting a risk or potential risk of harm to children. See Chapter 12 for further information.

Prisons

2.135 Governors of prisons (or, in the case of contracted prisons, their Directors) also have a duty to make arrangements to ensure that their functions are discharged with regard to the need to safeguard and promote the welfare of children and young people, not least those who have been committed to their custody by the courts.

2.136 In particular, Governors/Directors of women's establishments that have Mother and Baby Units must ensure that staff working on the units are prioritised for child protection training, and that there is always a member of staff on duty in the unit who is proficient in child protection, health and safety and first aid/child resuscitation. Each baby must have a childcare plan, setting out how the best interests of the child will be maintained and promoted during the child's time of residence on the unit.

2.137 Governors/Directors of all prison establishments must have in place arrangements that protect the public from prisoners in their care. This includes having effective processes in place to ensure prisoners are not able to cause harm to the public, particularly children. Restrictions are placed on prisoner communications (visits, telephone and correspondence) that are proportionate to the risk they present. As a response to incidents where prisoners have attempted to 'condition and groom' future victims, all prisoners who have been identified as presenting a continued risk of harm to children are not allowed contact with children, unless a favourable risk

assessment has been undertaken. This assessment takes into consideration information held by the police, probation, prison and children's social care services.

2.138 The wishes and feelings of the child or young person are an important element of the assessment. When seeking the views of the parent or carer (person with parental responsibility) regarding contact, it is important that the child's wishes and feelings are sought. In the letter to the child's parent or carer, it should be emphasised that the child's wishes and feelings should be taken into account. If a child or young person is able to make an informed choice, these wishes and feelings must be given due consideration. Local authority children's social care services will ascertain the views of the child or young person during the home visit.

2.139 Governors should ensure that any staff working directly with the children of offenders are trained in child protection.

The secure estate for children and young people

2.140 The Children Act 1989 applies to children and young people in the secure estate and the local authority continues to have responsibilities towards them in the same way as they do for other children in need. LSCBs will have oversight of the safeguarding arrangements within secure settings in their area.

2.141 The Youth Justice Board (YJB) has a statutory responsibility for the commissioning and purchasing of all secure accommodation for children and young people who are sentenced or remanded by the courts. It does not deliver services directly to young people but is responsible for setting standards for the delivery of those services.

2.142 There are three types of secure accommodation in which a young person can be placed, which together make up the secure estate for children and young people:

- *Young Offender Institutions (YOIs)* – YOIs are facilities run by both the Prison Service and the private sector and accommodate 15 to 17 year olds. Young people serving Detention and Training Orders can be accommodated beyond the age of 17 subject to child protection considerations. The majority of YOIs accommodate male young people, although there are four dedicated female units;

- *Secure Training Centres (STCs)* – STCs are purpose-built centres for young offenders up to the age of 17. STCs can accommodate both male and female young people who are held separately. They are run by private operators under contracts, which set out detailed operational requirements. There are four STCs in England; and

- *Secure Children's Homes (SCHs)* – Most SCHs are run by local authority children's social care. They can also be run by private or voluntary organisations. They accommodate children and young people who are placed there on a secure welfare order for the protection of themselves or others, and for those placed under criminal justice legislation. SCHs are generally used to accommodate young offenders aged 12 to 14, girls up to the age of 16, and 15 to 16 year old boys who are assessed as vulnerable.

2.143 All these establishments have a duty to effectively safeguard and promote the welfare of children and young people, which should include:

- protection of harm from self;
- protection of harm from adults; and
- protection of harm from peers.

Local authorities, LSCBs, YOTs and secure establishments should have agreed protocols setting out how they will work together and share information to safeguard and promote the welfare of children and young people in secure establishments.

2.144 All members of staff working in secure establishments have a duty to promote the welfare of children and young people and ensure that they are safeguarded effectively. In addition, Governors, Directors and senior managers have a duty to ensure that appropriate procedures are in place to enable them to fulfil their safeguarding responsibilities. These procedures should include, but not be limited to, arrangements to respond to:

- child protection allegations;
- incidents of self-harm and suicide; and
- incidents of violence and bullying.

2.145 All staff working within secure establishments should understand their individual safeguarding responsibilities and should receive appropriate training to enable them to fulfil these duties. Appropriate recruitment and selection processes should be in place to ensure staff's suitability to work with children and young people. These procedures should cover any adult working within the establishment, whether or not they are directly employed by the Governor/Director.

Youth Offending Teams

2.146 The principal aim of the youth justice system is to prevent offending by children and young people. YOTs have a key role. YOTs are multi-agency teams that must include

a probation officer, a police officer, a representative of the PCT, someone with experience in education, and someone with experience of social work relating to children. YOTs are responsible for the supervision of children and young people subject to pre-court interventions and statutory court disposals.

2.147 YOTs are well placed to identify those children and young people known to relevant organisations as being most at risk of offending, and to undertake work to prevent them offending. A significant number of the children who are supervised by the YOTs will also be children in need, and some of their needs will require safeguarding. It is necessary, therefore, for there to be clear links between youth justice and local authority children's social care, both at a strategic level and at an operational level for individual children and young people. YOT Management Boards are made up of statutory and other YOT partners at a senior level and provide strategic direction and oversight to YOTs at a local level.

2.148 YOTs, in partnership with these wider statutory partners, have a mutual duty to make effective local arrangements to ensure that their functions are discharged with regard to the need to safeguard and promote the welfare of children known to the youth justice system.

The UK Border Agency

2.149 The primary duties of the UKBA are to maintain a secure border, to detect and prevent border tax fraud, smuggling and immigration crime, and to ensure controlled, fair migration that protects the public and that contributes to economic growth and benefits the country. The UKBA also has a role in granting protection to those who need it according to international conventions and the laws of the UK. It is also required to enforce immigration legislation and this will at times mean removing from the UK persons who have no legal entitlement to remain in the UK, which may include the short-term detention of individuals and families in Immigration Removal Centres.

2.150 The UKBA does not directly provide services to children and young people but it does play a part in identifying and acting upon concerns about the welfare of children with whom it comes into contact. Under section 55 of the Borders, Citizenship and Immigration Act 2009 the UKBA has a duty to ensure that its functions are discharged with regard to the need to safeguard and promote the welfare of children. Its main contributions to safeguarding and promoting the welfare of children include:

- ensuring good treatment and good interactions with children throughout the immigration, detention (where appropriate) and customs process;

- applying laws and policies that prevent the exploitation of children throughout and following facilitated illegal entry and trafficking; and
- detecting at the border any material linked to child exploitation through pornography.

2.151 Other elements of the UKBA's contribution include:

- exercising vigilance when dealing with children with whom staff come into contact and identifying children who may be likely to suffer harm; and
- making timely and appropriate referrals to agencies that provide ongoing care and support to children.

2.152 The UKBA makes referrals to the statutory agencies responsible for child protection or child welfare such as the police or local authority children's social care services. Wherever it is appropriate the UKBA will seek to establish national, regional and local protocols for joint working with these bodies.

The UKBA and trafficking of persons, including children

2.153 Since 1 April 2009, the UK has been bound by the Council of Europe Convention on Action against Trafficking in Human Beings. All UKBA staff at operational and case working grades complete training on how to identify potential victims of trafficking, and this includes specific sections on the features of child trafficking. Where a child is identified as vulnerable as a result of a suspicion of trafficking, details of the case are referred simultaneously to the relevant local authority and to specially trained 'competent authority' teams based in the UKBA and the UK Human Trafficking Centre.

2.154 These 'competent authority' teams consider all relevant information, including any provided by local authority children social care services, in determining whether a case meets the thresholds for trafficking set out in the Convention. A positive decision will lead to an extendable 45-day reflection period during which the victim will have access to support and will not be removed from the UK. Following this they may be eligible for a residence permit under current immigration policy. This is a significant safeguarding role for all UKBA staff and a major contribution by the Agency to the wider safeguarding of children.

Schools and further education institutions

2.155 Schools (including independent schools and non-maintained special schools) and FE institutions should give effect to their duty to safeguard and promote the welfare of their pupils (students under 18 years of age in the case of FE institutions) under

the Education Act 2002 and, where appropriate, under the Children Act 1989 (see paragraph 2.5) by:

- creating and maintaining a safe learning environment for children and young people; and
- identifying where there are child welfare concerns and taking action to address them, in partnership with other organisations where appropriate.

Schools also contribute through the curriculum by developing children's understanding, awareness and resilience. Ofsted inspect against the extent to which schools and colleges fulfil their safeguarding responsibilities. In Schools and FE colleges, how effectively the safeguarding of learners is promoted, is a limiting grade on overall effectiveness.

2.156 Creating a safe learning environment means having effective arrangements in place to address a range of issues. These include child protection arrangements, pupil health and safety, and bullying (including cyberbullying). Others include arrangements for meeting the health needs of children with medical conditions, providing first aid, school security, tackling drugs and substance misuse, having arrangements in place to safeguard and promote the welfare of children on extended vocational placements and ensuring support and planning for young people in custody and their resettlement back into the community.

2.157 Education staff have a crucial role to play in helping identify welfare concerns, and indicators of possible abuse or neglect, at an early stage. They should refer those concerns to the appropriate organisation, normally local authority children's social care, contributing to the assessment of a child's needs and, where appropriate, to ongoing action to meet those needs. When a child has special educational needs or is disabled, the school will have important information about the child's level of understanding and the most effective means of communicating with the child. The school will also be well placed to give a view on the impact of treatment or intervention on the child's care or behaviour. As the numbers of 14-16s in FE colleges for at least part of the week has increased, staff in this sector will need to be part of the arrangements for providing support for their role on safeguarding.

2.158 In addition to the features common to organisations working with children listed in paragraph 2.11, schools and FE institutions should have a senior member of staff who is designated to take lead responsibility for dealing with child protection issues, providing advice and support to other staff, liaising with the authority, and working with other organisations as necessary. A school or FE institution should remedy without delay any deficiencies or weaknesses in its arrangements for safeguarding and promoting welfare that are brought to its attention.

2.159 Staff in schools and FE institutions should not themselves investigate possible abuse or neglect. They have a key role to play by referring concerns about those issues to local authority children's social care, providing information for police investigations and/or enquiries under section 47 of the Children Act 1989, and by contributing to assessments.

2.160 Where a child of school age, including those attending FE institutions, is the subject of an inter-agency child protection plan, the school or FE institution should be involved in the preparation of the plan. The school's role and responsibilities in contributing to actions to safeguard the child, and promote his or her welfare, should be clearly identified.

2.161 Special schools, including non-maintained special schools and independent schools, that provide medical and/or nursing care should ensure that their medical and nursing staff have appropriate training and access to advice on child protection and on safeguarding and promoting the welfare of children.

2.162 Schools play an important role in making children and young people aware both of behaviour towards them that is not acceptable, and of how they can help keep themselves safe. The non-statutory framework for personal, social and health education (PSHE) provides opportunities for children and young people to learn about keeping safe. For example, pupils should be given information about:

- the availability of advice and support in their local area and online;
- recognising and managing risks in different situations, including on the internet, and then deciding how to respond;
- judging what kind of physical contact is acceptable and unacceptable; and
- recognising when pressure from others (including people they know) threatens their personal safety and wellbeing and develop effective ways of resisting pressure.

2.163 PSHE curriculum materials provide resources that enable schools to tackle issues regarding healthy relationships, including domestic violence, bullying and abuse. Discussions about personal safety and keeping safe can reinforce the message that any kind of violence is unacceptable, let children and young people know that it is acceptable to talk about their own problems, and signpost sources of help.

2.164 Corporal punishment is outlawed for all pupils in all schools, including independent schools, and FE institutions. The law forbids a teacher or other member of staff from using any degree of physical contact that is deliberately intended to punish a pupil, or that is primarily intended to cause pain or injury or humiliation.

2.165 Teachers at a school are allowed to use reasonable force to control or restrain pupils under certain circumstances. Other staff may also do so, in the same way as teachers, provided they have been authorised by the head teacher to have control or charge of pupils. All schools should have a policy about the use of force to control or restrain pupils. See *The Use of Force to Control or Restrain Pupils*[58] for further guidance.

Early years services

2.166 Early years services – children's centres, nurseries, childminders, preschools, playgroups, and holiday and out-of-school schemes – all play an important part in the lives of large numbers of children. Many childcare providers have considerable experience of working with families where a child needs to be safeguarded from harm, and many local authorities provide, commission or sponsor specific services, including childminders, to work with children in need and their families.

2.167 All early years providers, regardless of type, size or funding of the setting, must:

- take necessary steps to safeguard and promote the welfare of children;
- promote the good health of children, take necessary steps to prevent the spread of infection, and take appropriate action when they are ill;
- manage children's behaviour effectively and in a manner appropriately for their stage of development and particular individual needs; and
- ensure that adults looking after children, or having unsupervised access to them, are suitable to do so.

2.168 These general welfare requirements are set out in detail in the *Statutory Framework for the Early Years Foundation Stage (EYFS)*[59].

2.169 Millions of families use early years services on an annual basis, meaning that early years services are a key route through which welfare concerns can be identified early in a child's life. The EYFS makes clear that all registered providers, excepting childminders, must have a practitioner who is designated to take lead responsibility for safeguarding children within each early years setting and who should liaise with local statutory children's services agencies as appropriate. This lead must also attend a child protection course. In addition, all early years settings must implement an effective safeguarding children policy and procedure.

2.170 It is expected that every person working in the early years sector should have an up-to-date knowledge of safeguarding children issues and be able to implement

58 www.teachernet.gov.uk/_doc/12187/ACFD89B.pdf
59 Available at: http://nationalstrategies.standards.dcsf.gov.uk/earlyyears

their setting's safeguarding children policy and procedures appropriately. These policies should be in line with LSCB guidance and procedures.

2.171 The EYFS also makes clear that registered early years providers should follow the guidance *What to do if you're worried a child is being abused*. Such providers must notify local child protection agencies of any suspected child abuse or neglect in line with LSCB local guidance and procedures.

Children and Family Court Advisory and Support Service (Cafcass)

2.172 Cafcass's functions are to:

- safeguard and promote the welfare of children who are the subject of family proceedings;
- give advice to any court about any application made to it in such proceedings;
- make provision for children to be represented in such proceedings;
- provide information, advice and other support for children and their families; and
- assess risk.

2.173 Cafcass Officers have different roles in private and public law proceedings. These roles are denoted by different titles:

- Children's Guardians, who are appointed to safeguard the interests of a child who is the subject of specified proceedings under the Children Act 1989, or who is the subject of adoption proceedings;
- Parental Order Reporters, who are appointed to investigate and report to the court on circumstances relevant under the Human Fertilisation and Embryology Act 1990; and
- Children and Family Reporters, who prepare welfare reports for the court in relation to applications under section 8 of the Children Act 1989 (private law proceedings, including applications for residence and contact). Increasingly they also work with families at the stage of their initial application to the court.

Cafcass Officers can also be appointed to provide support under a Family Assistance Order under the Children Act 1989 (local authority officers can also be appointed for this purpose).

2.174 The Cafcass Officer has a statutory right in public law cases to access and take copies of local authority records relating to the child concerned and any application under the Children Act 1989. That power also extends to other records that relate to the

child and the wider functions of the local authority, or records held by an authorised body (for example, the NSPCC) that relate to that child.

2.175 Where a Cafcass Officer has been appointed by the court as Children's Guardian and the matter before the court relates to specified proceedings (specified proceedings include public law proceedings; applications for contact; residence, specific issue and prohibited steps orders that have become particularly difficult can also be specified proceedings) they should be invited to all formal planning meetings convened by the local authority in respect of the child. This includes statutory reviews of children who are accommodated or looked after, child protection conferences, and relevant Adoption Panel meetings. The conference chair should ensure that all those attending such meetings, including the child and any family members, understand the role of the Cafcass Officer.

The armed services

2.176 Young people under 18 may be in the armed forces as recruits or trainees, or may be dependants of a service family. The life of a service family differs in many respects from that of a family in civilian life, particularly for those stationed overseas, or on bases and garrisons in the UK. The services support the movement of the family in response to service commitments. The frequency and location of such moves make it essential that the service authorities are aware of any concerns regarding safeguarding and promoting the welfare of a child from a military family. The armed forces are fully committed to co-operating with statutory and other agencies in supporting families in this situation, and have procedures to help safeguard and promote the welfare of children. In areas of high concentration of service families, the armed forces seek particularly to work alongside local authority children's social care, including through representation on LSCBs and at child protection conferences and reviews.

2.177 Looking after under-18s in the armed forces comes under the MoD's comprehensive welfare arrangements, which apply to all members of the armed forces. Commanding Officers are well aware of the particular welfare needs of younger recruits and trainees and, as stated above, are fully committed to co-operating with statutory and other agencies in safeguarding and promoting the welfare of under-18s. Local authority children's social care already has a responsibility to monitor the wellbeing of care leavers, and those joining the armed forces should have unrestricted access to local authority social care workers.

2.178 Local authorities have the statutory responsibility for safeguarding and promoting the welfare of the children of service families in the UK. All three services provide professional welfare support, including 'special to type' social work services to augment those provided by local authorities. In the Royal Navy (RN) this is provided

by the Naval Personal and Family Service (NPFS) and the Royal Marines Welfare Service; within the army this is provided by the Army Welfare Service (AWS); and in the Royal Air Force by the Soldiers Sailors Airmen and Families Association-Forces Help (SSAFA-FH). Further details of these services and contact numbers are given in Appendix 4.

2.179 When service families or civilians working with the armed forces are based overseas, the responsibility for safeguarding and promoting the welfare of their children is vested with the MoD, who fund the British Forces Social Work Service (Overseas). This service is contracted to SSAFA-FH, who provide a fully qualified Social Work and Community Health service in major overseas locations (for example, in Germany and Cyprus). Instructions for the protection of children overseas, which reflect the principles of the Children Act 2004 and the philosophy of inter-agency co-operation, are issued by the MoD as a Joint Service Publication (JSP) 834 *Safeguarding Children*. Larger overseas commands issue local child protection procedures, hold a Command list of children who are the subject of a child protection plan and have a Command Safeguarding Children Board, which operates in a similar way to those set up under this guidance, in upholding standards and making sure that best practice is reflected in procedures and observed in practice.

Movement of children between the United Kingdom and Overseas

2.180 Local authorities should ensure that SSAFA-FH, the British Forces Social Work Service (Overseas), or the NPFS for RN families is made aware of any service child who is the subject of a child protection plan and whose family is about to move overseas. In the interests of the child, SSAFA-FH, the British Forces Social Work Service (Overseas) or NPFS can confirm that appropriate resources exist in the proposed location to meet identified needs. Full documentation should be provided and forwarded to the relevant overseas command. All referrals should be made to the Director of Social Work, HQ SSAFA FH or Area Officer, NPFS (East) as appropriate, at the addresses given in Appendix 4. Comprehensive reciprocal arrangements exist for the referral of child protection cases to appropriate UK authorities, relating to the temporary or permanent relocation of such children to the UK from overseas.

United States Forces stationed in the United Kingdom

2.181 Each local authority with a United States (US) base in its area should establish liaison arrangements with the base commander and relevant staff. The requirements of English child welfare legislation should be explained clearly to the US authorities, so that local authorities can fulfil their statutory duties.

Enquiries about children of ex-service families

2.182 Where a local authority believes that a child who is the subject of current child protection processes is from an ex-service family, NPFS, AWS or SSAFA-FH can be contacted to establish whether there is existing information that might help with enquiries. Such enquiries should be addressed to NPFS, AWS or the Director of Social Work, SSAFA-FH, at the address given in Appendix 4.

The voluntary and private sectors

2.183 Voluntary organisations, both local and national, and private sector providers play an important role in delivering services for children and young people, including in early years provision, family support services, youth work and children's social care and healthcare. Many voluntary organisations are skilled in preventative work and may be well placed to reach the most vulnerable children, young people and families. The vast majority work in partnership and will play an important part in protecting and supporting a child and their family.

2.184 Voluntary organisations offer, for example:

- therapeutic work with children, young people and families, particularly in relation to child sexual abuse;
- specialist support and services for children and young people with disabilities or health problems;
- services for children and young people who are being sexually exploited and for children who abuse other children; and
- advocacy for looked after children and young people, and for parents and children who are the subject of section 47 enquiries and child protection conferences.

2.185 Voluntary organisations play a key role in providing information and resources to the wider public about the needs of children and young people, and resources to help families. Many campaign on specific issues on behalf of groups.

2.186 The NSPCC is the only voluntary organisation authorised to initiate proceedings to protect children under the terms of the Children Act 1989 and offers a number of services to children, adults and practitioners. It operates a helpline service advising adults and professionals on safeguarding matters and where necessary liaises with local statutory agencies to refer children at risk of abuse. The NSPCC also operates ChildLine which provides a telephone helpline across the UK for all children and young people who need advice about abuse, bullying, and other concerns. These services, along with other helplines such as Stop it Now! (which specialises in child

sexual abuse prevention) and Parentline Plus (which offers support to anyone parenting a child), provide information, advice and support as well as important routes into statutory and voluntary services.

2.187 The voluntary sector is active in working to safeguard the children and young people with whom it works. A range of umbrella and specialist organisations, including the national governing bodies for sports, offer standards, guidance, training and advice for voluntary organisations on keeping children and young people safe from harm. In conjunction with other bodies, the NSPCC provides child protection advice; for example the Child Protection in Sport Unit, established in partnership with Sport England, provides advice and assistance on developing codes of practice and child protection procedures to sporting organisations. The Safe Network, jointly managed by the NSPCC and Children England, provides advice for the third sector and is working to create safeguarding standards for voluntary/non-profit sector organisations.

2.188 Organisations in the voluntary and private sectors that work with children need to have the arrangements described in paragraph 2.11 in place in the same way as organisations in the public sector, and need to work effectively with LSCBs. Paid and volunteer staff need to be aware of their responsibilities for safeguarding and promoting the welfare of children, and of how they should respond to child protection concerns in line with this guidance (see *What to do if you're worried a child is being abused*). There should be clear and published local guidance for the voluntary sector on access pathways to services and how thresholds are applied when making a referral to social care.

Faith communities

2.189 Churches, other places of worship and faith-based organisations provide a wide range of activities for children and young people. They are some of the largest providers of children and youth work, and have an important role in safeguarding children and supporting families. Religious leaders, staff and volunteers who provide services in places of worship and in faith-based organisations will have various degrees of contact with children.

2.190 Like other organisations that work with children, churches, other places of worship and faith-based organisations need to have appropriate arrangements in place for safeguarding and promoting the welfare of children, as described in paragraph 2.11. In particular, these arrangements should include:

- procedures for staff and others to report concerns that they may have about the children they meet that are in line with *What to do if you're worried a child is being*

abused and LSCB procedures, as well as arrangements such as those described above;

- appropriate codes of practice for staff, particularly those working directly with children, such as those issued by the Churches' Child Protection Advisory Service (CCPAS), the Catholic Safeguarding Advisory Service (CSAS) or other denomination or faith groups; and
- recruitment procedures in accordance with safer recruitment guidance[60] and LSCB procedures, alongside training and supervision of staff (paid or voluntary).

2.191 Where the police or local authority children's social care services wish to contact specific faith communities they should make contact with the relevant organisation listed at appendix 6, who will assist in speaking to the appropriate person.

Specific considerations

2.192 As appropriate, churches, other places of worship and faith organisations should report all allegations against people who work with children to the local authority Designated Officer (LADO), and notify the Independent Safeguarding Authority (ISA) of any relevant information so that those who pose a risk to vulnerable groups can be identified and barred. In addition where they are a charity all serious incidents need reporting to the Charity Commission.

2.193 It is essential that faith communities have in place effective arrangements for working with sexual and violent offenders who wish to worship and be part of their religious community. This should include a contract of behaviour stipulating the boundaries an offender would be expected to keep. Faith communities should consult the MAPPA Guidance (2009) issued by the National Offender Management Service Public Protection Unit which specifically addresses 'Offenders and Worship'. Other resources are briefly outlined in appendix 6.

60 Recruiting safely: Safer recruitment guidance helping to keep children and young people safe and associated materials. www.cwdcouncil.org.uk/safeguarding/safer-recruitment/resources

Chapter 3 – Local Safeguarding Children Boards

3.1 Safeguarding and promoting the welfare of children requires effective co-ordination in every local area. The Children Act 2004 required each local authority to establish a Local Safeguarding Children Board (LSCB) by 1 April 2006.

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

LSCB role

Objectives of the LSCB

3.3 The functions of an LSCB are set out in primary legislation[61] and regulations[62]. The core objectives of the LSCB are as follows:

a. to co-ordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area of the authority; and

b. to ensure the effectiveness of what is done by each such person or body for that purpose.

3.4 As explained in Chapter 1, safeguarding and promoting the welfare of children is defined for the purposes of this guidance as:

- protecting children from maltreatment;
- preventing impairment of children's health or development;
- ensuring that children are growing up in circumstances consistent with the provision of safe and effective care;

and undertaking that role so as to enable those children to have optimum life chances and enter adulthood successfully.

61 Sections 14 and 14 A of the Children Act 2004.
62 Local Safeguarding Children Regulations 2006, SI 2006/90.

3.5 The LSCB will therefore ensure that the duty to safeguard and promote the welfare of children is carried out in such a way as to contribute to improving all five *Every Child Matters* outcomes.

3.6 Safeguarding and promoting the welfare of children includes protecting children from harm. Ensuring that work to protect children is properly co-ordinated and effective remains a primary goal of LSCBs. When this core business is secure, however, LSCBs should go beyond it to work to their wider remit, which includes preventative work to avoid harm being suffered. This will help ensure a long-term impact on the safety of children.

Scope of the LSCB

3.7 The scope of the LSCB includes safeguarding and promoting the welfare of children in three broad areas of activity.

3.8 First, activity that affects all children and aims to identify and prevent maltreatment, or impairment of health or development, and ensure children are growing up in circumstances consistent with safe and effective care. For example:

- mechanisms to identify abuse and neglect wherever they may occur;
- work to increase understanding of safeguarding children issues in the professional and wider community, promoting the message that safeguarding is everybody's responsibility;
- work to ensure that organisations working or in contact with children, operate recruitment and human resources practices that take account of the need to safeguard and promote the welfare of children;
- monitoring the effectiveness of organisations' implementation of their duties under section 11 of the Children Act 2004;
- ensuring children know who they can contact when they have concerns about their own or others' safety and welfare;
- ensuring that adults (including those who are harming children) know who they can contact if they have a concern about a child or young person;
- work to prevent accidents and other injures and, where possible, deaths; and
- work to prevent and respond effectively to bullying.

3.9 Second, proactive work that aims to target particular groups. For example:

- developing/evaluating thresholds and procedures for work with children and families where a child has been identified as 'in need' under the Children Act 1989, but where the child is not suffering or likely to suffer significant harm; and
- work to safeguard and promote the welfare of groups of children who are potentially more vulnerable than the general population, for example children living away from home, children who have run away from home, children missing from school or childcare, children in the youth justice system, including custody, disabled children and children and young people affected by gangs.

3.10 Thirdly, responsive work to protect children who are suffering, or are likely to suffer significant harm, including:

- children abused and neglected within families, including those harmed:
  - in the context of domestic violence; and
  - as a consequence of the impact of substance misuse, or of parental mental ill health;
- children abused outside families by adults known to them;
- children abused and neglected by professional carers, within institutional settings, or anywhere else where children are cared for away from home;
- children abused by strangers;
- children abused by other young people;
- young perpetrators of abuse;
- children abused through sexual exploitation; and
- young victims of crime.

3.11 Where particular children are the subject of interventions then that safeguarding work should aim to help them to achieve the planned developmental outcomes (see paragraphs 5.128–5.135) and to have optimum life chances. It is within the remit of LSCBs to check the extent to which this has been achieved as part of their monitoring and evaluation work.

LSCB functions

3.12 The core functions of an LSCB are set out in primary legislation and regulations. This guidance gives further detail on what is required as well as examples of how the

functions can be carried out. In all their activities, LSCBs should take account of the need to promote equality of opportunity and to meet the diverse needs of children.

Thresholds, policies and procedures function

3.13 This general function has a number of specific applications set out in primary legislation and regulations.

a) Developing policies and procedures for safeguarding and promoting the welfare of children in the area of the authority, including policies and procedures in relation to:

i) The action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention

3.14 This includes concerns under both section 17 and section 47 of the Children Act 1989. It may mean for example:

- setting out thresholds for referrals to children's social care of children who may be in need, and processes for robust multi-agency assessment of children in need;
- agreeing inter-agency procedures for section 47 enquiries and developing local protocols on key issues of concern such as:
  - children abused through sexual exploitation;
  - children living with domestic violence, substance abuse, or parental mental ill health;
  - female genital mutilation;
  - forced marriage;
  - children missing from school;
  - children who may have been trafficked; and
  - safeguarding looked after children who are away from home.
- setting out how section 47 enquiries and associated police investigations should be conducted, and in particular, in what circumstances joint enquiries are necessary and/or appropriate.

3.15 Chapter 5 includes some further key points on which LSCBs should ensure that they have policies and procedures in place.

3.16 Clear thresholds and processes and a common understanding of them across local partners should help ensure that appropriate referrals are made and improve the

effectiveness of joint work, leading to a more efficient use of resources. In developing these thresholds and processes the LSCB should work with the Children's Trust Board.

3.17 The Children's Trust Board working with the LSCB should ensure that the local arrangements for undertaking a common assessment are clear about when it is appropriate to use the Common Assessment Framework (CAF) and when it is appropriate to refer a possible child in need to children's social care services:

ii) Training of persons who work with children or in services affecting the safety and welfare of children

3.18 It is the responsibility of the LSCB to ensure that single agency and inter-agency training on safeguarding and promoting welfare is provided in order to meet local needs. This covers both the training provided by single agencies to their own staff, and multi-agency training where staff from more than one agency train together.

3.19 LSCBs may decide to carry out their function by taking a view as to the priorities for inter-agency and single-agency child protection training in the local area and feeding those priorities into the local workforce strategy. LSCBs will also want to evaluate the quality of this training, ensuring that relevant training is provided by individual organisations, and checking that the training is reaching the relevant staff within organisations.

3.20 In some areas it may be decided that the LSCB should also organise or deliver inter-agency training. As explained in Chapter 4, this is not part of the core requirement for LSCBs.

iii) Recruitment and supervision of persons who work with children

3.21 For example, by establishing effective policies and procedures, based on national guidance, for checking the suitability of people applying for work with children and ensuring that the children's workforce is properly supervised, with any concerns acted on appropriately. LSCBs should ensure that robust quality assurance processes are in place to monitor compliance by relevant agencies within their area with requirements to support safe practices. These processes should include audits of vetting practice and sampling of compliance with checks with Criminal Records Bureau and, once it is introduced, Independent Safeguarding Authority registration.

iv) Investigation of allegations concerning persons working with children

3.22 For example policies and procedures, based on national guidance (see paragraphs 6.32 to 6.42 and Appendix 5), to ensure that allegations are dealt with properly and quickly.

v) Safety and welfare of children who are privately fostered

3.23 For example, by ensuring the co-ordination and effective implementation of measures designed to strengthen private fostering notification arrangements including: raising awareness of private fostering across partner agencies, third sector organisations and commissioned services; ensuring that relevant training practices are developed and followed up at multi-agency level; reviewing and responding to the findings of the annual private fostering report submitted by the local authority to the Chair of the LSCB; acting upon the findings of Ofsted inspections and research evidence on effective practice; providing effective leadership and challenge in this area; and reporting on private fostering in their own annual report as appropriate.

3.24 The requirements and expectations of local authorities are set out in amendments to the Children Act 1989 made by section 44 of the Children Act 2004, the Children (Private Arrangements for Fostering) Regulations 2005, and National Minimum Standards for private fostering.

vi) Co-operation with neighbouring children's services authorities (i.e. local authorities) and their Board partners

3.25 For example, by establishing procedures to safeguard and promote the welfare of children who move between local authority areas, including as a result of out of area placements, in line with the requirements in Chapters 5, 7 and 8. This might include harmonising procedures, where appropriate, to bring coherence to liaison with an organisation (such as a police force) which spans more than one LSCB area. This could be relevant to geographically mobile families such as: asylum seeking children, traveller children, children in migrant families and children of families in temporary accommodation.

Other policies and procedures

3.26 LSCBs should consider the need for other local protocols under this function, beyond those specifically set out in regulations, including:

- quick and straightforward means of resolving professional differences of view in a specific case, for example, on whether a child protection conference should be convened;
- attendance at child protection conferences, including quora;
- attendance at family group conferences;
- involving children and family members in child protection conferences, the role of advocates, criteria for excluding parents in exceptional circumstances;

- a decision-making process for the need for a child protection plan based upon the views of the agencies present at the child protection conference;
- handling complaints from families about the functioning of child protection conferences; and
- a procedure for handling complaints regarding requests to share information.

Communicating and raising awareness function

b) Communicating to persons and bodies in the area of the authority the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done, and encouraging them to do so

3.27 For example, by contributing to public campaigns to raise awareness in the wider community, including faith and minority communities and among statutory and independent agencies, including employers, about how everybody can contribute to safeguarding and promoting the welfare of children. This should involve listening to and consulting children and young people and ensuring that their views and opinions are taken into account in planning and delivering safeguarding and promoting welfare services.

Monitoring and evaluation function

c) Monitor and evaluate the effectiveness of what is done by the local authority and Board partners individually and collectively to safeguard and promote the welfare of children and advise them on ways to improve

3.28 The LSCB has a key role in achieving high standards in safeguarding and promoting welfare, not just through co-ordinating but by evaluation and continuous improvement. For example, by asking individual organisations to self-evaluate under an agreed framework of benchmarks or indicators and then sharing results with the Board. It might also involve leading multi-agency arrangements to contribute to self-evaluation reports.

3.29 To evaluate multi-agency working the LSCB could perform joint audits of case files, looking at the involvement of the different agencies, and identifying the quality of practice and lessons to be learned in terms of both multi-agency and multi-disciplinary practice.

3.30 The LSCB should have a particular focus on ensuring that those key people and organisations that have a duty under section 11 of the Children Act 2004 or section 175 or 157 of the Education Act 2002 are fulfilling their statutory obligations about safeguarding and promoting the welfare of children.

3.31 LSCBs should ensure appropriate links with any secure setting in its area and be able to scrutinise restraint techniques, the policies and protocols which surround the use of restraint, and incidences and injuries. LSCBs with a secure establishment(s) in its areas should report annually to the Youth Justice Board on how effectively the establishment(s) is managing use of restraint. LSCBs should report more frequently if there are concerns on the use of restraint. Consideration should be given to sharing the information with relevant inspectorates (HMIP and Ofsted). Where appropriate, members of LSCBs (with secure establishments in its area) should be given demonstrations in the techniques accredited for use to assist their consideration of any child protection or safeguarding issue that might arise in relation to restraint. See paragraph 2.141 for more detail about the role of the secure estate.

3.32 All incidents when restraint is used in custodial settings and which results in an injury to a young person should be notified to, and subsequent action monitored by, the LSCB.

3.33 The function of an LSCB also includes advising the local authority and Board partners on ways to improve. The LSCB might do this by making recommendations (such as the need for further resources), by helping organisations to develop new procedures, by spreading best practice, by bringing together expertise in different bodies, or by supporting capacity building and training. Where there are concerns about the work of partners and these cannot be addressed locally, the LSCB should raise these concerns with others, as explained further in paragraph 3.109.

d) Produce and publish an annual report on the effectiveness of safeguarding in the local area

3.34 The Apprenticeships, Skills, Children and Learning Act 2009 introduces a requirement for LSCBs to produce and publish an annual report on the effectiveness of safeguarding in the local area. This report should provide an assessment of the effectiveness of local arrangements to safeguard and promote the welfare of children, set against a comprehensive analysis of the local area safeguarding context. It should recognise achievements and the progress that has been made in the local authority area as well as providing a realistic assessment of the challenges that still remain.

3.35 The report should demonstrate the extent to which the functions of the LSCB as set out in Working Together are being effectively discharged. This should include assessments of policies and procedures to keep children safe, including:

- the policies and procedures for the safe recruitment of frontline staff;

- an assessment of single and inter-agency training on safeguarding and promoting the welfare of children to meet the local needs;
- lessons learnt about the prevention of future child deaths which have been identified by the Child Death Overview Panel; and
- progress on priority issues (for example, child trafficking, sexual exploitation and domestic violence).

3.36 Annual reports should also include a clear account of progress that has been made in implementing actions from individual Serious Case Reviews (SCRs) completed during the year in question, plans to evaluate the impact of these actions and to monitor how these improvements are being sustained over time. This also applies to SCRs commissioned in previous years where any actions remained outstanding at the start of the reporting year. Where SCRs have been commissioned but not completed the annual report should note action already taken to learn lessons arising from the relevant cases. Common themes and recurring recommendations may be addressed together but the report must be clear on action taken in response to individual SCRs.

3.37 The report should provide robust challenge to the work of the Children's Trust Board in driving improvements in the safeguarding of children and young people and in promoting their welfare.

3.38 The LSCB must send a copy of the annual report to the Children's Trust Board. The Children's Trust Board in turn will be expected to respond to reports through the local Children and Young People's Plan. In preparing the Children and Young People's Plan, Children's Trust Boards will be expected to draw upon the advice from and the findings in the LSCB annual report, and show how they intend to respond to the issues raised.

3.39 This requirement will come into force from 1 April 2010. This will mean that a LSCB must publish its first report by 1 April 2011. Children's Trust Boards must produce a Children and Young People's Plan by 1 April 2011. The LSCB and the Children's Trust Board, within the parameters set by legislation, should work together to ensure that the LSCB annual report is developed in time so that it can be properly considered and effectively utilised by the Children's Trust Board.

Function of participating in planning and commissioning

e) Participating in the local planning and commissioning of children's services to ensure that they take safeguarding and promoting the welfare of children into account

3.40 This will be achieved to a large extent by contributing to the Children and Young People's Plan, and ensuring in discussion with the Children's Trust partners that planning and commissioning of services for children within the local authority area takes account of their responsibility to safeguard and promote children's welfare.

3.41 Where it is agreed locally that the LSCB is the 'responsible authority' for 'matters relating to the protection of children from harm' under the Licensing Act 2003, it must be notified of all licence variations and new applications for the sale and supply of alcohol and public entertainment.

Functions relating to child deaths

3.42 From 1 April 2008, each LSCB acquired the compulsory functions set out in regulations relating to child deaths.

f) Collecting and analysing information about the deaths of all children in their area with a view to identifying:

i) any matters of concern affecting the safety and welfare of children in the area of the authority, including any case giving rise to the need for a Serious Case Review;

ii) any general public health or safety concerns arising from deaths of children.

g) Putting in place procedures for ensuring that there is a co-ordinated response by the authority, their Board partners and other relevant persons to an unexpected death of a child.

3.43 Chapter 7 explains how these functions should be implemented.

Serious Case Review function

h) Undertaking reviews of cases where abuse or neglect of a child is known or suspected, a child has died or a child has been seriously harmed, and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

3.44 By developing procedures and the detail of organisations' and individuals' roles, in accordance with Chapter 8, and ensuring that organisations undertake those roles. All relevant staff should be aware of when SCRs are required or should be considered.

Other activities

3.45 The regulations make clear that in addition to the functions set out above, a LSCB may also engage in any other activity that facilitates, or is conducive to, the achievement of its objectives.

3.46 These further activities should be discussed and agreed as part of wider Children's Trust planning and the preparation of the Children and Young People's Plan.

3.47 For example, the LSCB could agree to take the lead within the Children's Trust partnership on work to tackle bullying, or could lead an initiative on domestic violence.

3.48 The LSCB will not in general be an operational body or one which delivers services to children, young people and their families. Its role is co-ordinating and ensuring the effectiveness of what its member organisations do, and contributing to broader planning, commissioning and delivery. It may however take on operational and delivery roles under this part of the regulations.

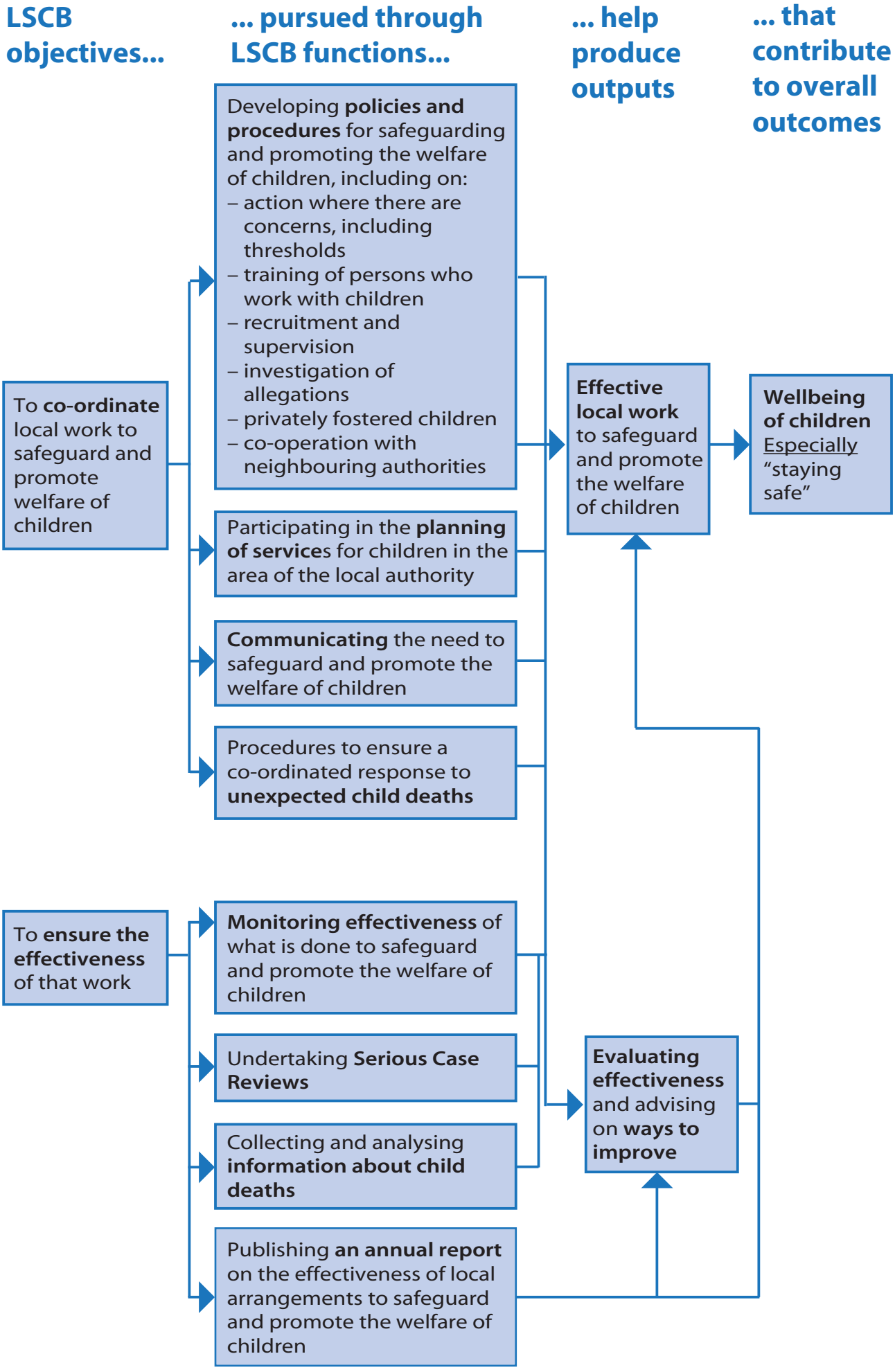
Accountability for operational work

3.49 Whilst the LSCB has a role in co-ordinating and ensuring the effectiveness of local individuals' and organisations' work to safeguard and promote the welfare of children, it is not accountable for their operational work. Each Board partner retains their own existing lines of accountability for safeguarding and promoting the welfare of children by their services. The LSCB does not have a power to direct other organisations.

LSCB governance and operational arrangements

3.50 County level and unitary local authorities are responsible for establishing an LSCB in their area and ensuring that it is run effectively.

3.51 An LSCB can cover more than one local authority area. Local authorities and their partners will wish to consider whether this is desirable, perhaps to ensure a better fit with the areas covered by other bodies, or because issues are common to different areas.


LSCB objectives...
... pursued through LSCB functions...
... help produce outputs
... that contribute to overall outcomes
To co-ordinate local work to safeguard and promote welfare of children
To ensure the effectiveness of that work
Developing policies and procedures for safeguarding and promoting the welfare of children, including on:
– action where there are concerns, including thresholds
– training of persons who work with children
– recruitment and supervision
– investigation of allegations
– privately fostered children
– co-operation with neighbouring authorities
Participating in the planning of services for children in the area of the local authority
Communicating the need to safeguard and promote the welfare of children
Procedures to ensure a co-ordinated response to unexpected child deaths
Monitoring effectiveness of what is done to safeguard and promote the welfare of children
Undertaking Serious Case Reviews
Collecting and analysing information about child deaths
Publishing an annual report on the effectiveness of local arrangements to safeguard and promote the welfare of children
Effective local work to safeguard and promote the welfare of children
Evaluating effectiveness and advising on ways to improve
Wellbeing of children Especially "staying safe"

Chair

3.52 It is the responsibility of the local authority, after consultation with the LSCB partners, to appoint the LSCB chair. It is important that the chair, who must be of sufficient stature and authority, is selected with the agreement of a group of partners representing the key services involved in safeguarding children locally and should have access to training to support them in their role. There should be a presumption that the chair will be someone independent of the local agencies so that the LSCB can exercise its local challenge function effectively. It may take time to develop sufficient availability of suitable independent chairs but it is expected that LSCBs will work towards this over time.

3.53 The chair will have a crucial role in making certain that the Board operates effectively and secures an independent voice for the LSCB. He or she should be of sufficient standing and expertise to command the respect and support of all partners. The chair should act objectively and distinguish their role as LSCB chair from any day-to-day role.

Relationship between the LSCB and the Children's Trust Board

3.54 The responsibilities of the LSCB are complementary to those of the Children's Trust – to promote co-operation to improve the wellbeing of children in the local area across all five *Every Child Matters* outcomes. The LSCB's role is:

- to ensure the effectiveness of the arrangements made by wider partnership and individual agencies to safeguard and promote the welfare of children.

3.55 An LSCB is not an operational sub-committee of the Children's Trust Board. Whilst the work of the LSCB contributes to the wider goals of improving the wellbeing of all children, it has a narrower focus on safeguarding and promoting welfare.

- The LSCB should not be subordinate to nor subsumed within the Children's Trust Board structures in a way that might compromise its separate identity and independent voice.

3.56 There must be a clear distinction between the roles and responsibilities of the LSCB and the Children's Trust Board. There should be:

- agreed local protocols between the LSCB and the Children's Trust Board in place to ensure that the LSCB is able to challenge and scrutinise effectively the work of the Children's Trust Board and partners.

3.57 The LSCB must be able to form a view of the quality of local activity, to challenge organisations as necessary, and to speak with an independent voice.

- For that reason the LSCB and Children's Trust Board should be chaired by different people.

3.58 The Children's Trust Board should work with the LSCB to agree:

- a strategic approach to understanding needs, including a sophisticated analysis of data and effective engagement with children, young people and families;
- a clear approach to understanding the effectiveness of current services, and identifying priorities for change – including where services need to be improved, reshaped or developed;
- integrated and effective arrangements for ensuring that priorities for change are delivered in practice through the Children and Young People's Plan; and
- effective approaches to understand the impact of specialist services on outcomes for children, young people and families, and using this understanding constructively to challenge lack of progress and drive further improvement.

3.59 The Children's Trust Board – drawing on support and challenge from the LSCB – will ensure that the Children and Young People's Plan reflects the strengths and weaknesses of safeguarding arrangements and practices in the area and what more needs to be done by each partner to improve safeguarding and promotion of welfare. The LSCB is a formal consultee during the development of the Children and Young People's Plan.

- Through the LSCB annual report, the LSCB will provide a comprehensive analysis of safeguarding in the local area. The report should challenge the work of the Children's Trust Board and its partners to ensure that necessary overarching structures, processes and culture are put in place to ensure that children are fully safeguarded.
- The Children's Trust Board will draw on the advice and evidence in the annual report to inform the development and review of the local Children and Young People's Plan, and should show in the Plan how they intend to respond to issues raised by the LSCB.

3.60 Regulations make clear that there is flexibility for a local area to decide that an LSCB should have an extended role in addition its core functions. Those must of course still be related to its objectives.

- In general the LSCB is not a body that commissions or delivers services to children, young people and their families. Where the LSCB has an extended role beyond its core functions, for example undertaking research or delivering

training on safeguarding issues, there is scope for confusion between the respective roles of the LSCB and the Children's Trust Board. These additional activities should be discussed and agreed as part of the wider Children's Trust planning arrangements and in the preparation of the Children and Young People's Plan. In such cases, the LSCB as a body should be represented on the Children's Trust Board so that the Children's Trust Board can call the LSCB to account for the extent to which it has acted in accordance with the Children and Young People's Plan.

3.61 As set out in paragraph 3.68, the local authority Chief Executives and Council Leaders should satisfy themselves that the Directors of Children's Services are fulfilling their managerial responsibilities for safeguarding and promoting the welfare of children and young people, including in particular by ensuring that the relationship between the Children's Trust Board and the LSCB is working effectively.

Membership of an LSCB

The nature of members

3.62 As far as possible, organisations should designate particular, named people as their representative on the LSCB, so that there is consistency and continuity in the membership of the LSCB.

3.63 Members should be people with a strategic role in relation to safeguarding and promoting the welfare of children within their organisation. They should be able to:

- speak for their organisation with authority;
- commit their organisation on policy and practice matters; and
- hold their organisation to account.

Role of Elected Members and Directors of Children's Services

3.64 Local authority Elected Members and non-executive directors of other board partners should through their membership of governance bodies such as the cabinet of the local authority or a scrutiny committee or a governance board, hold their organisation and its officers to account for their contribution to the effective functioning of the LSCB.

3.65 Directors of Children's Services and Lead Members for Children's Services have central and complementary roles. Directors of Children's Services have responsibility for improving outcomes for all children and young people in their area. Lead Members for Children's Services have delegated responsibility from the Council for

children, local young people and families and are politically accountable for ensuring that the local authority fulfils its legal responsibilities for safeguarding and promoting the welfare of children and young people. The Lead Member should provide the political leadership needed for the effective co-ordination of work with other relevant agencies with safeguarding responsibilities (such as the police and the health service). Lead Members should also take steps to assure themselves that effective quality assurance systems for safeguarding are in place and functioning effectively.

3.66 The Lead Member should be a 'participating observer' of the LSCB. In practice this means routinely attending meetings as an observer and receiving all its written reports. Lead Members should engage in discussions, ask questions and seek clarity, but not be part of the decision making process. This will enable the Lead Member to challenge, when necessary, from a well informed position.

3.67 Directors of Children's Services should ensure that all appropriate local authority services engage effectively with the LSCB. The Directors of Children's Services will be held to account for the effective working of the LSCB by their Chief Executive and challenged where appropriate by their Lead Member.

Role of local authority Chief Executives and Council Leaders

3.68 Local authority Chief Executives and Council Leaders also have critical roles to play. Chief Executives are responsible for satisfying themselves that the Directors of Children's Services are fulfilling their managerial responsibilities for safeguarding and promoting the welfare of children and young people, including in particular by ensuring that the relationship between the Children's Trust Board and the LSCB is working effectively; that clear responsibility has been assigned within the local authority and among Children's Trust partners for improving services and outcomes; and that targets for improving safeguarding and progress against them are reported to the Local Strategic Partnership.

3.69 Every year, as part of the Children's Trust annual report, the Chief Executive and the Leader of the Council should make an assessment of the effectiveness of local governance and partnership arrangements for improving outcomes for children and supporting the best possible standards for safeguarding children.

Statutory members

3.70 The LSCB should include representatives of the local authority and its Board partners, the statutory organisations which are required to co-operate with the local authority in the establishment and operation of the board and have shared

responsibility for the effective discharge of its functions. These are the Board partners set out in section 13(3) of the Children Act (2004):

- District Councils in local government areas which have them;
- the Chief Officer of Police for a police area any part of which falls within the area of the local authority;
- the Local Probation Trust for an area any part of which falls within the area of the local authority;
- the Youth Offending Team for an area any part of which falls within the area of the local authority;
- Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs) for an area any part of which falls within the area of the local authority;
- NHS Trusts and NHS Foundation Trusts all or most of whose hospitals, establishments and facilities are situated in the local authority area;
- the Connexions Service providing services in any part of the area of the local authority;
- Cafcass (Children and Family Courts Advisory and Support Service);
- the Governor or Director of any Secure Training Centre in the area of the local authority; and
- the Governor or Director of any prison in the local authority area which ordinarily detains children.

3.71 The local authority should ensure that those responsible for adult social services functions are represented on the LSCB, given the importance of adult social care in the context of safeguarding and promoting the welfare of children. Similarly health organisations should ensure that adult health services and in particular adult mental health, adult drug and alcohol services and adult disability services are represented on the LSCB.

3.72 It will also be important to ensure that the LSCB has access to appropriate expertise and advice from all the relevant sectors, including a designated doctor and nurse.

3.73 The Children Act 2004 sets out that the local authority and its partners must co-operate in the establishment and operation of an LSCB. This places an obligation on local authorities and statutory LSCB partners to support the operation of the LSCB.

Lay members

3.74 The Apprenticeships, Skills, Children and Learning Act 2009 amends sections 13 and 14 of the Children Act 2004 (c.31) and provides for the appointment of two representatives of the local community to each LSCB in England.

3.75 The local authority must take reasonable steps to ensure that the LSCB includes two lay members from the local community. The role for lay members should in particular relate to:

- supporting stronger public engagement in local child safety issues and contributing to an improved understanding of the LSCB's child protection work in the wider community;
- challenging the LSCB on the accessibility by the public and children and young people of its plans and procedures; and
- helping to make links between the LSCB and community groups.

3.76 Lay members should operate as full members of the LSCB, participating on the Board itself and on relevant committees. LSCBs will need to think carefully about the type of training they will need to provide for lay members to ensure they are able to bring the most value to its work.

3.77 The local authority should set out its expectations of the role of the lay member within the LSCB, the length of appointment, the expected code of conduct of any lay member and the amount they will recompense them as appropriate for their time and contribution.

Representation from schools

3.78 From 1 April 2010, local authorities must take all reasonable steps to ensure schools are represented on the LSCB. This means taking steps to ensure that the following are represented: the governing body of a maintained school; the proprietor of a non-maintained special school; the proprietor of a city technology college, a city college for the technology of the arts or an Academy; and the governing body of a further education institution the main site of which is situated in the authority's area[63]. The local authority should also include independent schools as appropriate.

3.79 It would clearly be impractical for every school to attend the LSCB so a robust and fair system of representation needs to be identified to enable all schools to receive information and feed back comments to their representatives on the LSCB.

63 The Local Safeguarding Children Boards (Amendment) Regulations 2010, S.I. 2010/622, made under section 13(4) of the Children Act 2004 (c. 31).

3.80 Each LSCB should establish with the schools in its area a system that takes account of local circumstances, and the diverse range of schools should be represented. Where appropriate the LSCB should build on existing arrangements and avoid duplication. It would also need to consider the relationship with the school representatives who sit on the Children's Trust Board. School representatives need to speak for, and on behalf of, the body of schools they represent. This will require an efficient and effective means to communicate with all schools both to seek their views on issues and to feed information back.

Other members

3.81 The local authority should also secure the involvement of the NSPCC and other relevant national and local organisations. The knowledge and experience of the NSPCC and other large voluntary sector providers is an important national resource on which LSCBs should draw. At a minimum local organisations should include faith groups, children's centres, GPs, independent healthcare organisations, and voluntary and community sector organisations including bodies providing specialist care to children with severe disabilities and complex health needs. In areas where they have significant local activity, the armed forces (in relation both to the families of service men and women and those personnel that are under the age of 18), should also be included. In areas where there is an airport or seaport, an asylum screening unit or a number of asylum seeking families or unaccompanied asylum seeking children or a number of migrants with children, arrangements should be made to include the UK Border Agency and to ensure that the issues are dealt with in a strategic way as well as at the level of individual cases.

3.82 Where the number or size of similar organisations precludes individual representation on the LSCB, for example in the case of voluntary youth bodies, the local authority should seek to involve them through existing networks or forums, or by encouraging and developing suitable networks or forums to facilitate communication between organisations and with the LSCB.

Involvement of other agencies and groups

3.83 The LSCB should make appropriate arrangements at a strategic management level to involve others in its work as necessary. For example, there may be some organisations or individuals which are in theory represented by the statutory board partners but which should be engaged because of their particular role in service provision to children and families or in public protection. There will be other organisations and processes which the LSCB needs to link to, either through inviting them to join the LSCB, or through some other mechanism. For example:

- the coronial service;

- dental health services;
- domestic violence forums;
- drug and alcohol misuse services;
- Drug Action and Alcohol Teams;
- housing, culture and leisure services;
- housing providers;
- local authority legal services;
- local Multi-Agency Public Protection Arrangements (MAPPA);
- local sports bodies and services;
- local Family Justice Council;
- Local Criminal Justice Board;
- other health providers such as pharmacists;
- representatives of service users;
- sexual health services;
- the Crown Prosecution Service;
- witness support services;
- Family Intervention Projects; and
- Multi Agency Risk Assessment Conferences (MARACs).

3.84 LSCBs will also need to draw on the work of key national organisations and liaise with them when necessary, for example, the Child Exploitation and Online Protection Centre (CEOP).

The role of members

3.85 The individual members of LSCBs have a duty as members to contribute to the effective work of the LSCB, for example, in making the LSCB's assessment of performance as objective as possible, and in recommending or deciding upon the necessary steps to put right any problems. This should take precedence, if necessary, over their role as a representative of their organisation. Members of each LSCB should have a clear written statement of their roles and responsibilities.

Further advice on how SHAs should engage with LSCBs is set out in Annex D of the *Local Safeguarding Children Boards: A Review of Progress* report[64].

Ways of working

3.86 The working practices of LSCB members need to be considered locally with a view to securing effective operation of LSCB functions and ensuring that all member organisations are effectively engaged.

3.87 Where there are multiple organisations of a particular kind in the local authority area, for example NHS Trusts or District Councils, they may decide to share attendance at meetings. Organisations pooling representation in this way need to agree how they will be consulted and how their views will be fed in to Board discussions.

3.88 It may be appropriate for the LSCB to set up working groups or sub-groups, on a short-term or a standing basis to:

- carry out specific tasks, for example: maintaining and updating procedures and protocols; reviewing serious cases; and identifying inter-agency training needs;
- provide specialist advice, for example: in respect of working with specific ethnic and cultural groups, or with disabled children and/or parents;
- bring together representatives of a sector to discuss relevant issues and to provide a contribution from that sector to LSCB work, for example: schools, the voluntary and community sector, faith groups; and
- focus on defined geographical areas within the LSCB's boundaries.

3.89 It is possible to form a 'core group' or 'executive group' of LSCB members to carry out some of the day-to-day business by local agreement.

3.90 In undertaking the child death review processes set out in Chapter 7, LSCBs should set up a Child Death Overview Panel which has a standing membership and whose Chair is a member of the LSCB. Two or more LSCBs can set up a panel to cover their combined area.

3.91 All groups working under the LSCB should be established by the LSCB, and should work to agreed terms of reference, with explicit lines of reporting, communication and accountability to the LSCB. This may take the form of a written constitution detailing a job description for all members and service level agreements between the LSCB, agencies and other partnerships. Chairs of sub-groups should be LSCB members.

64 www.dcsf.gov.uk/everychildmatters/_download/?id=3082

3.92 Where boundaries between LSCBs and their partner organisations such as the health service and the police are not co-terminous, there can be challenges for some member organisations in having to work to different procedures and protocols according to the area involved, or having to participate in several LSCBs. It may be helpful in these circumstances for adjoining LSCBs to collaborate as far as possible on establishing common policies and procedures, and joint ways of working, under the function *'Co-operation with neighbouring children's services authorities and their Board partners'*.

3.93 LSCBs should consider how to put in place arrangements to ascertain the views of parents and carers and the wishes and feelings of children (including children who might not ordinarily be heard) about the priorities and the effectiveness of local safeguarding work, including issues of access to services and contact points for children to safeguard and promote welfare. LSCBs should also consider how children, parents and carers can be given a measure of choice and control in the development of services.

Information sharing for the purpose of LSCB functions

3.94 The Children, Schools and Families Bill currently before Parliament includes provision requiring compliance with a request from a LSCB for appropriate information to be disclosed to it in order to assist it in the exercise of its functions. Subject to the passage of the Bill this provision will help remove uncertainty and give greater confidence to practitioners to share **appropriate** information with a LSCB. This could include confidential personal information about children who are the subject of reviews and about third parties who have a relationship with those children (for example, parents and siblings).

3.95 Where the LSCB requests personal information, the request should be for appropriate information that is relevant and proportionate to the purpose for which the information is sought. The LSCB should be able to explain that purpose to record holders, and why the information sought is appropriate, relevant and proportionate should the record holder require any justification of the need for the information or of the overriding public interest served by the disclosure of personal information in each case. No request should require a record holder to breach data protection principles, or other protections of confidential or personal information (for example, under the Human Rights Act) in a manner which cannot be justified; the 'golden rules' set out in *Information Sharing: Guidance for practitioners and managers* will help record holders observe these protections and principles.

Financing and staffing

3.96 To function effectively LSCBs have to be supported by their member organisations with adequate and reliable resources.

3.97 Section 15 of the Children Act 2004 sets out that statutory board partners (or in the case of prisons, either the Secretary of State or the contractor) may:

- make payments towards expenditure incurred by, or for purposes connected with, an LSCB, either directly, or by contributing to a fund out of which payments may be made; and
- provide staff, goods, services, accommodation or other resources for purposes connected with an LSCB.

3.98 The budget for each LSCB and the contribution made by each member organisation should be agreed locally. The member organisations' shared responsibility for the discharge of the LSCB's functions includes shared responsibility for determining how the necessary resources are to be provided to support it.

3.99 The core contributions should be provided by the responsible local authority, the PCTs, and the police. Other organisations' contributions will vary to reflect their resources and local circumstances. For some, taking part in LSCB work may be the appropriate extent of their contribution. Other organisations may wish to contribute by committing resources in kind, rather than funds, as provided for in the legislation.

3.100 Where an LSCB member organisation provides funding, this should be committed in advance, usually into a pooled budget.

3.101 The board may choose to use some of its funding to support the participation of some organisations, such as local voluntary or community sector groups, for example, if they cannot otherwise afford to take part.

3.102 The funding requirement of the LSCB will depend on its circumstances and the work which it plans to undertake (which will in turn depend on the division of responsibilities between the LSCB and other parts of the wider Children's Trust partnership). However, each LSCB will have a core minimum of work.

3.103 The LSCB's resources will need to enable it to have staff to take forward its business, whether those are paid for from a common fund, or seconded as part of a contribution in kind. The particular staffing of each LSCB should be agreed locally by

the Board partners. An effective LSCB needs to be staffed so that it has the capacity to:

- drive forward the LSCB's day to day business in achieving its objectives, including its co-ordination and monitoring/evaluating work;
- take forward any training and staff development work carried out by the LSCB, in the context of the local workforce strategy; and
- provide administrative and organisational support for the Board and its sub-committees, and those involved in policy and training.

Planning

3.104 From 1 April 2010, under the Apprenticeships, Skills, Children and Learning Act 2009, Children's Trust Boards are responsible for a joint strategy which sets out how the Children's Trust partners will co-operate to improve children's wellbeing in the local area. Every area must publish a new joint Children and Young People's Plan on or before 1 April 2011.

3.105 In preparing the Children and Young People's Plan, the Children's Trust Board will conduct a comprehensive needs assessment following an extensive consultation to agree their priorities and set out how the partners will work together and align or pool their budgets to address those priorities. The Board should also identify the resources available across the partner agencies and the contribution each will make. LSCBs should contribute to, and work within, the framework established by the Children and Young People's Plan.

3.106 It is expected that all local areas should investigate the possibilities of integrating frontline delivery of services such that staff from children's social care services work in active partnership with the police, paediatric and relevant health services to maximise effectiveness. This, however, is a matter for local determination.

3.107 The LSCB's own activities should fit clearly within the framework of the Children and Young People's Plan. The voice and experiences of young people should strongly inform the LSCB's work programme. The LSCB should have a clear work programme, including measurable objectives; and a budget.

Monitoring and inspection

3.108 The LSCB's role in ensuring the effectiveness of work to safeguard and promote the welfare of children by member organisations will be a peer review process based on self evaluation. This will be achieved to a large extent through performance indicators and joint audits. Its aim is to promote high standards of safeguarding

work and to foster a culture of continuous improvement. It will also identify and act on identified weaknesses in services. To avoid unnecessary duplication of work the LSCB should ensure that its monitoring role complements and contributes to the work of both the Children's Trust Board and the inspectorates.

3.109 Where it is found that a Children's Trust partner is not performing effectively in safeguarding and promoting the welfare of children, and the LSCB is not convinced that any planned action to improve performance will be adequate, the LSCB chair or a member or employee designated by the chair should explain these concerns to those individuals and organisations that need to be aware of the failing and may be able to take action. For example, to the most senior individual(s) in the partner organisation, to relevant monitoring bodies such as Government Offices or SHAs, to the relevant inspectorate, and, if necessary, to the relevant government department.

3.110 The local inspection framework will play an important role in reinforcing the ongoing monitoring work of the LSCB. Individual services will be assessed through their own quality regimes. Part of the established inspection arrangements – led by Ofsted but involving other inspectorates – includes (1) annual unannounced inspections on safeguarding and services for looked after children under section 138 of the Education and Inspections Act 2006, and (2) a full inspection under section 20 of the Children Act 2004 of safeguarding and services for looked after children in each local authority area at least once every three years. The LSCB should draw on these.

3.111 The LSCB will be able to feed its views about the quality of work to safeguard and promote the welfare of children into these processes.

3.112 The effectiveness of the LSCB itself should also form part of the judgement of the Inspectorates, particularly through the Comprehensive Area Assessment. This may be done, for example, by examining the quality of the LSCB's planning and determining whether key objectives have been met. It will be for the local authority to lead in taking action, if intervention in the LSCB's own processes is necessary.

Chapter 4 – Training, development and supervision for inter-agency working

Introduction and definitions

4.1 This chapter provides guidance for employers, LSCBs and Children's Trust Boards and their constituent members on the training and development of staff and volunteers necessary for them to effectively safeguard and promote the welfare of children. This includes being able to recognise when a child may require protection, taking account of their age and ability and knowing what to do in response to concerns about the safety and welfare of a child. Practitioners and managers must also be able to work effectively with others, both within their own agency and across organisational boundaries and this can be achieved by a combination of single-agency and inter-agency training.

4.2 Particular terms are used to describe different types and aspects of training and development. **Training for inter- and multi-agency work** means training and education that equips people to work effectively with those from other agencies to safeguard and promote the welfare of children. This training typically takes place in two ways:

- **single-agency training**, which is training carried out by a particular agency for its own staff; and
- **inter- (or multi-) agency training**, which is for employees of different agencies who either work together formally or come together for training or development.

4.3 Research for the Department of Children, Schools and Families and the Department of Health[65] has shown that inter-agency training is highly effective in helping professionals understand their respective roles and responsibilities, the procedures of each agency involved in safeguarding children and in developing a shared understanding of assessment and decision-making practices. Further, the opportunity to learn together is greatly valued; participants report increased confidence in working with colleagues from other agencies and greater mutual respect.

---

65 Carpenter et al (2009) *The Organisation, Outcomes and Costs of Inter-agency Training to safeguard and promote the welfare of children*. London: Department for Children, Schools and Families

Purpose

4.4 The purpose of training for inter-agency work at both strategic and operational levels is to achieve better outcomes for children and young people by fostering:

- a shared understanding of the tasks, processes, principles, roles and responsibilities outlined in national guidance and local arrangements for safeguarding children and promoting their welfare;
- more effective and integrated services at both the strategic and individual case level;
- improved communication and information sharing between professionals, including a common understanding of key terms, definitions and thresholds for action;
- effective working relationships, including an ability to work in multi-disciplinary groups or teams;
- sound child focused assessments and decision-making; and
- learning from Serious Case Reviews (SCRs) and reviews of child deaths.

Roles and responsibilities

Employers

4.5 Employers are responsible for ensuring that their staff are competent and confident in carrying out their responsibilities for safeguarding and promoting children's and young people's welfare.

4.6 It is the responsibility of employers to recognise that in order for staff to fulfil their duties in line with Working Together, they will have different training needs which are dependent on their degree of contact with children and young people and/or with adults who are parents or carers, their level of responsibility and independence of decision-making. A number of competency frameworks have been published by professional bodies to assist employers in identifying training needs (for example, *Safeguarding Children and Young People: Roles and Competences for Health Care Staff (2006); Roles, Skills, Knowledge and competencies for Safeguarding Children in the Sports Sector (2007))*.

4.7 Employers should ensure that all those in contact or working with children and young people and/or with adults who are parents or carers have a mandatory induction, which includes familiarisation with their child protection responsibilities and the policies and procedures to be followed if they have concerns about a child's

safety or welfare. The Children's Workforce Development Council provides induction guidance[66] and supporting materials. Induction should be completed within the first six months of employment and before individuals take part in inter-agency training. Regular refresher training should also be provided at least every three years.

4.8 Employers should ensure that their employees who work or have contact with children are appropriately trained in child development and in how to recognise and act on potential signs of child abuse and neglect. Training should also include associated vulnerability and risk factors and resilience and protective factors, identifying potential violent behaviour and assessing the capacity of a parent or carer to meet a child's needs, taking into account their own needs/circumstances/history/illness/addiction. Increasingly, professional bodies are requiring their members to demonstrate relevant education and training as part of revalidation.

4.9 Employers should ensure that appropriately qualified staff undertaking specialist roles in both children's and adults' services receive the necessary specialist training. For those experienced social workers undertaking key management and supervisory roles in duty or intake teams this should include training on managing referrals where there are concerns about the safety and welfare of a child or children.

4.10 Employers also have a responsibility to identify adequate resources and support for inter-agency training by:

- committing resources for inter-agency training, for example through funding, providing venues, providing staff who contribute to the planning, delivery and/or evaluation of inter-agency training;
- providing staff who have the relevant expertise to support the LSCB (for example, by actively contributing to the LSCB training sub-group);
- releasing staff to attend the appropriate inter-agency training courses and ensuring the time for them to complete inter-agency training tasks and apply their learning in practice; and
- ensuring that staff receive relevant single-agency training that enables them to maximise the learning derived from inter-agency training.

4.11 In advance of the roll out of a clear national standard for the support social workers should expect from their employers, the Social Work Task Force has developed an initial framework to help employers and practitioners to assess the 'health' of their organisation on a range of issues affecting workload. This is published in their final

66 www.cwdcouncil.org.uk/induction-standards

report[67]. It is recommended that all employers of social workers make use of this tool to assess and improve the support they provide to frontline staff in managing their workload.

4.12 Employers have a responsibility to ensure that all staff, including administrative staff, are given opportunities to attend local courses in safeguarding and promoting the welfare of children, or ensure that safeguarding training is provided within the team. As employers, GPs have an important role to play in ensuring staff whom they employ are trained and should ensure that practice nurses, practice managers, receptionists and any other staff whom they employ are given the opportunity to attend local courses in safeguarding and promoting the welfare of children.

Children's Trust Board

4.13 Through their work on the local Children and Young People's Plan (CYPP), Children's Trust Boards are responsible for ensuring that workforce strategies are developed in their local area. This includes making sure that training opportunities to meet priority needs identified by the LSCBs are available, and that all staff who work or have contact with children are appropriately trained in child development, recognise potential signs of abuse and neglect and know how to respond if they have concerns about a child's welfare.

4.14 Children's Trust Boards should ensure that systems are in place to deliver both single-agency and inter-agency training on safeguarding and promoting the welfare of children. They should consider, in discussion with the LSCB, which bodies should commission or deliver single and inter-agency training.

The LSCB

4.15 The LSCB is responsible for developing local policies for safeguarding and promoting the welfare of children, in relation to the training of people who work with children or in services affecting the safety and welfare of children (see paragraphs 3.18–3.20). This includes training in relation to the child death review processes[68] and Serious Case Reviews.

4.16 LSCBs should contribute to, and work within, the framework of the local workforce strategy. They may decide to identify training needs and priorities and feed this information into the local workforce strategy to inform the planning and commissioning of training. LSCBs will want to review and evaluate the provision and

67 See *Building a safe, confident future: the final report of the Social Work Task Force* and the Government response, which can be found at www.dcsf.gov.uk/swtf

68 See http://childdeath.ocbmedia.com/

availability of single and inter-agency training and to check that the training is reaching all relevant staff within organisations.

4.17 As set out in 3.45, regulations make clear that there is flexibility for a local area to decide that an LSCB should have an extended role in addition to its core functions. Those must, of course, still be related to its objectives. The LSCB and Children's Trust Board may wish to make arrangements in their local area for the LSCB to manage the delivery of the inter-agency safeguarding training – research[69] indicates that where this currently happens the resulting training is highly effective.

4.18 If a LSCB provides such services there must be an agreed protocol in place between the Boards to enable the LSCB to be treated in the same way as other partners making a contribution to delivering the CYPP. Specifically the Children's Trust Board would need to be able to call the LSCB to account for the extent to which it acted in accordance with the CYPP.

4.19 The LSCB should ensure that all staff who work or have contact with children are appropriately trained to understand normal child development and to recognise and act on potential signs of abuse and neglect.

4.20 LSCBs should review and evaluate the quality, scope and effectiveness of single and inter-agency training to ensure it is meeting local needs and should report on this annually to the Children's Trust Board. LSCBs should include in their annual report an assessment of their progress in ensuring that all staff who work with or have contact with children are appropriately trained.

4.21 Where LSCBs have the responsibility for delivering or commissioning training, they should ensure adequate funding arrangements are in place to meet the priority needs identified and to achieve appropriate reach and scope of the training to meet the LSCB's strategic objectives.

4.22 LSCBs should ensure that they are appropriately staffed and have sufficient capacity to take forward any training and development work they carry out. This includes having the necessary administrative support and having adequate resources both to contribute to the planning and delivery or commissioning of training and its evaluation. Research[70] suggests over-reliance on a single inter-agency training co-ordinator makes LSCB training programmes vulnerable.

---

69 Carpenter et al (2009) *The Organisation, Outcomes and Costs of Inter-Agency Training to Safeguard and Promote the Welfare of Children.* London: Department for Children, Schools and Families

70 Ibid.

4.23 Induction and training for LSCB members, including lay members, independent chairs and any employees of the LSCB should be provided to support them to fulfil their responsibilities effectively.

Content, audiences and values

4.24 This section provides further guidance for employers, LSCBs, Children's Trust Boards and their constituent partners on the content, audiences and values of training for working together to safeguard and protect children and to promote their welfare.

Values

4.25 All training should place the child at the centre and promote the importance of understanding the child's daily life experiences, ascertaining their wishes and feelings, listening to the child and never losing sight of his or her needs.

4.26 All training should create an ethos that values working collaboratively with others (valuing different roles, knowledge and skills), respects diversity (including culture, race, religion and disability), promotes equality and encourages the participation of children and families in the safeguarding processes.

Content and Audiences

4.27 Given that safeguarding children is everybody's responsibility, audiences for training are vast and diverse. This includes the whole of the children and young people's workforce and those working with adults who are parents or carers (for example, adult psychiatrists and probation staff). It includes paid staff and volunteers working in the statutory, voluntary, community and independent sectors.

4.28 *The Common Core of Skills and Knowledge for the Children's Workforce*[71] sets out six areas of expertise that **everyone** working with children, young people and families – including those who work as volunteers – should be able to demonstrate. These are:

- effective communication and engagement with children, young people and their families and carers;
- child and young person development;
- safeguarding and promoting the welfare of the child;

71 www.dcsf.gov.uk/everychildmatters/strategy/deliveringservices1/commoncore/commoncoreofskillsandknowledge/

- supporting transitions;
- multi-agency working; and
- sharing information.

4.29 While it may not be practical for everyone to participate in inter-agency training, working together is an essential feature of all training in safeguarding and promoting the welfare of children. Single-agency training, and training provided in professional settings, should always equip staff for working with, communicating and sharing information with others. All safeguarding training should be consistent with *The Common Core of Skills and Knowledge*.

4.30 Table 1 at the end of this chapter groups audiences together based on their degree of contact with children and/or parents/carers and their levels of responsibility, in order to assist with the identification of training and development needs. The groups are as follows:

- those who have **occasional contact** with children, young people and/or parents/carers;
- those in **regular or in intensive but irregular contact** with children, young people and/or parents/carers;
- those who **work predominantly** with children, young people and/or parents/carers;
- those who have particular **specialist** child protection responsibilities;
- professional advisers and **designated** leads for child protection;
- **operational managers** of services for children, young people and/or parents/carers;
- **senior managers** responsible for strategic management of services for children, young people and/or parents/carers; and
- members of LSCBs.

4.31 Training should be available at a number of levels to address the learning needs of these staff. The table at the end of the chapter outlines responsibilities and suggests possible methods of delivery. Decisions should be made locally about how the levels are most appropriately delivered, as part of the planning of training.

4.32 Whilst the detailed content of training at each level of the framework should be specified locally, programmes should usually include the following:

- recognising and responding to safeguarding and child protection concerns;

- working together;
- completing child in need assessments;
- safeguarding disabled children;
- safeguarding children when there are concerns about domestic violence, parental mental health; and
- substance misuse.

4.33 Where national guidance and competence frameworks have been developed by professional bodies, these should be reflected in the content. The content should also reflect the principles, values and processes set out in this guidance on work with children and families. Steps should be taken to ensure the relevance of the content and delivery methods to different groups from the statutory, voluntary and independent sectors who will have different professional needs. The content of training programmes should be regularly reviewed and updated in the light of changing policy and legislation, research, learning from SCRs, child death reviews and practice experience, and should always reinforce the centrality of the child's daily life experience.

4.34 All healthcare staff involved in working with children should attend training in safeguarding and promoting the welfare of children and have regular updates as part of continuing professional development. Advice regarding the competencies required of staff can be found in the intercollegiate document *Safeguarding Children and Young People: Roles and competencies for Health Care Staff*[72].

4.35 The National Police Improvement Agency (NPIA) has responsibility for the development of special training for child abuse investigation officers. In addition to this, Child Exploitation and On-Line Protection Centre (CEOP) provides a range of specialist courses to both police officers and colleagues in the wider child protection and safeguarding community. These have been developed through the CEOP Academy to support those working to protect children and students have the opportunity to attend individual courses or study for a Postgraduate Certificate in Behavioural Forensic Psychology.

4.36 It is important to ensure that training involves and is available to all people who work with children and young people. Some agencies involved in safeguarding and promoting the welfare of children may not be formally part of the local Children's Trust Board. LSCBs should ensure that the needs of all staff are included when setting up training arrangements.

72 www.rcpch.ac.uk/doc.aspx?id_Resource=1535

Planning, organisation, delivery and evaluation

Planning, organisation and delivery

4.37 Training on safeguarding children and young people should be embedded within a wider framework of commitment to inter and multi-agency working at strategic and operational levels underpinned by shared goals, planning processes and values. It is most likely to be effective if it is delivered within a framework that includes:

- a training strategy mandated by the LSCB and endorsed by member agencies, that makes clear the difference between single-agency and inter-agency training and which partnerships or agencies are responsible for commissioning and delivering training;
- adequate resources and capacity to deliver or commission training;
- policies, procedures and practice guidelines to inform and support training delivery in line with the strategy;
- identification and periodic review of local training needs, taking into account research, national developments, learning from SCRs and child death reviews (not only those carried out locally), followed by decisions about priorities;
- robust arrangements for organising and co-ordinating delivery;
- structures and processes for the delivery of inter-agency training that are not unduly dependent on a single individual; and
- quality assurance processes (for example, as part of evaluation processes put in place by the LSCB).

4.38 All training to support inter- and multi-agency work should:

- be delivered by trainers who are knowledgeable about safeguarding (which includes child protection) and promoting the welfare of children. When delivering training on complex areas of work, trainers should have the relevant specialist knowledge and skills;
- be delivered by trainers who have completed a training for trainers programme or professional equivalent;
- be informed by current research evidence, lessons from serious case and child death reviews, and local and national policy and practice developments;
- be consistent with the values outlined in paragraphs 4.25 and 4.26;

- reflect an understanding of the rights of the child, and be informed by an active respect for diversity and the experience of service users and a commitment to ensuring equality of opportunity;
- involve children, young people and their parents/carers in the design, delivery and/or evaluation; and
- be regularly reviewed and evaluated to ensure that it meets the agreed learning outcomes and has a positive impact in practice.

4.39 Research[73] has shown that effective training on safeguarding and promoting the welfare of children is most likely to be achieved if there is a member of the Board with lead responsibility for training, a training sub-group for which this Board member is responsible, and a designated and suitably skilled training co-ordinator to manage the training and development work of the LSCB.

4.40 To be effective, a training sub-group should include people with sufficient knowledge of training needs and processes to enable them to make informed contributions to the development and evaluation of a training strategy.

4.41 Many areas maintain an inter-agency training panel (also known as training pool) of suitably skilled and experienced practitioners and managers from LSCB member agencies, who work together to design, deliver and evaluate inter-agency training. The effectiveness of this approach relies on having a skilled person to co-ordinate and develop the panel, and on the allocation of time to enable panel members to undertake this work.

4.42 In some areas, training may be delivered more efficiently and effectively if there is collaboration across local areas, especially where police or health boundaries embrace more than one local authority area.

Quality assurance and evaluation of training

4.43 The LSCB, or the training sub-group acting on its behalf, has a responsibility to ensure that both single and inter-agency training is delivered to a consistently high standard, and that a process exists for evaluating the effectiveness of training.

4.44 Monitoring arrangements should be in place to ensure that:

- training is available for the target groups identified above;
- opportunities for refresher training are available and utilised; and

73 Carpenter et al (2009) *The Organisation, Outcomes and Costs of Inter-Agency Training to Safeguard and Promote the Welfare of Children*. London: Department for Children, Schools and Families.

- regular review and updating of training programmes takes place in line with the training strategy and local and national developments.

4.45 The LSCB should agree an evaluation strategy and determine the appropriate level at which evaluation of training courses should take place. The focus of the evaluation should be on the extent to which training is contributing to improving the knowledge and skills of the workforce with regard to working together to safeguard and promote the welfare of children. Evaluation should include the following:

- relevance, currency and accuracy of course content;
- quality of training delivery;
- short and longer term outcomes; and
- impact on working together and inter-professional relationships.

4.46 The LSCB should ensure that outcomes from an evaluation of training courses or programmes inform the planning of future training. In its annual report to the Children's Trust Board a review of the quality, scope, reach and effectiveness of both single and inter-agency training should be provided.

4.47 The Government has developed and disseminated a range of multi-disciplinary training resources[74]. These include materials on child development (*The Developing World of the Child (2006)*), assessing children in need (*The Child's World. Second Edition* (2009, 2010)) what to do if you are concerned that a child is being abused or neglected (*Safeguarding Children – a shared responsibility (2007)*) and fabricated or induced illness (*Incredibly Caring* (2008)) which help to support the provision of good quality training. The National Institute for Health and Clinical Excellence (NICE) published guidance on *When to suspect child maltreatment*[75]. *Guidance on Investigating Child Abuse and Safeguarding Children*[76] was published by the Association of Chief Police Officers and the National Policing Improvement Agency in 2009. In addition the Department for Children, Schools and Families publishes national overviews of SCRs and LSCBs publish executive summaries of individual SCRs, all of which should be used to inform the content of training.

Effective support and supervision

4.48 Working to ensure children are protected from harm requires sound professional judgements to be made. It is demanding work that can be distressing and stressful. All of those involved should have access to advice and support from, for example,

74 www.everychildmatters.gov.uk/workingtogether
75 www.nice.org.uk/nicemedia/pdf/CG89FullGuideline.pdf
76 www.npia.police.uk/en/14532.htm

peers, managers, named and designated professionals. Those providing supervision should be trained in supervision skills and have an up to date knowledge of the legislation, policy and research relevant to safeguarding and promoting the welfare of children. Supervision can be defined as:

> ''an accountable process which supports assures and develops the knowledge, skills and values of an individual, group or team. The purpose is to improve the quality of their work to achieve agreed outcomes.''
>
> *Providing Effective Supervision (Skills for Care and CWDC 2007, page 5)*

4.49 The key functions of supervision are:

- management (ensuring competent and accountable performance/practice);
- development (continuing professional development);
- support (supportive/restorative function); and
- engagement/mediation (engaging the individual with the organisation)[77].

4.50 For many practitioners involved in day-to-day work with children and families, effective supervision is important to promote good standards of practice and to supporting individual staff members. The arrangements for organising how supervision is delivered will vary from agency to agency but there are some key essential elements. It should:

- help to ensure that practice is soundly based and consistent with LSCB and organisational procedures;
- ensure that practitioners fully understand their roles, responsibilities and the scope of their professional discretion and authority; and
- help identify the training and development needs of practitioners, so that each has the skills to provide an effective service.

4.51 Good quality supervision can help to:

- keep a focus on the child;
- avoid drift;
- maintain a degree of objectivity and challenge fixed views;
- test and assess the evidence base for assessment and decisions; and
- address the emotional impact of work.

77 Morrison, T. (2005) *Staff Supervision in Social Care. Third edition*. Brighton: Pavilion.

4.52 Supervision should enable both supervisor and supervisee to reflect on, scrutinise and evaluate the work carried out, assessing the strengths and weaknesses of the practitioner and providing coaching development and pastoral support. Supervisors should be available to practitioners as an important source of advice and expertise and may be required to endorse judgements at certain key points in time. Supervisors should also record key decisions within the child's case records.

4.53 Supervision will be both educative and supportive and facilitate the supervisee to explore their feelings about the work and the family. Effective safeguarding supervision needs to be regular and provide continuity, so that the relationship between supervisor and supervisee develops. Each session should include agreeing the agenda, reviewing actions from previous supervision, listening, exploring and reflecting, agreeing actions and reviewing the supervision process itself.

4.54 It is particularly important that social workers have appropriate supervision. The recent report *Building a safe, confident future: the final report of the Social Work Task Force*[78] emphasised that supervision is a critical aspect of the support that employers should provide to social workers. It identified three specific functions of the supervision which must be in place to support effective practice: line management; professional (or case) supervision; and continuing professional development.

4.55 In line with the Task Force's recommendations, a national standard for supervision will be developed for social workers, as part of the comprehensive reform programme which the Government has committed to taking forward with the profession and employers. Whilst this is developed, it is strongly recommended that employers comply with existing guidance on the features of good supervision for social workers, for example *Providing Effective Supervision*[79] (Skills for Care/CWDC 2007).

78 www.dcsf.gov.uk/swtf
79 www.cwdcouncil.org.uk/providing-effective-supervision

Table 1: Suggested training for different target groups

Target groups to include members of statutory, voluntary, independent and community organisations	Suggested training content	Suggested training methods	Employer, LSCB and CT responsibilities
Group 1 Staff in infrequent contact with children, young people and/or parents/carers who may become aware of possible abuse or neglect. For example, librarians, GP receptionists, community advice centre staff, groundsmen, recreation assistants, environmental health officers.	• What is child abuse and neglect? • Signs and indicators of abuse and neglect. • Normal child development. • Maintaining a child focus. • What to do in response to concerns.	Integral part of agency induction. Refresher training at least every 3 years. For induction materials see CWDC website. Could be delivered through e-learning.	The employer is responsible for organisation and delivery. The LSCB is responsible for ensuring that single and inter-agency training is provided and that it is reaching relevant staff within organisations. The LSCB is responsible for quality assurance.
Group 2 Those in regular contact or have a period of intense but irregular contact, with children, young people and/or parents/carers including all health clinical staff[80], who may be in a position to identify concerns about maltreatment, including those that may arise from the use of CAF. For example, housing, hospital staff, YOT staff and staff in secure settings, the police other than those in specialist child protection roles, sports development officers, disability specialists, faith groups, community youth groups, play scheme volunteers.	The above plus: • Documentation and sharing of information regarding concerns. • Using the *Framework for the Assessment of Children in Need and their Families:* Own safeguarding roles and responsibilities.	Single-agency training Refresher training at least every 3 years. Could be delivered by workshops or e-learning or combination.	The employer is responsible for organisation and delivery. The LSCB is responsible for ensuring that single and inter-agency training is provided and that it is reaching relevant staff within organisations. The LSCB is responsible for quality assurance.

80 *Safeguarding Children and Young People: Roles and Competencies for Health Care Staff, Intercollegiate Document* (forthcoming)

Target groups to include members of statutory, voluntary, independent and community organisations	Suggested training content	Suggested training methods	Employer, LSCB and CT responsibilities
Group 3 Members of the workforce who work predominantly with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and reviewing the needs of a child and parenting capacity where there are safeguarding concerns. For example, paediatricians, GPs, youth workers, those working in the early years sector, residential staff, midwives, school nurses, health visitors, sexual health staff, teachers, probation staff, sports club welfare officers, those working with adults in, for example, learning disability, mental health, alcohol and drug misuse services, those working in community play schemes.	The above plus: ● Working together to identify, assess and meet the needs of children where there are safeguarding concerns. ● The impact of parenting issues, such as domestic abuse, substance misuse on parenting capacity. ● Recognising the importance of family history and functioning. ● Working with children and family members, including addressing lack of co-operation and superficial compliance within the context of role.	Inter-agency training. In addition single-agency training and professional development related to specific role. Refresher training at least every 3 years.	The employer is responsible for organisation and delivery. The LSCB is responsible for ensuring that single and inter-agency training is provided and that it is reaching relevant staff within organisations. The LSCB is also responsible for quality assurance. Depending on local arrangements, the LSCB or Children's Trust partners may take responsibility for the delivery of inter-agency training. The Children's Trust Board is responsible for ensuring training is available to met identified needs.

Target groups to include members of statutory, voluntary, independent and community organisations	Suggested training content	Suggested training methods	Employer, LSCB and CT responsibilities
Group 4 Members of the workforce who have particular responsibilities in relation to undertaking section 47 enquiries, including professionals from health, education, police and children's social care; those who work with complex cases and social work staff responsible for co-ordinating assessments of children in need.	The above plus: ● Section 47 enquiries, roles, responsibilities and collaborative practice. ● Using professional judgements to make decisions as to whether a child is suffering, or is likely to suffer, significant harm. ● Taking emergency action. ● Working with complexity. ● Communicating with children in line with interviewing vulnerable witness guidance.	Inter-agency training. In addition single-agency training and professional development related to specific role. Refresher training at least every 3 years.	The employer is responsible for organisation and delivery. The LSCB is responsible for ensuring that single and inter-agency training is provided and that it is reaching relevant staff within organisations. The LSCB is responsible for quality assurance. Depending on local arrangements, the LSCB or Children's Trust partners may take responsibility for the delivery of inter-agency training. The Children's Trust Board is responsible for ensuring training is available to met identified needs.

Target groups to include members of statutory, voluntary, independent and community organisations	Suggested training content	Suggested training methods	Employer, LSCB and CT responsibilities
Group 5 Professional advisors, named and designated lead professionals.	• Content as for groups 1, 2 and 3 and 4 if advising staff in that group. • Promoting effective. • professional practice. • Advising others.	Inter-agency training. In addition single-agency training and professional development related to specific role. Refresher training at least every 3 years.	The employer is responsible for organisation and delivery. The LSCB is responsible for ensuring that single and inter-agency training is provided and that it is reaching relevant staff within organisations. The LSCB is responsible for quality assurance. Depending on local arrangements, the LSCB or Children's Trust partners may take responsibility for the delivery of inter-agency training. The Children's Trust Board is responsible for ensuring training is available to met identified needs.

Target groups to include members of statutory, voluntary, independent and community organisations	Suggested training content	Suggested training methods	Employer, LSCB and CT responsibilities
Group 6 Operational managers at all levels including: practice supervisors; front line managers and managers of child protection units.	• Content as for groups 1, 2 and 3 and 4 if supervising staff in that group. • Supervising child protection cases. • Managing performance to promote effective inter-agency practice. Specialist training to undertake key management and/or supervisory roles in, for example, intake/duty teams.	Inter-agency training. In addition single-agency training and professional development related to specific role. Refresher training at least every 3 years.	The employer is responsible for organisation and delivery. The LSCB is responsible for ensuring that single and inter-agency training is provided and that it is reaching relevant staff within organisations. The LSCB is responsible for quality assurance. Depending on local arrangements the LSCB or Children's Trust partners may take responsibility for the delivery of inter-agency training. The Children's Trust Board is responsible for ensuring training is available to met identified needs.

Target groups to include members of statutory, voluntary, independent and community organisations	Suggested training content	Suggested training methods	Employer, LSCB and CT responsibilities
Group 7 Senior managers responsible for the strategic management of services; NHS board members.	• Content as for groups 1, 2 and 3 and section 11 expectations, roles and responsibilities.	In-house and LSCB induction programme. National and local leadership programmes. Refresher training every 3 years.	The employer is responsible for organisation and delivery. The LSCB is responsible for ensuring that single and inter-agency training is provided and that it is reaching relevant staff within organisations. The LSCB is responsible for quality assurance. Depending on local arrangements, the LSCB or Children's Trust partners may take responsibility for the delivery of inter-agency training. The Children's Trust Board is responsible for ensuring training is available to met identified needs.

Target groups to include members of statutory, voluntary, independent and community organisations	Suggested training content	Suggested training methods	Employer, LSCB and CT responsibilities
Group 8 Members of the LSCB including: Board members Independent chair Directors of Children's Services Elected member Lay members Members of executive and sub/task groups Business support team Inter-agency trainers.	• Content as for groups 1, 2 and 3 and roles, responsibilities and accountabilities. • Expectations on members in order to promote effective co-operation that improves effectiveness. • Current policy, research and practice developments. • Lessons from Serious Case Reviews. • Specialist training to undertake specific roles, for example independent chair; business manager.	LSCB induction programme. LSCB development days. Refresher training at least every 3 years. CWDC support materials? National Leadership Programme.	The employer in collaboration with the LSCB is responsible for organisation and delivery. The LSCB is responsible for ensuring that single and inter-agency training is provided and that it is reaching relevant staff within organisations. Depending on local arrangements, the LSCB or Children's Trust partners may take responsibility for the delivery of inter-agency training. The Children's Trust Board is responsible for ensuring training is available to met identified needs.

N.B these are illustrative examples of the audiences for each target group

Chapter 5 – Managing individual cases where there are concerns about a child's safety and welfare

Introduction

5.1 This chapter provides guidance on what should happen if somebody has concerns about the safety and welfare of a child (including those living away from home) and in particular, concerns that a child may be suffering, or is likely to suffer, significant harm. It incorporates the guidance on information sharing and sets out the principles which underpin work to safeguard and promote the welfare of children. Fundamental to safeguarding and promoting the welfare of each child is having a child centred approach. This means seeing the child and keeping the child in focus throughout assessments, while working with the child and family, and when reviewing whether the child is safe and his or her needs are being met. Undertaking direct work with the child is key: seeing the child alone when appropriate, ascertaining the child's wishes and feelings and understanding the meaning of their daily life experiences to them. Throughout this process, the safety of the child should be ensured.

5.2 This chapter is not intended as a detailed practice guide but it sets out clear expectations about the ways in which agencies and professionals should work together to safeguard and promote the welfare of children. In addition, the related practice guidance *What to do if you're worried a child is being abused*[81] is intended to be an accessible resource for practitioners and first line managers to use in their every day work.

Working with children when there are concerns about their safety and welfare

5.3 Achieving good outcomes for children requires all those with responsibility for assessment and the provision of services to work together according to an agreed plan of action. Effective collaboration requires organisations and people to be clear about:

81 www.dcsf.gov.uk/safeguarding

- their roles and responsibilities for safeguarding and promoting the welfare of children (see the *Statutory guidance on making arrangements to safeguard and promote the welfare of children under section 11 of the Children Act 2004* (2007) and Chapter 2);
- the purpose of their activity, the decisions required at each stage of the process and the planned outcomes for the child and family members;
- the legislative basis for the work;
- the policies and procedures to be followed, including the way in which information will be shared across professional boundaries and within agencies, and recorded for each child;
- which organisation, team or professional has lead responsibility and the precise roles of everyone else who is involved, including the way in which children and family members will be involved; and
- any timescales set down in regulations or guidance which govern the completion of assessments, making of plans and timing of reviews.

Principles underpinning work to safeguard and promote the welfare of children

5.4 The following principles, which draw on findings from research, underpin work with children and their families to safeguard and promote the welfare of children (see also paragraph 2.18 in the guidance issued under section 11 of the Children Act 2004). These principles should be followed when implementing the guidance set out in this chapter. They will be relevant to varying degrees depending on the functions and level of involvement of the organisation and the individual practitioner concerned.

5.5 Work to safeguard and promote the welfare of children should be:

- **Child centred**
  The child should be seen (alone when appropriate) by the lead social worker[82] in addition to all other professionals who have a responsibility for the child's welfare. His or her welfare should be kept sharply in focus in all work with the child and family. The significance of seeing and observing the child cannot be overstated. The child should be spoken and listened to, and their wishes and feelings ascertained, taken into account (having regard to their age and

82 Local authority children's social care is required by the Children Act 1989 (as amended by section 53 of the Children Act 2004) to ascertain the child's wishes and feelings and to give due consideration to the child's wishes and feelings having regard to their age and understanding, when determining what (if any) services to provide.

understanding) and recorded when making decisions about the provision of services. Some of the worst failures of the system have occurred when professionals have lost sight of the child and concentrated instead on their relationship with the adults.

- **Rooted in child development**
  Those working with children should have a detailed understanding of child development and how the quality of the care they are receiving can have an impact on their health and development. They should recognise that as children grow, they continue to develop their skills and abilities. Each stage, from infancy through middle years to adolescence, lays the foundation for more complex development. Plans and interventions to safeguard and promote the child's welfare should be based on a clear assessment of the child's developmental progress and the difficulties the child may be experiencing. Planned action should also be timely and appropriate for the child's age and stage of development.

- **Focused on outcomes for children**
  When working directly with a child, any plan developed for the child and their family or caregiver should be based on an assessment of the child's developmental needs and the parents/caregivers' capacity to respond to these needs within their family and environmental context. The plan should set out the planned outcomes for the child; progress against these should be regularly reviewed and the actual outcomes should be recorded. The purpose of all interventions should be to achieve the best possible outcomes for each child, recognising that each child is unique. These outcomes should contribute to the key outcomes set out for all children in the Children Act 2004 (see paragraph 1.1).

- **Holistic in approach**
  Having a holistic approach means having an understanding of a child within the context of their family (parents or caregivers and the wider family) and of the educational setting, community and culture in which he or she is growing up. The interaction between the developmental needs of children, the capacities of parents or caregivers to respond appropriately to those needs, the impact of wider family and environmental factors on children and on parenting capacity, requires careful exploration during an assessment. The ultimate aim is to understand the child's developmental needs and the capacity of the parents or caregivers to meet them and to provide services to the child and to the family members that respond to these needs. The child's context will be even more complex when they are living away from home and looked after by adults who do not have parental responsibility for them.

- **Ensuring equality of opportunity**
  Equality of opportunity means that all children have the opportunity to achieve

the best possible developmental outcomes, regardless of their gender, ability, race, ethnicity, circumstances or age. Some vulnerable children may have been particularly disadvantaged in their access to important opportunities and their health and educational needs will require particular attention in order to optimise their current welfare as well as their long-term outcomes into adulthood.

- **Involving children and families**
  In the process of finding out what is happening to a child it is important to listen to the child, develop a therapeutic relationship with the child and through this gain an understanding of his or her wishes and feelings.

  The importance of developing a co-operative working relationship is emphasised so that parents or caregivers feel respected and informed; they believe staff are being open and honest with them and in turn they are confident about providing vital information about their child, themselves and their circumstances. The consent of children or their parents/caregivers, where appropriate, should be obtained for sharing information unless to do so would place a child at risk of suffering significant harm. Similarly, decisions should also be made with their agreement, whenever possible, unless to do so would place the child at risk of suffering significant harm.

- **Building on strengths as well as identifying difficulties**
  Identifying both strengths (including resilience and protective factors) and difficulties (including vulnerabilities and risk factors) within the child, his or her family and the context in which they are living is important, as is considering how these factors are having an impact on the child's health and development. Too often it has been found that a deficit model of working with families predominates in practice and ignores crucial areas of success and effectiveness within the family on which to base interventions. Working with a child or family's strengths becomes an important part of a plan to resolve difficulties.

- **Integrated in approach**
  From birth there will be a variety of different agencies and services in the community involved with children and their development, particularly in relation to their health and education. Multi- and inter-agency work to safeguard and promote children's welfare starts as soon as it has been identified that the child or the family members have additional needs requiring support/services beyond universal services, not just when there are questions about possible harm.

- **A continuing process not an event**
  Understanding what is happening to a vulnerable child within the context of his or her family and the local community and taking appropriate action are continuing and interactive processes, and not single events. Assessment should

continue throughout a period of intervention and intervention may start at the beginning of an assessment.

- **Providing and reviewing services**
  Action and services should be provided according to the identified needs of the child and family in parallel with assessment where necessary. It is not necessary to await completion of the assessment process. Immediate and practical needs should be addressed alongside more complex and longer term ones. The impact of service provision on a child's developmental progress should be reviewed at regular intervals.

- **Informed by evidence**
  Effective practice with children and families requires sound professional judgements which are underpinned by a rigorous evidence base, and draw on the practitioner's knowledge and experience. Decisions based on these judgements should be kept under review, and take full account of any new information obtained during the course of work with the child and family.

The processes for safeguarding and promoting the welfare of children

5.6 Four key processes underpin work with children and families, each of which has to be carried out effectively in order to achieve improvements in the lives of children in need. They are assessment, planning, intervention and reviewing.

5.7 The flow charts at the end of this chapter illustrate the processes for safeguarding and promoting the welfare of children:

- from the point that concerns are raised about a child and are referred to a statutory organisation that can take action to safeguard and promote the welfare of children (Flow chart 1);
- through an initial assessment of the child's situation and what happens after that (Flow chart 2);
- taking urgent action, if necessary (Flow chart 3);
- to the strategy discussion, where there are concerns about a child's safety, and beyond that to the child protection conference (Flow chart 4); and
- what happens after the child protection conference, and the review process (Flow chart 5).

Being alert to children's safety and welfare

5.8 Everybody who works or has contact with children, parents and other adults in contact with children should be able to recognise, and know how to act upon, evidence that a child's health or development is or may be being impaired – especially when they are suffering, or likely to suffer, significant harm. Practitioners, foster carers, and managers should be mindful always of the safety and welfare of children – including unborn children, older children and children living away from home or looked after by the local authority – in their work:

With children

5.9 *For example:* early years staff, teachers, school nurses, health visitors, GPs, Accident and Emergency and all other hospital staff, and staff, in the youth justice system, including the secure estate, should be able to recognise situations where a child requires extra support to prevent impairment to his or her health or development or possible signs or symptoms of abuse or neglect in children. All professionals working with children, and especially those in health and social care, should be familiar with the core standards set out in the *National Service Framework for Children, Young People and Maternity Services Core Standards* and in particular, Standard 5, *Safeguarding and Promoting the Welfare of Children and Young People*. Those working with children living away from home should also be familiar with the relevant statutory Regulations and National Minimum Standards[83]. Children living in custodial settings should be assessed as potential children in need under section 17 of the Children Act 1989 and all children subject to a court ordered secure remand (COSR) automatically acquire the status of a looked after child.

With parents or caregivers who may need help in promoting and safeguarding their children's welfare

5.10 *For example:* adult mental health, substance misuse services and criminal justice agencies should always consider the implications for children of patients' or users' behaviours and the impact these may have on their parenting capacity. Day nurseries and children's and family centres should keep the interests of children uppermost in their minds when working with parents, work in ways intended to bring about better outcomes for children and be alert to possible signs or symptoms of abuse or neglect. When dealing with cases of domestic violence, the police and other involved agencies should consider the impact that this behaviour has on children, in particular their emotional development, and the victim's capacity to protect a child from harm and meet their identified needs.

83 www.dcsf.gov.uk/everychildmatters/safeguardingandsocialcare/childrenincare/childrenincare/

With family members, employees, or others who have contact with children

5.11 *For example:* the police, probation and prison services, mental health services and housing authorities should be alert to the possibility that an individual may pose a risk of causing harm to a particular child, or to children in a local community. Employers of staff or volunteers who have substantial unsupervised access to children should guard against the potential for abuse or neglect, through rigorous selection processes, appropriate supervision and by taking steps to maintain a safe environment for children. For further details on this matter see Chapter 12.

Use of the Common Assessment Framework

5.12 The Common Assessment Framework (CAF) offers a basis for early identification of children's additional needs, sharing of this information between organisations and the co-ordination of service provision. Where it is considered a child may have additional needs, with the consent of the child, young person or parents/carers, practitioners may undertake a common assessment in accordance with the national practice guidance[84] to assess these needs and to decide how best to support them. The findings from the common assessment may however give rise to concerns about a child's safety and welfare. Practitioners should be particularly concerned regarding children whose parents or caregivers are experiencing difficulties in meeting their needs as a result of domestic violence, substance misuse, mental illness and/or learning disability (see paragraphs 9.13–9.66). All staff members who have or become aware of concerns about the safety or welfare of a child or children should know:

- who to contact in what circumstances, and how; and
- when and how to make a referral to local authority children's social care services or the police.

Discussion of concerns about a child's safety and welfare

5.13 Irrespective of whether a common assessment has been undertaken, where there are concerns that a child may be a possible child in need, and in particular where there are concerns about a child being harmed, relevant information about the child and family should be discussed with a manager, or a named or designated health professional or a designated member of staff depending on the organisational setting. Concerns can also be discussed, without necessarily identifying the child in question, with senior colleagues in another agency, (for example, children's social care services) in order to develop an understanding of the child's needs and circumstances.

84 See www.dcsf.gov.uk/everychildmatters/strategy/deliveringservices1/caf/caffframework

5.14 Where a child is not considered to be a possible child in need under section 17 of the Children Act 1989 the practitioner should consider what other types of services, including possibly a common assessment, should be offered. If it is agreed that the child may be a child in need under the Children Act 1989 (see paragraph 1.25), then a referral to children's social care should be discussed with the child and parents. If they consent, then the child should be referred to local authority children's social care and the processes set out in this chapter followed. If the child is believed or suspected to be suffering significant harm a referral should always be made to children's social care (see paragraph 5.17 below). If concerns arise about a child who is already known to local authority children's social care the allocated social worker should be informed immediately of these concerns.

5.15 There should always be the opportunity to discuss concerns about a child's safety and welfare with, and seek advice from, colleagues, managers, a designated or named professional, or other agencies but:

- never delay emergency action to protect a child from harm;
- always record in writing concerns about a child's welfare, including whether or not further action is taken; and
- always record in writing discussions about a child's welfare in the child's file. At the close of a discussion, always reach a clear and explicit recorded agreement about who will be taking what action or that no further action will be taken.

The welfare of unborn children

5.16 The procedures and time scales set out in this chapter should also be followed when there are concerns about the welfare of an unborn child.

Referrals to local authority children's social care where there are concerns about a child's safety or welfare

5.17 Local authorities with children's social services functions have particular responsibilities towards all children whose health or development may be impaired without the provision of services, or who are disabled (defined in the Children Act 1989 as 'children in need'). Where a child is considered to be a possible child in need a referral to children's social care should be made in accordance with the agreed LSCB procedures and formats. Where a common assessment has already been undertaken it should be used to support a referral to children's social care: however undertaking a CAF is not a prerequisite for making a referral.

5.18 If somebody believes or suspects that a child may be suffering, or is likely to suffer, significant harm then s/he should always refer his or her concerns to the local

authority children's social care services. In addition to social care, the police and the NSPCC have powers to intervene in these circumstances. Sometimes concerns will arise within local authority children's social care itself, as new information comes to light about a child and family with whom staff are already in contact. While professionals should seek, in general, to discuss any concerns with the child and family and, where possible, seek their agreement to making referrals to local authority children's social care, **this should only be done where such discussion and agreement-seeking will not place a child at increased risk of suffering significant harm**.

Responding to child welfare concerns where there is or may be an alleged crime

5.19 Whenever local authority children's social care has a case referred to it which constitutes, or may constitute, a criminal offence against a child it should always discuss the case with the police at the earliest opportunity.

5.20 Whenever other agencies or the local authority in its other roles encounter concerns about a child's welfare which constitute, or may constitute, a criminal offence against a child they must always consider sharing that information with local authority children's social care or the police in order to protect the child or other children from suffering significant harm. If a decision is taken not to share information the reasons must be recorded.

5.21 Sharing of information in cases of concern about children's welfare will enable professionals to consider jointly how to proceed in the best interests of the child and to safeguard children more generally (see paragraph 5.3).

5.22 In dealing with alleged offences involving a child victim the police should normally work in partnership with children's social care and/or other agencies. In circumstances where it is suspected that the child may have been conceived as the result of an incestuous relationship or interfamilial abuse, consideration should be given to the use of DNA testing and the role of genetics and geneticists. Whilst the responsibility to instigate a criminal investigation rests with the police they should consider the views expressed by other agencies. There will be less serious cases where, after discussion, it is agreed that the best interests of the child are served by a children's social care led intervention rather than a full police investigation.

5.23 In deciding whether there is a need to share information professionals should consider their legal obligations, including whether they have a duty of confidentiality to the child. Where there is such a duty, the professional may lawfully share information if the child consents or if there is a public interest of sufficient force. This must be judged by the professional on the facts of each case. Where

there is a clear likelihood of a child suffering significant harm, or an adult suffering serious harm, the public interest test will almost certainly be satisfied. However, there will be other cases where practitioners will be justified in sharing some confidential information in order to make decisions on sharing further information or taking action – the information shared should be proportionate.

5.24 The child's best interests must be the overriding consideration in making any such decision, including in the cases of underage sexual activity on which detailed guidance is given below. The cross-government guidance, *Information Sharing: Guidance for practitioners and managers* (2008) provides advice on these issues[85]. Any decision on whether or not to share information must be properly documented. Decisions in this area should be made by, or with the advice of, people with suitable competence in child protection work such as named or designated professionals or senior managers.

Allegations of harm arising from underage sexual activity

5.25 Cases of underage sexual activity which present cause for concern are likely to raise difficult issues and should be handled particularly sensitively[86]. This includes situations where girls aged under 16 years present at a termination of pregnancy clinic.

5.26 A child under 13 years is not legally capable of consenting to sexual activity. Any offence under the Sexual Offences Act 2003 involving a child aged under 13 years is very serious and should be taken to indicate that the child is suffering, or is likely to suffer, significant harm.

5.27 Cases involving children aged under 13 years should always be discussed with a nominated child protection lead in the organisation. Under the Sexual Offences Act, penetrative sex with a child under 13 years old is classed as rape. Where the allegation concerns penetrative sex, or other intimate sexual activity occurs, there would always be reasonable cause to suspect that a child, whether girl or boy, is suffering, or is likely to suffer, significant harm. There should be a presumption that the case will be reported to children's social care and that a strategy discussion will be held in accordance with the guidance set out in paragraph 5.56 below. This should involve children's social care, police, health and other relevant agencies in discussing appropriate next steps with the professional. All cases involving under 13s should be fully documented including detailed reasons where a decision is taken not to share

85 See www.dcsf.gov.uk/informationsharing

86 Further guidance is provided by the Department of Health best practice guidance for doctors and other health professionals on the provision of advice and treatment to young people under 16 on contraception, reproductive and sexual health.

information. These decisions should be exceptional and only made with the documented approval of a senior manager.

5.28 Sexual activity with a child aged under 16 years is also an offence. Where it is consensual it may be less serious than if the child were aged under 13 years but may, nevertheless, have serious consequences for the welfare of the young person. Consideration should be given in every case of sexual activity involving a child aged 13–15 as to whether there should be a discussion with other agencies and whether a referral should be made to children's social care. The professional should make this assessment using the considerations below. Within this age range the younger the child the stronger the presumption must be that sexual activity will be a matter of concern. Cases of concern should be discussed with the nominated child protection lead and subsequently with other agencies if required. Where confidentiality needs to be preserved a discussion can still take place as long as it does not identify the child (directly or indirectly). Where there is reasonable cause to suspect that significant harm to a child has occurred, or is likely to occur, there should be a presumption that the case is reported to children's social care and a strategy discussion should be held to discuss appropriate next steps. Again, all cases should be carefully documented including where a decision is taken not to share information.

5.29 The considerations in the following checklist should be taken into account when assessing the extent to which a child (or other children) is suffering, or is likely to suffer, significant harm and therefore whether a strategy discussion should be held in order to share information:

- the age of the child. Sexual activity at a young age is a very strong indicator that there are risks to the welfare of the child (whether boy or girl) and, possibly, others;
- the level of maturity and understanding of the child;
- what is known about the child's living circumstances or background;
- age imbalance, in particular where there is a significant age difference;
- overt aggression or power imbalance;
- coercion or bribery;
- familial child sex offences;
- behaviour of the child i.e. withdrawn, anxious;
- the misuse of substances as a disinhibitor;

- whether the child's own behaviour because of the misuse of substances places him/her at risk of suffering harm so that he/she is unable to make an informed choice about any activity;
- whether any attempts to secure secrecy have been made by the sexual partner beyond what would be considered usual in a teenage relationship;
- whether the child denies, minimises or accepts concerns;
- whether the methods used are consistent with grooming; and
- whether the sexual partner/s is known by one of the agencies.

5.30 In cases of concern when sufficient information is known about the sexual partner/s, the agency concerned should check with other agencies, including the police, to establish whatever information is known about that person/s. In appropriate cases the police may share the required information without beginning a full investigation if the agency making the check requests this.

5.31 Sexual activity involving a 16 or 17 year old, even if it does not involve an offence, may still involve harm or the likelihood of harm being suffered. Professionals should still bear in mind the considerations and processes outlined in this guidance in assessing whether harm is being suffered, and should share information as appropriate. It is an offence for a person to have a sexual relationship with a 16 or 17 year old if they hold a position of trust or authority in relation to them.

Response of local authority children's social care to a referral

5.32 When a parent, professional, or another person contacts local authority children's social care with concerns about a child's welfare, it is the responsibility of local authority children's social care to clarify with the referrer (including self-referrals from children and families):

- the nature of concerns;
- how and why they have arisen;
- what appear to be the needs of the child and family; and
- what involvement they are having or have had with the child and/or family members.

The referrer should have the opportunity to discuss their concerns with a qualified social worker. The process of clarifying the nature of the referral should always identify clearly whether there are concerns about maltreatment and the associated risk factors, the evidence for these concerns and whether it may be necessary to

consider taking urgent action to ensure the child(ren) are safe from harm. Local authority children's social care should specifically ask the referrer if they hold any information about difficulties being experienced in the family/household due to domestic violence, mental illness, substance misuse and/or learning disability in order to inform its decision making.

5.33 Professionals who phone local authority children's social care should confirm their referrals in writing within 48 hours. The CAF provides a structure for the written referral but prior completion of a CAF should not be a pre-requisite for a referral being accepted by the local authority. At the end of any discussion about a child, the referrer (whether a professional or a member of the public or family) and local authority children's social care should be clear about the local authority's proposed course of action in response to the referral, timescales and who will be taking this action, or if no further action will be taken. The decision should be recorded by local authority children's social care in the child's case file and by the referrer (if a professional in another service). Local authority children's social care should acknowledge a written referral within one working day of receiving it. If the referrer has not received an acknowledgement within three working days they should contact local authority children's social care again.

5.34 **Local authority children's social care should decide how they will respond to the referral and record next steps of action within one working day.** This information should be consistent with the information set out in the Referral and Information Record (Department of Health, 2002). This decision should normally follow discussion with any referring professional/service, consideration of information held in any existing records and involve discussion with other professionals and services as necessary[87] (including the police, where a criminal offence may have been committed against a child). An initial consideration of the case should address – on the basis of the available evidence – whether there are concerns about impairment to the child's health and development or the child suffering harm which justifies an initial assessment to establish whether this child is a child in need. Local authority children's social care should ensure that the social work practitioners who are responding to referrals are supported by experienced first line managers competent in making sound evidence based decisions about what to do next. Further action by children's social care may also include referral to other agencies, the provision of information or advice – such as suggesting the completion of a common assessment by the referring agency or organisation – or no further action.

5.35 The parents' permission, or the child's where appropriate, should be sought before discussing a referral about them with other agencies unless permission-seeking may

87 ContactPoint provides an efficient way for people working with children to find out who else is working with the same child. Information is available at: www.dcsf.gov.uk/ecm/contactpoint

itself place the child at increased risk of suffering significant harm. When responding to referrals from a member of the public rather than another professional, local authority children's social care should bear in mind that personal information about referrers, including identifying details, should only be disclosed to third parties (including subject families and other agencies) with the consent of the referrer. In all cases where the police are involved, the decision about when to inform the parents (about referrals from third parties) will have a bearing on the conduct of police investigations.

5.36 Where local authority children's social care decides to take no further action at this stage, feedback should be provided to the referrer, who should be told of this decision and the reasons for making it. In the case of public referrals, this should be done in a manner consistent with respecting the confidentiality of the child. Sometimes it may be apparent at this stage that emergency action should be taken to safeguard and promote the welfare of a child (see paragraph 5.51). Such action should normally be preceded by an immediate strategy discussion between the police, local authority children's social care and other agencies as appropriate.

5.37 New information may be received about a child or family where the child or family member is already known to local authority children's social care. If the child's case is open and there are concerns that the child is, or is likely to be, suffering significant harm then a decision should be made about whether a strategy discussion should be held in order to consider whether to initiate section 47 enquiries (see paragraph 5.56). It may, also, be appropriate to consider undertaking a core assessment or to update a previous one in order to understand the child's current needs and circumstances and inform future decision making.

Initial assessment

5.38 The initial assessment is a brief assessment of each child referred to local authority children's social care where it is necessary to determine whether:

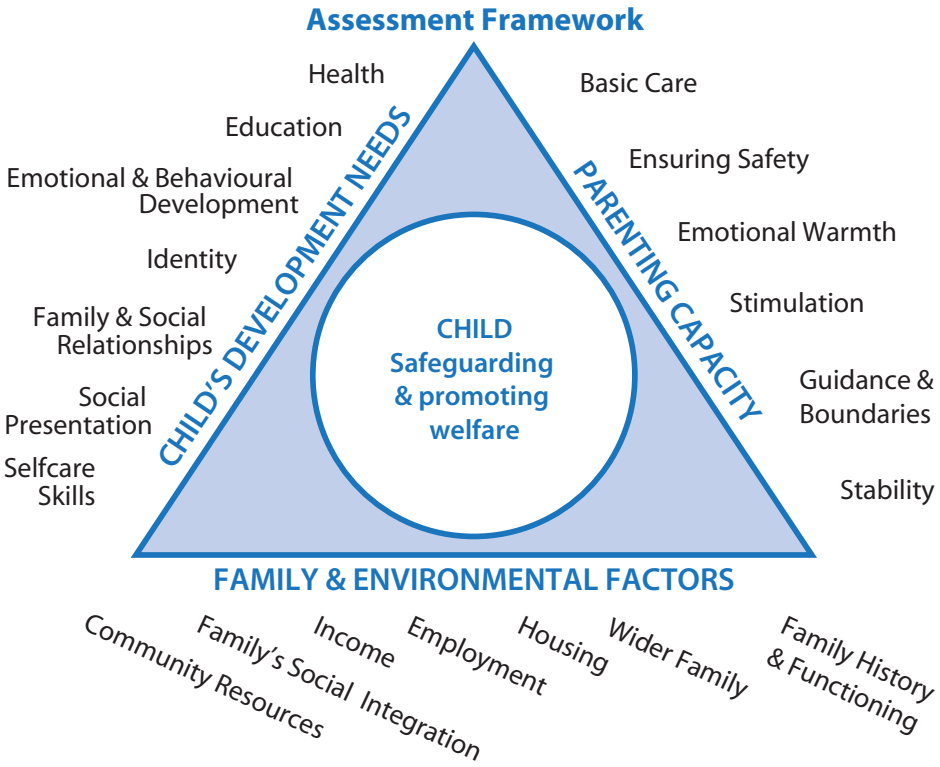
- the child is in need;
- there is reasonable cause to suspect the child is suffering, or is likely to suffer, significant harm;
- any services are required and of what types; and
- a further, more detailed core assessment should be undertaken (paragraph 3.9 of the *Framework for the Assessment of Children in Need and their Families* (2000)).

5.39 The initial assessment should be completed by local authority children's social care, working with colleagues, within a maximum of 10 working days of the date of referral. An initial assessment is deemed to be completed once the assessment has

been discussed with the child and family (or caregivers) and the team manager has viewed and authorised the assessment. The initial assessment period may be very brief if the criteria for initiating section 47 enquiries are met, i.e. it is suspected that the child is suffering, or is likely to suffer, significant harm. The initial assessment should be undertaken in accordance with statutory guidance, the *Framework for the Assessment of Children in Need and their Families* (Department of Health et al, 2000) (the 'Assessment Framework' – summarised in Appendix 2). Where a common assessment has been completed this information should be used to inform the initial assessment. Information should be gathered and analysed within the three domains of the Assessment Framework (see Figure1), namely:

- the child's developmental needs;
- the parents' or caregivers' capacity to respond appropriately to those needs; and
- the wider family and environmental factors.

Figure 1.



5.40 The initial assessment should address the following questions:

- what are the developmental needs of the child? What needs of the child are being met and how? What needs of the child are not being met and why not?

- are the parents able to respond appropriately to the child's identified needs? Is the child being adequately safeguarded from harm, and are the parents able to promote the child's health and development?
- what impact are family functioning (past and present) and history, and the wider family and environmental factors having on the parent's capacity to respond to their child's needs and the child's developmental progress?
- is action required to safeguard and promote the welfare of the child? Within what timescales should this action be taken?

5.41 The initial assessment should be led by a qualified and experienced social worker who is supervised by a highly experienced and qualified social work manager. It should be carefully planned, with clarity about who is doing what, as well as when and what information is to be shared with the parents. The planning process and decisions about the timing of the different assessment activities should be undertaken in collaboration with all those involved with the child and family. The process of initial assessment should involve:

- seeing and speaking to the child, including alone when appropriate;
- seeing and meeting with parents, the family and wider family members as appropriate;
- involving and obtaining relevant information from professionals and others in contact with the child and family; and
- drawing together and analysing available information (focusing on the strengths and positive factors as well as vulnerabilities and risk factors) from a range of sources (including existing agency records).

All relevant information (including information about the history and functioning of the family both currently and in the past, and adult problems such as domestic violence, substance misuse, mental illness and criminal behaviour/convictions) should be taken into account. This includes seeking information from relevant services if the child and family have spent time abroad. Professionals from agencies such as health, local authority children's social care or the police should request this information from their equivalent agencies in the country(ies) in which the child has lived. Information about who to contact can be obtained via the Foreign and Commonwealth Office or the appropriate Embassy or Consulate based in London[88].

5.42 The child should be seen by the lead social worker, without his or her caregivers present when appropriate, within a timescale which is appropriate to the nature of

88 See the London Diplomatic List (The Stationery Office), ISBN 0 11 591772 1, the FCO website www.fco.gov.uk or phone 020 7008 1500

concerns expressed at the time of the referral, according to the agreed plan. Seeing the child includes observing and communicating with the child in a manner appropriate to his or her age and understanding. Local authority children's social care is required by the Children Act 1989 (as amended by section 53 of the Children Act 2004) to ascertain the child's wishes and feelings and to give due consideration to the child's wishes and feelings, having regard to their age and understanding, when making decisions about what (if any) services to provide. Interviews with the child should be undertaken in the preferred language of the child. For some disabled children interviews may require the use of non-verbal communication methods.

5.43 **It will not necessarily be clear whether a criminal offence has been committed**, which means that even initial discussions with the child should be undertaken in a way that minimises distress to them and maximises the likelihood that she or he will provide accurate and complete information. It is important to avoid leading questions or suggesting answers.

5.44 Interviews with family members (which may include the child) should also be undertaken in their preferred language and where appropriate for some people by using non-verbal communication methods.

5.45 In the course of an initial assessment local authority children's social care should ascertain:

- is this a child in need? (section 17 of the Children Act 1989); and
- is there reasonable cause to suspect that this child is suffering, or is likely to suffer, significant harm? (section 47 of the Children Act 1989).

5.46 The focus of the initial assessment should be both on the safety and the welfare of the child. It is important to remember that even if the reason for a referral was a concern about abuse or neglect that is not subsequently substantiated, a child and family may still benefit from support and practical help to promote a child's health and development. When services are to be provided a child in need plan should be developed based on the findings from the initial assessment and on any previous plans, for example, those made following the completion of a common assessment. If the child's needs and circumstances are complex a more in-depth core assessment under section 17 of the Children Act 1989 will be required in order to decide what other types of services are necessary to assist the child and family (see the *Framework for the Assessment of Children in Need and their Families*). Appendix 1 sets out the statutory framework including relevant sections of the Children Act 1989. Appendix 3 *Using standardised assessment tools to evidence assessment and decision making* is intended for use by practitioners to support evidence-based assessment and decision making.

5.47 Once an initial assessment has been completed (see paragraph 5.39 for definition of completed) local authority children's social care should decide on the next course of action, following discussion with the child and family, unless such a discussion may place a child at increased risk of suffering significant harm. If there are concerns about a parent's ability to protect a child from harm, careful consideration should be given to what the parents should be told when and by whom, taking account of the child's welfare. Where it is clear that there should be a police investigation in parallel with a section 47 enquiry the considerations at paragraph 5.66 should apply. Whatever decisions are taken they should be endorsed at a managerial level agreed within local authority children's social care and recorded in writing. This information should be consistent with that contained in the Initial Assessment Record (Department of Health, 2002). The local authority record in relation to the child should include whether the child was seen and who else, if anyone, was present at the time of each visit and also the reasons for deciding (or not) to see the child alone. The local authority record should also set out the decisions made and future action to be taken. The family, the original referrer, and other professionals and services involved in the initial assessment should, as far as possible, be told what action has been and will be taken consistent with respecting the confidentiality of the child and family concerned, and not jeopardising further action in respect of concerns about harm (which may include police investigations). This information should be confirmed in writing to the agencies, the family and where appropriate the child.

Next steps – child in need but no suspected actual or likely significant harm

5.48 An initial assessment may indicate that a child is a 'child in need' as defined by section 17 of the Children Act 1989 but that there are no substantiated concerns that the child may be suffering, or is likely to suffer, significant harm. There may be sufficient information available on which to decide what services (if any) should be provided by whom according to an agreed plan. On the other hand a more in-depth assessment may be necessary in order to understand the child's needs and circumstances. In these circumstances, the Assessment Framework provides guidance on undertaking a core assessment which builds on the findings from the initial assessment and addresses the central or most important aspects of the needs of a child and the capacity of his or her parents or caregivers to respond appropriately to these needs within the wider family and community context. This core assessment can provide a sound evidence base for professional judgements on what types of services are most likely to bring about good outcomes for the child. Family Group Conferences (see paragraphs 10.2–10.4) may be an effective vehicle for taking forward work in such cases.

5.49 The definition of a 'child in need' is wide and it will embrace children in a diverse range of circumstances. The types of services that may help such children and their families will vary greatly according to their needs and circumstances.

The rest of the guidance in this chapter is concerned with the processes which should be followed where a child is suspected to be suffering, or is likely to suffer, significant harm.

The Children Act 1989 introduced the concept of significant harm as the threshold that justifies compulsory intervention in family life, in the best interests of children. It gives local authorities a duty under section 47 to make enquiries when they have *reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or likely to suffer, significant harm* to enable them to decide whether they should take action to safeguard or promote the child's welfare.

This statutory guidance adopts specifically the legislative terminology of 'significant harm' in preference to the use of the word "risk", given the need both to reflect the legislative requirements and to avoid confusion with the wide variety of contexts and associated tools and methodologies associated with risk assessment/analysis. When assessing whether a child is suffering, or likely to suffer, significant harm local authority children's social care will of course draw on a wide variety of information including the outcomes of relevant risk assessments or judgments provided by other agencies and professionals to inform their own evidence based assessment.

Next steps – suspicion that a child is suffering, or is likely to suffer, significant harm

5.50 Where it is suspected that a child is suffering, or is likely to suffer, significant harm the local authority is required by section 47 of the Children Act 1989 to make enquiries to enable it to decide whether it should take any action to safeguard and promote the welfare of the child. A section 47 enquiry should be carried out through a core assessment (see paragraph 5.62). The *Framework for the Assessment of Children in Need and their Families* provides a structured framework for collecting, drawing together and analysing available information about a child and family within and between the following three domains:

- the child's developmental needs;
- parenting capacity; and
- and family and environmental factors.

Using the framework will help to provide sound evidence on which to base often difficult professional judgements about whether to intervene to safeguard and promote the welfare of a child and if so, how best to do so and with what intended outcomes.

Immediate protection

5.51 Where there is a risk to the life of a child or a likelihood of serious immediate harm, an agency with statutory child protection powers[89] **should act quickly to secure the immediate safety of the child**. Emergency action might be necessary as soon as a referral is received or at any point in involvement with a child/ren and their family (see Appendix 1, paragraph 18 for the range of emergency protection powers available). The need for emergency action may become apparent only over time as more is learned about the circumstances of a child or children. Neglect, as well as abuse, can result in a child suffering significant harm to the extent that urgent protective action is necessary. When considering whether emergency action is required, an agency should always consider whether action is also required to safeguard and promote the welfare of other children in the same household, the household of an alleged perpetrator or elsewhere.

5.52 Planned emergency action will normally take place following an immediate strategy discussion between the police, local authority children's social care and other agencies as appropriate (including NSPCC where involved). Where a single agency has to act immediately to protect a child, a strategy discussion should take place as soon as possible after such action to plan next steps. Legal advice should normally be obtained before initiating legal action, in particular, when an Emergency Protection Order (EPO) is to be sought. For further guidance on EPOs see pages 55–65 of Volume 1 of the Children Act 1989 Guidance and Regulations, Court Orders[90].

5.53 In some cases, it may be sufficient to secure a child's safety by a parent taking action to remove an alleged perpetrator or by the alleged perpetrator agreeing to leave the home. In other cases, it may be necessary to ensure either that the child remains in a safe place or that the child is removed to a safe place, either on a voluntary basis or by obtaining an EPO. The police also have powers to remove a child to suitable accommodation in cases of emergency. If it is necessary to remove a child a local authority should wherever possible – and unless a child's safety is otherwise at immediate risk – apply for an EPO. **Police powers should only be used in exceptional circumstances where there is insufficient time to seek an EPO or for reasons relating to the immediate safety of the child.**

89 Agencies with statutory child protection powers comprise the local authority, the police, and the NSPCC.

90 www.dcsf.gov.uk/everychildmatters/publications/documents/childrenactguidanceregulations/

5.54 The local authority in whose area a child is found in circumstances that require emergency action is responsible for taking that action. If the child is looked after by, or the subject of a child protection plan in another authority, the first authority should consult the authority responsible for the child. Only when the second local authority explicitly accepts responsibility is the first authority relieved of its responsibility to take emergency action. Such acceptance should be confirmed subsequently in writing.

5.55 Emergency action addresses only the immediate circumstances of the child(ren). The local authority should follow this action quickly by initiating section 47 enquiries as necessary. The agencies primarily involved with the child and family should be involved in the core assessment to understand the needs and circumstances of the child and family, and agree action to safeguard and promote the welfare of the child in the longer-term. Where an EPO applies, local authority children's social care will have to consider quickly whether to initiate care or other proceedings or to let the order lapse and the child return home.

Strategy discussion

5.56 Whenever there is reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm there should be a strategy discussion involving local authority children's social care, the police, health and other bodies as appropriate (for example, children's centre/school or family intervention projects), in particular any referring agency. The strategy discussion should be convened and led by local authority children's social care and those participating should be sufficiently senior and able, therefore, to contribute to the discussion of available information and to make decisions on behalf of their agencies. If the child is a hospital patient (in- or out-patient) or receiving services from a child development team, the medical consultant responsible for the child's health care should be involved, as should the senior ward nurse if the child is an in-patient. Where a medical examination may be necessary or has taken place a senior doctor from those providing services should also be involved. Where the parents or adults in the household are experiencing problems such as domestic violence, substance misuse or mental illness it will also be important to consider involving the relevant adult services professional(s).

5.57 A strategy discussion may take place following a referral, or at any other time (for example, if concerns about significant harm emerge in respect of child receiving services under section 17). The discussion should be used to:

- share available information;
- agree the conduct and timing of any criminal investigation;

- decide whether section 47 enquiries should be initiated and therefore a core assessment be undertaken under section 47 of the Children Act 1989, or continued if it had already begun under section 17 of the Children Act 1989;
- plan how the section 47 enquiry should be undertaken (if one is to be initiated) including the need for medical treatment and who will carry out what actions, by when and for what purpose;
- agree what action is required immediately to safeguard and promote the welfare of the child, and/or provide interim services and support. If the child is in hospital decisions should also be made about how to secure the safe discharge of the child;
- determine what information from the strategy discussion will be shared with the family unless such information sharing may place a child at increased risk of suffering significant harm or jeopardise police investigations into any alleged offence(s); and
- determine if legal action is required.

5.58 Relevant matters will include:

- agreeing a plan for how the core assessment under section 47 of the Children Act 1989 will be carried out – what further information is required about the child(ren) and family and how it should be obtained and recorded;
- agreeing who should be interviewed, by whom, for what purpose and when. The way in which interviews are conducted can play a significant part in minimising any distress caused to children and increase the likelihood of maintaining constructive working relationships with families. When a criminal offence may have been committed against a child, the timing and handling of interviews with victims, their families and witnesses can have important implications for the collection and preservation of evidence;
- agreeing, in particular, when the child will be seen alone (unless to do so would be inappropriate for the child) by the lead social worker during the course of these enquiries and the methods by which the child's wishes and feelings will be ascertained so that they can be taken into account when making decisions under section 47 of the Children Act 1989;
- in the light of the race and ethnicity of the child and family, considering how these should be taken into account and establishing whether an interpreter will be required; and
- considering the needs of other children who may be affected – for example, siblings and other children, such as those living in the same establishment – in contact with alleged abusers.

5.59 A strategy discussion may take place at a meeting or by other means (for example, by telephone). In complex types of maltreatment a meeting is likely to be the most effective way of discussing the child's welfare and planning future action. More than one strategy discussion may be necessary. This is likely to be where the child's circumstances are very complex and a number of discussions are required to consider whether and if so, when to initiate section 47 enquiries as well as how best to undertake them. Such a meeting should be held at a convenient location for the key attendees, such as a hospital, school, police station or children's services office. Any information shared, all decisions reached and the basis for those decisions should be clearly recorded by the chair of the strategy discussion and circulated within one working day to all parties to the discussion. Local authority children's social care should record information in the child's file which is consistent with the information set out in the Record of Strategy Discussion (Department of Health, 2002). Any decisions about taking immediate action should be kept under constant review.

5.60 Significant harm to children gives rise to both child welfare and law enforcement concerns and section 47 enquiries may run concurrently with police investigations concerning possible associated crime(s). The police have a duty to carry out thorough and professional investigations into allegations of crime and the obtaining of clear strong evidence is in the best interests of a child, since it makes it less likely that a child victim will have to give evidence in criminal court. Enquiries may, therefore, give rise to information that is relevant to decisions that will be taken by both local authority children's social care and the police. The findings from the assessment and/or police investigation should be used to inform plans about future support and help to the child and family. They may also contribute to legal proceedings, whether criminal, civil or both.

5.61 Each LSCB should have in place a protocol for local authority children's social care and the police, to guide both agencies in deciding how section 47 enquiries and associated police investigations should be conducted jointly and in particular, in what circumstances section 47 enquiries and a linked criminal investigation are necessary and/or appropriate. When joint enquiries take place the police have the lead for the criminal investigation and local authority children's social care have the lead for the section 47 enquiries and the child's welfare.

Section 47 enquiries and core assessment

5.62 The core assessment is the means by which a section 47 enquiry is carried out. It should be led by a qualified and experienced social worker. Local authority children's social care has lead responsibility for the core assessment under section 47 of the Children Act 1989. In these circumstances the objective of the local authority's involvement is to determine whether and what type of action is required

to safeguard and promote the welfare of the child who is the subject of the section 47 enquiries. The *Framework for the Assessment of Children in Need and their Families* (2000) provides the structure for helping to collect and analyse information obtained in the course of section 47 enquiries. The core assessment should begin by focusing primarily on the information identified during the initial assessment as being of most importance or seriousness when considering whether the child is suffering, or is likely to suffer, significant harm. It should, however, cover all relevant dimensions in the Assessment Framework before its completion. Those making enquiries about a child should always be alert to the potential needs and safety of any siblings or other children in the household of the child in question. In addition, enquiries may also need to cover children in other households with whom the alleged offender may have had contact. At the same time, the police will have to (where relevant) establish the facts about any offence that may have been committed against a child and to collect evidence.

5.63 The Children Act 1989 places a statutory duty on health, education and other services to help the local authority in carrying out its social services functions under Part III of the Children Act 1989 and in undertaking section 47 enquiries. Assessing the needs of a child and the capacity of their parents or wider family network to ensure his or her safety, health and development, very often depends on building a picture of the child's situation on the basis of information from many sources. The local authority social worker, in leading the section 47 enquiry, should do his or her utmost to secure willing co-operation and participation from all professionals and services by being prepared to explain and justify the local authority's actions and to demonstrate that the process is being managed in a way that can help to bring about better outcomes for children. The LSCB has an important role to play in cultivating and promoting a climate of trust and understanding between different professionals and services.

5.64 The child's wishes and feelings should be ascertained and regard given to their age and understanding when making decisions about what (if any) services to provide. Section 47 enquiries should always involve interviews with the child who is the subject of concern. The child should be seen by the lead social worker and communicated with alone when appropriate. Some children may need to be seen, for example, with an interpreter or a person who can use their preferred method of communication (see paragraph 5.65). Others, such as babies, may need to be seen in the presence of their primary caregiver so as to minimise their distress. In addition, the enquiries should involve interviews with parents and/or caregivers (both with the child present and in the child's absence) and observations of the interactions between parents and child(ren) (where appropriate in a variety of settings).

Enquiries may also include:

- interviews with those who are personally (for example, wider family members) and professionally connected with the child;
- specific examinations or assessments of the child by other professionals (for example, medical or developmental checks, assessment of emotional or psychological state); and
- interviews with those who are personally and professionally connected with the child's parents and/or caregivers.

5.65 Individuals should always be enabled to participate fully in the enquiry process. Where a child or parent is disabled, it may be necessary to provide help with communication to enable the child or parent to express him/herself to the best of his or her ability. Where a child or parent speaks a language other than that spoken by the interviewer, an interpreter should be provided. If the child is unable to take part in an interview because of age or understanding, alternative means of understanding the child's wishes or feelings should be used, including observation where children are very young or where they have communication impairments.

5.66 Children are a key and sometimes the only source of information about what has happened to them especially in child sexual abuse cases but also in physical and other forms of abuse. Accurate and complete information is essential for taking action to safeguard and promote the welfare of the child, as well as for any criminal proceedings that may be instigated concerning an alleged perpetrator of abuse. When children are first approached, the nature and extent of any harm suffered by them may not be clear, nor whether a criminal offence has been committed. It is important that even initial discussions with children are conducted in a way that minimises any distress caused to them and maximises the likelihood that they will provide accurate and complete information. It is important, wherever possible, to have separate communication with a child. Leading or suggestive communication should always be avoided. Children may need time and more than one opportunity in order to develop sufficient trust to communicate any concerns they may have, especially if they have a communication impairment, learning disabilities, are very young or are experiencing mental health problems.

5.67 Exceptionally, a joint enquiry/investigation team may need to speak to a suspected child victim without the knowledge of the parent or caregiver. Relevant circumstances would include the possibility that a child would be threatened or otherwise coerced into silence, a strong likelihood that important evidence would be destroyed or that the child in question did not wish the parent to be involved at that stage and is competent to take that decision. As at paragraph 5.43 above, in all cases where the police are involved, the decision about when to inform the parent

or caregiver will have a bearing on the conduct of police investigations and the strategy discussion should decide on the most appropriate timing of parental participation.

5.68 In accordance with the practice guidance *Achieving Best Evidence* (2007), all such joint interviews with children should be conducted by those with specialist training and experience in interviewing children. Additional specialist help may be required if:

- the child is very young;
- the child does not speak English at a level which enables him or her to participate in the interview;
- the child appears to have a degree of psychiatric disturbance but is deemed competent;
- the child has an impairment; or
- the interviewers do not have adequate knowledge and understanding of the child's racial, religious or cultural background.

Consideration should also be given to the gender of interviewers, particularly in cases of alleged sexual abuse.

5.69 Criminal justice legislation, in particular the Youth Justice and Criminal Evidence Act 1999, creates particular obligations for courts who are dealing with witnesses under 17 years of age. These include the presumption of evidence-giving through pre-recorded videos, as well as the use of live video links for further evidence-giving and cross examination.

Child Assessment Orders

5.70 Local authority children's social care should make all reasonable efforts to persuade parents to co-operate with section 47 enquiries. If, despite these efforts, the parents continue to refuse access to a child for the purpose of establishing basic facts about the child's condition – but concerns about the child's safety are not so urgent as to require an EPO – a local authority may apply to the court for a child assessment order. In these circumstances, the court may direct the parents/caregivers to co-operate with an assessment of the child, the details of which should be specified. The order does not take away the child's own right to refuse to participate in an assessment, for example, a medical examination, so long as he or she is of sufficient age and understanding. For further guidance on child assessment orders see pages

52–55 of Volume 1 of the Children Act 1989 Guidance and Regulations, Court Orders[91].

The impact of section 47 enquiries on the family and child

5.71 Section 47 enquiries should always be carried out in such a way as to minimise distress to the child and to ensure that families are treated sensitively and with respect. Local authority children's social care should explain the purpose and outcome of section 47 enquiries to the parents and to the child, (having regard to their age and understanding) and be prepared to answer questions openly, unless to do so would affect the safety and welfare of the child. It is particularly helpful for families if local authority children's social care provide written information about the purpose, process and potential outcomes of section 47 enquiries. The information should be both general and specific to the particular circumstances under enquiry. It should include information about how advice, advocacy and support may be obtained from independent sources.

5.72 In the great majority of cases, children remain with their families following section 47 enquiries even where concerns about abuse or neglect are substantiated. As far as possible, section 47 enquiries should be conducted in a way that allows for future constructive working relationships with families. The way in which a case is handled initially can affect the entire subsequent process. Where handled well and sensitively there can be a positive effect on the eventual outcome for the child.

5.73 Where a child is living in a residential establishment, consideration should be given to the possible impact on other children living in the same establishment. Paragraphs 6.10–6.13 set out a summary of the Government's practice guidance on dealing with complex abuse cases.

The outcome of section 47 enquiries

5.74 Local authority children's social care should decide how to proceed following section 47 enquiries, after discussion between all those who have conducted, or been significantly involved in, those enquiries, including relevant professionals and agencies (as well as foster carers where involved) and the child and parents themselves. The information recorded on the outcome of the section 47 enquiries should be consistent with the information set out in the Outcome of the section 47 Enquiries Record (Department of Health, 2002). The local authority children's social care record for the child should set out clearly the dates on which the child was seen by the lead social worker during the course of the enquiries, if they were seen alone, and if not, who was present and for what reasons. Parents and children of sufficient

91 www.dcsf.gov.uk/everychildmatters/publications/documents/childrenactguidanceregulations/

age and appropriate level of understanding (together with professionals and agencies who have been significantly involved) should receive a copy of this record, in particular in advance of any initial child protection conference that is convened. This information should be conveyed in an appropriate format for younger children and those people whose preferred language is not English. Consideration should be given to whether the core assessment has been completed or what further work is required before it is completed. It may be valuable, following an evaluation of the outcome of enquiries, to make recommendations for action in an inter-disciplinary forum if the case is not going forward to a child protection conference. Enquiries may result in a number of outcomes. Where the child concerned is living in a residential establishment which is subject to inspection, the relevant inspectorate should be informed.

Concerns are not substantiated

5.75 Section 47 enquiries may not substantiate the original concerns that the child was suffering, or was likely to suffer, significant harm but it is important that the core assessment is completed. In some circumstances it may be decided that completion of the section 47 enquiry means that the core assessment has been completed and no further action is necessary. However, local authority children's social care and other relevant agencies, as necessary, should always consider with the child and family what support and/or services may be helpful, how the child and family might be provided with these services (if they wish it) and by whom. The focus of section 47 enquiries is the welfare of the child and the assessment may well reveal a range of needs. The provision of services to these children and their family members should not be dependent on the presence of abuse and neglect. Help and support to children in need and their families may prevent problems escalating to a point where a child is abused or neglected.

5.76 In some cases, there may remain concerns about the child's safety and welfare despite there being no real evidence. It may be appropriate to put in place arrangements to monitor the child's welfare. Monitoring should never be used as a means of deferring or avoiding difficult decisions. The purpose of monitoring should always be clear, that is, what is being monitored and why, in what way and by whom. It will also be important to inform parents about the nature of any ongoing concerns. There should be a time set for reviewing the monitoring arrangements through the holding of a further discussion or meeting.

Concerns are substantiated, but the child is not judged to be continuing to, or be likely to, suffer significant harm

5.77 There may be substantiated concerns that a child has suffered significant harm but it is agreed between the agencies most involved and the child and family, that a

plan for ensuring the child's future safety and welfare can be developed and implemented without having a child protection conference or a child protection plan. Such an approach will be of particular relevance where it is clear to the agencies involved that there is the child is not continuing to suffer, or be likely to suffer, significant harm.

5.78 A child protection conference may not be required when there are sound reasons, based on an analysis of evidence obtained through section 47 enquiries, for judging that a child is not continuing to, or be likely to, suffer significant harm. This may be because, for example, the caregiver has taken responsibility for the harm they caused the child, the family's circumstances have changed or the person responsible for the harm is no longer in contact with the child. It may be because significant harm was incurred as the result of an isolated abusive incident (for example, abuse by a stranger).

5.79 The agencies most involved may judge that a parent, caregiver or members of the child's wider family are willing and able to co-operate with actions to ensure the child's future safety and welfare and that the child is therefore not continuing to, or be likely to, suffer significant harm. This judgement can only be made in the light of all relevant information obtained during a section 47 enquiry, and a soundly based assessment of the likelihood of successful intervention, based on clear evidence and mindful of the dangers of misplaced professional optimism. Local authority children's social care have a duty to ascertain the child's wishes and feelings and take these into account (having regard to the child's age and understanding) when deciding on the provision of services. A meeting of involved professionals and family members may be useful to agree what actions should be undertaken by whom and with what intended outcomes for the child's health and development, including the provision of therapeutic services. Whatever process is used to plan future action, the resulting plan should be informed by the core assessment findings. It should set out who will have responsibility for what actions including what course of action should be followed if the plan is not being successfully implemented. It should also include a timescale for review of progress against planned outcomes. Family Group Conferences (paragraphs 10.2–10.4) may have a role to play in fulfilling these tasks.

5.80 Local authority children's social care should take carefully any decision not to proceed to a child protection conference where it is known that a child has suffered significant harm. A suitably experienced and qualified social work manager within local authority children's social care should endorse the decision. Those professionals and agencies who are most involved with the child and family and those who have taken part in the section 47 enquiry, have the right to request that local authority children's social care convene a child protection conference if they have serious concerns that a child's welfare may not otherwise be adequately

safeguarded. Any such request that is supported by a senior manager or a named or designated professional, should normally be agreed. Where there remain differences of view over the necessity for a conference in a specific case, every effort should be made to resolve them through discussion and explanation but as a last resort, LSCBs should have in place a quick and straightforward means of resolving differences of opinion.

Concerns are substantiated and the child is judged to be continuing to, or be likely to, suffer significant harm

5.81 Where the agencies most involved judge that a child may continue to, or be likely to, suffer significant harm local authority children's social care should convene a child protection conference. The aim of the conference is to enable those professionals most involved with the child and family, and the family themselves, to assess all relevant information and plan how best to safeguard and promote the welfare of the child.

The initial child protection conference

Purpose

5.82 The initial child protection conference brings together family members, the child who is the subject of the conference (where appropriate) and those professionals most involved with the child and family, following section 47 enquiries. Its purpose is:

- to bring together and analyse, in an inter-agency setting, the information which has been obtained about the child's developmental needs and the parents' or carers' capacity to respond to these needs to ensure the child's safety and promote the child's health and development, within the context of their wider family and environment;
- to consider the evidence presented to the conference and taking into account the child's present situation and information about his or her family history and present and past family functioning, make judgements about the likelihood of the child suffering significant harm in future and decide whether the child is continuing to, or is likely to, suffer significant harm; and
- to decide what future action is required in order to safeguard and promote the welfare of the child, including the child becoming the subject of a child protection plan, what the planned developmental outcomes are for the child and how best to intervene to achieve these.

Timing

5.83 The timing of an initial child protection conference will depend on the urgency of the case and on the time required to obtain relevant information about the child and family. If the conference is to reach well-informed decisions based on evidence, it should take place following adequate preparation and assessment of the child's needs and circumstances. At the same time, cases where children are continuing to, or are likely to, suffer significant harm should not be allowed to drift. Consequently, all initial child protection conferences should take place within 15 working days of the strategy discussion, or the strategy discussion at which the section 47 enquiries were initiated, if more than one has been held (see paragraph 5.57).

Attendance

5.84 Those attending conferences should be there because they have a significant contribution to make, arising from professional expertise, knowledge of the child or family or both. The local authority social work manager should consider whether to seek advice from, or have present, a medical professional who can present the medical information in a manner which can be understood by conference attendees and enable such information to be evaluated from a sound evidence base. There should be sufficient information and expertise available – through personal representation and written reports – to enable the conference to make an informed decision about what action is necessary to safeguard and promote the welfare of the child, and to make realistic and workable proposals for taking that action forward. At the same time, a conference that is larger than it needs to be can inhibit discussion and intimidate the child and family members. Those who have a relevant contribution to make may include:

- the child, or his or her representative;
- family members (including the wider family);
- local authority children's social care staff who have led and been involved in an assessment of the child and family;
- foster carers (current or former);
- residential care staff;
- professionals involved with the child (for example, health visitors, midwife, school nurse, children's guardian, paediatrician, school staff, early years staff, the GP, NHS Direct, staff in the youth justice system including the secure estate);
- professionals involved with the parents or other family members (for example, family support services, adult services (in particular those from mental health,

substance misuse, domestic violence and learning disability), probation, the GP, NHS Direct);

- professionals with expertise in the particular type of harm suffered by the child or in the child's particular condition, for example, a disability or long term illness;
- those involved in investigations (for example, the police);
- local authority legal services (child care);
- NSPCC or other involved voluntary organisations; and
- a representative of the armed services in cases where there is a service connection.

5.85 The relevant LSCB protocol should specify a required quorum for attendance and list those who should be invited to attend, provided that they have a relevant contribution to make. As a minimum, at every conference there should be attendance by local authority children's social care and at least two other professional groups or agencies who have had direct contact with the child, who is the subject of the conference. In addition, attendees may also include those whose contribution relates to their professional expertise or responsibility for relevant services. In exceptional cases, where a child has not had relevant contact with three agencies (that is, local authority children's social care and two others), this minimum quorum may be breached. Professionals and agencies who are invited to attend should make every effort to do so, but if unable to, they should submit a written report and, wherever possible, a well briefed agency representative should attend to speak to the report.

Involving the child and family members

5.86 Before a conference is held, the purpose of a conference, who will attend and the way in which it will operate, should always be explained to a child of sufficient age and understanding, and to the parents, and involved family members. Where the child/family members do not speak English well enough to understand the discussions and express their views, an interpreter should be used. The parents (including absent parents) should normally be invited to attend the conference and helped to participate fully. Children's social care staff should give parents information about local advice and advocacy agencies and explain that they may bring an advocate, friend or supporter. The child, subject to consideration about age and understanding, should be invited to attend and to bring an advocate, friend or supporter if s/he wishes. Where the child's attendance is neither desired by him/her nor appropriate, the local authority children's social care professional who is working most closely with the child should ascertain what his/her wishes and feelings are and make these known to the conference.

5.87 The involvement of family members should be planned carefully. It may not always be possible to involve all family members at all times in the conference, for example, if one parent is the alleged abuser or if there is a high level of conflict between family members. Adults and any children who wish to make representations to the conference may not wish to speak in front of one another. Exceptionally, it may be necessary to exclude one or more family members from a conference, in whole or in part. The conference is primarily about the child and while the presence of the family is normally welcome, those professionals attending must be able to share information in a safe and non-threatening environment. Professionals may themselves have concerns about violence or intimidation, which should be communicated in advance to the conference chair.

5.88 LSCB procedures should set out criteria for excluding a parent or caregiver, including the evidence required. A strong risk of violence or intimidation by a family member at or subsequent to the conference, towards a child or anybody else, might be one reason for exclusion. The possibility that a parent/caregiver may be prosecuted for an offence against a child is not in itself a reason for exclusion although in these circumstances the chair should take advice from the police about any implications arising from an alleged perpetrator's attendance. If criminal proceedings have been instigated the view of the Crown Prosecution Service (CPS) should be taken into account. The decision to exclude a parent or caregiver from the child protection conference rests with the chair of the conference, acting within LSCB procedures. If the parents are excluded, or are unable or unwilling to attend a child protection conference, they should be enabled to communicate their views to the conference by another means.

Chairing the conference

5.89 A professional who is independent of operational or line management responsibilities for the case should chair the conference[92]. The conference chair is accountable to the Director of Children's Services. The status of the chair should be sufficient to ensure inter-agency commitment to the conference and the child protection plan. Wherever possible, the same person should also chair subsequent child protection reviews in respect of a specific child. The responsibilities of the chair include:

- meeting the child and family members in advance, to ensure that they understand the purpose of the conference and what will happen;

92 In addition to this guidance *Putting Care into Practice,* the statutory guidance which accompanies the Care Planning, Placement and Case Review (England) Regulations 2010, sets out the expectations of the Independent Reviewing Officer (IRO) in relation to chairing the child protection review conference as part of the overarching review of the looked after child's case.

- setting out the purpose of the conference to all present, determining the agenda and emphasising the confidential nature of the occasion;
- enabling all those present, and absent contributors, to make their full contribution to discussion and decision-making;
- ensuring that the conference takes the decisions required of it in an informed, systematic and explicit way; and
- being accountable to the Director of Children's Services for the conduct of conferences.

5.90 A conference chair should be trained in the role and should have:

- a good understanding and professional knowledge of children's welfare and development, and best practice in working with children and families;
- the ability to look at objectively and assess the implications of the evidence on which judgements should be based;
- skills in chairing meetings in a way which encourages constructive participation, while maintaining a clear focus on the welfare of the child and the decisions which have to be taken;
- knowledge and understanding of anti-discriminatory practice; and
- knowledge of relevant legislation, including that relating to children's services and human rights.

Information for the conference

5.91 Local authority children's social care should provide the conference with a written report that summarises and analyses the information obtained in the course of the initial assessment and the core assessment undertaken under section 47 of the Children Act 1989 (in as far as it has been completed within the available time period), and information in existing records relating to the child and family. Where decisions are being made about more than one child in a family there should be a report prepared on each child. The information in the report for a child protection conference, which is be likely to be in the current core assessment record, should be consistent with the information which is set out in the Initial Child Protection Conference Report *(*Department of Health, 2002). The conference report should include information on the dates the child was seen by the lead social worker during the course of the section 47 enquiries, if the child was seen alone and if not, who was present and for what reasons. The core assessment is the means by which a section 47 enquiry is carried out. Although a core assessment will have been

commenced, it is unlikely it will have been completed in time for the conference given the 35 working day period that such assessments can take.

5.92 The child protection conference report should include:

- a chronology of significant events and agency and professional contact with the child and family;
- information on the child's current and past state of developmental needs;
- information on the capacity of the parents and other family members to ensure the child is safe from harm, and to respond to the child's developmental needs, within their wider family and environmental context;
- information on the family history and both the current and past family functioning;
- the expressed wishes and feelings of the child, and the views of parents and other family members;
- an analysis of the information gathered and recorded using the Assessment Framework dimensions to reach a judgement on whether the child is suffering, or likely to suffer, significant harm and consider how best to meet his or her developmental needs. This analysis should address:
  - how the child's strengths and difficulties are impacting on each other;
  - how the parenting strengths and difficulties are affecting each other;
  - how the family and environmental factors are affecting each other;
  - how the parenting that is provided for the child is affecting the child's health and development both in terms of resilience and protective factors, and vulnerability and risk factors; and
  - how the family and environmental factors are impacting on parenting and/or the child directly; and
- the local authority's recommendation to the conference.

5.93 Where appropriate, the parents and subject child should be provided with a copy of the report in advance of the conference. The contents of the report should be explained and discussed with the child and relevant family members in advance of the conference itself, in the preferred language(s) of the child and family members.

5.94 Other professionals attending the conference should bring with them details of their involvement with the child and family, and information concerning their knowledge of the child's developmental needs, capacity of the parents to meet the

needs of their child within their family and environmental context. This information should include careful consideration of the impact that the current and past family functioning and family history are having on the parents' capacities to met the child's needs. Contributors should, wherever possible, provide a written report in advance to the conference and these should be made available to those attending.

5.95 The child and family members should be helped in advance to think about what they want to convey to the conference and how best to get their points across on the day. Some may find it helpful to provide their own written report, which they may be assisted to prepare by their adviser/advocate.

5.96 Those providing information should take care to distinguish between fact, observation, allegation and opinion. When information is provided from another source, i.e. it is second or third hand, this should be made clear.

Action and decisions for the conference

5.97 The conference should consider the following questions when determining whether the child should be the subject of a child protection plan:

- has the child suffered significant harm? and
- is the child likely to suffer significant harm in the future?

5.98 The test for likelihood of suffering harm in the future should be that either:

- the child can be shown to have suffered ill-treatment or impairment of health or development as a result of physical, emotional, or sexual abuse or neglect, and professional judgement is that further ill-treatment or impairment are likely; or
- professional judgement, substantiated by the findings of enquiries in this individual case or by research evidence, is that the child is likely to suffer ill-treatment or the impairment of health or development as a result of physical, emotional, or sexual abuse or neglect.

5.99 If the child protection conference decides that the child is likely to suffer significant harm in the future, the child will therefore require inter-agency help and intervention to be delivered through a formal child protection plan. The primary purposes of this plan are to prevent the child suffering harm or a recurrence of harm in the future and to promote the child's welfare.

5.100 Child protection conference participants should base their judgements on all the available evidence obtained through existing records, the initial assessment and the in-depth core assessment undertaken following the initiation of section 47 enquiries, and any other relevant specialist assessments. The method of reaching a

decision within the conference on whether the child should be the subject of a child protection plan should be set out in the relevant LSCB protocol. The decision making process should be based on the views of all agencies represented at the conference and also take into account any written contributions that have been made.

5.101 If the conference decided that the child is in need of a child protection plan, the chair should determine which category of abuse or neglect the child has suffered or is likely to suffer. The category used (that is physical, emotional, sexual abuse or neglect) will indicate to those consulting the child's social care record the primary presenting concerns at the time the child became the subject of a child protection plan.

5.102 It is the role of the initial child protection conference to formulate the outline child protection plan in as much detail as possible. The decision of the conference and, where appropriate, details of the category of abuse or neglect, the name of the lead social worker (i.e. the social worker who is the lead professional for the case) and the core group membership should be recorded in a manner that is consistent with the Initial Child Protection Conference Report (Department of Health, 2002) and circulated to all those invited to the conference within one working day.

5.103 Where a child has suffered, or is likely to suffer, significant harm in the future it is the local authority's duty to consider the evidence and decide what, if any, legal action to take. The information presented to the child protection conference should inform that decision making process but it is for the local authority to consider whether it should initiate, for example, care proceedings. In some situations the child may become accommodated and acquire looked after child status. Where a child who is the subject of a child protection plan becomes looked after by the local authority, the child protection plan should form part of the looked after child's overarching care plan (see paragraphs 5.144–5.148).

5.104 A decision may have been made that a child does not require a child protection plan but he or she may nonetheless require services to promote his or her health or development. In these circumstances, the conference together with the family should consider the child's needs and what further help would assist the family in responding to them. Subject to the family's views and consent, it may be appropriate to continue and to complete the core assessment to help determine what support might best help promote the child's welfare. Where the child's needs are complex, inter-agency working will continue to be important. Where appropriate, a child in need plan should be drawn up and reviewed at regular intervals – no less frequent than every six months (see paragraphs 4.33 and 4.36 of the *Framework for the Assessment of Children in Need and their Families*).

5.105 Where a child is to be the subject of a child protection plan it is the responsibility of the conference to consider and make recommendations on how agencies, professionals and the family should work together to ensure that the child will be safeguarded from harm in the future. This should enable both professionals and the family to understand exactly what is expected of them and what they can expect of others. Specific tasks include the following:

- appointing the lead statutory body (either local authority children's social care or the NSPCC) and a lead social worker (who is the lead professional), who should be a qualified, experienced social worker and an employee of the lead statutory body;
- identifying the membership of a core group of professionals and family members who will develop and implement the child protection plan as a detailed working tool;
- establishing how the child, their parents (including all those with parental responsibility) and wider family members should be involved in the ongoing assessment, planning and implementation process, and the support, advice and advocacy available to them;
- establishing timescales for meetings of the core group, production of a child protection plan, and for child protection review meetings;
- identifying in outline what further action is required to complete the core assessment and what other specialist assessments of the child and family are required to make sound judgements on how best to safeguard and promote the welfare of the child;
- outlining the child protection plan, especially, identifying what needs to change in order to achieve the planned outcomes to safeguard and promote the welfare of the child;
- ensuring a contingency plan is in place if agreed actions are not completed and/or circumstances change, for example, if a caregiver fails to achieve what has been agreed, a court application is not successful or a parent removes the child from a place of safety;
- clarifying the different purposes and remit of the initial conference the core group, and the child protection review conference; and
- agreeing a date for the first child protection review conference and under what circumstances it might be necessary to convene the conference before that date.

5.106 The outline child protection plan should:

- identify factors associated with the likelihood of the child suffering significant harm and ways in which the child can be protected from harm through an inter-agency plan based on the current findings from the assessment, including information held by agencies on any previous involvement with the child and family;
- establish short-term and longer-term aims and objectives that are clearly linked to preventing the child suffering harm or a recurrence of the harm suffered, meeting the child's developmental needs and promoting the child's welfare, including contact with family members;
- be clear about who will have responsibility for what actions – including actions by family members – within what specified timescales;
- outline ways of monitoring and evaluating progress against the planned outcomes set out in the plan; and
- be clear about which professional is responsible for checking that the required changes have taken place and what action will be taken, by whom, and when they have not.

Complaints about a child protection conference

5.107 Parents/caregivers and, on occasion children, may have concerns about which they may wish to make representations or complain, in respect of one or more of the following aspects of the functioning of child protection conferences:

- the process of the conference;
- the outcome, in terms of the fact of and/or the category of primary concern at the time the child became the subject of a child protection plan; and/or
- a decision for the child to become, or not to become, the subject of a child protection plan or not to cease the child being the subject of a child protection plan.

5.108 Complaints about individual agencies, their performance and provision (or non-provision) of services should be responded to in accordance with the relevant agency's complaints handling process. For example, local authority children's social care are required (by section 26 of the Children Act 1989) to establish complaints procedures to deal with complaints arising in respect of Part III of the Act.

5.109 Complaints about aspects of the functioning of conferences described above should be addressed to the conference chair. Such complaints should be passed on to local authority children's social care, which, since they relate to Part V of the

Children Act 1989, should be responded to in accordance with the Complaints Directions 1990[93]. (This section will be updated when regulations on the revision of Local Authority Complaints Procedures under the Children Act 1989 are revised). In considering and responding to complaints, the local authority should form an inter-agency panel made up of senior representatives from LSCB member agencies. The panel should consider whether the relevant inter-agency protocols and procedures have been observed correctly and whether the decision that is being complained about follows reasonably from the proper observation of the protocol(s).

5.110 In addition, representations and complaints may be received by individual agencies in respect of services provided (or not provided) as a consequence of assessments and conferences, including those set out in child protection plans. Such concerns should be responded to by the relevant agency in accordance with its own processes for responding to such matters.

Administrative arrangements and record keeping

5.111 Those attending should be notified of conferences as far in advance as possible, and the conference should be held at a time and place likely to be convenient to as many people as possible. All child protection conferences, both initial and review, should have a dedicated administrative person to take notes and produce a record of the meeting. The record of the conference is a crucial working document for all relevant professionals and the family. It should include:

- the essential facts of the case;
- a summary of discussion at the conference, which accurately reflects contributions made;
- all decisions reached, with information outlining the reasons for decisions; and
- a translation of decisions into an outline or revised child protection plan enabling everyone to be clear about their tasks.

5.112 A copy should be sent as soon as possible after the conference to all those who attended or were invited to attend, including family members, except for any part of the conference from which they were excluded. This is in addition to sharing the main decisions within one working day of the conference (see paragraph 5.102). The record is confidential and should not be passed by professionals to third parties without the consent of either the conference chair or the lead social worker. However, in cases of criminal proceedings, the police may reveal the existence of the notes to the CPS in accordance with the Criminal Procedure and Investigation

93 The Directions are based on section 7B of the Local Authority Social Services Act 1970, inserted by section 50 of the National Health Service and Community Care Act 1990.

Act 1996. The record of the decisions of the child protection conference should be retained by the recipient agencies and professionals in accordance with their record retention policies.

Action following the initial child protection conference

The role of the lead social worker

5.113 When a conference decides that a child should be the subject of a child protection plan, one of the child care agencies with statutory powers (local authority children's social care or the NSPCC) should carry statutory responsibility for the child's welfare and designate a qualified and experienced member of its social work staff to be the lead social worker, i.e. the lead professional. Each child who is the subject of a child protection plan should have a named lead social worker.

5.114 The lead social worker is responsible for making sure that the outline child protection plan is developed into a more detailed inter-agency plan. S/he should complete the core assessment of the child and family, securing contributions from core group members and others as necessary. The lead social worker is also responsible for acting as the lead professional for the inter-agency work with the child and family. S/he should co-ordinate the contribution of family members and other agencies to planning the actions which need to be taken, putting the child protection plan into effect and reviewing progress against the planned outcomes set out in the plan. It is important that the role of the lead social worker is fully explained at the initial child protection conference and at the core group.

5.115 The lead social worker should see the child, alone when appropriate, in accordance with the plan. She or he should develop a therapeutic relationship with the child, regularly ascertain the child's wishes and feelings and keep the child up to date with the child protection plan and any developments or changes. The lead social worker should record in the child's local authority social care record when the child was seen and who else, if anyone, was present at the time of each visit and also the reasons for deciding (or not) to see the child alone.

The core group

5.116 The core group is responsible for developing the child protection plan as a detailed working tool and implementing it within the outline plan agreed at the initial child protection conference. Membership should include the lead social worker, who chairs the core group, the child if appropriate, family members and professionals or foster carers who will have direct contact with the family. Although the lead social worker has lead responsibility for the formulation and implementation of the child protection plan, all members of the core group are jointly responsible for carrying

out these tasks, refining the plan as needed and monitoring progress against the planned outcomes set out in the plan. Agencies should ensure that members of the core group undertake their roles and responsibilities effectively in accordance with the agreed child protection plan.

5.117 Core groups are an important forum for working with parents, wider family members and children of sufficient age and understanding. It can often be difficult for parents to accept the need for a child protection plan within the confines of a formal conference. Their co-operation may be gained later when details of the plan are worked out in the core group. Sometimes there may be conflicts of interest between family members who have a relevant interest in the work of the core group. The child's best interests should always take precedence over the interests of other family members.

5.118 The first meeting of the core group should take place within 10 working days of the initial child protection conference. The purpose of this first meeting is to flesh out the child protection plan. The meeting should also decide what steps need to be taken, by whom, to complete the core assessment on time so that future decisions and the provision of services can be fully informed when making decisions about the child's safety and welfare. Thereafter, core groups should meet sufficiently regularly to facilitate working together, monitor actions and outcomes against the child protection plan, and make any necessary alterations as circumstances change.

5.119 The lead social worker should ensure that there is a record of the decisions taken and actions agreed at core group meetings, as well as of the written views of those who were not able to attend. The child protection plan should be updated as necessary.

Completion of the core assessment

5.120 Completion of the core assessment, within 35 working days, should include an analysis of the child's developmental needs and the parents' capacity to respond to those needs within the context of their family and environment. This analysis should include an understanding of the parents' capacity to ensure that the child is safe from harm. It should include consideration of the information gathered about the family's history and their present and past family functioning. It may be necessary to commission specialist assessments (for example, from child and adolescent mental health services, adult mental health or substance misuse services, or a specialist in domestic violence) which it may not be possible to complete within this time period. This should not delay the drawing together of the core assessment findings at this point. A core assessment is deemed complete once the assessment has been discussed with the child and family (or caregivers) and the team manager has viewed and authorised the assessment.

5.121 The analysis of the child's needs and the capacity of the child's parents or caregivers to meet these needs within their family and environment should provide evidence on which to base judgements and decisions on how best to safeguard and promote the welfare of a child and where possible to support parents in achieving this aim. Decisions based on this analysis should consider what the child's future will be like if his or her met needs continue to be met, and if his or her unmet needs continue to be unmet. The key questions are, what is likely to happen if nothing changes in the child's current situation? What are the likely consequences for the child? The answers to these questions should be used to decide what interventions are required when developing the child protection plan and, in particular, in considering what actions are necessary to prevent the child from suffering harm or to prevent a recurrence of the abuse or neglect suffered.

The child protection plan

5.122 The initial child protection conference is responsible for agreeing an outline child protection plan. Professionals and parents/caregivers should develop the details of the plan in the core group. The overall aim of the plan is to:

- ensure the child is safe from harm and prevent him or her from suffering further harm by supporting the strengths, addressing the vulnerabilities and risk factors and helping meet the child's unmet needs;
- promote the child's health and development, i.e. his or her welfare; and
- provided it is in the best interests of the child, to support the family and wider family members to safeguard and promote the welfare of their child.

5.123 The child protection plan should be based on the findings from the assessment, following the dimensions relating to the child's developmental needs, parenting capacity and family and environmental factors, and drawing on knowledge about effective interventions. Where the child is also the subject of a care plan, the child protection plan should be part of the looked after child's care plan (see paragraph 5.103). The content of the child protection plans should be consistent with the information set out in the Child Protection Plan record (Department of Health, 2002). It should set out what work needs to be done, why, when and by whom. The plan should:

- describe the identified developmental needs of the child and what therapeutic services are required to meet these needs;
- include specific, achievable, child-focused outcomes intended to safeguard and promote the welfare of the child;

- include realistic strategies and specific actions to bring about the changes necessary to achieve the planned outcomes;
- set out when and in what situations the child will be seen by the lead social worker, both alone and with other family members or caregivers present;
- clearly identify and set out roles and responsibilities of family members and professionals including those with routine contact with the child (for example, health visitors, GPs and teachers) and the nature and frequency of contact by these professionals with the child and family members;
- include a contingency plan to be followed if circumstances change significantly and require prompt action (including initiating family court proceedings to safeguard and promote the child's welfare); and
- lay down points at which progress will be reviewed and the means by which progress will be judged.

5.124 The child protection plan should take into account the wishes and feelings of the child, and the views of the parents, insofar as they are consistent with the child's welfare. The lead social worker should make every effort to ensure that the child and parents have a clear understanding of the planned outcomes; that they accept the plan and are willing to work to it. If the parents are not willing to co-operate in the implementation of the plan the local authority should consider what action, including the initiation of family proceedings, it should take to safeguard the child's welfare.

5.125 The plan should be constructed with the family in their preferred language and they should receive a written copy in this language. If family members' preferences are not accepted about how best to safeguard and promote the welfare of the child, the reasons for this should be explained. Families should be told about their right to complain and make representations, and how to do so.

Agreeing the plan with the child

5.126 The child protection plan should be explained to and agreed with the child in a manner which is in accordance with their age and understanding. An interpreter should be used if the child's level of English means that s/he is not able to participate fully in these discussions unless they are conducted in her/his own language. The child should be given a copy of the plan written at a level appropriate to his or her age and understanding, and in his or her preferred language.

Negotiating the plan with parents

5.127 Parents should be clear about the evidence of significant harm which resulted in the child becoming the subject of a child protection plan, what needs to change and about what is expected of them as part of implementing the plan for safeguarding and promoting their child's welfare. All parties should be clear about the respective roles and responsibilities of family members and different agencies in implementing the plan. The parents should receive a written copy of the plan so that they are clear about who is doing what when and the planned outcomes for the child.

Intervention

5.128 Decisions about how to intervene, including what services to offer, should be based on evidence about what is likely to work best to bring about good outcomes for the child[94]. A number of aspects of intervention should be considered in the context of the child protection plan, in the light of evidence from the assessment of the child's developmental needs, the parents' capacity to respond appropriately to the child's needs and the wider family and environmental circumstances. Particular attention should be given to family history (for example, of domestic and other forms of violence, childhood abuse, mental illness, substance misuse and/or learning disability) and present and past family functioning.

5.129 The following questions need to be considered:

- What are the options for interventions which might help support strengths and/or help meet the child's identified unmet needs as well as addressing the known vulnerabilities and risk factors?
- What resources are available?
- With which agency or professional and with which approach is the family most likely to co-operate?
- Which intervention is most likely to produce the most immediate benefit and which might take time?
- What should be the sequence of interventions and why?
- Given the severity of any ill-treatment suffered or impairment to the child's health or development, the child's current needs and the capacity of the family to co-operate, what is the likelihood of achieving sufficient change within the child's time frame?

94 For further information from research findings on effective interventions see www.dcsf.gov.uk/nsdu/research.shtml

5.130 It is important that services are provided to give the child and family the best chance of achieving the required changes. If a child cannot be cared for safely by his or her caregiver(s) she or he will have to be placed elsewhere whilst work is being undertaken with the child and family. Irrespective of where the child is living, interventions should specifically address:

- the developmental needs of the child;
- the child's understanding of what has happened to him or her;
- the abusing caregiver/child relationship and parental capacity to respond to the child's needs;
- the relationship between the adult caregivers both as adults and parents;
- family relationships; and
- possible changes to the family's social and environmental circumstances.

5.131 Intervention may have a number of inter-related components:

- action to make a child safe from harm and prevent recurrence from harm;
- action to help promote a child's health and development, i.e. welfare;
- action to help a parent(s)/caregiver(s) in safeguarding a child and promoting his or her welfare;
- therapy for an abused or neglected child; and
- support or therapy for a perpetrator of abuse or neglect to prevent future harm to the child and where necessary to other children.

5.132 The development of secure parent–child attachments is critical to a child's healthy development. The quality and nature of the attachment will be a key issue to be considered in decision making, especially if decisions are being made about moving a child from one setting to another, re-uniting a child with his or her birth family or considering a permanent placement away from the child's family. If the plan is to assess whether the child can be reunited with the caregiver(s) responsible for the maltreatment, very detailed work will be required to help the caregiver(s) develop the necessary parenting skills.

5.133 A key issue in deciding on suitable interventions will be whether the child's developmental needs can be responded to within his or her family context and **within timescales that are appropriate for the child**. These timescales may not be compatible with those for the caregiver(s) who is/are in receipt of therapeutic help. The process of decision making and planning should be as open as possible, from an ethical as well as practical point of view. Where the family situation is not

improving or changing fast enough to respond to the child's needs, decisions will be necessary about the long-term future of the child. In the longer term it may mean it will be in the best interests of the child to be placed in an alternative family context. Key to these considerations is what is in the child's best interests, informed by the child's wishes and feelings and by the parents' capacity to make the required changes.

5.134 Children who have suffered significant harm may continue to experience the consequences of this abuse irrespective of where they are living, whether remaining with or being reunited with their families or alternatively being placed in new families; this relates particularly to their behavioural and emotional development. Therapeutic work with the child should continue, irrespective of where the child is placed, as long as is required in order for their needs to be met.

5.135 More information to assist with making decisions about interventions is available in the Chapter 4 of the *Assessment Framework* and the accompanying practice guidance (Department of Health, 2000). Recent research evidence on effective interventions in safeguarding children has been published by DCSF and DH[95].

The child protection review conference

Timescale

5.136 The first child protection review conference should be held within three months of the initial child protection conference and further reviews should be held at intervals of not more than six months for as long as the child remains the subject of a child protection plan. Where the child is also looked after, the child protection review should be part of the looked after child review (see paragraphs 5.144–5.148). It is important to ensure that momentum is maintained in the process of safeguarding and promoting the welfare of the child. Where necessary, reviews should be brought forward to address changes in the child's circumstances. Attendees should include those most involved with the child and family in the same way as at an initial child protection conference, and the LSCB protocols for establishing a quorum should apply.

Purpose

5.137 The purposes of the child protection review are to:

- review whether the child is continuing to suffer, or is likely to suffer, significant harm and their health and developmental progress against planned outcomes set out in the child protection plan;

95 www.dcsf.gov.uk/cgi-bin/rsgateway/search.pl?cat=3&subcat=3_1&q1=Search

- ensure that the child continues to be safeguarded from harm; and
- consider whether the child protection plan should continue or should be changed.

5.138 The reviewing of the child's progress and the effectiveness of interventions are critical to achieving the best possible outcomes for the child. The child's wishes and feelings should be sought and taken into account during the reviewing process. Every review should consider explicitly whether the child is suffering, or is likely to suffer, significant harm and hence continues to require safeguarding from harm through adherence to a formal child protection plan. If not, then the child should no longer be the subject of a child protection plan. If the child is considered to be suffering significant harm, the local authority should consider whether to initiate family court proceedings. For further guidance see Volume 1 of the Children Act 1989 Guidance and Regulations, Court Orders [96].

5.139 The same LSCB decision-making procedure should be used to reach a judgement on continuing to have a child protection plan as is used at the initial child protection conference. As with initial child protection conferences, the relevant LSCB protocol should specify a required quorum for attendance at review conferences. As a minimum, at every review conference there should be attendance by local authority children's social care and at least two other professional groups or agencies, which have had direct contact with the child who is the subject of the conference. In addition, attendees may also include those whose contribution relates to their professional expertise or responsibility for relevant services. In exceptional cases, where a child has not had relevant contact with three agencies (that is, local authority children's social care and two others), this minimum quorum may be breached.

5.140 The review requires as much preparation, commitment and management as the initial child protection conference. Each member of the core group has a responsibility to produce an individual agency report on the child and family for the child protection review. Together, these reports provide an overview of work undertaken by family members and professionals, and evaluate the impact of the interventions on the child's welfare against the planned outcomes set out in the child protection plan. Those unable to attend should send their report to the lead social worker prior to the core group meeting and where possible, delegate attendance to a well briefed colleague. The content of the report to the review child protection conference should be consistent with the information set out in the Child Protection Review (Department of Health, 2002).

96 www.dcsf.gov.uk/everychildmatters/publications/documents/childrenactguidanceregulations/.

Discontinuing the child protection plan

5.141 A child should no longer be the subject of a child protection plan if:

- it is judged that the child is no longer continuing to, or be likely to, suffer significant harm and therefore require safeguarding by means of a child protection plan (for example, the likelihood of harm has been reduced by action taken through the child protection plan; the child and family's circumstances have changed; or re-assessment of the child and family indicates that a child protection plan is not necessary). Under these circumstances, only a child protection review conference can decide that a child protection plan is no longer necessary;
- the child and family have moved permanently to another local authority area. In such cases, the receiving local authority should convene a child protection conference within 15 working days of being notified of the move, only after which event may discontinuing the child protection plan take place in respect of the original local authority's child protection plan; or
- the child has reached 18 years of age (to end the child protection plan, the local authority should have a review around the child's birthday and this should be planned in advance), has died or has permanently left the UK.

5.142 When a child is no longer the subject of a child protection plan notification should be sent, at a minimum, to all those agency representatives who were invited to attend the initial child protection conference that led to the plan.

5.143 A child who is no longer the subject of a child protection plan may still require additional support and services. Discontinuing the child protection plan should never lead to the automatic withdrawal of help. The key worker should discuss with the parents and the child what services might be wanted and required, based upon the re-assessment of the needs of the child and family.

Children looked after by the local authority

5.144 In most cases where a child who is the subject of a child protection plan becomes looked after it will no longer be necessary to maintain the child protection plan. There are however a relatively few cases where safeguarding issues will remain and a looked after child should also have a child protection plan. These cases are likely to be where a local authority obtains an interim care order in family proceedings but the child or young person who is the subject of a child protection plan remains at home, pending the outcome of the final hearing or where a young person's behaviour is likely to result in significant harm to themselves or others.

5.145 Where a looked after child remains the subject of a child protection plan it is expected that there will be a single planning and reviewing process, led by the Independent Reviewing Officer (IRO), which meets the requirements of both this guidance and the Care Planning, Placement and Case Review (England) Regulations 2010 and accompanying statutory guidance *Putting Care into Practice*.

5.146 The systems and processes for reviewing child protection plans and plans for looked after children should be carefully evaluated by the local authority and consideration given to how best to ensure the child protection aspects of the care plan are reviewed as part of the overall reviewing process leading to the development of a single plan. Given that a review is a process and not a single meeting, both reviewing systems should be aligned in an unbureaucratic way to enable the full range of the child's or young person's needs to be considered in the looked after child's care planning and reviewing processes.

5.147 It is recognised that there are different requirements for independence of the IRO function compared to the chair of the child protection conference. In addition, it is important to note that the child protection conference is required to be a multi-agency forum while children for the most part want as few external people as possible at a review meeting where they are present. However, it will not be possible for the IRO to carry out his or her statutory function without considering the child's safety in the context of the care planning process. In this context consideration should be given to the IRO chairing the child protection conference where a looked after child remains the subject of a child protection plan. Where this is not possible it will be expected that the IRO will attend the child protection review conference.

5.148 This means that the timing of the review of the child protection aspects of the care plan should be the same as the review under the Care Planning, Placement and Case Review (England) Regulations 2010, to ensure that up to date information in relation to the child's welfare and safety is considered within the review meeting and informs the overall care planning process. The looked after child's review when reviewing the child protection aspects of the plan should also consider whether the criteria continue to be met for the child to remain the subject of a child protection plan. Significant changes to the care plan should only be made following the looked after child's review.

Pre-birth child protection conferences and reviews

5.149 Where a core assessment under section 47 of the Children Act 1989 gives rise to concerns that an unborn child may be likely to suffer significant harm local authority children's social care may decide to convene an initial child protection conference prior to the child's birth. Such a conference should have the same status, and

proceed in the same way, as other initial child protection conferences, including decisions about a child protection plan. Similarly in respect of child protection review conferences. The involvement of midwifery services is vital in such cases.

Recording that a child is the subject of a child protection plan

5.150 Local authority children's social care IT systems should be capable of recording in the child's case record when the child is the subject of a child protection plan, including where the child is also looked after by the local authority. A key purpose of having the IT capacity to record that a child is the subject of a child protection plan is to enable agencies and professionals, when appropriate, to be aware that these children are the subject of a child protection plan. It is equally important that agencies and professionals can obtain relevant information about any child in need who is known or has been known to the local authority. Consequently, agencies and professionals who have concerns about a child's safety and welfare should be able to obtain information about a child that is recorded on the local authority's ICS IT system[97]. It is essential that legitimate enquirers such as police and health professionals are able to obtain this information both in and outside office hours.

5.151 Children should be recorded as having been, or being likely to be abused or neglected under one or more of the categories of physical, emotional, or sexual abuse or neglect, according to a decision by the chair of the child protection conference. These categories help indicate the nature of the current concerns. Recording information in this way also allows for the collation and analysis of information locally and nationally and for its use in planning the provision of services. The categories selected should reflect all the information obtained in the course of the initial assessment and core assessment under section 47 or the Children Act 1989 and subsequent analysis, and should not just relate to one or more abusive incidents. The initial category may change as new information becomes available during the time that the child is the subject of a child protection plan.

Managing and providing information about a child

5.152 Each local authority should designate a manager, normally an experienced social worker, who has responsibility for:

- ensuring that each local authority record on a child who has a child protection plan is kept up to date;

97 www.everychildmatters.gov.uk/socialcare/ics

- ensuring enquiries about children about whom there are concerns or who have child protection plans are recorded and considered in accordance with paragraph 5.150;
- managing other notifications of movements of children into or out of the local authority area, such as children who have a child protection plan and looked after children;
- managing notifications of people who may pose a risk of significant harm to children who are either identified with the local authority area or have moved into the local authority area; and
- managing requests for checks to be made to ensure unsuitable people are prevented from working with children.

This manager should be accountable to the Director of Children's Services.

5.153 The child's individual case file should provide a record of information known to local authority children's social care about that child and therefore it should be kept up-to-date on the local authority's ICS IT system. The content of the child's record should be confidential, available only to legitimate enquirers. This information should be accessible at all times to such enquirers. The details of enquirers should always be checked and recorded on the system before information is provided.

5.154 If an enquiry is made about a child and the child's case is open to local authority children's social care, the enquirer should be given the name of the child's lead social worker and the lead social worker informed of this enquiry so that they can follow it up. If an enquiry is made about a child at the same address as a child who is the subject of a child protection plan, this information should be sent to the lead social worker of the child who is the subject of the child protection plan. If an enquiry is made but the child is not known to local authority children's social care, this enquiry should be recorded on a contact record together with the advice given to the enquirer. In the event of there being a second enquiry about a child who is not known to children's social care, not only should the fact of the earlier enquiry be notified to the later enquirer but the designated manager should ensure that local authority children's social care consider whether this is or may be a child in need.

5.155 The Department for Children, Schools and Families holds lists of the names of designated managers and should be notified of any changes in designated managers.

Recording in individual case records

5.156 Keeping a good quality record about work with a child in need and his or her family is an important part of the accountability of all professionals to those who use their services. It helps to focus work and it is essential to working effectively across agency and professional boundaries. Clear and accurate records for each child ensure that there is a documented account of an agency's or professional's involvement with the child and/or his or her family or caregiver. They help with continuity when individual workers are unavailable or change and they provide an essential tool for managers to monitor work or for peer review. The child or adult's record is an essential source of evidence for investigations and inquiries, and may also be required to be disclosed in court proceedings. Where a child has been the subject of a section 47 enquiry which did not result in the substantiation of referral concerns, his or her record should be retained in accordance with agency retention policies. These policies should ensure that records are stored safely and can be retrieved promptly and efficiently.

5.157 To serve these purposes, records relating to work with the child and his or her family should use clear, straightforward language, be concise and be accurate not only in fact, but also in differentiating between opinion, judgement and hypothesis.

5.158 Well kept records about work with a child and his or her family provide an essential underpinning to good professional practice. Safeguarding and promoting the welfare of children requires information to be brought together from a number of sources and careful professional judgements to be made on the basis of this information. These records should be clear, accessible and comprehensive, with judgements made and decisions and interventions carefully recorded. Where decisions have been taken jointly across agencies, or endorsed by a manager, this should be made clear.

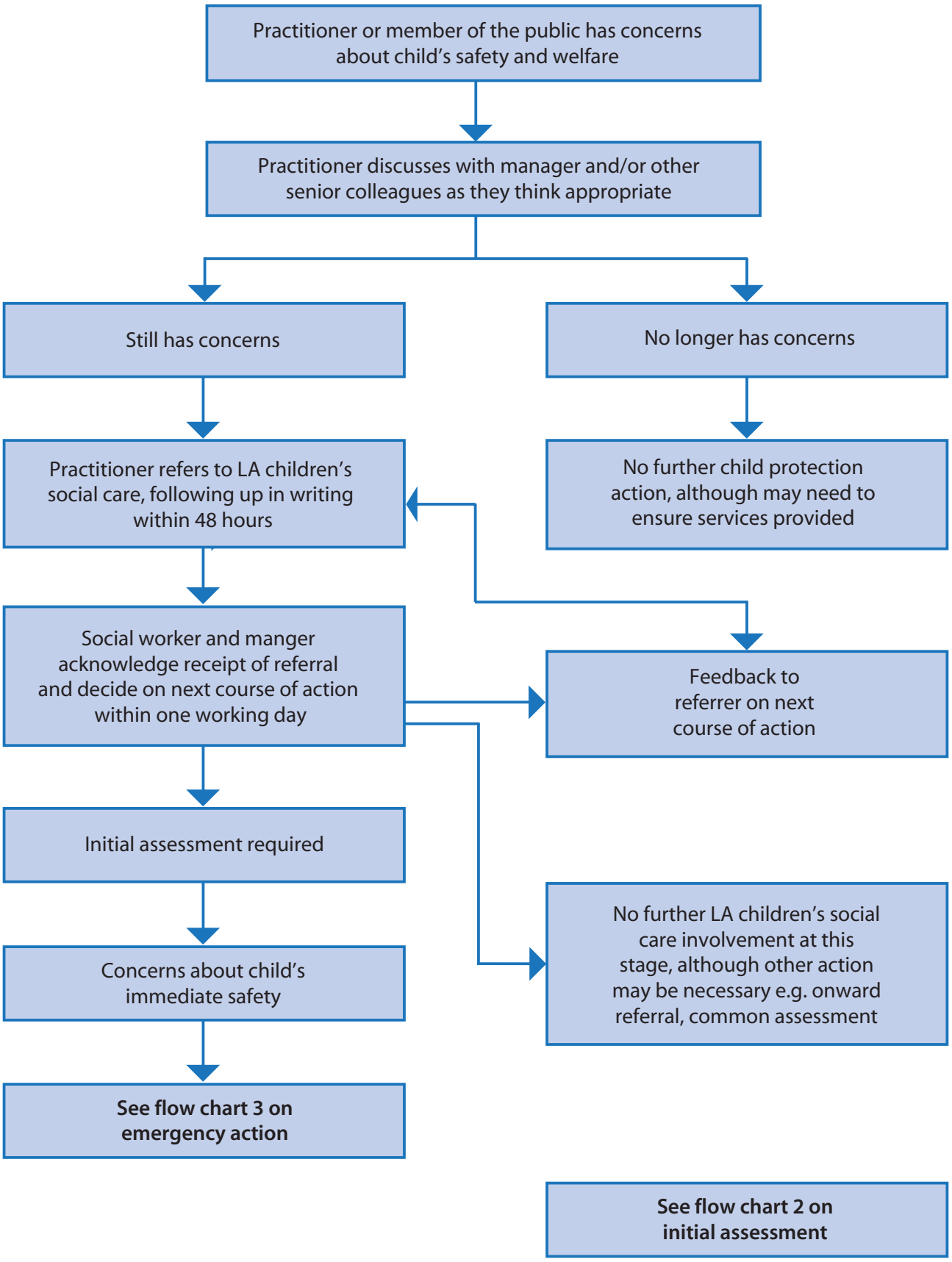
5.159 The records (Department of Health, 2002) produced to support the implementation of the Integrated Children's System contain the information requirements for local authority children's social care together with others when recording information about work with an individual child in need and his or her family. The appropriate type of record to use at different stages of the process of working with a child and his or her family has been referenced throughout this chapter.

5.160 The GP should retain child protection initial conference and review reports as part of the child's health record, where practicable. Ultimately, it is down to the individual GP, depending on their type of health recording system, to make the best judgement on how to incorporate this information into the child's health record.

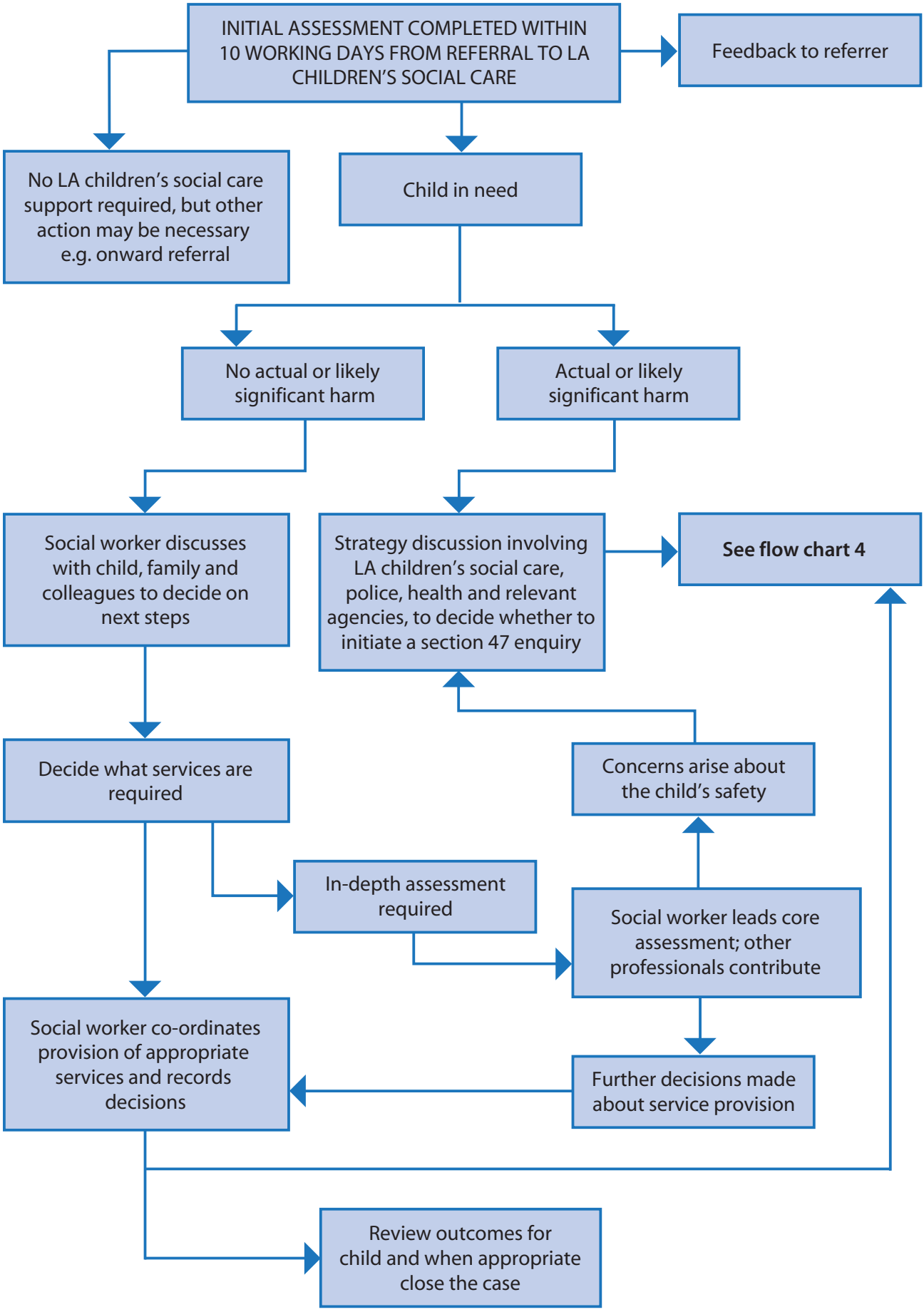
Request for a change of worker

5.161 Occasions may arise where relationships between parents, or other family members, are not productive in terms of working to safeguard and promote the welfare of their children. In such instances, agencies should respond sympathetically to a request for a change of worker, provided that such a change can be identified as being in the interests of the child who is the focus of concern.

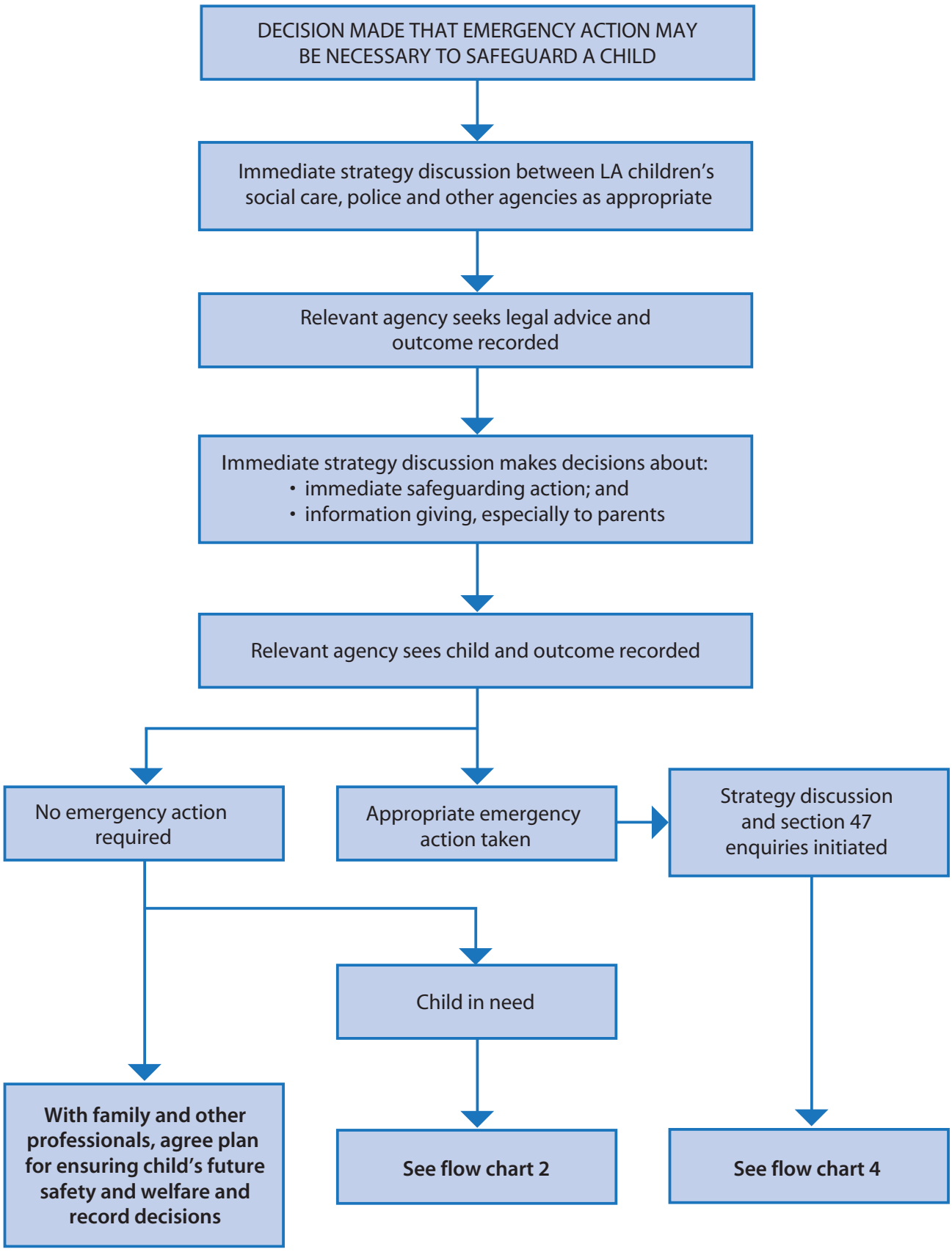
Flow chart 1: Referral



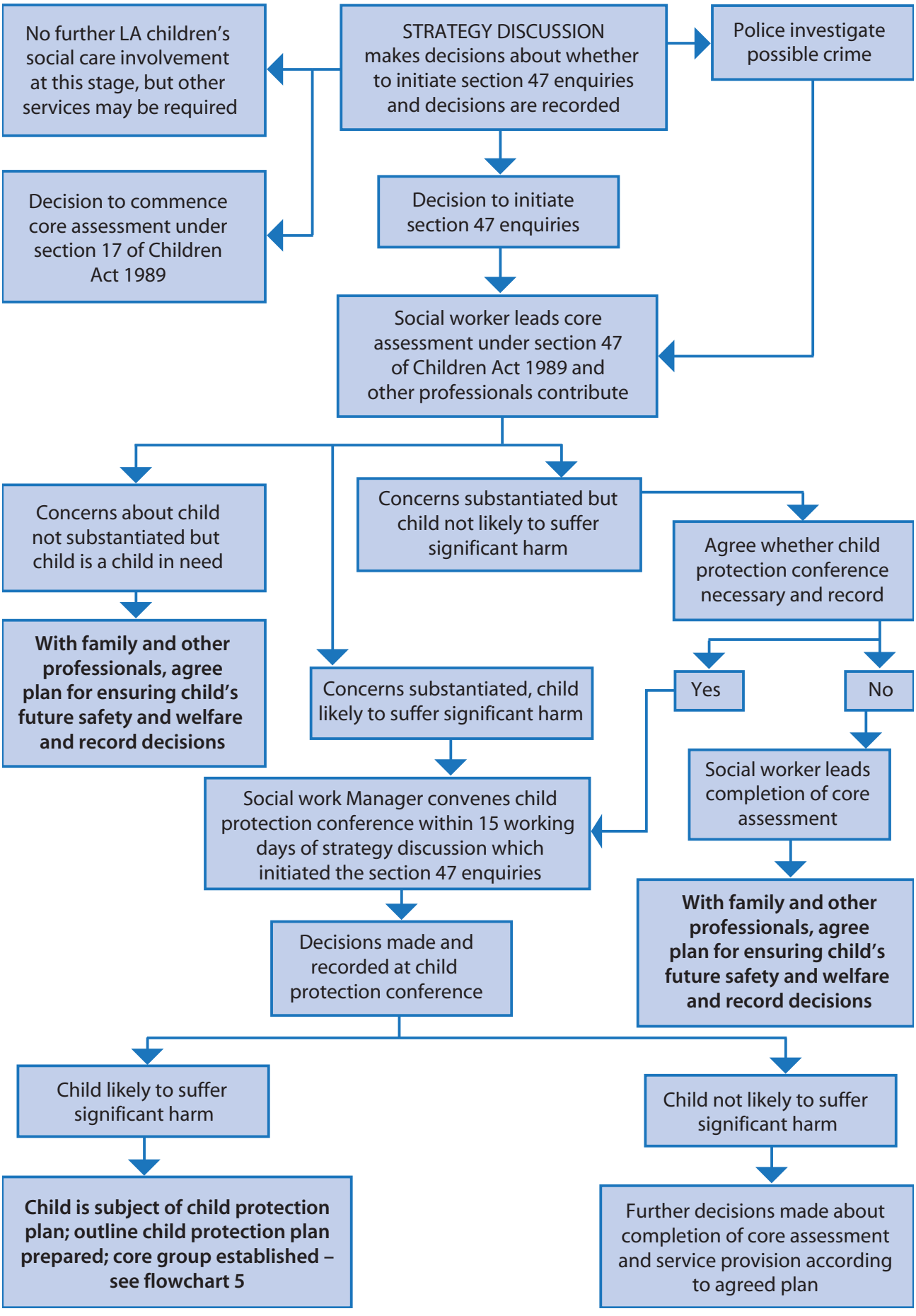
Flow chart 2: What happens following initial assessment?



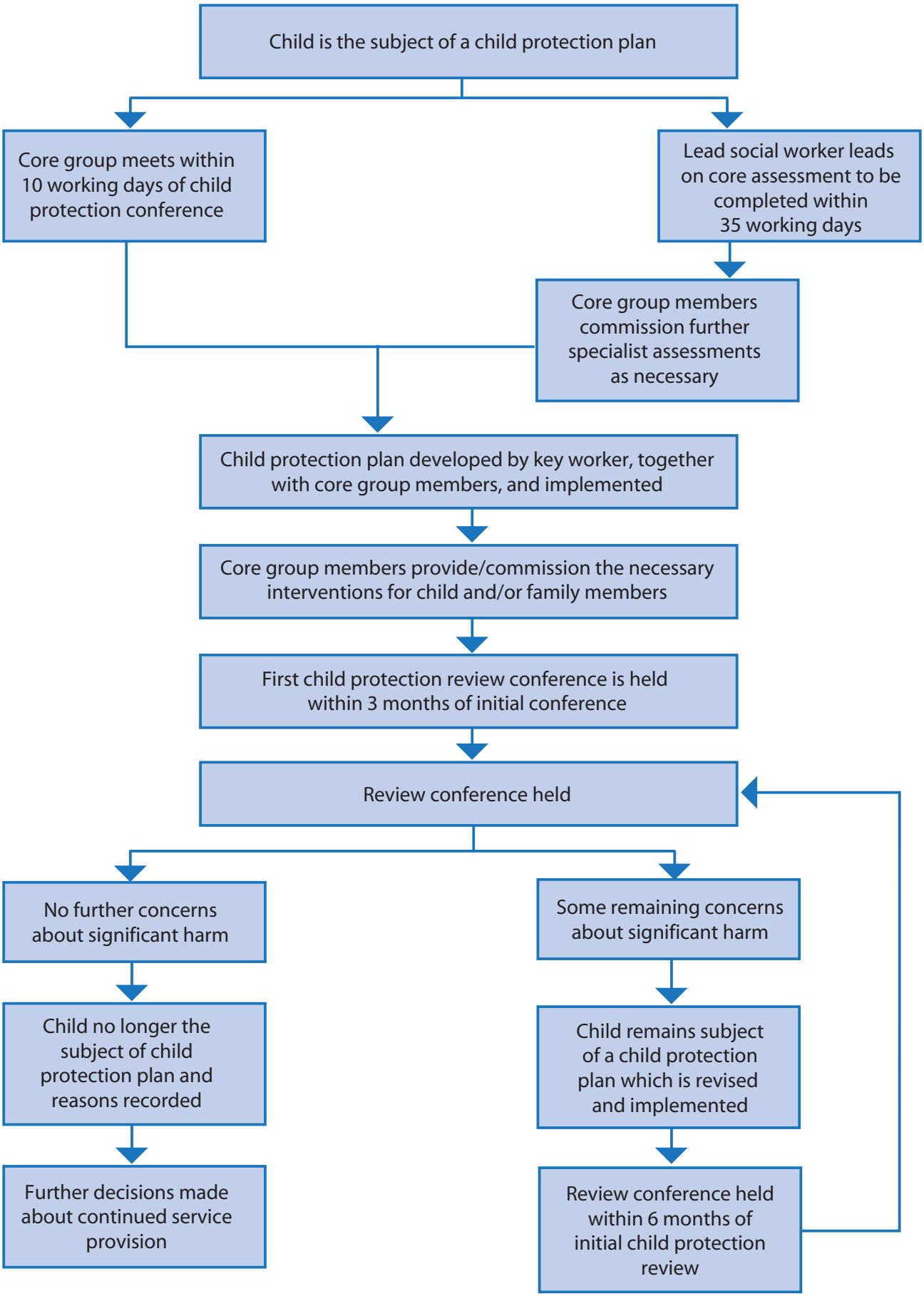
Flow chart 3: Urgent action to safeguard children



Flow chart 4: What happens after the strategy discussion?



Flow chart 5: What happens after the child protection conference, including the review process?



Chapter 6 – Supplementary guidance on safeguarding and promoting the welfare of children

Introduction

6.1 This chapter summarises supplementary guidance to *Working Together to Safeguard Children* and other guidance relevant to safeguarding and promoting children's welfare. The supplementary guidance follows the processes set out in Chapter 5 on how to respond to concerns about the welfare of a child or children, but is developed in more detail to reflect the specialist nature of the particular issues covered.

Sexually exploited children

6.2 Children and young people who are sexually exploited are the victims of child sexual abuse, and their needs require careful assessment. They are likely to be in need of welfare services and – in many cases – protection under the Children Act 1989. This group may include children who have been sexually abused through the misuse of technology, coerced into sexual activity by criminal gangs or the victims of trafficking. Every Local Safeguarding Children Board (LSCB) should assume that sexual exploitation occurs within its area unless there is clear evidence to the contrary, and should put in place systems to monitor prevalence and responses. The DCSF published guidance in June 2009 on *Safeguarding Children and Young People from Sexual Exploitation*[98].

6.3 The guidance states that LSCBs should ensure that specific local procedures are in place covering the sexual exploitation of children and young people. The procedures should be a subset of the LSCB procedures for safeguarding and promoting the welfare of children, and be consistent with local youth offending protocols. The identification of a child who is being sexually exploited, or at risk of being sexually exploited, should always trigger the agreed local procedures to ensure the child's safety and welfare and to enable the police to gather evidence about abusers and coercers.

6.4 The strong links that have been identified between different forms of sexual exploitation, running away from home, gang activity, child trafficking and substance misuse should be borne in mind in the development of procedures. These should

98 www.dcsf.gov.uk/everychildmatters/_download/?id=6021

include identifying signs of sexual exploitation, routes for referring concerns, advice on working with other professionals to disrupt sexual exploitation and support victims, gathering and preserving evidence about perpetrators, as well as how to deal with more complex issues such as those relating to the increasing use of the internet in sexual exploitation.

Children affected by gang activity

6.5 Children and young people who become involved in gangs are at risk of violent crime and as a result of this involvement are deemed vulnerable. Agencies and professionals have a responsibility to safeguard these children and young people and to prevent further harm both to the young person and other potential victims. Risks associated with gang activity include access to weapons (including firearms), retaliatory violence and territorial violence with other gangs. Other risks include increased likelihood of involvement in knife crime, sexual violence and substance misuse. The recently published guidance on *Safeguarding Children and Young People who may be affected by Gang Activity*[99] is intended to assist agencies and professionals ensure the safeguarding process effectively responds to children and young people at risk of gang related violence. The guidance promotes an approach whereby agencies should work together to:

- clearly define the local problem;
- understand the risks posed by local gangs;
- effectively identify young people at risk;
- assess the needs of children, young people and their families;
- identify effective referral pathways;
- support professionals in delivering effective interventions; and
- define the role of the LSCB and other agencies.

Fabricated or induced illness (FII)

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

- reported symptoms and signs found on examination are not explained by any medical condition from which the child may be suffering; or

99 http://publications.everychildmatters.gov.uk/default.aspx?PageFunction=productdetails&PageMode=publications&ProductId=DCSF-00064-2010

- physical examination and results of medical investigations do not explain reported symptoms and signs; or
- there is an inexplicably poor response to prescribed medication and other treatment; or
- new symptoms are reported on resolution of previous ones; or
- reported symptoms and found signs are not seen to begin in the absence of the carer; or
- over time the child is repeatedly presented with a range of signs and symptoms; or
- the child's normal, daily life activities are being curtailed, for example school attendance, beyond that which might be expected for any medical disorder from which the child is known to suffer.

There may be a number of explanations for these circumstances and each requires careful consideration and review. A full developmental history and an appropriate developmental assessment should be carried out. Consultation with peers, named or designated professionals or colleagues in other agencies will be an important part of the process of making sense of the underlying reason for these signs and symptoms. The characteristics of fabricated or induced illness are that there is a lack of the usual corroboration of findings with symptoms or signs, or, in circumstances of proven organic illness, lack of the usual response to proven effective treatments. It is this puzzling discrepancy which alerts the medical clinician to possible harm being suffered by the child.

6.7 There are three main ways of fabricating or inducing illness in a child. These are not mutually exclusive and include:

- fabrication of signs and symptoms. This may include fabrication of past medical history;
- fabrication of signs and symptoms and falsification of hospital charts and records, and specimens of bodily fluids. This may also include falsification of letters and documents; and
- induction of illness by a variety of means.

6.8 In 2008 the Government published statutory guidance *Safeguarding children in whom illness is fabricated or induced*[100]. This replaces the 2002 edition. This guidance provides a national framework within which agencies and professionals at a local level – individually and jointly – draw up and agree their own more detailed ways of

100 www.dcsf.gov.uk/everychildmatters/_download/?id=3161

working together where illness may be being fabricated or induced in a child by a caregiver who has parenting responsibilities for him or her. It is addressed to those who work in health, education, schools, probation, social care, the police and all others whose work brings them into contact with children and families. It is relevant to those working in the statutory, voluntary and independent sectors. It is intended that LSCBs' procedures should incorporate this guidance and its references to covert video surveillance, rather than having separate guidance on fabricated or induced illness in children. Within local procedures, the section on the use of covert video surveillance should make reference to the good practice advice for police officers which is available to them from the National Police Improvement Agency's Specialist Operations Centre.

6.9 To support the use of this statutory guidance the Government published *Incredibly Caring* in 2009. This training resource (in the form of a DVD) has been designed to assist both practitioners and managers promote the best outcomes for children where fabricated or induced illness is suspected; work sensitively with parents and carers in the child's best interests; and better exercise their professional judgement.

Investigating complex (organised or multiple) abuse

6.10 This abuse may be defined as abuse involving one or more abusers and a number of children. The abusers concerned may be acting in concert to abuse children, sometimes acting in isolation, or may be using an institutional framework or position of authority to recruit children for abuse.

6.11 Complex abuse occurs both as part of a network of abuse across a family or community, and within institutions such as residential homes or schools. Such abuse is profoundly traumatic for the children who become involved. Its investigation is time-consuming and demanding work, requiring specialist skills from both police and social work staff. Some investigations become extremely complex because of the number of places and people involved, and the timescale over which abuse is alleged to have occurred. The complexity is heightened where, as in historical cases, the alleged victims are no longer living in the setting where the incidents occurred or where the alleged perpetrators are also no longer linked to the setting or employment role.

6.12 Each investigation of organised or multiple abuse will be different, according to the characteristics of each situation and the scale and complexity of the investigation. Although there has been much reporting in recent years about complex abuse in residential settings, complex abuse can occur in day care, in families and in other provisions such as youth services, sports clubs and voluntary groups. Cases of children being abused through the misuse of technology is also a new form of abuse which agencies are having to address.

6.13 Each complex abuse case requires thorough planning, good inter-agency working and attention to the welfare needs of the child victims or adult survivors involved. The guidance *Complex Child Abuse Investigations: Inter-agency issues* (Home Office and Department of Health, 2002)[101] seeks to help agencies confronted with difficult investigations by sharing the accumulated learning from Serious Case Reviews. It sets out the overarching policy and practice framework to inform and shape the detailed strategic plans that agencies will need to develop when confronted with a complex child abuse case. It does not, however, provide detailed operational guidance on all aspects of such investigations. This guidance is equally relevant to investigating organised or multiple abuse within an institution. In addition, Appendix A of this guidance identifies the issues which should be addressed in all major investigations, and which should be reflected in local procedures. The Association of Chief Police Officers (ACPO) have also recently issued revised guidance on *Investigating Child Abuse and Safeguarding Children*[102].

Female genital mutilation

6.14 Female genital mutilation (FGM) is a collective term for procedures which include the removal of part or all of the external female genitalia for cultural or other non-therapeutic reasons. The practice is medically unnecessary, extremely painful and has serious health consequences, both at the time when the mutilation is carried out and in later life. The procedure is typically performed on girls aged between four and thirteen, but in some cases FGM is performed on new born infants or on young women before marriage or pregnancy. A number of girls die as a direct result of the procedure from blood loss or infection, either following the procedure or subsequently in childbirth.

6.15 FGM has been a criminal offence in the UK since the Prohibition of Female Circumcision Act 1985 was passed. The Female Genital Mutilation Act 2003 replaced the 1985 Act and made it an offence for UK nationals or permanent UK residents to carry out FGM abroad, or to aid, abet, counsel or procure the carrying out of FGM abroad, even in countries where the practice is legal. Further information about the Act can be found in *Home Office Circular 10/2004*[103].

6.16 FGM is much more common than most people realise, both worldwide and in the UK. It is reportedly practised in 28 African countries and in parts of the Middle and Far East but is increasingly found in Western Europe and other developed countries, primarily amongst immigrant and refugee communities. There are substantial populations from countries where FGM is endemic in London, Liverpool,

101 http://police.homeoffice.gov.uk/publications/operational-policing/child_abuse_guidancefb94.html?view=standard&pubID=184109

102 Available from www.ceop.police.uk.

103 Found at: www.homeoffice.gov.uk

Birmingham, Sheffield and Cardiff but it is likely that communities in which FGM is practised reside throughout the UK. It has been estimated that up to 24,000 girls under the age of 15 are at risk of FGM in the UK[104].

6.17 Suspicions may arise in a number of ways that a child is being prepared for FGM to take place abroad. These include knowing that the family belongs to a community in which FGM is practised and are making preparations for the child to take a holiday, arranging vaccinations or planning absence from school, and the child may talk about a 'special procedure' taking place. Indicators that FGM may have already occurred include prolonged absence from school with noticeable behaviour change on return and long periods away from classes or other normal activities, possibly with bladder or menstrual problems. Midwives and doctors may become aware that FGM has been practised on an older woman and this may prompt concern for female children in the same family.

6.18 A local authority may exercise its powers under section 47 of the Children Act 1989 if it has reason to believe that a child is likely to suffer or has suffered FGM. However, despite the very severe health consequences, parents and others who have this done to their daughters do not intend it as an act of abuse. They genuinely believe that it is in the girl's best interests to conform with their prevailing custom. So, where a child has been identified as at risk of significant harm, it may not be appropriate to consider removing the child from an otherwise loving family environment. Where a child appears to be in immediate danger of mutilation, consideration should be given to getting a prohibited steps order. If a child has already undergone FGM, particular attention should be paid to the potential risk of harm to other female children in the same family.

6.19 In local areas where there are communities who traditionally practice and positively promote FGM, consideration should be given to incorporating more detailed guidance on responding to concerns about FGM into existing procedures to safeguard and promote the welfare of children. LSCB policy should focus on a preventive strategy involving community education and be alert to the fact that the practice may also take place in this country. Further information in support of these guidelines can be found in *Local Authority Social Services Letter LASSL (2004)4*[105].

Forced marriage and honour-based violence

6.20 The terms 'honour crime', 'izzat' or 'honour-based violence' embrace a variety of crimes of violence (mainly but not exclusively against women), including assault, imprisonment and murder where the person is being punished by their family or community. They are being punished for actually, or allegedly, undermining what

104 Dorkenoo et al, 2007. Available from FORWARD UK.
105 available at: www.dcsf.gov.uk

the family or community believes to be the correct code of behaviour. In transgressing against this correct code of behaviour, the person shows that they have not been properly controlled to conform by their family and this is to the 'shame' or 'dishonour' of the family.

6.21 Forced marriage and honour-based violence are human rights abuses and fall within the Government's definition of domestic violence. Forced marriage is defined as a marriage conducted without the full consent of both parties and where duress is a factor. There is a clear distinction between forced marriage and an arranged marriage. In arranged marriages, the families may take a leading role in arranging the marriage, but the choice whether or not to accept remains with the prospective spouses. In a forced marriage, one or both spouses do not consent to the marriage. The young person could be facing physical, psychological, sexual, financial or emotional abuse to pressure them into accepting the marriage.

6.22 Forced marriage affects victims from many communities. The majority of cases reported to date in the UK involve South Asian families, but there have been cases involving families from across Europe, East Asia, the Middle East and Africa. Some forced marriages take place in the UK with no overseas element, while others involve a partner coming from overseas or a British national being sent abroad.

6.23 If there are concerns that a child (male or female) is in danger of a forced marriage, in addition to safeguarding procedures set out in this publication, the Forced Marriage Unit should be contacted. The Forced Marriage Unit (a joint Home Office/ Foreign and Commonwealth Office Unit) was launched in January 2005. It is responsible for developing Government policy on forced marriage, for raising awareness and for casework. It runs a public helpline[106] that provides confidential advice and support to victims, and to practitioners handling cases of forced marriage. Caseworkers in the Unit have extensive experience of the cultural, social and emotional issues surrounding forced marriage. They can also directly assist to help British nationals facing forced marriage abroad by helping them to a place of safety and helping them to return to the UK.

6.24 Although there is no specific criminal offence in England and Wales of 'forcing someone to marry', criminal offences may nevertheless be committed. Perpetrators – usually parents or family members – could be prosecuted for offences including threatening behaviour, assault, kidnap, abduction, theft (of passport), threats to kill, imprisonment and murder. Sexual intercourse without consent is rape, regardless of whether this occurs within a marriage or not. A woman who is forced into marriage is likely to be raped and may be raped until she becomes pregnant.

106 The helpline number is 0207 008 0151 (www.fco.gov.uk/forcedmarriage).

6.25 Hundreds of people in the UK (particularly girls and young women), some as young as nine, are forced into marriage each year. Some are taken overseas to marry whilst others may be married in the UK. Suspicions that a young person may be forced into marriage may arise in a number of ways. These include a family history of older siblings leaving education early and marrying early; depressive behaviour including self-harming and attempted suicide; unreasonable restrictions such as being kept at home by their parents ('house arrest') or being unable to complete their education; and a person always being accompanied including to school and doctors' appointments. A young person may also talk about an upcoming family holiday that they are worried about, fears that they will be taken out of education and kept abroad, or directly disclose that they are worried they will be forced to marry.

6.26 There may be only one opportunity to speak to a potential victim of forced marriage, so an appropriate initial response is vital. Without the right information being taken down (for example, a traceable address overseas), a victim may never be seen again. It is important to gather as much information as possible about the victim immediately, but this should be done on their own, in a private place where the conversation cannot be overheard. Victims should be reminded of their rights – they have the right to choose who they marry, when and where, and the right to make decisions about their lives.

6.27 Many victims are terrified that their families will find out that they have asked for help. **Do not** inform the victim's family, friends or members of the community that the victim has sought help as this is likely to increase the risk to the victim significantly. Forced marriage is closely linked to honour-based violence and honour killings. All those involved will want to bear in mind that *mediation as a response to forced marriage can be extremely dangerous.* There have been cases of victims being murdered by their families during mediation. Mediation can also place someone at risk of further emotional and physical abuse.

6.28 All those with a duty to safeguard and promote the welfare of children should have regard to the statutory guidance *The Right to Choose: Multi-agency statutory guidance for dealing with forced marriage*[107]. This statutory guidance sets out the responsibilities of Chief Executives, directors and senior managers. It covers issues such as staff training, developing inter-agency policies and procedures, raising awareness and developing prevention programmes through outreach work.

6.29 In addition, all practitioners working with children should have access to *Multi-agency practice guidelines: Handling cases of Forced Marriage*[108], published in 2009. These guidelines provide advice and support to front line practitioners.

---

107 www.fco.gov.uk/resources/en/pdf/3849543/forced-marriage-right-to-choose

108 www.fco.gov.uk/resources/en/pdf/3849543/forced-marriage-guidelines09.pdf

6.30 Anyone threatened with forced marriage or forced to marry against their will can apply for a Forced Marriage Protection Order. Third parties, such as relatives, friends, voluntary workers and police officers, can also apply for a protection order with the leave of the court. Fifteen county courts deal with applications and make orders to prevent forced marriages. Local authorities can now seek a protection order for vulnerable adults and children without leave of the court. Guidance published by the Ministry of Justice explains how local authorities can apply for protection orders and provides information for other agencies[109].

6.31 Where a case of forced marriage has resulted in the serious harm of a child or young person, practitioners should also consider undertaking a Serious Case Review.

Allegations of abuse made against a person who works with children

6.32 Children can be subjected to abuse by those who work with them in any setting. All allegations of abuse or maltreatment of children by a professional, staff member, foster carer, or volunteer must therefore be taken seriously and treated in accordance with consistent procedures. LSCBs have responsibility for ensuring there are effective inter-agency procedures in place for dealing with allegations against people who work with children, and monitoring and evaluating the effectiveness of those procedures – see Chapter 3.

6.33 In evaluating the effectiveness of local procedures LSCBs should have regard to the need to complete cases expeditiously. Data about allegations made against education staff show that it is reasonable to expect that 80% of cases should be resolved within one month, 90% within three months and that all but the most exceptional cases should be completed within 12 months, although it is unlikely that cases that require a criminal prosecution or a complex police investigation can be completed in less than three months.

6.34 All organisations which provide services for children, or provide staff or volunteers to work with or care for children, should operate a procedure for handling such allegations which is consistent with the guidance in Appendix 5.

109 This is available at www.justice.gov.uk/guidance/forced-marriage.htm

6.35 LSCB member organisations should have a named senior officer who has overall responsibility for:

- ensuring that the organisation operates procedures for dealing with allegations in accordance with the guidance in Appendix 5;
- resolving any inter-agency issues; and
- liaison with the LSCB on the subject.

County level and unitary local authorities should also designate officers (the Local Authority Designated Officer, or LADO) to be involved in the management and oversight of individual cases – providing advice and guidance to employers and voluntary organisations, liaising with the police and other agencies and monitoring the progress of cases to ensure that they are dealt with as quickly as possible consistent with a thorough and fair process.

6.36 Police forces should also identify officers to fill similar roles. There should be a senior officer to have strategic oversight of the arrangements, liaise with the LSCBs in the force area and ensure compliance, and others, perhaps unit managers, who will be responsible for liaising with the LADO(s), taking part in the strategy discussion (see Chapter 5), subsequently reviewing the progress of those cases in which there is a police investigation, and sharing information on completion of the investigation or any prosecution.

6.37 The scope of inter-agency procedures in this area is not limited to allegations involving significant harm or the risk of significant harm to a child. The guidance in Appendix 5 should be followed in respect of any allegation that a person who works with children has:

- behaved in a way that has harmed a child, or may have harmed a child;
- possibly committed a criminal offence against or related to a child; or
- behaved towards a child or children in a way that indicates s/he is unsuitable to work with children

in connection with the person's employment or voluntary activity. If concerns arise about the person's behaviour in regard to his/her own children, the police and/or children's social care need to consider informing the person's employer in order to assess whether there may be implications for children with whom the person has contact at work.

6.38 The child or children concerned should receive appropriate support. They, and their parents or carers, should be helped to understand the process, told the result of any

enquiry or disciplinary process[110], and where necessary helped to understand the outcomes reached. The provision of information and advice must take place in a manner that does not impede the proper exercise of enquiry, disciplinary and investigative processes.

6.39 Staff, foster carers, volunteers and other individuals about whom there are concerns should be treated fairly and honestly, and should also be provided with support throughout the investigation process as should others who are also involved. They should be helped to understand the concerns expressed and the processes being operated, and be clearly informed of the outcome of any investigation and the implications for disciplinary or related processes. However, the police, and other relevant agencies, should always be consulted before informing a person who is the subject of allegations which may possibly require a criminal investigation.

6.40 There have been a number of widely reported cases of historical abuse, usually of an organised or multiple nature (see paragraph 6.12). Such cases have generally come to light after adults have reported abuse that they had experienced when children, while living away from home in settings provided by local authorities, the voluntary sector or independent providers. When such allegations are made, they should be responded to in the same way as contemporary concerns. In those cases it is also important to find out whether the person accused is still working with children and, if so, to inform the person's current employer or voluntary organisation.

6.41 Those undertaking investigations should be alert to any sign or pattern which suggests that the abuse is more widespread or organised than it appears at first sight, or that it involves other perpetrators or institutions. It is important not to assume that initial signs will necessarily be related directly to abuse, and to consider occasions where boundaries have been blurred, inappropriate behaviour has taken place, and matters such as fraud, deception or pornography have been involved.

6.42 If an allegation is substantiated, the managers or commissioners of the relevant service should think widely about the lessons of the case and how they should be acted upon. This should include whether there are features of the organisation which may have contributed to the abuse occurring, or failed to prevent the abuse occurring. In some circumstances, a Serious Case Review may be appropriate (see Chapter 8).

110 In deciding what information to disclose, careful consideration should be given to duties under the Data Protection Act 1998, the law of confidence and, where relevant, the Human Rights Act 1998.

Abuse of disabled children

6.43 In July 2009, the Government published *Safeguarding Disabled Children – Practice Guidance*[111]. This guidance provides a framework within which LSCBs, agencies and professionals at local level – individually and jointly – draw up and agree detailed ways of working together to safeguard disabled children.

6.44 The available UK evidence on the extent of abuse among disabled children suggests that disabled children are at increased risk of abuse, and that the presence of multiple disabilities appears to increase the risk of both abuse and neglect (see Standards 5, 7 and 8 of the *National Service Framework for Children, Young People and Maternity Services*). Disabled children may be especially vulnerable to abuse for a number of reasons:

- many disabled children are at an increased likelihood of being socially isolated with fewer outside contacts than non-disabled children;
- their dependency on parents and carers for practical assistance in daily living, including intimate personal care, increases their risk of exposure to abusive behaviour;
- they have an impaired capacity to resist or avoid abuse;
- they may have speech, language and communication needs which may make it difficult to tell others what is happening;
- they often do not have access to someone they can trust to disclose that they have been abused; and/or
- they are especially vulnerable to bullying and intimidation.

Looked after disabled children are not only vulnerable to the same factors that exist for all children living away from home, but are particularly susceptible to possible abuse because of their additional dependency on residential and hospital staff for day to day physical care needs.

6.45 Safeguards for disabled children are essentially the same as for non-disabled children. Particular attention should be paid to promoting a high level of awareness of the risks of harm and high standards of practice, and strengthening the capacity of children and families to help themselves. Measures should include:

- making it common practice to help disabled children make their wishes and feelings known in respect of their care and treatment;

111 www.dcsf.gov.uk/everychildmatters/_download/?id=6195

- ensuring that disabled children receive appropriate personal, health, and social education (including sex education);
- making sure that all disabled children know how to raise concerns, and giving them access to a range of adults with whom they can communicate. Those disabled children with communication impairments should have available to them at all times a means of being heard;
- an explicit commitment to, and understanding of disabled children's safety and welfare among providers of services used by disabled children;
- close contact with families, and a culture of openness on the part of services;
- guidelines and training for staff on good practice in intimate care; working with children of the opposite sex; handling difficult behaviour; consent to treatment; anti-bullying strategies; and sexuality and sexual behaviour among young people, especially those living away from home; and
- guidelines and training for staff working with disabled children aged 16 and over to ensure that decisions about disabled children who lack capacity will be governed by the Mental Health Capacity Act once they reach the age of 16.

6.46 Where there are concerns about the welfare of a disabled child, they should be acted upon in accordance with the guidance in Chapter 5, in the same way as with any other child. Expertise in both safeguarding and promoting the welfare of child and disability has to be brought together to ensure that disabled children receive the same levels of protection from harm as other children (see *Safeguarding Disabled Children – Practice Guidance (2009)*).

6.47 Where a disabled child has communication impairments or learning disabilities, special attention should be paid to communication needs, and to ascertain the child's perception of events, and his or her wishes and feelings. In every area, children's social care and the police should be aware of non-verbal communication systems, when they might be useful and how to access them, and should know how to contact suitable interpreters or facilitators. Agencies should not make assumptions about the inability of a disabled child to give credible evidence, or to withstand the rigours of the court process. Each child should be assessed carefully, and helped and supported to participate in the criminal justice process when this is in the child's best interest and the interests of justice.

6.48 In criminal proceedings under the Youth Justice and Criminal Evidence Act 1999[112] witnesses aged under 17 (to be raised to under 18 by the end of 2010) may be eligible for special measures assistance when giving evidence in court. There is a presumption that child witnesses should give their evidence by video recorded

112 www.opsi.gov.uk/acts/acts1999/ukpga_19990023_en_1

statement (if taken) and live link, which allows a witness to give evidence during a trial from outside the courtroom through a televised link to the courtroom. The other special measures available to vulnerable witnesses include clearing the public gallery in sexual offence cases and those involving intimidation, screens to shield the witness from seeing the defendant, and assistance with communication through an intermediary or communication aid. *Achieving Best Evidence in Criminal Proceedings: Guidance on vulnerable and intimidated witnesses including children*[113] gives detailed guidance on planning and conducting interviews with children and vulnerable adults and includes a section on interviewing disabled children and also those that are very young or psychologically disturbed.

Child abuse linked to belief in 'spirit possession'

6.49 The belief in 'possession' and 'witchcraft' is relatively widespread. It is not confined to particular countries, cultures or religions, nor is it confined to new immigrant communities in this country.

6.50 The number of **identified** cases of child abuse linked to accusations of 'possession' are small, but the nature of the child abuse can be particularly disturbing and the children involved can suffer damage to their physical and mental health, capacity to learn, ability to form relationships and self-esteem.

6.51 There are a number of common factors which put a child at risk of harm, including rationalising misfortune by attributing it to spiritual forces and when a carer views a child as being 'different', attributes this difference to the child being 'possessed' or involved in 'witchcraft', and attempts to exorcise him or her. A child could be viewed as 'different' for a variety of reasons such as: disobedience; independence; bedwetting; nightmares; illness; or disability. The attempt to 'exorcise' may involve severe beating, burning, starvation, cutting or stabbing, and/or isolation, and usually occurs in the household where the child lives.

6.52 Agencies should look for these indicators, be able to identify children at risk of this type of abuse and intervene to prevent it. They should apply basic safeguarding children principles including: sharing information across agencies; being child-focused at all times; and keeping an open mind when talking to parents and carers. They should follow the guidance set out elsewhere in Working Together in their work with all children and families, ensure they liaise closely with colleagues and make connections with key people in the community, especially when working with new immigrant communities, so that they can ascertain the different dimensions of a family's cultural beliefs and how this might impact upon child abuse.

113 www.homeoffice.gov.uk/documents/ach-bect-evidence/

6.53 Good practice guidance for agencies, *Safeguarding Children from Abuse Linked to a Belief in Spirit Possession*[114], was published in April 2007.

Child victims of trafficking

6.54 Trafficking in people involves a collection of crimes, spanning a variety of countries and involving an increasing number of victims – resulting in considerable suffering for those trafficked. It includes the exploitation of children through force, coercion, threat and the use of deception and human rights abuses such as debt bondage, deprivation of liberty and lack of control over one's labour. It includes the movement of people across borders and also the movement and exploitation within borders. The persons who are trafficked have very little choice in what happens to them and usually suffer abuse due to the threats and use of violence against them and/or their family.

6.55 The UK is a transit and destination country for trafficked children and young people. Children are trafficked for various reasons, including sexual exploitation, domestic servitude, labour, benefit fraud and involvement in criminal activity such as pickpocketing, theft and working in cannabis farms. There are a number of cases, too, of minors being exploited in the sex industry. Although there is no evidence of other forms of exploitation such as 'organ donation, or 'harvesting', all agencies should remain vigilant.

6.56 Such children enter the UK through various means. Some enter as unaccompanied asylum seekers, or students or as visitors. Children are also brought in by adults who state that they are their dependents, or are met at airports or other ports of entry by an adult who claims to be a relative. It has been suggested that children have been brought in via internet transactions, foster arrangements, and contracts as domestic staff. In some cases girls aged 16 or 17 will have been tricked into a bogus marriage for the purpose of sexual exploitation. If it is suspected that a child is the victim of trafficking, the police or children's social care should be informed. Agencies should work together to ensure a joined-up response.

6.57 The DCSF and the Home Office published joint guidance on *Safeguarding children who may have been trafficked*[115] in December 2007. It sets out a comprehensive strategy to improve the identification and safeguarding of child victims of trafficking. DCSF guidance on sexual exploitation and young runways includes details of how services must work to protect children from trafficking.

---

114 www.dcsf.gov.uk/everychildmatters/_download/?id=661

115 *Safeguarding Children who may have been trafficked* (HM Government, 2008) http://publications.everychildmatters.gov.uk/default.aspx?PageFunction=productdetails&PageMode=publications&ProductId=HMG-00994-2007&

6.58 Early identification is key to protecting these vulnerable children. The child trafficking assessment toolkit has been designed to help front line staff identify children who may have potentially been trafficked as part of a new National Referral Mechanism (NRM). The NRM is a multi-agency framework designed to enable frontline practitioners to work together to identify and support victims of trafficking. Designated expert 'Competent Authorities' within the UK Human Trafficking Centre (UKHTC) and the UK Border Agency (UKBA) are responsible for determining, from the evidence gathered, but in particular on the basis of advice from children's services, whether a child meets the Council of Europe Convention on Action Against Trafficking in Human Beings ('the Convention') definition of trafficking. It was launched on 1 April 2009 and will ensure consistency of approach across all relevant agencies.

6.59 Children do not have to be trafficked across international borders to be exploited in this way. There is evidence that some UK resident children, mainly young girls, are being groomed, coerced and moved around between towns and cities within the UK for the purposes of sexual exploitation. Relevant agencies should remain alert to the possibility that this can happen and work together to address it.

6.60 The NRM process is a key element of the Convention. The purpose of the Convention is to prevent and combat trafficking, to identify and protect the victims of trafficking and to safeguard their rights; and to promote international co-operation against trafficking. The UK signed the Convention on 23 March 2007. The convention was ratified on 17 December 2008 and it came into force on 1 April 2009.

6.61 Decisions about who is a victim of trafficking are made by trained specialists in designated 'Competent Authorities'. The UKHTC hosts one such Competent Authority. The UKHTC Competent Authority deals with cases referred by all external agencies such as the police, local authorities etc where the person is a UK or EEA national, or where there is an immigration issue but the person is not yet known to UKBA. A linked but separate Competent Authority sits in UKBA for situations where trafficking is raised as part of an asylum claim or in the context of another immigration process.

6.62 An integral part of the NRM is the provision of accommodation and support to victims, and local authorities will continue to take the lead in providing appropriate services for vulnerable children (including trafficked children). Further details of the NRM process, including the trafficking toolkit, can be found on the Home Office crime reduction website[116].

116 www.crimereduction.homeoffice.gov.uk/humantrafficking005.htm

6.63 The offence of trafficking for prostitution, introduced in the Nationality, Immigration and Asylum Act 2002, carries a tough maximum penalty of 14 years. The Sexual Offences Act 2003 introduced wide-ranging offences covering trafficking into, out of or within the UK for any form of sexual offence, which also carries a 14 year maximum penalty. It also introduced a range of offences covering the commercial sexual exploitation of a child, protecting children up to 18. These include buying the sexual services of a child (for which the penalty ranges from seven years to life imprisonment depending on the age of the child) and causing or inciting, arranging or facilitating and controlling the commercial sexual exploitation of a child in prostitution or pornography, for which the maximum penalty is 14 years imprisonment. An offence of trafficking for exploitation, which covers trafficking for forced labour and the removal of organs, was introduced in the Asylum and Immigration (Treatment of Claimants, etc.) Act 2004. These offences will also take into account the UK's international obligations under the UN Palermo Trafficking Protocol (supplementing the UN Convention Against Transnational Organised Crime 2000) and the EU Framework Decision on Trafficking for the Purposes of Sexual and Labour Exploitation.

6.64 At the local level, LSCBs should be aware of the child trafficking agenda within their local authority and ensure all suspected child victims of trafficking are referred through the NRM using the correct procedure.

6.65 LSCBs should also identify trafficking co-ordinators who can ensure a co-ordinated campaign of information-sharing to support the safeguarding agenda between local authorities, police and the NRM Competent Authorities to ensure a full picture is provided on child NRM referrals and secure the best safeguarding outcome for the child.

6.66 For those requiring more information on the nature and scale of child trafficking in the UK, please refer to the *Child Trafficking Strategic Threat Assessment 2008/09* produced by the Child Exploitation and Online Protection (CEOP) Centre[117].

117 This and other related documents is available from www.ceop.police.uk/publications.

Chapter 7 – Child death review processes

Introduction

7.1 This chapter sets out the processes to be followed when a child dies in the Local Safeguarding Children Board (LSCB) area(s) covered by a Child Death Overview Panel. There are two interrelated processes for reviewing child deaths (either of which can trigger a Serious Case Review (SCR) – see Chapter 8):

a. rapid response by a group of key professionals who come together for the purpose of enquiring into and evaluating each unexpected death of a child (see paragraphs 7.48–7.93); and

b. an overview of all child deaths up to the age of 18 years (excluding both those babies who are stillborn and planned terminations of pregnancy carried out within the law[118]) in the LSCB area(s), undertaken by a panel (see paragraphs 7.25–7.47).

7.2 A sub-committee of the LSCB(s) known as the Child Death Overview Panel (CDOP) should be responsible for reviewing the available information on all child deaths, and should be accountable to the LSCB Chair. The disclosure of information about a deceased child is to enable the LSCB to carry out its statutory functions relating to child deaths. The LSCB should use the aggregated findings from all child deaths, collected according to the nationally agreed minimum data set[119] to inform local strategic planning on how best to safeguard and promote the welfare of the children in their area.

7.3 Guidance in this chapter relates to the deaths of all children and young people from birth (excluding those deaths set out in paragraph 7.1b) **up to the age of 18 years**. Implementation of some parts of the guidance will therefore need to take into account the needs of different age groups.

---

118 Reviews of deaths which follow a planned termination under the law (Abortion Act 1967) should not be carried out by Child Death Overview Panels even in instances where a death certificate has been issued. If the LSCB has general concerns about local procedures relating to planned terminations, it should contact the Care Quality Commission (enquiries@cqc.org.uk). All other deaths (i.e. excluding those deaths which follow a planned termination of pregnancy under the law) which have been registered as live with the General Registrar's Office, should be reviewed by the Child Death Overview Panel.

119 The nationally agreed data set is available at: www.dcsf.gov.uk/everychildmatters/safeguardingandsocialcare/safeguardingchildren/childdeathreviewprocedures/nationaltemplatesforlscbs/lscbtemplates/

Overall principles

7.4 Each death of a child is a tragedy for his or her family (including any siblings), and subsequent enquiries/investigations should keep an appropriate balance between forensic and medical requirements and the family's need for support. A minority of unexpected deaths are the consequence of abuse or neglect or are found to have abuse or neglect as an associated factor. In all cases, enquiries should seek to understand the reasons for the child's death, address the possible needs of other children in the household, the needs of all family members, and also consider any lessons to be learnt about how best to safeguard and promote children's welfare in the future.

7.5 Families should be treated with sensitivity, discretion and respect at all times, and professionals should approach their enquiries with an open mind.

7.6 Chronic illness, disability and life limiting conditions account for a large proportion of child deaths. Whilst it is to be expected that children with life limiting or life threatening conditions (LL/LT conditions) will die prematurely young, it is not always easy to predict when, or in what manner they will die. Professionals responding to the death of a child with a LL/LT condition should ensure that their response to these families is appropriate and supportive, does not cause any unnecessary distress at a time when they are dealing with the tragic but anticipated, natural death of their child, and that their child's expected death can be dignified and peaceful. End of life care plans may be in place and therefore families, where appropriate, should be supported, to choose where their child's body is cared for after death for example a children's hospice. The lives of children with LL/LT conditions are as valued and important as those of any other children, and hence the unexpected, death of a child with LL/LT conditions should be managed as for any other unexpected death so as to determine the cause of death and any contributory factors (see paragraphs 7.58–7.59). This is both out of respect for the child and family, and to fulfil any statutory requirements.

Involvement of parents and family members (for all child deaths)

7.7 It is vitally important that LSCBs establish mechanisms for appropriately informing and involving parents and other family members[120] in both the child death overview and the rapid response processes (see paragraphs 7.4–7.12, 7.36, 7.50, 7.57–7.62, 7.73–7.75 and 7.91–7.92)[121].

120 Parents includes carers where appropriate, and family members includes siblings where appropriate.

121 A leaflet which can be given to parents, carers and family members to explain the child death review process is available to order from DCSF Publications, Tel: 0845 60 222 60, please quote reference: 00180-2010LEF-EN

7.8 Parents and family members should be informed that their child's death will be reviewed, and often have significant information and questions to contribute to the review process.

7.9 Parents and family members should be assured that the objective of the child death review process is to learn lessons in order to improve the health, safety and well being of children and ultimately, hopefully, to prevent further such child deaths. The process is not about culpability or blame.

7.10 The LSCB, acting through the CDOP should agree what information is to be shared with parents and family members and ensure that a professional known to the family conveys to them agreed information in a sensitive and timely manner. Decisions on information sharing (i.e. what information is shared, with whom, and why) must be recorded in each agency's records. It is not appropriate however, for parents to attend the CDOP meeting as this is a meeting for professionals to discuss not only the individual case but also wider public health issues. Parents should however be encouraged to contribute any comments or questions they might have to the review of their child's death.

7.11 Parents should be informed that all cases will be anonymised prior to discussion by the CDOP, information gathered will be stored securely and only anonymised data will be collated at a regional or national level. Parents should also be made aware that the CDOP will make recommendations and report on the lessons learned to the LSCB. The LSCB produces an annual report which is a public document, but it will not contain any personal information that could identify an individual child or their family.

7.12 CDOPs should ensure that whenever necessary, arrangements are made for the family to have the opportunity to meet with relevant professionals, for example a professional known to the family before their child died, a paediatrician or a police officer to help answer their questions.

The Regulations relating to child deaths

7.13 One of the LSCB functions, set out in Regulation 6 of the Local Safeguarding Children Boards Regulations 2006, in relation to the deaths of any children normally resident in their area is as follows:

(a) collecting and analysing information about each death with a view to identifying –

(i) any case giving rise to the need for a review mentioned in Regulation 5(1)(e);

(ii) any matters of concern affecting the safety and welfare of children in the area of the authority; and

(iii) any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area; and

(b) putting in place procedures for ensuring that there is a co-ordinated response by the authority, their Board partners and other relevant persons to an unexpected death.

7.14 As explained in Chapter 3, the child death review functions became compulsory on 1 April 2008.

Supply of information about child deaths by registrars

7.15 Registrars of Births and Deaths are required by the Children and Young Persons Act 2008 to supply LSCBs with information which they have about the deaths:

- of persons aged under 18 in respect of whom they have registered the death; or
- of persons in respect of whom the entry of death is corrected and it is believed that person was or may have been under the age of 18 at the time of death.

Registrars must also notify LSCBs if they issue *a Certificate of No Liability to Register* where it appears that the deceased was or may have been under the age of 18 at the time of death.

7.16 Registrars are required to send the information to the appropriate LSCB no later than seven days from the date of registration, the date of making the correction/update or the date of issuing the certificate of no liability as appropriate. (The appropriate LSCB is the Board established by the children's services authority in England within whose area is situated the sub-district for which the register is kept). These requirements only apply in respect of deaths occurring on or after 1 April 2009.

7.17 In order to support these new responsibilities, it is a statutory requirement for each LSCB to make arrangements for the receipt of notifications from registrars and to publish these arrangements. In order to carry out this responsibility LSCBs are therefore required to notify the Department for Children, Schools and Families of the name and email address for the Child Death Overview designated person (hereafter referred to as the 'designated person') in each LSCB to whom child death notifications should be sent. This information is published by the Department on the *Every Child Matters* website[122].

122 A list of people designated by the Child Death Overview Panel to receive notifications of child death information is available at: www.dcsf.gov.uk/everychildmatters/resources-and-practice/IG00351/

Duty and powers of coroners to share information

7.18 The Coroners Rules 1984 as amended by the Coroners (Amendment) Rules 2008 place a duty on coroners to inform the LSCB, for the area in which the child died, of the fact of an inquest or post mortem. It also gives coroners powers to share information with LSCBs for the purposes of carrying out their functions, which include reviewing child deaths and undertaking SCRs. Where there is more than one LSCB in a coroner's area, arrangements should be made between the coroner and the LSCBs as to which LSCB should be informed of the coroner's decisions.

7.19 On receipt of an initial report of a death of a child, the LSCB or LSCBs with an interest in this information should inform the coroner of the address(es) (including email address(es)) to which future information should be supplied. If any information comes to the attention of an LSCB which it believes should be drawn to the attention of the relevant coroner, then the LSCB should consider supplying it to the coroner as a matter of urgency[123].

Duty and powers of Medical Examiners (MEs) to share information

7.20 In taking forward the proposed improvements to the process of death certification, the Department of Health will ensure that appropriate interfaces are established with these functions now being delivered by LSCBs. It is anticipated that under the Coroners and Justice Act 2009, MEs will be required to share information with LSCBs about child deaths that are not investigated by a coroner.

Definition of an unexpected death of a child

7.21 In this guidance an unexpected death is defined as the death of an infant or child (less than 18 years old) which:

- was not anticipated as a significant possibility for example, 24 hours before the death; or
- where there was a similarly unexpected collapse or incident leading to or precipitating the events which led to the death[124,125].

123 For further guidance see: www.justice.gov.uk/guidance/coroners-guidance.htm

124 PJ. Fleming, P.S. Blair, C. Bacon, and P.J. Berry (2000) *Sudden Unexpected Death In Infancy. The CESDI SUDI Studies 1993-1996. The Stationary Office. London. ISBN 0 11 3222 9988.*

125 Royal College of Pathologists and the Royal College of Paediatrics and Child Health (2004) *Sudden unexpected death in infancy. A multi-agency protocol for care and investigation. The Report of a working group convened by the Royal College of Pathologists and the Royal College of Paediatrics and Child Health*. Royal College of Pathologists and the Royal College of Paediatrics and Child Health, London. www.rcpath.org

7.22 The designated paediatrician responsible for unexpected deaths in childhood (see paragraph 7.29) should be consulted where professionals are uncertain about whether the death is unexpected. If in doubt, the processes for unexpected child deaths should be followed until the available evidence enables a different decision to be made.

Definition of preventable child deaths

7.23 For the purpose of producing aggregate national data, this guidance defines preventable child deaths as those in which modifiable factors may have contributed to the death. These factors are defined as those which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

7.24 In reviewing the death of each child, the CDOP should consider modifiable factors, for example in the family and environment, parenting capacity or service provision, and consider what action could be taken locally and what action could be taken at a regional or national level.

LSCB responsibilities for the child death review processes

Reviewing deaths of all children

7.25 The CDOP should undertake an overview of **all** child deaths (excluding those deaths set out in paragraph 7.1b) up to the age of 18 years in the LSCB area(s) covered by the CDOP. This is a paper based review, based on information available from those who were involved in the care of the child, both before and immediately after the death, and other sources including, perhaps, the coroner. The panel should:

- have a fixed core membership (see paragraph 7.27) to review these cases, with flexibility to co-opt other relevant professionals as and when appropriate;
- hold meetings at regular intervals to enable each child's case to be discussed in a timely manner (the length of the discussion may vary depending on the nature of the death in question and the quantity of information available);
- review the appropriateness of the professionals' responses to each death of a child, their involvement before and at the time of the death, and relevant environmental, social, health and cultural aspects of each death, to ensure a thorough consideration of how such deaths might be prevented in the future;
- determine whether or not the death was deemed preventable (as defined in paragraph 7.23). The decision must be agreed by the CDOP and approved by the Chair of the CDOP. This decision cannot be finalised however until the outcome of other investigations (for example SCRs, criminal proceedings, post mortem or inquests) is known;

- make recommendations to the LSCB or other relevant bodies as soon as these have been decided in order that prompt action can be taken to prevent future such deaths where possible; and
- identify any patterns or trends in the local data and report these to the LSCB.

7.26 Neighbouring LSCBs may decide to share a CDOP, depending on the local configuration of services and population served (experience shows that panels responsible for reviewing deaths from a total population greater than 500,000 gain experience more quickly, and review a sufficiently large number of deaths to be better able to identify significant recurrent contributory factors). In this situation LSCBs should agree lines of accountability with the CDOP in accordance with this guidance.

7.27 The CDOP has a permanent core membership drawn from the key organisations represented on the LSCB (see paragraph 3.70); although not all core members are necessarily involved in discussing all cases. The Panel should include a professional from public health as well as child health. Other members may be co-opted, either as permanent members to reflect the characteristics of the local population (for example, a representative of a large local ethnic or religious community), to provide a perspective from the independent or voluntary sector, or to contribute to the discussion of certain types of death when they occur (for example, fire fighters for house fires). The Panel will be chaired by the LSCB Chair or his or her representative, who will be a member of the LSCB. The Panel Chair should not be involved in providing direct services to children and families in the area.

7.28 Within each organisation represented on the LSCB, a senior person with relevant expertise should be identified as having responsibility for advising on the implementation of the local procedures on responding to child deaths. Each organisation should expect to be involved in a child death review at some time.

7.29 Each PCT should ensure that the LSCB, acting through the CDOP, has access to a consultant paediatrician whose designated role is to provide advice on:

- the commissioning of paediatric services from paediatricians with expertise in undertaking enquiries into unexpected deaths in childhood and the medical investigative services such as radiology, laboratory and histopathology services; and
- the organisation of such services.

The designated paediatrician for unexpected deaths in childhood may provide advice to more than one PCT, and is likely to be a member of the local CDOP. This is a separate role to the designated doctor for child protection, but does not

necessarily need to be filled by a different person. These responsibilities should be recognised in the job plan agreed between the consultant and his or her employer.

7.30 The CDOP should have a clear relationship and agreed channels of communication with the local coronial service.

7.31 The LSCB should ensure that appropriate single and inter-agency training (see Chapter 4) is made available to ensure successful implementation of these processes. LSCB partner agencies should ensure that relevant staff have access to this training[126].

Procedures to be followed by the local Child Death Overview Panel (for all child deaths)

7.32 In order for LSCBs to fulfil their child death reviewing responsibilities, the LSCB should be informed of all deaths of children normally resident in its geographical area. The LSCB Chair should decide who will be the designated person to whom the death notification and other data on each death should be sent[127]. The Chair of the CDOP is responsible for ensuring that this process operates effectively.

7.33 Deaths should be notified by the professional confirming the fact of the child's death. For unexpected deaths, this will be at the same time as they inform the coroner and the person designated by the LSCB to be notified of all children's deaths in the area in which the death occurred. If this is not the area in which the child is normally resident, the designated person should inform their opposite number in the area where the child normally resides[128].

7.34 In these situations, it should be decided on a case-by-case basis which Panel should take responsibility for gathering the necessary information for a Panel's consideration. In some cases this may be done jointly. Where partner agencies in more than one LSCB area have known about or have had contact with the child, the LSCB for the area in which the child was normally resident at the time of death should take lead responsibility for conducting the child death review. Any other LSCBs that have an interest or whose local agencies have had involvement in the case should co-operate as partners in jointly planning and undertaking the child death review. In the case of a looked after child, the LSCB for the area of the local authority looking after the child should exercise lead responsibility for conducting

126 *Responding when a child dies* – a multi-agency training resource to support LSCBs in implementing the child death review processes have been published to support the training of staff at all levels. The resources are available at: www.dcsf.gov.uk/everychildmatters/safeguardingandsocialcare/safeguardingchildren/childdeathreviewprocedures/trainingmaterials/trainingmaterials/

127 See footnote 122.

128 See footnote 122.

the child death review, involving other LSCBs with an interest or whose local agencies have had involvement as appropriate. The Registrar has a duty to send a notification of each child's death to the LSCB (see paragraphs 7.15–7.17), and this provides a check to ensure that all child deaths have been notified to the designated person in each LSCB[129]. Any professional (or member of the public) hearing of a local child death in circumstances that mean it may not yet be known about (for example, a death occurring abroad) can inform the designated person in the LSCB.

7.35 Section 32 of the Children and Young Persons Act 2008 gives the Registrar General a power to share child death information with the Secretary of State. However information about children who die abroad may not reach the Registrar General for some time after the death has occurred. Therefore, LSCBs should continue to utilise other sources, such as professional contacts or the media, to inform the CDOP with information about the death of a child who is normally resident in England and who dies abroad.

7.36 The functions of the CDOP include:

- reviewing the available information on all child deaths of children aged up to 18 years (including deaths of infants aged less than 28 days but excluding those deaths set out in paragraph 7.1b) to determine whether the death was preventable. This decision should always be approved by the Chair of the CDOP;
- implementing, in consultation with the local coroner, local procedures and protocols that are in line with this guidance on enquiring into unexpected deaths, and evaluating these as part of the information set held on all deaths in childhood;
- collecting and collating an agreed minimum data set[130] on each child who has died and, seeking relevant information from professionals and family members;
- meeting frequently to review and evaluate the routinely collected data (see paragraph 7.25) on the deaths of all children, and thereby identifying lessons to be learnt or issues of concern, with a particular focus on effective inter-agency working to safeguard and promote the welfare of children;
- having a mechanism to evaluate specific cases in depth, where necessary, at subsequent meetings. This may involve revisiting child deaths after the outcome of other types of investigations is known (for example, outcomes from SCRs or criminal proceedings);
- monitoring the appropriateness of the response of professionals to an unexpected death of a child, reviewing the reports produced by the rapid response team on each unexpected death of a child, including the extent to

129 See footnote 122.
130 See footnote 119.

which the team has brought together any recorded wishes and feelings of the child, making a full record of this discussion and providing the professionals with feedback on their work. Where there is an ongoing criminal investigation, the Crown Prosecution Service must be consulted as to what it is appropriate for the Panel to consider and what actions it might take in order not to prejudice any criminal proceedings;

- referring to the Chair of the LSCB any deaths where, on evaluating the available information, the Panel considers there may be grounds to undertake further enquiries, investigations or a SCR and explore why this had not previously been recognised;
- informing the Chair of the LSCB where specific new information should be passed to the coroner or other appropriate authorities;
- providing relevant information to those professionals involved with the child's family so that they, in turn, can convey this information in a sensitive and timely manner to the family;
- monitoring the support and assessment services offered to families of children who have died;
- advising and monitoring the LSCB on the resources and training required locally to ensure an effective inter-agency response to child deaths[131];
- organising and monitoring the collection of data for the nationally agreed minimum data set[132], and making recommendations (to be approved by LSCBs) for any additional data to be collected locally;
- identifying any public health issues and considering, with the Director(s) of Public Health, how best to address these and their implications for both the provision of services and for training; and
- co-operating with regional and national initiatives – for example, by the Centre for Maternal and Child Enquiries (CMACE)[133] – to identify lessons on the prevention of child deaths.

The process to be followed by Child Death Overview Panels (for all child deaths)

7.37 Any person notifying the designated person in the LSCB[134] of the death of a child should provide as much detail as is known to them in relation to the child and

131 See footnote 126.
132 See footnote 119.
133 found at: www.cmace.org.uk/
134 See footnote 122.

family and the circumstances of the death. They should inform the designated person of any professionals known to be involved with the child or family. Form A – The notification of the death of a child – is available at: www.dcsf.gov.uk/everychildmatters/safeguardingandsocialcare/safeguardingchildren/childdeathreviewprocedures/nationaltemplatesforlscbs/lscbtemplates/.

7.38 Following notification of the death of a child, the designated person should seek to establish which agencies and professionals have been involved with the child or family either prior to or at the time of death. A lead professional should be nominated in each agency to assist with this. Form B – Agency report form (and any relevant supplementary Form B's), is available at: www.dcsf.gov.uk/everychildmatters/safeguardingandsocialcare/safeguardingchildren/childdeathreviewprocedures/nationaltemplatesforlscbs/lscbtemplates/. Form B should be sent out to the lead professional in each agency and to any professionals known to be involved. If the death was either an early or a late neonatal death, the standard CMACE Perinatal Mortality Surveillance form should continue to be completed as normal and a copy should be sent to both the regional CMACE office and the relevant LSCB Child Death Overview designated person. This CMACE form is in addition to Form B2 having to be completed by the relevant professionals.

7.39 Professionals receiving an agency report form (Form B) should retrieve any relevant case records for the child or other family members to complete any information known to them or their organisation and return the form to the designated person within the requested time frame using a secure means of transfer. Normally this should be within three weeks of notification, although there will be circumstances where, because of ongoing medical or police investigations information may not be available for a longer period. It may be appropriate for the lead professional in each agency to collate information from all involved professionals within their agency.

7.40 Once all agency report forms are received by the designated person, the information should be collated onto a single Form B, anonymised and entered into a suitable database. The national agreed data set should be kept securely and separately from any identifiable data. The CDOP is likely to receive information that is personal data, including sensitive personal data, within the meaning of the Data Protection Act 1998 (DPA) for the purposes of child death reviews. CDOPs should be mindful of their obligations under the DPA when processing that information.

7.41 Prior to each panel meeting, anonymised, collated Form B's should be sent to all panel members in sufficient time to allow them to read all the material in preparation for the meeting. Panel members may wish for supplementary material (for example, individual case records, autopsy reports, scene photographs) to be made available at the panel meeting, but consideration should be given to its

appropriateness for the meeting and issues of confidentiality. This information should be sent to the designated person before the meeting.

7.42 The CDOP should review each case brought before it to consider any factors contributing to the death, its classification of the death, and any lessons to be learnt from this death or from patterns of similar deaths in the area. Form C – the case review form (available at: www.dcsf.gov.uk/everychildmatters/safeguardingandsocialcare/safeguardingchildren/childdeathreviewprocedures/nationaltemplatesforlscbs/lscbtemplates/) may be used to facilitate this discussion and provides a template for local and national data collection. These forms should remain anonymous with a unique identifier but no identifiable information. For each death, the panel should classify the cause of death, make a decision as to the preventability of the death, identify any modifiable factors, and consider any recommendations that may be made about actions which could be taken to prevent such deaths in the future and to whom these recommendations should be addressed.

7.43 If the CDOP is unable to classify the death, or adequately review it from the information available, a decision should be made as to whether and what further information could be obtained to assist the panel. Where appropriate, the case should be rescheduled for discussion at a subsequent meeting. Where it is recognised that no further learning is likely, even with further information, the final review of the case should not be delayed.

7.44 Panels should consider whether groups of similar deaths (for example, all road traffic deaths, sudden unexpected death in infancy (SUDI), or deaths of children with life limiting conditions) should be discussed at designated panel meetings. In addition to standing panel members, specialists in relation to the type of death being discussed could be invited.

7.45 When reviewing neonatal deaths, these deaths should be discussed by the CDOP with appropriate representation of the professionals involved in this specialist area for example, midwifery, obstetrics, neonatal care. The process should focus on learning lessons from the deaths, and should use the minimum national data set when collecting information.

7.46 Any recommendations made by the CDOP should be directed at interventions that could help to prevent future child deaths, or improve the safety and welfare of children in the local area or further afield. The panel will not normally make direct recommendations in respect to individual case management. Recommendations should be few in number and should be carefully thought through to be Specific, Measurable, Achievable, Relevant and Timely.

7.47 Recommendations should be submitted to the LSCB or any other relevant body identified by the CDOP. The LSCB should make arrangements for following up on the recommendations to ensure that appropriate actions are taken.

Roles and responsibilities when responding rapidly to an unexpected death of a child

7.48 The paragraphs below set out the roles of the various professionals for enquiring into and evaluating all unexpected child deaths (see paragraph 7.21 for a definition of unexpected child death). Information from this process should be considered by members of the CDOP which has responsibility for reviewing the deaths of all children normally resident in their area.

7.49 When a child dies unexpectedly, several investigative processes may be instigated, particularly when abuse or neglect is a factor. This guidance intends that the relevant professionals and organisations work together in a co-ordinated way, in order to minimize duplication and ensure that the lessons learnt contribute to safeguarding and promoting the welfare of children in the future.

7.50 It is intended that those professionals involved (before and/or after the death) with a child who dies unexpectedly should come together to respond to the child's death. This means that some roles may require an on-call rota for responding to unexpected child deaths in their area. The work of the team convened in response to each child's death should be co-ordinated, usually, by a local designated paediatrician responsible for unexpected deaths in childhood. LSCBs may choose to designate particular professionals to be standing members of a team because of their roles and particular expertise. The professionals who come together as a team will carry out their normal functions – for example, as a paediatrician, GP, nurse, health visitor, midwife, mental health professional, substance misuse worker, social worker, Youth Offending Team worker, probation or police officer in response to the unexpected death of a child in accordance with this guidance. They should also work according to a protocol agreed with the local coronial service. Other professionals known to the family from specialist agencies should be accessed on a case by case basis to support the core team; i.e. hospice support workers, children's community nurses. The joint responsibilities of these professionals include:

- responding quickly to the unexpected death of a child;
- making immediate enquiries into and evaluating the reasons for and circumstances of the death, in agreement with the coroner;
- undertaking the types of enquiries/investigations that relate to the current responsibilities of their respective organisations when a child dies unexpectedly.

This includes liaising with those who have ongoing responsibilities for other family members;

- collecting information in a standard, nationally agreed manner (see paragraph 7.2 and footnote 119);
- providing support to the bereaved family, and where appropriate referring on to specialist bereavement services; and
- following the death through and maintaining contact at regular intervals with family members and other professionals who have ongoing responsibilities for other family members, to ensure they are informed and kept up-to-date with information about the child's death.

Other related processes

7.51 Where there is an ongoing criminal investigation, the Senior Investigating Officer and the Crown Prosecution Service must be consulted as to what it is appropriate for the professionals involved in reviewing a child's death to be doing, and what actions to take in order not to prejudice any criminal proceedings. Where a death of a young person occurs in custody, local agencies must co-operate with the Prisons and Probation Ombudsman.

7.52 Where a child dies unexpectedly, all registered providers of healthcare services are obliged to notify the Care Quality Commission, but may discharge this duty by notifying the National Patient Safety Agency (NHS providers) or the Care Quality Commission, as set out in Regulation 16 of the Care Quality Commission (Registration) Regulations 2009[135]. The results of these investigations should be made available to the CDOP in order to allow the information to be included in the Panel's discussions.

7.53 The Youth Justice Board for England and Wales (YJB) requires Youth Offending Teams (YOTs) to report and undertake local reviews of youth offending practice in cases where a child or young person has either died or attempted suicide whilst under supervision or within three months of the expiry of supervision. Where a child has died, the Local Management Review undertaken by the YOT in relation to the death should feed into the child death processes initiated by the CDOP.

7.54 If it is thought, at any time, that the criteria for a SCR might apply (see paragraphs 8.9–8.12), the Chair of the LSCB should be contacted and the SCR procedures set out in Chapter 8 should be followed. If a SCR is initiated, the CDOP will not be able to

135 See 'Outcome 18 – Notification of death' in Guidance about Compliance Essential Standards of Quality and Safety, CQC, 2009). NHS organisations should also follow locally agreed procedures for reporting and handling serious untoward and/or patient safety incidents.

conclude the child death reviewing process until after the SCR Executive Summary has been published. Similarly, the child death reviewing process will not be able to be completed if the CDOP is awaiting the outcomes of criminal proceedings and/or an inquest. This should **not**, however, prevent lessons from being learned and from being acted upon in a timely manner.

7.55 If, during the enquiries, concerns are expressed in relation to the needs of surviving children in the family, discussions should take place with local authority children's social care. It may be decided that it is appropriate to initiate an initial assessment using the *Framework for the Assessment of Children in Need and their Families (2000)*[136]. If concerns are raised at any stage about the possibility of surviving children in the household being abused or neglected, the inter-agency procedures set out in Chapter 5 in this guidance should be followed. Local authority children's social care has lead responsibility for safeguarding and promoting the welfare of children. The police will be the lead agency for any criminal investigation. The police must be informed immediately that there is a suspicion of a crime, to ensure that the evidence is properly secured and that any further interviews with family members and other relevant people accord with the requirements of the Police and Criminal Evidence Act 1984.

7.56 When a child dies unexpectedly and no doctor is able to issue a medical certificate of the cause of death, the child's death must be reported to the coroner. Agencies and professionals contributing to the processes described in this chapter should co-operate with their local coroner to ensure the inquest is able to proceed appropriately. The process of the rapid response can greatly assist the coroner in gathering information to inform the inquest, whilst providing ongoing support to the family. Any information pertaining to the death arising from the rapid response, including the outcome of a final local case discussion should be passed to the coroner. The CDOP members may attend an inquest at the discretion of HM Coroner and ask questions as a 'properly interested person'; there may be issues identified through the inquest that the CDOP would then be able to review to identify any wider public health concerns.

136 www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_4003256

Processes for a rapid response from professionals to all unexpected deaths of children (0–18 years)[137]

Care of parents/family members when a child dies unexpectedly

7.57 Where a child has died in, or been taken to, a hospital their parents/carers should be allocated a member of the hospital staff to remain with and support them throughout the process. The parents should normally be given the opportunity to hold and spend time with their baby or child. During this time the allocated member of staff should maintain a discreet presence.

7.58 Children dying at home or in a hospice or other setting who have been undergoing end of life care will not usually be considered to have died unexpectedly, and a rapid response to such deaths is rarely indicated.

7.59 When a child with a known life limiting and or life threatening condition dies in a manner or at a time that was not anticipated, the rapid response team should liaise closely and promptly with a member of the medical, palliative or end of life care team who knows the child and family, to jointly determine how best to respond to that child's death. This should include consideration of whether the child's body should be transferred to a hospital or hospice, and whether any investigations or inquiries are required. Where an end of life plan has been agreed by the end of life care team and is in place, this should be followed unless there are pressing reasons not to do so. For example, the coroner decides where the child's body may be taken and this decision may be different to what was set out in the family's prepared plan. The presence of a community children's nurse on call as part of the rapid response team could facilitate the process of communication and fact-finding.

7.60 Within the local rapid response procedures there should be provision for an identified professional to provide support to the family where their child has died and has not been taken to a hospital.

7.61 Where a child is living in England but their parents live abroad, careful consideration should be given to how best to contact and support the bereaved family members.

7.62 Parents/carers should be kept up-to-date with information about their child's death and the involvement of each professional, unless such sharing of information would jeopardise police investigations or other criminal justice processes.

137 Resources to assist in the conduct of a rapid response to an unexpected child death are available at: www.dcsf.gov.uk/everychildmatters/safeguardingandsocialcare/safeguardingchildren/childdeathreviewprocedures/advancedtrainingrapidresponse/rapidresponsetraining/

Responding to the unexpected death of a child

7.63 The type of response to each child's unexpected death will depend to a certain extent on the age of the child, but there are some key elements that underpin all subsequent work. Supplementary information is required for making enquiries into, for example deaths of infants, those deaths in hospital that are the result of trauma, and suicides.

7.64 Once the death of a child has been referred to the coroner and s/he has accepted it, the coroner has jurisdiction over the body and all that pertains to it. Coroners must therefore be consulted over the local implementation of national guidance and protocols, and should be asked to give general approval for the measures agreed to reduce the need to obtain specific approval on each occasion.

7.65 A multi-professional approach is required to ensure collaboration among all involved, which may include ambulance staff, A&E department staff, coroners' officers, police, GPs, health visitors, school nurses, community children's nurses, midwives, paediatricians, palliative or end of life care staff, mental health professionals, substance misuse workers, hospital bereavement staff, voluntary agencies, coroners, pathologists, forensic medical examiners, local authority children's social care, YOTs, probation, schools, prison staff where a child has died in custody and any others who may find themselves with a contribution to make in individual cases (for example, fire fighters or faith leaders).

Immediate response to the unexpected death of a child

7.66 Children who die suddenly and unexpectedly at home or in the community should normally be taken to an A&E department rather than a mortuary, and resuscitation should always be initiated unless clearly inappropriate. Resuscitation, once commenced, should be continued according to the *UK Resuscitation Guidelines* (2005)[138] until an experienced doctor (usually the consultant paediatrician on call) has made a decision that it is appropriate to stop further efforts. There may be some situations where it is inappropriate for a child to be transferred to a hospital (for example, if the circumstances of the death require the body to remain at the scene for forensic examination).

7.67 As noted above, children who die at home or in a hospice or other setting in which they have been in receipt of planned end of life care will not normally be considered to have died unexpectedly, and therefore should not usually be moved to a hospital A&E department. Parents whose children die at home in such circumstances may wish their child to remain at home, or be taken to a hospice cool room. This death

138 Found at: www.resus.org.uk/pages/guide.htm

will be subject to local coronial guidelines if the doctor is unable to issue a Medical Certificate of the Cause of Death.

7.68 As soon as practicable (i.e. as a response to an emergency) after arrival at a hospital, the baby or child should be examined by the consultant paediatrician on call (in some cases this might be together with a consultant in emergency medicine or, for some young people over 16 years of age, the consultant in emergency medicine may be more appropriate than a paediatrician). A detailed and careful history of events leading up to and following the discovery of the child's collapse should be taken from the parents/carers. This should begin the process of collecting a nationally agreed data set[139]. The purpose of obtaining high-quality information at this stage is to understand the cause of the death when appropriate and to identify anything suspicious about it. The paediatrician should carefully document the history and examination findings in the hospital notes. This should include a full account of any resuscitation and any interventions or investigations carried out. The use of a structured proforma may assist with documenting the history, but this should always include a narrative account by the carer of the events leading to the death. The examination findings, including any post mortem changes should be documented on a body chart. Templates for recording the history and examination are available on the *Every Child Matters* website at: www.dcsf.gov.uk/everychildmatters/safeguardingandsocialcare/safeguardingchildren/childdeathreviewprocedures/trainingmaterials/trainingmaterials/.

7.69 Where the cause of death or factors contributing to it is uncertain, investigative samples should be taken immediately on arrival and after the death is confirmed. In order to be compliant with the Human Tissue Act 2004 (HTA Act), the removal of these investigative samples must take place on Human Tissue Authority licensed premises with the authorisation of the coroner (or, where the coroner is not involved, the consent of a parent)[140]. These samples need to be agreed in advance with the coroner (see paragraph 7.64) and should include the standard set for SUDI (Royal College of Pathologists and Royal College of Paediatrics and Child Health, 2004) and standard sets for other types of death presentation as they are developed. The removal of tissue without such coronial authorisation or consent under the Human Tissue Act 2004 would be unlawful. Consideration should always be given to undertaking a full skeletal survey and, when appropriate, it should be made before the autopsy starts as this may significantly alter the required investigations.

7.70 When the baby or child is pronounced dead, the consultant clinician should inform the parents, having first reviewed all the available information. S/he should explain future police and coroner involvement, including the coroner's authority to order a post mortem examination. This may involve taking particular tissue blocks and

139 See footnote 119.

140 Further information can be found at: www.hta.gov.uk/

slides to ascertain the cause of death (see paragraph 7.69). Consent from those with parental responsibility for the child is required for tissue to be retained beyond the period required by the coroner (for example, for use in research or for possible future review).

7.71 The consultant clinician who has seen the child should inform the designated paediatrician with responsibility for unexpected deaths in childhood immediately after the coroner is informed.

7.72 The same processes apply to a child who is admitted to a hospital ward and subsequently dies unexpectedly in hospital.

7.73 In most circumstances following the unexpected death of a child, it will be appropriate to allow the parents to spend time with and hold their child. This should be facilitated by the hospital staff and rapid response team, with a quiet, designated area provided for the family to be with their child. In most circumstances it will be appropriate for a nurse or other professional to maintain a discreet presence at all times. In most situations the parents will have already handled their child after the death, and allowing them to hold their child will not in any way interfere with the investigation into the cause of death.

7.74 Support should be offered to the family, including where available, a bereavement counsellor, hospital chaplain or other faith leader. The hospital team should offer to contact any relatives or friends to support the parents at this time. The parents should be allowed to spend as much time as they wish with the child and any examination of the child or further investigations should where possible be carried out in a manner that causes least disruption to the family. Unless there are clear reasons not to (this matter should be discussed with the senior investigating police officer first), mementos such as a photograph, lock of hair, or hand and footprints should be offered to the family.

7.75 Before the parents leave the hospital, or in the case of a child who is not transferred to hospital, before the professionals leave the home, the parents should be provided with contact details for the lead professionals (consultant paediatrician, senior investigating police officer or coroners officer), and the details of who they should contact for information on the progress of any investigation or if they wish to visit the hospital to see their child. Following this immediate response, parents should be kept informed of the whereabouts of their child and any planned moves.

Immediate response when a child is not transferred to a hospital

7.76 Where a child is not taken immediately to A&E, the professional confirming the fact of death should inform the designated paediatrician with responsibility for unexpected deaths in childhood at the same time as the coroner is informed.

7.77 The police will be involved and may decide that it is not appropriate to move the child's body. This may typically occur if there are clear signs that lead to suspicion. In most cases, however, it is expected that the child's body will already have been held or moved by the carer and, therefore, removal to A&E will not normally jeopardize an investigation.

7.78 The professional confirming the fact of death should consult the designated paediatrician with responsibility for unexpected deaths in childhood, who will ensure that relevant professionals (i.e. the coroner, the police and local authority children's social care) are informed of the death. This task may be undertaken by a person on behalf of the designated paediatrician. Contact may be required with more than one local authority if the child died away from home (see paragraphs 7.33–7.34 for more information about what should happen when a child who is normally resident within a LSCB area dies outside the area, including abroad). Any relevant information identified by local authority children's social care should be shared promptly with the police and on-call paediatrician. The health visitor or school nurse and GP should also be promptly informed as a matter of routine and relevant information should be shared.

7.79 When a child dies unexpectedly, a paediatrician (on-call or designated) should initiate an immediate information sharing and planning discussion between the lead agencies (i.e. health, police and local authority children's social care) to decide what should happen next and who will do what. This may also include the coroner's officer and consultant paediatrician on call, and any others who are involved (for example, the community children's nurse on call, other members of the primary health care team or other professionals who have been involved with the child and/or family prior to, or around the time of death). The agreed plan should include a commitment to collaborate closely and communicate as often as necessary, often by telephone. Where the death occurred in a hospital, the plan should also address the actions required by the Trust's serious incidents protocol. Where the death occurred in a custodial setting, the plan should ensure appropriate liaison with the investigator from the Prisons and Probation Ombudsman.

7.80 For all unexpected deaths of children (including those not seen in A&E) urgent contact should be made with any other agencies who know or are involved with the child (including CAMHS, school or early years provider) to inform them of the child's death and to obtain information on the history of the child, the family and other

members of the household. If a young person is under the supervision of a YOT, the YOT should also be approached.

7.81 The police will begin an investigation into the sudden or unexpected death of a child on behalf of the coroner. They will carry this out in accordance with relevant Association of Chief Police Officers guidelines.

7.82 When a baby or older child dies unexpectedly in a non-hospital setting, the senior investigating police officer and senior healthcare professional should make a decision about whether a visit to the place where the child died should be undertaken. This should almost always take place for infants who die unexpectedly (see paragraph 5.1 in the *Kennedy Report*)[141]. As well as deciding if the visit should take place, it should be decided how soon (within 24 hours) and who should attend. It is likely to be a senior investigating police officer and a healthcare professional (experienced in responding to unexpected child deaths (this will most commonly be a paediatrician or specialist nurse) who will visit, talk with the parents and evaluate the environment where the child died. They may make this visit together, or they may visit separately and then confer (details should be included in the local child death review protocol). After this visit the senior investigating police officer, visiting health care professional, GP, health visitor or school nurse and children's social care representative should review whether there is any additional information that could raise concerns about the possibility of abuse or neglect having contributed to the child's death. If there are concerns about surviving children in the household, the procedures set out in Chapter 5 should be followed. If there are grounds for considering initiating a SCR, the process set out in Chapter 8 should be followed.

Involvement of coroner and pathologist

7.83 If s/he deems it necessary (and in almost all cases of an unexpected child death it will be), the coroner will order a post mortem examination to be carried out as soon as possible by the most appropriate pathologist available (this may be a paediatric pathologist, forensic pathologist or both) who will perform the examination according to the guidelines and protocols laid down by The Royal College of Pathologists. The designated paediatrician should collate information collected by those involved in responding to the child's death and share it with the pathologist conducting the post mortem examination in order to inform this process. Where the death may be unnatural, or the cause of death has not yet been determined, the coroner will in due course hold an inquest.

---

141 *Sudden Unexpected Death in Infancy: a multi-agency protocol for care and investigation. The report of a working party convened by the Royal Colleges of Pathologists and the Royal College of Paediatrics and Child Health (2004).* London: RCPath.

7.84 All information collected relating to the circumstances of the death – including a review of all relevant medical, social and educational records – must be included in a report for the coroner prepared jointly by the lead professionals in each agency. This report should be delivered to the coroner within 28 days of the death, unless some of the crucial information is not yet available.

Case discussion following the preliminary results of the post mortem examination becoming available

7.85 The results of the post mortem examination belong to the coroner. In most cases it is possible for these to be discussed by the paediatrician and pathologist, together with the senior investigating police officer, as soon as possible, and the coroner should be informed immediately of the initial results. At this stage, the LSCB child death core data set[142] should be updated and, if necessary, previous information corrected to enable this change to be audited. If the initial post mortem findings or findings from the child's history suggest evidence of abuse or neglect as a possible cause of death, the police and local authority children's social care should be informed immediately, and the SCR processes in Chapter 8 of this guidance should be followed. If there are concerns about surviving children living in the household, the procedures set out in Chapter 5 should be followed with respect to these children.

7.86 In all cases, the designated paediatrician for unexpected child deaths or the paediatrician acting as his/her deputy should convene a further multi-agency discussion (usually on the telephone) very shortly after the initial post mortem results are available. This discussion usually takes place five to seven days after the death and should involve the pathologist, police, local authority children's social care and the paediatrician, plus any other relevant healthcare professionals, to review any further information that has come to light and that may raise additional concerns about safeguarding issues.

Case discussion following the final results of the post mortem examination becoming available

7.87 A case discussion meeting should be held as soon as the final post mortem result is available. The timing of this discussion varies according to the circumstances of the death. This may range from immediately after the initial post mortem examination to three-four months after the death. The type of professionals involved in this meeting depends on the age of the child. The meeting should include those who knew the child and family and those involved in investigating the death, for

142 See footnote 119.

example, the GP, health visitor or school nurse, paediatrician(s), pathologist, senior investigating police officers and where appropriate, social workers.

7.88 The designated paediatrician with responsibility for unexpected deaths in childhood (or agreed deputy) should convene and chair this meeting. At this stage, the collection of the LSCB child death core data set[143] should be completed and if necessary, previous information corrected to enable this change to the information to be audited.

7.89 The main purpose of the case discussion is to share information to identify the cause of death and/or those factors that may have contributed to the death, and then to plan future care for the family. Potential lessons to be learnt may also be identified by this process. Another purpose is to inform the inquest.

7.90 There should be an explicit discussion of the possibility of abuse or neglect either causing or contributing to the death. If no evidence is identified to suggest maltreatment, this should be documented as part of the minutes of the meeting.

7.91 At the case discussion, it should be agreed how detailed information about the cause of the child's death will be shared, and by whom, with the parents, and who will offer the parents ongoing support.

7.92 The results of the post mortem examination, with the consent of HM Coroner, should be discussed with the parents at the earliest opportunity, except in those cases where abuse or neglect is suspected and/or the police are conducting a criminal investigation. In these situations, the paediatrician should discuss with local authority children's social care, the police and the pathologist what information should be shared with the parents and when. This discussion with the parents is usually part of the role of the lead paediatrician involved in the investigation of the child's death and she or he will, therefore, have responsibility for initiating and leading the meeting. A member of the primary healthcare team should attend this meeting whenever possible.

7.93 An agreed record of the case discussion meeting and all reports should be sent to the coroner, to take into consideration in the conduct of the inquest and, in the cause of death, notified to the Registrar of Births and Deaths. The record of the case discussions and the record of the core data set should also be made available to the relevant local CDOP. When a child dies away from their normal place of residence, a joint decision will need to be made by the rapid response team in the LSCB area in which the death occurred and the team in the child's normal area of residence as to which team will lead the investigation and in which LSCB area the case review meeting should be held. On occasion separate meetings may be appropriate in

143 See footnote 119.

both LSCB areas, but good communication between the teams is essential (see paragraphs 7.33–7.34). This information can then be analysed and decisions can be made about what actions should be taken by whom to prevent similar deaths in the future.

Professionals meeting to discuss expected child deaths

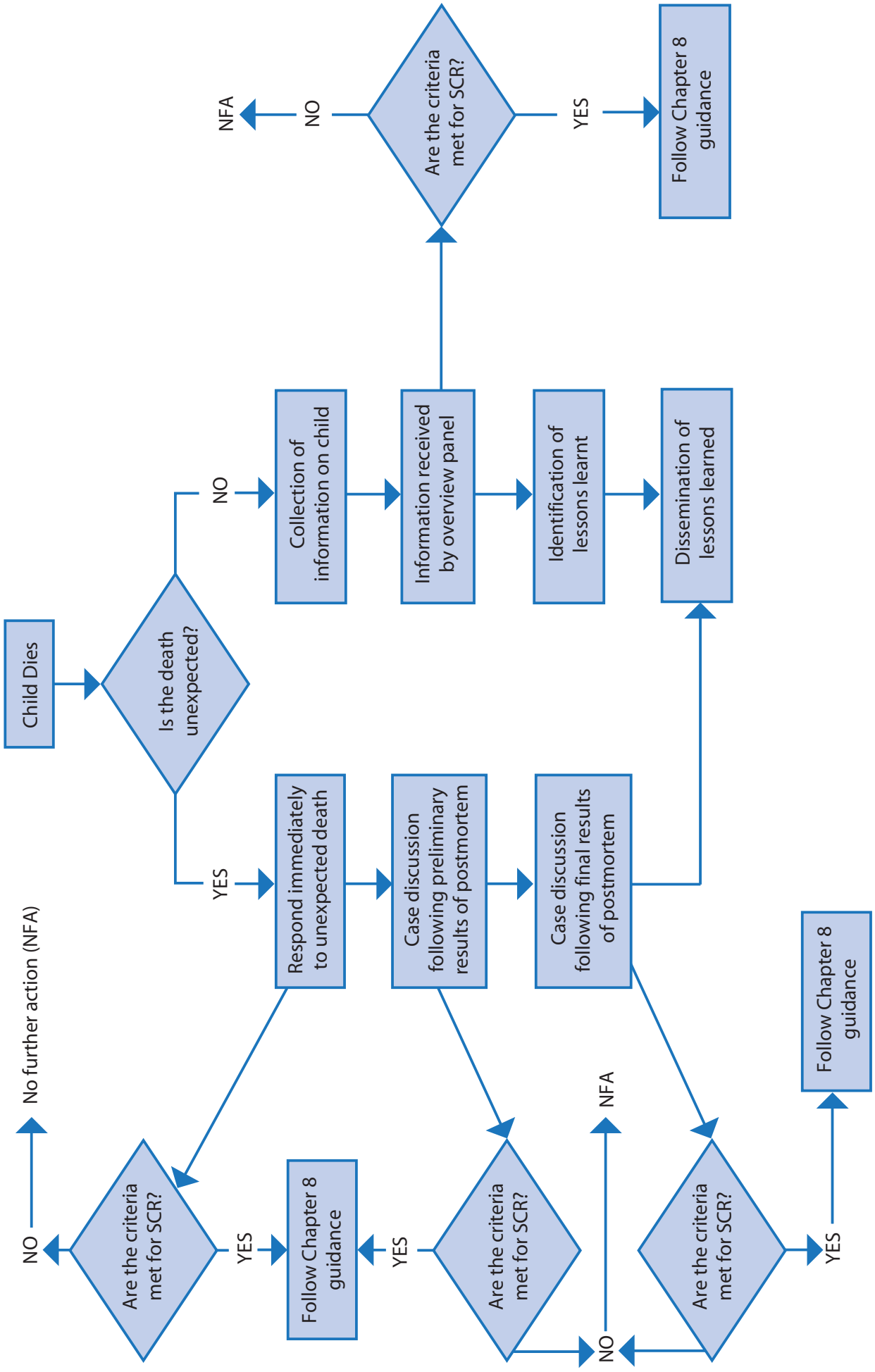
7.94 When a child's death is not regarded as 'unexpected', the team looking after the child may choose to organise a discussion of the case, since it is likely that important lessons can be learnt that might improve the care of other children. Such a discussion may be conducted using the same format as a professionals' meeting, the output of which could be captured on the Analysis Proforma (Form C). Information from these discussions would provide the CDOP with evidence of good local practice and allow a wider engagement of professionals with the child death review process.

Use of child death information to prevent future deaths

7.95 Each Child Death Overview Panel should prepare an annual report of relevant information for the LSCB. This information should in turn inform the LSCB annual report (see paragraph 3.35). This information should include the total numbers of deaths reviewed, recommendations made by the panel about required future actions to prevent child deaths, and any further description of the deaths that the panel deems appropriate. It should also include a review of actions taken to implement the recommendations from the previous year's report, and set out any such recommendations which have not yet been fully implemented which are to be carried forward. Appropriate care should be taken to ensure confidentiality of personal information and sensitivity to the bereaved families. Information which could lead to the identification of individual children or family members should not be included in the annual report. The LSCB annual report should serve as a powerful resource for driving public health measures to prevent child deaths and promote child health, safety and wellbeing.

7.96 The LSCB has responsibility for disseminating the lessons to be learned from the child death and other reviewing processes to all relevant organisations, ensures that relevant findings inform the Children and Young People's Plan and acts on any recommendations to improve policy, professional practice and inter-agency working to safeguard and promote the welfare of children. The LSCB is also required to supply anonymised data on child deaths to the Department for Children, Schools and Families, so that the Department can commission research and publish nationally comparable analyses of these deaths. The primary aims of this research are to support a reduction in the incidence of children whose deaths can be prevented, to improve inter-agency working and to safeguard and promote the welfare of children.

Flow chart 6: Interface between the child death and serious case review processes



Chapter 8 – Serious case reviews

Reviewing and investigative functions of Local Safeguarding Children Boards

8.1 The prime purpose of a Serious Case Review (SCR) is for agencies and individuals to learn lessons to improve the way in which they work both individually and collectively to safeguard and promote the welfare of children. The lessons learned should be disseminated effectively, and the recommendations should be implemented in a timely manner so that the changes required result, wherever possible, in children being protected from suffering or being likely to suffer harm in the future. It is essential, to maximise the quality of learning, that the child's daily life experiences and an understanding of his or her welfare, wishes and feelings are at the centre of the SCR, irrespective of whether the child died or was seriously harmed. This perspective should inform the scope and terms of reference of the SCR as well as the ways in which the information is presented and addressed at all stages of the process, including the conclusions and recommendations. Reviews vary in their breadth and complexity but, in all cases, **where possible lessons should be acted upon quickly without necessarily waiting for the SCR to be completed**.

8.2 Any professional or agency may refer a case to the Local Safeguarding Children Board (LSCB) if they believe that there are important lessons for intra- and/or inter-agency working to be learned from the case.

8.3 Regulation 5 of the Local Safeguarding Children Boards Regulations 2006[144] requires LSCBs to undertake reviews of serious cases. They should be undertaken in accordance with the processes set out in this chapter. The same criteria apply to all children, including those with a disability[145].

8.4 Regulation 5 sets out that:

(1) The functions of a LSCB in relation to its objective (as defined in section 14(1) of the Act) are as follows –

(e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

(2) For the purposes of paragraph (1) (e) a Serious Case Review is one where –

(a) abuse or neglect of a child is known or suspected; and

(b) either –

(i) the child has died; or

144 The Local Safeguarding Children Boards Regulations 2006, Statutory Instrument no. 2006/90.

145 *Safeguarding Disabled Children: Practice guidance* (2009). London: Department for Children, Schools and Families.

(ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

The purposes of Serious Case Reviews

8.5 The purposes of SCRs carried out under this guidance are to:

- establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children;
- identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result; and
- improve intra- and inter-agency working and better safeguard and promote the welfare of children.

8.6 SCRs are not inquiries into how a child died or was seriously harmed, or into who is culpable. These are matters for coroners and criminal courts, respectively, to determine as appropriate.

8.7 Nor are SCRs part of any disciplinary inquiry or process relating to individual practitioners. Where information emerges in the course of a SCR indicating that disciplinary action would be appropriate, such action should be undertaken separately from the SCR process and in line with the relevant organisation's disciplinary procedures. SCRs may be conducted at the same time, but should be separate from disciplinary action. In some cases (for example, alleged institutional abuse) it may be necessary to initiate disciplinary action as a matter of urgency to safeguard and promote the welfare of other children.

Safeguarding siblings or other children

8.8 When a child dies or is seriously harmed, and abuse or neglect is known or suspected to be a factor, the first priority of local organisations should be to consider immediately whether there are other children who are suffering, or likely to suffer, significant harm and who require safeguarding (for example, siblings or other children in an institution where abuse is alleged). Where there are concerns about the welfare of siblings or other children the guidance in Chapter 5 should be followed. Thereafter, organisations should consider whether there are any lessons to be learned about the ways in which they work individually and together to safeguard and promote the welfare of children.

When should a LSCB undertake a Serious Case Review?

8.9 When a child dies (including death by suspected suicide) **and** abuse or neglect is known or suspected to be a factor in the death, the LSCB should **always** conduct a SCR into the involvement of organisations and professionals in the lives of the child and family. This is irrespective of whether local authority children's social care is, or has been, involved with the child or family. These SCRs should include situations where a child has been killed by a parent, carer or close relative with a mental illness, known to misuse substances or to perpetrate domestic abuse. In addition, a SCR should always be carried out when a child dies in custody, either in police custody, on remand or following sentencing, in a Young Offender Institution (YOI), a Secure Training Centre (STC) or secure children's home, or where the child was detained under the Mental Health Act 2005.

8.10 The death of every child is reviewed in accordance with the child death review processes outlined in Chapter 7 of this guidance. A SCR may be triggered at any point in the child death reviewing process if a rapid response team or Child Death Overview Panel (CDOP) considers a case may meet the criteria for a SCR (see paragraph 7.1). In the case of a looked after child, the LSCB for the area of the local authority looking after the child should exercise lead responsibility for conducting the child death review, involving other LSCBs with an interest or whose local agencies have had involvement as appropriate (see paragraph 7.34). This CDOP may refer a case to its LSCB Chair if it considers the criteria for a SCR may be met and a SCR has not been initiated. Chapter 7, flow chart 6, shows the interface between the child death review and SCR processes.

When should a LSCB consider undertaking a Serious Case Review?

8.11 LSCBs should consider whether to conduct a SCR whenever a child has been seriously harmed in the following situations:

- a child sustains a potentially life-threatening injury or serious and permanent impairment of physical and/or mental health and development through abuse or neglect; or
- a child has been seriously harmed as a result of being subjected to sexual abuse; or
- a parent has been murdered and a domestic homicide review is being initiated under the Domestic Violence Act 2004[146]; or

146 The Home Office is working closely with other government departments to develop a process for undertaking domestic homicide reviews and will ensure that any relevant issues regarding SCRs, or any other statutory reviews, are fully considered and incorporated into that process.

- a child has been seriously harmed following a violent assault perpetrated by another child or an adult;

and the case gives rise to concerns about the way in which local professionals and services worked together to safeguard and promote the welfare of children. This includes inter-agency and/or inter-disciplinary working.

8.12 The following questions may also help in deciding whether a case should be the subject of a SCR. The answer 'yes' to one or more of these questions is likely to indicate that a SCR could yield useful lessons:

- Was there clear evidence of a child having suffered, or been likely to suffer, significant harm that was:
  - not recognised by organisations or professionals in contact with the child or perpetrator; **or**
  - not shared with others; **or**
  - not acted on appropriately?
- Was the child abused or neglected in an institutional setting (for example, school, nursery, children's or family centre, YOI, STC, immigration removal centre, mother and baby unit in a prison, children's home or Armed Services training establishment)?
- Was the child abused or neglected while being looked after by the local authority?
- Was the child a member of a family that has recently moved to the UK, for example as asylum seekers or temporary workers?
- Did the child suffer harm during an unauthorised absence from an institution, or having run away from home or other care setting?
- Does one or more agency or professional consider that its concerns about a child's welfare were not taken sufficiently seriously, or acted on appropriately, by another?
- Does the case indicate that there may be failings in one or more aspects of the local operation of formal safeguarding children procedures which go beyond the handling of this case?
- Was the child the subject of a child protection plan at the time of the incident, or had they previously been the subject of a plan or on the child protection register?

- Does the case appear to have implications for a range of agencies and/or professionals?
- Does the case suggest that the LSCB may need to change its local protocols or procedures, or that protocols and procedures are not being adequately promulgated, understood or acted on?
- Are there any indications that the circumstances of the case may have national implications for systems or processes, or that it is in the public interest to undertake a SCR?

Which LSCB should take lead responsibility?

8.13 Where partner agencies of more than one LSCB have known about or have had contact with the child, the LSCB for the area in which the child is or was normally resident should take lead responsibility for conducting the SCR. Any other LSCBs that have an interest or involvement in the case should co-operate as partners in jointly planning and undertaking the SCR. In the case of a looked after child, the local authority looking after the child should exercise lead responsibility for conducting the SCR, again involving other LSCBs with an interest or involvement.

Membership of SCR sub-committees and SCR Panels

8.14 Many LSCBs have a standing SCR sub-committee to oversee and quality assure all SCRs undertaken by the LSCB, and to provide advice to the LSCB Chair on whether the criteria for conducting a SCR have been met. A SCR sub-committee should involve representatives from local authority children's social care, health (commissioning Primary Care Trust (PCT) and other partners as relevant), education and the police at a minimum. Members of agencies which have responsibilities for completing Individual Management Reviews (IMRs) may be members of the SCR sub-committee but it should not consist solely of such people.

8.15 Following a decision by the LSCB Chair to undertake a SCR, the SCR sub-committee should commission a SCR Panel to manage the process. Where a LSCB does not have a standing SCR sub-committee, a SCR Panel should be convened by the LSCB to advise the LSCB Chair on whether the criteria for undertaking a SCR have been met and, where appropriate, to ensure the SCR is undertaken in accordance with this guidance. In such circumstances the same membership requirements apply to a SCR Panel as set out in paragraph 8.14 for a SCR sub-committee.

8.16 The Chair of the SCR sub-committee should be an experienced person and could be the independent Chair of the LSCB, or a member of the LSCB. The Chair of any SCR Panel should not be a member of the LSCB(s) involved in the SCR, an employee of any of the agencies involved in the SCR or the overview report author. The SCR

Panel Chair can be the independent LSCB Chair, someone from another LSCB which is not involved in the SCR or from an agency which is not involved in the case.

Instigating a Serious Case Review

Does the case meet the Serious Case Review criteria?

8.17 The LSCB Chair should consider whether a case might meet the criteria for a SCR, applying the criteria at paragraphs 8.9–8.12. Where the child has died, the LSCB Chair should also use information available from the professionals involved in reviewing the child's death (see Chapter 7) to assist in making this decision. In some cases, it may be valuable to conduct a single IMR rather than a full SCR, for example where there are lessons to be learned about the way in which staff worked within one agency rather than about how agencies worked together, or a smaller scale audit of an individual case that gives rise to concern but does not meet the criteria for a SCR. Methodologies such as those developed by Social Care Institute for Excellence (SCIE)[147] or root cause analysis used in the health service may be useful here. In such cases, arrangements should be made to share relevant findings with the SCR sub-committee or SCR Panel.

8.18 Where the LSCB Chair considers, in a particular case, that the criteria for a SCR may be met, he or she should request that the SCR sub-committee considers whether a SCR should take place. If the SCR sub-committee recommends that a SCR be undertaken, they should also recommend the scope and terms of reference for the review. These recommendations should be forwarded to the Chair of the LSCB, who has ultimate responsibility for deciding whether to conduct a SCR. The LSCB Chair should notify Ofsted of the outcome of this decision as soon as it has been made. Ofsted will then pass this information to the relevant Government Office (GO) and the Department for Children, Schools and Families (DCSF). PCT commissioners should ensure their Strategic Health Authority (SHA) and the Care Quality Commission (CQC) are notified. The police should also notify Her Majesty's Inspectorate of Constabulary (HMIC) and similarly the National Offender Management Service should notify Her Majesty's Inspectorate of Prisons (HMIP) and Her Majesty's Inspectorate of Probation (HMI Probation).

8.19 In all cases and at all stages in the SCR process from the first notification to Ofsted of a serious incident to the completion of the final SCR report, information relating to children, family members and professionals involved in the case (with the exception of the LSCB Chair, SCR Panel Chair and the overview report author) should be

147 Fish S., Munro E. and Bairstow S. (2008) *SCIE Report 19: Learning together to safeguard children: developing a multi-agency systems approach for case reviews*. London: Social Care Institute for Excellence.

anonymised by the LSCB before being submitted to any external organisation or body (including Ofsted, the relevant GO and DCSF).

Determining the scope and terms of reference of the review

8.20 The SCR sub-committee should consider, in the light of current information known in each case, the scope of the SCR and draw up clear terms of reference. The LSCB Chair should ensure that the terms of reference address the key issues in the case and approve them. The GO Children and Learners Team will be able to assist LSCBs where policy advice on undertaking a SCR is required. Where necessary LSCBs should seek their own legal advice. Relevant issues to consider include the following:

- What appear to be the most important issues to address in identifying the learning from this specific case? How can the relevant information best be obtained and analysed, including, for instance, information on the mental health of relevant adults?
- When should the SCR start, and by what date should it be completed, bearing in mind the timescales for completion set out below? Are there any relevant court cases or investigations pending which could influence progress or the timing of the publication of the executive summary?
- Over what time period should events in the child's life be reviewed, i.e. how far back should enquiries extend and what is the cut-off point? What family history/background information will help better to understand the recent past and the present?
- How should the child (where the review does not involve a death), surviving siblings, parents or other family members contribute to the SCR, and who should be responsible for facilitating their involvement? How will they be involved and contribute throughout the overall process?
- Are there any specific considerations around ethnicity, religion, diversity or equalities issues that may require special consideration?
- Did the family's immigration status have an impact on the child/children or on the parents' capacities to meet their needs?
- Which organisations and professionals should be asked to submit reports or otherwise contribute to the SCR including, where appropriate, for example the proprietor of an independent school or a playgroup leader?
- Who will make the link with relevant interests outside the main statutory organisations, for example independent professionals, independent schools, independent healthcare providers or voluntary organisations?

- Is there a need to involve organisations/professionals working in other LSCB areas (see paragraph 8.13), and what should be the respective roles and responsibilities of the different LSCBs with an interest?
- Will the LSCB need to obtain independent legal advice about any aspect of the proposed SCR?
- Who should be appointed as the independent author for the overview report (bearing in mind that this person should not be the Chair of the LSCB, the SCR sub-committee or the SCR Panel – see paragraph 8.33).
- Might it help the SCR Panel to bring in an outside expert at any stage, to help understand crucial aspects of the case?
- Will the case give rise to other parallel investigations of practice, for example, into the health or adult social care provided or multi-disciplinary suicide reviews, a domestic homicide review where a parent has been killed, a Prisons and Probation Ombudsman (PPO) Fatal Incidents Investigation[148] where the child has died in a custodial setting or a Serious Further Offence (SFO)[149] or MAPPA Serious Case Review (MSCR)[150] process where offenders are charged with serious further offences whilst subject to statutory supervision? And if so, how can a co-ordinated or jointly commissioned review process address all the relevant questions that need to be asked in the most effective way and with minimal delay? Arrangements should be agreed locally on how a NHS Serious Untoward Incident (SUI) investigation into the provision of healthcare should be co-ordinated with a SCR.
- How will the SCR terms of reference and processes fit in with those for other types of reviews – for example, for homicide, mental health or prisons?
- How should the review process take account of a coroner's inquiry, any criminal investigations (if relevant), family or other civil court proceedings related to the case? How will it be best to liaise with the coroner[151] and/or the Crown Prosecution Service (CPS) and to ensure that relevant information can be shared without incurring significant delay in the review process?
- How should the review process take account of relevant lessons learned from research (including the biennial overview reports of SCRs) and from SCRs which have been undertaken by the LSCB?
- How should any family, public and media interest be managed before, during and after the SCR? In particular, how should surviving children (where appropriate given their age and understanding) and family members be informed of the findings of the SCR?

148 See www.ppo.gov.uk/investigating-fatal-accidents.html
149 PC 22/2008 Revised Notification and Review Procedures for Serious Further Offences.
150 See www.probation.homeoffice.gov.uk/output/page30.asp
151 See www.justice.gov.uk/guidance/coroners-guidance.htm

8.21 Some of these issues may need to be revisited by the SCR Panel as the review progresses and new information emerges. This reconsideration of the issues may in turn mean that the terms of reference will need to be revised and agreed by the LSCB Chair.

Timescales for initiating and undertaking a Serious Case Review

8.22 Reviews vary widely in their breadth and complexity but, in all cases, where lessons are able to be identified they should be acted upon as quickly as possible without necessarily waiting for the SCR to be completed. Within one month of a case coming to the attention of the LSCB Chair, he or she should decide, following a recommendation from the SCR sub-committee, whether a review should take place. An initial decision may need to be revisited if further information comes to light, for example through a criminal investigation or a child death review in accordance with Chapter 7. Ofsted and other inspectorates should be notified accordingly as set out in paragraph 8.18.

8.23 Serious case reviews should be completed within six months from the date of the decision to proceed. Sometimes the complexity of a case does not become apparent until the SCR is in progress. If it emerges that a SCR cannot be completed within six months of the LSCB Chair's decision to initiate it (perhaps because of judicial proceedings), the LSCB should revise its timetable and immediately consult the relevant GO in their capacity to provide advice, support and challenge.

8.24 Where an extension beyond the six month timeframe is necessary, an update on progress and a revised project plan should be produced quickly for the relevant GO to consider. This update should include recommendations for action where these are not dependent on the SCR being concluded until after other proceedings have ended. It should also include actions taken to date and an explanation for the extension to the timescale, including the revised completion date. Where a decision to extend the period for completion is made, this information will be passed to Ofsted by the relevant GO. LSCBs should be proactive in keeping GO Children and Learners Teams fully appraised of timing expectations, of risks of delay and of interdependencies with other parallel or related processes.

8.25 In some cases, criminal proceedings may follow the death or serious injury of a child. The Chair of the SCR Panel should discuss with the relevant criminal justice agencies such as the police and the CPS, at an early stage, how the review process should take account of such proceedings. For example, how does this affect timing and the way in which the SCR is conducted (including any interviews of relevant personnel), what is its potential impact on criminal investigations, and who should contribute at what stage? Much useful work to understand and learn from the case can often proceed without risk of contamination of witnesses in criminal

proceedings. In some cases it may not be possible to finalise the IMRs and the overview report or to finalise and publish an executive summary until after coronial or criminal proceedings have been concluded, but this should not prevent early lessons learned from being acted upon.

8.26 SCRs should not be delayed as a matter of course because of outstanding family, civil or administrative court cases. The LSCB Chair should make these decisions on a case by case basis based on advice from the Chair of the SCR Panel and having consulted with the local authority where there are pending family cases. The LSCB Chair may also need to seek legal advice to assist in deciding how to proceed.

8.27 The final SCR report, including the executive summary, should take full account of salient, new information which becomes available during the course of these proceedings and the facts, conclusions and recommendations should be revised accordingly.

Who should be involved in the Serious Case Review?

8.28 The initial scoping of the SCR should identify those who should contribute, although it may emerge, as further information becomes available, that the involvement of others, such as those providing specialist adult services, would be useful. As noted above in paragraph 8.21, information of relevance to the review may become available at a later stage through, for example, criminal proceedings or investigations such as those undertaken by the PPO.

8.29 Each relevant service should undertake an IMR of its involvement with the child and family. This should begin as soon as a decision is taken to proceed with a SCR, and even sooner if a case gives rise to concerns within the individual organisation. Relevant independent professionals should contribute reports of their involvement. Where Cafcass contributes to a review, the prior agreement of the courts should be sought so that the duty of confidentiality which the children's guardian has under the court rules can be waived to the degree necessary.

8.30 Designated safeguarding health professionals, on behalf of the PCT(s) as commissioners, should review and evaluate the practice of all involved health professionals, including GPs and providers commissioned by the PCT area. Where more than one PCT has commissioned services the PCTs will need to agree locally how they will work together. This may involve reviewing the involvement of individual practitioners and NHS trusts, and advising named professionals and managers who are compiling reports for the review. The designated professionals should produce an integrated health chronology and a health overview report focusing on how health organisations have interacted together. This may generate additional recommendations for health organisations. The health overview report

will constitute the IMR for the PCTs as commissioners. Designated safeguarding health professionals also have an important role in providing guidance on how to balance confidentiality and disclosure issues to ensure an objective, just and thorough approach to identifying lessons in the IMR. If the designated health professional(s) have been clinically involved with the case the PCT should seek advice and help from another PCT designated professional as necessary.

8.31 The process of conducting an IMR requires access to records relevant to the child such as those from health bodies. The public interest served by this process warrants full disclosure of all relevant information within the child's own records. In some circumstances the person conducting the IMR may require access to information about third parties (for example, members of the child's immediate family or carers) that is either contained within the child's health records or in the health records of another person. While in most cases there will be a public interest in disclosing this information, the record holder(s) should ensure that any information they disclose about a third party is both necessary and proportionate. All disclosures of information about third parties need to be considered on a case by case basis, and the reasoning for either disclosure or non-disclosure should be fully documented. This applies to all records of NHS-commissioned care, whether provided under the NHS or in the independent or voluntary sector.

8.32 The SCR Panel, on behalf of the LSCB, should commission an overview report that brings together and analyses the findings of the various IMRs from organisations and others, and that makes recommendations for future action. It is crucial that the SCR Panel and the overview report author have access to all relevant documentation and where necessary individual professionals to enable both to undertake effectively their respective SCR functions.

8.33 The overview report should be commissioned from a person who is independent of all the local agencies and professionals involved and of the LSCB(s). The overview report author should not be the chair of the LSCB, the SCR sub-committee or the SCR Panel. Those conducting management reviews of individual services should not have been directly concerned with the child or family, or have been the immediate line manager of the practitioner(s) involved.

Individual management reviews – general principles

8.34 Once it is known that a case is being considered for review, each organisation should secure its records relating to the case to guard against loss or interference. Once it is decided that a SCR will be undertaken, individual organisations, having secured their case records promptly, should begin quickly to draw up a chronology of their involvement with the child and family.

8.35 The aim of IMRs should be to look openly and critically at individual and organisational practice and at the context within which people were working to see whether the case indicates that improvements could and should be made and, if so, to identify how those changes can be brought about. The IMR reports should be quality assured by the senior officer in the organisation which has commissioned the report and when they are satisfied the findings accepted. This senior officer will be responsible also for ensuring that the recommendations of the IMR, and where appropriate the overview report, are acted on.

8.36 Where a child dies in or whilst under escort to or from a custodial setting such as a YOI or STC, the PPO will conduct a fatal incidents investigation and report on the circumstances surrounding the death of that child. The investigation will examine the child's period in custody and assess the clinical care they received as well as examining relevant factors which led to the child being placed in custody. In such cases a representative of the Youth Justice Board (YJB) should be a member of the SCR Panel to help ensure that relevant youth justice issues are covered. The PPO may be invited to attend SCR Panel meetings for specific, agreed purposes. The SCR terms of reference should set out how the PPO, the SCR Panel and the SCR sub-committee will work together to share relevant information during the process of undertaking the SCR[152].

8.37 The following outline format should guide the preparation of IMRs, to help ensure that the relevant questions are addressed and to ensure that information is provided to LSCBs in a consistent format to help prepare an overview report. The questions posed do not comprise a comprehensive checklist relevant to all situations. Each case may give rise to specific questions or issues that need to be explored, and each SCR should consider carefully the circumstances of individual cases and how best to structure the SCR in the light of the particular circumstances.

8.38 Where staff or others are interviewed by those preparing IMRs, a written record of such interviews should be made and this should be shared with the relevant interviewee. If the review finds that policies and procedures have not been followed, relevant staff or managers should be interviewed in order to understand the reasons for this.

8.39 On completion of each IMR report there should be a process of feedback and debriefing for the staff involved in the case, in advance of completion of the overview report. There should also be a follow-up feedback session with these staff once the SCR report has been completed and before the executive summary is published. It is important that the SCR process supports an open, just and learning

152 The DCSF and PPO are agreeing a memorandum which will set out in more detail how LSCBs and the PPO relate to each other when a fatal incidents investigation is being undertaken by the PPO and a SCR is being undertaken by a LSCB(s) with respect to the same child.

culture and is not perceived as a disciplinary-type hearing which may intimidate and undermine the confidence of staff.

Scope and format of individual management reviews

What was our involvement with this child and family?

Construct a comprehensive chronology of involvement by the organisation and/or professional(s) in contact with the child and family over the period of time set out in the review's terms of reference. (This chronology should clearly set out when the child was seen and whether the wishes and feelings of the child were sought). Briefly summarise decisions reached, the services offered and/or provided to the child(ren) and family, and other action taken.

Where an agency has had relevant contact with the alleged perpetrator, the chronology should also cover these actions and should ask whether everything was done which might reasonably have been expected to manage effectively the risk of harm posed by the alleged perpetrator to the child.

Analysis of involvement

Consider the events that occurred, the decisions made, and the actions taken or not taken. Where judgements were made, or actions taken, which indicate that practice or management could be improved, try to get an understanding not only of what happened but **why** something either did or did not happen. Consider specifically the following:

- Were practitioners aware of and sensitive to the needs of the children in their work, and knowledgeable both about potential indicators of abuse or neglect and about what to do if they had concerns about a child's welfare?
- When, and in what way, were the child(ren)'s wishes and feelings ascertained and taken account of when making decisions about the provision of children's services? Was this information recorded?
- Did the organisation have in place policies and procedures for safeguarding and promoting the welfare of children and acting on concerns about their welfare?
- What were the key relevant points/opportunities for assessment and decision making in this case in relation to the child and family? Do assessments and decisions appear to have been reached in an informed and professional way?

- Did actions accord with assessments and decisions made? Were appropriate services offered/provided, or relevant enquiries made, in the light of assessments?
- Were there any issues, in communication, information sharing or service delivery, between those with responsibilities for work during normal office hours and others providing out of hours services?
- Where relevant, were appropriate child protection or care plans in place, and child protection and/or looked after reviewing processes complied with?
- Was practice sensitive to the racial, cultural, linguistic and religious identity and any issues of disability of the child and family, and were they explored and recorded?
- Were senior managers or other organisations and professionals involved at points in the case where they should have been?
- Was the work in this case consistent with each organisation's and the LSCB's policy and procedures for safeguarding and promoting the welfare of children, and with wider professional standards?
- Were there organisational difficulties being experienced within or between agencies? Were these due to a lack of capacity in one or more organisations? Was there an adequate number of staff in post? Did any resourcing issues such as vacant posts or staff on sick leave have an impact on the case?
- Was there sufficient management accountability for decision making?

What do we learn from this case?

Are there lessons from this case for the way in which this organisation works to safeguard and promote the welfare of children? Is there good practice to highlight, as well as ways in which practice can be improved? Are there implications for ways of working; training (single and inter-agency); management and supervision; working in partnership with other organisations; resources? Are there implications for current policy and practice?

Recommendations for action

What action should be taken by whom and when? What outcomes should these actions bring, and in what timescales, and how will the organisation evaluate whether they have been achieved? Are there any immediate statutory requirements for the notification of concerns and are there likely to be any media handling issues?

The Serious Case Review overview report

8.40 The SCR overview report should bring together, and draw overall conclusions from, the information and analysis contained in the IMRs, information from the child death review processes, where relevant, and reports commissioned from any other relevant interests. Overview reports should be produced according to the following outline format although, as with IMRs, the precise format will depend on the features of the case. This outline is most applicable to abuse or neglect that has taken place in a family setting. In certain circumstances, for example abuse in institutional settings or complex situations, the reviews are likely to be more complex.

Format of Serious Case Review overview report

Introduction

- Summarise the circumstances that led to a SCR being undertaken in this case.
- State the terms of reference of the review.
- Record the methodology used including the documents reviewed, and whether the information was provided in an interview or through written evidence.
- List agencies or types of contributors to review and the nature of their contributions (for example, IMR by local authority, report through the PCT as commissioner from adult mental health service). List the names of the LSCB Chair, SCR Panel Chair, the author of the overview report and the job titles and employing organisations of all the SCR Panel members.
- List parallel processes, if any, that are being conducted (for example, criminal proceedings, PPO investigation following the death of a child in custody or independent investigation of adverse events in mental health services).

The facts

- Prepare an anonymised genogram showing membership of family, extended family and household.
- Compile an integrated chronology of involvement with the child and family on the part of all relevant organisations, professionals and others who have contributed to the review process. Note specifically in the chronology each occasion on which the child was seen, if the child was seen alone and whether the child's wishes and feelings were sought or expressed.

- Consider explicitly any relevant ethnic, cultural or other equalities issues and whether these are relevant to the behaviours and approach taken by the organisations and professionals involved.
- Summarise the relevant information that was known to the agencies and professionals involved about the parents/carers, any perpetrator and the home circumstances of the children.

Analysis

This part of the overview report should look at how and why events occurred, decisions were made and actions taken or not taken. This is the part of the report where reviewers can consider, with the benefit of hindsight, whether different decisions or actions may have led to an alternative course of events. It is important that this is objective and open, being clear where systems could improve.
The analysis section is also where any examples of good practice should be highlighted. The findings from this SCR should be considered alongside learning from previous SCRs undertaken by the LSCB and findings from relevant research.

Conclusions and recommendations

This part of the report should summarise what lessons are to be drawn from the case, and how those lessons should be translated into recommendations for action, and to what timescales. Recommendations should include, but should not simply be limited to, the recommendations made in individual reports from each organisation. Recommendations should usually be few in number, focused and specific, and capable of being implemented. If there are lessons for national as well as local policy and practice, these should also be highlighted and the information sent to the relevant government department.

SCR Panel responsibilities for the overview report

8.41 The SCR Panel should:

- ensure that it actively manages the SCR process, seeking legal advice as necessary, so that the findings from other relevant processes such as care or criminal proceedings, an inquest or inquiry/investigation are incorporated into the SCR report;
- ensure that contributing organisations and individuals are satisfied that their information is fully and fairly represented in the overview report;
- ensure that the overview report is of a high standard and is written in accordance with this guidance;

- commission and agree the content of the executive summary for publication, ensuring that it accurately represents the full SCR, includes the action plan in full and is fully anonymised apart from including the names of the LSCB Chair, SCR Panel Chair and the overview author and the job titles and the employing organisations of all the SCR Panel members;
- translate recommendations into an action plan that should be signed up to by the senior manager in each of the organisations which will be involved in implementing the action plan. The plan should set out who will do what, by when, with what intended outcome and how success will be measured. The plan should set out the means by which improvements in practice/systems will be monitored and reviewed;
- clarify to whom in which agencies or organisations the executive summary and the action plan of the SCR should be made available to support implementation of the recommendations and the learning of the lessons; and
- make arrangements to provide feedback and debriefing to the child (if surviving) and family members/carers of the subject child as appropriate, following completion of the executive summary.

The executive summary

8.42 In all cases, the SCR overview report and the IMRs should be used to produce an executive summary that should be made public and which accurately reflects the full overview report. The executive summary should include information about the review process, key issues arising from the case, the recommendations and the action plan (including any actions that have been completed). The content of the executive summary needs to be suitably anonymised in order to protect the identity of children, relevant family members and others and to comply with the Data Protection Act 1998. The executive summary should, however, include the names of the LSCB Chair, SCR Panel Chair, the overview report author, and the job titles and employing organisations of all the SCR Panel members. Executive summaries should be produced according to the following outline format although, as with IMRs and overview reports, the precise format will depend on the features of the case.

Format of Serious Case Review executive summary

Introduction

- Summarise the circumstances that led to a SCR being undertaken in this case and the process followed by the review.
- List the names of the LSCB Chair, SCR Panel Chair and the author of the overview report, and the job titles and employing organisations of all SCR Panel members.
- Note the parallel processes, where relevant, that are being or have been conducted and how they have interrelated with the processes followed by the review (for example, criminal proceedings, PPO investigation following the death of a child in custody, or independent investigation of adverse events in mental health services).
- Note the extent to which the family (and the child, where he or she has been seriously harmed) have been involved in the review.

The facts/summary of events

- Summarise the key facts of the case and the sequence of events. This should be an accurate précis of circumstances of the child and their family and of the chronology of the involvement of the relevant agencies. The narrative should be consistent with the detailed chronology in the full overview report.
- Care should however be taken to ensure that the summary is appropriately anonymised and sensitive to the child and family in respect of information that will be available in the public domain.

Key issues or themes arising from the case

- Summarise the key issues or themes arising from the analysis in the overview report, and highlight the key decisions taken in respect of the child and their family and the opportunities for early intervention where they existed. With hindsight could or should different decisions or actions have been taken at the time?

Priorities for learning and change

- Describe clearly the conclusions and lessons learned from the review, both for individual agencies and for inter-agency working through the LSCB and the Children's Trust Board, ensuring these are in the context of the issues or themes that arose from the case.
- Identify examples of good practice as well as being clear where systems should improve.

Recommendations and action plan

- Reproduce the recommendations and action plan from the full SCR.
- The action plan should highlight which recommendations are relevant to which agencies, the agency/ies responsible for taking forward specific recommendations, how action will be monitored and by whom. It should also set out the progress that has already been made in implementing or completing recommendations and plans to evaluate the impact of these changes.

LSCB action on receiving the Serious Case Review report

8.43 The SCR sub-committee, on behalf of the LSCB, should quality assure the final SCR – that is, the IMR reports, the overview report, the executive summary and the action plan.

8.44 The LSCB should approve the final SCR and:

- provide an anonymised copy of the IMRs, overview report, executive summary and the individual and multi-agency action plans and chronologies to Ofsted, the relevant GO Children and Learners Team, the SHA and DCSF. All personal information relating to children, family members and professionals involved in the case (with the exception of the names of the LSCB and SCR Panel chairs and the overview report author) should be anonymised in all the SCR documentation submitted to Ofsted and the relevant GO. If the child died in a custodial setting, copies of the anonymised SCR should be made available to the YJB and copies of the executive summary should be provided to the PPO;
- make arrangements to provide feedback and debriefing to staff and the media as appropriate;
- disseminate the executive summary and key findings to relevant interested parties;
- publish only the SCR executive summary once the SCR has been completed;

- implement those actions for which the LSCB has lead responsibility and monitor the timely implementation of the SCR action plan;
- on receipt of the evaluation letter from Ofsted, take action as necessary to amend the action plan and/or the SCR report if the SCR executive summary has been published before receiving Ofsted's feedback; and
- formally conclude the review process when the action plan has been implemented and inform the relevant GO of this decision.

8.45 The LSCB should decide on a case by case basis when to publish the executive summary. This decision should take account of the timing of the conclusion of relevant court cases and statutory processes such as inquests or a PPO investigation. The LSCB, on advice from the SCR Panel and where relevant the CPS, the police or its lawyers, should decide whether new information may become available from these other processes which is likely to have an impact on the lessons to be learned from the SCR. If the findings are not likely to have an impact, then there should be no delay in publishing the SCR executive summary. On the other hand, in some cases it may be best to undertake the IMRs and finalise them and the SCR overview report in the light of this new information or findings before publication of the SCR executive summary. In addition, LSCBs may decide to take account of any points raised in Ofsted's evaluation of the SCR before publishing the SCR executive summary but, depending on local circumstances, it may be necessary for the LSCB to publish it prior to the completion of an evaluation by Ofsted.

8.46 All SCRs are evaluated by Ofsted and, in line with the arrangements agreed between inspectorates, the evaluation may involve other inspectorates notably the CQC and HMIC. The evaluation will be shared with the LCSB and, together with the SCR reports as appropriate, with partner inspectorates and Government. Where a SCR has been evaluated as 'inadequate' the LSCB should convene a SCR Panel, to be chaired by an independent person, to reconsider the review. The LSCB is then required to submit to Ofsted, within three months, an action plan that addresses the inadequacies of the SCR.

Reviewing institutional abuse

8.47 When serious abuse takes place in an institution, or multiple abusers are involved, the same principles of review apply. SCRs in these circumstances are likely to be more complex, on a larger scale, and may require more time (see paragraphs 6.10–6.13) on investigating complex (organisational or multiple) abuse. Terms of reference need to be carefully constructed to explore the issues relevant to the specific case. For example, if children are abused in a residential school, it is important to explore whether and how the school has taken steps to create a safe environment for children, and to respond to specific concerns raised.

8.48 There needs to be clarity over the interface between: the different processes of investigation (including criminal investigations); case management, including help for abused children and immediate measures to ensure that other children are safe; learning lessons from the SCR to reduce the chance of such events happening again. These three different processes should inform each other. Any proposals for review should be agreed with those leading criminal investigations, to make sure that they do not prejudice possible criminal proceedings.

Accountability and disclosure

8.49 LSCBs should consider carefully who might have an interest in SCRs – for example, elected and appointed members of authorities, staff, the child who was seriously harmed and the subject of the SCR, members of the child's family, the public, the media – and what information should be made available to each of these interests. There are difficult interests to balance, including:

- the need to maintain confidentiality in respect of personal information contained within reports on the child, family members and others;
- the accountability of public services and the importance of maintaining public confidence in the process of internal review;
- the need to secure full and open participation from the different agencies and professionals involved;
- the responsibility to provide relevant information to those with a legitimate interest; and
- constraints on public information sharing when criminal proceedings are ongoing, in that providing access to information may not be within the control of the LSCB.

8.50 It is important to anticipate requests for information and plan in advance how they should be met. For example, a lead agency may take responsibility for debriefing the child (where the SCR was undertaken in respect of a child who was seriously harmed) and family members, or for responding to media interest about a case, in liaison with contributing agencies and professionals. The publication of the executive summary needs to be timed in accordance with the conclusion of any related criminal court proceedings. Neither the SCR overview report nor the IMRs should be made publicly available.

8.51 The LSCB should ensure that the relevant GO Children and Learners Team, Ofsted and all other relevant bodies including the SHA, the CQC, HMIC, HMIP and HMI Probation are appropriately briefed in advance about the publication of the executive summary. Where a child has died in a custodial setting, this briefing

should include the YJB and the PPO. The SHA should brief the Department of Health.

Learning lessons locally

8.52 As the purpose of SCRs is to learn lessons for improving both individual agency and inter-agency working, it is essential that the lessons are learned and acted upon. This means that at least as much effort should be spent on implementing the recommendations as on conducting the review. The following may help in getting maximum benefit from the review process:

- as far as possible, conduct the review in such a way that the process is a learning exercise in itself for all those who have been involved in the case;
- consider what type and level of information needs to be disseminated, how and to whom, in the light of a SCR. Be prepared to communicate both examples of good practice and areas where change is required, as well as to integrate this information with that from other serious case or local reviews;
- incorporate the learning into local training programmes; and
- focus recommendations on a small number of key areas, with Specific, Measurable, Achievable, Relevant and Timely proposals for change and intended outcomes.

In addition:

- the LSCB should put in place a means of monitoring and auditing the actions of all agencies against recommendations and intended outcomes; and
- PCTs should seek feedback from SHAs who should use it to inform their performance management role, and the CQC may use the findings of SCRs to inform its processes for regulating NHS and independent sector provider organisations. PCTs will monitor the implementation of the recommendations by provider organisations.

8.53 The role of GOs in relation to safeguarding includes giving support and challenge to LSCBs and to Children's Trust Boards in relation to SCR and CDOP activity and implementation. This includes seeking assurance that LSCB and Children's Trust plans are in place and action is being taken to effectively address recommendations.

8.54 Day-to-day good practice can help ensure that reviews are conducted successfully and in a way most likely to maximise learning:

- establish a culture of audit and review. Make sure that tragedies are not the only reason inter-agency work is reviewed;

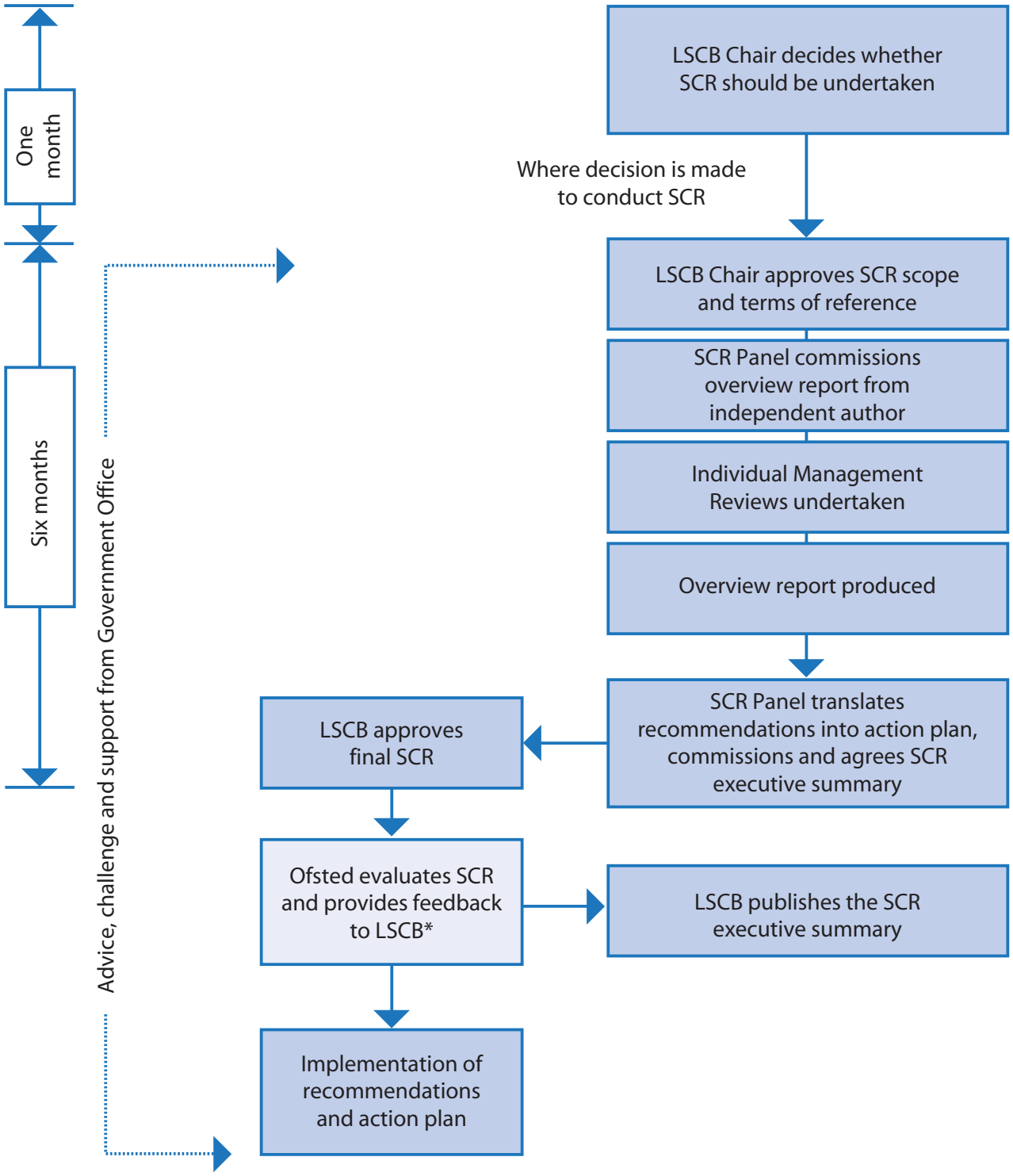
- have in place clear, systematic case recording and record-keeping systems;
- develop good communication and mutual understanding between different disciplines and different LSCB members;
- communicate with the local community and media to raise awareness of the positive and 'helping' work of statutory services with children, so that attention is not focused disproportionately on tragedies; and
- make sure staff and their representatives understand what can be expected in the event of a child death/SCR.

8.55 The SCR sub-committee should provide information to relevant LSCB(s) on the actions taken in response to SCRs which have been completed by the LSCB(s) in the previous year. LSCBs will draw on this information when publishing their annual reports (paragraph 3.36 sets out LSCB's annual reporting requirements in relation to SCRs). Appropriate care should be taken to ensure confidentiality of personal information and sensitivity to the families whose child is the subject of a SCR. The LSCB annual report should support the driving forward of measures to prevent child deaths and serious harm where abuse and neglect have been factors and to safeguard and promote the welfare of children.

Learning lessons nationally

8.56 Taken together, child death reviews and SCRs are an important source of information to inform national policy and practice. The DCSF is responsible for identifying and disseminating common themes and trends across review reports, and acting on lessons for policy and practice. The DCSF commissions regular reports, drawing out key findings of SCRs and their implications for policy and practice to assist the process of learning lessons. In the future relevant findings from the work of the local child death overview teams will be integrated into these reports.

Flow chart 7: Overview of Serious Case Review process



* Where a SCR has been evaluated as 'inadequate' the LSCB should convene a SCR Panel, to be chaired by an independent person, to reconsider the review. The LSCB is then required to submit to Ofsted within three months, an action plan that addresses the inadequacies of the SCR.

Part 2: Non-statutory practice guidance

Chapter 9 – Lessons from research

Introduction

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

9.2 This chapter summarises what is known about the impact of maltreatment on children's health and development, and sources of stress in families that may also have an impact on children's developmental progress (see also *The Developing World of the Child*, 2006). Further information on findings from the joint Department for Children, Schools and Families and Department of Health Safeguarding Children Research Initiative and other related research can be found on the NSDU research website[153].

The impact of maltreatment on children

9.3 The maltreatment of children – physically, emotionally, sexually or through neglect – can have major long-term effects on all aspects of a child's health, development and wellbeing. **The immediate and longer-term impact can include anxiety, depression, substance misuse, eating disorders and self-destructive behaviours, offending and anti-social behaviour**. Maltreatment is likely to have a deep impact on the child's self-image and self-esteem, and on his or her future life. Difficulties may extend into adulthood: the experience of long-term abuse may lead to difficulties in forming or sustaining close relationships, establishing oneself in work, and to extra difficulties in developing the attitudes and skills necessary to be an effective parent.

9.4 It is not only the stressful events of maltreatment that have an impact, but also the context in which they take place. Any potentially abusive incident has to be seen in context to assess the extent of harm to a child and decide on the most appropriate

153 www.dcsf.gov.uk/nsdu/research.shtml

intervention. Often, it is the interaction between a number of factors that increases the likelihood or level of significant harm.

9.5 For every child and family, there may be factors that aggravate the harm caused to the child, and those that protect against harm. Relevant factors include the individual child's means of coping and adapting, support from a family and social network, and the impact of any interventions. The effects on a child are also influenced by the quality of the family environment at the time of maltreatment, and by subsequent life events. The way in which professionals respond also has a significant bearing on subsequent outcomes.

9.6 Serious Case Reviews[154], together with other research findings, show that children under one year of age and in particular very young babies are extremely vulnerable to being seriously injured or to dying as a result of abuse or neglect. Young people aged 11 and over also have a heightened level of vulnerability and likelihood of suffering harm, yet their needs and distress are often missed or deemed too challenging for services.

9.7 Some children may be living in families that are considered resistant to change. A knowledge review on effective practice to protect children living in such families, undertaken by C4EO, has identified practices which can enable practitioners to engage with these types of families and improve outcomes for children (see www.c4eo.org.uk/themes/safeguarding/default.aspx?themeid=11&accesstypeid=1).

Physical abuse

9.8 Physical abuse can lead directly to neurological damage, physical injuries, disability or, at the extreme, death. Harm may be caused to children both by the abuse itself and by the abuse taking place in a wider family or institutional context of conflict and aggression, including inappropriate or inexpert use of physical restraint. Physical abuse has been linked to aggressive behaviour in children, emotional and behavioural problems and educational difficulties. Violence is pervasive and the physical abuse of children frequently coexists with domestic violence[155].

154 Brandon, M., Bailey, S., Belderson, P., Gardner, R., Sidebottom, P., Dodsworth, J., Warren, C. and Black, J. (2009) *Understanding Serious Case Reviews and their Impact: A Biennial Analysis of Serious Case Reviews 2005-7*. London: Department for Children Schools and Families.

155 Montgomery, P.Ramchandani, P. Gardner, F. and Bjornstad,G. (2009) *Systematic reviews of interventions following physical abuse: helping practitioners and expert witnesses improve the outcomes of child abuse*. London: Department for Children, Schools and Families.

Emotional abuse

9.9 There is increasing evidence of the adverse long-term consequences for children's development where they have been subject to sustained emotional abuse, including the impact of serious bullying[156]. Emotional abuse has an important impact on a developing child's mental health, behaviour and self-esteem. It can be especially damaging in infancy. Underlying emotional abuse may be as important, if not more so, as other more visible forms of abuse in terms of its impact on the child. Domestic violence is abusive in itself. Adult mental health problems and parental substance misuse may be features in families where children are exposed to such abuse.

Sexual abuse

9.10 Disturbed behaviour – including self-harm, inappropriate sexualised behaviour, sexually abusive behaviour, depression and a loss of self-esteem – has been linked to sexual abuse. Its adverse effects may endure into adulthood. The severity of impact on a child is believed to increase the longer the abuse continues, the more extensive the abuse, and the older the child. A number of features of sexual abuse have also been linked with severity of impact, including the relationship of the abuser to the child, the extent of premeditation, the degree of threat and coercion, sadism, and bizarre or unusual elements. A child's ability to cope with the experience of sexual abuse, once recognised or disclosed, is strengthened by the support of a non-abusive adult carer who believes the child, helps the child understand the abuse, and is able to offer help and protection. The reactions of practitioners also have an impact on the child's ability to cope with what has happened, and on his or her feelings of self worth. (For further information see *Child Sexual Abuse: Informing Practice from Research*)[157].

9.11 A proportion of adults and children and young people who sexually abuse children have themselves been sexually abused as children. They may also have been exposed as children to domestic violence and discontinuity of care. However, it would be quite wrong to suggest that most children who are sexually abused inevitably go on to become abusers themselves.

Neglect

9.12 Severe neglect of young children has adverse effects on children's ability to form attachments and is associated with major impairment of growth and intellectual

156 Barlow, J and Schrader-MacMillan, A. (2009) *Safeguarding Children From Emotional Abuse – What Works?*. London: Department for Education and Skills. DCSF-RBX-09-09.

157 Jones, D.P.H. and Ramchandani, P. (1999) *Child Sexual Abuse. Informing Practice from Research. Abingdon: Radcliffe Medical Press Ltd.*

development. Persistent neglect can lead to serious impairment of health and development, and long-term difficulties with social functioning, relationships and educational progress. Neglected children may also experience low self-esteem, and feelings of being unloved and isolated. Neglect can also result, in extreme cases, in death. The impact of neglect varies depending on how long children have been neglected, the children's age, and the multiplicity of neglectful behaviours children have been experiencing[158,159].

Sources of stress for children and families

9.13 Many families under great stress succeed in bringing up their children in a warm, loving and supportive environment in which each child's needs are met. Sources of stress within families may, however, have a negative impact on a child's health, development and wellbeing, either directly, or because when experienced during pregnancy they may result in delays in the physical and mental development of infants, or because they affect the capacity of parents to respond to their child's needs[160]. This is particularly so when there is no other significant adult who is able to respond to the child's needs, for example where children experience a parent in prison as a result of offending behaviour.

9.14 Undertaking assessments of children and families requires a thorough understanding of the factors that influence children's development: the developmental needs of children; the capacities of parents or caregivers to respond appropriately to those needs; and the impact of wider family and environmental factors on both children's development and parenting capacity. An analysis of how these three domains of children's lives interact enables practitioners to understand the child's developmental needs within the context of the family and to provide appropriate services to respond to those needs. (See the *Framework for the Assessment of Children in Need and their Families 2000*.)

9.15 The following sections summarise some of the key research findings on parental mental illness, learning disability, substance misuse and domestic violence[161]. The information should be drawn on when assessing children and families, providing services to meet their identified needs and reviewing whether the planned

158 Daniel, B. Taylor, J. and Scott, J. (2009) *Noticing and helping the neglected child.* London: Department for Children, Schools and Families. DCSF-RBX-09-03.

159 Stein, M. Rees, G. Hicks, L. and Gorin, S. (2009) *Neglected adolescents: a review of the research and the preparation of guidance for multi-disciplinary teams and a guide for young people.* London: Department for Children, Schools and Families. DCSF-RBX-09-04.

160 Chapter 6 of the Government's strategy document *Carers at the heart of 21st Century families and communities* (2008) addresses the needs of young carers.

161 Cleaver, H. Unell, I. and Aldgate, A. (2010) Children's Needs – Parenting Capacity: The impact of parental mental illness, learning disability, problem alcohol and drug use, and domestic violence on children's safety and development. 2nd Edition. London: The Stationery Office.

outcomes for each child have been achieved. In each section the issue is defined, information on its prevalence given, and the likely impact on the child identified. The research findings are explored in relation to four stages of childhood: the unborn child, babies and infants (under 5 years), middle childhood (5 to 10 years) and adolescence (11 to 16 plus years).

Social exclusion

9.16 Many of the families who seek help for their children, or about whom others raise concerns in respect of a child's welfare, are multiply disadvantaged. These families may face chronic poverty, social isolation, racism, and the problems associated with living in disadvantaged areas, such as high crime rates, poor housing, childcare, transport and education services, and limited employment opportunities. Many lack a wage earner. Poverty may mean that children live in crowded or unsuitable accommodation, have poor diets, health problems or disability, are vulnerable to accidents, and lack ready access to good educational and leisure opportunities. When children themselves become parents this exacerbates disadvantage and the potential for social exclusion. Racism and racial harassment are an additional source of stress for some families and children, as is violence in the communities in which they live. Social exclusion can also have an indirect effect on children, through its association with parental substance misuse, depression, learning disability, and long-term physical health problems.

Domestic violence

9.17 The Home Office[162] defines domestic violence as 'Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality'. Nearly a quarter of adults in England are victims of domestic violence. Although both men and women can be victimised in this way, a greater proportion of women experience all forms of domestic violence, and are more likely to be seriously injured or killed by their partner, ex-partner or lover.

9.18 Domestic violence affects both adults and children within the family. Some 200,000 children (1.8%) in England live in households where there is a known risk of domestic violence or violence[163]. Prolonged and/or regular exposure to domestic violence can have a serious impact on children's safety and welfare, despite the best

162 Home Office (2009) *What is Domestic Violence?* London: Home Office.

163 Lord Laming (2009) *The Protection of Children in England: Progress Report*. London: The Stationery Office.

efforts of parents to protect them. An analysis of Serious Case Reviews found evidence of past or present domestic violence present in over half (53%) of cases[164].

9.19 Domestic violence rarely exists in isolation. Many parents also misuse drugs or alcohol, experience poor physical and mental ill health and have a history of poor childhood experiences themselves. The co-morbidity of issues compounds the difficulties parents experience in meeting the needs of their children, and increases the likelihood that the child will experience abuse and/or neglect.

9.20 Domestic violence has an impact on children in a number of ways. Children are at increased risk of physical injury during an incident, either by accident or because they attempt to intervene. Even when not directly injured, children are greatly distressed by witnessing the physical and emotional suffering of a parent. Children's exposure to parental conflict, even where violence is not present, can lead to serious anxiety and distress which may express itself in anti-social or criminal behaviour. Although separating from a violent partner should result in women and children being safe from harm, the danger does not automatically end. Moreover, the point of leaving an abusive relationship is the time of highest risk for a victim. Contact arrangements can be used by violent men not only to continue their controlling, manipulative and violent behaviour but also as a way of establishing the whereabouts of the victim(s).

9.21 Domestic violence also affects children because it impacts on parenting capacity. A parent (in most families, the mother) may have difficulty in looking after the children when domestic violence results in injuries, or in extreme cases, death. The impact on parenting, however, is often more subtle. Exposure to psychological and emotional abuse has profound negative effects on women's mental health resulting in a loss of confidence, depression, feelings of degradation, problems with sleep, isolation, and increased use of medication and alcohol. These are all factors that can restrict the mother's capacity to meet the developmental needs of her child. Moreover, belittling and insulting a mother in front of her children undermines not only her respect for herself, but also the authority she needs to parent confidently. A mother's relationship with her children may also be affected because, in attempts to avoid further outbursts of violence, she prioritises her partner's needs over those of her children.

9.22 The impact of domestic violence on children increases when directly abused, witnessing the abuse of a parent, or colluding (willingly or otherwise) in the concealment of assaults. Other relevant factors include the chronicity and degree of violence, and its co-existence with other issues such as substance misuse. No age

164 Brandon, M., Bailey, S., Belderson, P., Gardner, R., Sidebottom, P., Dodsworth, J., Warren, C. and Black, J. (2009) *Understanding Serious Case Reviews and their Impact: A Biennial Analysis of Serious Case Reviews 2005-7*. London: Department for Children Schools and Families.

group is particularly protected from or damaged by the impact of domestic violence. Children's ability to cope with parental adversity is related to their age, gender and individual personality. However, regardless of age, support from siblings, wider family, friends, school and community can act as protective factors. Key to the safety of women and children subjected to violence and the threat of violence is an alternative, safe and supportive residence[165].

9.23 An exploration of the possible impact on the unborn child shows the foetus is at risk of injury because violence towards women increases both in severity and frequency during pregnancy, and often involves punches or kicks directed at the women's abdomen. Such assaults can result in a greater rate of miscarriage, still or premature birth, foetal brain injury and fractures. Domestic violence is also associated with women's irregular or late attendance for ante-natal care. Poor attendance may be the result of low self esteem and depression or due to an abusive partner controlling and restricting women's use of medical services. Once born, the baby continues to be at risk of injury. For example, the infant may be in his or her mother's arms when an assault occurs. A young child's health and development may also be compromised when violence results in the mother having difficulty in concentrating, becoming depressed, or self medicating. When domestic violence undermines the mother's capacity to provide her infant with a sense of safety and security it can impact on the attachment process. Finally, domestic violence may influence a young child's social relationships, increasing their outbursts of anger, peer aggression and other behaviour problems.

9.24 Children in middle childhood, who live with domestic violence, continue to be at risk of being physically injured. Injuries may occur when the child is caught in the cross-fire or when trying to intervene to protect his or her mother. There is also evidence to link domestic violence with elevated levels of child sexual abuse[166],[167]. Witnessing domestic violence affects children's emotions and behaviour and can lead to temper tantrums and aggression which are directed at family and peers, and cruelty towards animals. Exposure to domestic violence is also associated with children being more anxious, sad, worried, fearful and withdrawn, than children who are not exposed[168]. Some children cope with the stress and fear of violence by seeking to escape. During middle childhood this may be through fantasy and make-believe, or by withdrawing into themselves, or seeking a place of safety.

---

165 Cleaver, H., Unell, I. and Aldgate, A. (2010) *Children's Needs – Parenting Capacity: The impact of parental mental illness, learning disability, problem alcohol and drug use, and domestic violence on children's safety and development. 2nd Edition*. London: The Stationery Office.

166 Humphreys, C. and Stanley, N. (eds) (2006) *Domestic Violence and Child Protection*. London: Jessica Kingsley Publishers.

167 Hester, M., Pearson, C. and Harwin, N. with Abrahams, H. (2007). *Making an impact: children and domestic violence. A reader. 2nd Edition*. London: Jessica Kingsley Publishers.

168 Onyskiw, J. E. (2003) 'Domestic Violence and Children's Adjustment: A Review of Research.' *Journal of Emotional Abuse 3*, 1/2, 11-45.

Experiencing domestic violence and seeing parents unable to control themselves or their circumstances may result in feelings of helplessness and confusion. Children may blame themselves for their parent's violence and feel inadequate and guilty when unable to stop the violent episode or prevent its reoccurrence.

9.25 Adolescents exposed to domestic violence may live in constant fear of violent arguments, being threatened, or actual physical violence being directed at a parent (usually the mother) or themselves. The likelihood of being physically injured continues. Furthermore, in a recent survey of 13 to 17-year-old girls in intimate relationships, one in six girls said they had been hit by their boyfriends (4% regularly)[169] and one in sixteen said they had been raped[170]. Experiencing domestic violence has a serious emotional impact: feelings can include fear, sadness, loneliness, helplessness and despair, and anger. In the home teenagers may focus their anger on both parents, towards the abuser for inflicting the violence and towards the victim for accepting the behaviour. Witnessing the abuse of a parent or experiencing intimate partner violence may result in adolescents exhibiting behavioural problems, both at home and in school, which have an impact on friendships and educational progress. Education can suffer when adolescents stay home to protect their parent or themselves from an abusive partner. Friends are highly valued by teenagers as confidants and sources of support, but behavioural difficulties may jeopardise friendships. Many adolescents cope with the stress of domestic violence by distancing themselves from their family or friends. They may withdraw emotionally through music, reading or participating in on-line virtual worlds, or physically by spending long periods out of the home, or running away.

9.26 Assessments, judgements and plans for children living with domestic or intimate partner violence benefit from the expertise of practitioners working in services for domestic violence. Services for children and families and young people need to take a proactive, collaborative approach to identifying and responding appropriately to domestic and intimate partner violence. Children and families and adolescents experiencing domestic and intimate partner violence are likely to need well targeted support from a range of different agencies. Mothers and children need safe places to stay and children and adolescents need mentors to ensure their needs are identified and met and their welfare is safeguarded and promoted.

Mental illness of a parent or carer

9.27 A wide range of mental ill health can affect parents and their families. This includes depression and anxiety, and psychotic illnesses such as schizophrenia or bipolar disorder. Depression and anxiety are common. At any one time one in six adults in

169 Body Shop YouGov survey (2004).

170 NSPCC and University of Bristol (2009) *Partner exploitation and violence in teenage intimate relationships*. London: NPSCC.

Great Britain may be affected. Psychotic disorders are much less common with about one in two hundred individuals being affected. Mental illness may also be associated with alcohol or drug use, personality disorder and significant physical illness. Approximately 30% of adults with mental ill health have dependent children[171], mothers being more at risk than fathers.

9.28 Appropriate treatment and support usually means that mental illness can be managed effectively and as a result parents are able to care successfully for their children[172]. Mental ill health in a parent or carer does not necessarily have an adverse impact on a child's development. Just as there is a range in severity of illness, so there is a range of potential impact on families. The consequent likelihood of harm being suffered by a child will range from a minimal effect to significant one. It is essential to assess the implications of parental ill health for each child in the family. This would include assessment of the impact on the family members of the social, physical ill heath or substance use difficulties that a parent with mental illness may also be experiencing. After assessment appropriate additional support should be provided where needed[173].

9.29 Given the wide range of mental ill health, the effect on parents and the potential impact on their capacity to meet the needs of their children is varied. Depression can result in the individual experiencing feelings of worthlessness and hopelessness which may lead to everyday activities being left undone. Parents may neglect their own and their children's physical and emotional needs. In psychotic disorders such as schizophrenia, when the person is actively psychotic, they can lose contact with reality, experiencing hallucinations and delusions with consequent inability to understand and respond to their children's needs. In some people with chronic psychotic illness self-neglect in a range of areas of life may be an issue and this may have an impact on their capacity to care for their children. Overall children with mothers who have mental ill health are five times more likely to have mental health problems themselves. Parental mental illness, particularly in the mother, is also associated with poor birth outcomes[174], increased risk of sudden infant death[175] and

171 Meltzer, D. (2003) 'Inequalities in mental health: A systematic review.' *The research findings register, Summary No. 1063*. London: Department of Health.

172 Reupert, A. and Maybery, D. (2007) 'Families Affected by Parental Mental Illness; A Multiperspective Account of Issues and Interventions.' *American Journal of Orthopsychiatry 77*, 3, 362-369.

173 New Horizons: A Shared Vision for Mental Health (2009). London: Department of Health. http://www.newhorizons.dh.gov.uk

174 King-Hele S, Webb R, Mortensen PB, Appleby L, Pickles A, Abel KM. Risk of stillbirth and neonatal death linked with maternal mental illness: a national cohort study. *Archives of Disease in Childhood Fetal & Neonatal Edition* 2009; 94: F105-F110.

175 Webb RT, Wicks S, Dalman C, Pickles AR, Appleby L, Mortensen PB, Haglund B, Abel KM. Influence of environmental factors in higher risk of sudden infant death syndrome linked with parental mental illness. *Archives of General Psychiatry* 2010; 67: 69-77.

increased mortality in offspring[176] – probably through complex interaction of sociological, biological and risk behaviours such as smoking. This research indicates that these vulnerable families need additional support and help.

9.30 The majority of parents with a history of mental ill health present no risk to their children. However, in rare cases a child may sustain severe injury, profound neglect, or even die. Very serious risks may arise if the parent's illness incorporates delusional beliefs about the child, and/or incorporates the child in a suicide plan. Information from the National Confidential Inquiry into Suicides and Homicides suggests that there are about 30 convictions a year where a parent or step parent kills a child (this excludes those cases where the parent then goes on to commit suicide). In 37% of these cases the parent was found to have a mental disorder including depressive illness or bipolar affective disorder, personality disorder, schizophrenia, and/or substance or alcohol dependence[177]. In a review of Serious Case Review reports where children had either died or been seriously harmed, current or past mental illness was found in two thirds of cases[178].

9.31 The potential impact of a parental mental illness and the child's ability to cope with it is related to age, gender and individual personality.

9.32 For babies and infants post natal depression may hamper the mother's capacity to empathise with, and respond appropriately to, her baby's needs. A consistent lack of warmth and negative responses increases the likelihood that the infant will become insecurely attached. Depression may also reduce the level of interaction and engagement between mother and child. Parents in these circumstances may have greater difficulty in listening to their children and offering praise and encouragement. Mothers who experience psychotic symptoms after giving birth, and those who continue to be depressed at six months after the birth, are more likely than other mothers to regard their babies negatively and ignore cries for warmth and comfort[179]. Women with a history of severe mental illness are at particular risk of relapse post partum and should be under the care of a psychiatrist, as should any mother who develops psychotic symptoms post birth[180]. Mood swings, a common feature in mental disorders, can result in inconsistent parenting, emotional unavailability and unexpected and unplanned for separations, which

176 Webb RT, Abel KM, Pickles AR, Appleby L, King-Hele SA, Mortensen PB. Mortality risk among offspring of psychiatric inpatients: a population-based follow-up to early adulthood. *American Journal of Psychiatry* 2006; 163: 2170-7.

177 NPSA Alert. Preventing harm to children from parents with mental health needs. NPSA, 2009.

178 Brandon, M., Bailey, S., Belderson, P., Gardner, R., Sidebottom, P., Dodsworth, J., Warren, C. and Black, J. (2009) *Understanding Serious Case Reviews and their Impact: A Biennial Analysis of Serious Case Reviews 2005-7*. London: Department for Children Schools and Families.

179 Egeland, B. (2009) 'Taking stock: Childhood emotional maltreatment and developmental psychopathology.' *Child Abuse & Neglect 33*, 1, 22-27.

180 NICE (2007) *Guidelines on antenatal and postnatal care*. London: NICE.

infants find bewildering and frightening. Young children can be supported by the vigilance of primary health care workers, the presence of an alternative caring adult, the support of wider family, and good community facilities.

9.33 Parental mental disorders affect children in middle childhood rather differently. Children react to parenting difficulties which result from mental disorders with an increased level of behavioural problems. Some children experience depression and anxiety disorders[181] while others show high rates of conduct disorder[182]. It is widely accepted that boys are more likely to act out their distress with anti social and aggressive behaviours while girls tend to respond by internalising their worries. Children of this age can escape into fantasy to cope with disturbing parental behaviour, or use more down to earth methods such as withdrawing into themselves, or escaping to a safe place. Relatives, particularly grandparents, can provide children with the emotional and practical support they need. However, children of this age are acutely aware of the social stigma of mental illness and consequently maybe reluctant to talk about family problems. Relatives and other adults who would be able to offer help and support may be unaware of what the child is experiencing. Same age friendships can also be supportive, although a fear of ridicule could keep children from discussing their circumstances with friends. Nonetheless, play and the companionship of friends can offer children respite from family concerns.

9.34 The prevalence of mental ill health in children increases with the advent of adolescence. A survey of children's mental health suggests 11% of children aged 11-16 years have a mental disorder[183]. Parental mental ill health exacerbates the likelihood of young people experiencing psychological and behavioural symptoms[184]. The volatility of this age group means that the impact of parental mental illness, while similar to that at a young age, maybe more intense. Teenagers whose mothers suffer from depression show more behaviour problems than those whose mothers are well[185]. Conduct disorders, depression and a preoccupation with family problems affect young people's ability to concentrate and education and learning may be impaired. Education may also be interrupted when parental mental health problems become severe and young people stay at home in order to look

181 Tunnard, J. (2004) Parental Mental Health Problems: Key Messages from Research, Policy and Practice. Dartington: Research in Practice.

182 Klein, D., Clark, D., Dansky, L. and Margolis, E.T. (1988) 'Dysthymia in the offspring of parents with primary unipolar affective disorder.' *Journal of Abnormal Psychology 94*, 1155-1127.

183 Green, H., McGinnity, A., Meltzer, H., Ford, T. and Goodman, R. (2005) *Mental health of children and young people in Great Britain, 2004*. London: Office for National Statistics.

184 Weissman, M.M., John, K., Merikangas, K.R., Prusoff, B.A., Wickramaratne, P., Gammon, G.D., Angold, A. and Warner, V. (1986) 'Depressed parents and their children: General health, social and psychiatric problems.' *American Journal of Diseases of Children 140*, 801-805.

185 Somers, V. (2007) 'Schizophrenia: The Impact of Parental Illness on Children.' *British Journal of Social Work 37*, 8, 1319-1334.

after their parent or younger siblings. Although relationships between parent and child may suffer as a result of parental mental illness, the opposite may also be true. As children reach adolescence, and their understanding and empathy develops, parental mental health problems may strengthen the bond between them. However, this can also result in accelerating the normal pace of emotional maturity, resulting in a loss of childhood. Young people may not only become responsible for shouldering the burden of practical tasks, but also assume the emotional responsibility for a parent or younger siblings. To do this young people may curtail their leisure time and restrict their friendships. Friendships can be a great source of support, but an acute awareness of the stigma of mental illness may result in young people coping alone. It is essential that the needs of young carers are assessed to ensure they receive the support they need. Many families in these circumstances would benefit from practical and domestic help. Young people value the support of sympathetic and trusted adults with whom they can discuss sensitive issues, a mutual friend and knowing who to contact in the event of a crisis regarding their parent.

9.35 It is important not to assume that all young people will have problems just because they grow up living with a parent who has mental ill health. Research has shown that the adverse effects on children and young people are less likely when parental disorders are mild, last only a short time, are not associated with family disharmony and do not result in the family breaking up. Children may also be protected from harm when the other parent or a family member can respond to the child's needs, and the child or young person has the support of friends and other caring adults[186].

9.36 Advice to services in responding to the needs of families where there is parental mental ill health is found in the NPSA Alert[187] and in practice guidance produced by SCIE[188].

186 Cleaver, H., Unell, I. and Aldgate, A. (2010) *Children's Needs – Parenting Capacity: The impact of parental mental illness, learning disability, problem alcohol and drug use, and domestic violence on children's safety and development*. 2nd Edition. London: The Stationery Office.

187 National Patient Safety Agency (2009) *Rapid Response Report NPSA/2009/RRR003: Preventing harm to children from parents with mental health needs*. London: National Patient Safety Agency. See www.npsa.nhs.uk/patientsafety/alerts-and-directives.

188 Social Care Institute for Excellence (2009) *Think child, think parent, think family*. London: SCIE.

Parental problem drug use

9.37 The Government's 2008 Drug Strategy refers to that group of illegal drug misusers who present the greatest problems overall – i.e. those using opiates such as heroin and/or crack cocaine – as 'Problem Drug Users' (PDUs). Whilst the 'PDUs' are a priority group for policy and for access to services, these services are at the same time available for all those with problems with their drug use.

9.38 Although as many as one in three adults have used illicit drugs at least once, problem drug users are less than one percent of the population in England[189]. It is hard to know with any degree of certainty how many children are living with parents who are problem drug users as such behaviour is against the law and characterised by denial and secrecy. In England and Wales it is estimated that one per cent of babies are born each year to women with problem drug use, and that two to three per cent of children under the age of 16 years have parents with problem drug use. Not all these children will be living with their parents and only about a third of fathers and two-thirds of mothers with problem drug use are still living with their own children[190]. It is not only their parents whose drug misuse may place the child at risk of suffering significant harm, but problem drug use of other family members such a parent's new partner, siblings, or other individuals within the household.

9.39 To understand how problem drug use can affect parents' capacity to meet the developmental needs of their children is far from simple and it is important not to generalise or make assumptions about the impact on children of parental drug misuse. Consideration needs to be given to both the type of drug used and its effects on the individual; the same drug may affect different people in different ways. The situation is further complicated because the same drug may have very different consequences for the individual depending on their current mental state, experience and/or tolerance of the drug, expectations, personality, the environment in which it is taken, the amount used and the way it is consumed. When parents, or others in the home, stop taking drugs children can be particularly vulnerable. For example, the withdrawal symptoms both physical and psychological may interfere, at least for a while, with parent's capacity to meet the needs of their children. Problematic drug use is likely to continue over time, and although treatment may prolong periods of abstinence or controlled use, for some individuals relapse should be expected. Assumptions about the use or abstinence of drugs should not be based on whether or not parents, or others in the home, are engaged with services for their problem drug use.

---

189 Hoare, J. and Flatley, J. (2008) *Drug Misuse Declared: Finding from the 2007/08 British Crime Survey, England and Wales*. London: Home Office Statistical Bulletin.

190 Advisory Council on the Misuse of Drugs (2003) *Hidden harm: Responding to the needs of children of problem drug users*. London: Home Office.

9.40 Parental problem drug misuse is generally associated with some degree of child neglect and emotional abuse. It can result in parents or carers experiencing difficulty in organising their own and their children's lives, being unable to meet children's needs for safety and basic care, being emotionally unavailable and having difficulty in controlling and disciplining their children[191,192]. Difficulty in organising day to day living means that important events such as birthdays or holidays are disrupted and family rituals and routines such as meal or bed times, which cement family relationships, are difficult to sustain. Problem drug misuse may cause parents to become detached from reality or lose consciousness. When there is no other responsible adult in the home, children are left to fend for themselves. Some problem drug using parents may find it difficult to give priority to the needs of their children. Finding money for drugs may reduce what is available to meet basic needs, or may draw families into criminal activities. Poverty and a need to have easy access to drugs may lead families to live in unsafe communities where children are exposed to harmful anti-social behaviour and environmental dangers such as dirty needles in parks and other public places. At its extreme, parental problem drug misuse can be implicated in the serious injury or death of a child. The study of Serious Case Reviews[193] found that in a third of cases there was a current or past history of parental drug misuse.

9.41 Such negative scenarios are not inevitable. A significant proportion of children who live with parents who are problem drug users will show no long term behavioural or emotional disturbance. Some problem drug users ensure their children are looked after, clean and fed, have all their needs met and that drugs are stored safely. A caring partner, spouse or relative who does not use drugs can provide essential support and continuity of care for the child. Other protective factors include drug treatment, wider family and primary health care services providing support, the child's attendance at nursery or day care, sufficient income and good physical standards in the home. Many parents, however, who are problem drug users often base their social activities around the procurement and use of the drug and are isolated and rejected by their communities. Drug related debts and angry neighbours may result in unplanned moves which disrupt children's schooling, community links and friendships. The safety, health and development of a considerable number of children are adversely affected by parental problem drug

191 Hogan, D. and Higgins L. (2001) When Parents Use Drugs: Key Findings from a Study of Children in the Care of Drug-using Parents. Dublin: The Children's Research Centre.

192 Cleaver, H., Nicholson, D., Tarr, S. and Cleaver, D. (2007) *Child Protection, Domestic Violence and Parental Substance Misuse: Family Experiences and Effective Practice*. London: Jessica Kingsley Publishers.

193 Brandon, M., Bailey, S., Belderson, P., Gardner, R., Sidebottom, P., Dodsworth, J., Warren, C. and Black, J. (2009) *Understanding Serious Case Reviews and their Impact: A Biennial Analysis of Serious Case Reviews 2005-7*. London: Department for Children Schools and Families.

misuse and would benefit from services to meet the needs of both children and parents.

9.42 The impact of parental problem drug misuse will depend on the child's age and stage of development as well as this or her personality and ability to cope. Drug use while pregnant may endanger the unborn child depending on the pharmacological make-up of the drug, the gestation of pregnancy and the route/amount/duration of drug use. Structural damage to the foetus is most likely during 4-12 weeks of gestation; drugs taken later can affect growth or cause intoxication or abstinence syndromes[194]. However, gauging the impact of maternal drug use on the unborn child is complicated when mothers take a combination of substances. Some of the problems associated with maternal problem drug misuse can be ameliorated by good ante-natal care. Unfortunately, some pregnant problem drug users do not seek ante-natal care, either because the drugs affect menstruation and leave women uncertain of dates, or because they fear that revealing their drug use to health professionals will result in judgemental attitudes, the involvement of children's social care services and the possible loss of the baby once it is born. For pregnant drug users in general, irrespective of the substance used, especially where poor social conditions prevail, there is an increased risk of low birth weight, premature delivery, perinatal mortality and cot death[195]. While there is general agreement that problem drug use while pregnant can increase the risk of impairment to the unborn child's development, it is also probable that most women who misuse drugs will give birth to healthy children who suffer from no long term effects[196].

9.43 Maternal problem drug misuse can impact on the attachment relationship between mother and child in a number of ways. Babies who need treatment for withdrawal symptoms may become sleepy and unresponsive. Mothers who undergo rapid drug reduction or abstinence may find it difficult to respond appropriately to their new-born baby. Problem drug misuse may also affect the parents' ability to empathise with the baby. Research has shown that many parents who misuse drugs, particularly heroin, are often emotionally unavailable to their children[197]. A consistent lack of warmth and negative responses may result in the infant becoming insecurely attached. Babies and young children who are exposed to dramatic and sometimes frightening parental mood swings may become

194 Julien, R.M. (1995) *A Primer of Drug Action: A Concise, Non-Technical Guide to the Actions, Uses, and Side Effects of Psychoactive Drugs. 7th Edition*. New York: W.H. Freeman and Co.

195 Standing Conference on Drug Misuse (SCODA) (1997) *Working with Children and Families Affected by Parental Substance Misuse.* London: Local Government Association Publications.

196 Powell, J. and Hart, D. (2001) 'Working with Parents who Use Drugs.' In R. Gordon and E. Harran (eds) *Fragile handle with care: protecting babies from harm: Reader.* Leicester: NSPCC.

197 Hogan, D. and Higgins L. (2001) *When Parents Use Drugs: Key Findings from a Study of Children in the Care of Drug-using Parents.* Dublin: The Children's Research Centre.

unnaturally vigilant as they try to alter their behaviour according to their parent's state of mind. Serious drug dependency may result in parents placing their own needs before the safety and welfare of their children. For example, young children may be left alone at home, or in the care of unsuitable and unsafe people, while the parent prioritises the acquisition of drugs.

9.44 Parental problem drug misuse also affects children during middle childhood. Research suggests that children's education and performance in school may suffer because parental problems dominate the child's thoughts and can affect concentration[198]. Some children feel responsible for their parent's actions, believing they are to blame for their parent's drug taking. This can lead to feelings of inadequacy and guilt when their actions fail to make any impact on their parent's use of drugs. Parental problem drug misuse may have very negative effects on the parent/child relationship. The need for drugs is paramount and children may believe that they take second place in their parent's lives, leaving them with feelings of anger, betrayal and worthlessness. Children may also have to grow up too quickly, as parental problem drug use may result in some children having to assume adult responsibilities. Children may be left to take care of themselves for much of the time, which can lead to school work being neglected, erratic school attendance, curtailment of friendships, and a general loss of childhood. Parental problem drug use is associated with higher levels of aggressive, noncompliant, disruptive, destructive and antisocial behaviours in children[199]. For some children school and friendships offer respite and a safe haven from a troubled home situation. Other protective factors for this age group include: the presence in the home of an alternative, caring adult who does not misuse drugs, a supportive older sibling and/or members of the wider family, regular school attendance, vigilant and sympathetic teachers, learning different ways of coping and developing the confidence to know what to do when parents are incapacitated.

9.45 As children grow up parental problem drug use affects them in different ways. Adolescence ushers in great physical changes. Parental problem drug misuse may mean parents are unaware of children's worries over their changing body and fail to provide support and advice. Children's health may be affected because parental problem drug use is associated with an increased risk during adolescence, of children experimenting with drugs. Some young people learn to mirror their parents coping strategies and come to depend on drugs to deal with difficult situations and negative feelings[200]. The relationship, however is complex and most

198 Cleaver, H., Unell, I. and Aldgate, A. (2010) *Children's Needs – Parenting Capacity: The impact of parental mental illness, learning disability, problem alcohol and drug use, and domestic violence on children's safety and development. 2nd Edition*. London: The Stationery Office.

199 Barnard, M. (2007) *Drug Addiction and Families.* London: Jessica Kingsley Publishers.

200 Covell, K. and Howe, R.B. (2009) *Children, families and violence: Challenges for children's rights*. London: Jessica Kingsley Publishers.

children of parents with drug problems do not themselves become problem drug users. The likelihood that children's education is affected continues into adolescence as young people take on greater responsibility for looking after the home and assuming the care of a parent and younger siblings. Nonetheless, the majority of adolescent children whose parents are problem drug users attend school regularly. When parents are unable to look after adolescent children adequately, the normal pace of emotional maturity can be accelerated and for some the relationship between parent and child is reversed. Problem drug use can result in parents continuing to put their own needs above those of their adolescent children, leading to feelings of worthlessness and anger. To deal with these emotions young people may resort to self harm, illicit drug use, spending long periods outside the home, or leaving home altogether.

9.46 Parental problem drug use is a feature in the backgrounds of many young homeless people. Loneliness and isolation are not the experience of all adolescents whose parents misuse drugs. Friendships are valued highly and many teenagers of parents with drug problems gain solace and support from friends, regardless of whether they are able to discuss family problems. Sadly for some, unplanned moves, often as a result of drug related issues, mean adolescents experience school changes, lose ties with their community and perhaps most mourned, lose the support and love of close friends. The key factors that support young people living with parental problem drug use include practical and domestic help, a trusted mentor with whom the adolescent can discuss sensitive issues, a mutual friend, and the ability to separate safely, either psychologically or physically, from stressful situations.

Parental problem alcohol use

9.47 The Government's strategy on alcohol reduction defines harmful drinking as:

'Drinking at levels that lead to significant harm to physical and mental health and at levels that may be causing substantial harm to others... Women who regularly drink over 6 units a day (or over 35 units a week) and men who regularly drink over 8 units a day (or 50 units a week) are at highest risk of such alcohol-related harm'[201].

9.48 Findings from the *General Lifestyle Survey 2008* suggest that 7% of men and 4% of women regularly drink at higher-risk levels: rates which have fallen slightly over the past few years. In addition to regular higher-risk drinking, problems can also result from binge drinking or, for example, drinking before driving. Nearly a fifth of men and 14% of women are drinking more than twice the lower-risk limit at least one day per week, a figure that is used as a proxy for 'binge drinking' at a population

201 Department of Health, Home Office, Department for Education and Skills and Department for Culture, Media and Sport (2007) *Safe. Sensible. Social. The next steps in the National Alcohol Strategy*. London: Department of Health and Home Office. Page 3.

level[202]. It is estimated that up to 1.3 million children are affected by parental alcohol problems in England (Strategy Unit 2004). An analysis of calls received by ChildLine[203] shows that the majority (57%) of callers identified their father or father figure as the problem drinker, a third their mother or mother figure and 7% indicated both parents had a drink problem.

9.49 The impact of excessive alcohol consumption on parents' capacity to look after their children will depend on their current mental state and personality, their experience and tolerance of alcohol and the amount of alcohol consumed. For example, parenting may be affected because excessive drinking can affect concentration, induce sleep or coma, or reduce psychomotor co-ordination. In addition inhibitions may be lost, which can result in diminished self control and violence.

9.50 Parental problem drinking can be associated with violence within the family and the physical abuse of children, but who has the alcohol problem is relevant. Alcohol misuse by a father or father figure can be related to violence and the physical abuse of children, while mothers with an alcohol problem are more likely to neglect their children[204]. Children are most at risk of suffering significant harm when alcohol misuse is associated with violence. If parents with a chronic drink problem stop drinking, the physical reactions they experience may also affect their capacity to meet the children's needs. As noted in relation to chronic drug misuse, severe and chronic alcohol problems are likely to continue over time and, although treatment may result in abstinence, relapse is possible. The adverse effects of parental alcohol misuse on children are less likely when not associated with violence, family discord, or the disorganisation of the family's day to day living. Particularly important is the presence of a parent or family member who does not have an alcohol problem and is able to respond to the child's developmental needs.

9.51 Many of the problems associated with problem alcohol use during pregnancy could be ameliorated to some extent by good ante-natal care. However, pregnant women with alcohol problems may not attend ante-natal care until late in pregnancy because they fear professionals will judge them. The effect of drinking on the developing foetus is related to the amount and pattern of alcohol consumed by the mother, and the stage of gestation. The foetus is most vulnerable to damage during the first three months but is at risk throughout pregnancy. Drinking during pregnancy, particularly in the first three months, is associated with an increased rate of miscarriage. Heavy drinking can cause Fetal Alcohol Syndrome (FAS), whose features include growth deficiency for height and weight, a distinct pattern of facial

202 General Lifestyle Survey 2008, *Smoking and Drinking among adults 2008*. ONS: 2010.

203 ChildLine (1997) *Beyond the limit: children who live with parental alcohol misuse*. London: ChildLine.

204 Cleaver, H., Unell, I. and Aldgate, A. (2010) *Children's Needs – Parenting Capacity: The impact of parental mental illness, learning disability, problem alcohol and drug use, and domestic violence on children's safety and development. 2nd Edition*. London: The Stationery Office.

features and physical characteristics and central nervous system dysfunction. A syndrome that does not show the full characteristic features of FAS, Fetal Alcohol Spectrum Disorder, has been reported, and may develop at lower levels of drinking than is reported for FAS. The Chief Medical Officer and NICE both advise pregnant women or women trying to conceive to avoid drinking alcohol. If they choose to drink, to minimise the risk to the baby, they should not drink more than one to two units of alcohol once or twice a week and should not get drunk. The NICE guidelines emphasise the importance of avoiding alcohol especially during the first three months of pregnancy as this is the key time for organ and nervous system development[205]. It is generally accepted that heavy alcohol consumption during pregnancy increases the risk of damage to the foetus. Most mothers with alcohol problems, however do give birth to healthy babies. Only approximately 4% of pregnant women who drink heavily give birth to a baby with Fetal Alcohol Spectrum Disorder[206].

9.52 Once born, babies may be likely to suffer significant harm. When alcohol problems result in parents being pre-occupied with their own feelings and emotions they may fail to notice or respond appropriately to their baby. Chronic alcohol problems may limit the mother's capacity to engage with and stimulate her baby. A consistent lack of warmth can result in the infant becoming insecurely attached. Supervision is essential to keep the more mobile infant safe from harm, but harmful drinking can affect parents' concentration and lead to a lack of oversight. Chronic drinking may also mean parents fail to recognise when their baby or infant is unwell, or delay seeking medical help for minor injuries if these have resulted from a lack of supervision. The infant's health may also be affected because high levels of alcohol consumption can depress appetite, and parents may fail to respond to their child's need for food. Research suggests parental problem drinking may also impact on the young child's cognitive development. Babies and infants are more likely to be protected from significant harm when one parent does not have an alcohol problem and is able to respond to the emotional and cognitive needs of the child, there is sufficient income and good physical standards in the home and the parent who is drinking at harmful levels acknowledges their problem and receives treatment[207].

9.53 Parental alcohol problems continue to affect the health and development of children during middle childhood. For example, children's health may be

205 National Institute for Health and Clinical Excellence (2008) *Updated NICE guideline published on care and support that women should receive during pregnancy*. www.nice.org.uk/media/E5D/8B/2008022AntenatalCare.pdf

206 Abel, E.L. (1998) 'Fetal Alcohol Syndrome: The American Paradox.' *Alcohol and Alcoholism 33*, 3, 195-201.

207 Cleaver, H., Unell, I. and Aldgate, A. (2010) *Children's Needs – Parenting Capacity: The impact of parental mental illness, learning disability, problem alcohol and drug use, and domestic violence on children's safety and development. 2nd Edition*. London: The Stationery Office.

endangered because, although alcohol consumption is not common during this period of childhood, maternal drinking increases the likelihood that children aged 10 years will start drinking[208]. Learning may also be affected. Children of parents with chronic alcohol problems are more likely to experience reading problems, poor concentration and low academic performance[209]. When parents are intoxicated they may not be capable of encouraging the child to learn, or of providing sufficient support with schooling. Alcohol can make parents behave in inconsistent and unexpected ways, loving and caring at one moment and rejecting and cold at another. This can leave children feeling betrayed, let down, angry, and uncertain that they are loved. Middle year children tend to feel guilty and blame themselves for their parents' drinking; emotions which are compounded when parents deny the problem. A further possible consequence of parental problem drinking is that children may grow up too quickly, having to look after themselves, younger siblings and their alcoholic parent. It should not be assumed that all children in middle childhood who live with a parent with alcohol problems experience emotional and behavioural difficulties. Older siblings and close relatives can provide children with much needed emotional and practical support. Unfortunately, wider family and friends are often unaware of the family difficulties as a fear of stigma and ridicule may keep all family members silent. There is considerable evidence to suggest that the combination of parental chronic drinking with domestic violence causes a more detrimental impact on children than parental alcohol misuse in isolation[210].

9.54 To ensure children understand the physical changes that result from puberty and how to cope safely with new relationships, they need the support of their parents or carers. When alcohol problems dominate parents' lives children may be left to deal with these issues alone. Chronic alcohol problems may also result in parents failing to provide adolescents with adequate supervision. Research suggests youngsters aged 11-12 years are more likely to use alcohol, cannabis and tobacco if their parents have an alcohol problem[211]. Young people who start drinking at an early age are at greater risk of poor health and being involved in accidents and accidental injury. The relationship between parental problem drinking and young people's drinking patterns is complex, because observing the devastating effect alcohol has

208 Macleod, J., Hickman, M., Bowen, E., Alati, R., Tilling, K. and Davey Smith, G. (2008) 'Parental drug use, early adversities, later childhood problems and children's use of tobacco and alcohol at age 10: birth cohort study.' *Addiction 103,* 1731-43.

209 Cleaver, H., Nicholson, D., Tarr, S. and Cleaver, D. (2007) *Child Protection, Domestic Violence and Parental Substance Misuse: Family Experiences and Effective Practice*. London: Jessica Kingsley Publishers.

210 Cleaver, H., Unell, I. and Aldgate, A. (2010) *Children's Needs – Parenting Capacity: The impact of parental mental illness, learning disability, problem alcohol and drug use, and domestic violence on children's safety and development. 2nd Edition.* London: The Stationery Office.

211 Li, C., Pentz, A. and Chou, C-P. (2002) 'Parental substance use as a modifier of adolescent substance use risk.' *Addiction 97*, 1537-50.

on their parents' lives may act as a strong deterrent[212]. Young people's education may continue to be affected by their parents' alcohol problems and they may find themselves facing the stress of examinations with little or no support. Education may also be interrupted because teenagers feel compelled to stay at home to look after their parent or younger siblings. A lack of educational attainment has long term effects on young people's life chances. However, generalisations should not be made. For some young people school offers an escape from the problems at home and an opportunity to build a different life from that of their parents. Relationships between teenagers and their parents can also be affected. Chronic alcohol problems may result in parents putting their own needs above those of their children, leaving teenagers feeling let down, angry and worthless. Teenagers may experience physical neglect when drinking takes precedence and there is not sufficient money for household essentials and clothes. Such neglect may jeopardise friendships or lead to bullying. To keep up appearances some young people may resort to stealing or other illegitimate ways of obtaining money to keep up appearances. Others may seek to escape the difficulties within the home by withdrawing into themselves, using alcohol or drugs, or leaving home altogether[213]. Many young people who leave home will experience homelessness which is associated with poorer mental and physical health and an increased likelihood of substance misuse[214].

9.55 It is important not to assume that all young people will have problems just because they grow up living with a parent who has alcohol problems. The majority outgrow their childhood problems[215]. Research suggests that the following factors can support young people: sufficient income and good physical standard in the home, regular medical and dental checks, a trusted adult, a mutual friend, supportive and harmonious family environment, and regular attendance at school, work-based training or a job[216].

Parents with a learning disability

9.56 The cause of learning disabilities can have its roots in genetic factors, infection before birth, brain injury at birth, brain infections or brain damage after birth. A learning disability may be mild, moderate, severe or profound, but it is a life-long

212 Velleman, R. and Orford, J. (2001) *Risk and Resilience: Adults who were the children of problem drinkers*. Amsterdam: Harwood Academic Publishers.

213 Velleman, R. and Orford, J. (2001) *Risk and Resilience: Adults who were the children of problem drinkers*. Amsterdam: Harwood Academic Publishers.

214 Quilgars, D., Johnsen, S. and Pleace, N. (2008) *Youth homelessness in the UK. A decade of progress?* York: Joseph Rowntree Foundation.

215 Velleman, R. and Orford, J. (2001) *Risk and Resilience: Adults who were the children of problem drinkers*. Amsterdam: Harwood Academic Publishers.

216 Cleaver, H., Unell, I. and Aldgate, A. (2010) *Children's Needs – Parenting Capacity: The impact of parental mental illness, learning disability, problem alcohol and drug use, and domestic violence on children's safety and development. 2nd Edition*. London: The Stationery Office.

condition. Traditionally, scores on standardised intelligence tests have been used to define learning disability. However, difficulties arise over how to classify those with borderline IQs (70 to 85), and individuals who exhibit different ability levels across the components of IQ tests. The Department of Health's definition of learning disability encompasses people with a broad range of disabilities. *'Learning disability includes the presence of:*

- *a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence); with*
- *a reduced ability to cope independently (impaired social functioning);*
- *which started before adulthood, with a lasting effect on development'*[217].

9.57 The most recent research estimates that there are 985,000 people in England with a learning disability, equivalent to an overall prevalence rate of 2% of the adult population[218]. Estimates of the number of adults with learning disabilities who are parents vary widely from 23,000 to 250,000[219].

9.58 It is important not to generalise or make assumptions about the parenting capacity of parents with learning disabilities. Parental learning disability is not correlated with child abuse or wilful neglect, although there is evidence that children may suffer neglect from omission where parents are not adequately supported or where there was no early intervention. In most cases where physical or sexual abuse occurs it is the mother's male partner who is responsible[220]. A study of Serious Case Reviews found that in 15% of cases parents had a learning disability[221].

9.59 Parents with learning disabilities will need support to develop the understanding, resources, skills and experience to meet the needs of their children. Such support is particularly important when parents experience additional stressors such as having a disabled child, domestic violence, poor physical and mental health, substance misuse, social isolation, poor housing, poverty and a history of growing up in care. It is these additional stressors when combined with a learning disability that are most likely to lead to concerns about the care and safety of a child. A study of children

---

217 Cm 5086 (2001) *Valuing People: A New Strategy for Learning Disability for the 21st Century*. London: The Stationery Office. Cm 5086 2001, p.14, paragraph 1.5.

218 Emerson E. and Hatton, C. (2008) *People with Learning Disabilities in England*. Lancaster: Centre for Disability Research.

219 Department of Health and Department for Education and Skills (2007) *Good practice guidance on working with parents with a learning disability*. London: Department of Health.

220 Booth, T. and Booth, W. (2002) 'Men in the Lives of Mothers with Intellectual Disabilities'. *Journal of Applied Research in Intellectual Disabilities 15*, 187-199.

221 Brandon, M., Bailey, S., Belderson, P., Gardner, R., Sidebottom, P., Dodsworth, J., Warren, C. and Black, J. (2009) *Understanding Serious Case Reviews and their Impact: A Biennial Analysis of Serious Case Reviews 2005-7*. London: Department for Children Schools and Families.

living with learning disabled parents who had been referred to local authority child's social care services highlighted the need for collaborative working between children's and adults' services and support for the family that lasts until the children reach adulthood[222]. There are many examples of positive practice in supporting parents with learning disabilities[223].

9.60 Parental learning disability may impact on the unborn child because if affects parents in their decision-making and preparation for the birth. Many women with learning disabilities are poorly informed about contraception and the significance of changes in their menstrual pattern and, as a result, may fail initially to recognize their pregnancy. The quality of the woman's ante-natal care is often jeopardized by late presentation and poor attendance. When women with learning disabilities do attend antenatal care they may experience difficulty in understanding and putting into practice the information and advice they receive.

9.61 For new born babies to thrive they need love, adequate nutrition, sleep, warmth, and to be kept clean. Mothers with learning disabilities may not know what is appropriate food for the baby and developing infant and experience difficulty in establishing a beneficial routine. Health checks may be missed and when the baby is unwell a mother with learning disabilities may not recognise the seriousness of the illness. As the infant develops and becomes more mobile, parents with learning disabilities may not realise the importance of supervising bath times and ensuring the infant is protected from potential dangers within the home. The ongoing support and advice from their wider family and health workers will be essential to ensure parents adapt to their babies changing needs. The infant's cognitive development may be delayed due to an inherited learning disability. However, the environment can still make a difference; children brought up in a warm and stimulating environment will have better outcomes than those with inherited learning disabilities that are not[224]. Mothers with learning disabilities may experience difficulty in engaging with and providing sufficient stimulation for the infant's development and learning. For example, a learning disability may curtail parents' ability to read simple stories to their children and result in a restricted repertoire of nursery rhymes and other songs. Finally, babies and infants may be left with unsafe

222 Cleaver, H. and Nicholson, D. (2007) *Parental Learning Disability and Children's Needs: Family Experiences and Effective Practice*. London: Jessica Kingsley Publishers.

223 Working Together with Parents Network (2009), *Supporting parents with learning disabilities and difficulties: stories of positive practice* Norah Fry Research Centre.; DH/DCSF *Joint Good Practice Guidance on Supporting Parents with a Learning Disability*. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_075119; *SCIE Knowledge Review on disabled parents and parents with additional support needs*. www.scie.org.uk/publications/knowledgereviews/kr11.pdf.

224 Cleaver, H., Unell, I. and Aldgate, A. (2010) *Children's Needs – Parenting Capacity: The impact of parental mental illness, learning disability, problem alcohol and drug use, and domestic violence on children's safety and development. 2nd Edition*. London: The Stationery Office.

adults because parents fail to recognise the threat they pose, or lack the self confidence to prevent them having access to the child. Babies and young children can be supported by the presence of a non-abusive, caring adult, other responsible adults such as grandparents involved in the care of the child, on-going support for the parent, stable home, adequate finances, and harmonious family relationships[225].

9.62 The impact of parental learning disability on children becomes more evident during middle childhood[226]. Children's health may suffer because of a lack of hygiene and a poor diet. Health problems may not be recognised or adequately dealt with, for example dental and doctor's appointments may be missed. Learning may also be affected. Parents with literacy and numeracy problems will have difficulty in helping with school work and encouraging learning. Children's school attendance may be erratic or frequently late. Parents' own poor school experiences may mean they are reluctant to attend school events, and they may experience difficulty in understanding and putting into practice the advice teachers give them. A learning disability may affect parents' capacity to set boundaries and exert authority as their children reach middle childhood; a situation that can be exacerbated if the child is more able than their parent. Children's self image and self esteem may be affected if parents do not understand the importance of recognising the individuality of their children. Parental learning disabilities may also affect children's relationships within the family and with their peers. Inconsistent parenting can cause children to become anxious and uncertain of their parents' affection; emotions which will be exacerbated if parents fail to protect their children from childhood abuse. The consequences of abuse and neglect, particularly in relation to hygiene, low self esteem, and poor control over emotions and behaviour, may result in children being rejected and bullied by their peers. Finally, growing up with parents with learning disability may mean that an able child assumes a major caring role within the family, and as a consequence loses out on his or her own childhood. Positive outcomes for middle year children are associated with the provision of emotional and practical support by relatives, particularly grandparents, regular attendance at school, empathic and vigilant teachers, sufficient income, good physical standards in the home, and belonging to organised out of school activities[227].

9.63 Teenagers of parents with learning disabilities may be left to cope alone with the physical and emotional changes that result from puberty. Parents themselves do not fully understand the significance of puberty and they may fail to educate,

---

225 Cleaver, H., Unell, I. and Aldgate, A. (2010) *Children's Needs – Parenting Capacity: The impact of parental mental illness, learning disability, problem alcohol and drug use, and domestic violence on children's safety and development. 2nd Edition.* London: The Stationery Office.

226 Cleaver, H. and Nicholson, D. (2007) *Parental Learning Disability and Children's Needs: Family Experiences and Effective Practice*. London: Jessica Kingsley Publishers.

227 Cleaver, H. and Nicholson, D. (2007) *Parental Learning Disability and Children's Needs: Family Experiences and Effective Practice*. London: Jessica Kingsley Publishers.

support or protect their children. The problems are compounded when parents need to care for an adolescent child with profound learning and physical disabilities. Physical and emotional neglect, low self esteem and inadequate supervision increases the likelihood that young people will engage in risky behaviour, such as drinking and drug taking, self harming, and early sexual relationships. When children are more intellectually able than their parents, acting effectively and setting boundaries as they reach adolescence becomes more difficult[228]. The likelihood that education will suffer continues into adolescence. Learning disabilities can result in parents not attending meetings and other school events and not having the capacity to support teenagers through the stress of examinations. Research suggests that many children of parents with learning disabilities experience school related problems such as being suspended for aggressive behaviour, truancy, frequent punishment, being bullied and having few friends[229]. Teenagers who are more able than their parents are increasingly likely to take on the parenting role, becoming responsible for housework, cooking, correspondence, dealing with authority figures, and the general care of their parents and younger siblings. When parents become increasingly dependent on their teenage children it may lead both parties to feel resentful and angry. For many teenagers peer friendships are a source of great support, but low self esteem and behavioural and emotional problems can make it more difficult for teenagers to make friends. Young people whose parents have a learning disability will benefit from factual information about sex and contraception, a trusted adult or peer with whom they can discuss sensitive issues, a good friend, regular attendance at school, training or work, practical help in the home, and access to a young carers projects.

9.64 To support families where a parent has a learning disability a specialist assessment will often be needed and is recommended[230]. Where specialist assessments have not been carried out and/or learning disability support services have not been involved, evidence from inspections has shown that crucial decisions could be made on inadequate information[231].

9.65 Adult learning disability services, and community nurses, can provide valuable input to core assessments and there are also validated assessment tools available[232].

---

228 James, H. (2004) 'Promoting Effective Working with Parents with Learning Disabilities.' *Child Abuse Review 13*, 1, 31-41.

229 Cleaver, H., Unell, I. and Aldgate, A. (2010) *Children's Needs – Parenting Capacity: The impact of parental mental illness, learning disability, problem alcohol and drug use, and domestic violence on children's safety and development. 2nd Edition*. London: The Stationery Office.

230 Department of Health, Department for Education and Employment, Home Office (2000) *Framework for the Assessment of children in Need and their Families*. London: The Stationery Office. Paragraph 6.18-6.21.

231 Social Services Inspectorate (2000) *A Jigsaw of Services: Supporting disabled adults in their parenting role*. London: Department of Health. Paragraph 1.29.

232 McGaw, S. and Newman, T. (2005) *What works for parents with learning disabilities*. Essex: Barnardo's.

However, most parents with learning disabilities do not meet eligibility criteria for adult services and a lack of co-operation between children's and adults' services can create great difficulties.

9.66 A comparative study of methods of supporting parents with learning disabilities found that group education combined with home based support, increases parenting capacity[233]. In some areas, services provide accessible information, advocacy, peer support, multi-agency and multi-disciplinary assessments and on-going home based and other support. This 'parenting with support' appears to yield good results for both parents and children[234].

233 McGaw, S., Ball, K. and Clark, A. (2002) 'The effect of group intervention on the relationships of parents with intellectual disabilities'. *Journal of Applied Research in Intellectual Disabilities 15*, 4, 354-366.

234 Tarleton, B., Ward, L. and Howarth, J. (2006) *Finding the right support? A review of issues and positive practice to support parents with learning difficulties and their children.* London: The Baring Foundation.

Chapter 10 – Implementing the principles on working with children and their families

Introduction

10.1 The general principles set out in Chapter 5 draw on findings from research. They underpin work with children and their families to safeguard and promote the welfare of children[235]. This chapter sets out in more detail specific aspects of working with children and their families.

Family group conferences

10.2 A family group conference (FGC) is a decision making and planning process whereby the wider family group makes plans and decisions for children and young people who have been identified either by the family or by service providers as being in need of a plan that will safeguard and promote their welfare. FGCs do not replace or remove the need for child protection conferences, which should always be held when the relevant criteria are met. FGCs may be valuable, for example:

- for children in need, in a range of circumstances where a plan is required for the child's future welfare;
- where section 47 enquiries do not substantiate concerns about significant harm, but where support and services are required; and
- where section 47 enquiries progress to a child protection conference, the conference may agree that an FGC is an appropriate vehicle for the core group to use to develop the outline child protection plan into a fully worked-up plan.

10.3 It is essential that all parties are provided with clear and accurate information, which will make effective planning possible. The family is the primary planning group in the process. Family members need to be able to understand what the issues are from the perspective of the professionals. The family and involved professionals should be clear about:

- what the professional findings are from any core assessment of the child and family;

235 See also paragraph 2.18 in *Statutory guidance on making arrangements to safeguard and promote the welfare of children under section 11 of the Children Act 2004* (2007) London: HM Government.

- what the family understands about their current situation;
- what decisions are required;
- what decisions have already been taken;
- the family's scope for decision-making, and whether there are any issues/ decisions that are not negotiable; and
- what resources are, or might be, available to implement any plan. Within this framework, agencies and professionals should agree to support the plan if it does not place the child at risk of suffering significant harm, and if the resources requested can be provided.

10.4 Where there are plans to use FGCs in situations where there are concerns about possible harm to a child, they should be developed and implemented under the auspices of the Local Safeguarding Children Board (LSCB). This work should involve all relevant organisations and individuals, and ensure that their use is applicable to other relevant LSCB policies and procedures. Inter-agency training is necessary to build the relevant skills required to work with children and families in this way, and to promote confidence in, and develop a shared understanding of, the process.

Support, advice and advocacy to children and families

10.5 Children and families may be supported through their involvement in safeguarding processes by advice and advocacy services, and they should always be informed of services that exist locally and nationally. Independent advocates provide independent and confidential information, advice, representation and support, and can play a vital role in ensuring children have appropriate information and support to communicate their views in formal settings, such as child protection conferences and court proceedings.

10.6 Where children and families are involved as witnesses in criminal proceedings, the police, witness support services and other services, such as those provided by Victim Support and Youth Offending Team work with young victims of crime, can do a great deal to explain the process, make it feel less daunting, and ensure that children are prepared for and supported in the court process. The practice guidance *Provision of Therapy for Child Witnesses prior to a Criminal Trial* (2001)[236] makes it clear that the best interests of a child are paramount when deciding whether, and in what form, therapeutic help is given to child witnesses. Information about the Criminal Injuries Compensation Scheme should also be provided in relevant cases.

236 www.cps.gov.uk/publications/prosecution/therapychild.html

Communication and information

10.7 The local authority has a responsibility to make sure children and adults have all the information they require to help them understand the processes that are followed when there are concerns about a child's welfare. Information should be clear and accessible and available in the family's preferred language.

10.8 Family members or friends should not be used as interpreters, since the majority of domestic and child abuse is perpetrated by family members or adults known to the child. Children should not be used as interpreters.

Race, ethnicity and culture

10.9 Children from all cultures are subject to abuse and neglect. All children have a right to grow up safe from harm. In order to make sensitive and informed professional judgements about a child's needs, and parents' capacity to respond to their child's needs, it is important that professionals are sensitive to differing family patterns and lifestyles and to child-rearing patterns that vary across different racial, ethnic and cultural groups. **At the same time they must be clear that child abuse cannot be condoned for religious or cultural reasons**.

10.10 Professionals should also be aware of the broader social factors that serve to discriminate against black and minority ethnic people. Working in a multi-racial and multicultural society requires professionals and organisations to be committed to equality in meeting the needs of all children and families and to understand the effects of racial harassment, racial discrimination and institutional racism, as well as cultural misunderstanding or misinterpretation.

10.11 The assessment process should maintain a focus on the needs of the individual child. It should always include consideration of the way religious beliefs and cultural traditions in different racial, ethnic and cultural groups influence their values, attitudes and behaviour and the way in which family and community life is structured and organised. Cultural and religious factors should not be regarded as acceptable explanations for child abuse or neglect and are not acceptable grounds for inaction when there are concerns that a child is or may be suffering or likely to suffer harm. Professionals should be aware of, and work with, the strengths and support systems available within families, ethnic groups and communities, which can be built on to help safeguard children and promote their welfare.

10.12 Professionals should guard against myths and stereotypes – both positive and negative – of black and minority ethnic families. Anxiety about being accused of racist practice should not prevent the necessary action being taken to safeguard and promote a child's welfare. Careful assessment – based on evidence – of a child's

needs, and a family's strengths and difficulties, understood in the context of the wider social environment, will help to avoid any distorting effect of these influences on professional judgements.

10.13 All children, whatever their religious or cultural background, must receive the same care and safeguards with regard to abuse and neglect.

Children in 'Families at risk' having very poor outcomes

10.14 'Families at risk' is a shorthand term for families whose members experience, or are at risk of, multiple and complex problems – such as worklessness, poor mental health or substance misuse, offending behaviour by adults or children – which frequently lead to very poor outcomes for children, young people and adults within the families. The safety and welfare of children living within these families are more likely to be a cause for concern than those from the population as a whole.

10.15 The term 'families at risk' was first was adopted following the Families at Risk Review undertaken by the Cabinet Office's Social Exclusion Taskforce with the Department for Children's Schools and Families[237].

10.16 The review found that families at risk, because of the multiple difficulties they face, have a significant likelihood of facing a crisis situation without preventative support. Problems experienced by family members, could include combinations of the following factors:

- poverty, debt, inactivity or worklessness and low aspirations;
- low parental education and skills;
- domestic violence;
- relationship conflict;
- child neglect and poor parenting and family functioning;
- poor mental health;
- poor physical health and disabilities;
- teenage pregnancy;
- learning disability;
- poor school attendance and attainment;
- involvement in crime, anti-social behaviour, substance misuse; and

237 See www.cabinetoffice.gov.uk/social_exclusion_task_force/families_at_risk.aspx.

- poor housing and homelessness.

10.17 Early action to prevent and address problems for children and young people is critical to stop children living in these circumstances having poor outcomes in life. This means a co-ordinated approach across services to identify and intervene early with families with children who are at the greatest risk of having poor outcomes. An agreed list of warning signs which could prompt concerns being raised about a child's welfare (such as a permanent exclusion from school, repeated truancy or involvement in anti-social behaviour, knife crime, violence, and/or gangs) should identify that whole family intervention may be necessary to safeguard and promote a child's welfare. Targeted parenting and family support is provided through services such as Family Intervention Projects (FIPs) and parenting programmes and services as set out in the local authority's Parenting Strategy.

Think Family practice

10.18 'Think Family' is an approach promoted by Government based on co-ordinating the support provided by adult and children's services to a single family in order to secure better outcomes for the children through the use of targeted, specialised and whole-family approaches to addressing family needs. It is about making sure the different parts of the systems around families work together in a way which intervenes early in family dysfunction. In addition, that they tailor the support provided to individual family members, taking into account the needs of the family as a whole and how addressing family needs can contribute to safeguarding and promoting each child's welfare.

10.19 Services of all types come into contact with families at risk of poor outcomes: universal, targeted and specialist; statutory, voluntary and independent; and children, adult and family. The Social Exclusion Taskforce research showed that whilst families at risk of very poor outcomes are often in contact with a wide range of services, evidence suggests that the support provided is only effectively co-ordinated and persistent when a crisis occurs. This was despite the fact that universal services such as schools, GPs and health visitors had often identified them as highly vulnerable to poor outcomes very early in their involvement.

10.20 Effective interventions for children in families at risk of very poor outcomes depends upon the ability of services and the practitioners already working with family members, to 'assess' and then 'decide' on the most appropriate types of interventions to support and achieve better outcomes for each child whilst at the same time, whenever possible, helping the child's parents and other adult family members if they are experiencing problems which are having an impact on the families ability to function effectively. However, focusing on the full range of needs

within a family should not detract from the over-riding duty to safeguard and promote the welfare of the children within the family.

10.21 'Think Family' practice depends on children's services developing arrangements with local adult services so that the impact of any problems that mothers, fathers and other key carers are experiencing are seen in the context of the welfare of the children for whom they are responsible. Adult services also have a crucial role to play in minimising the risk of parental problems such as domestic violence, learning disability, substance misuse or worklessness affecting children's outcomes.

Effectiveness of parenting and family interventions

10.22 Supporting mothers and fathers and key carers can be a sustainable way of securing better outcomes for children. Research suggests that using evidence-based parenting and family support programmes, for example, through the Parenting Early Intervention Programme, can have lasting effects in improving behaviour even in cases where they are initially reluctant to accept help. Providing help with parenting impacts upon a range of outcomes for children and young people. A meta-analysis of over 40 studies conducted in 2003 showed Family Based Interventions had substantial desirable effects[238]. A review by the National Institute for Clinical Excellence (NICE) highlighted the value of parenting programmes in improving the behaviour of children with conduct disorder[239]. Eleven out of fifteen studies showed statistical long terms effects (between one and ten years). Conduct disorder is one of the main reasons for referrals to Children and Adolescent Mental Health Services (CAMHS) and the estimated cost of a one-year cohort of children with conduct disorders in the UK is £5.2 billion[240].

10.23 Parenting interventions tend to work best when both parents are included in the intervention (or separate partner-support is provided). The ability of workers to engage parents effectively and consistently and to achieve 'buy in' to what is often a demanding and rigorous change management programme, is crucial to the success of any intervention. There is considerable skill, tenacity, determination and tolerance required by parenting practitioners and key workers who will need to identify the appropriate drivers for change in their clients. They need to understand the underlying reasons for the behaviours displayed by families and agencies, be solution focused in their approach and be able to draw on the necessary support themselves to enable them to set and sustain realistic goals.

238 Farrington and Welsch (2007). *Saving children from a life of crime*; Farrington and Welsh (2003). Meta analysis in ANZJC.

239 NICE (2006). Parent – Training/education programmes in the management of children with conduct disorders. In NICE Technology appraisal guidance 102.

240 Friedli and Parsonage (2007). *Mental Health Promotion: Building an Economic Case*. Northern Ireland Association for Mental Health.

Working with fathers

10.24 When working with families it is important to 'Think Fathers' as well, including where the father is himself a young person. A child's father can have a significant, positive impact on the child's outcomes but only where he is causing no harm to the child – for example, research shows that children with highly involved fathers do better at school and are more empathic in the way that they behave. More and more fathers want to be involved within their family and in their children's upbringing even if they are no longer living with the children and their mother. However, many fathers find this difficult and feel they are not recognised or encouraged to get involved, by schools or health services. For example, children's services as a whole can still be very mother-focused and fathers can, often inadvertently, be made to feel unwelcome or uncomfortable when they try to use them. Managers and commissioners should therefore make sure that their services take account of the needs of fathers and actively look for ways to engage them. *The Dad Test* (2009)[241] sets out practical steps organisations can take to remove these barriers to fathers' participation.

Family Intervention Projects

10.25 Joint work with FIPs funded through the local authority 'Think Family' Grant may also be appropriate where the needs of a family are complex and require a high level of face to face contact and family-focused interventions. All local authorities receive funding to set up at least one FIP. The health contribution is key to this and is currently funded centrally to pay for a part-time health professional to work with the FIP team in every local authority. With their systematic contact with families FIPs can help identify earlier, children about whom there are concerns that they are, or may be, suffering or be likely to suffer harm. In these situations, a member of the FIP team should make a referral to children's social care. Family involvement with FIPs does not replace or remove the need for the processes set out in Chapter 5 to be followed. Where a FIP team is involved with a family they should continue to be involved, as appropriate, in any assessments, section 47 enquiries and subsequent work led by children's social care.

10.26 Chief Executives will need to nominate an officer responsible for reporting to the Director of Children's Services (DCS) on the adequacy of safeguarding arrangements between FIPs and children's social care. In addition, the FIP also should have a designated person for safeguarding with clear lines of accountability through their manager to the Head of Quality and Safeguarding in their relevant service and through them to the DCS/Chief Executive for ensuring the implementation of effective practice with regard to safeguarding and promoting the welfare of children.

241 See www.think-fathers.org.

Family Nurse Partnership

10.27 The Family Nurse Partnership is an evidence based, intensive preventive programme for vulnerable, young first time mothers that is being tested across England. The programme is voluntary and family nurses visit from early pregnancy until the child is two years old. The family nurses build close relationships with clients and use the programme methods and materials to improve antenatal health, child health and development and parents' economic self-sufficiency.

10.28 The family nurse works with vulnerable young people and their babies. They play a key role in the prevention and early identification of babies and young people who may have been, or are likely to be, abused or neglected. They will refer a child to children's social care as a 'child in need', when appropriate, and will act on concerns that a child may suffering or likely to suffer significant harm. Family nurses receive weekly supervision and together with the supervisor work closely with named professionals with safeguarding responsibilities.

10.29 Family nurses have close contact with and in depth knowledge of children and families which means they have an important role at all stages of the safeguarding and child protection process. This includes completing common assessments, taking on the lead professional role where appropriate, information sharing, contributing to assessments, and involvement in implementing a child protection plan. Family nurses will make available relevant information to child protection conferences about a child and family, whether or not they are able to attend.

Chapter 11 – Safeguarding and promoting the welfare of children who may be particularly vulnerable

Introduction

11.1 This chapter outlines some groups of children who may be particularly vulnerable. The purpose of this chapter is simply to help inform the procedures in Chapter 5, which sets out the basic framework of action to be taken in **all** circumstances when a parent, professional, or any other person has concerns about the welfare of any child. This chapter cannot provide a comprehensive list of every group of vulnerable children, but highlights some specific groups of particular concern in relation to safeguarding, and some specific issues in relation to promoting their welfare.

Children living away from home

General

11.2 Previous high profile inquiries and reports into abuse of children living away from home have raised awareness of the particular vulnerability of these children. We should not be complacent that such abuse could not occur again. We need to be continually vigilant so that children today do not suffer as others have.

11.3 All settings where children live away from home should provide the same basic safeguards against abuse, founded on an approach which promotes their general welfare, protects them from harm of all kinds and treats them with dignity and respect. The current regulatory system, including the regulations and National Minimum Standards which apply to such settings, has a clear focus on safeguarding children and promoting their welfare and development. All those who work with children should be able to recognise evidence that a child's welfare or development may be being impaired and know how to act on such evidence.

11.4 Local Safeguarding Children Board (LSCB) procedures for safeguarding and promoting the welfare of children should apply in every situation and to all settings, including those where children are living away from home. Individual agencies that provide care for children living away from home should implement clear and unambiguous procedures to respond to potential matters of concern about

children's welfare in line with the relevant legal requirements and LSCB's arrangements. Where children are living away from their home area it is essential that there is clarity about the respective and complementary roles and responsibilities of the local authority and agencies involved. Specifically it is important that the local authority covering the area where the child comes from but is currently not resident understands its continuing responsibilities in relation to safeguarding the child.

Essential safeguards

11.5 There are a number of essential safeguards that should be observed in all settings in which children live away from home, including children in care, private fostering, healthcare, boarding schools (including residential special schools), prisons, young offenders' institutions, secure training centres and secure units, and when children are detained whilst within the immigration system. Detailed guidance and standards are in place for service providers in each of these sectors. Where services are not directly provided essential safeguards should be explicitly addressed in contracts with external providers. These safeguards should ensure that:

- children feel valued and respected and their self-esteem is promoted;
- there is an openness on the part of the institution to the external world and to external scrutiny, including contact with families and the wider community;
- staff and foster carers are trained in all aspects of safeguarding children, alert to children's vulnerabilities and risks of harm and knowledgeable about how to implement safeguarding children procedures;
- children who live away from home are listened to, and their views and concerns responded to;
- children have ready access to a trusted adult outside the institution – for example, a family member, the child's social worker, independent visitor or children's advocate. Children should be made aware of the help they could receive from independent advocacy services, external mentors and ChildLine;
- staff recognise the importance of ascertaining the wishes and feelings of children and understand how individual children communicate by verbal or non-verbal means;
- there are clear procedures for referring safeguarding concerns about a child to the relevant local authority;
- complaints procedures are clear, effective, user-friendly and are readily accessible to children and young people including those with disabilities and those for whom English is not their preferred language. Procedures should

address informal as well as formal complaints. Systems that do not promote open communication about 'minor' complaints will not be responsive to major ones and a pattern of 'minor' complaints may indicate more deeply seated problems in management and culture that needs to be addressed. Records of complaints should be kept by providers of children's services or secure settings – for example, there should be a complaints register in every children's home and secure establishment that records all representations or complaints, the action taken to address them and the outcomes. Children should genuinely be able to raise concerns and make suggestions for changes and improvements which should be taken seriously;

- bullying is effectively countered;
- recruitment and selection procedures are rigorous and create a high threshold of entry to deter abusers;
- there is effective supervision and support that extends to temporary staff and volunteers;
- contractor staff are effectively checked and supervised when on site or in contact with children;
- clear procedures and support systems are in place for dealing with expressions of concern by staff and carers about other staff or carers. Organisations should have a code of conduct instructing staff on their duty to their employer and their professional obligation to raise legitimate concerns about the conduct of colleagues or managers. There should be a guarantee that procedures can be invoked in ways that do not prejudice the 'whistle-blower's' own position and prospects;
- there is respect for diversity and sensitivity to race, culture, religion, gender, sexuality and disability; and
- staff and carers are alert to the risks of harm to children in the external environment from people prepared to exploit the additional vulnerability of children living away from home.

Looked after children

11.6 The full range of safeguards which apply to all looked after children are set out in the relevant regulations, statutory guidance and National Minimum Standards. This section highlights certain issues of particular relevance to safeguarding.

11.7 Local authorities placing children in another local authority area are required to notify the host authority prior to placement.

11.8 As part of their statutory responsibilities for planning children's care, social workers are required to maintain a regular up to date assessment of child's needs, see looked after children in foster care on their own and take appropriate account of the child's wishes and feelings. Evidence of their engagement with the child must be recorded so that the plan for the child's care is kept up to date, with the child being offered the right services to respond to the full range of their needs.

11.9 Independent Reviewing Officers (IROs) are responsible for chairing meetings that must be scheduled at prescribed intervals to review the child's care plan. IROs have specific responsibilities to ensure that the plan has taken the child's wishes and feelings into account and that their care plan remains appropriate in view of the child's needs, including their need to be effectively safeguarded.

11.10 Foster carers should be provided with full information about the foster child and his/her family, including details of the child's previous experiences of harm and/or neglect so that they can provide an appropriate pattern of care for the child, which takes into account the child's needs and those of the carers own children.

11.11 Carers must be properly aware of the whereabouts of the children they look after, their patterns of absence and contacts. Carers should follow the recognised procedure of their agency whenever a child is missing from their home[242]. This involves notifying the placing authority and, where necessary, the police of any unauthorised absence by a child.

11.12 The local authority's duty to undertake section 47 enquiries, when there are concerns about significant harm to a child, applies on the same basis to looked after children as it does to children who live with their own families. Enquiries should consider the safety of any other child living in the household/placement, including foster carers' own children. The local authority in which the child is living has the responsibility to convene a strategy discussion, which should include representatives from the responsible local authority that placed the child. At the strategy discussion it should be decided which local authority should take responsibility for the next steps, which may include a section 47 enquiry. For further details on this see Chapter 5.

Private fostering

11.13 A private fostering arrangement is essentially one that is made privately (i.e. without the involvement of a local authority) for the care of a child under the age of 16, under 18 if disabled, by someone other than a parent or close relative for 28 days or more, in the carer's own home.

242 Fostering Services: National Minimum Standards – 9.8

11.14 Privately fostered children are a diverse and potentially vulnerable group. They include:

- children where arrangements are made due to parental illness or distress or when parents' work or study involves long or anti-social hours;
- young people who stay with friends because they have fallen out with their parents and who may not be in touch with agencies such as education services;
- children staying with families while attending a school away from their home area; and
- children from overseas whose parents do not reside in this country.

11.15 Under the Children Act 1989, private foster carers and those with parental responsibility are required to notify the local authority of their intention to privately foster; or to have a child privately fostered, or where a child is privately fostered in an emergency. Teachers, health and other professionals, such as Youth Offending Team (YOT) workers, should notify the local authority of a private fostering arrangement that comes to their attention where they are not satisfied that the local authority has been, or will be, notified of the arrangement.

11.16 It is the duty of every local authority to satisfy itself that the welfare of children who are privately fostered within its area is being satisfactorily safeguarded and promoted, and to ensure that such advice as appears to be required is given to private foster carers. In order to do so, local authority officers must visit privately fostered children at regular intervals and the minimum visiting requirements are set out in the Children (Private Arrangements for Fostering) Regulations 2005. The local authority officer should visit a child alone unless the officer considers it inappropriate. Local authorities must also arrange for visits to be made to the privately fostered child, the private foster carer, or parent of the child when reasonably requested to do so. Children should be given contact details of the social worker who will be visiting them while they are being privately fostered.

11.17 Local authorities must satisfy themselves as to such matters as the suitability of the private foster carer and the private foster carer's household and accommodation. They have the power to impose requirements on the private foster carer or, if there are serious concerns about an arrangement, to prohibit it.

11.18 The Children Act 1989 creates a number of offences in connection with private fostering, including for failure to notify an arrangement or to comply with any requirement or prohibition imposed by the authority. Certain people are disqualified from being private foster carers.

11.19 Local authorities are required to promote awareness in their area of notification requirements, and to ensure that such advice as appears to be required is given to those concerned with children who are, or are proposed to be, privately fostered. This includes private foster carers (proposed and actual) and parents.

11.20 The Children (Private Arrangements for Fostering) Regulations 2005 require local authorities to satisfy themselves of the suitability of a proposed arrangement before it commences (where advance notice is given).

11.21 The private fostering regulations require local authorities to monitor their compliance with all their duties and functions in relation to private fostering, and place a duty on them to appoint an officer for this purpose.

11.22 In addition, local authorities are inspected against the National Minimum Standards for private fostering.

11.23 The Children Act 2004 and regulations strengthen and enhance the private fostering notification scheme, and provide additional safeguards for privately fostered children. These measures, along with the National Minimum Standards and the role of LSCBs in relation to private fostering, focus local authorities' attention on private fostering and require them to take a more proactive approach to identifying arrangements in their area.

11.24 Private fostering is a key area of child protection. Privately fostered children may be very vulnerable if private fostering arrangements have not been notified to the local authority. Local authorities are expected to improve notification rates and compliance with the existing legislative framework for private fostering to safeguard privately fostered children.

11.25 All professionals working with children have an important role in relation to safeguarding privately fostered children. If they become aware of a private fostering arrangement, and they are not confident that it has been notified to the local authority, they should contact the local authority themselves. LSCBs can play a vital role in helping protect children who are privately fostered, exercising leadership and raising awareness in the community of the requirements and issues around private fostering.

11.26 Children Act 1989 guidance on private fostering, issued in July 2005[243], reflects the new measures on private fostering in the Children Act 2004 and in the regulations.

243 This guidance, along with the National Minimum Standards and guidance for local authorities on promoting awareness within their areas, is available at: www.dcsf.gov.uk/everychildmatters/_download/?id=2596

Children and young people in hospital

11.27 *The National Service Framework for Children, Young People and Maternity Services (NSF), (2004)* sets out standards for children and young people's healthcare. Standard 6, 'Children who are Ill' should be used in conjunction with Standard 7 'Children in Hospital', which was published in 2003 to meet the commitment made in the Government's response to *The Report of the Public Enquiry into Children's Heart Surgery at the Bristol Royal Infirmary 1984-1995: Learning from Bristol to develop hospital services for children and young people*. The Healthcare Commission undertook an improvement review of the NHS implementation of the hospital standard in 2006[244].

11.28 Children and young people should be cared for at home wherever possible providing it is safe and sustainable to do so. When admission to hospital is unavoidable the highest standards of privacy and dignity must be maintained and care should be provided in a location and environment that is safe, healthy, child friendly and suitable to the age and stage of development of the child or young person *(NSF Standard 7, 2003)*. Care should be provided by staff who have been trained and educated in the care of children and young people. Nursing care should be delivered by a ratio of staff supervised by registered children's nurses to ensure safe standards of care. Children should not be cared for in an adult ward; where treatment and care will continue into adulthood arrangements should be in place to plan and facilitate a smooth transition to adult services at a time when the young person is ready to make this change. Where there is no adolescent unit available hospitals should take the additional needs of adolescents into account and provide appropriate facilities. Wherever possible, children and young people should be consulted about where they would prefer to stay in hospital and their views should be taken into account and respected. Hospital admission data should include the age of children so that hospitals can monitor whether they are being given appropriate care in appropriate wards.

11.29 When children are in hospital, this should not in itself jeopardise the health of the child or young person further. The NSF requires hospitals to ensure that their facilities are secure and regularly reviewed. There should be policies relating to breaches of security involving the police and local safeguarding procedures should be followed should there be suspicion of child abuse. The local authority where the hospital is located is responsible for the welfare of children in its hospitals. Primary Care Trusts (PCTs) are responsible for ensuring hospitals commissioned to provide services for their children and young people population have processes in place to protect them including out of area services.

244 www.cqc.org.uk/_db/_documents/children_improving_services_Tagged.pdf

11.30 Additionally, section 85 of the Children Act 1989 requires PCTs to notify the 'Responsible Authority' – i.e. the local authority for the area where the child is ordinarily resident, or where the child is accommodated if this is unclear – when a child has been, or will be, accommodated by the PCT for three months or more for example, in hospital. This is so that the local authority can assess the child's needs and decide whether services are required under the Children Act 1989. Arrangements for this notification process should be included by PCTs in local contracts.

Children in contact with the youth justice system

11.31 In fulfilling their statutory function of reducing offending and reoffending by children and young people, YOTs have dual responsibilities in the area of safeguarding as well as public protection, including protection of other children and young people. It is important that public protection in a youth justice context is seen as integral to wider approaches to working effectively with children and young people.

11.32 These complex responsibilities are discharged both by YOTs' involvement in prevention work, including initiatives such as Safer Schools Partnerships, as well as work with victims of crime. YOTs co-operate with various partner agencies, including the police, Multi-agency Public Protection Agencies (MAPPA) and Crime and Disorder Reduction Partnerships (CDRPs), in initiatives aimed at making communities safer, including projects to reduce gang violence and violent extremism, thus directly contributing to the safeguarding of children and young people from violence in their communities. All partners working in the youth justice system should see *When to share information: best practice guidance for everyone working in the youth justice system*[245]; joint Department of Health, Department for Children, Schools and Families, Youth Justice Board and Prison Service, which includes best practice case studies used to identify when, what, where and how information needs to be shared to ensure improved outcomes for children and young people.

11.33 In order to effectively manage the risk posed by young people in the youth justice system, it is important that managers and practitioners distinguish clearly between risk (likelihood) of reoffending, risk of serious harm to others and risk to the young person either from themselves or others.

11.34 All young people involved with the formal youth justice system are referred to a YOT at the earliest stage and will have a named responsible caseworker. In many cases, this work requires the active engagement of broader children's health and

245 www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084703

family services – specifically, when assessing and addressing the needs of individual children and young people in order to safeguard the child or young person and address the causes of vulnerability as well as improve outcomes.

11.35 Key partner agencies are required to support YOTs in fulfilling these duties as set out under the Crime and Disorder Act 1998. As outlined in the NSF, this includes Children and Adolescent Mental Health Services (CAMHS) services, as well as other generic and specialist health and social care services delivered locally.

Children and young people in custody

11.36 Children and young people sentenced or remanded in custody are among the most vulnerable. Specific consideration to the safeguarding of this particular group is therefore called for and requires ongoing support from children's services and LSCBs in addition to the establishment's day to day duty of care.

11.37 The functions, powers, duties, responsibilities and obligations imposed on local authorities by the Children Act 1989 – in particular, by sections 17 and 47 – do not cease to arise merely because a child is in the secure estate. Such functions, powers, duties and responsibilities operate subject to the necessary requirements of imprisonment. Prisons have a legal obligation to safeguard the wellbeing of children in their care.

11.38 It is important that agreed procedures between the secure establishment and the local authority (in particular the LSCB) with that establishment in its geographical area are in place outlining how to deal with and undertake child in need assessments as well as how to deal with child protection allegations. In discharging these duties, local authority children's social care services should consider seconding social workers to work in secure establishments and establish effective links with a child or young person's home local authority. The home local authority and YOT have continuing responsibilities to children and young people in custody.

11.39 Continuity of services when children and young people transfer into and out of the secure estate is a vital element of good safeguarding practice and good resettlement planning. This includes ensuring that young people have suitable supported accommodation, help with mental health and substance misuse issues and with identifying appropriate education, training or employment.

11.40 Issues of transition to adult services can cause particular problems for children and young people in the youth justice system. The different thresholds for children's and adult services and the complexity of need posed by many young people in the youth justice system, as well as emotional immaturity, can result in a breakdown of services, including accommodation, substance misuse and health services. Standard

4 of the Core Standards in the Children's NSF describes that 'Young people with additional and sometimes complex needs, such as mental health problems or disabilities may find it more difficult to make these transitions successfully and they and their families may require additional support'. High quality transition services should be delivered in a multi-agency context.

11.41 *Healthy Children, Safer Communities: a strategy and action plan to promote the health and well being of those in contact with the youth justice system*[246] incorporates coverage of transition issues as a key element. Children's services transitions and leaving care teams are also key agencies in ensuring successful transition.

11.42 *Healthy Children, Safer Communities* is designed to try to ensure that the health and wellbeing needs of children and young people in contact with the youth justice system are addressed and responded to with appropriate and timely mainstream services wherever possible. In addition it aims to encourage co-ordinated, multi-faceted care tailored to individual needs, continuity of care between the community and the secure estate, and a safe and effective transition to appropriate adult provision. The strategy also responds to the three recommendations for children in Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system (April 2009)[247].

Looked after children and custody

11.43 Where a looked after child who is the subject of a care order, meaning that their responsible authority shares parental responsibility for them, enters a young offender institution (YOI), either on sentence or on remand, the responsible authority has continuing responsibilities as a corporate parent to visit and continue to assess their needs. The responsible authority must make arrangements for regular contact with the looked after child, continue to ensure that reviews of their care plan take place at the prescribed intervals and facilitate ongoing contact with parents and siblings where that is part of the care plan. These responsibilities will mean that the responsible authority must be closely involved in making plans for resettling the child in their community once they are able to be released from custody. For some children this will involve them returning to foster care or other kind of supported placement.

11.44 Where a child under 16 who has previously been accommodated as a result of a voluntary agreement under section 20 of the Children Act enters custody they do not remain a looked after child. However, regulations to be enacted as a result of

246 www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_109771

247 www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_098694

section 15 of the Children and Young Persons Act 2008 will require a responsible local authority to ensure that they appoint a representative to visit all children and young people who have ceased to be accommodated. The representative will be responsible for assessing the child's needs in order to make recommendations about the support they will need whilst detained, and, in particular, the support necessary on release which could include planning for the child to become looked after again.

11.45 Children aged 16+ who were looked after prior to being sentenced may well be 'relevant children' as defined by section 23A of the Children Act 1989[248]. Their responsible authority must appoint a personal adviser and prepare a pathway plan setting out the support that they will provide to prepare the child for the responsibilities of adulthood. The pathway plan must include information about where the child will live on release and the support they will receive to re-establish themselves in their communities with positive plan for their futures, to minimise the possibility of their re-offending.

Abuse by children and young people

Peer abuse

11.46 Children, particularly but not exclusively those living away from home, are also vulnerable to physical, sexual and emotional bullying and abuse by their peers. Such abuse should always be taken as seriously as abuse perpetrated by an adult. Whenever a child may have harmed another, all agencies must be aware of their responsibilities to both children and multi-agency management of both cases must reflect this. Agencies should also be alert to the possibility that a child or young person who has harmed another may well also be a victim. However, the interests of the identified victim must always be the paramount consideration and professionals should also be alert to the fact that there is likely to be a risk to children other than the current victim. A significant proportion of sex offences are committed by teenagers although, on occasion, such offences are committed by younger children. Staff working with children, including carers of children living away from home need clear guidance and training to identify the difference between consenting and abusive, and between appropriate and exploitative peer relationships. Staff should not dismiss some abusive sexual behaviour as 'normal' between young people, and should not develop high thresholds before taking action.

11.47 Work with children and young people who abuse others, including those who sexually abuse/offend, should recognise that such children are likely to have considerable needs themselves, and that they may pose a significant risk of harm to

248 As amended by the Children (Leaving Care) Act 2000

other children. Evidence suggests that children who abuse others may have suffered considerable disruption in their lives, been exposed to violence within the family, may have witnessed or been subject to physical or sexual abuse, have problems in their educational development and may have committed other offences. Such children and young people are likely to be children in need, and some will, in addition, be suffering, or at risk of suffering, significant harm, and may themselves be in need of protection. Children and young people who abuse others should be held responsible for their abusive behaviour, while being identified and responded to in a way that meets their needs as well as protecting others.

11.48 A cross-government service delivery framework for young people who display sexually harmful behaviour is due for publication in early 2010. The purpose of the framework is to deliver a document that sets service development across the pathway from early intervention, through the community, and within custody, ensuring that there are clear plans for this group of children and young people. The framework aims to ensure that services that address health, wellbeing and education needs are delivered equitably to all children and young people, including those who display sexually harmful behaviour, and that services are delivered, based on evidence for what is effective for meeting specific needs.

11.49 The Ofsted survey *Exclusion from school of children from four to seven* (May 2009) highlighted the issue of sexually inappropriate behaviour in very young children as one faced by a small number of schools and early years settings. The survey acknowledged that exclusions from school generally and sexually inappropriate behaviours specifically were extremely rare in children from this age group, but where they did occur they highlighted important underlying issues which schools and early years settings need to be equipped to address.

11.50 Three key principles should guide work with children and young people who abuse others:

- there should be a co-ordinated multi-agency approach including youth justice (where appropriate), children's social care, education (including educational psychology) and health (including child and adolescent mental health) agencies and police;
- the needs of children and young people who abuse others should be considered separately from the needs of their victims; and
- a multi-agency assessment should be carried out in each case, appreciating that these children may have considerable unmet developmental needs, as well as specific needs arising from their behaviour.

11.51 LSCBs and YOTs should ensure that there is a clear operational framework in place within which assessment, decision-making and case-management take place. Neither child welfare nor criminal justice agencies should embark on a course of action that has implications for the others without appropriate consultation.

11.52 In assessing a child or young person who abuses another, relevant considerations include:

- the nature and extent of the abusive behaviours. In respect of sexual abuse, there are sometimes perceived to be difficulties in distinguishing between normal childhood sexual development and experimentation, and sexually inappropriate or aggressive behaviour. Expert professional judgement may be required, within the context of knowledge about normal child sexuality;
- the context of the abusive behaviours;
- the child's development, and family and social circumstances;
- needs for services, specifically focusing on the child's harmful behaviour as well as other significant needs; and
- the risks to self and others, including other children in the household, extended family, school, peer group or wider social network. This risk is likely to be present unless the opportunity for further abuse is ended, the young person has acknowledged the abusive behaviour and accepted responsibility and there is agreement by the young abuser and his/her family to work with relevant agencies to address the problem.

11.53 Decisions for local agencies (including the Crown Prosecution Service where relevant) according to the responsibilities of each include:

- the most appropriate course of action within the youth justice system if the child is above the age of criminal responsibility;
- whether the young person who perpetrated the abuse should be the subject of a child protection conference; and
- what plan of action should be put in place to address the needs of the young abuser, detailing the involvement of all relevant agencies.

11.54 A young abuser should be the subject of a child protection conference if he or she is considered personally to be at risk of continuing significant harm. Where there is no reason to hold a child protection conference there is likely to be a need for a multi-agency approach if the young abuser's needs are complex. Issues regarding suitable educational and accommodation arrangements often require skilled and careful consideration.

11.55 Children with inappropriate sexual or very violent behaviour who are re-entering the community following a custodial sentence or time in secure accommodation, or who move into an area from another local authority, require the multi-agency response (assessment/intervention) initiated at the earliest opportunity. Where a child who has been convicted of sexual offences involving the abuse of other children is released into the community, the MAPPA must be invoked.

Bullying

11.56 Bullying may be defined as deliberately hurtful behaviour, usually repeated over a period of time, where it is difficult for those bullied to defend themselves. It can take many forms, but the three main types are:

- physical (for example, hitting, kicking, theft);
- verbal (for example, racist or homophobic remarks, threats, name-calling); and
- emotional (for example, isolating an individual from the activities and social acceptance of their peer group).

11.57 The damage inflicted by bullying (including bullying via the internet) can frequently be underestimated. It can cause considerable distress to children, to the extent that it affects their health and development or, at the extreme, causes them significant harm (including self-harm). All settings in which children are provided with services or are living away from home should have in place rigorously enforced anti-bullying strategies.

11.58 Since 1999 schools have been under a legal duty to put measures in place to promote good behaviour, respect for others and to prevent all forms of bullying among pupils. In practice schools need to draw up an anti-bullying policy linked to the behaviour policy.

11.59 In cases of sexist, sexual and transphobic bullying schools must always consider whether safeguarding processes need to be followed. This is because of the potential seriousness of violence (including sexual violence) that these forms of bullying characterise through inappropriate sexual behaviour. It is important for schools to consider whether to apply safeguarding procedures both to young people being bullied and to perpetrators. Young people being bullied may need to be protected from the child or young person engaging in bullying behaviour using safeguarding processes. If a young person is engaging in these behaviours this may be an indication that they are acting out the prejudices they see, to fit in. It could

also be an indication that the young person could be experiencing abuse at home and therefore require some form of safeguarding intervention[249].

11.60 The Department for Children, Schools and Families (DCSF) has produced a comprehensive suite of guidance for schools under the title *Safe to Learn: Embedding Anti-bullying Work in Schools*. This includes overarching guidance and specialist materials on cyberbullying, homophobic bullying (launched in 2007) which links to existing guidance on bullying around race, religion and culture (2006)[250]. Materials on bullying, preventing and tackling the cyberbullying of teachers, and bullying related to special educational needs and disabilities were launched in April and May 2008 respectively.

11.61 In addition the *Safe from Bullying* suite of guidance documents on tackling bullying outside of schools was published in April 2009. This includes guidance for practitioners in several target settings, such as children's homes and journeys to and from schools; it also includes a guide for local authorities and a set of training resources for staff.

11.62 New *Guidance for schools on preventing and tackling sexist, sexual and transphobic bullying*[251] was published in December 2009, following the DVD resource pack on bullying related to SEN and disabilities[252] launched in September 2009.

11.63 The DCSF provides support and challenge to local authorities and schools on bullying issues through a universal programme of support provided by the National Strategies and a more targeted programme provided by the Anti-Bullying Alliance. The Anti-Bullying Alliance provides support also to local areas to tackle bullying in their communities. Ofsted has a challenge role with schools in looking at how children and young people are being kept safe from bullying as part of their inspections and canvass views direct from parents and children and young people as part of this process. If weaknesses are identified these will be flagged up in the Ofsted report.

11.64 The LSCB, Children's Trust partners and all organisations involved with providing services to children are required to share information and work together to safeguard and promote the welfare of children and young people who should also be consulted on issues that affect them as individuals and collectively. Children's Trust partners should consider tackling bullying as part of their wider role in

249 For more detailed guidance please see Chapter 2 of the document, 'The law, policy and guidance for schools' and the tackling school bullying guidance at: http://publications.teachernet.gov.uk/default.aspx?PageFunction=productdetails&PageMode=publications&ProductId=DCSF-00668-2007

250 www.teachernet.gov.uk/wholeschool/behaviour/tacklingbullying/racistbullying/

251 www.teachernet.gov.uk/wholeschool/behaviour/tacklingbullying/sexistsexualandtransphobicbullying/

252 www.teachernet.gov.uk/wholeschool/behaviour/tacklingbullying/sendisab/

safeguarding children and young people. The role of Government Offices is to support and challenge on how local authorities and their partners are delivering improved outcomes in respect of keeping children and young people safe from bullying.

Children whose behaviour indicates a lack of parental control

11.65 When children are brought to the attention of the police or the wider community because of their behaviour, this may be an indication of vulnerability, poor supervision or neglect in the wider sense. It is important to consider whether these are children in need and to offer them assistance and services that reflect their needs. This should be done on a multi-agency basis. A range of powers should be used to engage families to improve the child's behaviour where engagement cannot be secured on a voluntary basis.

11.66 A child safety order (CSO) is a compulsory intervention available below the threshold of the child being at risk of significant harm. A local authority can apply for a CSO where a child has committed an act that would have been an offence if s/he were aged 10 or above, where it is necessary to prevent such an act, or where the child has caused harassment, distress or harm to others (i.e. behaved anti-socially). It is designed to help the child improve his or her behaviour, and is likely to be used alongside work with the family and others to address any underlying problems.

11.67 A parenting order can be made alongside a CSO or when a CSO is breached. This provides an effective means of engaging with and supporting parents, while helping them develop their ability to undertake their parental responsibilities. A parenting order consists of two elements:

- a requirement on the parent to attend counselling or guidance sessions (for example, parenting education or parenting support classes). This is the core of the parenting order and lasts for three months; and
- a requirement on the parent to comply with such requirements as are determined necessary by the court. This element can last up to 12 months.

11.68 Harassment and anti social behaviour by children can have a major impact on adults and other children living in a neighbourhood. Arrangements should ideally exist whereby local community safety teams can seek help or advice about when antisocial behaviour by children should be regarded as evidence of need.

11.69 Children may also be members of households in which a vulnerable adult is being neglected or mistreated and may participate in such neglect or mistreatment themselves. Arrangements should ideally exist in which local safeguarding adults'

teams can seek help or advise about appropriate interventions for children in such cases. Staff working with children in need in households in which there are vulnerable adults should be alert to the possibilities of mistreatment of the vulnerable adult.

11.70 In case of behaviour problems at school, schools will need to make use of a full range of strategies when working to engage with parents, families and communities, including:

- offering specific support for parents and carers who need help either because their child is being bullied or in managing their child's behaviour. There is a range of support mechanisms available in schools and through partner agencies but parents and carers need to feel this support is accessible to them;
- employing some of the formal strategies for parental engagement including the use of parenting contracts and home-school agreements. Many parents will react positively to such offers of help and particularly value group support;
- some schools find that the use of an education related parenting contract for behaviour is helpful in protecting the interests of the child. This is a voluntary arrangement between the parent and school/local authority; and
- parenting orders can also be applied for by a school or local authority where a parent has refused or failed to comply with a parenting contract and where the court considers that parenting is a factor in the child's behaviour.

11.71 An education related parenting order is a civil court order which consists of the same two elements as standard parenting orders, except that they focus specifically on improving the behaviour and attendance of the child[253].

11.72 Parent Support Advisers (PSAs) can enable the school-home relationship to grow and flourish. There is a comprehensive package of materials available from the Training and Development Agency for Schools on PSAs, which local authorities can draw upon when considering what information to include in their training materials. Guidance on securing parental involvement in managing pupil behaviour is due to be updated in 2010.

Race and racism

11.73 Racism can be a significant factor in cases of abuse. The experience of racism is also likely to affect the responses of the child and family to assessment and enquiry processes. Failure to consider the effects of racism undermines efforts to protect

253 More information can be found at: www.teachernet.gov.uk/wholeschool/behaviour/pcspospns/

children from other forms of significant harm. The effects of racism differ for different communities and individuals and should not be assumed to be uniform. Attention should be given to the specific needs of all children. Evidence from research and previous abuse enquiries suggests particular issues for children of mixed parentage and refugee children. The need for neutral, high-quality translation or interpretation services should be taken into account when working with children and families whose preferred language is not English. All organisations working with children, including those operating in areas where black and minority ethnic communities are numerically small, should address institutional racism defined in the *Macpherson Inquiry Report* (2000) as 'the collective failure by an organisation to provide an appropriate and professional service to people on account of their race, culture and/or religion'.

Violent extremism

11.74 Exposure to, or involvement with, groups or individuals who condone violence as a means to a political end is a particular risk for some children. Children and young people can be drawn into violence themselves or they can be exposed to messages if a family member is involved in an extremist group.

11.75 Experience suggests that young people from their teenage years onwards can be particularly vulnerable to getting involved with radical groups through direct contact with members or, increasingly, through the internet. This can put a young person at risk of being drawn in to criminal activity and has the potential to cause significant harm.

11.76 The cross-Government strategy to stop people becoming terrorists or supporting violent extremism is known as 'Prevent'[254]. One of Prevent's primary objectives is to support individuals who are vulnerable to recruitment or have already been recruited by violent extremists. There are a number of local projects across the country that contribute to this aim. All local authority areas should have an agreed process in place for safeguarding vulnerable children and young people susceptible to violent extremism. All staff should understand the nature of the risk and how to respond.

11.77 Levels of risk vary across different areas so LSCBs, safeguarding adults boards and children's services practitioners should ensure they are informed of the particular risks in their area. Most local authority areas have a Prevent partnership group that is responsible for co-ordinating work on this agenda across all agencies. Children's services departments should be involved in this partnership group to ensure services that support children and young people are contributing to Prevent.

254 For more information on the Prevent Strategy, visit www.dcsf.gov.uk/violentextremism

11.78 All children and young people's partnerships should have an agreed process in place for safeguarding vulnerable individuals, including children's, transition and vulnerable adult services. In some areas there is a bespoke multi-agency process known as 'Channel', which is an agreed mechanism for referring those at risk and providing support. Channel guidance states that if a referred individual is under the age of 18[255] the Channel co-ordinator must liaise with the common assessment framework (CAF) co-ordinator/manager or social care office in children and young people's services (who should be represented on the Prevent partnership and multi-agency Channel panel) to agree how best to handle the case. Following initial discussion a decision needs to be made on how to progress the case (for example, as a safeguarding issue, under Channel, CAF, or another support process) and establish how this will be reviewed. This decision can be taken on a case by case basis or a decision can be made by all local partners to use one particular system for the referral of all under 18s. If an area does not have Channel, local areas should incorporate referrals of under 18s within safeguarding procedures.

Domestic violence

11.79 As outlined in Chapter 9, children may suffer both directly and indirectly if they live in households where there is domestic violence. Domestic violence includes any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults, or young people, who are or have been intimate partners, family members or extended family members, regardless of gender and sexuality. Domestic violence is likely to have a damaging effect on the health and development of children, who are likely to suffer emotional and psychological maltreatment, and it will often be appropriate for them to be regarded as children in need. Women are more likely to experience the most serious forms of domestic violence but it is important to acknowledge that there are female perpetrators and male victims and that domestic violence also occurs within same-sex relationships. Professionals should be aware to these possibilities.

11.80 Everyone working with women and children should be alert to the frequent inter-relationship between domestic violence and the abuse and neglect of children (*National Service Framework for Children, Young People and Maternity Services*, 2004). There may be serious effects on children who witness domestic violence, which often result in behavioural issues, low self esteem, depression, absenteeism, ill health, bullying, antisocial or criminal behaviour, drug and alcohol misuse, self-harm and psychosocial impacts. Where there is evidence of domestic violence the implications for any children in the household should be considered, including the possibility that the children may themselves be subject to violence or may be

255 The Channel guidance also makes clear that children and young people's services may have responsibility for care beyond the age of 25 if additional vulnerabilities are present such as for children in care, care leavers or disability.

harmed by witnessing or overhearing the violence. Children affected by domestic violence often find disclosure difficult or go to great lengths to hide it.

11.81 The three central imperatives of any intervention for children living with domestic violence are:

- to protect the child/ren, including unborn child/ren;
- to empower the mother to protect herself and her child/ren; and
- to identify the abusive partner, hold him accountable for his violence and provide him with opportunities to change.

11.82 Professionals in all agencies are in a position to identify or receive a disclosure about domestic violence. Professionals should ask direct questions about domestic violence and be alert to the signs that a child or mother may be experiencing domestic violence or that a father/partner may be perpetrating domestic violence. Similarly, professionals should ask young people direct questions about whether they are experiencing intimate partner violence. Everyone working with women and children should be alert to the frequent inter-relationship between domestic violence and other issues which should be considered, such as drugs and alcohol misuse, deprivation and social exclusion, homelessness and housing needs, mental health difficulties, or child abuse and/or animal abuse.

11.83 Conversely, where it is believed that a child is being abused those involved with the child and family should check whether there is domestic violence within the family or in a young person's partner relationship. Professionals should offer all children, young people and women, accompanied or not, the opportunity of being seen alone (including in all assessments) with a female practitioner, wherever practicable, and asked whether they are experiencing or have previously experienced domestic violence. Professionals in all agencies should take all disclosures seriously and the impact of the domestic violence on the mother and her child/ren should be clearly explained to her. She should be provided with full information about her legal rights and the extent and limits of statutory duties and powers. Maintaining and strengthening the mother/child relationship is in most cases key to helping the child/ren to survive and recover from the impact of the violence and abuse. Children who are experiencing domestic violence are likely to benefit from a range of support and services.

11.84 As soon as a professional becomes aware of domestic violence within a family or a young person's relationship they should help the young person or mother and each child, according to their age and understanding, develop a safety plan. Children's safety plans should emphasise that the best thing a child can do for themselves and

their mother is not to try to intervene but to keep safe and, where appropriate, to get away and seek help.

11.85 Separation itself does not ensure safety, it often at least temporarily increases the risk to the child/ren or mother. Where a mother's safety plan is to separate from the abusive partner the possibility of removing the abusive partner rather than the mother and child/ren should be considered first. Professionals should ensure that there is sufficient support in place to enact this plan. Where a mother proposes to remain with the abusive partner a multi-agency assessment should be undertaken of whether the safety plan is sufficient to safeguard the children.

11.86 The police are often (but not always) the first point of contact with families in which domestic violence takes place. When responding to incidents of violence the police should find out whether there are any children living in the household. They should see any children present in the house to assess their immediate safety. There should be arrangements in place between the police and children's social care to enable the police to find out whether any such children are the subject of a child protection plan. The police are already required to determine whether any court orders or injunctions are in force in respect of members of the household. The police should make an assessment of risk of harm to the children and their mother using a dedicated assessment tool for example, the Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH) 2009 Risk Assessment Model. If they have specific concerns about the safety or welfare of a child they should make a referral to children's social care and to a Multi-Agency Risk Assessment Conference (MARAC) – a multi-agency meeting that focuses on the safety of high-risk domestic violence victims. MARACs and LSCBs should agree joint working arrangements for identifying, protecting and supporting children affected by domestic violence.

11.87 It is also important that there is clarity about whether the family is aware that a referral is to be made. Any response by children's social care to such referrals should be discreet in terms of making contact with victims in ways that will not further endanger them or their child/ren. In some cases, a child may be in need of immediate protection. The amendment to the Children Act 1989 made in section 120 of the Adoption and Children Act 2002 clarifies the meaning of 'harm' in the Children Act to make explicit that 'harm' includes, for example, impairment suffered from seeing or hearing the ill-treatment of another.

11.88 Normally one serious or several lesser incidents of domestic violence where there is a child in the household indicate that children's social care should carry out an initial assessment of the child and family, including consulting existing records. Babies under 12 months old are particularly vulnerable to violence. Where there is domestic violence in families with a child under 12 months old (including an unborn

child), even if the child was not present, professionals should make a referral to children's social care if there is any single incident of domestic violence.

11.89 Children's social care should assess the child/ren and their family using the *Framework for the Assessment of Children in Need and their Families* (DH, 2000), taking into account such factors as the:

- nature of the abuse;
- risks to the child posed by the abuser;
- risks of serious injury or death;
- abuser's pattern of assault and coercive behaviours;
- impact of the abuse on the mother;
- impact of the abuse on the child;
- impact of the abuse on parenting roles;
- protective factors; and
- outcome of the mother's past help-seeking.

Contact can be a mechanism for the abusive partner to locate the mother and children. Professionals should complete an assessment of the risks from contact to the mother and child/ren.

11.90 Education, early years and health service professionals are well placed to identify domestic violence. Safe information sharing arrangements are necessary to ensure that staff are confident about when and how to share information between education, children's social care, health and the police is key. Guidance on best practice for health service staff is available in the toolkit *Improving safety, Reducing harm: Children, young people and domestic violence – A practical toolkit for front line practitioners*[256]. The toolkit provides information on children and domestic violence, including the ways children experience domestic violence and the impact of abuse.

11.91 Domestic Violence Forums have been set up in many areas to raise awareness of domestic violence, to promote co-ordination between agencies in preventing and responding to violence, and to encourage the development of services for those who are subjected to violence or suffer its effects. LSCBs should have clearly defined links with their local Domestic Violence Forums, including cross-membership and jointly-undertaken workstreams. The LSCB and the Domestic Violence Forum should jointly contribute – in the context of the Children and Young People's Plan – to an assessment of the incidence of children and young people experiencing domestic

256 www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_108704.pdf

violence, their needs, the adequacy of local arrangements to meet those needs and the implications for local services. Other work might include developing joint protocols, safe information sharing arrangements and training. Local authorities and health, together with the police and other partner agencies, need to assure themselves that they have in place the services and responses which will satisfy the *Every Child Matters* Outcomes Framework target: Children affected by domestic violence are identified, protected and supported. To have in place appropriate local integrated services, planners and commissioners are encouraged to take guidance from *A Vision for Services for Children and Young People affected by Domestic Violence* (LGA, ADSS, Women's Aid and Cafcass, 2005)[257]. This guidance focuses on meeting the needs of children affected by domestic violence within the planning of integrated children's services and provides a framework to ensure that the range of different needs that children/young people experience in relation to domestic violence are identified and addressed.

11.92 There is an extensive range of services for women and children, delivered mainly through the voluntary sector, which includes Independent Domestic Violence Advisors for high risk victims of abuse, refuges, outreach services and a 24 hour domestic violence helpline. There is also probation service provision of Women's Safety Workers for partners of male perpetrators of domestic abuse where they are on a domestic abuse treatment programme (in custody or in the community). These services have a vital role in contributing to an inter-agency approach in child protection cases where domestic violence is an issue. In responding to situations where domestic violence may be present, considerations include:

- asking direct questions about domestic violence;
- checking whether domestic violence has occurred whenever child abuse is suspected and considering the impact of this at all stages of assessment, enquiries and intervention;
- identifying those who are responsible for domestic violence in order that relevant family law or criminal justice responses may be made;
- taking into account that there may be continued or increased risk of domestic violence towards the abused parent and/or child after separation especially in connection with post-separation child contact arrangements;
- providing women with full information about their legal rights and about the extent and limits of statutory duties and powers;
- helping victims and children to get protection from violence by providing relevant practical and other assistance;

257 http://new.lga.gov.uk/lga/aio/1224298

- supporting non-abusing parents in making safe choices for themselves and their children; and
- working separately with each parent where domestic violence prevents non-abusing parents from speaking freely and participating without fear of retribution.

Child abuse and information communication technology (ICT)

11.93 The range of child abuse definitions and concepts (described in Part 1 of this guidance) are now being seen in an ICT environment. As technology develops the internet and its range of content services can be accessed through various devices.

11.94 The internet has, in particular, become a significant tool in the distribution of indecent photographs/pseudo photographs of children. Internet chat rooms, discussion forums and bulletin boards are used as a means of contacting children with a view to grooming them for inappropriate or abusive relationships, which may include requests to make and transmit pornographic images of themselves, or to perform sexual acts live in front of a webcam. Contacts made initially in a chat room are likely to be carried on via email, instant messaging services, mobile phone or text messaging. There is also growing cause for concern about the exposure of children to inappropriate material via interactive communication technology – for example, adult pornography and/or extreme forms of obscene material. Allowing or encouraging a child to view such material may warrant further enquiry. Children themselves can engage in text bullying and use mobile phone cameras to capture violent assaults of other children for circulation.

11.95 Where there is evidence of a child using ICT excessively, this may be a cause for concern more generally about the child's welfare or development in the sense that it may inhibit the development of real-world social relationships or become a factor contributing to obesity.

11.96 There is some evidence that people found in possession of indecent photographs/pseudo photographs of children are likely to be involved directly in child abuse. Thus, when somebody is discovered to have placed or accessed such material on the internet the police should normally consider the likelihood that the individual is involved in the active abuse of children. In particular, the individual's access to children should be established, within the family, employment contexts and in other settings (for example, work with children as a volunteer or in other positions of trust). If there are particular concerns about one or more specific children it may be necessary to undertake, in accordance with the guidance set out in Chapter 5, section 47 enquiries (see the Memorandum of Understanding with the police for the

appropriate notification to the Internet Watch Foundation of concerns about possible child pornography and other illegal materials on the internet).

11.97 As part of their role in preventing abuse and neglect LSCBs should consider activities to raise awareness about the safe use of the internet. LSCBs are a key partner in the development and delivery of training and education programmes with the Child Exploitation and Online Protection Centre[258] (CEOP).This includes building on the work of the British Educational Communications and Technology Agency (BECTA), the Home Office and the ICT industry in raising awareness about the safe use of interactive communication technologies by children.

Children with families whose whereabouts are unknown

11.98 Local agencies and professionals should bear in mind, when working with children and families where there are outstanding concerns about the children's safety and welfare (including where the concerns are about an unborn child who may be at future risk of significant harm), that a series of missed appointments may indicate that the family has moved out of the area or overseas. Children's social care and the police should be informed as soon as such concerns arise. In the case of children taken overseas it may be appropriate to contact the Consular Directorate at the Foreign and Commonwealth Office[259], which offers assistance to British nationals in distress overseas. They may be able to follow up a case through their consular post(s) in the country concerned.

11.99 Particular consideration needs to be given to appropriate legal interventions where it appears that a child for whom there are outstanding concerns about their safety and welfare may be removed from the UK by his/her family in order to evade the involvement of agencies with safeguarding responsibilities. Particular consideration should also be given to appropriate legal interventions when a child who is subject to a care order has been removed from the UK. Children's social care, the police Child Abuse Investigation Unit and the Child Abduction Section at the Foreign and Commonwealth Office should be informed immediately.

Children who go missing

11.100 Children who decide to run away are unhappy, vulnerable and in danger. As well as short term risks to their immediate safety there are longer term implications as well

258 The Child Exploitation and Online Protection Centre, which came into being in April 2006, is a partnership between Government, law enforcement, NGOs (including children's charities) and industry, with the common aim of protecting children. It works to protect children, families and society from paedophiles and sex offenders – in particular, those who seek to exploit children sexually online.

259 www.fco.gov.uk, 020 7008 1500

with children and young people who run away being less likely to fulfil their potential and live happy, health and economically productive lives as adults. In July 2009 the Government published new statutory guidance setting how local authorities and agencies should respond when a child or young person goes missing[260].

11.101 Local and regional Runaway and Missing from Home and Care protocols should be agreed between children's services, the police and other agencies and relevant voluntary sector agencies. Protocols should define roles and responsibilities when a child goes missing and when they return and should include:

- an agreed definition of a missing or runaway child or young person;
- an agreed inter-agency framework for classifying the degree of risk when a child goes missing from home or when a missing young person comes to agency notice;
- guidance on the threshold for referrals to social care;
- where CAF would be beneficial and the parents/carers agree, details of who should carry out a CAF and how this information should be shared, where appropriate;
- the basis on which agencies offer 'Return interviews' for children who have run away from home; and
- details of preventative approaches.

11.102 Return interviews for children and young people missing from both home and care are a crucial element in exploring the reasons they ran away and instances where the young person has run away from care, referring on, or linking into, care planning as appropriate. Where there is the possibility that the young person has runaway or gone missing as a result of child protection concerns the local authority where the child is placed, in liaison with the authority responsible for the child's placement and in partnership with the police, must follow its procedures to safeguard and promote the welfare of children in the area where the child is living (see also the National Minimum Standards for fostering services and residential care).

Children who go missing from education

11.103 If a child or young person is receiving an education not only do they have the opportunity to fulfil their potential but they are also in an environment that enables local agencies to safeguard and promote their welfare. If a child goes missing from education they could be at risk of significant harm.

260 www.dcsf.gov.uk/everychildmatters/_download/?id=6178

11.104 There are a number of reasons why children go missing from education. These can include:

- failing to start appropriate provision and hence never entering the system;
- ceasing to attend due to exclusion (for example, illegal unofficial exclusions) or withdrawal; and
- failing to complete a transition between providers (for example, being unable to find a suitable school place after moving to a new local authority area).

11.105 Children's personal circumstances, or those of their families, may contribute to the withdrawal process and the failure to make a transition.

11.106 Certain groups of vulnerable children are more likely than others to go missing from education:

- young people who have committed offences;
- children living in women's refuges;
- children of homeless families, perhaps living in temporary accommodation;
- young runaways;
- children with long-term medical or emotional problems;
- looked after children;
- children with a gypsy/traveller background;
- young carers;
- children from transient families;
- teenage mothers;
- children who are permanently excluded from school;
- migrant children, whether in families seeking asylum or economic migrants; and
- children/teenagers being forced into marriage.

11.107 There is a Child Missing Education (CME) named point of contact in every local authority. Every practitioner working with a child has a responsibility to inform their CME contact if they know or suspect that a child is not receiving education. To help local agencies and professionals find children who are missing from education and identify those at risk of going missing from education, guidance was issued in July

2004, *Identifying and maintaining contact with children missing, or at risk of going missing, from education*[261].

Children of families living in temporary accommodation

11.108 Placement in temporary accommodation, often at a distance from previous support networks or involving frequent moves, can lead to individuals and families falling through the net and becoming disengaged from health, education, social care and welfare support systems. Some families who have experienced homelessness and are placed in temporary accommodation by local authorities under the main homeless duty, can have very transient lifestyles.

11.109 It is important that effective systems are in place to ensure that children from homeless families receive services from health and education, as well as any other specific types of services, because these families move regularly and may be at risk of becoming disengaged from services. Where there are concerns about a child or children the procedures set out in Chapter 5 should be followed.

11.110 Statutory guidance on making arrangements under section 11 of the Children Act 2004 to safeguard and promote the welfare of children sets out local authorities' responsibilities for homeless families.

Migrant children

11.111 In recent years the number of migrant children in the UK has increased for a variety of reasons including the expansion of the global economy and incidence of war and conflict. Local agencies should have due regard to the need to safeguard and promote the welfare of these children offering the same level of support and protection as for children who are UK nationals. Given that migrant children may have serious health needs, in addition to their complex other social needs, particular attention should be given to ensuring that they receive appropriate health care services.

Unaccompanied asylum-seeking children (UASC)

11.112 A UASC is an asylum-seeking child under the age of 18 who is not living with their parent, relative or guardian in the UK. In most cases UASC will be referred to local authorities by the UK Border Agency (UKBA) shortly after they arrive in the United Kingdom.

261 http://publications.everychildmatters.gov.uk/default.aspx?PageFunction=productdetails&PageMode=publications&ProductId=LEA%2F0225%2F2004&

11.113 Local authorities should adopt the same approach to assessing the needs of a UASC as they use to assess other children in need in their area. The child will not have a parent, relative or other suitable adult carer in the United Kingdom, and will likely to have to be accommodated under section 20 of the Children Act.

11.114 The child's immigration status should not affect the quality of care, support and services that are provided as a result of the assessment. Immigration status will, however, have a bearing on the child's future and very careful thought should therefore be given to the range of services provided to the proportion of the children that are not granted asylum or long term leave to remain in the UK – with a view to making sure that the children are equipped for life in their countries of origin as well as the United Kingdom. These considerations should be reflected in the child's care (or their pathway plan for those aged 16+), which will be subject to the same statutory review process, chaired by an Independent Reviewing Officer, appropriate for other looked after children.

11.115 In assessing the needs of UASC and providing effective care local authorities will normally need to build close links with the UKBA 'case owner' responsible for resolving the child's immigration status. This should extend to sharing key information necessary to safeguard the child's welfare, including:

- information relevant to the assessment of the child's identity and age (given that most UASCs may not have reliable documentary evidence of their age and identity);
- information that might be relevant to the immigration decision made in respect of the child (where, for example, the child has complex medical needs or is suffering from trauma); and
- information about any efforts to trace the location of family members in the country of origin (many UASCs will have lost contact with family members because of the circumstances of their journey to the United Kingdom).

11.116 In order to plan appropriately for the future of unaccompanied asylum seeking children it will be necessary for their social worker or personal adviser to seek up to date information on the progress of their asylum case from the UK Border Agency. It should not be assumed that a UASC will remain permanently in the UK, unless and until they have been granted British Nationality, refugee status or indefinite leave to remain. Opportunities available in the country of origin should be addressed in the care or pathway plan review to prepare for the eventuality that the child may decide to or be required to return to their country of origin.

11.117 Where there are safeguarding concerns relating to the care and welfare of any UASC[262] then these must be investigated in line with the LCSB procedures in the area where they are living, in the same way as any other looked after child.

262 See for example para. 2.23 of the Statutory Guidance to the UK Border Agency on Making Arrangements to Safeguard and Promote the Welfare of Children.

Chapter 12 – Managing individuals who pose a risk of harm to children

Introduction

12.1 This section provides practice guidance and information about a range of mechanisms that are available when managing adults, or children and young people, who have been identified as presenting a risk, or potential risk, of harm to children. Areas covered include:

- collaborative working between organisations and agencies to identify and manage individuals who present a risk of harm to children;
- the Multi-Agency Public Protection Arrangements (MAPPA), which enable agencies to work together within a statutory framework for managing risk of harm to the public; and
- other processes and mechanisms for working with individuals who present a risk of harm to children.

Collaborative working

12.2 The Children Act 1989 recognised that the identification and investigation of child abuse, together with the protection and support of victims and their families, requires multi-agency collaboration. This is rightly focused on the child and the supporting parent/carer. As part of that protection, action has been taken, usually by the police and children's social care services, to prosecute known offenders and/or control their access to vulnerable children.

12.3 This work, while successful in addressing the safety of particular victims, has not always acknowledged the ongoing risk of harm that an individual perpetrator may present to other children in the future. Nor does it acknowledge that a young person may also be a perpetrator and that the same young person may simultaneously be both suffering, or likely to suffer harm, and present a risk of harm to other children and young people.

Use of the term 'Schedule One offender'

12.4 The terms 'Schedule One offender' and 'Schedule One offence' have been commonly used for anyone convicted of an offence against a child listed in

Schedule One of the Children and Young Person's Act 1933. However, a conviction for an offence in Schedule One does not trigger any statutory requirement in relation to child protection issues, and inclusion on the schedule was determined solely by the age of the victim and offence for which the offender was sentenced, and not by an assessment of whether the offender may pose a future risk of harm to children.

12.5 **Therefore the term 'Schedule One offender' is no longer used. It has been replaced with 'Risk to children'**. This clearly indicates that the person has been identified as presenting a risk, or potential risk, of harm to children.

12.6 *Guidance on offences against children (Home Office Circular 16/2005)*[263], explains how those people who present a risk, or potential risk, of harm to children should be identified. The circular explains that the present method of automatically identifying as a risk of harm to children an offender who has been convicted of an offence listed in Schedule One of the Children and Young Person's Act 1933 fails to focus on those who **continue** to present a risk of harm.

12.7 Practitioners working in this area should use the new list of offences as a 'trigger' to a further assessment, including consideration of previous offences and behaviours, to determine if an offender should be regarded as presenting a continuing risk of harm to children. This allows agencies to focus resources on the correct group of individuals, and not include those who have been identified solely because a child was harmed during the offence, for example, as in the case of a road traffic accident. An offender who has harmed a child might not continue to present a risk or harm towards that child or other children. Where a child or young person (aged under 18 years) offends against another child, a thorough and specialist assessment should be undertaken to establish the extent to which the young person who has offended continues to pose a risk of harm to other children and young people. They should be alert to the possibility that there may be little or no continuing risk of harm to other children and young people, but never losing sight of taking all possible actions to ensure that children are adequately protected from any future harm. Practitioners should also assess and put in place services to respond to the, often complex, needs of the young person who has offended.

12.8 Once an individual has been sentenced and identified as presenting a risk of harm to children, agencies have a responsibility to work collaboratively to monitor and manage the risk of harm to others. Where an offender is given a community sentence, Offender Managers or Youth Offending Team (YOT) workers will monitor the individual's risk of harm to others and their behaviour, and liaise with partner agencies as appropriate.

263 See www.homeoffice.gov.uk/about-us/publications/home-office-circulars/circulars-2005/016-2005/index.html

12.9 In cases where an offender has been sentenced to a period of custody, prison establishments undertake a similar responsibility and, in addition, notify other agencies prior to any period of release. Similarly for offenders released on licence into the community who are assessed as potentially presenting a risk of harm to children, consideration will be given to including licence conditions which seek to prevent the offender's contact with children.

New offences targeted at those who sexually exploit children and young people

12.10 The Sexual Offences Act 2003 introduced a number of new offences to deal with those who sexually exploit children and young people. The offences protect children up to the age of 18 and can attract tough penalties. They include:

- paying for the sexual services of a child;
- causing or inciting child prostitution;
- arranging or facilitating child prostitution; and
- controlling a child prostitute.

12.11 These are not the only charges that may be brought against those who sexually exploit children or young people. Abusers and coercers often physically, sexually and emotionally abuse these children, and may effectively imprison them. If a child is a victim of serious offences, the most serious charge that the evidence will support should always be used.

Multi-Agency Public Protection Arrangements (MAPPA)

12.12 MAPPA provide a national framework in England and Wales for the assessment and management of the risk of serious harm posed by specified sexual and violent offenders, including offenders (including young people) who are considered to pose a risk, or potential risk, of serious harm to children. The arrangements are statutory. Sections 325–327 of the Criminal Justice Act 2003 require the police, prisons and probation services (the 'Responsible Authority') in each area to establish and monitor the arrangements. A number of other agencies – including children's and adult's social care services, health, housing, YOTs, Jobcentre Plus and electronic monitoring providers – are under a statutory duty to co-operate with the Responsible Authority in this work.

12.13 National MAPPA Guidance (2009)[264] further develops processes particularly with regard to young people who pose a risk and the role of YOTs.

264 See www.probation.homeoffice.gov.uk/output/page30.asp.

12.14 MAPPA's focus is on specified sexual and violent offenders in, and returning to, the community, and its aims are to:

- ensure more comprehensive risk assessments are completed, taking advantage of co-ordinated information sharing across the agencies; and
- share information, assess and manage risk and direct the available resources to best protect the public from serious harm.

12.15 Offenders eligible for MAPPA are identified and information is gathered/shared about them across relevant agencies. The extent to which they pose a risk of serious harm is assessed and a risk management plan is implemented to protect the public.

12.16 Each area has a MAPPA Strategic Management Board (SMB) attended by senior representatives of each of the responsible authority and duty to co-operate agencies, plus two lay advisers. It is the SMB's role to ensure that the MAPPA are working effectively and to establish and maintain working relationships with the Local Safeguarding Children Boards (LSCBs).

Identifying MAPPA eligible offenders

12.17 There are three categories of offender eligible for MAPPA:

- **registered sexual offenders** (Category 1) – sexual offenders who are required to notify the police of their name, address and other personal details and notify any changes subsequently;
- **violent offenders** (Category 2) – offenders sentenced to imprisonment/ detention for 12 months or more, or detained under hospital orders (in relation to murder or offences specified in schedule 15 of the Criminal Justice Act 2003). This category also includes a small number of sexual offenders who do not qualify for registration, and offenders disqualified from working with children; and
- **other dangerous offenders** (Category 3) – offenders who do not qualify under categories 1 or 2 but who currently pose a risk of serious harm, there is a link between the offending and the risk posed, and they require active multi-agency management.

Sharing of relevant information

12.18 Exchange of information is essential for effective public protection. The MAPPA guidance[265] details how MAPPA agencies may/should exchange information among themselves to better manage offenders. It also explains why and how information

265 See www.probation.homeoffice.gov.uk/output/page30.asp.

may be disclosed to those not involved in the MAPPA management of the offender. The expectation is that information on offenders will be disclosed to others – for example, partners, employers, schools – where this is required to manage the risks posed by the offender.

ViSOR

12.19 ViSOR is a national database which currently carries details of MAPPA eligible offenders and other potentially dangerous individuals. The police have been using ViSOR since 2005 and probation and prisons have had access since 2008–09. The benefit is that, for the first time, all three responsible authority agencies can access the same IT system, thus improving the quality and timeliness of risk assessments and of interventions to prevent offending.

Assessment of the risk of serious harm

12.20 The National Offender Management Service (NOMS) assesses risk of serious harm using the Offender Assessment System (OASys) supplemented by additional assessment procedures, depending on the nature of the offending and the specific risks identified. The Youth Justice Board uses ASSET for under-18-year-olds. The levels of risk are as follows:

- **low**: current evidence does not indicate likelihood of causing serious harm;
- **medium**: identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm, but is unlikely to do so unless there is a change in circumstances, for example, failure to take medication, loss of accommodation, relationship breakdown, drug or alcohol misuse;
- **high**: identifiable indicators of risk of serious harm. The potential event could happen at any time, and the impact would be serious; and
- **very high**: an imminent risk of serious harm. The potential event is more likely than not to happen imminently, and the impact to be serious.

12.21 Risk is categorised by reference to the potential subject of the harm. This includes children who may be vulnerable to harm of various kinds, including violent or sexual behaviour, emotional harm or neglect. In this context, MAPPA works closely with LSCBs to ensure the best local joint arrangements can be made for any individual child being considered by either setting.

Managing risk of serious harm

12.22 In most cases, a MAPPA eligible offender will be managed without recourse to MAPPA meetings under the ordinary arrangements applied by the agency or

agencies with supervisory responsibility. This will generally be the police for registered sexual offenders who are not on a licence to probation, and probation for violent offenders and those on a licence, but YOTs will lead with young offenders and Mental Health Services with those on hospital orders. A number of offenders, though, require active multi-agency management and their risk management plans will be formulated and monitored via multi-agency public protection (MAPP) meetings attended by various agencies.

12.23 There are 3 levels of management within the MAPPA framework, which are based upon the level of multi-agency co-operation required to implement the risk management plan effectively:

- **Level 1 – Ordinary Management**. These offenders are subject to the usual management arrangements applied by whichever agency is supervising them. But this does not rule out information sharing between agencies, via ViSOR and other routes;
- **Level 2 – Active Multi-Agency Management**. The risk management plans for these offenders require the active involvement of several agencies via regular MAPP meetings; and
- **Level 3 – Active Multi-Agency Management**. As with level 2 but these cases additionally require the involvement of senior officers to authorise the use of special resources, such as police surveillance or specialised accommodation, and/or to provide ongoing senior management oversight.

Offenders will be moved up and down levels as appropriate.

12.24 YOTs have a duty to identify cases that meet MAPPA criteria and make appropriate referrals. However, the guidance emphasises that young people should be assessed and managed differently from adults, using age-appropriate assessment tools and always bearing in mind the need to safeguard the welfare of the young offender as well as to protect others from harm. Children's social care services should **always** be represented at MAPPA meetings when a young person is being discussed.

12.25 The national MAPPA guidance sets out the framework in full. The guidance and the area annual reports, which describe how the arrangements are working locally, are available on the National Probation Service website[266].

266 www.probation.homeoffice.gov.uk/output/page30.asp

Other processes and mechanisms

Multi-Agency Risk Assessment Conference (MARAC)

12.26 A MARAC is a multi-agency meeting which has the safety of high risk victims of domestic abuse as its focus. The identification of high risk victims has been made possible by the use of a risk identification tool[267], for use across a wide range of agencies. This has permitted practitioners, both within and outside of the criminal justice system, to identify high risk victims of domestic abuse. As a result many more high risk victims are being identified and, in response, the MARAC is being rolled out across England and Wales with a view to meeting this need.

12.27 The MARAC is a process involving the participation of all the key statutory and voluntary agencies who might be involved in supporting a victim of domestic abuse. This includes those from the criminal justice system, those supporting children, those from the health service, the local authority, housing, substance misuse and, critically, specialist domestic violence services most frequently in the form of an Independent Domestic Violence Advisor (IDVA). The IDVA is a specialist caseworker who receives accredited training to work with high risk victims of domestic abuse from the point of crisis and whose focus is very much on the MARAC.

12.28 At a typical MARAC meeting 15 to 20 high risk cases are discussed in half a day with a very brief and focused information sharing process followed by a simple multi-agency action plan being put into place to support the victim and to make links with other public protection procedures, particularly safeguarding children, vulnerable adults and, of course, the management of perpetrators.

12.29 It is important to understand the MARAC meeting as part of a wider process which hinges on the early involvement and support from an IDVA and continued specialist case management, both before and after the meeting. The MARAC should combine the best of specialist support together with the co-ordination of the generic agencies whose resources and involvement will be needed to keep victims and their children safe.

12.30 Where an offender is being managed at MAPPA Level 2 or Level 3, to avoid duplication of effort and resources, the MAPP meeting should take the lead over the MARAC. The reason for this is that the MAPPA is a statutory set of arrangements and therefore it takes precedence over the MARAC.

---

267 See www.caada.org.uk/Practitioner_resources/Quick%20Start%20Guidance%20&%20RIC%20090620 09.doc

Offending behaviour programmes

12.31 Rehabilitation of offenders is the best guarantee of long-term public protection. A range of independently accredited treatment programmes, which have been developed or commissioned by NOMS, have been 'tried and tested' at a national level. Examples include sex offender treatment programmes, programmes for offenders convicted of internet-related sexual offences, and programmes for perpetrators of domestic abuse.

The Vetting and Barring Scheme

12.32 The Vetting and Barring Scheme (VBS) aims to ensure that unsuitable people do not work with children, whether in paid employment or on a voluntary basis. The scheme comprises:

- two barred lists, maintained by the Independent Safeguarding Authority (ISA). One list comprises persons barred from working with children, and the other is for persons barred from working with vulnerable adults. From 12 October 2009 these lists replaced the list held under section 142 of the Education Act 2002 known as 'List 99', the list held under the Protection of Children Act 1999 and the list held under the Protection of Vulnerable Adults Scheme. It is a criminal offence for a barred person to engage in 'regulated activity' (see below) or for an employer knowingly to engage a barred person to carry out such work; and
- a register of those wishing to work with vulnerable groups. Except where there is a specific exception, from November 2010 all new entrants to the children's workforce will be required to register with the Scheme before being allowed to engage in any relevant duties. From this date, it will be a criminal offence for anyone entering the sector to work in regulated activity or for an organisation to allow a non-registered individual to do so. Registration for existing workers will be phased in over the period 2011-2015, and employers will be expected to facilitate the registration, at the appropriate time, of staff that carry out regulated activity. Guidance on the coverage of the scheme, on the exceptions from registration and on phasing will be made available on the ISA website[268].

12.33 Since October 2009, the duties to refer concerns regarding individuals under List 99 and the Protection of Children Act 1999 were replaced with a duty to refer information to the ISA. The circumstances where a referral must be made are where:

a. an individual has been removed from 'regulated activity' (or would or might have been removed if they had not already left); and

268 www.isa-gov.org.uk

b. the employer/volunteer manager thinks that 'relevant conduct' has occurred, or the individual poses a risk of harm.

12.34 The duties to refer and to provide information to the ISA on request are placed on regulated activity providers and certain other bodies, including local authorities in their children's services and adult social care capacities. Failure by regulated activity providers to carry out the duty is a criminal offence. Compliance by local authorities is subject to local government performance management systems. 'Regulated activity' is defined in guidance on the ISA's website[269].

12.35 'Relevant conduct' is defined as:

a. conduct which endangers a child or is likely to endanger a child;

b. conduct which, if repeated against or in relation to a child, would endanger that child or would be likely to endanger him;

c. conduct involving sexual material relating to children (including possession of such material);

d. conduct involving sexually explicit images depicting violence against human beings (including possession of such images), if it appears to the Independent Safeguarding Authority that the conduct is inappropriate; or

e. conduct of a sexual nature involving a child, if it appears to the ISA that the conduct is inappropriate.

12.36 Full guidance on referrals and the VBS can be found on the ISA's website. The Secretary of State has issued guidance on what constitutes 'inappropriate' in 12.35(d) and 12.35(e) above. This guidance is available on the ISA's website.

12.37 The new barred lists will in time replace the regime of disqualification orders imposed by the courts under the Criminal Justice and Court Services Act 2000 (CJCSA), as amended by the Criminal Justice Act 2003. Until the VBS is fully phased in, individuals working with children could be either barred or subject to disqualification orders. Either way, they must be removed from such work and commit an offence if they carry out such work.

Criminal Records Bureau (CRB)

12.38 The Criminal Records Bureau (CRB) is an executive agency of the Home Office. The CRB's Disclosure Service aims to help employers make safer recruitment decisions by identifying candidates who may be unsuitable for certain types of work. In some

269 At the time of writing, the guidance on the ISA's website should be read alongside information about Sir Roger Singleton's recommendations relating to regulated activity, also available on the ISA website. These recommendations will be incorporated into the ISA guidance in due course.

cases, employers must ask successful candidates to apply to the CRB for a Standard or Enhanced Disclosure, depending on the duties of the particular position or job involved. In other cases, employers are eligible to ask for disclosures. Relevant sectoral guidance sets out the requirements and eligibility in detail.

12.39 In addition to information about a person's criminal record, enhanced disclosures supplied in connection with work with children contain details of whether a person is registered with the ISA, or barred. It should be noted that barred status is no longer shown on a standard disclosure. Enhanced disclosures may contain details of acquittals or other non-conviction information held on local police records, relevant to the position or post for which the person has been selected, and the police may also provide additional information to employers in a separate letter. Further information, including details of how to apply for disclosures, is available on the CRB website[270]. The Government is shortly to consult on proposals to amend its requirements for CRB disclosures once individuals have been ISA registered.

The Sex Offenders Register

12.40 The notification requirements of Part 2 of the Sexual Offences Act 2003 (known as the Sex Offenders Register) are an automatic requirement on offenders, including young people who have offended, who receive a conviction or caution for certain sexual offences. The notification requirements are intended to ensure that the police are informed of the whereabouts of offenders in the community. The notification requirements do not bar offenders from certain types of employment or from being alone with children.

12.41 Offenders must notify the police of certain personal details within three days of their conviction or caution for a relevant sexual offence (or, if they are in prison on this date, within three days of their release).

12.42 Such an offender must then notify the police, within three days, of any change to the notified details and whenever they spend seven days or more at another address.

12.43 All offenders must reconfirm their details at least once every twelve months, and notify the police seven days in advance of any travel overseas for a period of three days or more.

12.44 The period of time for which an offender must comply with these requirements depends on whether they received a conviction or caution for their offence and, where appropriate, the sentence they received.

270 www.crb.gov.uk

12.45 Failure to comply with these requirements is a criminal offence, with a maximum penalty of five years' imprisonment. The police should be contacted if such an offence is committed.

Child Sex Offender Review Disclosure Process

12.46 In June 2007, the Government published the *Review of the Protection of Children from Sex Offenders*. Action 4 of the Review created a process which allows members of the public to register a child protection interest in an identified individual who has access to, or a connection with, a particular child or children.

12.47 If an individual is found to have convictions for sexual offences against children and poses a risk of causing serious harm, there is a presumption that this information will be disclosed to the person who is best placed to protect the child or children, where it is necessary to do so for this purpose.

12.48 It should be noted that, under the scope of the Disclosure Process, the presumption for disclosure will only exist in cases where the individual has convictions for child sexual offences. However, it is felt that to restrict access to information regarding convicted child sexual offenders would severely limit the effectiveness of the process and ignore significant issues regarding offences committed against children.

12.49 The Disclosure Process will therefore include routes for managed access to information regarding individuals who are not convicted child sexual offenders but who pose a risk of harm to children. This may include:

- persons who are convicted of other offences for example, serious domestic violence; and
- persons who are unconvicted but about whom the police, or any other agency, holds intelligence indicating that they pose a risk of harm to children.

There would not however be a presumption to disclose such information.

12.50 It is important that the disclosure of information about previous convictions, for offences which are not child sex offences, is able to continue as it is not the intention of the Disclosure Process to make access to information concerning safeguarding children more restricted.

12.51 It should be stressed that the Disclosure Process will build on existing procedures such as MAPPA and will provide a clear access route for the public to raise child protection concerns and be confident that action will follow.

12.52 It is of paramount importance to all involved in delivering this process that we ensure that children are being protected from harm. By making a request for disclosure, a parent, guardian or carer will often also be registering their concerns about possible risks to the safety of their child or children. For that reason, it is essential to this process that police forces, local authority children's social care and LSCBs work closely together to ensure that any possible risks of harm to the child or children are fully assessed and managed.

12.53 This process is due to be rolled-out nationally from August 2010. The roll-out will be regionally staggered and full details of progress and national and local contact details can be found on the Home Office website[271].

12.54 For full guidance on this process please see ACPO *Guidance on Protecting the Public: Managing Sexual Offenders and Violent Offenders*. Prior to this visit the Home Office Circular website[272].

Notification Orders

12.55 Notification Orders are intended to ensure that British citizens or residents, as well as foreign nationals, can be made subject to the notification requirements (the Sex Offenders Register) in the UK if they receive convictions or cautions for sexual offences overseas. The provisions also apply to young people who have offended.

12.56 Notification Orders are made on application from the police to a magistrates' court. Therefore, if an offender is identified who has received a conviction or caution for a sexual offence overseas, the case should be referred to the local police for action.

12.57 If a Notification Order is in force, the offender becomes subject to the requirements of the Sex Offenders Registration.

12.58 For example, a Notification Order could ensure that the notification requirements apply to a British man who, while on holiday in Southeast Asia, received a caution for a sexual offence on a child.

12.59 Any information that an individual has received a conviction or caution for a sexual offence overseas should, where appropriate, be shared with the police.

Sexual Offences Prevention Orders (SOPOs)

12.60 Introduced by the Sexual Offences Act 2003, SOPOs are civil preventative orders designed to protect the public from serious sexual harm. A court may make a SOPO

271 www.homeoffice.gov.uk
272 www.homeoffice.gov.uk/about-us/publications/home-office-circulars/

when it deals with an offender, including a young person who has offended, who has received a conviction for an offence listed at Schedule 3 (sexual offences) or Schedule 5 (violent and other offences) to the Act and is assessed as posing a risk of serious sexual harm. The police can also apply for a SOPO to a magistrates' court in respect of an offender who has a previous conviction or caution for a Schedule 3 or 5 offence and who poses a risk of serious sexual harm.

12.61 SOPOs include such prohibitions as the court considers appropriate. For example, a sex offender who poses a risk of serious sexual harm to children could be prohibited from loitering near schools or playgrounds. The offender will also, if s/he is not already, become subject to the notification requirements for the duration of the order.

12.62 SOPOs can be made on application from the police, so any violent or sex offender who poses a risk of serious sexual harm should be referred to MAPPA agencies, and the police in particular. In an application for an order, the police can set out the prohibitions they would like the court to consider.

12.63 Breach of any of the prohibitions in a SOPO is a criminal offence, with a maximum punishment of five years imprisonment. Therefore the police should be contacted whenever a SOPO is breached.

12.64 SOPOs can be particularly helpful in the management of sex offenders who are assessed as continuing to pose a high risk of harm, but are no longer subject to statutory supervision.

Risk of Sexual Harm Orders (RSHOs)

12.65 Introduced by the Sexual Offences Act 2003, RSHOs are civil preventative orders. They cannot be applied to young people under the age of 18. They are used to protect children from the risks of harm posed by individuals who do not necessarily have a previous conviction for a sexual or violent offence but who have, on at least two occasions, engaged in sexually explicit conduct or communication with a child or children, and who pose a risk of further such harm. For a RSHO to be made, it is not necessary for there to be a risk that the defendant will commit a sexual offence against a child – the risk may be that s/he intends to communicate with children in a sexually explicit way. The RSHO can contain such prohibitions as the court considers necessary. For example, in the case of an adult found regularly communicating with young children in a sexual way in internet chat rooms, a RSHO could be used to prohibit the person from using the internet in order to stop him/her from such harmful activity.

12.66 RSHOs are made on application from the police, so any person who is thought to pose a risk of sexual harm to children should be referred to the police. In an application for an order, the police can set out the prohibitions they would like the court to consider.

12.67 Breach of any of the prohibitions in a RSHO is a criminal offence, with a maximum punishment of five years imprisonment. It is also an offence that makes the offender subject to the notification requirements. The police should be contacted whenever a RSHO is breached.

Violent Offender Orders (VOOs)

12.68 Violent Offender Orders (VOOs) are civil preventative orders that came into effect on 3 August 2009 (contained in Part 7 of the Criminal Justice and Immigration Act 2008). VOOs were developed as a tool to help the Police Service to manage those offenders who continue to pose a risk of serious violent harm to the public even after their release from prison or when their licence has ceased. Although not specifically designed as a tool to protect children, there may be circumstances where VOOs would be an appropriate mechanism to manage an individual who poses a serious risk of harm to children.

12.69 VOOs are available on application by a chief officer of police to a Magistrates' Court and, if granted, will contain such restrictions, prohibitions or conditions authorised by section 102 of the Act as the court considers necessary to protect the public from the risk of serious violent harm caused by the offender. This may include prohibiting their access to certain places, premises, events or people to whom they pose the highest risk.

12.70 Breach of any of the prohibitions, restrictions or conditions contained in a VOO without reasonable excuse is a criminal offence, with a maximum punishment of five years' imprisonment.

12.71 Full guidance on VOOs is available on the Home Office's Crime Reduction website[273].

273 www.crimereduction.homeoffice.gov.uk/violence/violence027.htm

Appendix 1 – Statutory framework

1. All organisations that work with children and families share a commitment to safeguard and promote their welfare, and for many agencies that is underpinned by a statutory duty or duties.

2. This appendix briefly explains the legislation most relevant to work to safeguard and promote the welfare of children.

Children Act 2004

3. **Section 10** requires each local authority to make arrangements to promote co-operation between the authority, each of the authority's relevant partners (see Table A below) and such other persons or bodies working with children in the local authority's area as the authority considers appropriate. The arrangements are to be made with a view to improving the wellbeing of children in the authority's area – which includes protection from harm or neglect alongside other outcomes. This section of the Children Act 2004 is the legislative basis for children's trust arrangements.

4. **Section 11** requires a range of organisations (see Table A) to make arrangements for ensuring that their functions, and services provided on their behalf, are discharged with regard to the need to safeguard and promote the welfare of children.

5. **Section 12** enables the Secretary of State to require local authorities to establish and operate databases relating to the section 10 or section 11 duties (above) or the section 175 duty (below), or to establish and operate databases nationally. This section limits the information that may be included in those databases, and sets out which organisations can be required to, and which can be enabled to, disclose information to be included in the databases. This section is the statutory basis for ContactPoint.

6. **Section 12A** was inserted by section 194 of the Apprenticeships, Skills Children and Learning Act 2009 and requires the co-operation arrangements made under section 10 to include the establishment of a Children's Trust Board.

7. **Section 13** requires each children's services authority to establish a Local Safeguarding Children Board (LSCB). It also requires a range of organisations (see the list in column 5 of Table A) to take part in LSCBs. Sections 13–16 set out the framework for LSCBs, and the LSCB Regulations set out the requirements in more detail, in particular on LSCB functions.

Table A: Bodies covered by key duties (in addition to local authorities)

Body	CA 2004 Section 10 – duty to co-operate	CA 2004 Section 11 – duty to s'guard & promote welfare	Ed Act 2002 Section 175 – duty to s'guard & promote welfare + and regs	CA 2004 Section 12A – statutory partners on CTBs	CA 2004 Section 13 – statutory partners in LSCBs	CA 1989 Section 27 – help with children in need	CA 1989 Section 47 – help with enquiries about sig harm
District councils	X	X		X	X	X	X
Police authority	X	X		X			
Chief officer of police	X	X		X	X		
Local probation board	X	X		X	X		
SoS re functions in s2-3 of the Offender Management Act 2007	X	X		X	X		
Provider of probation services required under s3(2) OMA 2007	X	X		X	X		
British Transport Police		X					
Prison or secure training centre		X			X (which detains children)		
Youth offending team	X	X		X	X		
Strategic Health Authority	X	X		X	X	X	X
Primary Care Trust	X	X		X	X	X	X

Body	CA 2004 Section 10 – duty to co-operate	CA 2004 Section 11 – duty to s'guard & promote welfare	Ed Act 2002 Section 175 – duty to s'guard & promote welfare + and regs	CA 2004 Section 12A – statutory partners on CTBs	CA 2004 Section 13 – statutory partners in LSCBs	CA 1989 Section 27 – help with children in need	CA 1989 Section 47 – help with enquiries about sig harm
Special Health Authority		X (as designated by the Secretary of State)				X	X
NHS trust		X			X	X	X
NHS foundation trust		X			X	X	X
Connexions Service	X	X		X	X		
Learning and Skills Council	X	X		X			
Cafcass					X		
Maintained schools	X		X	X			
FE colleges	X		X	X			
Independent schools	X		X	X			
Contracted services		X	X				
SoS re functions in section 2 Employment and Training Act 1973	X			X			
Such other persons as the authority considers appropriate	X			X (after consulting partners)			

Education Act 2002

8. **Section 175** puts a duty on local education authorities, maintained (state) schools and further education institutions, including sixth-form colleges, to exercise their functions with a view to safeguarding and promoting the welfare of children – children who are pupils, and students under 18 years of age in the case of schools and colleges.

9. The same duty is put on independent schools, including academies, by Regulations made under section 157 of that Act.

Children Act 1989

10. The Children Act 1989 places a duty on local authorities to promote and safeguard the welfare of children in need in their area.

> Section 17(1) of the Children Act 1989 states that:
>
> It shall be the general duty of every local authority:
>
> - to safeguard and promote the welfare of children within their area who are in need; and
> - so far as is consistent with that duty, to promote the upbringing of such children by their families, by providing a range and level of services appropriate to those children's needs.
>
> Section 17(10) states that a child shall be taken to be in need if:
>
> a) he is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him of services by a local authority under this Part;
>
> b) his heath or development is likely to be significantly impaired, or further impaired, without the provision for him of such services; or
>
> c) he is disabled.
>
> (Children Act 1989, section 17)

11. The primary focus of legislation about children in need is on how well they are progressing and whether their development will be impaired without the provision of services.

12. It also places a specific duty on other local authority services and health bodies to co-operate in the interests of children in need in section 27. Section 322 of the

Education Act 1996 places a duty on social services to assist the local education authority where any child has special educational needs.

Where it appears to a local authority that any authority mentioned in sub-section (3) could, by taking any specified action, help in the exercise of any of their functions under this Part, they may request the help of that other authority, specifying the action in question. An authority whose help is so requested shall comply with the request if it is compatible with their own statutory or other duties and obligations and does not unduly prejudice the discharge of any of their functions.

The authorities are:

a. any local authority;

b. any local education authority;

c. any local housing authority;

d. any health authority, special health authority, Primary Care Trust, National Health Service Trust or NHS Foundation Trust; and

e. any person authorised by the Secretary of State for the purpose of this section.

(Children Act 1989, section 27)

13. Under section 47 of the Children Act 1989, the same agencies are placed under a similar duty to assist local authorities in carrying out enquiries into whether or not a child is at risk of significant harm.

14. Section 47 also sets out duties for the local authority itself, around making enquiries in certain circumstances to decide whether they should take any action to safeguard or promote the welfare of a child.

Section 47(1) of the Children Act 1989 states that:

Where a local authority:

a. are informed that a child who lives, or is found, in their area (i) is the subject of an emergency protection order, or (ii) is in police protection, or (iii) has contravened a ban imposed by a curfew notice imposed within the meaning of Chapter I of Part I of the Crime and Disorder Act 1998; or

b. have reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm:

The authority shall make, or cause to be made, such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare.

In the case of a child falling within paragraph (a) (iii) above, the enquiries shall be commenced as soon as practicable and, in any event, within 48 hours of the authority receiving the information.

(Children Act 1989, section 47)

15. Under section 17 of the Children Act 1989, local authorities carry lead responsibility for establishing whether a child is in need and for ensuring that services are provided to that child as appropriate. This does not necessarily require local authorities themselves to be the provider of such services.

16. Section 17(5) of the Children Act 1989 enables the local authority to make arrangements with others to provide services on their behalf.

Every local authority:

a. shall facilitate the provision by others (including in particular voluntary organisations) of services which the authority have power to provide by virtue of this section, or section 18, 20, 23, 23B to 23D, 24A or 24B; and

b. may make such arrangements as they see fit for any person to act on their behalf in the provision of any such service.

(Children Act 1989, section 17(5))

17. Section 53 of the Children Act 2004 amends both section 17 and section 47 of the Children Act 1989, to require in each case that before determining what services to provide or what action to take, the local authority shall, so far as is reasonably practicable and consistent with the child's welfare:

- ascertain the child's wishes and feelings regarding the provision of those services or the action to be taken; and
- give due consideration (with regard to the child's age and understanding) to such wishes and feelings of the child as they have been able to ascertain.

Emergency protection powers

18. There is a range of powers available to local authorities and others such as the NSPCC and the police to take emergency action to safeguard children.

Emergency protection orders

The court may make an emergency protection order under section 44 of the Children Act 1989, if it is satisfied that there is reasonable cause to believe that a child is likely to suffer significant harm if:

- s/he is not removed to different accommodation; or
- s/he does not remain in the place in which s/he is then being accommodated.

An emergency protection order may also be made if enquiries (for example, made under section 47) are being frustrated by access to the child being unreasonably refused to a person authorised to seek access, and the applicant has reasonable cause to believe that access is needed as a matter of urgency.

An emergency protection order gives authority to remove a child, and places the child under the protection of the applicant.

Exclusion requirement

The court may include an exclusion requirement in an interim care order or emergency protection order (sections 38A and 44A of the Children Act 1989). This allows a perpetrator to be removed from the home instead of having to remove the child. The court must be satisfied that:

- there is reasonable cause to believe that if the person is excluded from the home in which the child lives, the child will cease to suffer, or cease to be likely to suffer, significant harm, or that enquires will cease to be frustrated; and
- another person living in the home is able and willing to give the child the care that it would be reasonable to expect a parent to give, and consents to the exclusion requirement.

Police protection powers

Under section 46 of the Children Act 1989, where a police officer has reasonable cause to believe that a child would otherwise be likely to suffer significant harm, s/he may:

- remove the child to suitable accommodation and keep him or her there; or
- take reasonable steps to ensure that the child's removal from any hospital, or other place in which the child is then being accommodated is prevented.

No child may be kept in police protection for more than 72 hours.

Homelessness Act 2002

19. Under section 12 (which inserts section 213A of the Housing Act 1996), housing authorities are required to refer to adult social care services homeless persons with dependent children who are ineligible for homelessness assistance, or are intentionally homeless, as long as the person consents. If homelessness persists, any child in the family could be in need. In such cases, if social services decide the child's needs would be best met by helping the family to obtain accommodation, they can ask the housing authority for reasonable advice and assistance in this, and the housing authority must give reasonable advice and assistance.

Appendix 2 – Framework for the Assessment of Children in Need

1. The *Framework for the Assessment of Children in Need and their Families* (outlined at Figure 1) provides a systematic basis for collecting and analysing information to support professional judgements about how to help children and families in the best interests of the child. Practitioners should use the framework to gain an understanding of:

   - a child's developmental needs;
   - the capacity of parents or caregivers to respond appropriately to those needs, including their capacity to keep the child safe from harm; and
   - the impact of wider family and environmental factors on the parents and child.

   Each of the three main aspects of the framework is outlined in more detail in Boxes 1, 2 and 3 respectively.

2. The framework is to be used for the assessment of all children in need, including those where there are concerns that a child may be suffering significant harm. The process of engaging in an assessment should be viewed as being part of the range of services offered to children and families. Use of the framework should provide evidence to help, guide and inform judgements about children's welfare and safety from the first point of contact, through the processes of initial and more detailed core assessments, according to the nature and extent of the child's needs. The provision of appropriate services need not and should not wait until the end of the assessment process, but should be determined according to what is required, and when, to promote the welfare and safety of the child.

3. Evidence about children's developmental progress – and their parents' capacity to respond appropriately to the child's needs within the wider family and environmental context – should underpin judgements about:

   - the child's welfare and safety;
   - whether, and if so how, to provide help to children and family members;
   - what form of intervention will bring about the best possible outcomes for the child; and
   - the intended outcomes of intervention.

Box 1: Dimensions of children's developmental needs

Health

Includes growth and development as well as physical and mental wellbeing. The impact of genetic factors and of any impairment need to be considered. Involves receiving appropriate health care when ill, an adequate and nutritious diet, exercise, immunisations where appropriate and developmental checks, dental and optical care and, for older children, appropriate advice and information on issues that have an impact on health, including sex education and substance misuse.

Education

Covers all areas of a child's cognitive development which begins from birth. Includes opportunities:

- for play and interaction with other children;
- to access books;
- to acquire a range of skills and interests; and
- to experience success and achievement.

Involves an adult interested in educational activities, progress and achievements, who takes account of the child's starting point and any special educational needs.

Emotional and behavioural development

Concerns the appropriateness of response demonstrated in feelings and actions by a child, initially to parents and caregivers and, as the child grows older, to others beyond the family. Includes nature and quality of early attachments, characteristics of temperament, adaptation to change, response to stress and degree of appropriate self control.

Identity

Concerns the child's growing sense of self as a separate and valued person. Includes the child's view of self and abilities, self image and self esteem, and having a positive sense of individuality. Race religion, age, gender, sexuality and disability may all contribute to this. Feelings of belonging and acceptance by family, peer group and wider society, including other cultural groups.

Family and social relationships

Development of empathy and the capacity to place self in someone else's shoes. Includes a stable and affectionate relationship with parents or caregivers, good relationships with siblings, increasing importance of age appropriate friendships with peers and other significant persons in the child's life and response of family to these relationships.

Social presentation

Concerns the child's growing understanding of the way in which appearance, behaviour, and any impairment are perceived by the outside world and the impression being created. Includes appropriateness of dress for age, gender, culture and religion; cleanliness and personal hygiene; and availability of advice from parents or caregivers about presentation in different settings.

Self care skills

Concerns the acquisition by a child of practical, emotional and communication competencies required for increasing independence. Includes early practical skills of dressing and feeding, opportunities to gain confidence and practical skills to undertake activities away from the family and independent living skills as older children. Includes encouragement to acquire social problem solving approaches. Special attention should be given to the impact of a child's impairment and other vulnerabilities, and on social circumstances affecting these in the development of self care skills.

Box 2: Dimensions of parenting capacity

Basic care

Providing for the child's physical needs, and appropriate medical and dental care. Includes provision of food, drink, warmth, shelter, clean and appropriate clothing and adequate personal hygiene.

Ensuring safety

Ensuring the child is adequately protected from harm or danger. Includes protection from significant harm or danger, and from contact with unsafe adults/ other children and from self-harm. Recognition of hazards and danger both in the home and elsewhere.

Emotional warmth

Ensuring the child's emotional needs are met giving the child a sense of being specially valued and a positive sense of own racial and cultural identity. Includes ensuring the child's requirements for secure, stable and affectionate relationships with significant adults, with appropriate sensitivity and responsiveness to the child's needs. Appropriate physical contact, comfort and cuddling sufficient to demonstrate warm regard, praise and encouragement.

Stimulation

Promoting the child's learning and intellectual development through encouragement and cognitive stimulation and promoting social opportunities. Includes facilitating the child's cognitive development and potential through interaction, communication, talking and responding to the child's language and questions, encouraging and joining the child's play, and promoting educational opportunities. Enabling the child to experience success and ensuring school attendance or equivalent opportunity. Facilitating child to meet challenges of life.

Guidance and boundaries

Enabling the child to regulate their own emotions and behaviour. The key parental tasks are demonstrating and modelling appropriate behaviour and control of emotions and interactions with others, and guidance which involves setting boundaries, so that the child is able to develop an internal model of moral values and conscience, and social behaviour appropriate for the society within which they will grow up. The aim is to enable the child to grow into an autonomous adult, holding their own values, and able to demonstrate appropriate behaviour with others rather than having to be dependent on rules outside themselves. This includes not over protecting children from exploratory and learning experiences. Includes social problem solving, anger management, consideration for others, and effective discipline and shaping of behaviour.

Stability

Providing a sufficiently stable family environment to enable a child to develop and maintain a secure attachment to the primary caregiver(s) in order to ensure optimal development. Includes: ensuring secure attachments are not disrupted, providing consistency of emotional warmth over time and responding in a similar manner to the same behaviour. Parental responses change and develop according to child's developmental progress. In addition, ensuring children keep in contact with important family members and significant others.

Box 3: Family and environmental factors

Family history and functioning

Family history includes both genetic and psycho-social factors. Family functioning is influenced by:

- who is living in the household and how they are related to the child;
- significant changes in family/household composition;
- history of childhood experiences of parents;
- chronology of significant life events and their meaning to family members;
- nature of family functioning, including sibling relationships and its impact on the child;
- parental strengths and difficulties, including those of an absent parent; and
- the relationship between separated parents.

Wider family

Who are considered to be members of the wider family by the child and the parents? This includes related and non-related persons and absent wider family. What is their role and importance to the child and parents and in precisely what way?

Housing

Does the accommodation have basic amenities and facilities appropriate to the age and development of the child and other resident members? Is the housing accessible and suitable to the needs of disabled family members? Includes the interior and exterior of the accommodation and immediate surroundings. Basic amenities include water, heating, sanitation, cooking facilities, sleeping arrangements and cleanliness, hygiene and safety and their impact on the child's upbringing.

Employment

Who is working in the household, their pattern of work and any changes? What impact does this have on the child? How is work or absence of work viewed by family members? How does it affect their relationship with the child? Includes children's experience of work and its impact on them.

Income

Income available over a sustained period of time. Is the family in receipt of all its benefit entitlements? Sufficiency of income to meet the family's needs. The way resources available to the family are used. Are there financial difficulties which affect the child?

Family's social integration

Exploration of the wider context of the local neighbourhood and community and its impact on the child and parents. Includes the degree of the family's integration or isolation, its peer groups, friendship and social networks and the importance attached to them.

Community resources

Describes all facilities and services in a neighbourhood, including universal services of primary health care, day care and schools, places of worship, transport, shops and leisure activities. Includes availability and standard of resources and impact on the family, including disabled members.

Appendix 3 – Using standardised assessment tools to evidence assessment and decision making

1. **The Strengths and Difficulties Questionnaires** (Goodman et al, 1997; Goodman et al, 1998). These scales are a modification of the very widely used instruments to screen for emotional and behavioural problems in children and adolescents – the Rutter A + B scales for parents and teachers. Although similar to Rutter's, the Strengths and Difficulties Questionnaire's wording was re-framed to focus on a child's emotional and behavioural strengths as well as difficulties. The actual questionnaire incorporates five scales: pro-social, hyperactivity, emotional problems, conduct (behavioural) problems, and peer problems. In the pack, there are versions of the scale to be completed by adult caregivers, or teachers for children from age three to sixteen, and children between the ages of 11 to 16. These questionnaires have been used with disabled children and their teachers and carers. They are available in 40 languages on the following website: www.sdqinfo.com/

2. **The Parenting Daily Hassles Scale** (Crinic and Greenberg, 1990; Crinic and Booth, 1991) aims to assess the frequency and intensity/impact of 20 potential parenting 'daily' hassles experienced by adults caring for children. It has been used in a wide variety of research studies concerned with children and families – particularly families with young children. It has been found that parents (or caregivers) generally like filling it out, because it touches on many aspects of being a parent that are important to them.

3. **The Recent Life Events Questionnaire** (Taken from Brugha et al, 1985) helps to define negative life events over the last 12 months, but could be used over a longer time-scale, and significantly whether the respondent thought they have a continuing influence. Respondents are asked to identify which of the events still affects them. It was hoped that use of the scale will:

   - result in a fuller picture of a family's history and contribute to greater contextual understanding of the family's current situation;
   - help practitioners explore how particular recent life events have affected the carer and the family; and
   - in some situations, identify life events which family members have not reported earlier.

4. **The Home Conditions Assessment** (Davie et al, 1984) helps make judgements about the context in which the child was living, dealing with questions of safety, order and cleanliness which have an important bearing where issues of neglect are the focus of concern. The total score has been found to correlate highly with indices of the development of children.

5. **The Family Activity Scale** (derived from The Child-Centredness Scale – Smith, 1985) gives practitioners an opportunity to explore with carers the environment provided for their children, through joint activities and support for independent activities. This includes information about the cultural and ideological environment in which children live, as well as how their carers respond to their children's actions (for example, concerning play and independence). They aim to be independent of socio-economic resources. There are two separate scales; one for children aged two to six, and one for children aged seven to twelve.

6. **The Alcohol Scale** was developed by Piccinelli et al (1997). Alcohol abuse is estimated to be present in about 6% of primary carers, ranking it third in frequency behind major depression and generalised anxiety. Higher rates are found in certain localities, and particularly amongst those parents known to social services. Drinking alcohol affects different individuals in different ways. For example, some people may be relatively unaffected by the same amount of alcohol that incapacitates others. The primary concern therefore is not the amount of alcohol consumed, but how it impacts on the individual and, more particularly, on their role as a parent. This questionnaire has been found to be effective in detecting individuals with alcohol disorders and those with hazardous drinking habits.

7. **Adult Wellbeing Scale** (Irritability, Depression, Anxiety – IDA Scale. Snaith et al, 1978). This scale, which was based on the Irritability, Depression and Anxiety Scale, was devised by a social worker involved in the pilot. The questions are framed in a 'personal' fashion (that is, I feel, my appetite is…). This scale looks at how an adult is feeling in terms of their depression, anxiety and irritability. The scale allows the adult to respond from four possible answers, which enables the adult some choice, and therefore less restriction. This could enable the adult to feel more empowered.

8. **The Adolescent Wellbeing Scale** (Self-rating Scale for Depression in Young People. Birleson, 1980) was originally validated for children aged between seven and sixteen. It involves 18 questions each relating to different aspects of a child or adolescent's life, and how they feel about these. As a result of the pilot the wording of some questions was altered in order to be more appropriate to adolescents. Although children as young as seven and eight have used it, older children's thoughts and beliefs about themselves are more stable. The scale is intended to enable practitioners to gain more insight and understanding into how an adolescent feels about their life.

9. **The Home Inventory** (Cox and Walker, 2002) assessment through interview and observation provides an extensive profile of the context of care provided for the child and is a reliable approach to assessment of parenting. It gives a reliable account of the parents' capacities to provide learning materials, language stimulation, and appropriate physical environment, to be responsive, stimulating, providing adequate modelling variety and acceptance. A profile of needs can be constructed in these areas, and an analysis of how considerable the changes would need to be to meet the specific needs of the significantly harmed child; and the contribution of the environment provided by the parents to the harm suffered. The HOME Inventory has been used extensively to demonstrate change in the family context as a result of intervention, and can be used to assess whether intervention has been successful.

10. **The Family Assessment** (Bentovim and Bingley Miller, 2001) provides a systematic and systemic assessment in complex child care cases of family functioning, family relationships, the quality of parenting and the parents' capacity to adapt to the children's needs as well as the impact of family history. It provides a standardised evidence-based approach to assessing current family strengths and difficulties which have played a role in the significant harm of the child, and also in assessing the capacity for change, resources in the family to achieve a safe context for the child, and the reversal of family factors which may have played a role in significant harm, and aiding the recovery and future health of the child. The Family Assessment Profile draws together the assessment and provides qualitative and quantitative information on the parents' understanding of the child's state, and the level of responsibility they take for any significant harm or likelihood of harm, the capacity of the parents to adapt to the children's changing needs in the past and future, their abilities to promote development, provide care-giving which enables their children to have secure attachments with them as care-givers, provide adequate guidance, care and to manage conflict, make decisions and relate to the wider family and community.

Appendix 4 – MOD child protection contacts

1. Appendix 4 offers points of contact for the relevant Service agencies in child protection matters.

Royal Navy

2. All child protection matters within the Royal Navy are managed by the Naval Personal and Family Service (NPFS), the Royal Navy's social work department. This provides a confidential and professional social work service to all Naval personnel and their families, liaising as appropriate with local authority children's social care services. Child protection issues involving the family of a member of the Royal Navy should be referred to the relevant Area Officer, NPFS.

NPFS Eastern Area Portsmouth	(02392) 722712	Fax: 725803
NPFS Northern Area Helensburgh	(01436) 672798	Fax: 674965
NPFS Western Area Plymouth	(01752) 555041	Fax: 555647

Royal Marines

3. The Royal Marines Welfare Service is staffed by trained but unqualified Royal Marine senior non-commissioned officers (NCOs). They are accountable to a qualified social work manager at Headquarters Royal Marines, Portsmouth. For child protection matters involving Royal Marines families, social services departments should notify SO3 (WFS) at Portsmouth. Tel: (02392) 547542.

Army

4. Staffed by qualified civilian Social Workers and trained and supervised Army Welfare Workers, the Army Welfare Service (AWS) provides professional welfare support to Army personnel and their families. AWS also liaises with local authorities where appropriate, particularly where a child is subject to child protection concerns. Local Authorities who have any enquiries or concerns regarding safeguarding or promoting the welfare of a child from an Army Family should contact the Senior Army Welfare Worker in the nearest AWS team location or:

Chief Personal Support Officer
HQ AWS
HQ Land Command
Erskine Barracks
Wilton
Salisbury
SP2 0AG

Tel: 01722 436564
Fax: 01722 436307
e-mail: LF-AWS-CPSO@mod.uk

Royal Air Force

5. Welfare Support for families in the RAF is managed as a normal function of Command and co-ordinated by each Station's Personnel Officer, the Officer Commanding Personnel Management Squadron (OCPMS) or the Officer Commanding Administrative Squadron (OCA), depending on the size of the Station.

6. A number of qualified SSAFA Forces Help Social Workers and trained professionally supervised Personal and Family Support Workers are located throughout the UK to assist the chain of Command in providing welfare support.

7. Any Local Authority who have any enquiries or concerns regarding safeguarding or promoting the welfare of a child from an RAF family should contact the parent's unit, or if this is not known, contact the OC PMS/OCA of the nearest RAF Unit. Additionally, the SSAFA Forces Help Head of Service RAF can be contacted at:

Head of Service
SSAFA-Forces Help
HQ Air Command
RAF High Wycombe
Buckinghamshire
HP14 4UE

Tel: 01494 496477
Fax: 01494 497971

e-mail: AirPersPol-SSAFAForcesHelpHd@mod.uk

Or

Director of Social Work SSAFA-Forces Help
19 Queen Elizabeth Street
London SE1 2LP

Tel: 020 7403 8783
Fax: 020 7403 8815

Email: directorofsocialwork@ssafa.org.uk

Overseas

The following should be consulted:

Royal Navy

Area Officer (NPFS) Eastern
HMS Nelson
Queen Street
Portsmouth
PO1 3HH

Tel: (02392) 722712
Fax: (02392) 725083

Army and Royal Air Force

Director of Social Work SSAFA-Forces Help
Contact details shown above.

*For **any** child being taken abroad and subject to child protection procedures or the subject of a child protection plan, the Director of Social Work SSAFA-Forces Help **must** be consulted, using the same contact details shown above.*

Appendix 5 – Procedures for managing allegations against people who work with children

Scope

1. The framework for managing cases set out in this guidance applies to a wider range of allegations than those in which there is reasonable cause to believe a child is suffering, or is likely to suffer, significant harm. It also caters for cases of allegations that might indicate that s/he is unsuitable to continue to work with children in their present position, or in any capacity. It should be used in respect of all cases in which it is alleged that a person who works with children has:

   - behaved in a way that has harmed a child, or may have harmed a child;
   - possibly committed a criminal offence against or related to a child; or
   - behaved towards a child or children in a way that indicates s/he is unsuitable to work with children.

2. There may be up to three strands in the consideration of an allegation:

   - a police investigation of a possible criminal offence;
   - enquiries and assessment by children's social care about whether a child is in need of protection or in need of services; and
   - consideration by an employer[274] of disciplinary action in respect of the individual.

274 For convenience the term employer is used throughout this guidance to refer to organisations that have a working relationship with the individual against whom the allegation is made. That includes organisations that use the services of volunteers, or people who are self employed, as well as service providers, voluntary organisations, employment agencies or businesses, contractors, fostering services, regulatory bodies such as Ofsted in the case of childminders, and others that may not have a direct employment relationship with the individual, but will need to consider whether to continue to use the person's services, or to provide the person for work with children in future, or to deregister the individual. N.B. In some circumstances the term 'employer' for these purposes will encompass more than one organisation. For example, where staff providing services for children in an organisation are employed by a contractor, or where temporary staff are provided by an agency. In those circumstances both the contractor or agency, and the organisation in which the accused individual worked will need to be involved in dealing with the allegation.

3. Some cases will also need to be referred to the ISA for consideration of including the person on the ISA barred lists, or for consideration by professional bodies or regulators.

Supporting those involved

4. Parents or carers of a child or children involved should be told about the allegation as soon as possible if they do not already know of it (subject to paragraph 15 below). They should also be kept informed about the progress of the case, and told the outcome where there is not a criminal prosecution. That includes the outcome of any disciplinary process. NB. The deliberations of a disciplinary hearing, and the information taken into account in reaching a decision, cannot normally be disclosed, but those concerned should be told the outcome.

5. In cases where a child may have suffered significant harm, or there may be a criminal prosecution, children's social care, or the police as appropriate, should consider what support the child or children involved may need.

6. The employer should also keep the person who is the subject of the allegations informed of the progress of the case, and arrange to provide appropriate support to the individual while the case is ongoing (that may be provided via occupational health or employee welfare arrangements where those exist). If the person is suspended the employer should also make arrangements to keep the individual informed about developments in the workplace. As noted in paragraph 16, if the person is a member of a union or professional association s/he should be advised to contact that body at the outset.

Confidentiality

7. Every effort should be made to maintain confidentiality and guard against publicity while an allegation is being investigated/considered. In accordance with ACPO guidance, the police will not normally provide any information to the Press or media that might identify an individual who is under investigation, unless and until the person is charged with a criminal offence (In exceptional cases where the police might depart from that rule, for example, an appeal to trace a suspect, the reasons should be documented and partner agencies consulted beforehand). The system of self-regulation, overseen by the Press Complaints Commission, also provides safeguards against the publication of inaccurate or misleading information.

Resignations and 'compromise agreements'

8. The fact that a person tenders his or her resignation, or ceases to provide their services, must not prevent an allegation being followed up in accordance with these

procedures. It is important that every effort is made to reach a conclusion in all cases of allegations bearing on the safety or welfare of children including any in which the person concerned refuses to co-operate with the process. Wherever possible the person should be given a full opportunity to answer the allegation and make representations about it, but the process of recording the allegation and any supporting evidence, and reaching a judgement about whether it can be regarded as substantiated on the basis of all the information available should continue even if that cannot be done or the person does not co-operate. It may be difficult to reach a conclusion in those circumstances, and it may not be possible to apply any disciplinary sanctions if a person's period of notice expires before the process is complete, but it is important to reach and record a conclusion wherever possible.

9. By the same token so called 'compromise agreements' by which a person agrees to resign, the employer agrees not to pursue disciplinary action, and both parties agree a form of words to be used in any future reference, must not be used in these cases. In any event, such an agreement will not prevent a thorough police investigation where appropriate. Nor can it override an employer's statutory duty to make a referral to the Independent Safeguarding Authority where circumstances require that.

Record keeping

10. It is important that employers keep a clear and comprehensive summary of any allegations made, details of how the allegation was followed up and resolved, and details of any action taken and decisions reached, on a person's confidential personnel file and give a copy to the individual. Such information should be retained on file, including for people who leave the organisation, at least until the person reaches normal retirement age or for 10 years if that will be longer. The purpose of the record is to enable accurate information to be given in response to any future request for a reference. It will provide clarification in cases where a future CRB Disclosure reveals information from the police that an allegation was made but did not result in a prosecution or a conviction. And it will prevent unnecessary re-investigation if, as sometimes happens, allegations re-surface after a period of time.

Timescales

11. It is in everyone's interest to resolve cases as quickly as possible consistent with a fair and thorough investigation. Every effort should be made to manage cases to avoid any unnecessary delay. Indicative target timescales are shown for different actions in the summary description of the process. Those are not performance indicators: the time taken to investigate and resolve individual cases depends on a

variety of factors including the nature, seriousness, and complexity of the allegation, but they provide useful targets to aim for that are achievable in many cases.

Oversight and monitoring

12. LSCB member organisations, county level and unitary local authorities, and police forces should each have officers who fill the roles described in paragraphs 6.35 and 6.36.

13. Other employers' procedures should identify a senior manager within the organisation to whom allegations or concerns that a member of staff or volunteer may have abused a child should be reported, and should make sure that all staff and volunteers know who that is. The procedures should also identify an alternative person to whom reports should be made in the absence of the named senior manager, or in cases where that person is the subject of the allegation or concern, and include contact details for the local authority designated officer responsible for providing advice, liaison, and monitoring the progress of cases to ensure that they are dealt with as quickly as possibly consistent with a fair and thorough process.

Initial considerations

14. Procedures need to be applied with common sense and judgement. Some allegations will be so serious as to require immediate referral to children's social care and the police for investigation. Others may be much less serious and at first sight might not seem to warrant consideration of a police investigation, or enquiries by children's social care. However, it is important to ensure that even apparently less serious allegations are seen to be followed up, and that they are examined objectively by someone independent of the organisation concerned. Consequently, the local authority designated officer should be informed of all allegations that come to the employer's attention and appear to meet the criteria in paragraph 1, so that s/he can consult police and social care colleagues as appropriate. The local authority designated officer should also be informed of any allegations that are made directly to the police (which should be communicated via the police force designated officer) or to children's social care.

15. The local authority designated officer should first establish, in discussion with the employer, that the allegation is within the scope of these procedures, see paragraph 1, and may have some foundation. If the parents/carers of the child concerned are not already aware of the allegation, the designated officer will also discuss how and by whom they should be informed. In circumstances in which the police or children's social care may need to be involved, the local authority officer should consult those colleagues about how best to inform parents. However, in some circumstances an employer may need to advise parents of an incident involving

their child straight away, for example if the child has been injured while in the organisation's care and requires medical treatment.

16. The employer should inform the accused person about the allegation as soon as possible after consulting the local authority designated officer. However, where a strategy discussion is needed, or it is clear that police or children's social care may need to be involved, that should not be done until those agencies have been consulted and have agreed what information can be disclosed to the person. If the person is a member of a union or professional association s/he should be advised to seek support from that organisation.

17. If there is cause to suspect a child is suffering or is likely to suffer significant harm, a strategy discussion should be convened in accordance with paragraph 5.56. NB. In these cases the strategy discussion should include a representative of the employer (unless there are good reasons not to do that), and take account of any information the employer can provide about the circumstances or context of the allegation.

18. In cases where a formal strategy discussion is not considered appropriate because the threshold of 'significant harm' is not reached, but a police investigation might be needed, the local authority designated officer should nevertheless conduct a similar discussion with the police, the employer, and any other agencies involved with the child to evaluate the allegation and decide how it should be dealt with (NB. The police must be consulted about any case in which a criminal offence may have been committed). Like a strategy discussion that initial evaluation may not need to be a face to face meeting. It should share available information about the allegation, the child, and the person against whom the allegation has been made, consider whether a police investigation is needed and, if so, agree the timing and conduct of that. In cases where a police investigation is necessary the joint evaluation should also consider whether there are matters which can be taken forward in a disciplinary process in parallel with the criminal process, or whether any disciplinary action will need to wait completion of the police enquiries and/or prosecution.

19. If the complaint or allegation is such that it is clear that investigations by police and/or enquiries by children's social care are not necessary, or the strategy discussion or initial evaluation decides that is the case, the local authority designated officer should discuss next steps with the employer. In those circumstances options open to the employer will range from taking no further action to summary dismissal or a decision not to use the person's services in future. The nature and circumstances of the allegation and the evidence and information available will determine which of the range of possible options is most appropriate.

20. In some cases further investigation will be needed to enable a decision about how to proceed. If so, the local authority designated officer should discuss with the person's employer how and by whom the investigation will be undertaken. That should normally be undertaken by the employer. However in some circumstances appropriate resources may not be available in the employer's organisation or the nature and complexity of the allegation might point to the employer commissioning an independent investigation.

Suspension

21. The possible risk of harm to children posed by an accused person needs to be effectively evaluated and managed – in respect of the child(ren) involved in the allegations, and any other children in the individual's home, work or community life. In some cases that will require the employer to consider suspending the person. Suspension should be considered in any case where there is cause to suspect a child is at risk of significant harm, or the allegation warrants investigation by the police, or is so serious that it might be grounds for dismissal. People must not be suspended automatically, or without careful thought. Employers must consider carefully whether the circumstances of a case warrant a person being suspended from contact with children until the allegation is resolved. NB. Neither the local authority, the police, nor children's social care can require an employer to suspend a member of staff or a volunteer. The power to suspend is vested in the employer alone. However, where a strategy discussion or initial evaluation discussion concludes that there should be enquiries by children's social care and/or an investigation by the police, the local authority designated officer should also canvass police/children's social care views about whether the accused member of staff needs to be suspended from contact with children, to inform the employer's consideration of suspension.

Monitoring progress

22. The local authority designated officer should regularly monitor the progress of cases either via review strategy discussions or by liaising with the police and/or children's social care colleagues, or the employer as appropriate. Reviews should be conducted at fortnightly or monthly intervals depending on the complexity of the case.

23. If the strategy discussion or initial evaluation decides that a police investigation is required, the police should also set a target date for reviewing the progress of the investigation and consulting the Crown Prosecution Service (CPS) to consider whether to charge the individual, continue to investigate or close the investigation. Wherever possible that review should take place **no later than four weeks** after the initial action meeting. Dates for subsequent reviews, at fortnightly or monthly intervals, should be set at the meeting if the investigation continues.

Information sharing

24. In the initial consideration at a strategy discussion or joint evaluation the agencies concerned, including the employer, should share all relevant information they have about the person who is the subject of the allegation, and about the alleged victim.

25. Wherever possible the police should obtain consent from the individuals concerned to share the statements and evidence they obtain with the employer, and/or regulatory body, for disciplinary purposes. That should be done as the investigation proceeds rather than after it is concluded. That will enable the police and CPS to share relevant information without delay at the conclusion of their investigation or any court case.

26. Children's social care should adopt a similar procedure when making enquiries to determine whether the child or children named in the allegation is in need of protection or services so that any information obtained in the course of those enquiries which is relevant to a disciplinary case can be passed to the employer or regulatory body without delay.

Action following a criminal investigation or a prosecution

27. The police or the CPS should inform the employer and local authority designated officer straightaway when a criminal investigation and any subsequent trial is complete, or if it is decided to close an investigation without charge, or not to prosecute after the person has been charged. In those circumstances the local authority designated officer should discuss with the employer whether any further action is appropriate and, if so, how to proceed. The information provided by the police and/or children's social care should inform that decision. Action by the employer, including dismissal, is not ruled out in any of those circumstances. The range of options open will depend on the circumstances of the case and the consideration will need to take account the result of the police investigation or trial, as well as the different standard of proof required in disciplinary and criminal proceedings.

Action on conclusion of a case

28. If the allegation is substantiated and the person is dismissed or the employer ceases to use the person's services, or the person resigns or otherwise ceases to provide his/her services, the local authority designated officer should discuss with the employer whether a referral to the Independent Safeguarding Authority is required, or advisable, and the form and content of a referral. A referral must always be made if the employer thinks that the individual has harmed a child or poses a risk of harm to children. Also, if the person is subject to registration or regulation by a

professional body or regulator, for example by the General Social Care Council, General Medical Council, Ofsted etc. the designated officer should advise on whether a referral to that body is appropriate.

29. If it is decided on the conclusion of the case that a person who has been suspended can return to work the employer should consider how best to facilitate that. Most people will benefit from some help and support to return to work after a very stressful experience. Depending on the individual's circumstances, a phased return and/or the provision of a mentor to provide assistance and support in the short term may be appropriate. The employer should also consider how the person's contact with the child or children who made the allegation can best be managed if they are still in the workplace.

Learning lessons

30. At the conclusion of a case in which an allegation is substantiated the employer should review the circumstances of the case to determine whether there are any improvements to be made to the organisation's procedures or practice to help prevent similar events in the future. This should include issues arising from any decision to suspend a member of staff, the duration of the suspension and whether or not suspension was justified.

Action in respect of unfounded or malicious allegations

31. If an allegation is determined to be unfounded or malicious, the employer should refer the matter to children's social care to determine whether the child concerned is in need of services, or may have been abused by someone else. In the rare event that an allegation is shown to have been deliberately invented or malicious, the police should be asked to consider whether any action might be appropriate against the person responsible.

Summary of Process

Allegation made to employer

32. The allegation should be reported to the senior manager identified in the employer's procedure immediately unless that person is the subject of the allegation in which case it should be reported to the designated alternative.

33. If the allegation meets any of the criteria set out in paragraph 1 the employer should report it to the local authority designated office within 1 working day.

Allegation made to the police or children's social care

34. If an allegation is made to the police, the officer who receives it should report it to the force designated liaison officer without delay and the designated liaison officer should in turn inform the local authority designated officer straight away. Similarly if the allegation is made to children's social care the person who receives it should report it to the local authority designated officer without delay.

Initial consideration

35. The local authority designated officer will discuss the matter with the employer and where necessary obtain further details of the allegation and the circumstances in which it was made. The discussion should also consider whether there is evidence/information that establishes that the allegation is false or unfounded.

36. If the allegation is not patently false and there is cause to suspect that a child is suffering or is likely to suffer significant harm, the local authority designated officer will immediately refer to children's social care and ask for a strategy discussion to be convened straight away. In those circumstances the strategy discussion should include the local authority designated officer and a representative of the employer.

37. If there is not cause to suspect that 'significant harm' is an issue, but a criminal offence might have been committed, the local authority designated officer should immediately inform the police and convene a similar discussion to decide whether a police investigation is needed. That discussion should also involve the employer.

Action following initial consideration

38. Where the initial evaluation decides that the allegation does not involve a possible criminal offence it will be dealt with by the employer. In such cases, if the nature of the allegation does not require formal disciplinary action, appropriate action should be instituted **within three working days**. If a disciplinary hearing is required and can be held without further investigation, the hearing should be held **within 15 working days**.

39. Where further investigation is required to inform consideration of disciplinary action the employer should discuss who will undertake that with the local authority designated officer. In some settings and circumstances it may be appropriate for the disciplinary investigation to be conducted by a person who is independent of the employer or the person's line management to ensure objectivity. In any case the investigating officer should aim to provide a report to the employer **within 10 working days**.

40. On receipt of the report of the disciplinary investigation, the employer should decide whether a disciplinary hearing is needed **within two working days,** and if a hearing is needed it should be held **within 15 working days**.

41. In any case in which children's social care has undertaken enquiries to determine whether the child or children are in need of protection, the employer should take account of any relevant information obtained in the course of those enquiries when considering disciplinary action.

42. The local authority designated officer should continue to liaise with the employer to monitor progress of the case and provide advice/support when required/requested.

Case subject to police investigation

43. If a criminal investigation is required, the police will aim to complete their enquiries as quickly as possible consistent with a fair and thorough investigation and will keep the progress of the case under review. They should at the outset set a target date for reviewing progress of the investigation and consulting the CPS about whether to proceed with the investigation, charge the individual with an offence, or close the case. Wherever possible that review should take place **no later than four weeks** after the initial evaluation, and if the decision is to continue to investigate the allegation dates for subsequent reviews should be set at that point (it is open to the police to consult the CPS about the evidence that will need to be obtained in order to charge a person with an offence at any stage).

44. If the police and/or CPS decide not to charge the individual with an offence, or decide to administer a caution, or the person is acquitted by a Court, the police should pass all information they have which may be relevant to a disciplinary case to the employer without delay. In those circumstances the employer and the local authority designated officer should proceed as described in paragraphs 37–41 above.

45. If the person is convicted of an offence the police should also inform the employer straight away so that appropriate action can be taken.

Referral to the Independent Safeguarding Authority

If the allegation is substantiated and on conclusion of the case the employer dismisses the person or ceases to use the person's services, or the person ceases to provide his/her services, the employer should consult the local authority designated officer about whether a referral to the Independent Safeguarding Authority and/or to a professional or regulatory body is required. If a referral is appropriate the report should be made within one month. A referral must always be made if the employer thinks that the individual has harmed a child or poses a risk of harm to children.

Appendix 6 – Faith community contacts and resources

Appendix 6 offers points of contact for faith communities in child protection matters and outlines some key resources that may be useful.

Faith community contacts

Organisation	Telephone number	Website
Baptist Church	01235 517 700	www.baptist.org.uk
Catholic Church – CSAS	0121 237 6076	www.csas.uk.net
Church of Jesus Christ and the Latter-day Saints	0121 712 1251	www.lds.org.uk
Church in Wales	0292 034 8234	www.churchinwales.org.uk
Methodist and Church of England	020 7467 5189	www.methodistchurch.org.uk
Mosques and Imams National Advisory Board (MINAB)	020 8993 7141	www.minab.org.uk
Movement for Reform Judaism	020 8349 5656	www.reformjudaism.org.uk
Muslim Council of Britain	0845 2626 786	www.mcb.org.uk
Religious Society of Friends	020 7663 1023	www.quaker.org.uk
Salvation Army	020 7367 4772	www.salvationarmy.org.uk
United Reform Church	020 7916 2020	www.urc.org.uk
United Synagogue	020 8343 8989	www.theus.org.uk

For those from Hindu or Sikh faith, please contact the local temple.

For other faiths including independent Christian churches, please contact the Churches' Child Protection Advisory Service (CCPAS) who are an independent christian child care charity working across the faith sector. Please ring 0845 120 4550, visit www.ccpas.co.uk or email info@ccpas.co.uk.

Faith community resources

CCPAS, together with the Lucy Faithful Foundation, have produced materials to assist faith communities in working with offenders, including a DVD, *SOS Supporting Offenders Safely*, and a booklet, *Help... a sex offender has joined my church*.

CCPAS has also produced *Safe and Secure*, ten safeguarding standards for faith communities, which contains both policies and procedures, as well as an hour long safeguarding DVD drama documentary set around the 10 standards

Faith communities should also refer to Section 6.49 to 6.53 Child abuse linked to belief in 'spirit possession' and the DCSF good practice guidance *Safeguarding Children from Abuse Linked to a belief in Spirit Possession* (DCSF, 2007). Further information is available on '*Good Practice for Working with Faith Communities – Spirit Possession & Abuse*' from CCPAS.

Appendix 7 – A guide to acronyms in the document

A&E	Accident and Emergency
ACPO	Association of Chief Police Officers
AWS	Army Welfare Service
BECTA	British Educational Communications and Technology Agency
CAF	Common Assessment Framework
Cafcass	Children and Family Court Advisory and Support Service
CAIUs	Child abuse investigation units
CAMHS	Child and Adolescent Mental Health Services
CCPAS	Churches' Child Protection Advisory Service
CDOP	Child Death Overview Panel
CDRPs	Crime and Disorder Reduction Partnerships
CEOP	Child Exploitation and On-Line Protection Centre
CJCSA	Criminal Justice and Court Services Act
CMACE	Centre for Maternal and Child Enquiries
CME	Child Missing Education
CPS	Crown Prosecution Service
CPSU	Child Protection in Sport Unit
CQC	Care Quality Commission
CRB	Criminal Record Bureau
CSAS	Catholic Safeguarding Advisory Service
CSO	Child Safety Order
CT	Children's Trust
CTB	Children's Trust Board
CWDC	Children's Workforce Development Council
CYPP	Children and Young People's Plan
DASH	Domestic Abuse, Stalking and Harassment and Honour Based Violence
DCPs	Dental practitioners and dental care professionals
DCS	Director of Children's Services
DCSF	The Department for Children, Schools and Families
DH	The Department of Health
DPA	Data Protection Acts
EEA	European Economic Area
EPO	Emergency Protection Order
EYFS	Early Years Foundation Stage
FAS	Fetal Alcohol Syndrome
FCO	Foreign and Commonwealth Office
FE	Further Education
FGCs	Family Group Conferences

FGM	Female Genital Mutilation
FII	Fabricated or induced illness
FIPs	Family Intervention Projects
GMC	General Medical Council
GO	Government Office
GP	General Practitioner
HMI Probation	Her Majesty's Inspectorate of Probation
HMIC	Her Majesty's Inspectorate of Constabulary
HMIP	Her Majesty's Inspectorate of Prisons
ICS	Integrated Children's System
ICT	Information Communication Technology
IDVA	Individual Domestic Violence Advisor
IMR	Individual Management Review
INI	IMPACT Nominal Index
IRO	Independent Reviewing Officer
ISA	Independent Safeguarding Authority
JSP	Joint Service Publication
LADO	Local authority Designated Officer
LASSL	Local Authority Social Services Letter
LAYS	Local authority youth services
LL/LT	Life Limiting or Life Threatening
LSCB	Local Safeguarding Children Board
MAPPA	Multi Agency Public Protection Arrangements
MARAC	Multi Agency Risk Assessment Conference
MEs	Medical Examiners
MSCR	MAPPA Serious Case Review
NICE	The National Institute for Health and Clinical Excellence
NOMS	National Offenders Management Service
NPFS	Naval Personal and Family Service
NPIA	The National Police Improvement Agency
NRM	National Referral Mechanism
NSF	National Service Framework
OSSys	Offender Assessment System
PACE	Police and Criminal Evidence Act
PCTs	Primary Care Trusts
PDUs	Problem Drug Users
PND	Police National Database
PPO	Probation and Prisons Ombudsman
PSAs	Parenting Support Advisers
PSHE	Personal, Social and Health Education
RN	Royal Navy
RSHOs	Risk of Sexual Harm Orders
RSLs	Registered Social Landlords

SARCs	Sexual Assault Referral Centres
SARS	Sexual Assault Referral Services
SCHs	Secure Children's Homes
SCRs	Serious Case Reviews
SEN	Special Education Needs
SFO	Serious Further Offence
SHAs	Strategic Health Authorities
SMB	Strategic Management Board
SOPOs	Sexual Offences Prevention Orders
SSAFA-FH	Sailors Airmen and Families Association-Forces Help
STCs	Secure Training Centres
SUDI	Sudden Unexpected Deaths in Infancy
TAC	Team around the Child
TSA	Tenant Services Authority
UASC	Unaccompanied Asylum Seeking Child
UK	United Kingdom
UKBA	United Kingdom Border Agency
UKHTC	UK Human Trafficking Centre
US	United States
VBS	Vetting and Barring Scheme
VISOR	The Violent and Sexual Offenders Register
VOOs	Violent Offender Orders
YCWs	Youth and community workers
YJB	Youth Justice Board
YJS	Youth Justice System
YOIs	Young Offender Institutions
YOTs	Youth Offending Teams

References and internet links

Chapter 1

Every Child Matters Green Paper.
Internet link:
http://publications.everychildmatters.gov.uk/eOrderingDownload/CM5860.pdf

The Protection of Children in England: A Progress Report.
Internet link:
http://publications.everychildmatters.gov.uk/eOrderingDownload/HC-330.pdf

The Protection of Children in England: Action Plan.
Internet link:
http://publications.dcsf.gov.uk/eOrderingDownload/DCSF-Laming.pdf

Guidance on the roles and responsibilities of the Director of Children's Services and Lead Member for children's services.
Internet link:
http://publications.everychildmatters.gov.uk/default.aspx?PageFunction=productdetails&PageMode=publications&ProductId=DCSF-00686-2009

Adcock, M. and White, R. (1998). *Significant Harm: its management and outcome*. Surrey: Significant Publications.

Jones, D. P. H. (2003). *Communicating with Vulnerable Children: a Guide for Practitioners*. London: Gaskell.

Chapter 2

Children Act 2004
Internet link:
www.opsi.gov.uk/acts/acts2004/ukpga_20040031_en_1

Making Arrangements to Safeguard and Promote the Welfare of Children.
Internet link:
www.everychildmatters.gov.uk/resources-and-practice/IG00042/

Education Act 2002
Internet link:
www.opsi.gov.uk/acts/acts2002/ukpga_20020032_en_1

Safeguarding Children and Safer Recruitment in Education.
Internet link:
www.dcsf.gov.uk/everychildmatters/resources-and-practice/IG00175/

Children Act 1989.
Internet link:
www.opsi.gov.uk/acts/acts1989/ukpga_19890041_en_1

National Minimum Standards.
Internet link:
www.dh.gov.uk/en/PublicationsAndStatistics/Legislation/ActsAndBills/DH_4001911

Childcare Act 2006.
Internet link:
www.opsi.gov.uk/acts/acts2006/ukpga_20060021_en_1

Criminal Justice and Court Services Act 2000.
Internet link:
www.opsi.gov.uk/Acts/acts2000/ukpga_20000043_en_1

Borders, Citizenship and Immigration Act 2009.
Internet link:
www.opsi.gov.uk/acts/acts2009/ukpga_20090011_en_1

Arrangements to Safeguard and Promote Children's Welfare in the United Kingdom Border Agency.
Internet link:
www.ukba.homeoffice.gov.uk/sitecontent/documents/policyandlaw/legislation/bci-act1/
and www.dcsf.gov.uk/everychildmatters/12870

Information Sharing: Guidance for practitioners and managers.
Internet link:
www.dcsf.gov.uk/ecm/informationsharing

The *Embedding information sharing toolkit.*
Internet link:
www.dcsf.gov.uk/ecm/informationsharing

The Children Act 2004 Information Database (England) Regulations 2007.
Internet link:
www.opsi.gov.uk/si/si2007/uksi_20072182_en_1

National Service Framework for Children Young People and Maternity Services.
Internet link:
www.dh.gov.uk/en/Publicationsandstatistics/Publications/
PublicationsPolicyAndGuidance/DH_4089101

Building a safe, confident future: the final report of the Social Work Task Force.
Internet link:
www.dcsf.gov.uk/swtf

Government Response to the Social Work Task Force.
Internet link:
www.dcsf.gov.uk/swtf

Statutory guidance on making arrangements to safeguard and promote the welfare of children under section 11 of the Children Act 2004.
Internet link:
www.everychildmatters.gov.uk/resources-and-practice/IG00042/

Staying Safe: Action Plan.
Internet link:
www.dcsf.gov.uk/everychildmatters/_download/?id=443

When to suspect child maltreatment.
Internet link:
www.nice.org.uk/nicemedia/pdf/CG89FullGuideline.pdf

What to do if you're worried a child is being abused.
Internet link:
www.dcsf.gov.uk/everychildmatters/_download/?id=760

Responding to domestic abuse: A handbook for health professionals.
Internet link:
www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/
digitalasset/dh_4126619.pdf

Improving safety, Reducing Harm: Children, young people and domestic violence; a practical toolkit for front line practitioners.
Internet link:
www.dh.gov.uk/en/Publicationsandstatistics/Publications/
PublicationsPolicyAndGuidance/DH_108697

Safeguarding Children and Young People: Roles and competencies for Health Care Staff.
Internet link:
www.rcpch.ac.uk/doc.aspx?id_Resource=1535

Local Safeguarding Children Boards: A Review of Progress report.
Internet link:
www.dcsf.gov.uk/everychildmatters/_download/?id=3082

The Healthy Child Programme.
Internet link:
www.dh.gov.uk/en/Healthcare/Children/Maternity/index.htm

Good Medical Practice (GMC).
Internet link:
www.gmc-uk.org/GMC_Good_Medical_Practise_1209.pdf_30373048.pdf

Patients as Parents.
Internet link:
www.rcpsych.ac.uk/files/pdfversion/cr105.pdf

Child Abuse and Neglect: the Role of Mental Health Services.
Internet link:
www.rcpsych.ac.uk/files/pdfversion/cr120.pdf

Think child, think parent, think family: a guide to parental mental health and child welfare (SCIE Guide 30).
Internet link:
www.scie.org.uk/publications/guides/guide30/index.asp

Guidance on the Visiting of Psychiatric Patients by Children.
Internet link:
www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4012658.pdf

Guidance on Development of Local Protocols between Drug and Alcohol Treatment Services and Local Safeguarding and Family Services.
Internet link:
www.nta.nhs.uk/publications/documents/yp_drug_alcohol_treatment_protocol_1109.pdf

Safeguarding Children and Young People: Roles and Competencies for Health Care Staff.
Internet link:
www.rcpch.ac.uk/doc.aspx?id_Resource=1535

Guidance on Paediatric Forensic Examinations in Relation to Possible Child Sexual Abuse.
Internet link:
www.rcpch.ac.uk/doc.aspx?id_Resource=1750

Acting as an expert witness (GMC).
Internet link:
www.gmc-uk.org/guidance/ethical_guidance/expert_witness_guidance.asp

Medical Expert Witness: Guidance from the Academy of Medical Royal Colleges.
Internet link:
www.aomrc.org.uk

Child protection and the Dental Team – an introduction to safeguarding children in dental practice.
Internet link:
www.cpdt.org.uk/

Investigating Child Abuse and Safeguarding Children 2nd Edition.
Internet link:
www.npia.police.uk/en/14532.htm

Home Office Circular 017/2008.
Internet link:
www.homeoffice.gov.uk/about-us/publications/home-office-circulars/circulars-2008/017-2008/

The Use of Force to Control or Restrain Pupils.
Internet link:
www.teachernet.gov.uk/_doc/12187/ACFD89B.pdf

Statutory Framework for the Early Years Foundation Stage (EYFS).
Internet link:
http://nationalstrategies.standards.dcsf.gov.uk/earlyyears

Recruiting safely: Safer recruitment guidance helping to keep children and young people safe and associated materials.
Internet link:
www.cwdcouncil.org.uk/safeguarding/safer-recruitment/resources

Chapter 3

Children Act 2004.
Internet link:
www.opsi.gov.uk/acts/acts2004/ukpga_20040031_en_1

The Local Safeguarding Children Boards Regulations 2006, SI 2006/90.
Internet link:
www.opsi.gov.uk/SI/si2006/20060090.htm

Chapter 4

Carpenter et al. (2009) *The Organisation, Outcomes and Costs of Inter-agency Training to safeguard and promote the welfare of children*. London: Department for Children, Schools and Families

Induction guidance and supporting materials (CWDC).
Internet link:
www.cwdcouncil.org.uk/induction-standards

Training in relation to the child death review processes and Serious Case Reviews.
Internet link:
http://childdeath.ocbmedia.com/

The Common Core of Skills and Knowledge for the Children's Workforce.
Internet link:
www.dcsf.gov.uk/everychildmatters/strategy/deliveringservices1/commoncore/commoncoreofskillsandknowledge/

Department of Children, Schools and Families et al. (2008) *The Developing World of the Child*. Resource Pack. London: NSPCC.

Department for Education and Skills (2007) *Safeguarding Children – a shared responsibility*. London: NSPCC.

Department of Children, Schools and Families (2009) *Incredibly Caring*. Oxford: Radcliffe Publishing.

Department of Children, Schools and Families (2010) *The Child's World*. Training Resource. Second Edition. London, DCSF.

When to suspect child maltreatment (NICE).
Internet link:
www.nice.org.uk/nicemedia/pdf/CG89FullGuideline.pdf

Guidance on Investigating Child Abuse and Safeguarding Children (NPIA and ACPO).
Internet link:
www.npia.police.uk/en/14532.htm

Morrison, T. (2005) *Staff Supervision in Social Care*. Third edition. Brighton: Pavilion.

Building a safe, confident future: the final report of the Social Work Task Force.
Internet link:
www.dcsf.gov.uk/swtf

Bools, C. (2007) *Fabricated or induced illness in a child by a carer: A reader*. Oxford: Radcliffe Publishing.

Aldgate, J., Jones, J., Rose, W. and Jeffery, C. (Eds) (2006) *The Developing World of the Child*. London: Jessica Kingsley Publishers.

Cleaver, H., Cawson, P., Gorin, S. and Waller, S. (Eds) (2009): *Safeguarding Children: A Shared Responsibility*. Chichester: Wiley-Blackwell.

Horwath, J. (2009) *The Child's World: The Comprehensive Guide to Assessing Children in Need*. 2nd edition. London: Jessica Kingsley Publishers.

Providing Effective Supervision (Skills for Care/CWDC).
Internet link:
www.cwdcouncil.org.uk/providing-effective-supervision

Chapter 5

What to do if you are worried a child is being abused.
Internet link:
www.dcsf.gov.uk/everychildmatters/resources-and-practice/IG00182/

National Minimum Standards and regulations.
Internet link:
www.dcsf.gov.uk/everychildmatters/safeguardingandsocialcare/childrenincare/childrenincare/

Information Sharing: Guidance for practitioners and managers.
Internet link:
http://publications.everychildmatters.gov.uk/default.aspx?PageFunction=productdetails&PageMode=publications&ProductId=DCSF-00807-2008&

Framework for the Assessment of Children in Need and their Families.
Internet link:
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4003256

Volume 1 of the Children Act 1989 Guidance and Regulations, Court Orders.
Internet link:
www.dcsf.gov.uk/everychildmatters/publications/documents/childrenactguidanceregulations/

Recent research evidence on effective interventions in safeguarding children.
Internet link:
www.dcsf.gov.uk/cgi-bin/rsgateway/search.pl?cat=3&subcat=3_1&q1=Search

Bentovim, A., Cox A., Bingley Miller, L., and Pizzey, S (2009) *Safeguarding Children Living with Trauma and Family Violence. Evidence-Based Assessment, Analysis and Planning Interventions*. London, Jessica Kingsley Publishers.

Chapter 6

Safeguarding Children and Young People from Sexual Exploitation.
Internet link:
www.dcsf.gov.uk/everychildmatters/_download/?id=6021

Safeguarding Children in whom Illness is fabricated or induced.
Internet link:
www.dcsf.gov.uk/everychildmatters/_download/?id=3161

Complex Child Abuse Investigations: Inter-agency issues.
Internet link:
www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/fs/en

The Female Genital Mutilation Act 2003.
Internet link:
www.opsi.gov.uk/acts/acts2003/ukpga_20030031_en_1

Home Office Circular 10/2004.
Internet link:
www.homeoffice.gov.uk/about-us/publications/home-office-circulars/circulars-2004/010-2004/index.html

Dorkenoo et al. (2007). *A Statistical Study to Estimate the Prevalence of Female Genital Mutilation in England and Wales.* Available from FORWARD UK.

Local Authority Social Services Letter LASSL (2004)4.
Internet link:
www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Localauthoritysocialservicesletters/AllLASSLs/DH_4074779

The Right to Choose: Multi-agency statutory guidance for dealing with forced marriage.
Internet link:
www.fco.gov.uk/resources/en/pdf/3849543/forced-marriage-right-to-choose

Multi-agency practice guidelines: Handling cases of Forced Marriage.
Internet link:
www.fco.gov.uk/resources/en/pdf/3849543/forced-marriage-guidelines09.pdf

Forced marriage guidance for local authorities and relevant third parties.
Internet link:
www.justice.gov.uk/guidance/forced-marriage.htm.

Safeguarding Disabled Children – Practice Guidance.
Internet link:
www.dcsf.gov.uk/everychildmatters/_download/?id=6195

The Youth Justice and Criminal Evidence Act 1999.
Internet link:
www.opsi.gov.uk/Acts/acts1999/ukpga_19990023_en_1

Achieving Best Evidence in Criminal Proceedings: Guidance on vulnerable and intimidated witnesses including children.
Internet link:
www.homeoffice.gov.uk/documents/ach-bect-evidence/

Safeguarding Children from Abuse Linked to a Belief in Spirit Possession.
Internet link:
www.dcsf.gov.uk/everychildmatters/_download/?id=661

Safeguarding Children who may have been trafficked.
Internet link:
http://publications.everychildmatters.gov.uk/default.aspx?PageFunction=productdetails&PageMode=publications&ProductId=HMG-00994-2007&

Child Trafficking Strategic Threat Assessment (CEOP).
Internet link:
www.ceop.police.uk/publications

Safeguarding children and young people who may be affected by gang activity.
Internet link:
publications.everychildmatters.gov.uk/default.aspx?PageFunction=productdetails&PageMode=publications&ProductId=DCSF-00064-2010

Chapter 7

Guidance about Compliance Essential Standards of Quality and Safety (CQC).
Internet link:
www.cqc.org.uk/publications.cfm?fde_id=13512

Children and Young Persons Act 2008.
Internet link:
www.opsi.gov.uk/acts/acts2008/ukpga_20080023_en_1

Responding when a child dies. Training resources.
Internet link:
www.dcsf.gov.uk/everychildmatters/safeguardingandsocialcare/safeguardingchildren/childdeathreviewprocedures/trainingmaterials/trainingmaterials/

National templates for LSCBs to use when collecting information about child deaths.
Internet link:
www.dcsf.gov.uk/everychildmatters/safeguardingandsocialcare/safeguardingchildren/childdeathreviewprocedures/nationaltemplatesforlscbs/lscbtemplates/

Framework for the assessment of children in need and their families.
Internet link:
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_4003256

Foundation for Sudden Infant Deaths (2010) *The child death review: A guide for parents and carers.* Available to order from DCSF Publications, 00180-2010LEF-EN

Human Tissue Act 2004.
Internet link:
www.opsi.gov.uk/acts/acts2004/ukpga_20040030_en_1

LSCB designated person to whom child notifications should be sent by the DCSF.
Internet link:
www.everychildmatters.gov.uk/resources-and-practice/IG00351/

Guidance for coroners and Local Safeguarding Children Boards on the supply of information concerning the death of children.
Internet link:
www.justice.gov.uk/guidance/coroners-guidance.htm

Fleming P. J., Blair P. S., Bacon C., and Berry P. J. (2000) *Sudden Unexpected Death In Infancy. The CESDI SUDI Studies 1993-1996*. London: The Stationery Office.

Resuscitation Council (UK) (2005) *UK Resuscitation Guidelines*.
Internet link:
www.resus.org.uk/pages/guide.htm

Sudden unexpected death in infancy. A multi-agency protocol for care and investigation.
Internet link:
www.rcpath.org

The Report of a working group convened by the Royal College of Pathologists and the Royal College of Paediatrics and Child Health.
Internet link:
www.rcpath.org

The Coroners (Amendment) Rules 2008.
Internet link:
www.opsi.gov.uk/si/si2008/uksi_20081652_en_1

Chapter 8

The Local Safeguarding Children Boards Regulations 2006, Statutory Instrument no. 2006/90.
Internet link:
www.opsi.gov.uk/SI/si2006/20060090.htm

Safeguarding Disabled Children: Practice guidance (2009). London: Department for Children, Schools and Families.
Internet link:
www.dcsf.gov.uk/everychildmatters/_download/?id=6195

Fish S., Munro E. and Bairstow S. (2008) *SCIE Report 19: Learning together to safeguard children: developing a multi-agency systems approach for case reviews*. London: Social Care Institute for Excellence.
Internet link:
www.scie.org.uk/publications/reports/report19.asp

Prisons and Probation Ombudsman (PPO) Fatal Incidents Investigation
Internet link:
www.ppo.gov.uk/investigating-fatal-accidents.html

Serious Further Offence (SFO) Probation Circular 22/2008 – Revised Notification and Review Procedures for Serious Further offences
Internet link:
www.probation.homeoffice.gov.uk/output/page31.asp

MAPPA Serious Case Review (MSCR).
Internet link:
www.probation.homeoffice.gov.uk/output/page30.asp

How best to liaise with the coroner. See guidance for coroners on reports to prevent future deaths and on the supply of information concerning the death of children
Internet link:
www.justice.gov.uk/guidance/coroners-guidance.htm

Chapter 9

Brandon, M., Bailey, S., Belderson, P., Gardner, R., Sidebottom, P., Dodsworth, J., Warren, C. and Black, J. (2009) *Understanding Serious Case Reviews and their Impact: A Biennial Analysis of Serious Case Reviews 2005-7*. London: Department for Children Schools and Families.

Montgomery, P., Ramchandani, P., Gardner, F., and Bjornstad, G. (2009) *Systematic reviews of interventions following physical abuse: helping practitioners and expert witnesses improve the outcomes of child abuse*. London: Department for Children, Schools and Families.

Barlow, J., and Schrader-MacMillan, A. (2009) *Safeguarding Children From Emotional Abuse – What Works?* London: Department for Children Schools and Families. DCSF-RBX-09-09.

Jones, D. P. H. and Ramchandani, P. (1999) *Child Sexual Abuse. Informing Practice from Research*. Abingdon: Radcliffe Medical Press Ltd.

Daniel, B., Taylor, J., and Scott, J. (2009) *Noticing and helping the neglected child*. London: Department for Children, Schools and Families. DCSF – RBX-09-03.

Stein, M., Rees, G., Hicks, L. and Gorin, S. (2009) *Neglected adolescents: a review of the research and the preparation of guidance for multi-disciplinary teams and a guide for young people*. London: Department for Children, Schools and Families. DCSF-RBX-09-04.

Home Office (2009) *What is Domestic Violence?* London: Home Office.

Cleaver, H., Unell, I. and Aldgate, A. (2010) *Children's Needs – Parenting Capacity: The impact of parental mental illness, learning disability, problem alcohol and drug use, and domestic violence on children's safety and development. 2nd Edition*. London: The Stationery Office.

The Protection of Children in England: A Progress Report.
Internet link:
http://publications.everychildmatters.gov.uk/eOrderingDownload/HC-330.pdf

Humphreys, C. and Stanley, N. (eds) (2006) *Domestic Violence and Child Protection*. London: Jessica Kingsley Publishers.

Hester, M., Pearson, C. and Harwin, N. with Abrahams, H. (2007) *Making an impact: children and domestic violence*: *A reader. 2nd Edition*. London: Jessica Kingsley Publishers.

Onyskiw, J. E. (2003) 'Domestic Violence and Children's Adjustment: A Review of Research.' *Journal of Emotional Abuse 3*, 1/2, 11-45.

Mental Health Act 2007.
Internet link:
www.opsi.gov.uk/acts/acts2007/ukpga_20070012_en_1

Office for National Statistics (2006) *Labour Force Surve*y. London: The Stationary Office.

Melzer, D. (2003) 'Inequalities in mental health: A systematic review.' *The research findings register, Summary No. 1063*. London: Department of Health.

Reupert, A. and Maybery, D. (2007) 'Families Affected by Parental Mental Illness; A Multiperspective Account of Issues and Interventions.' *American Journal of Orthopsychiatry 77*, 3, 362-369.

Egeland, B. (2009) 'Taking stock: Childhood emotional maltreatment and developmental psychopathology.' *Child Abuse & Neglect 33*, 1, 22-27.

Tunnard, J. (2004) *Parental Mental Health Problems: Key Messages from Research, Policy and Practice*. Dartington: Research in Practice.

Klein, D., Clark, D., Dansky, L. and Margolis, E.T. (1988) 'Dysthymia in the offspring of parents with primary unipolar affective disorder.' *Journal of Abnormal Psychology 94*, 1155-1127.

Green, H., McGinnity, A., Meltzer, H., Ford, T. and Goodman, R. (2005) *Mental health of children and young people in Great Britain, 2004*. London: Office for National Statistics.

Weissman, M. M., John, K., Merikangas, K. R., Prusoff, B. A., Wickramaratne, P., Gammon, G. D., Angold, A. and Warner, V. (1986) 'Depressed parents and their children: General health, social and psychiatric problems.' *American Journal of Diseases of Children 140*, 801-805.

Somers, V. (2007) 'Schizophrenia: The Impact of Parental Illness on Children.' *British Journal of Social Work 37*, 8, 1319-1334.

Hoare, J. and Flatley, J. (2008) *Drug Misuse Declared: Finding from the 2007/08 British Crime Survey, England and Wales*. London: Home Office Statistical Bulletin.

Advisory Council on the Misuse of Drugs (2003) *Hidden harm: Responding to the needs of children of problem drug users.* London: Home Office.

Hogan, D. and Higgins, L. (2001) *When Parents Use Drugs: Key Findings from a Study of Children in the Care of Drug-using Parents*. Dublin: The Children's Research Centre.

Cleaver, H., Nicholson, D., Tarr, S. and Cleaver, D. (2007) *Child Protection, Domestic Violence and Parental Substance Misuse: Family Experiences and Effective Practice*. London: Jessica Kingsley Publishers.

Velleman, R. and Templeton, L. (2007) 'Understanding and modifying the impact of parental substance misuse on children.' *Advances in Psychiatric Treatment 13*, 79-89.

Cleaver, H. and Nicholson, D. (2007) *Parental Learning Disability and Children's Needs: Family Experiences and Effective Practice*. London: Jessica Kingsley Publishers.

Julien, R. M. (1995) *A Primer of Drug Action: A Concise, Non-Technical Guide to the Actions, Uses, and Side Effects of Psychoactive Drugs. 7th Edition*. New York: W.H. Freeman and Co.

Standing Conference on Drug Misuse (SCODA) (1997) *Working with Children and Families Affected by Parental Substance Misuse.* London: Local Government Association Publications.

Powell, J. and Hart, D. (2001) 'Working with Parents who Use Drugs.' In R. Gordon and E. Harran (eds) *Fragile handle with care: protecting babies from harm: Reader.* Leicester: NSPCC.

Barnard, M. (2007) *Drug Addiction and Families.* London: Jessica Kingsley Publishers.

Covell, K. and Howe, R. B. (2009) *Children, families and violence: Challenges for children's rights*. London: Jessica Kingsley Publishers.

Safe. Sensible. Social. The next steps in the National Alcohol Strategy.
Internet link:
www.dh.gov.uk/en/Publicationsandstatistics/Publications/
PublicationsPolicyAndGuidance/DH_075218

General Lifestyle Survey 2008 (2010) *Smoking and Drinking among adults 2008*. London: Office of National Statistics.

ChildLine (1997) *Beyond the limit: children who live with parental alcohol misuse*. London: ChildLine.

Updated NICE guideline on care and support that women should receive during pregnancy. Internet link:
www.nice.org.uk/media/E5D/8B/2008022AntenatalCare.pdf

Abel, E. L. (1998) 'Fetal Alcohol Syndrome: The American Paradox.' *Alcohol and Alcoholism 33*, 3, 195-201.

Macleod, J., Hickman, M., Bowen, E., Alati, R., Tilling, K. and Davey Smith, G. (2008) 'Parental drug use, early adversities, later childhood problems and children's use of tobacco and alcohol at age 10: birth cohort study.' *Addiction 103,* 1731-43.

Li, C., Pentz, A. and Chou, C-P. (2002) 'Parental substance use as a modifier of adolescent substance use risk.' *Addiction 97*, 1537-50.

Velleman, R. and Orford, J. (2001) *Risk and Resilience: Adults who were the children of problem drinkers*. Amsterdam: Harwood Academic Publishers.

Quilgars, D., Johnsen, S. and Pleace, N. (2008) *Youth homelessness in the UK. A decade of progress?* York: Joseph Rowntree Foundation.

Cm 5086 (2001) *Valuing People: A New Strategy for Learning Disability for the 21st Century*. London: The Stationery Office. Cm 5086 2001, p.14, paragraph 1.5

Emerson E. and Hatton, C. (2008) *People with Learning Disabilities in England*. Lancaster: Centre for Disability Research.

Department of Health and Department for Education and Skills (2007) *Good practice guidance on working with parents with a learning disability*. London: Department of Health.

Booth, T. and Booth, W. (2002) 'Men in the Lives of Mothers with Intellectual Disabilities'. *Journal of Applied Research in Intellectual Disabilities 15*, 187-199.

James, H. (2004) 'Promoting Effective Working with Parents with Learning Disabilities.' *Child Abuse Review 13*, 1, 31-41.

Framework for the Assessment of Children in Need and their Families. Internet link:
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4003256

Social Services Inspectorate (2000) *A Jigsaw of Services: Supporting disabled adults in their parenting role*. London: Department of Health.

Working Together with Parents Network (2009). Supporting parents with learning disabilities and difficulties: stories of positive practice Norah Fry Research Centre. DH/DCSF Joint Good Practice Guidance on Supporting Parents with a Learning Disability
Internet link:
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_075119

Supporting disabled parents and parents with additional support needs (SCIE).
Internet link:
www.scie.org.uk/publications/knowledgereviews/kr11.pdf

James, H. (2004) 'Promoting Effective Working with Parents with Learning Disabilities.' *Child Abuse Review 13*, 1, 31-41.

McGaw, S. and Newman, T. (2005) *What works for parents with learning disabilities*. Essex: Barnardo's.

McGaw, S., Ball, K. and Clark, A. (2002) 'The effect of group intervention on the relationships of parents with intellectual disabilities'. *Journal of Applied Research in Intellectual Disabilities 15*, 4, 354-366.

Tarleton, B., Ward, L. and Howarth, J. (2006) *Finding the right support? A review of issues and positive practice to support parents with learning difficulties and their children*. London: The Baring Foundation.

C4EO (2010) *Knowledge Review – Effective practice to protect children living in 'highly resistant' families.*
Internet link:
www.c4eo.org.uk/themes/safeguarding/default.aspx?themeid=11&accesstypeid=1

Chapter 10

Statutory guidance on making arrangements to safeguard and promote the welfare of children under section 11 of the Children Act 2004.
Internet link:
www.dcsf.gov.uk/everychildmatters/resources-and-practice/IG00042/

Families at Risk Review.
Internet link:
www.cabinetoffice.gov.uk/social_exclusion_task_force/families_at_risk.aspx

Farrington and Welsch (2007) Saving children from a life of crime; Farrington and Welsh (2003). Meta analysis in ANZJC.

NICE (2006) *Parent – Training/education programmes in the management of children with conduct disorders*. In NICE Technology appraisal guidance 102.

Friedli and Parsonage (2007) *Mental Health Promotion: Building an Economic Case*. Northern Ireland Association for Mental Health.

The Dad Test
Internet link:
www.think-fathers.org

Chapter 11

Fostering Services: National Minimum Standards – 9.8

Children Act 1989 guidance on private fostering (2005).
Internet link:
www.dcsf.gov.uk/everychildmatters/safeguardingandsocialcare/safeguardingchildren/privatefostering/fostering

Department of Health and the Department for Education and Skills (2004) *The National Service Framework for Children, Young People and Maternity Services*. London: Department of Health

The Healthcare Commission undertook an improvement review of the NHS implementation of the hospital standard in 2006.
Internet link:
www.cqc.org.uk/_db/_documents/children_improving_services_Tagged.pdf

When to share information: best practice guidance for everyone working in the youth justice system.
Internet link:
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084703

Healthy Children, Safer Communities: a strategy and action plan to promote the health and well being of those in contact with the youth justice system.
Internet link:
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_109771

Review of people with mental health problems or learning disabilities in the criminal justice system (the Bradley report).
Internet link:
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_098694

The law, policy and guidance for schools and the tackling school bullying guidance.
Internet link:
http://publications.teachernet.gov.uk/default.aspx?PageFunction=productdetails&PageMode=publications&ProductId=DCSF-00668-2007

Safe to Learn: Embedding Anti-bullying Work in Schools.
Internet link:
www.teachernet.gov.uk/wholeschool/behaviour/tacklingbullying/racistbullying/

New guidance for schools on preventing and tackling sexist, sexual and transphobic bullying.
Internet link:
www.teachernet.gov.uk/wholeschool/behaviour/tacklingbullying/sexistsexualandtransphobicbullying/

DVD Resource pack on bullying related to SEN and disabilities.
Internet link:
www.teachernet.gov.uk/wholeschool/behaviour/tacklingbullying/sendisab/

Prevent Strategy.
Internet link:
www.dcsf.gov.uk/violentextremism

Framework for the Assessment of Children in Need and their Families.
Internet link:
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4003256

Improving safety, Reducing harm: Children, young people and domestic violence – A practical toolkit for front line practitioners.
Internet link:
www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_108704.pdf

A *vision for services for children and young people affected by domestic violence* (LGA, ADSS, Women's Aid and Cafcass, 2005).
Internet link:
http://new.lga.gov.uk/lga/aio/1224298

Statutory guidance setting how local authorities and agencies should respond when a child or young person goes missing from home or care.
Internet link:
www.dcsf.gov.uk/everychildmatters/_download/?id=6178

Identifying and maintaining contact with children missing, or at risk of going missing, from education.
Internet link:
http://publications.everychildmatters.gov.uk/default.aspx?PageFunction=productdetails&PageMode=publications&ProductId=LEA%2F0225%2F2004&

Chapter 12

Guidance on offences against children (Home Office Circular 16/2005)
Internet link:
www.homeoffice.gov.uk/about-us/publications/home-office-circulars/circulars-2005/016-2005/

National MAPPA Guidance.
Internet link:
www.probation.homeoffice.gov.uk/output/page30.asp

Risk Identification tool.
Internet link:
www.caada.org.uk/searchresult.html?sw?risk%20identification%20checklist

Managing Sexual Offenders and Violent Offenders (ACPO).
Internet link:
www.homeoffice.gov.uk/about-us/publications/home-office-circulars.

Appendix 3

Bentovim, A. and Bingley Miller, L. (2001) *The Family Assessment*. Brighton: Pavilion Publishers.

Birleson, P. (1980) The validity of depressive disorder in childhood and the development of a self-rating scale: A research report. *Journal of Child Psychology & Psychiatry 22*, 73-88.

Brugha, T., Bebington, P., Tennant, C. and Hurry, J. (1985) The list of threatening experiences: A subset of 12 life event categories with considerable long-term contextual threat. *Psychological Medicine 15*, 189-194.

Cox, A. and Walker, S. (2002) *The Home Inventory*. Brighton: Pavilion Publishers.

Crnic, K. A. & Greenberg, M. T. (1990) Minor parenting stresses with young children. *Child Development 61*, 1628 – 1637.

Crnic, K. A. & Booth, C. L. (1991) Mothers' and fathers' perceptions of daily hassles of parenting across early childhood. *Journal of Marriage and the Family 53*, 1043 – 1050.

Davie, C. E., Hurt, S. J., Vincent, E. and Mason, M. (1984) *The young child at home*. Windsor: NFER-Nelson.

Department of Health (2000) *The Family Pack of Questionnaires and Scales*. London: The Stationery Office.

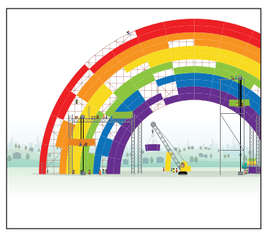
Goodman, R. (1997) The Strengths and Difficulties Questionnaire: A Research Note. *Journal of Child Psychology and Psychiatry 38*, 581 – 586.

Goodman, R., Meltzer, H. and Bailey, V. (1998) The strengths and difficulties questionnaire: A pilot study on the validity of the self-report version. *European Child and Adolescent Psychiatry 7*, 125 – 130.

Piccinelli, M., Tessari, E., Bortolomasi, M., Piasere, O., Semenzin, M., Garzotto, N. and Tansella, M. (1997) Efficacy of the alcohol use disorders identification test as a screening tool for hazardous alcohol intake and related disorders in primary care: A validity study. *British Medical Journal 514*, 420 – 424.

Smith, M. A. (1985) *The Effects of Low Levels of Lead on Urban Children: The relevance of social factors*. Ph.D. Psychology, University of London.

Snaith, R. P., Constantopoulos, A. A., Jardine, M. Y. and McGuffin, P. (1978) a clinical scale for the self-assessment for irritability. *British Journal of Psychiatry 132*, 164 – 171.



You can download this publication at
http://publications.dcsf.gov.uk/default.aspx?PageFunction=productdetails&PageMode=publications&ProductId=DCSF-00305-2010

Search using ref: DCSF-00305-2010

Copies of this publication can be obtained from:

DCSF Publications
PO Box 5050
Sherwood Park
Annesley
Nottingham NG15 0DJ
Tel: 0845 60 222 60
Fax: 0845 60 333 60
Textphone: 0845 60 555 60

Please quote the ref: 00305-2010DOM-EN

ISBN: 978-1-84775-715-9

D16(8643)/0310